Safeguarding Adult Review
Adult K

Presented to/approved by the Rochdale Borough Safeguarding Adults Board/Executive Group on 19 October 2023

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1. Introduction to the Review and Methodology

1.1. Adult K was sadly found deceased on the 19th of August 2022 at her home address. This succeeding Safeguarding Adult Review was commissioned by the Rochdale Borough Safeguarding Adults Board in accordance with the guidance provided in the Care Act 2014[1].

1.2. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with a legal background, who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews and safeguarding practice reviews in both children's and adults safeguarding, and domestic homicide reviews.

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

1.4. A multi-agency review panel[2] met on the 13th of March 2023 and considered the scope of the review. The panel decided that the review should focus upon the period from the 1st of November 2019, when Adult K removed her son (hereafter referred to as Child C) from education, until the 19th of August 2022, when Adult K was found deceased.

1.5. The panel agreed the Terms of Reference[3], and additional information was requested from the agencies involved to aid the review process.

1.6. The panel met on two further occasions to discuss the case and learning and to monitor the progress of the review. The review has also incorporated a practitioner learning event which was attended by professionals from the key agencies who had worked with Adult K[4]. 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.

1.7. 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.

1.8. 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.

2. Brief Summary of the Case

2.1. In December 2019, due to Child C not having been brought to school for a period of time and contact with Adult K having proven futile, education professionals raised concerns to Greater Manchester Police. Several unsuccessful attempts were made over a number of days by both education and police to access Adult K's property before Police Officers forced entry to the address and found Adult K and Child C inside.

[1] The Care Act 2014 states that Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

[2] The panel consisted of representatives from Pennine Care Foundation Trust, Adult Social Care, Greater Manchester Police, Integrated Care System, Rochdale Borough Safeguarding Board, Rochdale Borough Housing, Children's Social Care, Department of Work and Pension.

[3] Refer to Appendix 1

[4] Professionals from Pennine Care Foundation Trust, NHS Greater Manchester Integrated Care, Rochdale Borough Safeguarding Adult Board, Education (school), Rochdale Borough Housing, Children with Disabilities Team, Department of Work and Pension, Adult Social Care, North West Ambulance Service, Approved Mental Health Practitioners, Greater Manchester Police, and Children's Social Care.

2.2. Following this incident there was an escalation of concerns in respect of Adult K's ability to meet Child C's needs. This resulted in Child C becoming subject to a Child Protection Plan and Children's Social Care eventually seeking legal advice in June 2020.
2.3. Child C was removed from Adult K's care on the 12th of June 2020. Concerns were raised regarding Adult K's mental health, but the On-Call Psychiatrist and Section 12 Approved Doctor, who had urgently attended to assess her, did not deem Adult K to meet the requirements to be sectioned.
2.4. Whilst Adult K initially engaged with contacts arranged for her to see Child C, her contact ceased in December 2020 and the Children With Disabilities Team thereafter found Adult K hard to reach.
2.5. On the 19th of August 2022, two housing officers from Rochdale Borough Neighbourhood Housing attended Adult K's address due to an unpaid housing debt. On arrival, they saw flies against a window and as a result, tried the front door. The door was unlocked, but the chain was secured, and a piece of furniture was against it, obstructing entry. When the officers managed to gain entry to the address, they found Adult K in a decomposed state.

3. Family Engagement

3.1. Family engagement is an important part of the review process as family members are best placed to contribute their knowledge of a loved one to the review.
3.2. Rochdale Borough Safeguarding Adults Board contacted Adult K's sister and explained the Safeguarding Adult Review process. The reviewer is grateful to Adult K's sister (hereafter known as MI) for her willingness to speak and to help others through her reflections. Her voice is woven into the body of this report.
3.3. The Board, reviewer and panel members would like to extend their condolences to all members of Adult K's family.

4. Parallel Processes

4.1. Adult K's death was investigated as a Special Procedure Investigation. A post-mortem was carried out, but the cause of death was unascertained due to advanced decomposition.
4.2. Adult K's death was referred to HM Coroner. The Coroner's Inquest had not concluded at the time of writing this report.

5. Limitations

5.1. There have been some limitations to the review as unfortunately, despite various efforts to track them down in other Local Authorities, Rochdale Borough Safeguarding Adults Board was unable to secure attendance at the practitioner event of some of Child C's key Social Workers, both of which visited Adult K together at the home during the scoping period of this review, and one of which, was involved with the court proceedings.

6. Consideration and Analysis of the Case

To enable the review to understand who Adult K was, and the care and support she was offered, professionals explored her background and the following key practice episodes[5] with the Independent Reviewer.

Key Practice Episodes	Dates
Concerns leading to Child C becoming 'cared for'.	November 2019 – June 2020
Child C becoming 'cared for' and assessment of Adult K's mental health.	June 2020
Professional contact with Adult K following Child C's becoming 'cared for'.	June 2020 – August 2022

Adult K's Background

6.1. MI described how Adult K is the middle child of three siblings. Because their parents separated when they were young, they lived with their mum but remained in contact with their dad. MI described Adult K as loveable, smart, and intelligent with a stubborn streak. She said that Adult K was a giver, always willing to help and a good peace maker. She was a quiet person who did not enjoy rowdy environments.
6.2. Adult K was well educated to masters level. MI disclosed that after university Adult K became a born again Christian. She described her as fervent and devoted. Around this time Adult K started work with an airline company but by 2003 she had tired of the job and decided to move to the United Kingdom seeking 'greener pastures'. MI informed the review that Adult K had said that God was leading her.
6.3. MI said that Adult K taught in the United Kingdom when she first relocated. She described how Adult K kept in regular contact with the family but hid her pregnancy from them until her son, Child C[6] was a couple of months old.
6.4. Child C lives with Autism. He is non-verbal and uses communication aids and signs to express his wishes and feelings. Although Adult K's family knew that Child C couldn't speak, Adult K didn't ever discuss Child C's traits or characteristics in detail with them.
6.5. Until the scoping period of this review, Child C attended specialist education provisions for children and young people who have special educational needs and/or disabilities. This review has been informed that Child C can exhibit complex and challenging behaviours and would physically attack other students and staff members. School staff advised Adult K to seek medical help, believing that medication and mental health strategies could support Child C with his heightened behaviours, but following referrals having been made to services to support with Child C's complexities, Adult K said that she preferred to explore and use herbal remedies.
6.6. Child C has been known to the Children's Social Care Children With Disabilities Team since 2010 but his case had been closed prior to the scoping period of this review, in September 2019.
6.7. Nothing is known about the father of Child C.

Concerns Leading to Child C Becoming 'Cared For'.

6.8. Adult K stopped taking Child C to school from the 3rd of December 2019 and became increasingly difficult for school staff to contact. Prior to this, Child C's attendance had been good and Adult K had

[5] Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Adult K. 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.
[6] Child C was born in 2005.

communicated with school staff at least three times a day as she would drop Child C off, collect him for lunch and pick him up at end of the school day. In addition, Adult K was familiar to most of the staff as she was a known and respected Governor for the school.

6.9. Within the initial two weeks of Child C's absence, school staff attempted to call Adult K and also carried out home visits in an attempt to check on the family's welfare. No face to face communication was established, but Adult K did send text messages on the 4th and the 12th of December 2019 stating that Child C was overstimulated and hadn't slept. At the start of the third week of Child C's absences, school still hadn't managed any face to face contact with either Adult K or Child C, and neighbours told staff during attempted home visits that likewise, they had not seen either for days.

6.10. On the 19th of December 2019, school reported their concerns to Children's Social Care and the police. Following several unsuccessful visits to the property the police forced entry on the 28th of December 2019. Both Adult K and Child C were inside. Adult K said she hadn't answered the door because she had taken medication to help her sleep. The attending Officer created a care plan[7] and completed a referral to Children's Social Care.

6.11. Children's Social Care reopened Child C's case and attempted to visit Adult K and Child C in early January 2020 but could not engage Adult K. On the 13th of January 2020 Adult K contacted the school and informed them that Child C would not be attending for an indefinite period because *"she felt his life was not safe"*. Adult K said that she thought sugar was getting into Child C's bloodstream whilst he was at school, and he could not get rid of it. She said that this would ultimately lead to his death. Adult K told the school that she had informed the local authority of her decision.

6.12. Following a strategy meeting on the 16th of January 2020, Children's Social Care gained access to Adult K and Child C at the home address on the 27th of January 2020. During the visit Child C became aggressive towards Adult K and she consequently asked Children's Social Care to leave as she felt it was their presence that was impacting Child C's behaviour.

6.13. No further access was gained, and it was agreed in a further Strategy Meeting held on the 2nd of April 2020, that because Adult K could not be engaged and Child C remained out of education, a Section 47 investigation and Initial Child Protection Conference was required.

6.14. Despite numerous contact attempts by the safeguarding unit and conference chair, Adult K did not participate with the virtual[8] child protection conference, and on the 24th of April 2020, Child C was made subject to a child protection plan (under the category of neglect) in Adult K's absence. Because no professional gained further access to Adult K or Child C, Children's Social Care sought legal advice at the end of May 2020.

Child C Becoming 'Cared For' and Assessment of Adult K's Mental Health.

6.15. On the 8th of June 2020, following a virtual[9] court hearing which Adult K did not attend[10], Children's Social Care attempted to deliver her the ensuing Court Assessment Order. Because there was no response to their knocks on the door and no movement seen or heard within the home, the Social Workers posted the

[7] Where vulnerabilities of a person (child or adult) are identified a Care Plan (Adult Welfare Plans and Child Welfare Plans, referred to as a CAP) is created. The care plan allows for an accurate recording of what occurred during the incident and action taken. Information gathered during the incident is documented as it is important to understanding the risk to that individual or others and assist decision-making for what further action may need to be taken. The care plan is used for onward referrals to social care, for example. In this case a Child Welfare CAP was created, and onward referrals made to Children's Social Care.

[8] The conference convened virtually due to Covid Pandemic restrictions.

[9] The court hearing convened virtually due to Covid Pandemic restrictions.

[10] Adult K told the Doctor later undertaking her Mental Health Act Assessment that she had not attended because the letter had been in a different name to her own.

Order through the door with a slip requesting Adult K to urgently contact Child C's worker. Following a further futile home visit on the 9th of June 2020, Children's Social Care requested a police welfare visit.

6.16. Children's Social Care was present on the 10th of June 2020 when Police Officers forced entry into Adult K's home. Adult K was sat on a mattress in Child C's room with Child C. The Social Workers tried to talk to Adult K about engagement, and the court case, and explained that a Child and Family Assessment had to be completed. Adult K said she wanted to sleep and began to listen to music on her iPad.

6.17. The Social Workers found around 10/15 notepads containing handwritten scriptures. They recorded that it appeared that Adult K had been consistently writing scripts from the bible and writing about herself in the third person. She had also written about a teacher at Child C's school sacrificing her child and there were notes on the wall with passages from the bible with commandments. When asked, Adult K said the notepads were for her bible study.

6.18. An ambulance was called to review whether Adult K required hospital support for her mental health. Adult K decided not to go to hospital and the paramedics had no grounds to remove her as she was able to understand, retain and repeat information. In addition, the paramedics did not deem Adult K to be a danger to herself or Child C. Similarly, the attending Police Officers did not consider that the threshold of an *immediate risk of significant harm* had been met which would have permitted use of their Police Powers of Protection. The Social Workers consulted with their Practice Manager who said they would have to leave Child C in Adult K's care based on the ambulance and police decision. Adult K was informed that Children's Social Care would be asking for an Emergency Protection Order to remove Child C the following day and advised her to seek legal advice.

6.19. The Social Workers from Children's Social Care had contacted Adult Social Care to request an urgent Mental Health Assessment[11] for Adult K but had been advised to contact the Mental Health Team. The following day Adult Social Care emailed Children's Social Care to see if Adult K might require any support from them and during a subsequent phone call, the allocated Social Worker in Children's Social Care advised that she wasn't sure of the Mental Health Pathways. Adult Social Care directed her to contact the Community Mental Health Team to speak with the Approved Mental Health Professional hub and request a Mental Health Act Assessment.

6.20. Upon being made aware of Adult K's circumstances, the Approved Mental Health Professional hub contacted Adult K's GP on the 12th of June 2020 and updated him on a proposed plan regarding assessment. However, the GP said that he was unable to either review Adult K or attend for a Mental Health Act Assessment. Later the same day Adult K undertook a Mental Health Act Assessment with an On-Call Psychiatrist and Section 12 Approved Doctor.

6.21. Adult K did not meet the requirements to be detained under the Mental Health Act but she was provided with an emergency number to contact over the weekend should she need support, and both the On-Call Psychiatrist and Section 12 Approved Doctor said that they would refer Adult K to the Access and Crisis Team.

6.22. Also on the 12th of June 2020, an Interim Care Order was granted. Child C became a cared for child and was placed in The Bridge outreach centre.

Professional Contact with Adult K Following Child C's Becoming 'Cared For'.

6.23. On the 13th of June 2020 Children's Social Care contacted Adult K who said that she was much better since allowing Child C to be cared for elsewhere. Adult K asked how Child C was and the Social Worker said that feedback had been positive. Following this, most of Children's Social Care's communication attempts

[11] Professional confusion between a Mental Health Assessment and a Mental Health Act Assessment is discussed later in the report.

with Adult K went unanswered although she did engage with some parenting assessments and allowed a Social Worker to collect some of Child C's clothing.

6.24. On the 11th of September 2020 the Access and Crisis Team contacted Adult K by telephone for an assessment. Adult K advised that she had now taken advice from her lawyer who allegedly, strongly suggested that she cancel the appointment with the Access team and advised that no more assessments were needed. Adult K said that a doctor had completed a full assessment and passed all the information to the courts, to enable her to fight her case around Child C's care. The Access and Crisis Team advised the referrer, Children's Social Care, and the GP of the assessment outcome.

6.25. In December 2020, Adult K stopped engaging with the meetings about Child C's care and their family time contact sessions[12]. Concerned, Child C's Social Worker informed Children's Social Care Emergency Duty Team of how Adult K had not been seen since the 10th of December 2020, and the last contact had been an email that Adult K had sent to someone on the 20th of December 2020. The Social Worker said that she had tried to request a welfare check from the police but couldn't get through and asked that the Emergency Team attempt contact with the police over the weekend.

6.26. Subsequently police attended and spoke with Adult K on the 16th of January 2021 – Adult K said she had been in London.

6.27. There was very little further contact between Adult K and any professional throughout 2021 or 2022 although there is some email correspondence regarding the court hearings and some contact with the Department of Work and Pensions.

6.28. In May 2022 Adult K's sister reported a concern for Adult K to the police, having not seen or heard from her or Child C since November/December 2021. Adult K's sister was unaware that Child C was no longer in Adult K's care. The police later confirmed Adult K to be safe and well having seen her at her home address.

6.29. On the 19th of August 2022 Adult K was found deceased in her property.

7. Thematic Analysis

Following the multi-agency discussions of the Key Episodes and Terms of Reference, the following themes were identified for practice and organisational learning:

Theme 1 - Agencies Understanding of Adult K's Lived Experience

7.1. Adult K was born and raised in Nigeria. Nigeria is a country on the western coast of Africa. It gained independence in 1960, and its modern history has seen much strife and bloodshed, including a long civil war.

7.2. Adult K left Nigeria in 2003 when she was aged around 29 years. Within the documentation provided, this review seen very little reference to any professional who met Adult K, striving to understand and learn more about Adult K's cultural background, experiences, and beliefs. Yet such practice was necessary to attempt to understand Adult K's lived experience and to support professionals struggling to engage with her, to consider her behaviours alongside her cultural background. Exploration of Adult K's culture would have developed a better understanding of her as a person and could have led to a more effective person-centred approach which potentially may have facilitated Adult K to accept the support on offer.

7.3. For example, both MI and a representative from the Nigeria Community Association have informed this review that there are no Social Services in Nigeria. Therefore, even though Social Workers had been working with Child C for a long time, it cannot be presumed that Adult K would have had a full understanding of Child Protection procedures in the United Kingdom. The remit of Social Care, the importance of working with Social Workers, and the role of other support organisations could potentially have been alien to her.

[12] Adult K had previously been attending family time three times a week and had never missed.

7.4. Had a better understanding of Adult K's birth country been had by the professionals working with her and Child C, professionals could have learned how the Nigerian Child's Right Act 2003, which provides guidelines for all professional codes of conduct involving Nigerian children, though passed in 2003 has not been implemented nationally. In addition, Family Law has not been fully developed in Nigeria and not all of the states have separate family courts. Consequently, Adult K may not have understood how rejection of Social Care assessment process could lead to Child C becoming cared for.

7.5. This review has been informed by professionals of Nigerian heritage that in Nigeria, what is in a child's best interest is deemed to be whatever a parent/carer decides, and any arising social needs or problems are typically addressed by family, neighbours, and religious organisations. In collaboration with the idea that it is the parent's decision which is to be upheld, records show how Adult K was of the impression that she was able to close a casefile held by Social Care; when she wrote, *This text is to officially close my casefile. No need for Social Services to be concerned for my family's welfare, my husband and I are more than capable.* Other records of correspondence and telephone conversations during achieved communications, evidence that Adult K would reassure professionals that she was alright and would thank them for their contact. This also supports the theory that she was unaware of any potential repercussions of not accepting support on Child C's behalf.

7.6. Research, and conversation with MI, has identified further cultural issues that could have potentially affected Adult K's behaviours. Had professionals been aware of these cultural issues and thought about how they could potentially shape Adult K's lived experience, they may have been more understanding of Adult K's behaviours when attempting to engage her and build a relationship:

- Adult K spoke of a husband who was Child C's father, but he has remained unseen and unknown to professionals. It has not proved possible to trace Child C's father, and therefore it is reasonable to presume that Adult K was a single mother. This review has attempted to explore if and how Adult K's Nigerian culture may have affected her view of being a single parent. MI has helpfully explained that whilst it is reducing, there is a stigma in Nigeria for single mothers.
- Child C lives with autism. MI has told this review that autism in Nigeria is stigmatised and most of the time, such children are hidden from the public.
- Adult K was asked to undertake both a Mental Health Assessment and a Mental Health Act Assessment. A study[13] has identified that mental illness is widely stigmatised and misunderstood in Nigeria. The stigma means individuals are often sent to religious institutions and traditional healers, sometimes for decades[14][15].

7.7. This review has been informed that professionals could have consulted the AFRUCA Safeguarding Children network[16] for advice and support. AFRUCA work to promote the well-being and protection of children and families in black and ethnic communities across the United Kingdom. They provide a range of prevention and early intervention services and produce a guide for parents, Understanding Child Protection in the UK. The publication is targeted at parents who are unfamiliar with Child Protection laws and processes in the United Kingdom and who have found themselves involved in the Child Protection system.

7.8. AFRUCA also delivers specialist training courses aimed at enhancing the knowledge, skills and confidence of practitioners working with children and their families from diverse backgrounds. And can work with agencies to design relevant training courses which can be delivered face-to-face or remotely.

7.9. MI has told this review that Adult K *loved the Lord,* and that religion was very important to her. In line with this, the review was informed by professionals that Adult K was a member of a Pentecostal Church.

[13] Exploring Nigerian Mental Health Alex Robinson, Knowledge Exchange Intern

[14] Wada Y.H., Rajwani L., Anyam E., Kariakri E., Njikizana M., Srour L., et al., Mental Health in Nigeria: A Neglected Issue in Public Health. PHIP, 2021; 2

[15] World Health Organisation, Mental Health Atlas 2020 Country Profile: Nigeria. 2020. Accessed 3rd June 2022. Mental Health Atlas 2020

[16] AFRUCA Safeguarding Children

However, the church has advised that whilst Adult K was active, volunteering as a cleaner and being involved in various groups, she was not a member. And also, that Adult K ceased any involvement over ten years ago. MI recalled that Adult K said she had stopped attending the Pentecostal Church because God had asked her to. Instead, about five years ago, she started to follow the Jewish calendar.

7.10. As mentioned, when Social Workers attended Adult K's property on the 10th of June 2020, they found note pads containing handwritten scriptures and notes on the wall with passages from the bible with commandments. One of the notes written by Adult K was about a teacher at school sacrificing her child. Adult K said that the writings were part of her Bible study lessons.

7.11. It was clear that the professionals who attended the practitioner learning event were confused by the written scriptures. It was good practice that Adult K was asked about them, but upon learning that they were part of her bible studies, no more was asked in any attempt to understand their meaning and/or importance to Adult K until she undertook the Mental Health Act Assessment (the same day that Child C became cared for). During the assessment Adult K explained to the Doctor that she was one of the leaders of the Church, and a prophet who has to spread the word of God and is able to predict the future. In response to the Doctor's questions about the notes she had written, Adult K revealed numerous A4 notepads which extended back to 2004. Adult K said that she wrote down her thoughts, and information she had learned from the bible as it helped her mental health to write a diary. She said that the reference 'sacrificing her son' had been misinterpreted and that she had been talking about sacrifice in the context of giving up things for him.

7.12. It is interesting that the Doctor documented that Adult K's *beliefs did not appear to be delusional but consistent with her Nigerian cultural heritage and Christian religion.* This is the only documentation provided to this review which evidences a professional cogitating Adult K's behaviour in conjunction with her lived experience. The Doctor concluded that Adult K was likely experiencing an acute stress reaction to caring for Child C alone.

Learning 1 – As a result of not all professionals effectively exploring Adult K's background and culture, some professionals/agencies did not gain a vital understanding of Adult K's lived experiences or barriers to engagement.

7.13. A recent Safeguarding Adult Review[17] commissioned by Rochdale Borough Safeguarding Adults Board has already explored the importance of cultural curiosity[18] and how, regardless of how long a person has lived in the United Kingdom and/or has sought to integrate, understanding a person's culture is significant as a better understanding of a person's culture may offer insight into their interpretation of support services, and interventions. At the time of writing this report, the action plan for the aforesaid review was still being produced, but partner agencies reported additional training resources and sessions already being underway.

7.14. This review must also consider how the Coronavirus, which was identified as pandemic in December 2019, could have affected Adult K's lived experience. The first lockdown, initiated in March 2020, started to be lifted in May 2020, but in an attempt to contain the virus, there followed months of restrictions across England. The restrictions developed into a "four tier system", and at times affected further closure of non-essential retail and hospitality, and personal restrictions of movement. On the 6th of January 2021, a rising number of coronavirus cases saw national restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit with a plan, known as the 'roadmap' out of lockdown. This was intended to 'cautiously but irreversibly' ease lockdown restrictions. England moved through the roadmap as

[17] Adult H Final Report Adult H.pdf (nationalnetwork.org.uk)

[18] 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.

planned but step four was delayed until the 19th of July 2021 to allow more people to receive their first dose of a coronavirus vaccine. Consequently, professionals attending Adult K and Child C throughout the scoping period of this review were adapting to everchanging working conditions introduced to manage the virus and reduced staffing levels[19].

7.15. However, this review has been informed that most professionals still attempted to visit Adult K at home and consequently restrictions to practice introduced by Covid, did not remarkably affect the care and support offered to Adult K from professionals during the scoping period. This is with the exception of housing who have informed this review that their home visits were reduced during the pandemic and most contacts were instead made/attempted by telephone, email, text, and WhatsApp.

7.16. The practice around Adult K from Rochdale Borough Housing was further affected with regards to the response to arrears building on her property. Adult K was in receipt of full housing benefit, which was paid directly to Rochdale Borough Housing, but arrears began to accrue from November 2020. This review has been informed that during Covid arrears was not uncommon for Rochdale Borough housing and it was not unusual for housing to struggle to contact tenants to discuss arrears at this time. It was widely known that social housing tenants were protected by the Coronavirus Act 2020 which was delaying when landlords could evict tenants. The housing sector amended their arrears recovery processes accordingly.

7.17. Covid did not initially affect Child C's education as Adult K had already removed him from education when the pandemic hit. And whilst Child C's educational offer would at first have become remote learning, Adult K could still have taken him into school had she wanted to.

7.18. When in June 2020 Child C became cared for, the residential home had restrictions imposed by the Covid pandemic. Adult K's contact with Child C and meetings with the staff were consequently virtual but the Social Worker saw Adult K twice face to face at her home address to undertake some of the assessments.

7.19. Nevertheless, whilst professionals commendably continued to offer Adult K support during the Covid pandemic, the last few years of Adult K's life must have been affected by the pandemic, particularly as any church congregation she was attending would have been unable to meet. However, MI has told this review that she continued to speak with Adult K regularly during Covid and there were no indicators of Adult K finding it any harder than anyone else.

7.20. In summary, Adult K was an intelligent, deeply religious, Nigerian lady living in the Rochdale area. Her family network remained in Nigeria, but she drew support from her God and church. Whilst Adult K's relationship status remains unknown and we cannot establish the extent of any emotional support regarding the care of Adult K's son from his father, Adult K clearly managed her son's day to day physical care and wellbeing. Prior to the scoping period of this review there hadn't ever been concerns regarding Adult K's care of Child C. This review has been informed that Adult K provided a clean and tidy home and Child C was reported to be immaculately presented. However, it should be noted that by 2019 (the scoping period of this review) Child C had grown into an exceptionally strong, very tall young man with extremely challenging behaviours. It is known that he could be violent and had the potential to harm Adult K, albeit unintentionally.

7.21. Adult K was known to be incredibly articulated, and a very composed well-dressed lady. However, her demeanour is reported to have changed rapidly around December 2019. The reasons remain unknown. Following Adult K withdrawing Child C from school (because she feared that the school was providing him with sugar which would kill him), professionals attempted to reach out to her but were unsuccessful.

[19] It must be recognised that during much of this scoping period, even when the country was not in lockdown or subject to tier restrictions, the public was still being urged to exercise caution regarding the Covid situation. And whilst not always a legal requirement, any person pinged on the Test and Trace app, was expected to remain at home and self-isolate. This meant that reduced staffing levels - one of the problems that had arisen initially from the Covid pandemic, still remained a problem for agencies as staff who had been exposed to the virus, still had to self-isolate, and staff who had been unfortunate enough to contract Covid-19 were off work.

Insufficient engagement was achieved to complete any risk assessments and professionals' concerns escalated to the point that a court order was sought, and granted, for Child C to become cared for.

7.22. Following Child C becoming cared for, and over time, Adult K for unknown reasons, found herself unable to continue with her regular contact sessions with Child C and unable to reach out to professionals who may have been able to offer her support and advice.

7.23. By August 2022, when Adult K was sadly found deceased in her property, she had been living without her son for just over a year. It has not been possible to establish when or how she died. Even in death, Adult K's experience remains unknown.

7.24. Professionals needed to maximise the small windows of opportunity they had to explore Adult K's lived experience better. It has become clear during the course of this review that no professional gained a good understanding of Adult K. In particular, there wasn't enough professional understanding of Adult K's new lived experience after Child C became cared for (this is discussed further later in the report).

7.25. This highlights how more needs to be done over a longer period of time, post a child becoming cared for and how professionals must be alert to the possible long-term effects any parent can face. Only Adult K truly knows the extent of her grief and the circumstances of her death, but a lack of professional contact post Child C becoming cared for[20], has undoubtedly served to dramatically reduce professionals' ability to recognise any care needs and offer support.

7.26. Understanding Adult K's lived experience was crucial, and this serves as a reminder as to how important professional curiosity is.

Theme 2 – Think Family (and Referrals to other Agencies).

7.27. In December 2019 staff from Child C's school contacted both Children's Social Care and the police to report their concerns for Child C and Adult K, who they had not seen for some time despite several staff members attempting to persuade Adult K to open her door. This was good practice and evidenced a quick effective response to their concerns. However, professionals attending the learning event recognised that in line with a Think Family approach, Adult Social Care could have also been contacted at this time, as by now, because Adult K's behaviours were so different to how they had been before, staff at the school were concerned for her mental wellbeing.

7.28. Furthermore, it is recorded within the minutes of the Strategy Meeting (which convened in January 2020), that the change in Adult K's demeanour was discussed. The discussion is reflected in the summary notes which advise that *the information shared within the meeting … is very concerning, especially the significant and sudden change*. Two of the subsequent actions are for contact to be had with Adult K's GP re her mental health (it is not clear who is responsible for this action) and for the police to speak to mental health services.

7.29. It was good practice that Adult K was considered within the meeting in her own right, and that the actions were created, but there was a missed opportunity to include Adult Social Care in the meeting from the start. The Greater Manchester Safeguarding document: *Strategy Discussions*[21] notes within the section *Who should be involved?* that *where parents or adults in the household are experiencing problems such as … mental illness, it will also be important to consider involving the relevant adult services professionals.*

7.30. However, it is recognised that it could be argued that identifiable concern for Adult K and her mental health only surfaced when information was shared within the meeting. If this was the case, there was a further missed opportunity to refer Adult K to Adult Social Care within the actions.

Learning 2 - Practitioners did not consistently apply the Think Family approach and consequently opportunities were missed to engage Adult K in support in a timely way where there was chance to do so.

[20] This is discussed in detail later in this report.

[21] 4.4 Strategy Discussions (proceduresonline.com)

7.31. The Officer updated the Greater Manchester Police care plan noting that mental health checks had been completed with the police mental health liaison and that Adult K was not known. There is no record to confirm whether the GP was contacted post the meeting. The aforementioned *Strategy Discussions* guidance notes that it is the role and responsibility of Children's Social Care to record a *list of action points, timescales, agreed roles and responsibilities and an agreed mechanism for reviewing completion of the action points*. And to circulate this record to all parties within one working day.

7.32. In addition, section 6 notes that Social Workers with their managers are to *follow up actions to make sure what was agreed gets done*.

7.33. Panel members informed the review that usually, the chair of the meeting sets a review date to go over strategy actions. Such a review is usually scheduled for one or two weeks post the initial meeting. This Safeguarding Adult Review has not been able to establish why, on this occasion, this was not done but as a result, the actions drifted and neither outcome was recorded multi-agency. However, it must be noted that this omission is two-fold as in addition, individual organisations failed to review their own actions.

Learning 3 - A multi-agency opportunity to share information was missed when it went unnoticed that the actions of the strategy meeting had not been executed.

7.34. Child C became cared for in June 2020 following Children's Social Care being granted an Interim Care Order under the category of 'immediate harm'. From this time, the local authority shared parental responsibility with Adult K for making every important decision about Child C. Adult K did not lose her parental responsibility and importantly, she did not stop being Child C's mum.

7.35. As is reiterated in Rochdale Borough Council's procedure: Contact with Parents and Siblings[22], *the responsible authority has a duty to endeavour to promote contact between the child and parent…* This was done and initially Adult K was having regular contact with Child C.

7.36. Whilst this was ongoing, it was also important for professionals to support Adult K to address the problems which had resulted in Child C becoming cared for, i.e., her mental health.

7.37. In an attempt to assess and address Adult K's mental health, the Access and Crisis Team (now called the Response Hub) telephoned Adult K on the 19th of August 2020, but the telephone was not connecting. Following letter communication with Adult K, successful contact was had three months after Child C had become cared for (on the 11th of September 2020). At this time Adult K advised that she had undertaken a full assessment with a Doctor[23] which had been passed on to the courts as part of her challenge to Children's Social Care regarding Child C becoming cared for. Adult K said that she had now been legally advised not to engage with the Access and Crisis Team. The records note that Adult K was polite and calm throughout the call. The Access and Crisis Team had no concerns and were led by Adult K's decision not to partake in an assessment. Children's Social Care and Adult K's GP were updated with the outcome.

7.38. In December 2020, six months following Child C becoming cared for, Adult K stopped engaging with contact sessions with Child C and with the meetings. She also stopped answering phone calls, emails, and her door. As mentioned, as well as the onus being on the parent to be proactive in maintaining contact with the local authority when a child becomes cared for, there is an onus on the local authority to be proactive in maintaining contact and a positive relationship with the child's parent.

7.39. This review recognises how challenging this can be for professionals. Removing a child from a parent's care is one of the most invasive interventions into family life and parents are not always readily receptive to

[22] 5.3.1 Contact with Parents and Siblings (proceduresonline.com)

[23] A Doctor who did not work for the Pennine Care NHS Trust

working with professionals after their children have become cared for. This is why it is crucial that Social Workers are skilled in building good working relationships with parents.

7.40. In the middle of January 2021, when Adult K's withdrawal became clear, the Children With Disabilities team contacted Adult Social Care and requested that they do a welfare check. Adult Social Care informed the team to contact the police as it was the police who would do the initial check. Consequently, Officers attended on the 16th of January 2021 and found Adult K safe and well; she told them she had been in London.

7.41. No further contact was had with Adult Social Care from the Children With Disabilities team, and this was a missed opportunity to involve Adult Social Care further. Whilst the Children With Disabilities team were predominantly concerned with Child C, a Think Family approach would have seen better consideration of Adult K's situation and change in her behaviour regarding Child C's placement.

7.42. However, neither did Adult Social Care follow up the concern. Better practice could have seen Adult Social Care contacting either the Children With Disabilities team or Adult K directly, or both.

Learning 4 - The local authority effectively safeguarded Child C's welfare but there were missed opportunities to support Adult K to access services to help her manage the situation.

7.43. Post January 2022, most contact between Adult K and the Children With Disabilities team proved futile with Adult K not answering or returning calls. Some emails were communicated in February 2022 within which Adult K was polite but firm, indicating that she would hear from professionals through the judge.

7.44. Had, following key professionals losing contact with Adult K, multi-agency communications been had, professionals could have learned from each other that:

- Adult K was no longer having contact with Child C or engaging with meetings,
- Adult K's Disability Living Allowance ended in August 2021, her claim for Carers Allowance ceased in August 2021 and her Income Support ended in September 2021,
- Adult K's housing allowance was no longer being paid, debt was building and housing were struggling to contact her, and that,
- In May 2022, it became known to Greater Manchester Police that Adult K had stopped communicating with her sister[24] in Nigeria, and that Adult K had not informed family that Child C had become cared for.

7.45. Throughout this period of time, Child C's arrangements were subject to regular Looked After Children Reviews[25]. The Looked After Children reviews' focus was predominantly on Child C[26] and no other multi-agency meetings convened, therefore this information regarding Adult K, held by individual agencies was never gathered centrally.

7.46. Professionals at the learning event spoke of how Adult Social Care had, around the time that Child C became cared for, reached out to Children's Social Care initially. Following Children's Social Care contacting them to request an urgent mental health assessment, they had emailed Children's Social Care and made further telephone contact to obtain updates. In addition, Adult Social Care had attempted to call Adult K but there had been no response and no facility to leave a voicemail[27]. This was identified as good practice and representative of a dual approach which would benefit from greater structure and planning. Professionals spoke of the value of developing an interface between Children's Social Care and Adult Social Care at the point a child becomes cared for, and a protocol to follow regarding parental care.

[24] On the 12th of May 2022 MI reported a concern to the police having not heard from Adult K since November/December 2021. MI said she had spoken with Adult K's partner who had not heard from her either. Adult K was seen safe and well at her home address that day.

[25] Convened within twenty working days of a child becoming cared for, then within three months and then at subsequent six monthly intervals. Reviews must take place sooner if the Independent Reviewing Officer requests or if the Social Worker's assessment is that the child's welfare is not being adequately safeguarded and promoted.

[26] It was good practice that during the reviews, Adult K's withdrawal from communications with the Children With Disabilities Social Worker was discussed and it was agreed that the Social Worker would continue to try and make contact via phone, email, and home visits.

[27] This was on the same day that the Mental Health Act Assessment had been completed and Child C had become cared for.

Learning 5 – A proactive approach to parents is required at the time a child becomes cared for, in an attempt to pave the way for future professional engagement and support them to access support services.

7.47. Professionals also mooted offering parents a Specific Point Of Contact should they require any support in the future. They also agreed it was important that parents were signposted to support groups at regular intervals following a child becoming cared for, throughout court proceedings and their conclusion.
7.48. The review learned that whilst there is some support for parents from the Rochdale Borough NEST Team[28] for women who have had children removed through care proceedings within the last 2 years, and from the charity PAC-UK[29] post adoption, professionals remain concerned that support for parents is limited.
7.49. This review has heard how Adult K was involved with Rochdale Parent Carer Voice. A Parents' Forum for children with disabilities which is part of a Regional and National network of parent carer forums. The forum has built a reputation as a group which works co-productively with parents and professionals to bring about positive change[30]. Could some collaboration be had between the local authority and groups such as these to offer independent support to parents experiencing similar to Adult K?
7.50. With regards to extended family, MI has asked why family wasn't explored when Child C became cared for. The Children With Disabilities Team has explained how around July 2020 placement for Child C was explored with extended family living in Nigeria but found to be unsuitable. The team has explained that this was the earliest opportunity they had to consider extended family because prior to this, Adult K had not supplied any contact details.
7.51. It is for the same reason that MI wasn't included in Adult K's support package when Adult K was undertaking the Mental Health Act Assessment earlier within the scoping period of this review. As part of their role, the Approved Mental Health Professional must take all reasonable steps to identify a patient's Nearest Relative as defined by Section 26 of the Mental Health Act. This is because the Nearest Relative affords certain safeguards when intervention under the Mental Health Act is being considered and in addition, family members/carers will often hold valuable insights into the person's mental wellbeing, which inform the assessment process.
7.52. In the Mental Health Act Assessment of Adult K, the Approved Mental Health Professional was informed by colleagues in Children's Services that Adult K had reported that she lived with her husband, who according to Adult K, had come over to the United Kingdom in 2019, seeking asylum. Adult K had said that her husband was currently in London attending a court case around his asylum application and was not contactable, as he did not have a phone. Furthermore, although Adult K remained insistent that her husband was in the United Kingdom, Children's Services reported that all necessary checks had been completed and they could not find any evidence of this.
7.53. Adult K did not disclose the details of any other relatives at the time, and consequently this review has been informed how it was not possible for the Approved Mental Health Professional to liaise with any significant family members for the purpose of the Mental Health Act Assessment. The Mental Health Act Code of Practice (2015) recognises that there may be situations such as this where the Approved Mental Health Professional has insufficient information to identify or locate the Nearest Relative, and states that where an excessive amount of investigation is required causing unreasonable delay, then the Nearest Relative need not be involved/informed.

Theme 3 - Professional Understanding of Mental Health Pathways.

7.54. Professionals attending Adult K on the 10th of June 2020 became concerned for Adult K's mental health.

[28] NEST Team | Our Rochdale
[29] PAC-UK | Adoption & Permanency: Advice, Support, Counselling & Training
[30] Our Story - Rochdale Parent Carers Voice

7.55. Initially an ambulance was called and Adult K, having spent time with the ambulance crew agreed to attend the hospital for what is recorded as, a mental health assessment. A Social Worker asked the police whether Child C could be made subject to Police Protection Powers to facilitate him being placed with alternative local authority carers whilst Adult K attended hospital, but this was not possible and in time, Adult K changed her mind and declined to go to hospital. She was deemed to have capacity to make this decision.
7.56. The Social Workers now regarded a need for a Mental Health Act Assessment to decide whether Adult K needed hospital support.
7.57. Initially the Social Workers present were unsure of the process regarding a Mental Health Act Assessment and sought the advice of Adult Social Care who advised contact to be had with the Community Mental Health Team in order to speak with the Approved Mental Health Professional[31] hub. It was good practice that the following day, a duty Social Worker from Adult Social Care emailed Children's Social Care to ask if any further support from Adult Social Care was required and during a subsequent telephone call with the allocated Social Worker in Children's Services, guided further.
7.58. Discussion within the practitioner learning event has highlighted to this review the confusion that frontline professionals have around Mental Health pathways, in particular regarding the differences between a Mental Health Assessment and a Mental Health Act Assessment. For example, within Adult K's records the assessment requested around this time is recorded as both a Mental Health Assessment and a Mental Health Act Assessment – which are two very different assessments.
7.59. Under section 13 of the Mental Health Act[32], councils must arrange for Approved Mental Health Professionals to consider the cases in which an application may be required to admit a person to hospital under the act. Where Approved Mental Health Professionals decide that a Mental Health Act assessment is required, they must find two doctors whose agreement is necessary for an application for detention under the act to proceed. One of the doctors must be approved as having expertise in mental health, under section 12 of the act, and the other – generally – is expected to know the patient.
7.60. The Approved Mental Health Professional contacted Adult K's GP Practice and learned that according to records, Adult K had not had contact with her GP since January 2014. A message was left anyway for the GP to return the call. The Approved Mental Health Professional then contacted the On-Call Consultant Psychiatrist who informed to be available later that day and this was agreed to, due to the unlikeliness of the GP undertaking any home visits owing to the Covid restrictions then in place.
7.61. This review has learned that many NHS trusts cannot spare medics for Mental Health Act Assessment from busy ward rounds and similarly, GP Practices cannot always spare a GP. The GP Practice has explained to this review how GPs are rarely in a position to complete a home visit at short notice because they have to be available to attend pre-booked appointments, and the impact of any cancellation on another patient must be balanced against the effectiveness of the home visit. A named GP for safeguarding has confirmed that in most cases, when contacted by an Approved Mental Health Professional, the GPs will not be in a position to attend at short notice.
7.62. Consequently, it is not unusual for a GP to decline involvement with a Mental Health Act Assessment. However, the Approved Mental Health Professional who contacted Adult K's GP has spoken of the GP becoming irate when requested to review Adult K. Though it has not been possible to ascertain for certain, it is possible that the GP was unaware that such contact and the offer of the opportunity to attend the Mental Health Act Assessment, is part of the Mental Health Act Assessment process that must be followed to allow the Approved Mental Health Professional to search for another doctor to attend. The GP Practice has acknowledged that the GP in question was admittedly frustrated by the request but has reminded the review of how exhausted staff in Primary Care were at this time. There were issues around workload pre pandemic, but the Covid pandemic added layers of additional pressures to their work.

[31] The Approved Mental Health Professional is a statutory role created with the 2007 amendments to the Mental Health Act 1983, replacing the Approved Social Worker role. Eligible professionals undertake the Approved Mental Health Professional role on behalf of local authority social services departments who are legally responsible for the Approved Mental Health Professional service. The role works closely with NHS Mental Health Trusts, who provide many of the services that Approved Mental Health Professional's require, to undertake their role.
[32] Mental Health Act 1983 (legislation.gov.uk)

Learning 6 - Currently, not many professionals other than mental health practitioners, fully understand the mental health pathways.

7.63. The Approved Mental Health Professional Leads Network wants the government to use its impending reform of the Mental Health Act to reflect duties, similar to section 13 of the Mental Health Act, on partners (including Integrated Care Boards and Mental Health Trusts), to require them to support the assessment process. The network is calling for a requirement in the code of practice for there to be sufficient section 12 doctors available to carry out assessments, similar to the duty on councils to ensure sufficient Approved Mental Health Professionals. No such changes are included in the government's draft Mental Health Bill (published in 2022) and the parliamentary joint committee who recently scrutinised it, did not recommend the changes[33]. It will now need to rely on the government introducing the measures in its full Mental Health Bill, due for publication later this year, or on MPs or peers to push amendments making the changes during its passage through Parliament[34].

7.64. Adult K did not meet the requirements to be detained under the Mental Health Act, but both the On-Call Psychiatrist and Section 12 Approved Doctor said that they would refer Adult K to the Access and Crisis Team. It was good practice that the Approved Mental Health Professional ensured that this referral was completed and also provided the Access and Crisis team details of the Mental Health Act Assessment. This was important because Adult K was not known to services. Consequently, the Access and Crisis Team contacted Adult K to undertake a Mental Health Assessment.

7.65. A Mental Health Assessment is a conversation between a person and a mental health professional to help decide what kind of support a person needs. Adult K declined the assessment, and she was entitled to make this decision as there was nothing to suggest that she did not have decision-making capacity.

7.66. The Approved Mental Health Professional Hub has advised this review that instead of arranging the Mental Health Act Assessment, it may have been possible to arrange a Mental Health Assessment as a first step towards considering the concerns around Adult K's mental health. It is evident that agencies (outside of mental health) are often unclear about whether to request a Mental Health Assessment or a Mental Health Act Assessment, and this review has been assured to learn that the Approved Mental Health Professional Hub has already arranged briefings for Adult Social Care and other agencies such as the police to support learning. However, the hub has said that it is open to a more coordinated approach to enhance interface working and develop the understanding of mutual professional roles and pathways across mental health, adult care, and children's services.

8. Conclusion

8.1. Adult K was a devout Christian who moved to the United Kingdom from Nigeria.

8.2. In the United Kingdom, Adult K was known to Children's Social Care and education professionals because in 2005, she had a child (known as Child C), who lives with autism. Neither Adult K nor Child C were well-known to health professionals as Adult K believed in alternative medicine.

8.3. Early in the scoping period of this review, some professionals recognised that Adult K's demeanours and behaviours were rapidly changing, and they became concerned for both her mental health and her ability to meet Child C's needs.

8.4. Professionals attempted to reach out to Adult K to support her with Child C but struggled to engage her in any support. Adult K informed them that whilst Child C would no longer be attending school as she believed staff were allowing him sugar; she and Child C were fine. Unassured professionals started to escalate concerns for Child C. Professionals overlooked to consider what support could be offered to Adult K in her own right.

[33] The draft Mental Health Bill: parliamentary proposals for change - Community Care

[34] Unavailability of beds, doctors and transport increasing risks for those in crisis, warn AMHP heads - Community Care

8.5. Mostly throughout this time Adult K did not respond to professional correspondence and/or visits, and in June 2020 Children's Social Care decided to request police assistance to gain entry to Adult K's property. Upon gaining entry, Social Workers' concerns heightened, and whilst it was clear that Adult K was continuing to meet Child C's basic care needs (i.e., food and a clean, tidy home), events resulted in Child C becoming cared for.
8.6. With the exception of the Approved Mental Health Professional (who, though confused by mental health pathways, professionals now referred Adult K to), there is no evidence of any professional applying cultural curiosity to Adult K and exploring her Nigerian nationality and Christian faith with her. This resulted in key professionals never gaining a true understanding of Adult K's behaviours or lived experience.
8.7. Following Child C becoming cared for, Adult K found herself living without her child for the first time in 15 years. Her family still lived in Nigeria and because of the Covid pandemic, her church congregation would have been often unable to meet.
8.8. For unknown reasons, within six months of Child C becoming cared for, Adult K disengaged from contacts with him and withdrew from the Children With Disabilities team.
8.9. At this time, there was no multi-agency information sharing or multi-agency consideration of the impact on Adult K, of Child C becoming cared for. And, though concerned, there was a lack of professional support offered to Adult K at this critical time.
8.10. The events of Adult K's death sadly remain unknown, but there is no doubt that Adult K was failed by a lack of positive action being taken by professionals to help Adult K to understand the circumstances of Child C becoming a cared for child, and to learn of the effect upon Adult K.

9. Good Practice

9.1. The agency reports submitted to this review and the discussions around Adult K, have highlighted examples of good practice[35] from professionals involved with Adult K and Child C. Some examples are included in the body of this report, but others include:

9.1.1. A quick response was had by school when Adult K and Child C became hard to reach and several staff members attempted to contact Adult K in the hope that she may feel able to respond to one of them.
9.1.2. Greater Manchester Police made the appropriate referral to Children's Social Care when they gained entry to the address in December 2019.
9.1.3. Adult Social Care, upon learning of the mental health concerns for Adult K, shared the information with the GP Practice.
9.1.4. The Approved Mental Health Professional Hub responded quickly and set up the Mental Health Act Assessment at short notice. This was in difficult circumstances around Child C becoming cared for.
9.1.5. The Approved Mental Health Professional's case recording and report writing ensured timely information available to adult care colleagues in the event of further contact.
9.1.6. The Approved Mental Health Professional checked progress of the referral to the Access and Crisis team and followed this up when it was clear this had not been actioned.

10. Improving Systems and Practice

10.1. Agencies have already made some important amendments to practice since the scoping period of this review. Some of these developments have been included in the body of this report. Others include:

[35] Good practice in this report includes both expected practice and what is done beyond what is expected.

10.1.1. Pennine Care NHS Foundation Trust has informed this review that whilst all interactions with Adult K were in line with their policies and procedures, the Trust is developing a new policy entitled – Disengagement from Service Policy.

10.1.2. The Approved Mental Health Professional Hub are in the process of developing some standard outcome letters to support Approved Mental Health Professional's to follow a Mental Health Act Assessment in line with the Mental Health Act Code of Practice.

• the patient's nearest relative
• the doctors involved in the assessment
• the patient's mental health care co-ordinator (if they have one), and
• the patient's GP, if they were not one of the doctors involved in the assessment

Had this been available at the time the GP would have received in writing the outcome of the Mental Health Act Assessment from the Approved Mental Health Professional who assessed Adult K.

10.1.3. Whilst the Approved Mental Health Professional ensured that their case recording was completed immediately following the Mental Health Act Assessment on the Adult Social Care record, the Approved Mental Health Professional should have included a case notification to the relevant duty team as a prompt. To ensure that this isn't missed in the future, this will be included in Approved Mental Health Professional practice assurance audits completed quarterly and Approved Mental Health Professionals will be reminded of the need to communicate their decision as above.

10.1.4. When Adult Care received an email from Greater Manchester North Coroners querying information/details for services provided, Adult Care business support advised that they had not assessed Adult K and that no care plans had been put in place via any of the Adult Social Care teams. This was incorrect as the Adult Social Care Approved Mental Health Professional Hub had assessed Adult K and Children's Services had been involved. To address this, a new process for all communication received from the Coroner's Office to go through the Training Practice Assurance and Safeguarding team has been implemented.

11. Questions for Rochdale Borough Safeguarding Adult Board

11.1. The learning which has been identified throughout the course of this review, and the questions to support Rochdale Borough Safeguarding Adult Board to address it, is as follows:

11.1.1.

Learning 1: As a result of not all professionals effectively exploring Adult K's background and culture, some professionals/agencies did not gain a vital understanding of Adult K's lived experiences or barriers to engagement.

This is learning that has been recently highlighted to Rochdale Borough Safeguarding Adult Board within the Safeguarding Adult Review, Adult H.

Question 1 – How can Rochdale Borough Safeguarding Adult Board ensure that their subgroup considers the action plan produced in response to Adult H, against the learning within this report?

11.1.2.

Learning 2: Practitioners did not consistently apply the Think Family approach and consequently opportunities were missed to engage Adult K in support in a timely way where there was chance to do so.

Question 2- How can partner agencies assure both Rochdale Borough Safeguarding Adult Board and Safeguarding Children's Partnership that professionals from all agencies are informed of a 'Think Family' approach and support one another to include it within practice?

11.1.3.

Learning 3: A multi-agency opportunity to share information was missed when it went unnoticed that the actions of the strategy meeting had not been executed.

Question 3 – How can Rochdale Borough Safeguarding Adult Board (with the support of the Rochdale Borough Safeguarding Children Partnership) establish the extent of actions produced in Strategy Meetings being missed, using a multi-agency system audit process?

11.1.4.
Learning 4: The local authority effectively safeguarded Child C's welfare but there were missed opportunities to support Adult K to access services to help her manage the situation.
This learning should be addressed in conjunction with the learning/question 2 at paragragh11.1.2.

11.1.5.
Learning 5: A proactive approach to parents is required at the time a child becomes cared for, in an attempt to pave the way for future professional engagement and support them to access support services.
Question 4 – How can Rochdale Borough Safeguarding Adult Board (with the support of the Rochdale Borough Safeguarding Children Partnership) produce a guidance document for professionals working with the parents of children becoming cared for?
The guidance should:

- **develop/explore what support/advocacy services are available,**
- **explain how a parent can be connected to support, and**
- **support professionals to understand consent issues which can arise when referring a parent.**

11.1.6.
Learning 6: Currently, not many professionals other than mental health practitioners, fully understand the mental health pathways.
Question 5 – How can the Rochdale Borough Safeguarding Adult Board work with mental health agencies/professionals to understand and improve mental health pathway training and be assured that training includes visual documentation for professional reference at a later date when required?

11.2. In order to address the above learning, the review would ask the Rochdale Borough Safeguarding Adult Board to deliberate the questions. It is the responsibility of Rochdale Borough Safeguarding Adult Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

12. Appendix 1 – Terms of Reference

- Determine the extent to which decisions and actions were focussed on the needs of Adult K
- 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.