



ROCHDALE BOROUGH  
SAFEGUARDING ADULTS BOARD

## **Safeguarding Adult Review Adult H**

Presented to the Rochdale Borough Safeguarding Adults Board on  
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## **1. Introduction to the Review and Methodology**

**1.1.** This Safeguarding Adult Review was commissioned by the Rochdale Borough Safeguarding Adults Board.

**1.2.** Upon reflection of discussion had by the Safeguarding Adult Review Screening Panel the Independent Chair of Rochdale Borough Safeguarding Adults Board concluded that the criteria for the review were met.

**1.3.** Adult H sadly died on the 13<sup>th</sup> of February 2021 in hospital. Adult H had undergone lifesaving emergency surgery in his best interests after he had been admitted into the hospital having been found unresponsive in a bus stop suffering frostbite, rhabdomyolysis<sup>1</sup> and acute kidney injury.

**1.4.** The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant 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.

**1.5.** Allison does not have any current links to Rochdale Borough Safeguarding Adults Board or any of its partner agencies.

**1.6.** A multi-agency review panel<sup>2</sup> met on the 27<sup>th</sup> of September 2022 and considered the scope of the review. The panel decided that the review should focus upon the period from the 1<sup>st</sup> of November 2020, around the time a member of public reported Adult H to be presenting in an unresponsive state, until the 13<sup>th</sup> of February 2021, when Adult H died.

**1.7.** The panel agreed the Terms of Reference<sup>3</sup> and additional information was requested from the agencies involved to aid the review process.

**1.8.** The panel met on two further occasions to discuss the case and learning and to monitor the progress of the review. These meetings incorporated a practitioner learning event which was attended by professionals from the key agencies who had worked with Adult H<sup>4</sup>. Contribution from the participants generated positive discussion around both good practice and areas of practice that could be developed and improved; this has formed the basis of this report.

**1.9.** It was agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Safeguarding Adult Review process will drive Rochdale Borough Safeguarding Adults Board, and its partner agencies, to develop an action plan that will respond directly to the identified learning.

**1.10.** Panel members had an opportunity to review the final draft of the report and discuss the learning prior to presentation to Rochdale Borough Safeguarding Adults Board.

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<sup>1</sup> Muscle tissue breakdown which leads to muscle fibre contents entering the blood and can cause kidney damage

<sup>2</sup> The panel consisted of representatives from Pennine Care Foundation Trust, Adult Social Care, Northern Care Alliance, Greater Manchester Police, Manchester Foundation Trust, Integrated Care System, Rochdale Borough Safeguarding Board, West Yorkshire Police.

<sup>3</sup> Refer to Appendix 1

<sup>4</sup> West Yorkshire Police, Manchester City Council, Pennine Care Foundation Trust, Adult Social Care, Greater Manchester Police, Manchester Foundation Trust, Rochdale Borough Safeguarding Board.

## **2. Family Engagement**

**2.1.** Family engagement is an important part of the review process. Discussion with family members about the support offered to a subject of a review is hugely beneficial to identifying both good practice, and practice which can be improved upon.

**2.2.** Rochdale Borough Safeguarding Adults Board contacted Adult H's ex-partner and explained the Safeguarding Adult Review process. Initially Adult H's ex-partner agreed to speak with the reviewer but subsequent messages from the reviewer and letters and emails from the Board have not been responded to. The reviewer and the Board understand and respect her decision to not be part of this process.

**2.3.** Rochdale Borough Safeguarding Adults Board has attempted letter contact with a sibling of Adult H's but have not received a response. Again, the reviewer and the Board understand and respect the decision to not be part of this process.

**2.4.** The Board, reviewer and panel members would like to extend their condolences to all members of Adult H's family.

## **3. Parallel Processes**

**3.1.** The cause of Adult H's death is recorded on the death report as Pneumonia, caused by Acquired Immunodeficiency Syndrome, with a Cytomegalovirus Infection contributing to the process.

**3.2.** Following notification of Adult H's death to HM Coroner, confirmation has been had that an inquest will not be held in this case.

**3.3.** Pennine Care carried out a Table Top Review. This has been shared within this Safeguarding Adult Review process. A list of the recommended actions can be found at Appendix 2.

## **4. Background Information**

**4.1.** Adult H was born in Zimbabwe. He came to live in the United Kingdom in 2005 and is known to have lived in multiple counties across the country.

**4.2.** Though it cannot be verified, this review has been informed that Adult H had family connections to the Rochdale area by way of two siblings. Adult H also has a child (age unconfirmed but thought to now be around 7/8 years of age), who lives with his ex-partner in the West Midlands.

**4.3.** In 2006 Adult H was refused Indefinite Leave to Remain in the United Kingdom.

**4.4.** In December 2006 Adult H was confirmed HIV positive. He was referred to the Department of Infectious Diseases and Tropical Medicine where he was reviewed as an outpatient until December 2007 (it has not been possible to establish why Adult H stopped engaging with his HIV reviews).

**4.5.** In November 2010 Adult H was served immigration paperwork as an overstayer.

**4.6.** In 2012 Adult H was sentenced to 14 months imprisonment for fraud offences committed in 2009. Due to this criminality, Adult H was made subject of a deportation order in July 2013. However, whilst Adult H did not have right to remain in this country, he was offered voluntary deportation due to unrest in Zimbabwe.

**4.7.** The Home Office has advised this review that voluntary deportation, also known as the Voluntary Returns Service, differs from 'deportation'. It is used when a foreign national who has become an immigration overstayer in the United Kingdom, wants to return to their country but in order to do so, requires assistance from the Home Office. The assistance can range from the Home Office returning their passport to providing financial assistance. Depending on the country the person is returning to, depends on what assistance the person is entitled to. A person returning to their country can receive a re-entry ban into the United Kingdom (ranging from 1-5 years), but in some circumstances, there is no re-entry ban.

**4.8.** The voluntary deportation status caused Adult H not to be forcibly deported and he was thus able to apply for asylum. However, Adult H did not apply for asylum and was consequently left without recourse to public funds.

**4.9.** Immediately prior to the scoping period of this review, (on the 31<sup>st</sup> of October 2020) Police Officers attended Adult H's ex-partner's address after she had reported that Adult H had locked her and their daughter out.

**4.10.** Adult H's ex-partner told the attending officers that Adult H had recently been discharged from hospital after being admitted with an infection and issues with mobility in his legs. She said that Adult H had been staying at her address since discharge as he had said that he wanted to spend some time with their child before he requested his voluntary departure and returned to Zimbabwe.

**4.11.** Adult H was sat on a chair in the kitchen staring at the walls. After about an hour, Adult H managed to answer the door. He presented as confused and dazed and said that he hadn't answered the door because he could hear a noise from far away. His ex-partner said that he had previously mentioned hearing the devil and had said that the devil was inside him.

**4.12.** Paramedics assessed Adult H. He had a low temperature and confusion. Due to the infection, Adult H was transported to hospital but there were deemed to be no medical issues. Because Adult H's ex-partner had said that she didn't want him back at the address due to his behaviour, the police took Adult H to the police station with the intention of contacting housing solutions. Adult H refused to enter the station and officers were unable to engage him. Adult H said he was going to try and stay with a friend but would not disclose who the friend was.

## **5. Consideration and Analysis of Key Practice Episodes**

To enable the review to meet the Terms of Reference, professionals explored the following key practice episodes with the Independent Reviewer. Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Adult H. The episodes do not form a complete history but are thought key from a practice perspective and summarise the significant professional involvements that informed the review.

Key Practice Episodes	Dates
Adult H's Hospital Admission under Section 2 Mental Health Act and Discharge	3 <sup>rd</sup> of November 2020 – 21 <sup>st</sup> of December 2020
Professional Response to Adult H Being Found at the Bus Stop and Deemed to Require Surgery.	30 <sup>th</sup> of December 2020 – 22 <sup>nd</sup> of January 2021
Adult H's Post Operative Care	22 <sup>nd</sup> of January 2021 – 13 <sup>th</sup> of February 2021

### Key Practice Episode 1

#### ***Adult H's hospital admission under Section 2 of the Mental Health Act and discharge***

**5.1.** On the 3<sup>rd</sup> of November 2020 paramedics attended Adult H following concerns from a member of the public who had observed Adult H to be staring at the same spot in the sky for several hours. Paramedics attempted to engage Adult H in conversation, but he continued to stare into space. Adult H was transported to the Accident and Emergency Department at Bradford Royal Infirmary. Upon arrival, Adult H still did not speak. Because Adult H had urinated in his clothing, staff at the hospital attempted to help him to undress and get into something clean, but Adult H made an inappropriate sexualised comment which resulted in security removing him.

**5.2.** On the 4<sup>th</sup> of November 2020 a member of the public contacted 999 at 12:09 hours and reported that Adult H had been sitting at a bus stop unresponsive for two hours. Ambulance crew attended but other than giving a name, Adult H would not communicate with them. Adult H was taken to Bradford Royal Infirmary where following assessment, he was detained under section 2 of the Mental Health Act<sup>5</sup>.

**5.3.** It was established using NHS Spine<sup>6</sup> that Adult H was a Rochdale patient. Subsequently on the 6<sup>th</sup> of November 2020 Adult H was transferred to the Oak Ward in Oldham (there was no beds available in Rochdale at that time) where he stayed until a bed became available for him at the Hollingworth Ward in Rochdale on the 13<sup>th</sup> of November 2020.

**5.4.** When Adult H first arrived on the Hollingworth Ward, he was observed to be doubly incontinent. This review has been informed by some practitioners that, following being placed in a room with a bathroom, his incontinence was resolved. Case notes contradict this with reports of incontinence continuing sporadically.

**5.5.** Although Adult H presented as frail and often needed help to walk, his interaction with the staff on the ward was limited and he would sometimes refuse their care. Staff struggled to engage with Adult H and consequently struggled to gain insight into his circumstances.

**5.6.** On the 23<sup>rd</sup> of November 2020 staff contacted the Home Office and learned that Adult H was HIV positive. This information had not been recorded on Adult H's available health records<sup>7</sup>.

**5.7.** Staff on the ward referred Adult H to Adult Social Care for a Care Act assessment. Following Adult Social Care receiving this referral on the 24<sup>th</sup> of November 2021, a Social Worker contacted the Home Office for

<sup>5</sup> Section 2 Mental Health Act is the legal power that allows a person to be placed in a psychiatric hospital without that person's consent and against their will. It allows the hospital authorities to keep a person in hospital for a time up to 28 days from the date of detention.

<sup>6</sup> The NHS Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems across 20,500 organisations.

<sup>7</sup> It is a recognised risk when individuals move between areas that significant information can become 'lost' or not communicated, this appears to have happened in Adult H's case. Factors such as areas working on different health record systems contribute to this.

more information and was informed that Adult H had been due to be deported in 2014 but had absconded. Consequently, Adult Social Care was advised by its legal team to complete a Human Rights Assessment and establish Ordinary Residence<sup>8</sup>.

**5.8.** It was necessary to establish Ordinary Residence as the Local Authority where the person is 'ordinarily resident' is the authority with the responsibility under the Care Act to meet any eligible needs for care and support, that the person may have.

**5.9.** Unfortunately, the Social Worker was unable to engage Adult H in the assessment process. The Social Worker considered whether an advocate or a translator might assist, but during a discussion with Adult H's ex-partner, the Social Worker was assured that Adult H was fluent in English and did not require a translator. This was concurred by staff on the ward who also reported that Adult H was assumed to have capacity to make decisions about his health and care needs. Thereon the Social Worker concluded that advocacy was not necessary either as Adult H (with capacity and a thorough understanding of English) could understand the information being discussed with him.

**5.10.** Healthcare professionals deemed no evidence of Adult H enduring mental illness. Therefore, following Adult H's detention (under section 2 of the Mental Health Act) expiring on the 3<sup>rd</sup> of December 2020, attempts were made to engage Adult H with the migration helpline to help him seek asylum. Adult H did not accept the help and said that he did not want asylum. This review has been informed that Adult H's capacity was not considered at this time.

**5.11.** With discharge imminent and Adult H having no fixed abode, or recourse to public funds, the Social Worker asked healthcare professionals on the ward whether Adult H could be referred to an acute medical ward due to his renal issues, mobility issues and current unmedicated HIV status. The Social Worker was informed that this could only be done if Adult H's GP referred him to the sexual health outreach. However, Adult H was not registered with a local GP at that time.

**5.12.** Advice was sought from the Engagement Officer in the Homelessness Team and the Social Worker attempted further discussion with Adult H around his accommodation situation but Adult H

- did not respond to offers of assistance,
- insisted (despite assurance that under the circumstances he would be allowed to travel) that he couldn't go and live with family because there was a Covid ban on travel, and
- would not give the required consent for the Social Worker to apply for a Greater Manchester bed for people who did not have recourse to public fund.

**5.13.** Consequently, the Social Worker sought legal advice and was assured that there was nothing more Adult Social Care could offer at this time.

**5.14.** Upon discharge on the 22<sup>nd</sup> of December 2020, Adult H told staff on the ward that he was going to be staying at a 'friends' house in 'Moston'. He said he did not know the address details, but he denied homelessness. Staff ensured that Adult H had a contact number for the Migrant Helpline, and discharged him with clothing donated from the ward, a food voucher, and a safety plan by means of a 72-hour telephone review. He was also offered homelessness accommodation but refused.

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<sup>8</sup> 'Ordinary residence refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration'. [Ordinary Residence \(proceduresonline.com\)](http://proceduresonline.com). There is no definition of Ordinary Residence in the Care Act or any other legislation but statutory guidance states that the natural meaning of the term should apply, as used in the Shah case 1983

**5.15.** The ward asked Adult H to make contact the following day and advise of the address, but this was never done, and it remains unknown whether the friend in Moston existed.

**5.16.** The Home Office had requested the ward forward Adult H's address upon discharge. Staff contacted the Home Office to confirm discharge and explained that no address had been provided.

**5.17.** Whilst it is recognised that Adult H's discharge process was complicated by Adult H not having leave to remain in the United Kingdom and no recourse to public funds, it is clear that the Social Worker and staff on the ward attempted to support a safe discharge for Adult H with the input of homelessness and the Home Office. However, for unknown reasons Adult H was unable to engage with the process.

## **Key Practice Episode 2**

### **Professional Response to Adult H Being Found at the Bus Stop and Deemed to Require Surgery.**

**5.18.** On the 30<sup>th</sup> of December 2020 Adult H was admitted to North Manchester General Hospital after being found in a bus stop.

**5.19.** As previously mentioned, Adult H was suffering frostbite, rhabdomyolysis, and acute kidney injury. Adult H was initially treated as having sepsis. He was deemed to require bilateral leg amputation and a blood transfusion but refused both.

**5.20.** On the 2<sup>nd</sup> of January 2021 the ward referred Adult H to the Tissue Viability Nurse, Podiatry and for Social Work assessment.

**5.21.** On the 6<sup>th</sup> of January 2021 due to doubts around capacity following Adult H expressing a wish to discharge himself despite being unable to stand, the ward requested Mental Health Liaison services.

**5.22.** Adult H was seen by a Mental Health Liaison Practitioner on the 17<sup>th</sup> of January 2021. It was decided that a referral to the legal team was needed, and due to the complexity of the situation, liaison support should be offered with a capacity assessment.

**5.23.** Adult H continued to refuse treatment.

**5.24.** On the 18<sup>th</sup> of January 2021 during a Mental Health Assessment which determined that there was no evidence of acute mental illness, the Doctor questioned if there was a disease of the brain given Adult H's high viral count. The Doctor documented that 'on probability, it appeared that Adult H lacked capacity to give informed consent regarding his treatment plan'. The Doctor advised the medical team to seek advice from the Trust legal team and to refer Adult H for an Independent Mental Capacity Advocate. The Doctor also recommended a Best Interests meeting at the earliest opportunity.

**5.25.** An Independent Mental Capacity Advocate visited Adult H the following day but was unable to engage him. The advocate advised that an application be made to the Court of Protection.

**5.26.** Adult H continued to refuse treatment, although he did allow bloods to be taken on one occasion. He was noted to be clinically deteriorating and the medical team felt that surgery was a Best Interests decision and should not be delayed whilst waiting for the Court of Protection.

**5.27.** On the 21<sup>st</sup> of January 2021 Adult H agreed to talk to a Judge who 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.



**5.28.** Surgery was performed overnight.

### **Key Practice Episode 3**

#### **Post Operative Care**

**5.29.** Following surgery, Adult H started to engage with nurses, medical staff, and the Physiotherapy team - on the 29<sup>th</sup> of January 2021 Adult H consented to referral for a wheelchair and prosthetic limb and the following day, started oral diet and fluid.

**5.30.** On the 30<sup>th</sup> of January 2021 Adult H was transferred to the Infectious Diseases ward, but the following day, due to high blood pressure, temperature, and heart rate, Adult H was readmitted to the Intensive Care Unit.

**5.31.** Due to this Unit being an inappropriate environment for a psychiatric assessment, Adult H was discharged from the Mental Health Team. Staff were advised to re refer if needed.

**5.32.** Over the next few days Adult H's health appeared to improve. He was described as more lucid and brighter, and he was engaging with practitioners. Despite Adult H becoming delirious and hallucinating on the 5<sup>th</sup> of February 2021, on the 6<sup>th</sup> of February 2021 Adult H said he understood his treatment and care and he was stepped down from the Intensive Care Unit back to the Infectious Diseases ward.

**5.33.** Within days Adult H was talking of discharge and discussing wheelchair and prosthesis. A referral was made on the 8<sup>th</sup> of February 2021 for a Social Work Assessment and Discharge Nurse Assessment but sadly, Adult H's health deteriorated and on the 13<sup>th</sup> of February 2021 Adult H passed away.

## **6. Thematic Analysis**

### **Cultural Curiosity**

**6.1.** Adult H was born in Zimbabwe. This review has been informed that he moved to the United Kingdom in 2005 from the city of Bulawayo in Zimbabwe.

**6.2.** Since the late 20th century, Bulawayo has suffered a fall in living standards coinciding with the protracted economic crisis affecting the country<sup>9</sup>. The main challenges the city faces include underinvestment, weakening infrastructure, de-industrialisation and the effects of corruption and discrimination. This review heard from a professional who used to live in the city, that consequently many of its educated workers have migrated south to neighbouring South Africa or further afield to the United Kingdom, Canada, and Australia.

**6.3.** Professionals knew that Adult H had moved from Bulawayo and by chance, some nursing staff working with Adult H had also moved to the United Kingdom from the city. These staff members attempted to speak to Adult H about the city, but he didn't connect. This review has seen no reference to any other professional working with Adult H, striving to understand his culture and background.

**6.4.** Professionals may worry that acknowledging cultural differences could be perceived as negative stereotyping and be considered discrimination. But understanding Adult H's culture was significant as a better understanding may have offered insight into his interpretation of support services, and health interventions.

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<sup>9</sup> [Bulawayo, Zimbabwe | comprehensive report | Expert Africa](#)

The reviewer recognises that no individual necessarily represents what may be largely true of their cultural background, but if professionals do not acknowledge cultural differences, they will be unable to consider whether any changes are needed to a person's support package to ensure that they are not put at a disadvantage.

**6.5.** It is not possible for every professional to learn of every culture, but all can practice generic skills such as cultural curiosity and an open-minded awareness of the differences that cultural background can produce.

**6.6.** Cultural curiosity is about having an interest in understanding and learning more about a person's cultural background, experiences, and viewpoints. It involves learning about someone's cultural heritage and appreciating how that person thinks or conducts themselves, taking into consideration their cultural background. Thus, 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.

**6.7.** There are considerable references to Adult H refusing support across all services in the chronologies, which evidences how difficult professionals found it to engage Adult H. This struggle to engage Adult H is considered in more detail later in this report, but there appears to be no exploration as to whether there were any external cultural influences impacting upon Adult H's emotional availability to engage with professionals.

**6.8.** Although there is little research which has examined how cultural differences could affect how people may view support services differently, a better understanding of Adult H's cultural background may have offered some insight into his engagement with Social Workers and health professionals. For example, given that culture can significantly impact various aspects of mental health, including the perception of health and illness, treatment seeking behaviours and coping styles, did Adult H's cultural beliefs influence how he felt about being detained under the Mental Health Act.

**6.9.** A Zimbabwean attendee at the learning event spoke of the stigma associated with mental health in the country and explained that some people may consider mental health challenges to be a weakness and something to hide. This may have made it harder for Adult H to accept help.

**6.10.** Dr Debra Machando, the mental health technical officer at the Zimbabwe office of the World Health Organization, says that although misconceptions about mental illness persist (in Zimbabwe), there is *evidence that perceptions are gradually changing*. But given that Adult H left Zimbabwe in 2005, it is realistic that the cultural misconceptions may have still influenced him.

**6.11.** Adult H's cultural experience of HIV is a further example of when Adult H's background may have affected his ability to accept support.

**6.12.** In February 2013, the Stigma Index Research Advisory Board commissioned Impact Research International Zimbabwe to carry out HIV related Stigma Index research<sup>10</sup>. The study aimed to understand the nature, experiences, and rates of HIV-related stigma and discrimination at a national level in Zimbabwe.

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<sup>10</sup> [Final-Report\\_Zimbabwe-HIV-Related-Stigma-Index-Research-2015-1.pdf \(znnp.org\)](#)

**6.13.** Overall, 65.5% of the 1,905 study respondents, reported that they had experienced one or more forms of HIV-related stigma and discrimination. This included, amongst other things, gossip, exclusion from social, religious, and family activities, verbal abuse, and physical abuse.

**6.14.** HIV related stigma was reported to still be evident in the workplace, educational institutions, and also in the health institutions. There was also evidence to show that some people living with HIV suffered from self-stigma, which affected the decisions and choices that they make. These internalised forms of stigma are relevant to Adult H as being in the United Kingdom, his main source of stigmatism may have been internal.

**6.15.** 18.9% of the participants reported that they felt guilty and had low self-esteem respectively because of their HIV status. 17.9% said that they blamed themselves, while 16.7% felt ashamed, 16.5% said they blamed others, 5.4% felt suicidal and 3.5% felt they should be punished because of their HIV status. A significantly higher percentage of male than female respondents reported that they felt guilty because of their HIV status.

**6.16.** The study dates from 2013/2014 but the Zimbabwe Association of Church-Related Hospitals reported in September 2020<sup>11</sup>, that stigma and discrimination towards people living with HIV in Zimbabwe remained rife.

**6.17.** Once an understanding of Zimbabwean attitudes towards both mental health and HIV is gained, it becomes easier for professionals to recognise potential barriers that may have hindered Adult H's engagement with support, and also to emphasise with how he may have been feeling.

**Learning: Professionals are not always sensitive to the risk of intercultural misinterpretation in health and social care.**

**6.18.** Zimbabwe has 16 official languages, but the country's dominant languages are Shona, spoken by over 70% of the population and Ndebele, spoken by approximately 20%<sup>12</sup>. English is the first language of most white Zimbabweans and is the second language of a majority of black Zimbabweans<sup>13</sup>. Although professionals were told that Adult H was fluent in English, his first language was Shona.

**6.19.** The Rochdale Borough Safeguarding Adults Board Multi-Agency, Procedures, Protocols and Guidance, stipulates that adults who have difficulty communicating in English and those who have 'specific communication difficulties should have access to the services of an independent interpreter with a relevant knowledge of culture'. It is good practice that even though professionals had been informed that Adult H was fluent in English, on occasions whilst in hospital, Adult H was offered an interpreter.

**6.20.** Whilst, when people do not speak each other's language, it is obvious that an interpreter is required, when a foreign-born speaker uses the English language fluently, as Adult H did, professionals can assume that the person will be able to understand the whole conversation. However, this could be untrue and in verbal exchanges across a cultural divide it is unsafe to presume that a full mutual understanding is being achieved even when both parties are using English fluently.

**6.21.** It is unclear from records whether when Adult H declined the use of interpreters, the benefits of using one were explained to him. This is crucial as a person for whom English is not their first language, may

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<sup>11</sup> [HIV and AIDS in Zimbabwe – Avert – ZACH](#)

<sup>12</sup> [What Languages Are Spoken In Zimbabwe? - WorldAtlas](#)

<sup>13</sup> [Languages of Zimbabwe - Wikipedia](#)

overestimate the level of English they have and/or underestimate the level of English that can be required in a medical setting and thus turn down an interpreter.

**6.22.** Interpreters in health care have been shown to improve safety with respect to diagnosis and prescription<sup>14</sup>, and although it is documented that Adult H could speak English well this does not necessarily mean that his comprehension of the English language was sufficient to understand the complexities surrounding his situation, particularly when he was in poor health. In addition, an interpreter is often also able to act as a cultural liaison and can identify, for the provider, cultural or social factors that might impact the encounter. Best practice would see a brief pre-visit meeting with interpreters asking for their input into the background of the patient and for tips with regard to cultural expectations.

### **Adult H's Lived Experience**

**6.23.** *Adult H left Zimbabwe in 2005. Now, 16 years later, Adult H was subject to a Deportation Order, which although unenforceable, could inevitably result in him having to leave his daughter and ex-partner in England and return to Zimbabwe alone - unemployed, with a criminal record, having been detained on a mental health ward and living with HIV – two health conditions which are potentially stigmatised in Zimbabwe and thus could have caused Adult H shame, and embarrassment. It is reasonable to assume that he could have been worried that he may bring shame and embarrassment upon his family.*

**6.24.** *In addition, the economic situation in Bulawayo is not very good. Adult H could have been worried about how he would earn money and survive if he returned to Zimbabwe.*

### **Question 1:**

**How can partner agencies assure Rochdale Borough Safeguarding Adults Board that work is being undertaken to remind and encourage professionals to practice an open-minded awareness of the differences that cultural background can produce.**

### **Home Office Communications**

**6.25.** Following Adult H being found guilty of a criminal offence in the British Court System he became subject to (in 2013) a Deportation Order. Deportation is a statutory power given to the Home Secretary. A person who is not a British citizen can be liable to deportation if it is deemed to be conducive to the public good - which the Immigration Rules state it is, if the person has been sentenced to a prison sentence of more than 12 months.

**6.26.** However, in Adult H's case although this intended that he no longer had the right to remain in this country, due to unrest in Zimbabwe, he was not to be forcibly deported from the United Kingdom. Instead, Adult H was offered support to return to Zimbabwe under the Voluntary Returns Service.

**6.27.** When Adult H was admitted to the Hollingworth Ward in November 2020, there was confusion around the details of Adult H returning to Zimbabwe and the legalities around deportation. This was further challenged by Adult H's inability to communicate his circumstances with staff.

**6.28.** Consequently, both Pennine Care Foundation Trust staff and Adult Social Care contacted the Home Office to obtain further information around Adult H's immigration status. The Home Office advised that Adult H should apply for asylum. Unfortunately, Adult H refused this.

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<sup>14</sup> [Interpreters in Health Care: A Concise Review for Clinicians - ScienceDirect](#)

**6.29.** Sadly, we are unable to establish from Adult H his reasons, but the Home Office has confirmed that whilst identification documents are not required to claim asylum, once an application is received, checks are carried out with other government databases to confirm identity and an asylum interview is conducted in order to obtain further information from the applicant regarding their identity.

**6.30.** Given that Adult H used several names and had no fixed address, he could have potentially perceived the process to be problematic. It is also reasonable to assume that Adult H may have feared failing asylum and being deported back to Zimbabwe forcibly.

**6.31.** Although Pennine Care tried to ascertain a clearer picture of Adult H's immigration status by discussing it with the Home Office, there is no evidence to suggest that Pennine Care discussed the situation in detail with Adult H himself. However Adult Social Care did attempt discussion with Adult H but was unable to establish further clarity around his circumstances, views, and level of understanding.

**6.32.** This difficult communication between professionals and Adult H regarding his immigration status was a problem as the Home Office has informed this review that anyone acting on an applicant's behalf needs a signed letter of authority from the applicant. Without a letter no specific information about a person's case will be disclosed to a third party. Adult H would have been unlikely to provide a letter of authority until a relationship of trust had developed between himself and those attempting to support him.

**6.33.** It was good practice that professionals who were trying to understand Adult H's status, discussed what they were able to with members of his family who had contacted the ward to see how he was. Information contained within the discharge risk assessment and safety plan, documented that family had reported that Adult H had said he would kill himself if returned to Zimbabwe; whilst his hospital records suggested that family had informed the ward that Adult H wanted to return to Zimbabwe to die and had expressed suicidal ideation.

**6.34.** In the absence of seeking asylum Adult H had No Recourse to Public Funds and consequently was unable to access benefits or housing assistance even if he met the relevant qualifying requirements. Manchester City Council<sup>15</sup> guidance states that it is the role of the Local Authority to provide information - *practitioners should help non-European Economic Area nationals who are not seeking asylum to access immigration information to establish an appropriate pathway.*

**6.35.** Professionals have informed this review that this was difficult for them because:

- no professional was successful in engaging Adult H or gaining enough trust for him to discuss his thoughts and feelings around his immigration options, and
- professionals weren't confident of their own understanding of the options and pathways available to Adult H regarding immigration and recourse to public funds, to confidently advise him.

**6.36.** In the midst of all the uncertainty, professionals have informed this review that understanding Adult H's Home Office status became a predominant focus of their work and that they spent a lot of time trying to contact the Home Office in order to gain a better comprehension of the situation and options.

**6.37.** Whilst general advice is available on the Government website and citizens advice website, professionals all reported limited information and a lack of available guidance for professionals. Staff had difficulties in distinguishing which department they should communicate with and thereafter, finding the correct contact details for the correct department.

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<sup>15</sup> 9.4 No Recourse to Public Funds – Manchester Adult Policies, Procedures and Practice Portal ([manchesterapp.co.uk](http://manchesterapp.co.uk))

**6.38.** Adult Social Care has now received training on No Recourse to Public Funds and has access to the No Recourse to Public Funds Connect System, which is used to help staff track, and receive information from the Home Office. However Adult Social Care reported that a check sheet for immigration cases with useful information and contacts would be valuable for front line staff.

**Learning: Professionals feel uninformed and unsupported around Home Office procedure.**

### **Adult H's Lived Experience**

**6.39.** *Adult H was entitled to Home Office support to return to Zimbabwe under the Voluntary Returns Service. He did not share with professionals whether he wanted to return to Zimbabwe or not. However, although it is known that Adult H had family in Zimbabwe, and presumably friends, leaving the United Kingdom would have meant leaving his daughter. It would also have meant facing potential stigma and discrimination regarding his health, and potentially shaming his family.*

**6.40.** *Adult H did not engage with the Voluntary Returns Service. Therefore, he chose not to return to Zimbabwe by default and consequently needed to seek asylum. This would have involved a paperwork process and interview which could have potentially intimidated him. Adult H could have been particularly concerned and put off the process by the fact that he had used several alias names and dates of birth whilst living in the United Kingdom.*

**6.41.** *The Home Office has confirmed that had Adult H applied for asylum and failed, he would have been expected to leave the United Kingdom at the earliest opportunity. Had he not complied, the Home Office would have sought to forcibly remove him from the United Kingdom unless he had been entitled to any form of leave to remain.*

### **Question 2:**

**How can Rochdale Borough Safeguarding Adults Board support professionals to understand immigration and recourse to public funds and ensure that they know how to contact the Home Office when required?**

### **Question 3:**

**How can partner agencies assure Rochdale Borough Safeguarding Adults Board that arrangements are in place for ensuring that the care and support needs, and health needs, of vulnerable migrants are met?**

## **Human Immunodeficiency Virus (HIV) Management**

**6.42.** Adult H was diagnosed with HIV in 2006. HIV is a virus that damages the cells in your immune system and weakens your ability to fight everyday infections and disease<sup>16</sup>. Whilst there is currently no cure for HIV, effective drug treatments are available that enable people to live a healthy life.

**6.43.** Adult H had been an inpatient detained under the Mental Health Act for 17 days before staff learned from the Home Office that he lived with HIV. Staff then contacted the Sexual Health Clinic in Darlington and learned from the clinic doctor that Adult H had last been seen 4 months ago and had reported at that time that he had stopped taking his HIV medication as he was having problems with his leg and diarrhoea. The doctor also said that Adult H's renal system had not been working properly and that Adult H had been referred

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<sup>16</sup> HIV and AIDS - NHS ([www.nhs.uk](http://www.nhs.uk))

to a hospital in Newcastle. A contact number was provided for the hospital but when staff tried to make contact no one was available. It is unclear whether any further attempts at contact were made.

**6.44.** A different reason for Adult H stopping his medication was provided to the ward from Adult H's ex-partner who said, during a telephone call, that whilst Adult H had initially engaged with prescribed HIV medication, he had become non-concordant at the beginning of lockdown as he 'could not get to collect it'. She explained that at the time Adult H was living in Durham and the Health Practice was a train ride away but travelling had been hampered by the Covid restrictions.

**6.45.** Adult H's ex-partner reported that Adult H had been unable to collect his medication from nearer his new address as he was unable to register with a GP without a passport. Whilst Adult H may have thought this, it is untrue - anyone can register with a GP Practice. It is free to register, and you do not need proof of address or immigration status, identification, or an NHS number.

**6.46.** It is not known whether Adult H understood the associated health risks when he stopped taking his medication but a SMART study<sup>17</sup> which was conducted (amongst other things) to see if people taking treatment breaks remained well, examples the risks.

**6.47.** The study recruited people to take part who were taking HIV treatment with a CD4 cell count above 350. CD4 cells, also known as T cells, are white blood cells that fight infection and play an important role in the immune system. A CD4 count is used to check the health of the immune system in people infected with HIV. HIV attacks and destroys CD4 cells.

**6.48.** Participants were divided into two groups: the first group continued to take HIV treatment as normal, the other group stopped treatment, restarting when their CD4 cell count fell to around 250, and then stopping again when their CD4 cell count once again reached 350.

**6.49.** However, in January 2006 the study was stopped early because 4% of people who interrupted their HIV treatment became ill compared to only 2% of people who took their HIV drugs all the time. The researchers found that people taking treatment breaks were more than twice as likely to become ill or die than people taking continuous HIV treatment.

**6.50.** As well as an increased risk of HIV disease progression, people taking treatment breaks also had an increased risk of other illnesses such as cardiovascular disease, and kidney or liver disease. This was a surprise, as these conditions can be side-effects of HIV treatment and the study's researchers had expected to see more of these illnesses in people taking HIV treatment all the time.

**6.51.** This review has been informed that a Junior Doctor had a discussion with Adult H about his HIV status and treatment, but it remains unknown whether Adult H understood the risks he was taking when he interrupted his antiretroviral treatment because the content of the discussion is not recorded within case notes.

**6.52.** Whilst this lack of robust documentation within case notes does not affect the level of care provided to an individual, it does influence the ability of professionals to look back and consider previous interactions between professionals and individuals in their care. And in the case of Safeguarding Adult Reviews such as this one, inadequate documentation hinders analysis and learning from previous practice. For example, this review is interested to learn if it was ever discussed with Adult H how he felt about his HIV status being shared with all the staff on the ward. This may feel irrelevant but a reluctance or embarrassment to share this information may have impacted on his ability to engage.

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<sup>17</sup> The Strategies for Management of Antiretroviral Therapy (SMART) Study Group

**6.53.** To ensure that Adult H was being treated and cared for to the highest standard, best practice would have seen staff on the Hollingworth Ward making a direct phone call to the HIV specialist nursing team at North Manchester General Hospital<sup>18</sup>. The team could have offered appropriate advice/arranged an outreach visit and/or arranged follow up, urgent, discussion with one of the HIV doctors if pertinent concerns and a more urgent review was required.

**6.54.** This review has been informed that in Adult H's case, the team at North Manchester General Hospital would have highly likely advised on blood tests to assess Adult H's current immune system status and may have been able to offer an outreach visit to establish contact and attempt to re-engage Adult H in HIV care. Again, in this specific case, given the fact that Adult H was not on treatment and had not been for some time (and therefore was likely to have been quite immunosuppressed<sup>19</sup> – as he was subsequently found to be), it is almost certain that the nursing team would then have discussed him with one of the HIV specialist doctors and given his presentation, arrangements may have been made to transfer Adult H to North Manchester General Hospital for further assessment.

**6.55.** There is no evidence of any consideration being had by the Hollingworth Ward as to whether Adult H's non-concordance with HIV medication could have impacted his mental health, physical health and/or decision-making and capacity.

**6.56.** Had there been such consideration then it is possible that Adult H may have been diagnosed with HIV-encephalopathy<sup>20</sup> and recognised to be in a profoundly immunosuppressed state due to HIV infection, sooner than his admission into North Manchester General Hospital. This would have resulted in Adult H receiving care and treatment before he reached crisis point.

**Learning: Professionals do not know who to contact for advice when they have concerns regarding a person living with HIV who is not currently engaging with care, support and/or treatment.**

**6.57.** The Encephalitis Society website<sup>21</sup> gives information on the potential impact of HIV-encephalopathy. Complications include concentration and memory problems, loss of interest in things people used to enjoy doing, becoming withdrawn and stopping socialising. People with HIV-encephalopathy may present with personality changes or depression. It can also cause physical movements that slow a person down, cause difficulties with fine motor movements and some people experience difficulties with walking. These problems tend to develop slowly over months or even years but can become quite severe and some people may need help to look after themselves.

**6.58.** Further, this review has been advised that Medscape<sup>22</sup> states that presentation can include clumsiness, poor balance, and tremors, and that behavioural changes may include apathy, lethargy and diminished emotional responses and spontaneity. 'Later stages of disease may present with bowel and or bladder complaints. If left untreated - can be fatal.'

**6.59.** Sadly, in Adult H's case whilst most of these features were present, they were not considered as part of a possible organic problem at either the Emergency Department of the hospital Adult H attended in Bradford, the Oak Ward in Oldham, or the Hollingworth Ward. In fact, the Oak Ward informed the Hollingworth Ward that their impression of Adult H's presentation was that it was behavioural due to his legal/immigration status.

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<sup>18</sup> On 0161 7202637 or 0161 7202638

<sup>19</sup> Immunosuppression is the state in which your immune system is not functioning as well as it should.

<sup>20</sup> HIV encephalopathy is a serious complication of HIV when the HIV infection causes the brain to swell.

<sup>21</sup> [Human immunodeficiency virus \(HIV\) and the brain | The Encephalitis Society](#)

<sup>22</sup> [Latest Medical News, Clinical Trials, Guidelines - Today on Medscape](#)



**6.60.** This demonstrates the need for staff to remain open-minded during assessment and treatment and of how conscious and unconscious bias relating to social/cultural factors of a patient can impact such open-mindedness.

**Learning: Changes to an individual's behaviour and mental state may be due to organic or non-organic causes.**

**6.61.** The missed opportunity to consider organic disease has been recognised within the aforementioned Pennine Care tabletop review and is addressed within their recommendations.

#### ***Adult H's Lived Experience:***

**6.62.** *Adult H's HIV positive status was confirmed in December 2006. Initially Adult H was compliant with medication, but this review has been informed that he stopped taking his HIV antiretroviral medication at the beginning of lockdown because he was unable to collect it.*

**6.63.** *When Adult H stopped engaging with the sexual health clinic, he lost the known professional with whom he could discuss his treatment if he so wished, and his viral load and CD4 T-cell count was no longer being monitored.*

**6.64.** *Antiretroviral treatment keeps HIV under control, protecting the immune system so that people can stay healthy and live a long life. When Adult H stopped his medication, the virus will have begun to attack the white blood cells in Adult H's body again. Adult H's viral load will have increased, and the number of his CD4-T cells will have significantly decreased. Adult H's immune system will have become very weak, and he will have become susceptible to infection which his body will have been unable to fight.*

**6.65.** *Adult H was subsequently diagnosed with HIV-encephalopathy, a condition which caused his brain to swell and could consequently have caused personality changes and depression.*

#### **Question 4:**

**How can partner agencies assure Rochdale Borough Safeguarding Adults Board that staff know who to contact when concerned for, or in need of advice regarding a person they are working to support who is living with HIV?**

#### **Assessment of Mental Capacity**

**6.66.** Adult H was admitted into hospital under section 2 of the Mental Health Act and reported to be catatonic. At this time Adult H was assessed as not having capacity to consent to an admission into hospital.

**6.67.** During the time Adult H was an inpatient on the Hollingworth Ward, he was assessed and deemed to not have a mental health condition. Following from this, Adult H was deemed to have capacity to make decisions.

**6.68.** Under the Mental Capacity Act 2005<sup>23</sup>, Adult H had to be presumed to have capacity unless proved otherwise. Therefore, considering Adult H's capacity rightly involved professionals asking themselves whether there was any reason to doubt his capacity in the first instance. However, rationale for assuming his capacity is not documented and this review remains unclear as to how Adult H's capacity was fully considered.

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<sup>23</sup> The Mental Capacity Act 2005 provides the legal framework for supporting people aged 16 and over to make decisions.

**6.69.** There have been recent proposed changes<sup>24</sup> to the Mental Capacity Act Code of Practice which expand upon how to apply the statutory principle; 'A person must be assumed to have capacity unless it is established that he lacks capacity.' The draft code states that, assuming capacity should not be used as a reason for not assessing capacity in relation to a decision. There should always be a proper assessment where there are doubts about a person's capacity to make a decision. And the onus is on the person intending to carry out the intervention to have properly established that capacity is really lacking in the individual concerned.

**6.70.** Consequently, the absence of a reason to not presume capacity should not have automatically concluded that assessment was not necessary. Instead of assuming capacity, professionals attempting to support Adult H could have afforded Adult H's capacity further critical reflection, and ruminated on how, given his presentation, mood, and sporadic communication they could be sure of their assumption of his ability to make decisions.

**6.71.** Best practice would have seen more professional curiosity. Additional questions could have been asked in an attempt to engage Adult H sufficient to confirm whether he could retain and understand information, was able to assess and weigh up the information, and communicate his decisions back to the ward. There is no evidence of this being done.

**6.72.** Capacity is specific to both the type of decision to be made, and when the decision must be made. It can change or fluctuate and can be influenced by the complexity of the decision and support available to the person. As such, Adult H's capacity should have been considered with regards to all decisions about how he managed, for example, his health, discharge, accommodation, and deportation status. In particular, the knowledge of Adult H's HIV status should have promoted discussions to have taken place with him in relation to treatment options available to him, including the recommencing of his previous medication.

**6.73.** If it had been established that Adult H did not have capacity to make any of the decisions, Adult H could have been given additional support to help involve him in decision making. This could have included consideration of an Independent Mental Capacity Advocate who could have acted on his behalf to make certain decisions. If appointed an Independent Mental Capacity Advocate would have played a pivotal role in treatment for HIV, and decisions upon where Adult H was discharged too.

**6.74.** Adult H being assumed to have capacity on the ward not only impacted upon the ward decision-making around Adult H's health, ongoing support needs, and follow up care - it also influenced Adult Social Care.

**6.75.** Adult Social Care attempted to support Adult H by means of a Human Rights Assessment and Care Act Assessment. Unfortunately, the local authority was unable to engage Adult H in these assessments but as the worker had been told by staff on the ward that Adult H's capacity was not in doubt, Adult Social Care deemed Adult H's non-engagement to be behavioural. Adult H's capacity to engage was not further considered or assessed, but his decision-making around engagement could have been an indicator of Adult H lacking capacity or understanding. Unconscious bias towards non-engagement perhaps played a part here – professionals' struggles to engage Adult H are discussed in more detail later in the report.

**6.76.** A week following Adult H's discharge from the Hollingworth Ward Adult H was admitted into North Manchester General Hospital and deemed to require bilateral leg amputation and a blood transfusion. Adult H refused both.

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<sup>24</sup> The draft Mental Capacity Act Code of Practice was published for public consultation on the 17<sup>th</sup> of March 2022. Consultation ended on the 14<sup>th</sup> of July 2022.

**6.77.** Documentation suggests that staff at North Manchester General Hospital did not doubt Adult H's capacity until seven days into this admission when he attempted to self-discharge. Following this there was ongoing differences in professional opinion with regard to Adult H's capacity to make decision for his care and treatment. On the 16<sup>th</sup> of January 2021, the medical team, recognising that they were undecided, sought support from the Mental Health Liaison Team. This was good practice. However, consideration should have also been had at this time to a Deprivation of Liberty Safeguards application.

**6.78.** The Mental Health Liaison Team consultant's opinion was that Adult H did have capacity, but still unsure, the medical team decided to contact the hospital legal team for advice and guidance. The legal team recommended the case be referred to the Court of Protection and a referral be made for an Independent Mental Capacity Advocate.

**6.79.** Some professionals at the learning event expressed concern regarding a delay in Adult H's treatment due to the capacity assessment issues. But all recognised the complexities of capacity and agreed that the ward's professional challenge of the capacity decision and their seeking of legal advice, demonstrated best practice when a professional is unsure around the use of the Mental Capacity Act either within their own practice or another's.

**6.80.** Further discussion was had at the learning event around whether Adult H's executive functioning was explored and considered by professionals working with him.

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

**6.82.** There is no formal diagnosis, or medication to correct weak executive functioning but had tests suggested that Adult H was experiencing it, behaviour therapy and cognitive behavioural therapy could have been explored to improve his decision-making capacity. However, it is recognised that such therapy would have been dependent upon Adult H's ability to engage.

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

**6.84.** This leads the review to consider the term executive capacity. In 2010 the authors (Naik, A et al) of the paper; *Patient autonomy for the management of chronic conditions: A two-component re-conceptualization*<sup>25</sup>, summarised 'executive capacity' and wrote:

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

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<sup>25</sup> [Patient Autonomy for the Management of Chronic Conditions: A Two-Component Re-conceptualization - PMC \(nih.gov\)](#)

**6.85.** Given the complexities of Adult H's health and ongoing health management best practice would have seen professionals considering his executive functioning alongside his capacity and documenting their thoughts and findings.

**Learning: Capacity remains a complex area of professional practice and all practitioners must be confident to challenge decisions and seek advice.**

**6.86.** At the time Adult H was admitted into North Manchester General Hospital, the hospital was under the Northern Care Alliance Trust. In April 2021 the hospital merged with the Manchester University Foundation NHS Trust and the merge necessitated operational changes including the restructuring of policies and procedures. Since April 2021 the Manchester Foundation Trust has provided all staff at the North Manchester General Hospital with ongoing training around the application of the Mental Capacity Act and Deprivation of Liberty Safeguard. Also, the trust also has a Mental Capacity Act Officer who cover all the sites across the trust. The Mental Capacity Officer role involves:

- delivering training to all medical professionals around the Mental Capacity Act and completion of Mental Capacity assessments.
- organising and supporting a Mental Health Act Officer with mental health tribunals
- supporting wards and the safeguarding team with staff concerns around capacity

**6.87.** Whilst it is recognised that only one Mental Capacity Act Officer covers the whole of the Manchester Foundation Trust footprint, staff at North Manchester General Hospital are now better supported around the use of the Mental Capacity Act.

### ***Adult H's Lived Experience***

**6.88.** *Adult H's presentation during the scoping period of this review was reported (by his ex-partner) to be significantly changed from usual. Despite this, professionals' assumed that Adult H's behaviour was a result of his circumstances rather than organic.*

**6.89.** *Adult H would have been in a confused state and unable to explain any changes to his behaviour - this review has seen no written evidence of any exploration being had with any family members who rang the ward and conversed with staff at the Hollingworth Ward, of how Adult H had changed.*

**6.90.** *Adult H was unwell, in pain, and away from his family. He was reliant on other people recognising the changes and exploring potential reasons for his changed behaviour.*

### **Question 5:**

**How can partner agencies assure Rochdale Borough Safeguarding Adults Board that staff understand how and when to assess an individual's capacity and are confident to challenge decisions and seek advice.**

### **Consideration of Organic Conditions Causing Changed Behaviours**

**6.91.** Organic conditions can often present with symptoms suggestive of psychiatric disease but can be attributed to a physical cause. Because of this, individuals presenting with symptoms suggestive of psychiatric conditions as Adult H did, should always be thoroughly assessed to ensure organic causes are excluded.

**6.92.** Clearly to undertake such assessment, an examination is necessary, but assessment also includes consideration of an individual's history. The two combined assist in narrowing the differential diagnoses and differentiating between organic and psychiatric causes.

**6.93.** It is recognised that Adult H's collateral history was not readily available or easy to obtain - predominantly because Adult H used several alias names and dates of birth, didn't cooperate or answer questions, and wasn't currently registered to or utilising the services or a GP Practice. However, several physical investigations can be undertaken to assist, including:

- Nursing Observations
- Blood Glucose
- Urea and Electrolytes
- Thyroid Function Test
- Full Blood Count
- Liver Function Test

**6.94.** This review understands that several of these investigations aren't suitable to being undertaken in the Emergency Department owing to the length of time required to obtain the results, but would respectfully ask whether adequate consideration of an organic cause to Adult H's behaviours and presentation, was had?

**6.95.** When Adult H presented at the Emergency Department of a hospital on the 3<sup>rd</sup> of November 2020 he did not speak, and urinated where he stood in his clothing. Staff at the hospital attempted to help Adult H get into clean clothes but Adult H made an inappropriate sexualised comment which resulted in security removing him. Disturbed patients can be disruptive and act inappropriately, and it is understandable why hospitals may wish for such people to be discharged quickly, but a thorough assessment and consideration of organic causes must still be taken to prevent mistaken removal of a person suffering ill health.

**6.96.** Adult H continued to demonstrate symptoms of incontinence when he presented again at an Emergency ward the following day, and when he was admitted onto hospital wards. And whilst this review has been informed by some practitioners that, following being placed in a room with a bathroom, his incontinence was resolved, case notes contradict this with reports of incontinence continuing sporadically.

**6.97.** On the 18<sup>th</sup> of November 2020 Adult H's incontinent pads were removed from his bed as he was deemed able to use the toilet independently. However, case notes evidence that Adult H continued to be doubly incontinent. It was good practice that consideration was then had of whether there was an organic cause to the incontinence and on the 22<sup>nd</sup> of November 2020 Adult H provided a urine sample which was sent for urodynamics testing. Urodynamics testing is a set of tests that doctors order to assess the ability of the bladder to retain urine inside and to empty - fully and effectively. The testing can tell if the bladder is experiencing involuntary contractions which can cause urine to leak out. Adult H's tests were negative, and the sample was sent elsewhere for full culture screening.

**6.98.** There is no record of incontinence pads being returned to Adult H (the next reference to pads is on the 10<sup>th</sup> of December 2020 when Adult H requested some) which suggests that staff suspected Adult H's incontinence was behavioural and something that he was able to control. However, this non provision of incontinence pads could be construed as an Act of Omission and is not acceptable, particularly in the absence of evidence of the incontinence being within Adult H's control. Even if tests ruled out any organic cause, Adult H's presentation which is described frequently in case notes as vacant, flat, and monotonic, may have indicated such emotional confusion or distraction that he could have found himself unable to get to the bathroom in time, causing incontinence.

**6.99.** Moving away from Adult H's incontinence, his general behaviour was reported to be unusual, and according to his ex-partner - out of character. Adult H was exhibiting periods of muteness and confusion. This, as previously mentioned, was not considered as a potential HIV related organic problem, even when it became known that he lived with HIV and was non-concordant with medication.

**6.100.** Prior to Adult H's HIV status becoming known, the Oak Ward had informed the Hollingworth Ward that their impression of Adult H's presentation was that it was behavioural due to his legal/immigration status. This voiced presumption unintentionally labelled Adult H's behaviours, and possibly obstructed professional's curiosity into potential organic cause, even in the presence of the new health information (when it became known that he lived with HIV).

### **Adult H's Lived Experience**

**6.101.** *Adult H was taken to the Emergency Department of a Bradford hospital by ambulance after he had been observed to be staring at the same spot in the sky for several hours. Adult H was not communicating and when hospital staff attempted to remove Adult H's clothing because he had urinated, he was inappropriate towards them. It remains unknown whether Adult H understood what was happening to him, why he was taken to hospital, why his clothes were being removed and what he had said.*

**6.102.** *Adult H then found himself escorted off the hospital premises by security and returned to the streets in an unwell, disorientated state.*

**6.103.** *Following Adult H again being observed to be in a public place in an unresponsive state, he found himself back in an Emergency Department. This time he was admitted into hospital. On the wards, Adult H was presenting low in mood, flat and spending extended periods of time in his bed. He was struggling to engage with professionals, and other patients, and was not showing any interest in joining activities.*

**6.104.** *Adult H was sporadically doubly incontinent but because he was sometimes demonstrating an ability to use the toilet, his incontinent pads were taken from him.*

**6.105.** *Adult H was completely dependent upon healthcare professionals recognising that his behaviours and incontinence may have been the result of an organic cause and not behavioural.*

### **Question 6:**

**How can healthcare partners assure Rochdale Borough Safeguarding Adults Board that health practitioners are being reminded to thoroughly assess individuals, presenting with symptoms suggestive of psychiatric conditions, to ensure organic causes are excluded.**

**Rochdale Borough safeguarding Adults Board should bring this section of the report to the attention of the Bradford Safeguarding Adults Board<sup>26</sup> and request that they share with their subgroup and the Bradford Hospital for learning purposes.**

### **Hard to Reach Service Users**

**6.106.** A barrier to Adult H receiving supportive intervention was professionals' inability to engage him:

- Staff on the Hollingworth Ward (including nurses, Doctors, an Occupational Therapist, and a Physiotherapist) were unable to engage Adult H and learn of his circumstances/history,
- Adult H did not respond to offers of assistance with accommodation from the Engagement Team,
- A Social Worker from Adult Social Care was unable to engage Adult H in assessment processes,
- Attempts made to engage Adult H with Migration helpline to help him to seek asylum, proved unsuccessful, and
- Staff at North Manchester General Hospital were mostly unable to engage Adult H.

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<sup>26</sup> [BSAB@bradford.gov.uk](mailto:BSAB@bradford.gov.uk)

**6.107.** Some insight into why Adult H potentially found it difficult to engage with professionals can be gleaned from consideration of the earlier section; Cultural Exploration, which highlights the stigma and prejudice Adult H may have perceived owing to his health status.

**6.108.** Nevertheless, professionals at the learning event recognised that relationship building was possible with Adult H as it was achieved by a judge whilst Adult H was an inpatient in North Manchester General Hospital. This review has been informed that 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.

**6.109.** This demonstrates how building up some rapport before discussing the personal issues, is potentially key to successful engagement. But, in such a scenario like Adult H's where most professionals struggled to achieve engagement, advocacy services are important and can also assist.

**6.110.** An Independent Mental Health Advocate's role is to support people to understand their rights under the Act and participate in decisions about their care and treatment. A referral was received by Advocacy Together<sup>27</sup> for an Independent Mental Health Advocate on the 16<sup>th</sup> of November 2020 and a mental health advocate was allocated. On the same day the advocate attempted contact with the Hollingworth Ward but was not successful in obtaining information. Following the advocate leaving the service at the end of November 2020, another advocate attempted contact on the 23<sup>rd</sup> of November 2020 but was not able to speak to Adult H. On a later contact, the advocate was informed that Adult H had been discharged from the ward.

**6.111.** Under normal circumstances Advocacy Together see patients face-to-face, however it has been identified that sometimes patients in short term care are discharged before the Independent Mental Health Advocate can have contact with them. To prevent this from happening, a team of Independent Mental Health Advocates are now proactive in attending named wards on numerous specific days during the week to ensure all patients are offered an Independent Mental Health Advocate.

**6.112.** There are some further improvements that Advocacy Together believe would improve advocacy engagement (and would welcome):

- For times when direct access is limited (ward infection), Advocacy Together would welcome the opportunity to run a Virtual Drop-In Service. They are able to provide a Duty Independent Mental Health Advocate to support patients who want to see and speak to an Independent Mental Health Advocate via video. However, they recognise that technology is an issue on some wards and patient access to a laptop can be problematic.
- Regular meetings/catch up sessions with Ward Managers and the Advocacy Together Service Manager to promote shared good practice and to review gaps in service.
- Advocacy Together advocates being able to attend NHS and Local Authority Staff Team meetings to raise awareness concerning the role of Advocates.
- Advocates supporting new ward staff during their induction with an informal introduction to the Independent Mental Health Advocate Service and the role of the Independent Mental Health Advocate, Independent Mental Capacity Advocate and Care Act Advocacy.

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<sup>27</sup> Together for Mental Wellbeing have run established Independent Advocacy Services in Rochdale since 2012. The Service is contracted by Rochdale Borough Council to offer Statutory Independent Advocacy for persons living in Rochdale Borough. This includes Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards, Care Act and NHS Independent Complaints advocacy.

**6.113.** As previously mentioned, Adult H could have benefited from advocacy in the form of an Independent Mental Capacity Advocate who would have been able to act on Adult H's behalf if he had been found to lack capacity with certain decision-making aspects of his life. As it was presumed that Adult H did have capacity, he was not thought to be eligible for this, and this form of advocacy was not offered.

**6.114.** In November 2020 a Social Worker considered an advocate to support Adult H to communicate with assessment processes. The worker, upon learning that Adult H was fluent in the English language, had capacity, and could therefore understand the information being discussed with him, subsequently concluded it unnecessary and this form of advocacy was not offered to Adult H either. However, the role of an Independent Advocate is to discuss a person's options with them and identify which option a person wishes to follow. The Independent Advocate will then ensure that the person's voice is heard, and their rights are upheld. Thus, this is a service that could have been given more consideration and would have been best provided early in Adult H's journey within the professional system.

**6.115.** Advocacy Together have informed this review that many of the referrals they receive are received after a case has been within the professional system for some time. Such delays in advocacy referrals, under the Care Act specifically, are also echoed in many Safeguarding Adult Reviews.

**6.116.** Advocacy Together have told this review that they consider the delays to be occurring as a result of many Health and Social Care Practitioners lacking confidence in knowing when to refer for an Independent Advocate. To help address this the Advocacy Together Service Manager offers an 'Independent Advocacy Referral Pathway' presentation (also available on the website). This is offered to Health and Social Care Practitioners and to student social workers on placement with Adult Social Care. The Service Manager also offers the opportunity to meet with all new Health and Social Care employees during their induction period.

**6.117.** Advocacy Together report that they continue to look for improved ways to work with Health and Social Care. They would like to bridge any gaps of knowledge professional's may have and raise awareness of the legal obligations, and the benefits, of instructing Independent Advocacy for persons who fit remit. They would welcome further opportunities to deliver training across the health and Social Care sector.

**Learning: Practitioners may be confused by legislation around advocacy services.**

**6.118.** Moving away from advocacy services, this review has repeatedly been informed by multiple agencies, that Adult H 'did not engage' and has identified incidents whereby professionals have communicated Adult H's 'non-engagement' to one another.

**6.119.** It is important to explore such language, as labels can close minds and, because a label is often seen before the person, once a label is attached to a person - it is in danger of defining a professional's journey with that person in advance.

**6.120.** Hence, the language label 'non-engagement', and the term 'does not engage' can contribute to creating a professional unconscious bias of a person who is not going to engage. This concept is likely an uncomfortable one for workers and managers alike, but unconscious bias is, by its nature, impossible to see past without the support of others suggesting it. Everyone has biases that shape their decisions, but that they are unaware of. Influences such as a heavy workload, could unconsciously sway a professional's decision to accept that they cannot engage a person, rather than work to understand and achieve. The language can then be used as justification for, in the case of Adult H, failure to have successful communications.



**6.121.** Such labels also apportion blame to the service user; the term non-engagement suggests that Adult H consciously and deliberately chose not to engage when in reality, it remains unknown why he found himself unable to engage. It could have been due to fear, poor understanding, or something else. Labels which describe a person who services have been unable to engage, as a non-engager, contrast with any person-centred, strengths-based approach - and need to change.

**Learning: language labels (for example 'does not engage') are in danger of apportioning blame to the service-user and contrast with a person-centred, strengths-based approach.**

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

**6.123.** 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.

### ***Adult H's Lived Experience***

**6.124.** *Adult H in varying states of poor health found himself subject to many questions from a variety of professionals, paramedics, police, healthcare staff in the hospitals, a Social Worker, housing officer and a judge.*

**6.125.** *Given his HIV-encephalopathy, a condition which can cause the emotional changes described in 6.51 and 6.52, Adult H potentially may not have understood who everyone was, may have found it hard to know who to trust, and struggle to consider decisions.*

### **Question 7:**

**How can Rochdale Borough Adults Safeguarding Board be assured that health and social care professionals confidently understand when to refer for an Independent Mental Health Advocate, Independent Mental Capacity Advocate and/or an Independent Advocate.**

### **Question 8:**

**How can Rochdale Borough Adults Safeguarding Board work with partner agencies to change the use of language labels such as 'does not engage' in line with a person-centred, strengths-based approach?**

### **The Effects of the Covid Pandemic**

**6.126.** It is important that this review highlight that professionals supporting Adult H during the scoping period of this review were working under the everchanging backdrop of the regulations and restrictions introduced to control the Covid pandemic.

**6.127.** At the beginning of the scoping period of this review, the United Kingdom had just entered a two-week national 'circuit breaker' lockdown to slow the spread of Coronavirus in the community and protect the health service. This effected the closure of all non-essential retail and hospitality, household gatherings of more than one household were not allowed, and people were told to stay at home other than for essential purposes such as education, healthcare needs, to care for others or outdoor exercise.

**6.128.** On the 2<sup>nd</sup> of December 2020, the lockdown ended and was replaced with a strengthened tier system. Rochdale was subject to Tier three. However, by the end of December 2020 most of the country had moved to Tier four, including Rochdale, and on the 6<sup>th</sup> of January 2021, the Prime Minister placed all of England into Tier four, effecting a further full lockdown. This was still in place when Adult H died.

**6.129.** It is also important to remember that during the scoping period of this review, the NHS were following a plan drawn up by the Joint Committee on Vaccination and Immunisation and were continuing to roll out vaccinations with an aim of offering a vaccination to everyone in the top four priority groups<sup>28</sup> by the 15<sup>th</sup> of February 2021.

**6.130.** The staffing requirements of the vaccination scheme, coupled with staff who had been exposed to, or had contracted the virus, having to self-isolate, undoubtedly negatively influenced staffing levels within hospital settings - but there is no evidence that this affected any of the care provided to Adult H.

**6.131.** However, whilst all aspects of care planning, discharge and safeguarding should have remained unchanged (i.e., the same as pre-covid) within the hospitals, there were restrictions on visiting whilst Adult H was an inpatient on the wards.

**6.132.** Members of Adult H's family contacted the ward on occasions and asked to speak with Adult H, but Adult H refused. Had family attended Adult H in person, it is possible (but not definite) that they may have been able to assist Adult H to engage with professionals and/or could have advocated for Adult H. In addition, family members attending in person, may have furnished professionals with more background information on Adult H, cultural information, and/or discussed changes to his presentation in more detail.

**6.133.** Whilst there is no evidence that the Covid pandemic and its associated restrictions affected any professional care and support provided to Adult H, including that from the ambulance service, the police, and Adult Social Care, Adult H could have still experienced personal effects. For example, according to Adult H's partner, Covid impacted on Adult H's ability to pick up his prescription for his HIV medication in relation to the travelling distance from his home. (Though it must be highlighted that the reason Adult H stopped his medication remains unconfirmed by him and is unsubstantiated<sup>29</sup>.)

**6.134.** Whatever Adult H's reason for stopping his medication it was crucial that the risk be explained to Adult H because, as highlighted in a World Health Organisation report<sup>30</sup>, HIV infection was a significant independent risk factor for both severe/critical Covid presentation at hospital admission, and in-hospital mortality. Overall, nearly a quarter (23.1%) of all people living with HIV who were hospitalized with Covid, died.

**6.135.** The World Health Organisation had also warned<sup>31</sup> that countries must ensure an appropriate balance between protecting health, preventing economic and social disruption, and respecting human rights to ensure that people living with HIV had the same access to services as others, and that HIV-related services continued without disruption as the health system responded rapidly and effectively to Covid.

**6.136.** It is unknown, but possible, that Adult H knew of the heightened vulnerability to Covid that his HIV status afforded him and was worried by it. These worries may explain Adult H's reluctance to accept support

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<sup>28</sup> The top 4 priority groups were older care home residents and staff, everyone over 70, all frontline NHS and care staff, and the clinically extremely vulnerable.

<sup>29</sup> The Doctor from the clinic reported that ADULT H had informed him that he wasn't taking his medication due to having diarrhoea and issues with his leg

<sup>30</sup> [WHO warns that HIV infection increases risk of severe and critical COVID-19](#)

<sup>31</sup> [HIV and COVID-19 \(who.int\)](#)

with accommodation as he could have feared being placed to live amongst others who may not be cautious of the Covid virus.

**6.137.** Such worries are understandable, particularly when Adult H's heightened vulnerability caused by his HIV status is coupled with other research<sup>32</sup>. On the 14<sup>th</sup> of December 2020 the Office for National Statistics published research which indicated that Black and South Asian Communities suffered a higher mortality rate from Covid. In fact, the research specifically found that the Covid 19 mortality for people of Black African or Black Caribbean ethnicity in the first half of this year [2020] was 2 to 2 and a 1/2 times higher than for people of White ethnicity.

**6.138.** Adult H's refusal to seek asylum could have been Covid related too. Had Adult H failed asylum he would have been deported to Zimbabwe forcibly. In December 2020, the number of locally transmitted infections in Zimbabwe were increasing (an analysis of official Covid-19 data showed that new cases had been rising since November and were now averaging 100 cases daily) and police had stepped up operations to enforce coronavirus measures, including hitting people in the country with penalties for not adhering to Covid-19 guidelines such as wearing face masks and observing physical distancing. Whilst the Bulawayo Provincial Medical Director Welcome Mlilo, described the situation in the city as "fairly stable" and "not so alarming as some parts of the country"<sup>33</sup> it is understandable that Adult H may have been worried.

**6.139.** When Adult H was being discharged from hospital in December 2020, he told staff that he was unable to go and stay with relatives because the Covid restrictions prevented him from travelling. Professionals explained that an exception would be made under such circumstances, but he remained steadfast that it was forbidden.

**6.140.** If Adult H was confused about Covid restrictions and what he was and wasn't allowed to do, he was not alone – confusion was echoed across the country particular post October 2020 when the Tier system was introduced.

**6.141.** Knowledge about Covid-19 restrictions had often been sub-optimal, with people finding guidance confusing and in a new study, the CORSAIR (The Covid-19 Rapid Survey of Adherence to Interventions and Responses) team sought to understand whether people understood what tier they were in (and what that meant for what they could do) through a representative survey of 1,728 participants. The first author was Dr Louise Smith (King's College London), University College London's Professors Henry Potts and Susan Michie were also part of the team. Over 80% of participants correctly identified which tier they lived in, but knowledge of the specific restrictions applying to them was variable. 73% were confident they understood which tier they were in, while 71% were confident they understood the guidance for their tier. There was some indication that nuanced guidance (for example, behaviour allowed in some settings but not others) was more poorly understood than guidance which was absolute (i.e., behaviour is either allowed or not allowed).<sup>34</sup>

**6.142.** Such confusion, if felt by Adult H, could have contributed to his failure to follow professional advice regarding what he should or could do upon discharge from the hospital.

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<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14>

<sup>33</sup> Zimbabwe tightens gathering limits as COVID-19 cases rise | Coronavirus pandemic News | Al Jazeera

<sup>34</sup> New Paper: Did People Understand Local COVID Tiers, Guidance and Restrictions? | UCL Institute of Health Informatics - UCL – University College London

## The Equality Act 2010

**6.143.** The terms of reference asked the review to consider Adult H against the protected characteristics under the Equality Act 2010<sup>35</sup>. Ergo, the review has not learned of any discrimination against Adult H arising from his race or religion but would bring attention to a lack of professional cultural curiosity into Adult H's cultural background and religion.

**6.144.** Consequently stigma, still associated by many Zimbabweans, to both mental health and HIV, went unrecognised and as a result professionals were ignorant as to how Adult H, within the backdrop of his Zimbabwean heritage, could have potentially felt shame and embarrassment around his circumstances and how this may have theoretically influenced his decision making and ability to respond to professional's who were trying to engage him with support services.

**6.145.** Although professionals have informed this review that Adult H was a religious man, the reviewer has been unable to ascertain Adult H's religious beliefs. Discussion was had at the learning event as to whether there was a missed opportunity to ask the hospital chaplain to spend time with Adult H whilst he was in hospital, particularly when he was finding it difficult to communicate.

**6.146.** The hospital chaplain is there to provide emotional and spiritual support to patients, relatives, and staff regardless of whether they are practising believers or not. The chaplain role is to sit and connect with people who may be going through difficult times. Although it is recognised that Adult H was admitted into hospital during the Covid pandemic, and that as a result hospital chaplaincy services may have been reduced, it is possible that a visit may have brought Adult H some comfort. Also, that the chaplain could have been utilised as a 'go between' for Adult H and professionals and advanced engagement.

**6.147.** The review has also considered Adult H's diagnosis of HIV within the framework of The Equality Act. The 2010 act has replaced previous anti-discrimination laws, bringing them together under one piece of legislation. This includes the Disability Discrimination Act which was originally written in 1995 to stop discrimination against disabled people. Consequently, the Equality Act introduces a duty to all service providers to make reasonable adjustments to ensure that anyone with a disability can use their service in the same way as any person without a disability.

**6.148.** Anyone diagnosed with HIV has the same protections as disabled people, regardless of their health status. Therefore, this review has considered whether Adult H, as a person living with HIV, experienced equal access to rights, opportunities, and services, and was protected from discrimination. It has concluded that Adult H was never at any disadvantage whilst under any service provision, owing to his HIV status.

## 7. Good Practice

The agency reports submitted to this review and the discussions around Adult H, have highlighted examples of good practice<sup>36</sup> from professionals involved with him. Including:

- North Manchester General Hospital raised concerns in relation to Adult H's presentation 9 days after his discharge from Hollingworth Ward. In view of his subsequent presentation with severe bilateral cold injury to the legs, diagnosis of HIV encephalopathy, lack of capacity and subsequent deterioration they advised that a review of his assessment and discharge from mental health services should be undertaken.

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<sup>35</sup> Age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

<sup>36</sup> Good practice in this report includes both expected practice and what is done beyond what is expected.

- Adult Social Care attempted to reassure Adult H that they would support him and were not from the Home Office.
- Adult Social Care tried hard to seek an alternative to discharge.
- Adult Social Care sought legal advice early to ensure that all available support had been offered.
- Healthcare staff at North Manchester General Hospital challenged the decision around capacity and sought legal advice resulting in Adult H's case going to Court of Protection.

## 8. Improving Systems and Practice

### 8.1. Developments Since the Scoping Period of the Review

Agencies have already made some important amendments to practice since the scoping period of this review. These developments have been included in the body of this report.

### 8.2. Conclusion

**8.2.1.** Adult H was a Zimbabwean male, living with HIV, subject to the Voluntary Returns Service.

**8.2.2.** In November 2020 Adult H was detained in hospital under section 2 of the Mental Health Act after being found unresponsive at a bus stop. Adult H was presenting as doubly incontinent, frail, and mostly uncommunicative.

**8.2.3.** Upon health professionals learning of Adult H's HIV status, no consideration was initially had as to whether his presentation could be linked to his HIV and the discontinuation of medication.

**8.2.4.** In time Adult H was deemed to not be experiencing any mental health illness and was assumed to have capacity to make decisions around his own care and support. He was not engaging with support services, including the Home Office asylum processes, when he was discharged from hospital with no fixed abode or right to public funds.

**8.2.5.** A week later, Adult H was again found unresponsive at a bus stop and was re admitted into a hospital.

**8.2.6.** On this occasion, following Adult H expressing a desire to discharge himself (even though he was unable to walk), and refusing lifesaving surgery, some professional's began to doubt his capacity and sought legal advice.

**8.2.7.** Thereafter lifesaving surgery was performed under a best interest decision but sadly, whilst initially he showed signs of recovery, Adult H died on the 13<sup>th</sup> of February 2021.

**8.2.8.** The following practice themes have been explored and analysed with professionals throughout the course of this Safeguarding Adult Review, and good practice has been identified alongside areas of practice which would benefit from development and improvement.

- Cultural Curiosity
- Home Office Communications
- Human Immunodeficiency Virus (HIV) Management
- Assessment of Mental Capacity
- Consideration of Organic Conditions Causing Changed Behaviours

- Hard to Reach Service Users
- The Effects of the Covid Pandemic
- The Equality Act

**8.2.9.** Two of those themes in particular underpin all of the support offered to Adult H. They comprise of professional's ability to engage Adult H (Hard to Reach Service Users) and Adult H's capacity to make decisions around his care and support needs (Assessment of Mental Capacity). Without engagement and thorough assessment of capacity, professionals were unable to deliver their support offer.

**8.2.10.** Indicative of the fact that a professional approach needs to be urgently identified to address these areas of practice, is that they are recurring themes in Safeguarding Adult Reviews across the country.

**8.2.11.** The review has concluded that initially to address professionals' inability to engage Adult H, priority needed to be given to making safeguarding personal and developing an understanding of Adult H's life experiences. To do this, professionals needed to be curious about Adult H's culture and how this could affect his perception of his health and his decision making. To gain enough trust with Adult H to commence exploration of this, professionals needed to test ways of engaging with Adult H. A good example of this was provided to the review by means of a productive conversation had between Adult H and a judge. The judge started his conversation with Adult H by chatting about topics of interest unrelated to the current situation and other professionals noted that in doing so, the judge learned more about Adult H. This communication exemplified the advantages of first establishing a rapport before steering the conversation towards promoting a support framework. As a result, a service user may be more open to, and able to recognise the potential of, engaging with support services in order to bring him or her an improved quality to his or her life.

**8.2.12.** Of course, hand in hand with Adult H's decision-making around engagement and support was his mental capacity to make such decisions. Adult H was assumed to have capacity until the middle of January 2021 when his request to discharge himself from hospital (although unable to walk), caused professionals to doubt it. However, had more curiosity been had earlier and more exploration of how able Adult H was to understand and execute decisions he was being required to make, his capacity may have been doubted earlier and subject to assessment. Earlier assessment, had it concluded that Adult H did not have capacity, would have resulted in Adult H's care and support being addressed in his best interest sooner.

### **8.3. Learning**

**8.3.1.** The review would ask the Rochdale Borough Safeguarding Adults Board to deliberate the following questions which identify where improvement to systems and practice is required. It is the responsibility of Rochdale Borough Safeguarding Adults Board to use the ensuing debate to model an action plan to support learning.

#### **Question 1:**

How can partner agencies assure Rochdale Borough Safeguarding Adults Board that work is being undertaken to remind and encourage professionals to practice an open-minded awareness of the differences that cultural background can produce.

#### **Question 2:**

How can Rochdale Borough Safeguarding Adults Board support professionals to understand immigration and recourse to public funds and ensure that they know how to contact the Home Office when required?

#### **Question 3:**

How can partner agencies assure Rochdale Borough Safeguarding Adults Board that arrangements are in place for ensuring that the care and support needs, and health needs, of vulnerable migrants are met?

**Question 4:**

How can partner agencies assure Rochdale Borough Safeguarding Adults Board that staff know who to contact when concerned for, or in need of advice regarding a person they are working to support, who is living with HIV?

**Question 5:**

How can partner agencies assure Rochdale Borough Safeguarding Adults Board that staff understand how and when to assess an individual's capacity and are confident to challenge decisions and seek advice.

**Question 6:**

How can healthcare partners assure Rochdale Borough Safeguarding Adults Board that health practitioners are being reminded to thoroughly assess individuals, presenting with symptoms suggestive of psychiatric conditions, to ensure organic causes are excluded.

**Rochdale Borough safeguarding Adults Board should bring this section of the report to the attention of the Bradford Safeguarding Adults Board<sup>37</sup> and request that they share with their subgroup and the Bradford Hospital for learning purposes.**

**Question 7:**

How can Rochdale Borough Adults Safeguarding Board be assured that health and social care professionals confidently understand when to refer for an Independent Mental Health Advocate, Independent Mental Capacity Advocate and/or an Independent Advocate.

**Question 8:**

How can Rochdale Borough Adults Safeguarding Board work with partner agencies to change the use of language labels such as 'does not engage' in line with a person-centred, strengths-based approach?

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<sup>37</sup> [BSAB@bradford.gov.uk](mailto:BSAB@bradford.gov.uk)



## Appendix 1 - Terms of Reference

The panel agreed the following terms of reference:

- Consider how race, culture, ethnicity, and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management:
  - particularly in regard to organic versus mental health, consideration of his presentation inclusive of legislation i.e., MCA/other legal frameworks and consider how race, culture, ethnicity, and other protected characteristics as codified by the Equality Act 2010 may have impacted on his treatment and care.
- Other factors are the response to Adult H in relation to his immigration status/Home Office and the expectation on other agencies i.e., his access to medical healthcare services, in the community as well as acute hospital, would a patient routinely be discharged to no fixed abode? Explore cross-boundary/agency communication to enable a holistic approach.
- Consideration of Covid and the impact on access to support as above:
  - consider Adult H's access to medication and healthcare services both in the community and when an inpatient in hospital.
- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Rochdale Borough Safeguarding Adults Board.
- Examine inter-agency working and service provision.
- Determine the extent to which decisions and actions were focussed on the needs of Adult H
- Examine whether outcomes during the timeframe of the review met the principles of Making Safeguarding Personal.
- Identify any actions required by Rochdale Borough Safeguarding Adults Board to promote learning to support and improve systems and practice.
- Seek contributions to the review from significant family members and keep them informed of key aspects and progress.
- Highlight good practice and share this with Rochdale Borough Safeguarding Adults Board.
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults with care and support needs.
- Identify if the responses to non-engagement were appropriate.



## Appendix 2 – Pennine Care Tabletop Review Recommendations

**Recommendation One** – Qualified nurses and doctors to receive training around mental health presentations arising from organic disease and the role of Mental Health.

**Update** – Ongoing, exploring looking at how to raise a local awareness of HIV-related dementia on the wards through a learning event.

**Recommendation Two** – Equality and diversity training, focusing on conscious and unconscious bias relating to ethnicity/social/cultural factors as relating to ethnicity/social/cultural.

**Update** – Covered for eLearning equality and diversity, this is mandatory training and compliance is monitored by line managers. When implemented this training allows staff to reflect on their practice and actions. In Adult H's case it could have enabled staff to consider other reasons for his presentation.

**Recommendation Three** - All qualified staff and consultants to undertake Mental Capacity Act training (2005).

**Update** - This is provided via eLearning and line managers should support staff in attending.

**Recommended Four** - Care planning to be reviewed to ensure that physical health is included.

**Update** - This has been actioned via the local improvement plan within Pennine.

**Recommendation Five** - Review of the discharge arrangements for patients leaving the ward to ensure discharge is robust and that the patients' needs are considered on discharge.

**Update** discharge checklist are completed with consideration given to needs. There were difficulties with Adult H engaging with discharge process.

**Recommendation Six** - A process to be in place for patients discharged from the ward with no follow up address to ensure they have access to 72 hours follow up appointment offered.

**Update** all patients are offered a 72 follow up at outpatient's clinic. This was not offered to Adult H; I am unable to say if he had whether he would have engaged with process

**Recommendation Seven**- Risk assessment training and formulation for all qualified staff.

**Update** this is now provided by the trust there has also been some local learning delivered. This could have benefited Adult H in relation to his discharge, when considering if this was safe.

**Recommendation Eight** - A process to be put in place to ensure contacts with other professionals are followed up by the medics and ward staff as appropriate to ensure that essential information and advice is obtained.

**Update** – the importance of sharing information and multiagency working is covered within mandatory level three safeguarding training, delivered by the safeguarding team. The team have increased capacity on courses to ensure that professionals within Pennine can access.

Staff are also encouraged to contact safeguarding duty team to discuss any concerns they have in relation to safeguarding.