Mr D Safeguarding Adult Review (SAR)

Calderdale Safeguarding Adult Board Response

1.0 Introduction:

This document sets out the formal response of the Calderdale Safeguarding Adult Board (CSAB) to the findings and learning identified through the Safeguarding Adult Review (SAR) it commissioned following the suicide of a man who will be referred to in this report as Mr D.

It provides key information about the SAR process and its purpose and also gives an overview of how it was conducted and who was involved. Importantly it sets out the learning for the CSAB as the partnership responsible for ensuring that joint working arrangements to protect adults are effective. It also shows how the CSAB partnership will support and monitor the implementation of learning by each of the involved agencies.

All partners who are members of the CSAB have formally accepted the report and endorsed the findings. This response should be read in conjunction with the full Overview Report. These documents seek to demonstrate and support the transparent and objective approach all parties have taken to looking at and learning from death of Mr D.

1.1 SAR Information

The Care Act 2014 requires that SABs must conduct any SARs under Section 44 of the Act. The SAB must arrange for a review of a case relating to an individual if.

a) The person has died and the SAB suspects that the death resulted from abuse or neglect (whether or not the Local Authority had been alerted to the abuse or neglect prior to death); or
b) The person is alive but the SAB knows or suspects that they have experienced serious abuse or neglect; and
c) There is a reasonable cause for concern about how the SAB, its members or other persons involved worked together to safeguard the adult.

1.2 Background to the Mr D SAR

This report is about Mr. D, a 59 year old man, who sadly died in the autumn of 2020. Mr. D had been living at a Registered Care Home with nursing, since 2014, and was very settled. Mr. D lived relatively independently, in a bungalow, which was a satellite house within the grounds. Mr. D required access to staff 24/7 due to epilepsy and associated risks.

Mr. D had a complex physical and mental health history and had been in receipt of mental health support in the community from 2007. Mr. D had osteoarthritis affecting his hip. He was awaiting investigation into some scarring on his larynx. Mr. D had temporal lobe epilepsy, was prescribed anti-epileptic medication and had been diagnosed with paranoid schizophrenia. Due to Mr. D's medical history, it was predictable that he would require regular admissions to a mental health hospital following seizures.

Mr. D had a history of multiple suicide attempts and self-harm, including cutting his neck with a knife in May 2020. Mr. D had a known history of violence, use of weapons, admission to secure settings,

and arson. At the time of his death, Mr. D was awaiting the outcome of a decision by the Crown Prosecution Service, following an incident in June 2020 when he had assaulted staff members from the Registered Care Home.

An inquest held in July 2021 determined the cause of Mr. D's death was suicide.

2.0 Methodology

The CSAB decided that this review would have a panel of senior managers (independent from the case) from local agencies who work with adults, chronologies from each agency written by managers who were independent of the case, consultation events with practitioners and managers who had worked with Mr D, and an Independent Author and Chair: Carol Ellwood-Clark.

Unfortunately, following the death of Mr D, his mother, whom he was very close to, also died. Mr D was estranged from his other family and therefore no family member took part in the review of Mr D's life.

The report was guided by terms of reference completed by the Panel. Those terms contained some questions (listed below) set by the CSAB at the beginning of the review process. These questions were addressed by each agency report author and assisted the author in understanding what had happened and why.

1) Mr. D was known to be at risk to himself and others. Was the multi-agency assessment and response to this risk effective?
2) Richmond Fellowship were making changes to their service provision, how did this impact on the care provided to Mr. D? To what extent was this change in service provision managed effectively across agencies involved, in order to make sure that Mr. D received the care and treatment he required?
3) Were safeguarding incidents identified? Were these reported/referred effectively? Was the response to the safeguarding reports effective?
4) How were Mr. D's wishes and feelings about his accommodation needs, care and treatment included in care planning? Were they any gaps?
5) What was the impact on the Covid pandemic on Mr. D? Was this adequately recognised and responded to by services?
6) Were there any issues in relation to capacity or resources in your agency that effected its ability to provide services to Mr. D? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.
7) What learning has your agency identified and what is the plan for turning that learning into practice?

3.0 Agency Involvement

The following organisations produced chronologies detailing their involvement with Mr D, critiquing the practice of the professionals involved whilst considering broader contextual issues relating to guidance, systems and processes:

- Calderdale Metropolitan Borough Council Housing Services
- Calderdale and Huddersfield NHS Foundation Trust
- Calderdale Metropolitan Borough Council, Adult Social Care

- NHS Calderdale Clinical Commissioning Group (Continuing Health Care)
- NHS Calderdale Clinical Commissioning Group (GP Practice)
- Richmond Fellowship
- South West Yorkshire Partnership NHS Foundation Trust
- Together Housing Association
- West Yorkshire Police

4.0 SAR Recommendations

1) That all agencies provide evidence to Calderdale Safeguarding Adults Board which details the processes involved to ensure that there is a multi-agency response when there have been significant events within an individual's life, which require consideration of a multi-agency coordinated response. The evidence should be supported with examples of when the processes have been used.
2) That all agencies provide evidence and assurances to Calderdale Safeguarding Adult Board that their staff are aware of how to escalate concerns in relation to multi-agency working.
3) That all agencies provide evidence to Calderdale Safeguarding Adult Board that when there have been significant events involving an individual, that decisions are being made which are centered around the individual, and that those decisions clearly document the individual's involvement in the decision-making process. Anonymised examples should be provided.
4) That Calderdale Safeguarding Adults Board provides access to a glossary, where Professionals can find further information on key definitions, and processes regarding housing and accommodation, to support them in their role when working with individuals who are in receipt of services and/or living in residential accommodation.
5) That Calderdale Clinical Commissioning Group provides evidence and assurances to Calderdale Safeguarding Adults Board that the contractual arrangements with residential accommodation service providers are current and up to date.

5.0 Response to the learning from the case

Evidence of how it's different now

5.1 Adult Services & Wellbeing (Calderdale Metropolitan Borough of Calderdale)

There are now Practice leads in place to ensure that learning is practice based and each team will have a practice session on a fortnightly basis to embed learning.

Escalation processes are being disseminated to ensure staff understand and are supported in achieving multi-agency working.

Person centred approaches are now being documented in the support plan to evidence the individual's involvement in the decision process.

On receipt of the glossary ASC will disseminated and document staff's acknowledgement of this and this will be embedded in a practice session.

5.2 Health Organisations:

Calderdale and Huddersfield NHS Foundation Trust

- A pilot relating to trauma informed training within the Emergency Departments has taken place and there are discussions about rolling this out trust wide. Mandatory safeguarding training is being reviewed to reflect trauma informed practice.
- Trauma navigator pilot to commence in the Emergency Departments and the project leads are developing trauma pathways.
- Reviewed our training offer regarding the Mental Capacity Act and this has been increased for staff. Bespoke and face to face training will also be re-introduced.
- Advanced care plans are being used for patients with mental health concerns in residential facilities. Where these are in place records are flagged to support staff awareness of the plan in place.
- The High Intensity User Group supports the management of patients who are frequent attenders.
- Increasing awareness of escalation processes relating to professional disagreements through training/ supervision.

South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust have incorporated the learning into the safeguarding mandatory training and the Trust safeguarding team support practitioners through professional escalation procedure as and when required.

The Operational Managers have good working relationships across services in Calderdale which enable a multi-agency coordinated response. The Trust is actively engaged in supporting the Calderdale Safeguarding Adult Board to achieve the recommendations from this investigation.

Calderdale Cares Partnership (formerly Calderdale Clinical Commissioning Group prior to 1st July 2022)

Calderdale Cares Partnership has provided evidence and assurance to Calderdale Safeguarding Adults Board (CSAB) that the contractual arrangements with residential accommodation service providers are current and up to date.

Health organisations contribute to the delivery of CSAB multi-agency training on the self-neglect policy/protocol used in Calderdale and they have increased commitment to attend and embed this in practice.

Through the process of this review, health organisations have contributed to workstreams looking at escalation procedures, professional curiosity and shared the learning from this SAR.

5.3 Housing:

Together Housing Association

Given that the application relating to Mr D's rehousing came via CMBC's Housing Options team following a homelessness assessment, monthly meetings now in place between CMBC Housing and THA's Lettings team to jointly consider and discuss applications for those with complex needs.

Arrangements now in place in THA's Lettings team to seek further information from multiagency partners and / or request a multiagency meeting if THA considers an application is made for

rehousing where there are indications that the applicant has complex needs. This could include agreeing with CMBC Housing Options team to jointly seek a multiagency meeting following discussions on applications with CMBC that have been referred following a homelessness assessment. This will help ensure that the type of accommodation required and the proposed care & support arrangements to ensure appropriateness and sustainability of any tenancy that may be subsequently offered is fully discussed and clarified with multiagency partners. Also, to use multiagency meetings/information-sharing requests to clarify what an applicant themselves feels is appropriate housing.

(Recent example cited by the Lettings Manager who had arranged a multiagency meeting for an applicant with complex needs seeking rehousing. Whilst this was in another Borough in which THA operates, it illustrates the proactive approach now being taken by THA where information has not been shared regarding needs and risk assessment relating to housing requirements and associated arrangements proposed to support an applicant to sustain a tenancy).

Arrangements have also been strengthened to ensure that the Lettings Coordinators/ manager seek advice and support from peers within THA relating to applications where there are indicators of abuse and / or complex needs (in particular, via THA's safeguarding team, Supported Housing Managers, Tenancy Sustainability Manager, Neighbourhood Managers). This peer support includes both via internal case management meetings and at multiagency meetings. Briefings and discussions following the learning have included building the confidence and knowledge within all operational teams around these internal escalation arrangements and externally with partner agencies when concerns are raised by THA, including lack of information.

Additional guidance being added to Lettings procedures as per above re: dealing with applications with complex needs.

Review of tenancy sustainability assessments - piloted in another area and now includes a housing action plan to be put into place for all new tenants where the assessment has determined high risk. A housing action plan would run alongside a wider multiagency care & support plan which THA would expect to be in place to support tenancy sustainment and would seek clarification if not forthcoming or evident. Plans in place to roll out across the wider THA group.

Guidance drafted for operational staff (linked to Incident management procedures) relating to the management of unexplained/suspicious deaths. Final draft completed and will shortly be rolled out.

Case studies now being collated on an ongoing basis via THA's Safeguarding Performance & Quality sub group to be used to share with multiagency partners (including via strategic links e.g. MEAM) to illustrate any ongoing gaps/barriers in practice relating to customers with complex needs and/or facing abuse. Case studies to include customers applying for rehousing as well as current tenants.

5.4 West Yorkshire Police

Officers and staff have been reminded that when persons with multiple complex needs are released from custody that consideration needs to be given to multi-agency discussions regarding bails conditions and the impact of such.

Officers and staff have been reminded of the need to consider the professional escalation procedure as and when required and have been provided contact details of such.

Additional training is being delivered across West Yorkshire Police around adult safeguarding investigations and the wider impact of such investigations.

West Yorkshire Police are actively engaging with the Calderdale Safeguarding Adult Board to achieve the collective recommendations from this investigation.

6.0 How the Board will oversee and ensure that the recommendations are acted upon

All the agencies involved are working together to address the review's recommendations. The Safeguarding Adult Board and its partners are working to strengthen the development of trusting relationships with people with multiple, complex needs, with a focus on how we can best engage and support people who have experienced trauma.

Partners are working to ensure that when several organisations are involved in a complex case, the work is joined up and information is shared so that everyone understands how to best meet the individual's needs. This includes making sure that care plans are focussed on the individual at risk, including an understanding of the person's mental capacity.

The following list includes ways in which the Calderdale Safeguarding Adult Board will continue to regularly review and monitor progress to ensure recommendations are fully implemented.

a) The CSAB partnership will ensure that areas of improvement to joint working practice are reflected in the revision of the Business Plan as appropriate. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.
b) Progress and impact will be managed through the appropriate CSAB work streams, with the SAR sub group monitoring an overarching action plan.
c) The CSAB and its members will formally and regularly monitor the implementation of the action plan and recommendations in order to ensure progress is being made
d) The CSAB SAR subgroup will maintain a register of all recommendations and require both the CSAB and its partner organisations to report on progress on a regular basis
e) The CSAB multi agency case file audit programme may be revised to reflect the learning from this case to seek assurance about any changes to front line practice or management
f) The CSAB multi agency training programme may be amended to reflect key learning and reported to the Board in annual evaluations
g) The CSAB will review policies and procedures and where necessary update or put in place appropriate amendments or new policies
h) The CSAB, in its annual report, will report on the progress made and the wider impact across partners, to consider whether progress and impact has been enough
i) A Challenge Event will be held after 6 months from the date of publication to test out the sustainability of the changes made as a result of this SAR. Learning from this will be reported to the CSAB.

6.1 Dissemination, implementation and monitoring of impact of learning

The Board and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained, and we will test this through regular monitoring and review. Some examples of how the learning from this review will be promoted and embedded in practice are through training and briefing sessions, newsletters, 7-minute guides, and publication on the website.

7.0 Final Summary from Independent Chair

Mr D had significant and complex physical and mental health support needs. A head injury resulted in him developing epilepsy. Following an epileptic seizure, for which hospital admission would be required, Mr D could become violent. He had a history of self-harm including attempted suicide. Mr D was living in a residential nursing care setting, albeit living semi independently in a bungalow in the grounds. He needed access to care 24x7.

Mr D had been married with children but had been estranged from them following the breakdown of his marriage. The constant in his live was his relationship with his mum. Sadly, Covid curtailed his weekly face to face visits with her, which no doubt impacted on his personal resilience and exacerbated his low mood.

There were several missed opportunities and therefore there is significant learning for several of the agencies involved in this case. We need to improve how we work together to support those with multiple and complex needs. Every agency or organisation should feel confident to escalate their concerns where they feel an individual's needs are not being met, or where they feel another organisation should be doing more. Taking a trauma informed approach would have really benefitted Mr D and improved the effectiveness of those involved in supporting him.

The learning from this SAR, as well as other recent reviews is shaping the way that individual agencies work and also how collectively we work as Multi-Disciplinary Teams to support those with Multiple and Complex needs. However, we should not be complacent, and the SAB is committed to ensuring that all the recommendations from this SAR are implemented and that there is evidence that they are improving outcomes for people.

Marianne Huison
Independent Chair of the Calderdale Safeguarding Adults Board
September 2022