Rochdale Borough

Safeguarding Adults Board

Safeguarding Adults Review

Adult G

Overview Report

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1. Introduction

1.1. This review considers the sad circumstances of the death of Adult G in December 2020.

1.2. Adult G was a gentleman of white British ethnicity who was 55 when he died. Adult G had been employed in several roles after leaving school. He was tall, fit and healthy and had no underlying physical or mental health diagnoses. In early adulthood Adult G had been invited to play rugby for Lancashire. His family believe that he began to take addictive drugs when he worked as a doorman at night clubs which led to an increasing use of these in his twenties.

1.3. Adult G first became known to the Community Drug Team in 1994 when he was in his late twenties. He described trying various drugs as a teenager, including glue sniffing. He described serious regular use from age 20 which included cannabis. He first reported using heroin at age 24 and crack cocaine from age 26.

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

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The SAR is conducted under Section 44(2) of the Care Act, based on Adult G's long standing illicit drug use and the lack of multi-agency involvement following a safeguarding adult referral for self-neglect.

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

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

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

Empowerment:	Understanding how Adult G was involved in his care; involving those close to Adult G in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.

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

Proportionality:	Understanding whether services offered to Adult G were proportionate to the risk he presented both to himself and to staff working with him.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

3. Terms of Reference

3.1. Adult G is the primary subject of this SAR and will focus on the time frame between June 2019 and December 2020 when he sadly died. The review aimed to:

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

3.2.

Terms of Reference
To determine whether decisions and actions in the case comply with the policy and procedures of the named services and RBSAB: ○ Did ASC respond appropriately to the safeguarding referral made by NWAS for Adult G made in July 2019? ○ Examine whether outcomes during the timeframe of the review met the principles of Making Safeguarding Personal ○ How well did agencies recognise and address risks surrounding continued non-engagement whilst respecting Adult G's right to make decisions that others may view as unwise? ○ How well was the MCA 2005 utilised in the assessment of Adult G? ○ What was the quality of risk assessments, and care planning and were responses appropriate and proportionate to the nature and degree of risk? Were there clear escalation routes? ○ Were Adult G's family appropriately involved in the arrangements for this care?
To consider the effectiveness of multi-agency working and service provision for Adult G:

○ What services were in place to support multi-agency working for people with long term substance misuse (where Care Act section 42 safeguarding criteria do not apply) and were these used effectively? ○ How well did interagency working and service provision support Adult G?
To examine service provision and wider systems issues that impacted on Adult G: ○ What systems factors enabled or acted as a barrier to meeting Adult G's needs? ○ How does the system support people with long term substance misuse? ○ Were peer support models considered to support Adult G in accessing healthcare to support his admission to hospital?

4. Methodology

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

4.2. Understanding the experiences of those receiving support from agencies is central to learning. The independent author is grateful to Adult G's Sister for her contribution to this SAR.

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

Agencies Providing Reports to the Review and Context of Involvement	
Rochdale Borough Council (RBC) Adult Social Care (ASC)	Rochdale Borough Council provided Adult Social Care to Adult G The Council also had commissioning responsibilities to provide community service provision for adults requiring substance misuse treatment.
North West Ambulance Service (NWAS)	North West Ambulance Service cover the geographical area Adult G's property was in and responded to calls from District Nurses, Adult G and his sister.
Greater Manchester Police (GMP)	Police were called upon to respond to welfare concerns relating to Adult G following reports by both neighbours and Adult G himself, following aggressive sounding noise disturbances and people not leaving Adult G's property when asked to do so.
Northern Care Alliance NHS Group (NCA)	Adult G was known Northern Care Alliance staff since 2006. The service was previously run by Pennine Care Foundation Trust and moved over to Pennine Acute Trust now Northern Care Alliance in 2016. Adult G was seen by several staff covering his different health needs.
Heywood Middleton and Rochdale NHS Clinical	The CCG provided information about the role of Adult G's GP Practice in his care.

Commissioning Groups (CCG)	The CCG also had commissioning responsibilities to develop community service provision.
Pennine Care NHS Foundation Trust (PCFT)	The Pathways Service Community Drug Team was managed by Pennine Care NHS Foundation Trust until March 2018 when following a tender process, the service was transferred to Turning Point. The Trust has provided helpful background information in relation to Adult G's contact with substance misuse services prior to the timeframe of this review.
Turning Point (TP)	Rochdale and Oldham Active Recovery provide integrated drug and alcohol services, Adult G was referred to them during the period of this review.

• Structure of the Report

The report is structured as follows:

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

5. The Background of Adult G

5.1. Adult G was a man of white British ethnicity. He was in his fifties when he died. None of the 9 protected characteristics[3] applied to Adult G for the purposes of this review. Adult G's sister and professionals who worked with him during previous drug treatment episodes gave some insights about him.

5.2. Adult G lived in the Rochdale Borough area all his life. He enjoyed school and had a wide circle of friends. He had several jobs when he left school, being tall and athletic he was invited to play rugby for Lancashire. His family believe that his substance misuse became more problematic when he was employed as a doorman at a local bar in the 1990's.

5.3. Adult G was first known to the Pathways Community Drug Team (CDT) in Rochdale from 1994. His care from the service appears to have been punctuated by episodes where he had dropped out of treatment then later re-presented for further treatment.

5.4. Adult G himself described to staff at the CDT a fairly positive upbringing with good school attendance. Throughout his case notes he described his mum and sister as being a solid support for him. He described that his family held concerns about his ongoing drug use and associated health issues, but that they were not fully aware of the extent of his situation.

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

5.5. Adult G maintained contact with several friends who were not drug-users, however there was notably less mention of non-drug-using friends in more recent treatment episodes.

5.6. Adult G described trying various drugs as a teenager including glue sniffing. He described serious/regular use from the age of 20 (cannabis) and from the age of 24 using heroin and crack cocaine from the age of 26. Adult G appeared to have a substantial period where he used injectable drugs, however from 2004 he was increasingly struggling with his veins and complications from injecting, including deep vein thrombosis (DVT) and leg ulcers. He maintained that from 2008 he was no longer injecting drugs, instead smoking them.

5.7. Adult G had 3 in-patient admissions to hospital for detoxification over the years, the most recent being in 2011. Adult G quickly relapsed back to illicit drug use and alcohol misuse after each inpatient admission. He declined abstinence support such as mutual aid (Narcotics Anonymous and Alcoholics Anonymous), and structured group work.

5.8. Between 2015 and 2016 Adult G self-reported smoking heroin between 2-3 times a week. He was also noted to be drinking alcohol daily at hazardous levels. His drug use appeared to have escalated in 2016 with him reporting smoked crack cocaine in addition to his heroin use. Reducing the risk of accidental overdose was discussed with Adult G at regular intervals during his keyworker sessions. Conversations took place with Adult G in line with safe prescription issuing policy at the time (the use of an alcometer to assess level of intoxication prior to prescription being issued to him or indeed withheld if his level of intoxication was found to be too high).

5.9. Adult G's physical health concerns were now chronic, he had significant leg ulcers to both legs and circulatory difficulties arising from a past DVT. He was known to both the District Nursing (DN) Service and the Specialist Leg Ulcer Clinic. Health concerns also included difficulties with nausea and vomiting, particularly in the morning, which was felt to be linked with his dependent drinking.

5.10. His care at this time was very much focussed on encouraging and promoting Adult G's engagement with other health providers including the leg ulcer clinic, and his GP. However, despite concerted efforts Adult G did not always attend as planned. The option of a further detoxification admission was explored and promoted in detail on a number of occasions both in terms of enabling him to cease his alcohol and drug use, and also affording him opportunity to address some of his physical health concerns. Adult G appeared resistant to discuss this and there are documented records where it is recorded that he 'flatly refused' to consider it.

5.11. In April 2017 records indicate that Adult G was verbally abusive and threatened to physically assault his keyworker and the doctor during his appointment. In line with the NHS 'Zero Tolerance' of violence and abuse towards staff policy this resulted in Adult G being barred from the service for a period of 3 months following a downward planned reduction of his methadone prescription, meaning that his treatment wasn’t stopped abruptly.

5.12. Adult G re-presented to enter treatment in September 2017, in line with local practice at the time he was referred into Pathways CDT as he required specialist substitute prescribing. Adult

G described ongoing problems with his leg ulcers with an open wound. The outreach worker suggested he present in the Emergency Department (ED) to have the wound assessed.

5.13. Adult G had an appointment to recommence treatment at the CDT at the end of September 2017 however on the day of the appointment this was cancelled due to his difficult and verbally abusive behaviour whilst in the waiting area following a request by staff to remove the alcohol from the premises. This resulted in a further 4 week ban from the service.

5.14. Adult G was reassessed at the end of October 2017, he was commenced on appropriate treatment. Unfortunately, Adult G did not remain in treatment with the service moving forwards and had disengaged by December 2017. He did not respond to attempts to re-engage him, and so his case was closed to Pathways CDT in January 2018.

5.15. Throughout his treatment Adult G was not known to have any contact with mental health services. At various points he did describe low mood secondary to his current circumstances and substance misuse. At points he was prescribed anti-depressant medication by his GP for low mood.

5.16. At each risk assessment completed on re-entering treatment and reviewed at regular intervals throughout his care, Adult G denied any suicidal ideation or intent. His risk assessments in the domain of self-neglect highlight concerns regarding his often-poor engagement with services, alongside how his substance misuse was impacting on other areas of his life.

Adult G Summary of Key Events

5.17. **June 2019** North West Ambulance Service (NWAS) received a call from Adult G who stated he had taken IV drugs and may have overdosed. Adult G made a further call to cancel as he felt he was coming out of his rush and would be ok. The ambulance attended despite this because it was felt Adult G needed a welfare check. Adult G was apologetic towards the crew who noted that he had full capacity to make the decision that he did not require treatment.

5.18. **July 2019** NWAS received another call from Adult G who felt he may be overdosing again. The crew attended and spoke with Adult G who reported to be a regular user of heroin. He stated that his sister brings him regular food but is struggling to help him as he often refuses support. Adult G was again noted to be capacitous and allowed the crew to redress his legs because he had missed his normal DN appointment the day before. The DN's were contacted by the crew with a view to them seeing him soon and Adult G's sister was also contacted, she stated she was concerned about his deteriorating condition. Adult G consented to a safeguarding referral which documented 'welfare concerns and self-neglect' being sent to Adult Social Care (ASC). He refused to attend hospital and was referred to his GP.

5.19. As a result of this contact with Adult G ASC received the safeguarding referral from NWAS noting that there was concern about a drug overdose and that the GP had been informed. Adult G attended for a GP appointment where he was noted to be in a poor state of neglect. He requested medication for sleep and anxiety which was given.

5.20. In **August 2019** ASC rang Adult G and offered a referral to access and crisis and thinking ahead which he refused, he also declined support from ASC to access the community that he originally stated he would like. The GP was informed of the paramedic attendance for suspected drug overdose, this communication also identified that 'adult safeguarding were aware'.

5.21. Adult G contacted his GP in September 2019 stating that he wanted to talk to someone as he felt 'his life was a mess'. At his appointment 3 days later, it was noted that he was using crutches to walk. He reported a general decline in his health, that his mobility was poor, and falls had increased. It was noted that DN's were involved in his care and that he had an appointment with the Ambulatory Care Unit that afternoon.

5.22. In **October and November 2019** Greater Manchester Police (GMP) were contacted on 3 occasions in relation to Adult G. The first time by a neighbour who could hear a verbal disturbance which sounded violent and worried that it might escalate. On the second and third occasions Adult G was the caller stating his friend's son was in his property and was refusing to leave, and lastly that a male who had just come out of prison had walked into his unlocked home and again was refusing to leave.

5.23. In **November 2019** Adult G was commenced on home visits by the DN service having had several occasions in the months previously where he had not attended clinic appointments sometimes because he struggled with his mobility. It was also noted by the DN's that Adult G was also noncompliant with the treatment for his leg ulcers. He struggled with the compression bandages as they caused him pain. His lack of mobility had also resulted in him developing a superficial pressure ulcer to his sacrum. He was advised to move his bed downstairs, but he refused. A referral for support was made to ASC.

5.24. Adult G was seen by the Tissue Viability Nurse (TVN) at his home address in **December 2019** and a full assessment of his needs was completed. His level of self-neglect was discussed with his GP and a referral was made to the Community Physiotherapy Team. The Dieticians were already supporting Adult G with supplemental drinks to try to improve his nutritional intake and promote wound healing.

5.25. The same month Adult G was noted by the DN's to be continuing to remove his leg dressings stating that they hurt. The importance of keeping them on was reiterated to Adult G due to the risk of infection when removed and he was offered a referral to the Drug Rehabilitation Team. The TVN referred him for a Duplex Scan.

5.26. In **December 2019** Adult G was seen by his GP in his sister's car at the practice he was encouraged to accept a referral to Turning Point (TP) for assessment of his drug dependence. He was felt to be capacitous at this time and agreed to the referral. Adult G's sister took him home after being given worsening condition advice by the GP. Following a further visit by the DN's to Adult G this month they assessed him as being high risk under the malnutrition universal screening tool. Adult G's mother arrived during the visit and was visibly upset by her son's home situation and level of self-neglect, she was pleased however to see that he had let staff

into his home to treat his leg ulcers. It was noted that Adult G's family had purchased equipment to help improve his quality of life. The out of hours GP services also visited Adult G at home and wanted to admit him to hospital but he refused admission.

5.27. Between **December 2019 and January 2020** ASC made attempts to start a care package, one agency accepted but no further action was taken until **June 2020**.

5.28. Throughout **January and February 2020** Adult G was seen by the DN service as often as he would allow. He was provided with pressure relieving equipment which he would not always use. Staff continued to engage him in taking steps to improve his health. Adult G informed staff that he was going into hospital at the beginning of February for rehabilitation arranged by his GP. There was a further referral by the GP to TP to assist Adult G with his opioid dependency.

5.29. In **January 2020** following discussions between the GP and the DN service Adult G was placed on the Gold Standard Framework[4] (GSF) used by clinicians to identify patients who may be approaching the last year of life in order to help them plan for the future. He was recorded as being in a state of severe self-neglect, housebound due to immobility of lower legs, and not engaging with Turning Point. Adult Safeguarding Team, District Nurses and Community Matron aware. It was identified that Adult G needed a home visit routine. Adult G consented to a multi-agency team meeting to discuss his ongoing care needs.

5.30. In **March 2020** Adult G was visited at his home address by his GP. The GP examined Adult G's leg and had a long conversation with him about the extent of the deterioration and the need for urgent hospital admission. The GP explained that without an urgent hospital admission he might lose the limb or even die. The GP noted that Adult G could understand, retain and weigh the risk and communicate back his decision and the consequences if he delayed. Adult G still refused to go into hospital stating he had a 'family commitment' that evening but he would go in the following day. He refused permission for the GP to share any information with his sister. The GP left giving advice about contacting an ambulance should his condition worsen. A note was also made for the duty doctor to ring Adult G the following day. This action was completed but the telephone was not answered by Adult G. The DN's also attended Adult G's home on this day where they saw him through a window, and he told them to 'go away' a telephone call was also attempted but this also went unanswered.

5.31. The DN's contacted Royal Oldham Hospital in **March 2020** to see if a vascular referral had been made and were put through to the on-call registrar. It was confirmed that the registrar did not know of Adult G but gave advice that if he were referred via his GP or attended ED he would be admitted if this was what he wanted. When attended by the DN at his home address Adult G stated he was waiting for his sister to take him into hospital. 9 days later after Adult G had not gone to hospital his sister met with the GP who completed a referral to the vascular clinic and a referral to ASC. In late **March 2020** TP sent the GP a letter advising they would close the case as they had had no contact from Adult G but that he could be re referred if he agreed to engage with treatment.

[4] The Gold Standard Framework supports earlier recognition of patients with life limiting conditions

5.32. In **May 2020** Adult G's sister was present in his home when the DN's visited. Adult G stated he felt suicidal and wanted to go into hospital, he then changed his mind and stated he would go tomorrow. Following advice from the GP a 999 call was made to NWAS. The call handler spoke with Adult G who became abusive stating that he was not suicidal just fed up and refused to go into hospital.

5.33. In early **June 2020** DN's noted that there was bone visible on the right leg due to Adult G continuing to scrape and scratch his leg with scissors and a knife. Advice was sought from the TVN, a dressing change was advised and an update to Adult G's GP. The GP rang and spoke with Adult G, the GP explained the possible infection of the bone of his leg and that without urgent treatment he was highly likely to die. Adult G replied that he understood but would have to think about hospital admission.

5.34. In **June 2020** concerns were raised again that Adult G was unkempt, that his hair was matted and that there was faeces and urine on the sofa and chairs, urine bottles on the floor some knocked over with urine on the carpet. It appeared that Adult G had been sleeping on his sofa due to his mobility issues. A further referral was made to ASC.

5.35. ASC made a duty visit to Adult G's home when his sister was present. He refused to accept services, although he was advised about the need for an amputation. Adult G stated he had not got a date yet, his sister added it was because he had declined treatment. The following day ASC opened a safeguarding enquiry.

5.36. The same month steps were taken by the GP to assist Adult G in deciding about amputation. He agreed to accept a patient information leaflet about amputation but expressed the view that he was scared about contracting Covid in hospital and was very distressed about the thought of an amputation but was also aware that his poor quality of life would not improve without surgery.

5.37. In late **June 2020** ASC undertook a further home visit, living conditions were documented to be in a malodorous state while Adult G appeared underweight. Adult G stated he had DN's attending 3 times a week and had received a letter about amputation but was not sure what would happen. He stated his meals were provided by his sister and that he did eat. Adult G felt his situation was 'alright' but accepted a package of care. Attempts were made to start a package of care; 2 agencies were contacted but did not have any availability to provide 2 carers at each visit.

5.38. In **July 2020** ASC made a further visit to see Adult G at his home. He continued to say he was ok and refused to go into hospital for amputation due to the Covid risks.

5.39. Later that month the DN's found that there was bone visible on Adult G's left leg that appeared to be snapped. Advice from senior colleagues was sought and a 999 call was advised. Adult G was not happy about this and told staff to get out of his home fully aware that an ambulance was en-route. There were no concerns about Adult G's ability to refuse further treatment. When NWAS attended Adult G refused to allow them to assess his leg and refused to be taken to hospital. The crew informed the DN's and the GP of this outcome because they had no

concerns about Adult G's capacity to make this decision, he was asked to sign the refusal of treatment statement.

5.40. In the same month, ASC attended the GSF meeting at the GP surgery. The GP advised that Adult G's reluctance to go into hospital pre-dated the Covid pandemic both agreed that Adult G had the mental capacity to make this decision. The Social Worker (SW) expressed concerns that Adult G never closed his front door and was vulnerable due to his lack of mobility if people were to walk in. He was going to investigate the possibility of getting funding for Adult G to have an automatic door fitted to his property. Further attempts were made to start a package of care, but another agency stated they too did not have any availability.

5.41. In **August 2020** Adult G was increasingly refusing to allow the DN's to redress his wounds, when he did consent it was noted that the right leg had 16cm of bone visible and the left leg had 9cm of bone exposed which was snapped at the upper aspect. He also refused pressure area checks.

5.42. In the middle of the month Adult G was visited by a SW. Adult G stated he was tired and asked them to leave and return the following day. He again refused a call for an ambulance. Later that month a care support package was due to start but Adult G declined the service, so it was not commenced.

5.43. At a further GSF meeting at the GP surgery the DN's shared recent photographs of Adult G's legs showing a further deterioration in their condition. It was noted that Adult G had the mental capacity to make an unwise decision. He had been advised that amputation was necessary, talks had taken place with the vascular surgeons, but Adult G was refusing to engage with the service. Staff agreed to keep monitoring and reviewing him.

5.44. In **August and September 2020** 2 further calls were made to GMP in relation to Adult G. The first was made by Adult G complaining that someone had walked into his property and was refusing to leave. The second was from a neighbour for noise disturbance at Adult G's property.

5.45. In **September 2020** Adult G was placed on daily DN calls due to their concerns about his deteriorating health. He would only agree to have dressing changes 3 times a week. Adult G's sister was grateful for the increased visits to monitor his health. She tried to encourage Adult G to have baseline clinical observations recorded but he refused.

5.46. Later the same month discussion with Adult G took place in relation to a Do Not Attempt Cardiopulmonary Resuscitation (NDACPR) order[5]. Adult G said he would think about it. A joint visit between health and social care was undertaken which resulted in an MDT meeting concluding in the need for a joint visit to formally assess Adult G's capacity again. This was undertaken and following a long conversation with Adult G it was documented that he had the men-

[5] DNACPR and ReSPECT decisions are made with the individual if their condition indicates that they are unlikely to survive even with resuscitation attempts. A decision around CPR can increase the possibility of a peaceful and dignified death.

tal capacity to continue to refuse treatment. At this time his wounds were continuing to deteriorate, and Adult G stated to the DN's that he was still thinking about surgery and would discuss it further with his sister.

5.47. During **October 2020** the DN's continued to try to redress Adult G's legs as and when he would allow. Mental Capacity assessments were carried out by the DN's and on each occasion he refused treatment Adult G was found to have capacity to make an unwise decision.

5.48. In **November 2020** the adult safeguarding enquiry was closed and referral to the MRM process was being considered. DN visits continued, Adult G was increasingly unwilling to have his dressings changed and appeared to be managing his pain control with alcohol.

5.49. In mid-**December 2020** Adult G's sister called NWAS concerned about the deterioration in her brother's health. NWAS attended and found Adult G to be at times confused and lacking the capacity to make decisions for himself. The crew felt that it was in Adult G's best interest to be transferred to hospital and his sister agreed. As arrangements were being made to place him on the ambulance stretcher it appeared that Adult G seemed to understand what was happening to him and he did not resist. The crew placed a pre alert to the hospital and Adult G was taken to hospital accompanied by his sister.

5.50. Following admission to hospital Adult G was treated for suspected acute confusion because of sepsis. Treatment was commenced under a best interest decision however Adult G did not respond to treatment and sadly died.

6. Analysis and Learning

To determine whether decisions and actions in the care of Adult G comply with the policy and procedures of the RBSAB and their named services

6.1 NWAS Policy and Procedures

6.1.1. NWAS submitted what they intended as a 'safeguarding referral' to ASC with the consent of Adult G in July 2019 following a call from him stating he felt he may be overdosing again (an earlier call for the same reason was made the previous month).

6.1.2. The GP received notification of the NWAS attendance and was informed that 'adult safeguarding were aware'.

6.1.3. Both actions above were in line with both NWAS internal, and RBC safeguarding procedures for reporting a safeguarding concern.

6.1.4. In July 2020 when Adult G made a capacitous decision not to allow NWAS to examine his leg and possibly take him to hospital this resulted in the crew asking him to sign the NWAS refusal of treatment statement. This too was in accordance with NWAS policy and procedure.

6.2 NHS Northern Care Alliance Policy and Procedures

6.2.1. The DN Service in Rochdale have a Non-Concordance Process[6] which sets out the background to its use. The aim of the concordance is the establishment of a therapeutic alliance between the clinician and patient. The non-concordance process is designed 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.

6.2.2. The summary flowchart outlines the steps staff are to take when the patient declines to follow the District Nurse Care Plan. Staff attending the Learning Event stated they were not aware of this process however they did discuss Adult G and the difficulties getting him to allow them to monitor and redress his leg ulcers at the District Nurse huddles which is what the process advises in the initial stages. As in other SAR's Shirley Williams Independent Chair Safeguarding Adults Board[7] identified that preventing/reducing harm is more realistic than changing behaviour. This can be seen in the approach of the DN's in their management of Adult G's ulcerated legs.

[Recommendation 3]

6.2.3. The DN team also had available to them their Legal Advice Request Guidelines which they could have used to seek legal advice from their own organisation about the ongoing difficulties in getting Adult G to accept care and treatment. Staff at the time were also unaware of these guidelines.

6.2.4. They sought safeguarding advice not from within their own service but from the Social Worker who informed them in the later months of 2020 that an application to the court under inherent jurisdiction and overriding Adult G's unwise decisions in relation to his health were being considered, and that they would be invited to a 'safeguarding meeting'. No formal S42 enquiry meeting was ever held. No joint responsibility for advancing the safeguarding concern was taken.[8]

[Recommendation 2]

6.3 Greater Manchester Police Policy and Procedures

6.3.1. GMP have 2 processes that are referred to in the timeframe of the review. One is CAP which is an electronic care plan on the GMP policeworks system which an officer completes where a welfare issue is identified. It is triaged by the safeguarding units Multi Agency Adult Safeguarding Team (MAAST) screening meeting. This meeting happens twice weekly, from here referrals are made to the relevant agencies such as childrens social care, adult social care, and mental health team being examples.

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[6] Non-Concordance Process (Adult Community Nursing) NHS Northern Care Alliance NHS Group September 2019

[7] How do we know it is 'self' neglect and does a self-neglect policy/protocol help prevent self-neglect becoming a safeguarding matter? HC-UK 30th April 2021

[8] Understanding what constitutes a safeguarding concern and how to support effective outcomes Local Government page 5 September 2020

6.3.2. GMP also use the national Threat Harm Risk Investigation Vulnerability Engagement (THRIVE) system. This allows the evaluation of the risk from either the call handler or the radio operator. The THRIVE would inform the grading log and is given based on the information provided initially i.e urgent response, less urgent response grading.

6.3.3. GMP had 7 contacts in relation to Adult G during the timeframe of this review. In October 2019 they were called by a neighbour reporting a noise disturbance in Adult G's property which sounded 'violent'. This was an unattended incident and recorded as a matter for the Council should the noise be an ongoing issue. The incident was closed.

6.3.4. Later the same month Adult G called GMP to report that a friend's son would not leave his property. This call was attended, no weapons or children were seen at the property. The man was removed from the property and taken to hospital for treatment of an injury to his head; he declined to explain how it happened.

6.3.5. The following month Adult G rang to state that another man was in his property refusing to leave. He stated the front door was open and he had let himself in, Adult G was concerned he might become violent. GMP tried to call back when the call was abruptly terminated. They suspected alcohol was involved, due to no offence being committed the risk was deemed low so the call was not attended.

6.3.6. GMP next attended Adult G in January 2020, on one occasion the call was unrelated to Adult G, he was reporting harm on behalf of another individual. On the second occasion a neighbour called stating they could hear shouting and screaming coming from Adult G's property. This call was attended Police noted that there were no signs of any disturbance and that Adult G told them he and a friend were watching a loud action film.

6.3.7. In August 2020 GMP were called on 2 occasions. Adult G called to report that a drunken friend had just walked into his property and was refusing to leave. When questioned further Adult G refused to engage in conversation and terminated the call. He later called back to say that the friend had left. Adult G was not attended, the log was closed as no crimes or offences had been committed.

6.3.8. 3 days later GMP were contacted by a neighbour to report noise disturbance. Adult G reported that a drunken neighbour had let himself in, but the problem was now resolved. THRIVE was applied on this occasion, no offences were logged, and the Neighbourhood Team would review.

6.3.9. At the Learning Event Police identified that the MAAST has been in place since 2019 and that there is good information sharing at this meeting that has ASC and MHT attendance at the meetings. Police feel that having the MAAST in place has increased their awareness and understating of the complexities of self-neglect. Adult G was however not discussed at the MAAST during the timeframe of this review. GMP are assured that their policies and procedures were followed by staff accordingly when handling calls in relation to Adult G.

6.4 Turning Point

6.4.1. The CDT was managed by Pennine Care NHS Foundation Trust prior to March 2018 when following a tender process, the service was transferred to Turning Point. Adult G was not a current client of the service at this point, as a result his summary case notes were not transferred to the new provider. This was in line with standard practice for transfer of care following the change in commissioning arrangements as well as General Data Protection Regulations (GDPR). For the purposes of this review Adult G never engaged with face-to-face contact with Turning Point.

6.4.2. The first referral received by Turning Point was from Adult G's GP in December 2019. They attempted to contact Adult G the same day, but the number given stated that the call could not be connected. An engagement letter was sent to Adult G to encourage him to contact the service. By March 2020, no further contact had been made by Adult G to Turning Point. A letter was sent by the service to the GP to advise that they would close the case but encouraged the GP to re refer if Adult G consented. This attempt at engaging Adult G was in line with Turning Point's Engagement Policy.

6.5 Primary Care GP Services

6.5.1. Adult G was registered with the same GP surgery throughout the timeframe for this review. At the Learning Event the GP stated that they always attempted to ensure a senior member of the GP team engaged with Adult G recognising he could be challenging to engage with. His reluctance to accept support and his ongoing substance misuse were well known within the clinical team. No safeguarding referral for self-neglect was made by practice staff because they believed that Adult G was already in safeguarding procedures following the NWAS referral in July 2019.

6.5.2. There were regular conversations between the GP surgery and the DN's updating the staff on how Adult G's leg ulcers and pressure ulcers were following reviews that he allowed. They were also informed of his referral to the TVN because of the extensive ulcerated wounds and concerns around the risk of sepsis. Home visits were carried our when felt necessary due to the concerns about Adult G's deteriorating health.

6.5.3. In January 2020, the GP placed Adult G on the GSF. At the Learning Event the GP stated that the use of the GSF was to provide supportive care to Adult G and prompted further discussion with him about his future treatment, including conversations about DNACPR record on his patient case notes. The GSF can also be used to start discussions with patients' who have capacity about Advance Decision to Refuse Treatment[9] (ADRT). Both conversations with Adult G would have been appropriate, DNACPR was discussed however Adult G never made a final decision on this following conversation with him about how his non engagement was putting his life at significant risk.

6.6 Rochdale Borough Council Safeguarding Policy and Procedures

[9] An advance decision to refuse treatment lets a person while they have the mental capacity choose and explain which medical treatments you do not want doctors to give you

6.6.1. The Adult Safeguarding Referral made by NWAS in July 2019 was not recognised as such by ASC despite self-neglect one of the Care Act 2014[10] categories of abuse being identified on the referral form.

6.6.2. In line with Rochdale Borough Council's Safeguarding Policy and Procedure[11] section 12 sets out when the **statutory safeguarding enquiries** – section 42 are triggered. The individual meets the criteria when:

- They are experiencing, or at risk of, abuse or neglect AND
- Have needs for care AND support (whether or not the Local Authority is meeting any of those needs) AND
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

6.6.3. Councils are not required by law to carry out enquiries for those individuals who do not fit the criteria; however, they may do so at their own discretion, these are identified in the policy and procedure as **non-statutory safeguarding enquiries.** These enquiries would relate to an adult who is believed to be experiencing or is at risk of abuse or neglect but does not have care and support needs.

6.6.4. As in an earlier safeguarding adult review commissioned by RBSAB SAR Adult E[12] published in 2021 the NWAS safeguarding referral was not processed in line with the above criteria but was dealt with as a 'care concern'. The NWAS referral for Adult G was screened by the ASC duty team to assess whether it met the section 42 criteria as above. It was decided that the criteria were not met, and the referral was subsequently managed under Section 9 of the Care Act 2014 which requires the Local Authority to carry out an assessment, which is referred to as a 'needs assessment' where it appears that an adult may have needs for care and support. Initial telephone contact was made by ASC with Adult G in July 2019 resulting in a letter being sent to him offering support. A further telephone contact was made in August 2019, Adult G was offered a referral to access and crisis and thinking ahead but he refused so the referral was closed.

6.6.5. This initial screening of the referral resulted in ongoing miscommunication between ASC and the GP and DN's throughout 2019-2020. No initial enquiries into what information partner agencies held was commenced and the referral was not shared with the ASC Safeguarding Manager for further screening purposes. This was a missed opportunity for the DN's to be made aware of what information the Police knew about Adult G and his home address. The DN's risk assessment could have been amended and staff issued with personal alarms for added protection.

6.6.6. The DN's and GP attending the Learning Event confirmed that they understood Adult G had had safeguarding enquiries commenced and the DN's were expecting throughout 2020 to be called to a meeting under safeguarding procedures. They also asked ASC regularly in 2020 whether there was anything further they should be doing to safeguard Adult G who remained

[10] Care Act 2014 sets out the categories of abuse/neglect under safeguarding procedures
[11] RBSAB Policy and Procedures 2018
[12] SAR Adult E RBSAB 2021

difficult to engage with despite the ever-increasing decline in his physical health. They were assured by the SW that there was nothing else that they should be doing.

6.6.7. ASC received a further referral from the DN's in November 2019 raising their concerns about Adult G's support needs given his lack of mobility, weight and ongoing self-neglect. Contact by telephone was again difficult to establish with Adult G. He was eventually seen in his own home for a Care Act assessment in December 2019. Between mid-December 2019 and late January 2020 attempts were made to start a care package with 1 agency accepting with 2 carers attending each visit. There is no documentation in the record in ASC that any further action was taken by the allocated worker who then went on a period of sick leave in early May. The case was not looked at again until early June 2020.

6.6.8. In June 2020 ASC managed to contact Adult G's sister who stated that she was worried about the state of his home and that he had refused hospital admission. This coincided with a further referral to ASC by the domiciliary phlebotomy service who had concerns about Adult G's self-neglect and the conditions on his property. A home visit by a duty worker was made with Adult G's sister present. Adult G gave the impression that he was waiting on a date for surgery, but his sister added that he had not got a date because he had refused hospital admission. The Duty Worker discussed safeguarding concerns and that his lack of engagement could result in agencies meeting under a Multi-Agency Risk Management[13] (MRM) meeting to see how best they could co-ordinate support to assist Adult G. Following this discussion Adult G asked the worker to leave his property. The following day a safeguarding enquiry was opened by ASC.

6.6.9. At the end of June Adult G agreed to a package of care to support him and to lessen the burden of caring responsibilities on his sister and mother. His property was noted to be malodorous, and he was underweight. 2 care agencies were contacted but neither had availability. In mid-July, a further visit was undertaken by ASC to review Adult G due to the lack of care package. Adult G expressed the view that he was OK and that his sister provided him with meals.

6.6.10. There is no evidence to support that there was any discussion or escalation within ASC around convening a MRM meeting to discuss partner agencies information and conduct a multi-agency risk assessment and action plan until November 2020 when even then ASC were only considering it. The reviewer concludes that this is possibly due to the view within ASC that Adult G was presenting largely as needing health and social care support. This view is supported by the SW agreeing to attend the GSF meetings held at the GP surgery with the DN's.

6.6.11. A further attempt to start a reablement package for Adult G was started in late August 2020 but he declined the service and therefore it did not commence. A multi-disciplinary team meeting (MDT) was then convened by ASC in September because of this a joint visit was planned by the SW and GP to assess Adult G's mental capacity. A long conversation with Adult G was held and he agreed that he would decide about surgery within the week.

[13] RBSAB Multi Agency Risk Management Protocol Nov 2020 MRM may be applicable when there is an inability or unwillingness to care for self and environment or were there is a refusal of essential services

6.6.12. In November when the safeguarding enquiry was opened professionals never met to discuss a shared safeguarding plan for Adult G prior and it was closed again the month before his death in December without evidence of wider consultation or escalation within ASC.

[Recommendation 2]

6.7 Consideration of Legal Frameworks to support workers managing self-neglect cases

6.7.1. Mental Capacity Act 2005

6.7.2 The chronology documents the continued efforts by different professionals to encourage Adult G's engagement with his care and treatment plan, recording his decision-making capacity in line with the Mental Capacity Act Code of Practice[14]

6.7.3. There were 6 MCA assessments completed by DN's on Adult G between January and November 2020. On each occasion they concluded that Adult G had the mental capacity to refuse dressing changes being fully aware of the consequences of doing so, even when he was observed to have snapped a bone in his leg and be at high risk of sepsis due to scraping his wounds with an unsterile knife.

6.7.4. There was a further capacity assessment made jointly by Adult G's GP and SW in July 2020 which also concluded that Adult G had capacity to make decisions about his care and treatment. This assessment has not been shared with the author for the purposes of the review. The reviewer believes it would have been advisable to discuss with Adult G an ADRT to establish his agreement to this following his reluctance to commit to a DNACPR decision. This documentation would have further supported defensible decision making in those capacitous adults who decline potentially lifesaving treatment.

6.8 Inherent Jurisdiction of the Court

6.8.1. Consideration was given to using the inherent jurisdiction of the High Court by the SW when the safeguarding enquiry was opened in June 2020. The regulations of the MCA have replaced the inherent jurisdiction of the High Court in the case of mentally incapacitated people. However, the High Court has extended the use of inherent jurisdiction to the group of vulnerable adults who possess capacity but still require protection for certain reasons[15].

6.8.2. Adult G's sister raised the possibility with the reviewer of professionals working with her brother using this legal framework. The reviewer understands that inherent jurisdiction cannot be used to compel a capacitated but vulnerable person to do or not do something which they have, after due consideration decided to do or not to do. A recent legal case (COP 13718293)[16] ruled that a woman in her 50's who refused medical advice to have an amputation of her leg had the right to self-determination and was able to refuse this intervention when the hospital trust put the matter before the court.

[14] Department of Constitutional Affairs, Mental Capacity Act 2005 Code of Practice
[15] Essex.ac.uk/resources/vulnerable-adults-and-the-inherent-jurisdiction-of the-high-court
[16] https://www.bailii.org/ew/cases/EWCOP/2021/39.html

6.8.3. There is no evidence to suggest that as part of the initial safeguarding enquiry legal advice was sought in respect of the safeguarding arrangements for Adult G by any agency involved.

6.9 Mental Health Act 1983

6.9.1. In the many face to face contacts professionals had with Adult G during the scope of this SAR staff never felt that Adult G's presentation warranted a Mental Health Act (MHA) assessment[17]. Section 5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time you should receive an assessment that decides if further detention under the Mental Health Act is necessary. Patients detained under Section 5(2) are in the same position regarding treatment as voluntary patients. No treatment, except when given in an emergency, can be administered without consent.

6.9.2. In section 5.3.2 of the report Adult G was seen by the DN's in May 2020 in his home with his sister present. He stated he felt suicidal and wanted to go to hospital for treatment of his legs. During this visit Adult G changed his mind and suggested he would go tomorrow. Following advice from the GP a 999 call was made to NWAS. The call handler spoke with Adult G who became abusive stating that he was not suicidal just fed up and refused to go into hospital

6.9.3. Section 5.15 of this report describing his earlier engagement with the CDT he did describe low mood secondary to his current circumstances and substance misuse. At points he was prescribed anti-depressant medication by his GP for low mood.

6.9.4. In part 1 of the National Institute of drug abuse[18] part of the National Institutes for Health (NIH) they define the connection between substance misuse disorder and mental illness. Two of the pathways they identify in comorbidity is that substance use and addiction can contribute to the development of mental illness and vice versa. Despite professionals not feeling that Adult G met the threshold for assessment in this case, comorbidity should always be considered when engaging with people exhibiting substance misuse presentations.

6.10 Human Rights Act 1998

6.10.1 The ethical dilemmas facing practitioners when managing self-neglect in the community are often described as being the respect for a person's autonomy and self-determination against the duty to protect and promote dignity.

6.10.2. Staff working with Adult G considered his Article 2 rights, the right to life balancing this against his Article 8 rights the right to private and family life. Adult G was always able to demonstrate he had the mental capacity to make the decisions required of him, as such staff recognised they could only treat with his informed consent.

[17] A Mental Health Act assessment is carried out to determine whether you should be detained under the Mental Health Act for the purposes of assessment and treatment for a mental health condition
[18] The National Institute of Drug Use part 1 describes the connection between substance use disorders and mental illness

7. Barriers to Adult G accessing services

7.1. The review has identified several times when Adult G appeared to want to be treated in hospital for amputation of his lower leg, however he either put it off for another day or changed his mind.

7.2. At the Learning Event the reluctance of Adult G to accept admission to hospital was identified as being multifactorial. Staff felt he was frightened of what having an amputation would mean for him and how he would cope. He was understandably concerned about the Covid pandemic and catching this when in hospital as well as how he would cope with an in-patient hospital admission if he had no access to substance replacements to manage his addiction to illicit drugs.

7.3. It was a subject that professionals continued to return to in repeated attempts to engage Adult G with throughout 2019 – 2020 using his family to try and persuade him to take up the offer of treatment.

7.4. Staff discussed the possibility of developing a referral pathway for such circumstances and the possibility of having co-ordinated care from both Health, Social Care and Turning Point. Whilst recognising this would not now help Adult G it was agreed that to have this available in future for others would be of benefit. The reviewer notes following the Learning Event that there is already a referral pathway to support hospitals in the area manage alcohol and opiate dependence if a patient requires this to allow them to access necessary healthcare. There is however no medical option for replacing a dependence on the substance Adult G was taking.

7.5. A referral pathway already exists with the hospital to enable treatment continuity for alcohol or opiate dependence and continuity of care between the hospital and community services. However Adult G was particularly concerned about access to a range of drugs which would not be legally available in hospital. Turning Point have recruited to a 'hospital liaison post', the funding for this like much contracting is short term and in this case until June 2022; a point clearly identified by Dame Carol Black in her review of drugs report[19]. The scope for this post could potentially include working to motivate resistant clients with potentially life-threatening conditions and drug or alcohol dependence across hospital.

7.6. The use of peer support for people with substance misuse problems was also considered. On their website Turning Point indicate that they offer peer support services by individuals who have gone through similar experiences and are willing to work with people who may benefit from this type of support/mentoring. Whilst it may not have been an offer taken up by Adult G the Learning Event attendees felt it was worthy of further exploration and awareness raising if those more willing to engage might benefit.

7.7. In relation to peer support for people who use illicit drugs Turning Point do have a limited service available. They have a full programme of training and development and a dedicated role to support peer mentoring throughout their service. The impact of the Covid pandemic meant that some of the peer mentors were told to isolate and with restrictions on face-to-face

[19] Independent review of Drugs Dame Carol Black 28 February 2020

client contact the role of mentor primarily became one of remote or telephone support, a consequence across a great number of care providers. The number of peer mentors also fluctuates at any given time. Some mentors go on to get paid work which is obviously a positive outcome for them. Raising staff awareness of this service resulting in greater demand would clearly result in prioritising those requests that were likely to gain the most benefit.

7.8. The reviewer acknowledges that Adult G was not receiving support from Turning Point during the timescale of this review. His sister provided the reviewer with some insights into how she perceived previous drug services had worked with her brother.

7.9. Adult G's sister had experience of supporting her brother to attend appointments, if they were 15 minutes late then they would on occasions be turned away and the treatment record would reflect did not attend (DNA). When this happened Adult G's sister recalled her brother being advised that if he wanted to engage with services again, he would need to be referred again by his GP.

7.10. Adult G's sister felt that expecting people who struggle with substance misuse to be up and organised to attend a morning appointment was to fail to understand the nature of the world the person existed in. She felt that services should be commissioned in a way that made them available on a 'drop in' basis.

7.11. Whilst this may not be a viable option it is assuring to note that Turning Point do currently offer an evening clinic and there is some flexibility in appointment times i.e., morning, afternoon, and evening.

7.12. On attending previous appointments with her brother at the earlier service provider his sister also had experience of what she believed was inappropriate behaviour by staff who she felt were quick to judge her brother and who she felt did not really want to help which left her with a poor opinion of a small number of staff who worked for the service. This is a disappointing reflection of how a minority of staff can perhaps come across even if they do not recognise that this the perception they are creating, and one staff across all agencies would be well reminded of.

8. Good Practice

8.1. The review considered direct practice with Adult G. This focussed on the perseverance of the DN's to engage Adult G in receiving care for both his ulcerated legs and latterly his pressure ulcers. The DN team never labelled him as a 'drug user' making 'lifestyle choices'. They never gave up encouraging Adult G to allow them to redress and monitor his ulcerated legs. They worked closely with the TVN to try different types of dressings to encourage wound healing even though they were aware that the legs required amputation. They also involved the dietician to encourage Adult G's nutritional intake to support wound healing. A diabetic nurse also reviewed Adult G to offer support.

8.2. When it became apparent that Adult G's mobility was so impaired that home visits were necessary a staff risk assessment was undertaken by the DN service. Staff were aware that Adult G kept a knife on the table in his lounge but felt that this was there to give Adult G a way of

protecting himself from others due to his lack of mobility making him vulnerable, rather than him having any intention of intimidating them. Staff were confident enough to continue home visits in pairs throughout 2020 during the Covid pandemic when often Adult G would refuse their support. They commented that on some visits were Adult G refused to engage with them they felt it was because he was expecting visitors who he could not guarantee would behave appropriately in front of them.

8.3. The DN's discussed Adult G every day and always discussed different approaches with him maintaining their aim to visit 3 times a week for wound dressings and then trying to contact him every day from mid-September for a welfare check.

8.4. There were continued efforts by staff to discuss the amputation of Adult G's lower legs and assess his capacity to understand the severe implications of delaying this decision. Plain language was used, and it was highlighted to Adult G that if he did not accept treatment the short-term outcome was likely to be that he died. Adult G was able to express that he understood and could retain this information long enough for him to make his decision.

8.5. On the last occasion NWAS attended Adult G in December 2020 they found him in a state of fluctuating capacity. On initial attendance he did not appear to understand his situation and the crew made a best interest decision which his sister agreed with, that he must be transferred to hospital. This was sensitively done; he was treated respectfully and on transferring Adult G onto the ambulance stretcher he appeared to acknowledge what has happening and nodded his agreement.

9. Wider Systems and Resources Impacting on Care

9.1. People with drug use disorders may have a range of health and social care problems. Drug misuse is more prevalent in areas characterised by social deprivation, which in turn is associated with poorer health. Rates of drug misuse death have a marked North – South divide.[20]

[Recommendation 5]

9.2. Treatment services have been limited by local government funding cuts. The total cost to society of illegal drugs is around £20 billion per year, but only £600 million is spent of treatment and prevention. The amount of unmet need is growing, some treatment services are disappearing, and the treatment workforce is declining in numbers and quality[21]

9.3. A prolonged shortage of funding has resulted in a loss of skills, expertise, and capacity from this sector with a significant fall in the number of Medical Staff, Psychologists, Nurses and Social Workers in the field.[22]

9.4. The review does not draw the conclusion that this had a direct impact on the root cause of Adult G's death, but lack of having an assertive outreach team with capacity to identify all people not engaging with services makes this a potential contributory factor. Where outreach

[20] Deaths related to drug poisoning in England and Wales 2020
[21] Ibid
[22] Ibid

teams have been funded previously, they have had successes, but this service is usually targeted at priority groups such as high impact users, veterans and the homeless.[23] Adult G would not have fitted any of these categories.

9.5. In current national and local commissioning there is an emphasis both in terms of the local contract providing harm reduction advice and ensuring understating of how to access services for those who may be resistant to change whilst focusing resource in supporting those who are motivated to change. Locally and nationally, it is a constant balancing act, one staff member at Turning Point summed it up recently as 'striking the right balance between saving lives and changing lives'.

10. Practice Developments

10.1. Northern Care Alliance

10.1.2 The NCA are undertaking work to improve the understanding of the role of the corporate adult safeguarding team and how they can support staff dealing with complex cases out in the community.

10.1.3. The team are increasing the knowledge of staff that cover their community areas in relation to their escalation pathways so that staff can seek early support with patients who are self-neglecting in the community, including MRM.

[Recommendation 3]

10.1.4. In line with the Intercollegiate Document for staff training NCA are in the process of rolling out level 3 training to all clinical staff which includes the safeguarding referral pathway for NCA.

10.1.5. The Adult Safeguarding Team based at NCA now have a physical presence in Oldham Royal Infirmary were previously the team were only contactable by telephone or e-mail. At the Learning Event the DN's felt that it was now much easier to access safeguarding support and supervision.

10.1.6. NCA are raising awareness of how all staff members can seek legal advice from the Trust Legal Team.

10.1.7. NCA are strengthening the application of the MCA 2005 and improving the quality of the capacity assessments completed by staff by offering bespoke training. They are developing an MCA pack for use by community teams that is available on the staff intranet.

10.2. Greater Manchester Police

10.2.1. Although the commencement of the MAAST predates this review GMP and partner agencies attending the Learning Event felt that the MAAST had improved information sharing about

[23] Joint integrated substance misuse treatment and recovery service for Bolton, Salford and Trafford 2016

cases of concern and that referrals to support services for vulnerable people were easier to achieve.

10.3. North West Ambulance Service

10.3.1. The changes to NWAS referral forms were discussed at the Learning Event following the recommendation from the SAR for Adult E *'RBSAB receives assurances that the changes to the NWAS referral forms is complete and communicated to staff'*, it was concluded that this was still a work in progress.

[Recommendation 1]

10.4. Heywood Middleton and Rochdale CCG

10.4.1. The CCG has undertaken to review the MCA assessment template used across primary care to support GPs in documenting comprehensive capacity assessments.

11. Conclusion

11.1. The review has examined the sad circumstances of Adult G's death following his continued refusal of services during 2019 – 2020.

11.2. Despite the tragic outcome there was much to commend the work of the services and individual practitioners who worked with Adult G. The review has also identified direct practice factors that could have been improved. Though this is important for future practice, this was not the root cause of Adult G's death.

11.3. Adult G's death resulted in his continued refusal of services and his lack of ability to put his physical health needs above his substance misuse needs.

11.4. Practitioners working with Adult G shared his sister and his mother's wish to see him engage with medical treatment which would potentially have allowed him to live an improved quality of life for the rest of his life.

11.5. Rochdale Borough Council are working to improve the services available to meet the needs of people like Adult G in the context of repeated funding constraints. Self-neglect and substance misuse are both challenging agendas but ones that must be progressed to improve the well-being of people like Adult G in the future.

11.6. Rochdale Borough Council have established a drug related death overview panel which will have responsibilities to review deaths that do not meet the Safeguarding Adult Review threshold under the Care Act 2014. There must be a clear understanding across partner agencies of the function of both this panel and the RBSAB.

[Recommendation 4]

12. Recommendations

The recommendations have taken account of the changes to practice that the panel members identified from their own organisations.

Recommendations
Recommendation 1: Embedding the changes made to NWAS referral paperwork
The RBSAB should seek an update report from NWAS in relation to the changes to their referral paperwork and how this is being communicated to staff members.
Recommendation 2: Joint accountability for safeguarding adults
The RBSAB should seek assurance that: Partner agencies are ensuring their staff are aware of their joint accountability to finding safeguarding responses to support outcomes using the National Framework as a driver o **Partner agencies should be able to evidence collaborative decision making in both preventing and finding responses to abuse and neglect whether within the responsibilities set out in the Care Act (2014) or through other powers or multi-agency arrangements.**
Recommendation 3: Staff Support
o **Partner agencies of RBSAB should provide assurance that their staff know how to escalate concerns about serious self-neglect cases where there is ongoing non-engagement from the person and the risks to life are increasing.** o **Partner agencies of RBSAB should make their staff aware that a 40-minute training video on the MRM is available if staff email rbsab.admin@rochdale.gov.uk**
Recommendation 4: Establishing the link between the RBSAB and the Rochdale drug-related death overview panel
o **The terms of reference for the Rochdale and Oldham drug related death overview panel should ensure all panel members attending are cognisant of the function of the RBSAB and Safeguarding Adult Review (SAR) process/requirements.** o **The panel terms of reference should be clear when to refer relevant cases to the RBSAB that may meet the threshold for undertaking a Safeguarding Adult Review to ensure the RBSAB is complaint with its statutory function.** o **A representative from the RBSAB should be invited and attend the Rochdale and Oldham drug related death overview panel when relevant/ necessary.** o **Any newly commissioned SAR that would benefit from having a panel member/s from the drug related death overview panel should ensure that engagement is sought.**
Recommendation 5: Escalation to the Regional SAR Network

The chair of the RBSAB should consider sharing the findings of this report in relation to the lack of central government funding for substance misuse services at a regional level to see if this affects other localities in the region. If so, this should be highlighted at national SAR network level to assist in drawing attention to the North-South divide.

13.

Glossary of Terms

- ASC Adult Social Care
- CCG Clinical Commissioning Group
- CDT Community Drug Team
- DN District Nurse
- Duplex Scan is an ultrasound scan that uses sound waves to create a colour map of the arteries in the body to identify any narrowing of your vessels resulting in reduced blood flow.
- DVT deep vein thrombosis is a blood clot in a vein, usually the leg.
- ED Emergency Department
- GMP Greater Manchester Police
- GSF Gold Standard Framework
- MAAST Multi Agency Adult Safeguarding Team
- MCA Mental Capacity Act
- MRM Multi-agency Risk Management
- MSP Making Safeguarding Personal
- NCA Northern Care Alliance
- NWAS North West Ambulance Service
- PCFT Pennine Care NHS Foundation Trust
- RBC Rochdale Borough Council
- RBSAB Rochdale Borough Safeguarding Adults Board
- SAR Safeguarding Adult Review
- TP Turning Point
- TVN Tissue Viability Nurse

14.

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15.

Statement by the Independent Reviewer

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

Prior to my involvement with this Safeguarding Adult Review:

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

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

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

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

Independent Reviewer

Signature:

Name: Michelle Grant

Date: 9th March 2022