Safeguarding Adult Review
Adult L

Presented to the Rochdale Borough Safeguarding Adults Board
on the 19th of October 2023

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Contents

1. Introduction to the Review and Methodology

1.1. Adult L was sadly found deceased in her home address on the 14th of November 2022, aged 31 years. This succeeding Safeguarding Adult Review was commissioned by 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[3] on the 18th of April 2023 and considered the scope of the review. The panel decided that the review should focus upon the period from the 22nd of January 2021, when Adult L was admitted into hospital with sepsis, until the 14th of November 2022, when Adult L was found deceased.

1.5. The panel agreed the Terms of Reference[4] 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 L[5]. 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, and a Consultant Bariatric Surgeon who is a co-chair of the British Obesity and Metabolic Surgery Society Patient Safety Committee, 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. Adult L came to the United Kingdom with her mother and siblings from Nigeria, to seek asylum, when she was around 12 years old. Professionals who knew Adult L when she was a teenager[6] report that her relationship with her mother became strained and when she was around 13/14 years old, her mother physically assaulted her. In 2005, following a period of Child in Need support, Adult L was accommodated into Local Authority Care. Adult L then experienced several changes in placement before settling with a foster carer. When Adult L turned 18 years of age, she moved to Rochdale in supported living accommodations.

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[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 Greater Manchester Police, Stepping Stones, Integrated Care Board, Rochdale Borough Safeguarding Adults Board, Rochdale Borough Housing, Adult Social Care, and Northern Care Alliance.

[3] All panel meetings and the practitioner event were held virtually.

[4] Refer to Appendix 1

[5] Representatives from Children's Social Care, Integrated Care Board (GP Practice Nurse), Rochdale Borough Safeguarding Adults Board, Adult Social Care, and Northern Care Alliance (District Nurses, Hospital Staff)

[6] Further consideration of Adult L's lived experience as a child is had later in the report.

2.2. Adult L lived with long standing issues with weight management, and by the scoping period of this review was a bariatric patient. She also experienced chronic back pain, ulcers to the back of her legs, anxiety, and depression.
2.3. In 2019, due to mobility issues and needing a level access shower, Adult L started a tenancy (ground floor flat) with Rochdale Boroughwide Housing, initially supported by Stepping Stones[7].
2.4. In January 2021, when Adult L was admitted into hospital with sepsis, her home was reported to be unkempt and cluttered and there was evidence of poor personal hygiene. A safeguarding referral was made but following Adult L's discharge from hospital, support services only achieved a limited engagement.
2.5. By February 2022 Adult L's property had deteriorated to an unkempt and malodorous condition. Adult L agreed to her property undergoing a deep clean but following a Care Act Assessment being completed by Adult Social Care, she declined further support. Adult L was deemed to have capacity to make this decision.
2.6. On the 22nd of September 2022 after a Housing Officer had visited Adult L and become concerned, Rochdale Borough Housing submitted a Safeguarding Referral. Consequently, a duty Social Worker communicated with Adult L, who then agreed to allow nurses into her home and to consider mental health support if delivered by telephone. Unfortunately, nurses still did not achieve physical access and on the 14th of November 2022, Adult L was sadly found deceased in her bed.

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. The Rochdale Borough Safeguarding Adults Board contacted Adult L's sister and her foster carer and explained the Safeguarding Adult Review process. The reviewer is grateful to both for their willingness to speak and to help others through their reflections. Their voices are woven into the body of this report.
3.3. Sadly, Adult L's sister and Adult L were estranged as teenagers, but Adult L's sister depicted how inspirational Adult L had been to her and their younger siblings. She describes Adult L as a very loving and caring sister who used to like to make sure that everyone was okay. Adult L's sister confided in the review how she had tried to locate Adult L on many occasions and had always hoped to rebuild their relationship.
3.4. Adult L's foster carer described how she and Adult L developed an excellent relationship in the few years they spent together, and she wished Adult L could have stayed with her longer. She described Adult L as having a larger than life character with a huge personality but said that she was also a very vulnerable lady.
3.5. The Board, reviewer and panel members would like to extend their condolences to all members of Adult L's family and those who cared for her.

4. Parallel Processes

4.1. Adult L's death was referred to the Coroner. The Coroner's Inquest had not concluded at the time of writing this report.
4.2. Rochdale Adult Social Care commissioned a Serious Incident Practice Review Report to review Adult L's case from the beginning of their involvement on the 25th of July 2017 until the 18th of November 2022 when Adult L sadly passed away[8].

[7] Stepping Stone Projects provides accommodation and support across the North-West to care leavers, people who are homeless and those currently at risk of losing their homes | Stepping Stone Projects (stepping-stone.org.uk)
[8] The terms of reference and learning recommendations from the report can be found at Appendix 2.

5. Limitations

5.1. There have been some limitations to the review. There was only one professional present at the learning event who had worked directly with Adult L during the scoping period. And with regards to cultural support for the review, whilst Rochdale Borough Safeguarding Adults Board's Reviewing Officer reached out to the Nigerian Community Association, the New Step for African Community, and Caring and Sharing, none responded with any offer of support. Rochdale Borough Safeguarding Adults Board's Reviewing Officer also spoke with an individual at the Nigerian High Commission, but no one returned any calls.

6. Consideration and Analysis of the Case

To enable the review to understand Adult L, and the care and support she was offered, professionals explored her background and the following key practice episodes[9] with the Independent Reviewer.

Key Practice Episodes	Dates
Hospital Admission.	22nd of January 2021 – 25th of January 2021
The Professional Support Offer.	25th of January 2021 – 17th of February 2022
House Clean.	17th of February 2022 – 2nd of September 2022
Safeguarding Referral.	22nd of September 2022 – 14th of November 2022

Admission to Hospital.

6.1. On the 22nd of January 2021 during a telephone consultation Adult L's GP advised Adult L that due to her reporting oedema in both legs and ongoing symptoms of anxiety and low mood, she needed to attend the surgery for a face to face review. Following Adult L explaining that she was unable to attend either the surgery or the emergency department at the hospital, as she could not walk, the GP advised the need for a home visit via the Acute Visiting Scheme[10].

6.2. As a result of the subsequent home visit and Adult L being found to be red flag sepsis[11], a GP arranged for North West Ambulance Service to attend and though reluctant, Adult L was persuaded to allow them to transport her to hospital. Following transportation, the ambulance crew raised a safeguarding concern notification, as the property had been noted to be cluttered (clutter score 3[12]) and Adult L had acknowledged that she needed support in the home with everyday tasks and personal hygiene.

6.3. At the hospital Adult L informed staff of her mobility issues and said that she hadn't been out of her home address for approximately a year. She also said that she had lost touch with family and friends.

6.4. The symptoms Adult L presented with (pain and swelling to her leg which was oozing fluid), led to an in-patient admittance. Whilst on the ward, a social work assessment completed by Adult Social Care deemed Adult L to need a bariatric bed and commode, and support with transfers at home. The paperwork stated that a long term package of support was needed.

[9] Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Adult L. 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.

[10] The service is for patients who need to be seen in their own home. The GP can choose to refer on to the acute home visiting scheme to manage urgent care needs and enable them to focus on other priorities in Primary Care.

[11] The presence of any of the "Red Flag" features on the screening tool. Predicts if the patient is at a higher risk of severe sepsis or septic shock.

[12] The clutter image rating scale consists of three sets of 9 colour photographs. Each set depicts a room in the home with varying amounts of clutter (1=least cluttered, 9=most cluttered). Participants are instructed to rate the level of clutter in the corresponding room in the home using the photographs.

6.5. Upon discharge on the 25th of January 2021, a referral was made for the Short Term Assessment and Reablement Service to assist with Adult L's personal care for morning and tea and evening combined visits. Adult L was also referred to the District Nurses.

The Professional Support Offer

6.6. Over the next 12 months several support services attempted to engage Adult L as follows:

Support Service	Contact	Action
Short Term Assessment and Reablement Service	Adult L said she only wanted a morning visit to allow staff to support her daily with a shower. Home visits completed on 5 consecutive days.	After 5 days Adult L cancelled the service. Cancellation request upheld.
District Nurses	Following hospital discharge, twice weekly home visits were mostly successful until May 21 (when they were reduced to monthly visits). No home visits were achieved between May and November 2021, although Adult L did occasionally speak with nurses at the window. Post November 2021 access was intermittent.	Adult L was discussed in Safety Huddles[13]. Referrals were made to other support services.
Occupational Therapy	Assessment completed. Equipment delivered.	Nothing else required.
Lymphedema nurses	District Nurses referred Adult L to Lymphedema nurses for specialist advice, but it was established that Adult L was not suitable for involvement with Lymphedema service at this time due to high Body Mass Index.	Lymphedema nurses advised District Nurses to re-refer if Adult L experienced improvement with weight management.
Rochdale Infirmary Nutrition and Dietetics	Initial appointment with Dietician took place via telephone. Adult L declined further involvement. The GP was informed.	Adult L declined input from the service.
GP Practice	Adult L did not always answer the telephone or return calls, but regular telephone contact was upheld. Nurses gained entry to the hall of Adult L's address to take bloods. The GP successfully visited Adult L in her home in August 2021.	Referrals were made to dietitian services, weight management services, and Adult Social Care as appropriate.
Social Prescribing Link Worker	Telephone contact successful.	The link worker was to call again after one month – this was not done, and the review has been unable to establish why it was missed.
North Manchester General Hospital Colorectal	Adult L did not attend her appointment. Attempts were made to reschedule but Adult L informed that she did not wish to attend.	Discharged from the service.
Adult Social Care	Adult L did not always want workers to attend her property and did not always answer the telephone. Some visits were successful.	Adult L deemed to have capacity to decline support.

[13] Safety Huddles are explained later in the report.

6.7. Professionals exampled good practice by completing Mental Capacity Assessments regarding Adult L's decision-making in relation to proposed treatment. She was always deemed to have capacity.
6.8. The District Nurses raised Adult L in their safety huddles on 18 occasions during the scoping period of this review - mostly referencing no access visits. Consequent action planning predominantly regarded professionals to keep trying, but on two occasions it was agreed to try and gain consent for a referral to be made for a Focus Worker. This review has been unbale to ascertain for certain whether this was ever discussed with Adult L, or whether any consent was gained.
6.9. During this period of support, many professionals struggled to engage Adult L in a consistent and meaningful manner. There is no reference to any professional gaining a good enough understanding of Adult L or her lived experience, in order to gain insight into any potential barriers to Adult L accepting support.

House Clean.

6.10. On the 17th of February 2022 Adult Social Care visited Adult L after a professional (who had been collecting some property) reported the address to be in an 'unkempt and malodorous condition'. Adult L allowed the worker entry and explained how she hadn't been wanting to let people in due to depression. Adult L acknowledged that the flat had got into a mess and said she was glad that she had answered the door and that she wanted help. Adult L said that she was willing to pay for a deep clean of the property.
6.11. Adult Social Care forwarded Adult L's contact details to a cleaning company and also arranged a Care Act Assessment for the 16th of March 2022. Sadly, Adult L later cancelled the Care Act Assessment stating that she felt unwell, and the cleaner said that they would not perform the deep clean due to the smell. Following a further cancelled appointment, Adult L engaged with a Care Act Assessment on the 29th of March 2022.
6.12. Although the Adult Care Social Worker maintained regular telephone contact with Adult L over the following few weeks, following the assessment, both the District Nurses and the Social Worker struggled to physically see Adult L as she refused them access to the home. On the 9th of June 2022 the Social Worker discussed with Adult L the importance of letting the District Nurses into the address to look at her wound. During the conversation it became clear that a new cleaner, sourced by Adult Social Care had failed to contact Adult L. Adult Social Care chased this up.
6.13. Adult L continued to refuse healthcare professionals entry to the house.
6.14. On the 12th of July 2022, Adult L advised the Social Worker that the cleaners had now been paid and were booked for the following week. However, the next contact attempted by the Social Worker, 3 weeks later, was unsuccessful and conversation with the cleaners established that Adult L had cancelled the deep clean and not re booked.
6.15. No further professional contact was had until the 8th of August 2022 when an employee at Rochdale Borough Housing reported a concern for Adult L. He had been at the address on a callout and become concerned as the flat was very dirty with boxes everywhere. The safeguarding co-ordinator actioned a welfare visit which was attempted 2 days later. Whilst the Housing Officer did not gain entry, she reported a bad smell when Adult L opened the door slightly and said that she had seen several bin bags in the hallway.
6.16. On the 15th of August 2022 Adult Social Care closed Adult L's case citing that Adult L had declined support and did not want anyone in her house - though she was happy to still have the property cleaned.
6.17. The deep clean was completed on the 24th of August 2022 by a cleaning company who had since been requested by housing. The cleaner described Adult L as a lovely, chatty person who was appreciative of the support. The cleaner did a few tip runs with rubbish from the home and recalled that Adult L was not at all anxious about any clutter/rubbish being removed. Adult L had asked for help clearing out-of-date food and sorting out the freezer. The cleaner focussed on the kitchen and the bathroom but also helped to organise the bedroom and looked to clear some space in the living room.

6.18. No access was further gained by any professional until the 2nd of September 2022 when Adult L allowed a Housing Officer inside as she had reported her bathroom floor to be peeling away.

Safeguarding referral

6.19. On the 16th of September 2022 the GP advised Adult L during a telephone consultation of the need for a fast-track referral for suspected lower gastrointestinal cancer. The referral was made on the same day, but Adult L did not attend the appointment and said that she did not wish to do so. Adult L was discharged from the service.

6.20. On the 22nd of September 2022 Rochdale Borough Housing raised a safeguarding concern after a Housing Officer had returned to the property and reported that she had found Adult L's door left open (Adult L had explained that this was because she couldn't get out of bed to open it for people), and a strong smell of urine. As a result, on the same day an Adult Social Care duty worker contacted Adult L by telephone and during the conversation it was decided that the worker would look into:

- Adult L accessing mental health support over the telephone, and a
- key safe.

Adult L declined a needs assessment but said that she would allow the District Nurses access.

6.21. In October 2022, Adult L contacted Adult Care Duty twice regarding her difficulties with putting her bins out. Adult L was signposted to the bin collection service however she stated that it was the difficulty of taking her rubbish out to the bins that was the issue. The duty worker discussed the option of a private arrangement and asked whether Adult L had anyone to assist her. Adult L advised that she could ask a friend.

6.22. On the 18th of October 2022 Rochdale Borough Housing Tenancy Sustainment Service closed Adult L's case after Adult L had advised that she didn't want the support. Adult L had said that she had carers who were going into the address, and she had her sister and was seeing her GP. On the same day Adult L contacted her GP practice to ask if she was still registered and request an appointment. She was advised that she was still registered as a patient and to call back the following morning to book a GP appointment.

6.23. Adult L continued to refuse any of the District Nurses access, but on the 8th of November 2022 Adult L did speak with a nurse on the telephone, disclosing depression, sleeping a lot, and feeling like she didn't get support. Adult L wouldn't allow the nurse to visit but did agree to speak again the following week.

6.24. On the 14th of November 2022 Adult L was sadly found deceased in bed.

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 L's Lived Experience

7.1. Adult L had travelled to the United Kingdom from Nigeria as a child to seek asylum. Professionals report that she didn't ever disclose anything about her journey, but it is reasonable to assume that it was potentially a frightening experience for her that would have taken some time. It remains unknown why the family left Nigeria, and why Adult L's father did not travel with them.

7.2. This review has been informed that exploration of Adult L's cultural background was attempted within a Care Act Assessment completed in 2018, and that the assessment records that Adult L had said that she didn't remember much about her early years, but that it had been a difficult time when she had been in the city. There is little more detail, and the Care Act Assessment completed in 2022 (within the scoping period) did not explore Adult L's culture at all. It is now recognised that this was a missed opportunity to progress

professional understanding of Adult L's culture, and to reflect upon how her experiences may have impacted upon her response to support offers.

7.3. A recent Safeguarding Adult Review[14] commissioned by Rochdale Borough Safeguarding Adults Board has already explored the importance of cultural curiosity[15] 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.

7.4. Whilst professionals working around Adult L during the scoping period of this review knew little about Adult L's past, they heard at the learning event of the anger Adult L had exhibited throughout her teenage years. A Social Worker (who had worked with Adult L when she was a teenager) spoke of how Adult L would often skip school and go missing. She said that Adult L sometimes stole food to hoard, and that she would sometimes overeat and purge. Despite working with Child and Adolescent Mental Health Services, the underlying drivers of Adult L's behaviours weren't ever fully understood - although Adult L had disclosed; missing her father who had remained in Nigeria; sexual abuse - both in Nigeria and on the journey to the United Kingdom; and being worried about her immigration status[16].

7.5. Adult L's sister bravely spoke of when she and her siblings[17] came to the United Kingdom. She explained how life in the United Kingdom significantly contrasted with their life in Nigeria and said she and her sister sought to 'fit in' and make friends. Looking back, she recognises that Adult L's eagerness to integrate and to 'belong', may have influenced her to partake in activities with peers that she wouldn't have previously considered.

7.6. A further consideration of Adult L's history is that when she turned 18 years of age, she had to leave her home with her foster carer and move into supported living accommodation. The foster carer has informed this review how upsetting the move was as they had developed a good relationship and Adult L was presenting as happy with her.

7.7. Adult L's history of Adverse Childhood Experiences[18] could have been explored and acknowledged by the professionals working to support her as an adult. Members of the District Nursing Team who attended the learning event reflected upon how no consideration was (or is) given to looking back at historic notes to help them to understand a patient. And they debated the benefits of doing so when working with someone who is finding it hard to trust professionals.

Learning 1: As a result of agencies not seeking further information when it became clear that they were struggling to engage Adult L effectively with support, no professional or agency gained a vital understanding of Adult L.

7.8. There is a 7 minute briefing available for practitioners[19] in Rochdale regarding Adverse Childhood Experiences which advises professionals on what they can do. However, it is notable that its focus is upon a child experiencing behavioural changes due to the impact of their experiences – not an adult. Consideration of an adult's Adverse Childhood Experiences and lived experiences, and of how their presentation can be an adaptation to past trauma (rather than a personal characteristic), affects a trauma-informed practice. Had a

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

[15] 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.

[16] When Adult L and her family first came to the United Kingdom, their application to seek asylum was failed. The family appealed the decision, but this was a source of anxiety for Adult L. Adult L was awarded indefinite Leave to Remain in April 2008.

[17] Adult L is the eldest of seven siblings – two girls and five boys.

[18] Adverse Childhood Experiences including violence, and trauma, are associated with poorer health outcomes, health risk behaviours and socioeconomic challenges.

[19] adverse_childhood_experiences_-_11.11.2021.pdf (rochdalesafeguarding.com)

trauma-informed practice been applied to Adult L, professionals would have sought to understand and respond more effectively to her personal circumstances.

7.9. This review has learned that in May 2022, Rochdale Borough Safeguarding Adults Board held an 'Introduction to Trauma Informed Practice' training session (with support from Research in Practice) and following this, the Rochdale Borough Safeguarding Adults Board, along with Adult Social Care, subscribed to Research in Practice in order to have access to their resources (as well as training). In addition, a video concerning Adverse Childhood Experiences was shared at a Safeguarding Adults Board meeting and members have been asked to share it widely[20]. To compliment the training, the Rochdale Borough Safeguarding Adults Board has produced a 7 minute briefing on Trauma Informed Approaches and Adverse Childhood Experiences (which has been adapted from Norfolk Safeguarding Adults Board, with their permission) and once approved, this will be posted on their website, and including in the Team Around the Adult launch during Safeguarding Adults Week in November 2023.

7.10. Adult L had a Body Mass Index over 80. Currently NHS guidelines define a healthy weight as a Body Mass Index of 18.5 up to 24.9. People who are overweight have a Body Mass Index of 25 to 29.9 and a Body Mass Index of thirty or above is considered obese. Extreme or severe obesity is defined as forty and above[21].

7.11. Adult L's foster carer and sister have informed that Adult L struggled with weight management as a teenager. Records evidence that Adult L continued to struggle as an adult. Whilst environmental issues such as food choices[22] and exercise contribute to struggles with weight management, weight is affected by many factors including genetics, age, gender, and underlying medical conditions. Also interestingly, studies, including those undertaken by the George Washington University[23]' have observed that *physical and sexual abuse during childhood greatly increase one's risk for severe obesity in adulthood*. One analysis[24] reported *more than double the risk for abused females and more than triple for abused males, compared to individuals with no history of abuse*. Another study[25] found that *69% of patients undergoing bariatric surgery reported some form of childhood abuse or neglect.*

7.12. This can be explained by the presence of toxic stress - a condition described by aces aware[26] as long-term disruptions in brain development and immune, hormonal, and metabolic systems, potentially resulting from experiencing high doses of cumulative adversity[27] during critical and sensitive periods in early life. The stress can cause obesity by affecting individuals' behaviours, inducing overeating and consumption of high calorific food, decreasing physical activity, and disrupting sleep. This evidences how obesity is a disease which requires more complex treatment than counting calories.

7.13. In February 2021, because Adult L's legs contained too much fatty tissue to permit the safe use of compression wraps, a Lymphoedema Nurse asked Adult L's GP to refer her to Nutrition and Dietetics Services. However, Adult L did not respond to two offers of a telephone consultation with the dietitian and was consequently discharged from their service. Given that at this time, Adult L's lack of ability to accept support services was affecting her health and potentially placing her at risk, a multi-disciplinary team meeting could have been considered to share Adult L's information and progress a plan to support her. Multi-agency information sharing is considered throughout this report.

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[20] The review has been assured that the video has been included in GP level 3 training since January 2022.

[21] What is the Body Mass Index (BMI)? - NHS (www.nhs.uk)

[22] It is known that Adult L would order take-away food extremely regularly.

[23] 'Strategies to Overcome and Prevent Obesity Alliance STOP Obesity Alliance | Milken Institute School of Public Health | The George Washington University (gwu.edu)

[24] The association between childhood sexual and physical abuse with incident adult severe obesity across 13 years of the National Longitudinal Study of Adolescent Health - PubMed (nih.gov)

[25] Relation of Childhood Sexual Abuse and Other Forms of Maltreatment to 12-Month Postoperative Outcomes in Extremely Obese Gastric Bypass Patients | SpringerLink

[26] The Science of ACEs & Toxic Stress | ACEs Aware – Take action. Save lives.

[27] Without the buffering protections of trusted, nurturing caregivers and safe, stable environments.

7.14. Whilst this review has not seen any documentation to evidence that further discussion was had with Adult L regarding her not feeling able to accept dietician support at this time (in 2021), it is captured in the Care Act Assessment (undertaken at the end of March 2022) how embarrassed Adult L was about her size and how this resulted in her avoiding contact with others. The subsequent effect of Adult L's weight upon both engagement and her mental health is considered later in this report.

7.15. This review must also consider how the Coronavirus, which had been identified as pandemic in December 2019, potentially affected Adult L's lived experience. The first lockdown, initiated prior to the scoping period of this review 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 which at times affected further closure of non-essential retail and hospitality, and personal restrictions of movement.

7.16. At the beginning of the scoping period, on the 6th of January 2021, a rising number of coronavirus cases saw national restrictions being reintroduced. And it wasn't until the 8th of March 2021, that England began a phased exit out of lockdown - intended to 'cautiously but irreversibly' ease lockdown restrictions. England moved through the roadmap as 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.

7.17. Consequently, although this review has been told that there is no evidence to suggest that Covid amended the offer of support to Adult L, professionals attending Adult L throughout the scoping period of this review were still adapting to everchanging working conditions introduced to manage the virus. For example, many professionals continued to work from home meaning that communication with colleagues was either by telephone or virtual communication, and this included multi-agency professionals meetings.

7.18. Also, during some of this scoping period, 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 self-isolate at home. This meant that for those professionals who were unable to work from home, reduced staffing levels - one of the problems that had arisen initially from the Covid pandemic, still remained a problem, 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.

7.19. It is also recognised that throughout the scoping period of this review, the NHS was caring for a rising number of Covid patients whilst simultaneously dealing with an increasing backlog of work. An additional layer of pressure was added to the NHS at this time regarding the aforementioned Covid vaccination programme, as 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[28] by the 15th of February 2021.

7.20. Covid also stifled professionals' ability to gain access to the property and engage face-to-face with Adult L as it provided a legitimate reason not to allow them access to the property – Adult L could defer contact by stating that she had symptoms or was feeling unwell.

7.21. Possibly the most significant Covid issue for Adult L, as a vulnerable person with limited mobility and problematic health - was the pandemic's personal effects. Adult L told her GP how she had stopped going out because she feared contracting the virus. It remains unknown how this fear affected her ability to allow professionals inside her home and, with regards to health professionals, to undertake health examinations at close proximity. Adult L would have known that such professionals had unavoidably had close contact with lots of other individuals who could have been carrying the virus. Similarly, Adult L attending the hospital Emergency Department could have potentially increased her fear and anxiety levels. The hospital Emergency Department would have been complicated when Adult L attended with Covid testing taking place and separate bays in use for those testing positive, negative, and suspected of contracting the virus.

[28] 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.

7.22. Despite her fear of Covid, Adult L did not respond to two text reminders inviting her for Covid vaccinations at the vaccination clinics - though it must be recognised that this decision could have potentially been because of the difficulties Adult L would have had physically attending a clinic.
7.23. This review has been informed that Adult L's GP record was not flagged to show that she was housebound. This has affected a missed opportunity to discuss the Covid vaccination programme directly with Adult L and to offer her a home visit. The GP Practice has reassured the review, that in response to learning from this case, it has since reviewed the bariatric patients and has added a read code[29] to patient's notes (visible to all clinicians). It has also established a monthly search to identify and code any new patients.
7.24. Whilst this review has been informed that the District Nurses service was fully maintained throughout Covid, it must be remembered that all visiting professionals would have worn full personal protective equipment. This could have had a two-fold effect on Adult L - firstly it could have offered reassurance that professionals were taking measures to reduce the spread of the virus, but secondly it could have served as a reminder of risk.

7.25. In summary, understanding all of the aforementioned factors which contributed to Adult L's lived experience was crucial, as without it professionals were unable to take her ensuing behaviours into consideration within their care and support offer. This serves as a further reminder as to how important professional curiosity is when working with adults at risk and how professionals must actively seek and utilise 'windows of opportunities' to ask questions and learn about a person. Because Adult L wasn't always able to engage with professionals or welcome them into her personal home, such junctures were infrequent. When they did arise, it was imperative that they were utilised to their maximum potential. When they didn't arise, it was imperative that professionals consulted each other, and historic case notes, in an attempt to understand Adult L better. District Nurses discussed Adult L with health and social care practitioners within the daily huddles, but there is no evidence of anything being shared other than an inability to gain access.
7.26. Professionals have now recognised that there were missed opportunities for District Nurses to have made a direct Safeguarding referral to the Trust's Safeguarding Team or to have at least had a discussion with their Safeguarding Team, who likely would have suggested a professionals meeting convene. This would have supported professionals to progress an understanding of Adult L, and to reflect upon how her experiences may have impacted upon her response to support offers. This review has been assured that to address this the Safeguarding Team is now attending the District Nurses daily safety huddle on a regular basis and the District Nurse team is now fully aware that raising a safeguarding concern in the daily safety huddle must also prompt a conversation/referral to the Trust's Safeguarding team.

Theme 2 – Information Sharing, in particular to Difficulties Engaging Adult L.

7.27. The table at 6.6 evidences how professionals often struggled to engage Adult L. As a consequence, Adult L was discharged from the Short Term Assessment and Reablement Service, Rochdale Infirmary Nutrition and Dietetics, Colorectal department, and her case was closed to Adult Social Care. Exploration of the discharge procedures with professionals during the learning event established that they were all as per policy.
7.28. Examination of professional attempts to engage Adult L highlighted some good practice examples of professionals being persistent with their efforts and having consideration for the Mental Capacity Act to determine whether Adult L was capable of making such decisions as to not accept support or deny professionals access. However, it is evident that there were missed opportunities in relation to joint working. For example, Adult Social Care did not share when Adult L declined further support from the Short term

[29] Electronic flag

Assessment and Reablement Service. And whilst the Nutrition and Dietetics, and Colorectal Services shared their discharges with the GP, no other agencies were informed.

7.29. This lack of joint working duped agencies into thinking that Adult L was being supported. For example,

- Adult L spoke with her GP at the beginning of February 2021, and informed that Adult Social Care was working with her. The GP, being unaware that Adult L had cancelled the Short Term Assessment and Reablement Service, was unable to question or challenge this, and
- Rochdale Borough Housing had no reason to doubt Adult L when she informed that she no longer required support from their Tenancy Sustainment Service because she was seeing her GP (when in fact she rang the Practice on the same day asking if she was still registered with them) and had carers attending the property (which she did not).

7.30. Had the professional contact and engagement with Adult L (including the discharge from services), been shared multi-agency, a plan could have been developed. Such a plan could have included,

- the professionals who were able to engage Adult L, supporting the agencies who were struggling,
- exploration of any relatives or friends who may have been able to support Adult L's contact with professionals, and
- advocacy services.

In addition, Adult L's background could have been more widely shared to support professionals to understand her lived experience. As previously mentioned, this would have allowed professionals to recognise how Adult L's presentation could have been an adaptation to previous trauma and offered the opportunity for professionals to adapt their practice methods to respond to Adult L's personal circumstances.

7.31. The District Nurses demonstrated good practice when they began to struggle to engage Adult L. They contacted Adult L by telephone to discuss her missed visits and importantly because they recognised how many different District Nurses were attempting to visit Adult L and how difficult that could potentially be for her, they limited the number of nurses visiting. The District Nurse team also deliberated Adult L in the daily huddles. This is in line with the Non-Concordance Process which was developed by Northern Care Alliance[30] to support *staff and recipients of care in situations where a person who has mental capacity is making unwise decisions about their health and social care needs, which places them at significant risk of harm.*

7.32. However, as mentioned there was a missed opportunity for the District Nurses to have made a direct Safeguarding referral to the Trust's Safeguarding Team or to have at least had a discussion with their Safeguarding Team who likely would have suggested a professionals meeting convene.

7.33. Similarly, there was a missed opportunity for Adult Social Care to have escalated Adult L's case when a month after the deep clean of the property, staff from Rochdale Borough Housing reported concerns of a strong smell of urine coming from the property and noted that Adult L was leaving her door open (because she was unable to get out of bed to open it). As a result of the concern, an Adult Care Duty worker contacted Adult L and spoke with her on the telephone. Adult L declined a Care Act assessment but agreed to a key safe being installed at the home and said that she would allow District Nurses entry to attend her. Adult L was deemed to have capacity to decline further Social Care intervention and/or the assessment, but improved practice would have seen more professional curiosity regarding how Adult L was able to (for example) get to the bathroom, clean herself, dress/undress herself, prepare food etc. Such questioning would have likely identified risks posed to Adult L and resulted in her circumstances being escalated to managers and/or considered against safeguarding processes such as the Rochdale Self-Neglect and Hoarding Strategy and Toolkit[31]. Because following this report of self-neglect, processes were not initiated[32], no multi-disciplinary

[30] Issued in April 2020.

[31] self_neglect_and_hoarding_strategy_and_toolkit_march_2021.docx.pdf (rochdalesafeguarding.com)

[32] Due to the professionals working directly with Adult L not attending the learning event, this review has been unable to explore whether the Rochdale Self-Neglect and Hoarding Strategy and Toolkit was considered.

meetings convened, and the Multi-Agency Risk Management principle wasn't followed[33]. Consequently, there was a missed opportunity in relation to collaborative working and better risk management.

7.34. These missed opportunities to refer Adult L to safeguarding were debated at the learning event and there was common consensus that mental capacity complicated professional decision making. Adult L's mental capacity commonly appeared in practitioners' narratives at the learning event and within the agency documentation provided to this review. This is good practice but Adult L's capacity to make decisions[34] was evidently a key determining factor of what intervention professionals deemed could and should take place.

7.35. Professionals spoke of Adult L's right to make 'unwise decisions'. This is correct but an unwise decision regarding a Care Act Assessment under section 1(3) of the Care Act 2014 does not negate the local authorities duties. Whilst section 1(3) of the Care Act 2014[35] is not dismissive of an individual's judgement and/or wishes and feelings, the word, 'unwise' does not appear and if an adult refuses an assessment of care and needs, it must still be carried out if the adult is experiencing or is at risk of abuse or neglect – including self-neglect. And in September 2022 it was known that

- Adult L was putting herself at risk by leaving the door open,
- was confined to her bed,
- was unable to maintain home conditions,
- had a high Body Mass Index,
- was not allowing health professionals access to her wounds and,
- was struggling with her mental health.

Nevertheless, this review does recognise that there was no legal power to forcibly intervene and assess, and therefore proposed safeguarding measures could not be enforced in the absence of it being possible under other legislation.

7.36. Professionals, being aware of Adult L's right to 'unwise' decisions and, her Right to Privacy under Article 8 of the Human Rights Act 1998 (which outlines everyone's right to respect for their private and family life) were challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care. However, whilst they rightly recognised that Adult L refusing them entry to her home, and/or declining support services may not have automatically met the threshold for a Section 42[36] enquiry, a referral could have still been made and any professional could have convened and led on a multi-disciplinary meeting to help develop a shared multi-agency understanding of Adult L's situation and inform intervention.

7.37. Whilst best practice would see such actions being undertaken with Adult L's consent, her consent could have been overridden if professional curiosity into Adult L's circumstances had identified she was at risk of significant harm.

7.38. Being professionally curiosity is not always easy, but it is an essential component of safeguarding procedures, and its application is embedded in safeguarding adult policies and the Care Act 2014.

7.39. There was an evident hesitancy of professionals to be professionally curious with Adult L. For example, better application of professional curiosity could have been used to explore:

- Why did Adult L not want nurses to touch her?
- How did Adult L's high Body Mass Index impact on her daily functioning?
- How would Adult L have vacated the flat in an emergency[37]?

[33] This is discussed further later in the report.

[34] Though not documented, this was presumably referencing decisions about her healthcare.

[35] The main statutory framework which guides safeguarding adult practice.

[36] Under Section 42 of the Care Act 2014, local authorities have a duty to make, or cause to be made, enquiries in cases where they reasonably suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and, as a result of those needs, is unable to protect themselves from this actual or risk of abuse and neglect.

[37] Adult L lived in a ground floor flat in a small block of flats. The property had two mains operated interconnected smoke alarms - one situated in the kitchen, and one in the hallway. These smoke alarms were serviced and tested by Rochdale Borough Housing twice during the scoping period of this review, and an additional fire risk assessment was carried out of all the communal areas in June 2022. There is no evidence in records of a referral

- Adult L's diet? Did Adult L require support with shopping and/or food preparation?
- Did Adult L's high Body Mass Index contribute to her reluctance to accept support?

Learning 2: Practitioners did not consistently apply curiosity to practice and as a result no single professional gained a greater understanding of Adult L. This impacted on the level of support offered to Adult L.

7.40. Professionals present at the learning event suggested that professional curiosity was hindered by conversations being had with Adult L over the telephone instead of face to face as there are no visual prompts over the telephone to potentially stimulate professional curiosity. For example, if a visiting professional had been told by Adult L that she was managing but could see that she was looking unclean and unkempt; the professional would pose further questions. Similarly, when professionals spoke with Adult L through the window, they lost any visual triggers regarding home conditions.

7.41. Sadly, due to the professionals working directly with Adult L not attending the learning event, this review has been unable to explore the barriers to professional curiosity further.

Learning 3: The learning objective of Safeguarding Adult Reviews is hindered if key frontline decision-making professionals do not attend learning events.

Theme 3 – Professional Understanding of the Link between Adult L's Physical Health and Bariatric Care Needs, and her Mental Health

7.42. Adult L's medical history reports that she had been diagnosed with compulsive overeating in 2012. Compulsive overeating is a form of a binge eating disorder which involves the repeated consumption of a large amount of food in a short amount of time. Different from bulimia, there is no purging after the consumption and consequently, compulsive overeaters may become overweight or obese.

7.43. As previously mentioned, by 2018 Adult L had a Body Mass Index of over 80. She also experienced lower back pain, leg pain, cellulitis, and lymphoedema[38]. A combined effect of these conditions was increasing mobility loss which created numerous challenges in completing everyday tasks, including walking, eating, dressing, bathing and/or showering, using the bathroom and getting in and out of bed.

7.44. Furthermore, insight into how Adult L's Body Mass Index affected her is gleamed from:

- the ambulance service's safeguarding concern dating from January 2021 which states, *the patient is bariatric and due to this expressed that she doesn't want to leave her home and initially refused to attend hospital,* and,
- the Adult Care Assessment undertaken in March 2022 within which, Adult L is reported to have said that she was very embarrassed.

7.45. These statements made by Adult L suggest that she felt shamed by her bariatric needs and these feelings, alongside the aforementioned loss of mobility, would have led to increasing isolation and potential loneliness[39][40]. In an attempt to reduce this, Adult L could have been signpost to the online charity Obesity UK[41] which besides being a useful resource for professionals, also provides a safe community for people with obesity to communicate and ensures that people with obesity have a voice.

being completed during the scoping period of this review asking Greater Manchester Fire Service to undertake any additional fire risk assessment of Adult L.

[38] A condition that results in swelling of the leg or arm. It occurs when the lymphatic fluid does not adequately drain from the limb region because of the damage to the lymph nodes.

[39] While loneliness is a common experience when it is long-term and enduring it can have a serious, detrimental effect on our mental health and it must be taken seriously. Loneliness policy briefing - England | Mental Health Foundation

[40] Loneliness work is currently being undertaken by Rochdale's Public Health Team. The work will be publicised on Rochdale Borough Safeguarding Adults Board website.

[41] Obesity UK

7.46. It is good practice that some professionals discussed Adult L's Body Mass Index with her[42] helping her voice to be heard, but as previously identified, better professional curiosity could have explored further how her Body Mass Index affected her daily functioning (including her mental health) and acknowledged that it could potentially contribute to her reluctance to accept support offers. For example, Adult L was referred to the Nutrition and Dietetics services, but she was discharged when she did not respond to their offer of appointments. This discharge was in line with protocol but if at the point of discharge, professionals had been more professionally curious and explored Adult L's circumstances and vulnerability in more depth, they may have gained a better understanding of why Adult L was unable to accept the appointments that were crucial to her health.

7.47. Given the risks that Adult L's high Body Mass Index was now posing, multi-agency information sharing was pertinent at this time and a multi-agency meeting could have proven invaluable. This review has been assured that as a response to previous Safeguarding Adult Reviews recommendations, specifically around decision-making where individual agencies do not have all an individual's information, Rochdale Borough Safeguarding Adults Board has developed a Multi-Disciplinary Team protocol (as both a stand-alone document but also embedded in the Multi-agency Risk Management protocol[43]). This will support professionals to work multi-agency.

7.48. This review is grateful to the Consultant Bariatric Surgeon who has taken the time to consider this report and Adult L's circumstances. The Surgeon has advised that Adult L, having an extremely high Body Mass Index of over 80, qualified under the NICE criteria for consideration of bariatric surgery. The ideal pathway would have been an initial assessment by a Tier 3 multimodal weight management service, but as mentioned, Adult L declined Nutrition and Dietetics services.

7.49. The surgeon concurred that declination is not unusual and patients with extreme obesity can present challenges in management as many patients have significant complex psychological issues and may additionally have fixed but erroneous pre-conceptions about bariatric surgery.

Learning 4: It is important to listen to, educate and possibly challenge patients with extreme obesity who decline services, and advice on the importance of weight intervention whist simultaneously respecting their autonomy.

7.50. As already alluded, two of the barriers Adult L was facing which potentially would have affected her ability to accept the appointments were problematic mobility and low mood and depression (which would have affected her motivation). Adult L's sister has informed the review how as children, both hers and Adult L's moods would reflect in their eating patterns. This likens with research[44] which has uncovered a link between depression and obesity, with the frequency of depression in individuals with an obese Body Mass Index being twice as high as in those of normal Body Mass Index.

7.51. Adult L reported low mood and depression to her GP, and she was prescribed anti-depressants. And, In line with the findings of research[45] which *provide preliminary evidence for the importance of weight loss in obese individuals experiencing low mood*, it was good practice that (in April 2021) the social prescribing link worker discussed health and diet with Adult L. During the conversation Adult L opened up about her link between feelings and eating, but for reasons that the review has not been unable to understand[46], this successful contact wasn't followed up upon by means of a further phone call in a month, as had been agreed.

7.52. Support had been offered to Adult L for her mental health on occasions, but sadly mental health agencies had been unable to engage her effectively. In September 2022, following Adult L admitting that she

[42] Health professionals reported to this review that they are comfortable discussing weight management with patients, but it is important that professionals from all agencies are not wary of asking questions. Public Health England has developed a resource, Let's Talk About Weight - step by step guide (publishing.service.gov.uk) to support professionals to appropriately open discussions.

[43] Both protocols are published on the website - Rochdale Safeguarding Partnership Board - Multi-Agency Policy, Procedures, Protocols and Guidance.

[44] Overweight and Obesity Associated with Higher Depression Prevalence in Adults: A Systematic Review and Meta-Analysis - PubMed (nih.gov)

[45] Diet, Obesity, and Depression: A Systematic Review - PMC (nih.gov)

[46] This review would recommend that the GP Practice review Social Prescribing record keeping.

didn't want people in her home, Adult Social Care discussed the possibility of her accessing mental health support over the telephone. Adult L agreed to this stating that it was okay as long as they didn't want to see her. There is no record of this contact commencing and in November 2022, Adult L informed a Community Matron Nurse (who had demonstrated good practice by being very persistent in ringing Adult L because entry was not being gained) that she was feeling really depressed, had no support from anyone and was sleeping a lot. Adult L said she knew her Body Mass Index was too high and was trying to diet which was making her more depressed. Adult L still refused the nurse a home visit but agreed to speak with her the following week. Sadly, Adult L was found deceased in her home six days later.

7.53. How to engage a person in mental health support when they feel unable to accept the support was mooted by professionals at the learning event. Suggestions included that an individual with care needs and poor mental health, could have a nominated professional point of contact who could help navigate the individual through the services and coordinate appointments. This guidance could potentially help a person feel supported and safe enough to accept mental health support offers. Professionals wondered whether such a role could be accommodated within the social prescribing link services.

7.54. However, it must be acknowledged that similar to this, Adult L's GP referred Adult L to Living Well for Health Coaching and their coaches offer one-to-one support. In reflection of the importance of multi-agency information sharing - the GP attending the learning event, noted that the Practice did not know what the response to the referral had been and now recognised the probability that Adult L had not been able to respond to Living Well's offer of support and that the referral had been ineffective.

7.55. The proportionalities of which Adult L's mental health and poor mobility affected her personal hygiene and home conditions cannot be ascertained for certain, but all professionals agreed that Adult L experienced self-neglect - with both personal hygiene and home conditions being described as unkempt and malodorous.

7.56. This review has been asked to examine the working and service provision around both self-neglect and hoarding. However, Adult L's hoarding is in dispute with some professionals reporting that hoarding tendencies were not something they had witnessed: In January 2021 paramedics submitted a safeguarding referral after they noted the property to be cluttered (clutter score 3[47]) and Adult L had acknowledged that she needed support in the home with everyday tasks and personal hygiene. But interestingly when professionals from the Short Term Assessment and Reablement Service attended Adult L in the property following her discharge from hospital, home conditions were not noted to be a concern. Professionals at the learning event wondered whether the difference in home conditions could be explained by varying interpretations of the clutter scale by different professionals, or whether it was because a team lead for Occupational Therapy and an assistant had attended the property and re-arranged furniture to provide space for a profiling bed.

7.57. What is indisputable is that by February 2022 when Adult L disclosed to a professional (attending her home regarding the supply of mobility equipment) that she was only washing once a week due to the state of the bathroom, home conditions had deteriorated to such an extent that a professional deep clean was deemed necessary. It was good practice that Adult Social Care found a cleaning company who would clean Adult L's home but the underlying drivers to the deterioration of conditions remained unaddressed and a month after a deep clean had been undertaken[48], a housing officer reported a strong smell of urine coming through the front door.

7.58. Whilst the referrals and the deep clean evidence that professionals were working to address the self-neglect, as previously mentioned, Rochdale has a Self-Neglect and Hoarding Strategy[49] which informs that

[47] The clutter image rating scale consists of three sets of 9 colour photographs. Each set depicts a room in the home (living room, bedroom, and kitchen) with varying amounts of clutter (1=least cluttered, 9=most cluttered). Participants are instructed to rate the level of clutter in the corresponding room in the home using these photographs.

[48] The deep clean was undertaken in August 2022

[49] self_neglect_strategy_-_re-formatted_november_2021.pdf (rochdalesafeguarding.com)

Rochdale Borough Safeguarding Adults Board agrees that responding to individuals with self-neglect/ hoarding behaviours must be a multi-agency priority and that when appropriate, the Multi-Agency Risk Management Protocol should be followed by all professionals and partners. There is no evidence of this being done.

7.59. Before the report considers professional use of the Multi-Agency Risk Management Protocol, the independent reviewer would like to bring to Rochdale Borough Safeguarding Adults Board attention, the six indicators of self-neglect within the document (of which Adult L's circumstances reflected most). And respectfully suggest that the third indicator; *poor diet and nutrition leading to severe weight loss and associated health issues*, be amended to include weight gain.

Theme 4 - Professional Application of the Multi-Agency Risk Management (MRM) Protocol

7.60. District Nurses referring Adult L into the safety huddle meetings was good practice, but the frequency of the referrals emphasises the uncertainty professionals can experience regarding whether concerns are within the remit of adult safeguarding. Further exploration of this concluded that whilst there was a build of concern regarding Adult L denying professionals access and/or accepting support offers, just as professionals started to consider the threshold for a safeguarding referral, contact was had with Adult L, and concern alleviated. In addition, plausible excuses for no access were being given such as, Adult L feeling unwell or being embarrassed because she was on her period and unable to use sanitary protection.

7.61. The question is; when attempts to see Adult L failed - when did her refusal to give access justify intervention? Regardless as to whether the threshold for section 42 had been reached or not, this decision and Adult L's circumstances would have benefitted at the time, from multi-agency discussion to identify risks, and explore the hypothetical consequences of both intervention and non-intervention.

7.62. Not all professionals involved in this review understood that they did not need to wait for the section 42 threshold to be reached before convening a multi-agency meeting. But having been:

- deemed to have mental capacity to understand the risks posed to her, and
- in continuing to place herself at risk of serious harm or death, and
- by being unable to engage effectively with health and Social Care services,

Adult L, with her care and support needs was suitable to be considered under the Multi-Agency Risk Management process.

7.63. This is further evidenced within the Rochdale Borough Safeguarding Adults Board Multi-Agency Risk Management protocol which states that the Multi-Agency Risk Management process may be applicable in any of the following:

- The inability or unwillingness to care for self and environment, including hoarding.
- Refusal of essential services
- Failure to protect self from abuse by a third party (where "mainstream" adult safeguarding processes are not applicable or sufficient to mitigate or eradicate the risk).

7.64. Had any professional working to support Adult L recognised that the Multi-Agency Risk Management process was appropriate, a multi-agency risk management meeting would have convened and professionals from multiple agencies would have shared their information about Adult L, considered risk, and worked a multi-agency plan to manage it.

7.65. In summary, the safeguarding system is unavoidably not designed for one professional/agency to work in silos. Instead, multiple professionals must play a part in meeting a person's needs and whilst all are accountable for their own work, they are also accountable for ensuring that other professionals can see what they are doing. In the absence of this, Adult L was afforded a disjointed service provision, which continued due to a lack of oversight of the support being offered. Although all the practitioners involved in supporting

Adult L were professional, conscientious, and strived to help her, their focus was predominantly on their own service remit and consequently a holistic approach, which could have been gained under the Multi-Agency Risk Management protocol, was foregone.

Learning 5: The Multi-Agency Risk Management Protocol is not being routinely used by professionals and this is preventing effective multi-agency risk identification and management.

8. Conclusion

8.1. As a child, Adult L had to adapt to living in a new country when she and her siblings came to the United Kingdom from Nigeria with their mother. Over time, Adult L's relationship with her mother deteriorated, and she developed an eating disorder and experienced poor mental health. By the time Adult L became an adult, she was living with obesity and facing declining mobility and isolation.

8.2. Following a brief inpatient stay in hospital in January 2021, professionals attempted to support Adult L in her home but were often unable to effectively engage her. There is no evidence of professionals taking Adult L's culture and/or childhood experiences into account when trying to encourage engagement. Similarly, there is little evidence of professional curiosity being applied to the practice around Adult L regarding how she was able to manage her own care when she declined the support. This effected professionals having little understanding of Adult L's lived experience.

8.3. Agencies predominantly managed their interactions with Adult L on a single agency basis. Some professionals referred concerns into their own agency safeguarding meetings but, challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care, professionals demonstrated uncertainty regarding whether their concerns around engagement warranted following the Multi-Agency Risk Management Protocol and/or a multi-disciplinary safeguarding concern.

8.4. In the months leading up to Adult L's death she had paid for a deep clean of her property, but sadly, property conditions soon deteriorated again, potentially ascribable to Adult L's lack of mobility and low mood. Adult L continued to refuse professionals' access but during a conversation with a duty Social Worker, she agreed to access mental health support if conducted over the telephone. Unfortunately, there is no evidence of any mental health support commencing and the week before she died, Adult L confided in a District Nurse during a telephone conversation, that she was feeling depressed, had no support, and was sleeping a lot.

8.5. This review hopes that its reflection upon professionals' understanding of Adult L will serve as a driver of change moving forward and that Adult L's history will lead us to better practice in the future.

9. Good Practice

9.1. The agency information submitted to this review and the discussions around Adult L, have highlighted examples of good practice[50] from professionals involved with Adult L. Some examples are included in the body of this report, but others include:

9.1.1. Bariatric equipment was provided for Adult L within the scoping period in a timely manner.

9.1.2. Mental capacity assessments were completed by the District Nurses which initiated the Negotiated Care Plan.

9.1.3. Rochdale Borough Housing responded swiftly to the concern being raised in August 2022 and visited Adult L's home.

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

9.1.4. There was good evidence of involvement by the GP in August 2021 when Adult L reported that she could not leave the house and a GP home visit was conducted the following day. Medication was reviewed and a referral sent to weight management service and Adult Social Care.

9.1.5. District Nurses were persistent with their efforts to engage Adult L and called her 4 times on one occasion to contact her (9.12.2021). Due to this they were able to speak with Adult L regarding their concerns and her engagement.

9.1.6. Adult Social Care have reported that it is evident from the case notes that a Social Worker had regular contact with Adult L and built up a good relationship.

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:

10.1.1. Bespoke Safeguarding training has been completed for the District Nurses team, and ongoing training from their Safeguarding lead will be available.

10.1.2. Planned continuous service improvements were implemented within Rochdale Borough Housing's Tenancy Sustainment Service from October 2022. Procedures around gathering information/background checks and making changes to assessing needs and risks have been improved. Procedures around case closure were improved with a new case monitoring stage introduced in December 2022.

10.1.3. At the time of this review, Rochdale Borough Housing were completing an annual review of their Hoarding policy and procedure which included using a trauma-informed approach when supporting customers who hoard. And Adverse Childhood Experiences and Trauma Informed training was being delivered to all teams.

10.1.4. Since October 2022 the Rochdale Borough Housing referral form has included the clutter index 'hoarding identification scale' and also prompts the referrer to complete the referral into Greater Manchester Fire and Rescue Service via the 'Home Fire & Safety Check' to avoid any unnecessary delays.

Questions for Rochdale Borough Safeguarding Adults Board

10.2. In order to address the learning identified within the report, the review would ask the Rochdale Borough Safeguarding Adult Board to deliberate the following 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.

Learning 1: *As a result of agencies not seeking further information when it became clear that they were struggling to engage Adult L effectively with support, no professional or agency gained a vital understanding of Adult L.*

Learning 2: *Practitioners did not consistently apply curiosity to practice and as a result no single professional gained a greater understanding of Adult L. This impacted on the level of support offered to Adult L.*

Question 1: How can partner agencies assure Rochdale Borough Safeguarding Adults Board of robust managerial oversight to support the incorporation of multi-agency professionals' meetings into practice when professionals are struggling to engage an individual (to share as much information and professional curiosity as possible and drive best decision making)?

Learning 3: *The learning objective of Safeguarding Adult Reviews is hindered if key frontline decision-making professionals do not attend learning events.*
Question 2: How can Rochdale Borough Safeguarding Adults Board encourage the attendance of frontline decision-making professionals at Safeguarding Adult Review learning events and how can future attendance be audited?

Learning 4: *It is important to listen to, educate and possibly challenge patients with extreme obesity who decline services and advice on the importance of weight intervention whist simultaneously respecting their autonomy.*
Question 3: How can Rochdale Borough Safeguarding Adults Board learn of the current challenges professionals from all agencies face when attempting to open dialect about a person's weight management when supporting people experiencing obesity (who are at risk of harm)? And how can partner agencies assure Rochdale Borough Safeguarding Adults Board that their staff are supported within this practice and informed of pathways and procedure?

Learning 5: *The Multi-Agency Risk Management Protocol is not being routinely used by professionals and this is preventing effective multi-agency risk identification and management.*
Question 4: How can Rochdale Borough Safeguarding Adults Board monitor how the Multi-Agency Risk Management Protocol is being embedded into practice from an assurance point of view and modify the promotion of the protocol accordingly in response?

In addition, the review would bring attention to paragraph 7.57 and ask:
Question 5: How can Rochdale Borough Safeguarding Adults Board assure themselves and partner agencies that their guidance to support professionals, references both low and high Body Mass Indexes where weight management is a factor.

11. Appendix 1 – Terms of Reference

- Consider how race, culture, and ethnicity may have impacted on Adult L's case management.
- Consider how Adult L's weight management/bariatric requirements may have impacted on Adult L's case management.
- Determine whether decisions and actions in Adult L's case considered Adverse Childhood Experiences or previous trauma.
- 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.
- Examine working and service provision around Adult L's self-neglect and hoarding.
- Determine the extent to which decisions and actions were focussed on the needs of Adult L.
- Examine whether outcomes during the timeframe of the review met the principles of Making Safeguarding Personal.
- Identify if the responses to non-engagement were appropriate.
- Examine how Covid potentially affected Adult L and/or the care and support offer.

12. Appendix 2 – Serious Incident Practice Review

Terms of Reference

- Identify practice strengths and good practice that will help inform future practice.
- Identify whether the risks were recognised and kept under review.

- Identify any lessons where practice could have been improved.
- Identify whether Adult Care appropriately engaged and worked with LN or whether there were any gaps in service.
- From the practice that was evident, identify if there are any training needs for individuals involved in the case or if there are training needs identified for the service as a whole.
- Did practice in the case demonstrate that legislation and appropriate policies and procedures were followed.

Learning Recommendations

1. Cases with high complexity and risk require a robust system in place in terms of case management, responding to, recording, and managing risks.
2. There is evidence throughout the case that the level of risk was not recognised and responded to appropriately. Assessment staff should be trained on robust Risk identification.
3. There is evidence throughout this case that there was a lack of professional curiosity. All assessment staff should be trained on this.
4. There is evidence that the concerns in this case were not escalated to managers; staff need to have an increased awareness of the process of escalation and familiarise themselves with the escalation protocol.
5. There is evidence throughout the case that there was a lack of multi-disciplinary working. Head of service to consider Duty working arrangements to enable multi agency meetings in order to address and responding to risk concerns robustly.
6. There was no evidence of manager oversight throughout the case notes; There needs to be clarity on the importance of recording managerial advice, recommendations, and actions.