Safeguarding Adult Review
Mr. D

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Content

1. Introductions

1.1 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 Moor View, 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 of Moor View. Mr. D required access to staff 24/7 due to epilepsy and associated risks.

1.2 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.

1.3 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.

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

2. Establishing the review

2.1 Decision to Hold a Safeguarding Adult Review

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB[1] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if-

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met

(2) Condition 1 is met if –

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

2.1.1 At a meeting of the Safeguarding Adult Review sub group held on 17 December 2020, it was agreed that the case met the criteria for a Safeguarding Adult Review. The decision was confirmed by the chair of the Board on 07 January 2021.

2.2 Safeguarding Adult Review Panel

2.2.1 Carol Ellwood-Clarke was appointed as the Independent Chair on 29 January 2021. She is an independent practitioner who has chaired and written previous adult and child serious case reviews, domestic homicide reviews and multi-agency public protection reviews. She has never been employed by any of the agencies involved with this Safeguarding Adult Review and was judged to have the experience and skills for the task.

[1] Safeguarding Adult Board

2.2.2 The first of five panel meetings was held on 5 May 2021. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via email and telephone.

2.3 Panel Membership

2.3.1 The panel comprised of representatives from agencies involved in the care of Mr. D and the investigation of criminal matters. A list of panel members appears as Appendix A.

2.4 The Safeguarding Review Process

2.4.1 The local process for conducting Safeguarding Adult Reviews (SAR) is set down in a policies and procedures by Calderdale Safeguarding Adult Board.

2.4.2 All agencies who had had contact with Mr. D between 1 January 2019 and his death were asked to provide a detailed chronology of their involvement. The combined chronology was used to identify key events which the SAR panel agreed required analysis. [See Section 3]

2.4.3 The following agencies submitted information regarding key events;

- 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[2]
- South West Yorkshire Partnership NHS Foundation Trust
- Together Housing Association
- West Yorkshire Police

2.4.4 In July 2021 two practitioners' events were held. These took place online due to the Covid-19 pandemic and were facilitated by the Independent Chair. The first event was attended by front line practitioners, and the second event by Operational Managers from agencies involved in the review.

2.4.5 All attendees contributed openly and freely and provided additional information which has been included in the review as relevant.

[2] Richmond Fellowship is a national mental health charity.

2.4.6 The Chair had access to an independent investigation commissioned by Richmond Fellowship undertaken following the death of Mr. D. The Chair also had access to information produced during the coronial investigation, these documents were released with the consent of H.M. Coroner.

2.4.7 The Chair also spoke with the Head of Continuing Health Care, and Operational Manager, for Mental Health and Learning Disability to gather further information in relation to the commissioning and placement of Mr. D. Relevant information has been included within the report.

2.5 **Notifications and Involvement of Families**

2.5.1 The Mother of Mr. D had died before the review was commissioned. The Chair sought information from agencies to inform of other family members. Mr. D was estranged from his family.

3. Key Events and Terms of Reference

3.1 The SAR panel agreed on the following key events and specific terms of reference –

3.2 **Key Events**

3.2.1 Event 1 – 16 June 2020 – 26 June 2020

This covers the Mental Health Assessment, assault, arrest, release from custody and subsequent multi-agency work in relation to risk, safeguarding, review of care and crisis plans.

3.2.2 Event 2 – 14 Aug 2020 – 26 Aug 2020

This covers a suicide attempt, safeguarding, Multi-Disciplinary Team meeting, review of risk and care plans, multi-agency working. Review of Mr. D's residency.

3.2.3 Event 3 – 21 Sept 2020 - 23 Nov 2020

This covers the serving of the notice to quit the property, occupancy agreement, subsequent assessments and outcomes relating to suitable alternative housing options and care and support requirements. Consideration of Mr. D's wishes, move-on plan, housing application process, and assessments, and implementation. A new staffing model was in place at Moor View, a property owned by Richmond Fellowship after an 8 week trial.

3.2.4 Event 4 – 1 Nov 2020 – 25 Nov 2020

This covers decline in Mr. D's mental health, presentation of suicidal thoughts and multi-agency working.

3.3 **Specific Terms**

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?

4. Background Information

A pen picture of Mr. D

4.1 Mr. D enjoyed music, he was an avid fan of Elvis Presley and it had been his ambition to visit Graceland. Mr. D enjoyed watching football, tennis, rugby, cricket, and athletics. Mr. D supported Leeds United Football Club. Mr. D enjoyed watching films, in particular films and programmes about the war. Mr. D described himself as being 'quite soft and can cry easily at sad films'. Mr. D had a good sense of humour and a caring nature. Mr. D had previously worked as a chef but had not worked for 28 years due to his illness.

4.2 At the age of 29 Mr. D had married. He had two children from this relationship. The marriage ended when the children were young. Mr. D had

no further contact with his wife or children until 2015 when his children sought contact with their Father. Mr. D found this contact difficult and upsetting and had no further contact with them.

4.3 Mr. D was very close to his Mother, visiting her twice a week, when they would meet in the town centre to shop and visit a café together. Mr. D spoke to his Mother every day on the telephone. Mr. D described his Mother as, 'the most important person to me'.

Medical Information

4.4 In 2001 Mr. D was diagnosed with schizophrenia[3]. In 2002, Mr. D was left with temporal lobe epilepsy following a head injury. Mr. D had a diagnosis of Postictal Psychosis[4] and Personality Disorder which resulted in Mr. D being likely to present as challenging[5] after a fit, with an expectation that he would require hospital admission. Whilst regular admissions were expected due to the severity of pre and post ictal psychosis related to Mr. D's epilepsy, this did not necessarily indicate a deterioration in his mental health. The length of his admission was usually very short (days) not weeks, until the epilepsy stabilised. It was usual during seizure activity for Mr. D to exhibit violent behaviour, which required admission to hospital. Whilst this type of epilepsy is not unusual, it tends to be less frequent and not as severe as that experienced by Mr. D.

4.5 Mr. D had numerous presentations and admissions to hospital. Of significance for this review, and prior to the time frame are two periods where Mr. D had been admitted to hospital under Section 2 Mental Health Act, (10 - 24 March 2020 and 1 - 20 April 2020), both admissions to The Dales[6], South West Yorkshire Partnership NHS Foundation Trust. Between 28 May and 8 June 2020 Mr. D was admitted as a voluntary patient at Dewsbury Hospital.

Mr. D's residency at Moor View

4.6 Mr. D moved to Moor View in 2014. Prior to this he resided in a mental health rehabilitation service for approximately 6 months. At the commencement of his residency, Moor View was a Registered Care Home with Nursing. Mr. D was subject to Section 117 Mental Health Act, which places an enforceable

[3] Schizophrenia is a mental illness which affects the way you think. The symptoms may affect how you cope with day to day life.

[4] Postictal psychosis (PIP), an episode of psychosis occurring after a cluster of seizures, is common and may be associated with profound morbidity, including chronic psychosis. Symptoms are often pleomorphic, involving a range of psychotic symptoms, including hallucinations and disorders of thought.

[5] See 1.2

[6] The Dales is managed by South West Yorkshire Partnership NHS Foundation Trust.

duty on both Health (NHS Calderdale Clinical Commissioning Group – hereafter referred to as CCG) and Adult Social Care to provide aftercare services on a named individual. In this case the CCG were responsible for the funding of Mr. D's accommodation and services. Any changes to Mr. D's accommodation were the responsibility of the CCG. [See 5.4]

4.7 When Mr. D was placed at Moor View, he moved straight into a bungalow and remained there for the whole of his stay. Mr. D was able to –

- Cook independently, with support for budgeting and planning.
- Launder clothes independently with prompts.
- Attend to his own personal hygiene and self-care with no prompts.
- Independently access the community.
- Administer medication under observation.

Moor View

4.8 Moor View was a Registered Care Home with Nursing which offered a medium to long-term rehab facility for people who had been in hospital with mental health issues. It was anticipated that residents would stay between 2 – 5 years. The main building of Moor View contained 16 bedrooms with en-suite facilities. There were communal lounges, kitchens, and staff offices within the building. Richmond Fellowship told the SAR panel that anyone placed in the main building had an Excluded Licence Agreement[7]. In the grounds of the home, were two bungalows which contained one bedroom, plus kitchen and lounge areas, with no staff offices or communal spaces. This accommodation was covered under the same Care Quality Commission (CQC) registration, with an Excluded Licence Agreement. There was no rent attached, and the placement was funded in the same way as residents in the main building. To reside in a bungalow, the resident would need to be assessed as capable of living independently, with access to staff support when required. Richmond Fellowship have provided the SAR panel with a copy of Mr. D's excluded licence agreement dated 21 May 2020.

4.9 Around 2015/2016 Richmond Fellowship had begun to communicate that they were looking to move away from Moor View being a Registered Care Home with Nursing, and to introduce a new model, aligned to their other CQC Registered Care Homes, all of which had a recovery and rehabilitation focus. The new model did not reduce the number of mental health trained staff but did reduce the number of Registered Mental Health Nurses. Richmond Fellowship CQC registered services are predominantly staffed by Recovery Workers, with some having nurses based within their team. All Richmond

[7] This means that under an excluded license, the landlord (or licensor) does not have to give notice to the licensee and there is no requirement to obtain a possession order from a court to lawfully evict an excluded licensee. The tenant can be served a 28-day notice to quit the property.

Fellowship staff undergo an induction and receive inhouse training in specialist skills. Discussions had taken place with the CCG, Mental Health services, Local Authority, and 3rd sector organisations regarding the decision to change the service provision. The Care Quality Commission (CQC) were also aware of the proposed plans and conversations were taking place to discuss the proposed changes.

4.10 Delays then took place in implementing the new service due to the findings of CQC inspections and an escalation of concerns raised by the CCG. This resulted in an improvement plan being put in place, that was actively monitored within the CCG. An improvement board was in place within Richmond Fellowship that over saw the implementation of a comprehensive improvement plan. By March 2020, improvements had been made, and the CCG planned to reinstate admissions to Moor View; however, the Covid-19 pandemic impacted on work in this area.

4.11 On 12 October 2020, Moor View changed to a 'Recovery and Rehabilitation care home. The change in provision was to be reviewed by the Registered Manager following an 8-week trial, with a review of the waking night duties and records. This model meant that nurses did not have to be available 24/7 allowing for a more flexible approach to service delivery and concentration on skilled nurse involvement in working hours – recovery focused specialism. The SAR identified that there was a difference of opinion around the knowledge of agencies regarding the change in service provision. This is covered in Section 6.

5. Notable Events

5.1. Key events from agency contacts were identified and these were used to inform the practitioner events and agency analysis. The analysis of the events appears in Section 6. Below is a summary of key events within those timeframes. The below entries do not replicate the full chronological data contained in the combined chronology.

5.2 **Event 1 – 16 June 2020 – 26 June 2020**

5.2.1 On 16 June a Mental Health Act assessment was undertaken with Mr. D due to concerns raised by Moor View. The concerns detailed that Mr. D's mental health was deteriorating – he presented as elated, delusional, agitated with a rapid speech, making inappropriate comments towards staff and other residents and being verbally aggressive towards staff. The outcome of the assessment determined that Mr. D did not meet the criteria for hospital admission and a plan was put in place for Mr. D to be closely monitored by

the Community Mental Health Team (CMHT) and Moor View, with advice to contact the police if Mr. D became violent.

5.2.2 In the early hours of 17 June Moor View called the Police. At this time, Mr. D was outside his property shouting and the neighbours had complained. He had made racist and sexual comments to staff. There was no record as to Mr. D's presentation prior to the Police being contacted. The staff requested help from the Police and told them that Mr. D could become violent. Moor View also told the Police that they were going to call an ambulance to take Mr. D to an acute mental health unit. It was recorded that Moor View had activated the crisis plan in line with the agreement with his care team. The Police told Moor View to contact them when it was known what time an ambulance would be at the premises. The Police received several calls during the remainder of the night and into the morning that an ambulance was at Moor View; however, the Police were unable to attend. The ambulance service informed Moor View that the crisis team advised them that Mr. D was not to be detained, and that Moor View should use the least restrictive practice and offer Mr. D medication, which staff subsequently administered.

5.2.3 At 1403 hours the Police received a call from Moor View that Mr. D had caused damage and had picked up a wooden stick and was threatening the Manager. The Police attended and determined that Mr. D did not need to be detained in accordance with Section 136 Mental Health Act 1983. The Police contacted Mr. D's care co-ordinator.

5.2.4 At 1713 hours the Police received a further call from Moor View that stated Mr. D was constantly ringing staff and had made a threat to kill staff. There were no specific details recorded about the threats, but information was shared that Mr. D had been making threats towards another resident in the day. The Police delayed the incident until 1800 hours when it was recorded that a mental health practitioner who worked within the call centre hub would be on duty. However, the Police received a further call at 1744 hours that Mr. D had assaulted staff with a knife. Police attended and Mr. D was arrested.

5.2.5 Mr. D was released from custody after interview on 18 June. Mr. D was released with bail conditions not to enter the main care complex of Moor View, not to be alone with any female staff or residents of Moor View, and to allow food and medication to be delivered to the door of his bungalow. It was documented on Police records that Moor View were content for Mr. D to return in the short term, with Moor View looking for another long-term placement thereafter.

5.2.6 Moor View submitted a safeguarding concern following the incident on 17 June, and a safeguarding strategy meeting was arranged, which was recorded as being on the basis of the deterioration of Mr. D's mental health.

5.2.7 On 20 June Mr. D's support plan was reviewed by Moor View. The support plan outlined ways Mr. D would be supported to be independent and working with staff and his care co-ordinator to move to a supported living service in the future. Mr. D was issued with a behavioural plan by Moor View, which he signed and agreed too. The behavioural plan stated that Mr. D could not enter the main building, could not make any sexual advances or threats towards any persons, must not be a public nuisance, that staff must not be alone with him, and that staff can remove any object from the bungalow they deem dangerous. It was documented that the plan would be reviewed in six months' time and was in response to the bail conditions that had been put in place to ensure that Mr. D knew what these involved. Two days later the behaviour care plan and crisis care plan were sent to the Safeguarding Adult Team.

5.2.8 On 23 June Richmond Fellowship Performance, Quality and Innovation team undertook a desk top review. The full report was shared with the Safeguarding Team and care co-ordinator. The report identified the following –

Recommendations for service:

- Reflect on and explore the relationship that staff have with Mr. D and how staff can improve a therapeutic relationship.
- Utilise and further develop the use of good questioning techniques such as using opening and close questions appropriately to help understand the person thinking, decisions and behaviours.
- Reading through the case notes there was a sense of a lack of care and compassion for this gentleman and poor communication. Staff to consider how to ensure a person centred and more respectful approach in working with this gentleman.
- Staff to reflect on their approach and how they could improve communication with Mr. D and how to ensure an adult to adult approach.
- De-escalation techniques were not used throughout the whole of this event, staff team to have some training in de-escalation techniques or a refresher if this has previously been done.
- Explore the availability of training around challenging behaviour.
- Continue to work with multi-agencies to improve the response when staff have difficulties in managing challenging situations.

Recommendations for Area:

- Area manager to set clear expectations for Registered Manager in changing the culture and some of the approaches within the service.
- Explore with the manager and team leader how three staff approaching 1 person impacts the person; staff need to see life from the recipients perspective.

5.2.9 Normal practice following a desk top review is for an action plan to be drafted and submitted to the quarterly Service Governance Group; however, in this case the Area Manager made the decision to address the concerns by taking the Registered Manager through a capability process.

5.3 **Event 2 – 14 Aug 2020 – 26 Aug 2020**

5.3.1 On 14 August 2020 Mr. D was taken from Moor View to Huddersfield Royal Hospital after he had been found with stab wounds on his neck under his chin. Mr. D was transferred to the specialist surgical team at Maxillofacial Unit, at Bradford Royal Infirmary and Intensive Home Base Treatment Team[8] (IHBTT). Mr. D was assessed by the Mental Health Liaison Team, referred to IHBTT and discharged back to Moor View. Concerns were raised by Moor View over the discharge of Mr. D with Bradford Royal Infirmary and to the on call Manager within Richmond Fellowship.

5.3.2 On 16 August Mr. D was seen by the IHBTT. The IHBTT were informed by Moor View that due to the bail conditions put in place by the Police following the recent attack on staff and a history of secreting knives, staff were not currently entering Mr. D's property and that as Mr. D went out independently, they had no way to manage the risk and were unsure if the knife Mr. D had used to self-harm had been removed. Moor View were telephoning Mr. D every hour to provide support and check on his welfare. Mr. D denied any thoughts to harm self or others and appeared settled. Staff were informed they could contact the IHBTT for support if needed and were aware to contact the Police if Mr. D became violent or aggressive. Mr. D's care co-ordinator called him the next day and he expressed remorse over his actions and stated he had no intentions to harm himself again. Mr. D stated he was worried over the bail conditions and criminal case.

5.3.3 On 17 August Adult Social Care received a safeguarding alert from Moor View regarding the incident on 14 August. This was allocated to the case worker who had received the alert in June 2020.

[8] https://www.southwestyorkshire.nhs.uk/services/intensive-home-based-treatment-team/
The two main roles of the intensive home based treatment team are to assess people experiencing a mental health crisis who may need to be referred to an inpatient unit and to care for people in their own homes as an alternative to admission to a mental health unit.

5.3.4 On 20 August a multi-disciplinary team meeting was held which was attended by a Social Worker, care co-ordinator, Area Manager and Registered Mental Health Nurse from Moor View and Mr. D. The meeting discussed recent incidents and how Mr D's needs could be supported. During the meeting Mr. D's bail conditions and the restrictions that these placed on him were discussed. Mr. D also expressed his concerns and worries regarding the criminal investigation. The meeting discussed the hourly telephone/telecom contact that Moor View had instigated and it was agreed to gradually reduce these over the following days; however, if Mr. D posed any risk to staff or himself the observations could be reviewed, and contact be reverted back to hourly.

5.4 **Event 3 – 21 Sept 2020 - 23 Nov 2020**

5.4.1 On 21 September 2020 Mr. D was served a 28-day notice terminating his licence from Moor View with his occupancy due to end on 19 October 2020. Mr. D's care co-ordinator was advised of this decision via email the same day. On 25 September Moor View contacted the Housing Team and an assessment was arranged for three days later. Contact was also made with Adult Social Care and the care co-ordinator.

5.4.2 On 2 October 2020 the Calderdale Team Manager for Housing Support Scheme for mental health met with the Manager from Moor View and a member of staff. The Manager explained that the service had changed with a focus on rehabilitation rather than a home for life and stated that Mr. D was very independent and no longer needed rehabilitation support. Discussions took place regarding the timescale for Mr. D to leave the property, during which it was recommended that a gold band letter could be written to Key Choice, (a choice based letting scheme in conjunction with Together Housing Association) which would give Mr. D the highest priority for moving. Mr. D's application had been previously assessed at silver. Discussions also took place regarding the sharing of information, including the previous incident with staff.

5.4.3 On 14 October 2020 concerns were raised by Housing Support with the care co-ordinator and CCG about Mr. D and his ability to live independently. Mr. D told Housing Support that he needed supported accommodation due to needing help managing his medication and that his Mum would worry also. Housing support spoke to Moor View who confirmed an extension until 30 November. Housing Support asked Moor View for a letter to assist Mr. D's application. Housing Support contacted the care co-ordinator who stated that the only option for Mr. D was independent accommodation with a care package, to replicate his current provision. The review were informed that other options were also being considered which included, supported living, a bespoke support package in his own home and out of area options.

5.4.4 On 3 November Together Housing received an email from Moor View with a letter dated 14 October. The letter was a request to approve gold banding for Mr. D's application, as he was imminently homeless. On 6 November the housing application became active which allowed Mr. D to bid for properties in social housing. Together Housing awarded silver band as information in the letter did not meet the threshold for gold banding.

5.4.5 Together Housing makes the decisions on banding as Together Housing manages the housing register on behalf of the Council. However, it does so in accordance with the allocations policy which is a joint policy between CMBC and Together Housing.

5.4.6 On 11 November a potential property was identified, but following a bid, this was not successful.

5.5 **Event 4 – 1 Nov 2020 – 25 Nov 2020**

5.5.1 On 13 November 2020 during a key worker session with a staff member from Moor View, Mr. D expressed concerns around the support that would be available to him after his move and in particular if he had a seizure that help would not arrive in time.

5.5.2 Two days later Mr. D started to show signs of postictal behaviour. Mr. D was placed on observations by staff from Moor View. Mr. D was described as constantly ringing staff throughout the day, he presented as anxious and confused and when staff had been to give him his medication Mr. D was described as being intimidating. Staff members contacted their on-call Management and were advised to ring the crisis team and the Police. Staff at Moor View were lone working at night. During the day Mr. D made several 999 calls to the Police in which he expressed that he feared dying. Mr. D made no mention of suicide or suicidal ideation. After the first call the Police contacted Moor View and asked for a member of staff to check on Mr. D's welfare. The Police were informed that staff did not wish to visit him as he had been violent in the past. After further calls to the Police from Mr. D the Police made a further call to Moor View, this was not answered, and a message was left on an answerphone.

5.5.3 On 16 November Mr. D's care co-ordinator received a call from Moor View which detailed that Mr. D's mental health had declined and that he was displaying anxieties and postictal relapse indicators. In addition, the care co-ordinator had received several missed calls from Mr. D the previous day. The care co-ordinator visited Mr. D who expressed worries about his upcoming bail date. It was documented that overall Mr. D was settled and although he was displaying some odd behaviours it did not raise significant concern. Mr. D had not taken his medication and it was agreed that staff from Moor View would visit him later to encourage him to take the medication.

5.5.4 Later that day the care co-ordinator received contact from Moor View requesting a mental health assessment of Mr. D due to a decline in his mental health. This request was not progressed as it was deemed by the care co-ordinator that Mr D was in place of safety at Moor View, he had been visited by his care co-ordinator that day and it was deemed that Mr. D's anxiety was linked to his bail meeting the following day. Moor View were advised that the situation would be discussed the following day and that the Crisis Team were on duty overnight should there be a further deterioration

5.5.5 The following day the care co-ordinator visited Mr. D and spoke to staff It was agreed for additional support and a staff member to be on duty that night. Whilst an additional waking night staff was brought in, case notes held by Moor View indicated that Mr. D did not require any support overnight. The Moor View Nurse conducted an assessment and along with the Team Manager it was reported that Mr. D had been compliant, and no further support was needed overnight. The care co-ordinator attended the Police Station as Mr. D was due to answer bail but was informed that Mr. D's bail had been extended until February 2021. Throughout this time Moor View carried out a mixture of in person and over the phone welfare checks providing reassurance and support to Mr. D. It was recorded that he appeared to be more settled on the 18 of November 2020.

5.5.6 Richmond Fellowship informed the SAR panel that records show the below staffing model –

- Day/Evening – at least 2 Recovery Workers and 1RMN on shift
- Nights – 1 waking Night Recovery Worker, 1 Sleeping Recovery Worker

The staffing model could be adjusted according to service needs and additional waking night cover brought in if needed (either RMN or Recovery Worker as applicable). At this time the service was mainly using agency RMNs so this would have been sourced via agency.

For Crisis Support – if a resident required additional support, the staff team would follow that person's crisis management plan and either de-escalate or seek out alternative support from other agencies as appropriate. In addition, staff had access to the Organisational Area/National on call.

5.5.7 Over the following days there were emails between Moor View, the care co-ordinator and Together Housing Association regarding Mr. D and the application for alternative accommodation. On 23 November 2020 it was confirmed by Moor View that Mr. D could remain living at Moor View until an alternative accommodation was sought.

5.5.8 On 24 November 2020 Mr D was given a letter by Moor View which detailed a 4-week extension to his current placement. The care co-ordinator spoke to Mr. D about the extension and options for alternative accommodation, including how he would be able to see his Mother. Mr. D expressed concerns regarding travelling the distance to travel to see his Mother. The care co-ordinator discussed with Mr. D the possibility of visiting alternative accommodation. The following day Mr. D was found deceased at Moor View.

6. Analysis

6.1 Mr. D was known to be at risk to himself and others. Was the multi-agency assessment and response to this risk effective?

6.1.1 The below analysis covers each significant event period within the terms of reference with an overall analysis as a conclusion.

Event 1

6.1.2 Prior to the timescales for this event Mr. D had recently been discharged from Dewsbury Hospital. A new care-co-ordinator had been allocated the case on 5 June 2020, and a meeting had been held on 10 June with Mr. D's current and new care co-ordinator and staff from Moor View. Mr. D declined to attend the meeting. It was agreed to continue with the current multidisciplinary crisis plan and to phone the emergency service and crisis team to manage future incidents.

6.1.3 On 16 June it was reported that Mr. D's mental health had started to decline. He presented as elated, delusional, agitated with a rapid speech, making inappropriate comments towards staff and other residents and being verbally aggressive towards staff. A mental health assessment took place later that day which concluded that Mr. D did not need to be detained under the Mental Health Act. The Social Worker advised staff to follow the crisis plan should Mr. D's mental health deteriorate further. The Social Worker stated during the practitioner event that they had been very clear in the information and direction that had been given to staff from Moor View during that assessment.

6.1.4 It was reported that Mr. D's mental health continued to decline, and this resulted in the crisis plan being activated and contact with the Police, Crisis Team, and care co-ordinator. Staff from Moor View were advised to use the least restrictive practice during engagement with Mr. D and offer medication as and when required. During the practitioner event the care co-ordinator stated that they had provided advice to Moor View, but they felt that this was not fully adhered to and that they had told them to provide Mr. D with space to calm whilst he was agitated; however, an ambulance had been

called and this was not part of the actions that had been discussed. This was in conflict to the views of Moor View who stated that there was evidence of staff escalating their concerns in a timely way to the care co-ordinator and social worker, and that they had followed their advice in managing the deterioration, activating the crisis plan appropriately, contacting the Police and providing him with medication as required. The incident when the staff member had been assaulted occurred whilst staff were administering medication. Richmond Fellowship are a non restraining organisation and staff do not carry out restrictive physical interventions. Staff are trained in 'Working With Challenging Behaviour', which covers: Managing challenging behaviour, self-awareness, picking up on early warning signals, de-escalation techniques, conflict resolution, maintaining boundaries, consistent teamwork, appropriate debriefing and support. Staff are made aware of the meaning of restraint and reasonable force within that training.

6.1.5 The initial attendance by the Police at 1415 hours determined that there was no legal requirement for Mr. D to be detained under Section 136 Mental Health Act. There was no clear rational recorded in how this decision had been reached and no apparent risk assessment undertaken of the risk to others if Mr. D remained at the accommodation. Several offences had been disclosed in the initial report including assault, damage, and public order, none of which resulted in them being recorded as a crime. Chapter 5 of West Yorkshire Police's policy on Mental ill health and learning disabilities states:

'The presumption must always be to deal positively with criminal matters and the National Crime Recording Standards will apply. Any offences should be recorded and dealt with accordingly.

An offence must not be ignored just because a person has been detained under the MHA[9] or MCA[10].'

Had Mr. D been detained under Section 136 a formal mental health assessment would have been undertaken and his community risk assessment updated.

6.1.6 At this time Mr. D was not detained under the Mental Health Act, and therefore, there was an opportunity, for Mr. D to have been arrested and the crimes investigated. West Yorkshire Police have identified learning in relation to this incident.

6.1.7 Several hours later, Mr. D assaulted a member of staff from Moor View with a knife. Mr. D was arrested and taken into custody. Mr. D was assessed whilst in custody. The Police recorded that Mr. D had capacity. There is no record

[9] Mental Health Act
[10] Mental Capacity Act

of a capacity assessment being completed and no record as to what he had capacity for. Mr D was interviewed in the presence of an appropriate adult, after which, he was released from custody with bail conditions.

6.1.8 Mr. D returned to Moor View. The bail conditions placed restrictions on Mr. D which included not allowing him into the main complex of Moor View, for him not to be alone with any female staff or residents, and to allow his food and medication to be delivered to the door of his bungalow. It was documented in Police records that Moor View were happy for Mr. D to be released back to his bungalow for the short term and that Moor View were to look for another long-term placement thereafter. There were limited options available to the Police. One option would have been to have charged Mr. D with a criminal offence and kept Mr. D in custody until the next court hearing. This would have required the authorisation of the Crown Prosecution Service and for all available evidence to have been gathered. In addition, the detention of Mr. D needed to have been necessary in order to preserve, protect life and prevent the interference of justice. This was not relevant for Mr. D's case. The Police could have released Mr. D to alternative accommodation; however, given that Moor View were not refusing to allow him to return this was not an alternative option. In releasing Mr. D the Police determined that it was safe to do so and that the bail conditions were relevant in managing his and other people's safety. During the practitioners event, practitioner's stated that they felt on reflection that the decision to release Mr. D, whilst they acknowledged was a criminal process, consideration could have been given to a multi-agency meeting prior to his release, to determine the risk to Mr. D and others. This would have allowed a plan to have been created as to how any risks would be managed in a multi-agency context rather than on the reliance on bail conditions.

6.1.9 A Multi-Disciplinary Team meeting was convened the next day. This was a timely meeting and evidence of joint working; however, it would have been useful for the Police to have been represented to inform the discussions around the case and risk management. Practitioners stated that they had not considered inviting the Police to this meeting, but in hindsight could see that this would have been beneficial. The SAR panel agreed that this meeting provided an opportunity for agencies to review the bail conditions and the impact that these placed on Mr. D in terms of his access to support both socially and professionally. This has been identified as an area of learning and a relevant recommendation made. [Recommendation 1].

6.1.10 The meeting discussed the crisis plan and the boundaries of what each service could provide and the remit of their work. Minutes from the meeting suggested that there was a difference of opinion about the plan being robust and effective. Moor View staff felt that their concerns about the effectiveness of the plan were not considered. and requests to review the plan were not

taken forward. Mr. D was given a behavioural plan that included his bail conditions and was advised that if he breached the conditions, he would be putting his occupancy at risk. By giving Mr. D a behavioural plan, it placed the onus on him to adhere, rather than Professionals managing his behaviour.

6.1.11 The practitioner event considered if the crisis plan was multi-agency led and whether individual agencies understood as to when the plan should have been activated and individual agencies roles. Representatives from Moor View stated that they felt like communication was lost in a loop between the crisis team, care co-ordinator and Police and that the plan was not followed which increased the risk to all. The care co-ordinator stated that the staff needed to follow the plan and the advice that had been given by them and the Social Worker in managing Mr. D. The difference of opinions during the meeting and within the practitioner event identified that there was no consensus amongst professionals regarding the use of the crisis plan. The SAR panel acknowledged that the crisis plan had been in place for many years and that services were familiar in following it. The SAR panel agreed that individual agencies could have held a Multi-Disciplinary Team meeting if they deemed it necessary to review the crisis plan, and that if this did not resolve the matter than the 'Calderdale SAB[11] - Procedure for Resolving Multi-Agency Professional Disputes and Escalation (April 2018)' could have been used. This has been identified as an area of learning and a relevant recommendation made. [Recommendation 1]

6.1.12 The review recognises that the incident was complex and a difficult situation for those involved to manage. Mr. D's mental health had deteriorated over several hours and his behaviour escalated. Staff involved had the knowledge of hindsight that Mr. D had previously been detained under the Mental Health Act and had previously self-harmed with a knife, although he had not previously sought staff support prior to incidents of self-harm. Staff from Moor View felt that their concerns were not taken seriously. The care co-ordinator felt that the use of hindsight had some influence as to how staff responded to Mr. D. and did not follow the guidance that had been given. Richmond Fellowship did not agree with this view and informed the review the only time staff did not follow the plan was in response to an incident when Mr. D had been shouting in the garden and staff went out to calm him down. Richmond Fellowship stated that it was understandable that hindsight may have had some influence as to how staff responded given that Mr. D was often very personable and well liked but he could also present as violent and high risk. The crisis plan had not been updated after the decision not to detain Mr. D on 16 June. Moor View stated that the decision for their staff being able to

[11] Calderdale Safeguarding Adult Board

manage Mr. D was not assessed in line with staff skills, abilities, known risks/unpredictability and Mr. D's presentation.

6.1.13 During the practitioner event Richmond Fellowship stated that there was no copy of Mr. D's care plan and risk assessment within their records. Richmond Fellowship told the SAR panel that they had their own support plans and risk assessments in place for Mr. D which had been shared with the safeguarding team and the care co-ordinator. Richmond Fellowship stated that as the staff at Moor View had not seen anything from other agencies that contradicted their plans, it would have been reasonable for staff to have considered that the plans were acceptable to all parties. Richmond Fellowship stated that their plans were reviewed every four weeks.

6.1.14 SWYPFT have a different understanding of the sharing of the care plan and risk assessments and have informed the SAR panel that the care co-ordinator discussed the care plan verbally with staff from Moor View a hard copy was provided in 2020. The care co-ordinator stated that they were aware that Moor View had been provided a hard copy of the risk assessment which they felt was robust, the content of the risk assessment had been suggested by the care co-ordinator and discussed within the safeguarding meetings with the Social Worker. The SAR panel has not been able to reconcile the variance in accounts between Richmond Fellowship and SWYPFT.

6.1.15 It is important that agencies involved in the care and provision of services to individuals have access to the most recent and upto date care and crisis plans to ensure that the service they are providing is relevant and line with the plan's requirements. Where there is doubt as to whether the plans have been provided, agencies need to be proactive in requesting such copies, recording requests and if necessary, consider escalating their requests further. [See 9.3]

6.1.16 The Richmond Fellowship completed a review of their response which identified several recommendations which included staff training on de-escalation techniques, training in managing complex and challenging behaviours and exploring and strengthening staff therapeutic relationship with Mr. D.

6.1.17 Whilst the Continuing Health Care (CHC) Manager had some overview during this period they were not involved directly as their role was commissioning support provision. Mr. D had been very settled at Moor View for several years, a change in presentation was not unpredictable, however crisis intervention did not appear to follow the care plan for such situations. After a significant incident the case manager should have ensured the provider review all care plans and risk assessments. The previous review of the placement took place in February 2020, with no reported concerns. It would have been appropriate

following the incident in June 2020 to have brought forward the CHC review due to the nature of the incident and changes in support provision/management. Due to bail conditions Moor View staff were unable to deliver adequate oversight and risk analysis that otherwise could have contributed to a fuller analysis of risk posed. The CHC were unaware that the direct support from Moor View had been curtailed by bail conditions and restructure. The CHC stated that Moor View should have informed them of the restrictions that the bail conditions put in place for Mr. D in terms of him being able to enter the main building to access support. Richmond Fellowship have informed the SAR panel that it would have been good practice for the CHC to be informed of the restrictions the bail conditions created.

Event 2

6.1.18 On 14 August 2020, Mr. D self-harmed. Mr. D was taken to Huddersfield Royal Infirmary and transferred to Bradford Royal Infirmary for physical health needs. Mr. D was later discharged following treatment of his wounds. There was no record of a formal mental health assessment undertaken whilst at Bradford Royal Hospital before he was discharged. This could not take place at Huddersfield Royal Infirmary as Mr D required urgent surgical intervention at another specialist unit due to the seriousness of his injuries. The MHLT should have been involved at Bradford Royal Infirmary and undertaken an initial assessment on admission particularly as Mr. D had self-harmed. Mr. D was referred to IBHTT. There were no crisis plans recorded on the hospital's electronic notes as Calderdale and Huddersfield Foundation Trust had not been provided with any. Staff from Moor View recorded that they raised concerns with the assessing psychiatrist on the discharge of Mr. D, soon after the incident. No copy of the discharge summary was received by Moor View from SWYFT. CHFT have stated that it would have been useful for them to have been included in minutes of risk assessment meetings to ensure that when he presented at the Emergency Department at the acute hospital, that staff would have had a broader understanding of his circumstances.

6.1.19 The SAR panel were informed that CHFT are exploring the use of advance care plans/Advance Management plans for high-risk patients in order that staff can be aware of the individual's circumstances when they attend the Emergency Department. Some Care Providers send information on a regular basis for individuals who attend Emergency Departments on a frequent basis. The information is also shared with the Mental Health Liaison Team, who work for SWYPFT and provide mental health services to CHFT. The SAR panel identified this as an area of good practice.

6.1.20 Staff from Moor View contacted their on-call Supervision to discuss the concerns around Mr. D's and other residents' safety should he be discharged. This included that the lock in the main building was broken, weekend staffing

and the impact of Mr. D's bail conditions. The last scheduled visit for Mr. D was 9pm. Moor View decided that upon Mr. D's return he would be put on hourly observations. The CCG state they were not aware of the reduction in staffing; however, Richmond Fellowship have stated that they had been informed by the Area and Regional Manager.

6.1.21 On 16 August IHBTT visited Mr. D. Mr. D denied any thoughts to harm self or others, and he appeared settled. Mr. D stated he had felt low over his bail conditions. Staff were informed they could contact the IHBTT for support if needed and were aware to contact the police if Mr. D became violent or aggressive.

6.1.22 A Multi-Disciplinary Team meeting was held on 20 August. It was recorded within records held by Moor View that the meeting was to discuss going forward if Moor View were unable to support Mr. D in service as his risks were currently too high. Records also indicated that a discussion had taken place amongst staff from Richmond Fellowship to serve Mr. D a notice terminating licence due to being unable to keep himself and others safe. The meeting was attended by Mr. D, the care co-ordinator, Social Worker and staff from Moor View. This included the staff member that Mr. D had assaulted in June. Mr. D had not been informed that the meeting was taking place and therefore was unprepared. There was no representation from the Police and Housing. Primary Care (GP) and CHFT had no record of a multi-agency meeting being held or the outcome. A Care Act (2014) assessment was undertaken, which identified that the management strategies that were undertaken were not thought to have been an appropriate proportionate response by Moor View. The plans from the care co-ordinator and Social Worker focused on providing Mr. D opportunity to remain at Moor View.

6.1.23 During the meeting Mr. D expressed his worries about the bail conditions and that he was scared as to what was going to happen in terms of the criminal investigation and that he may go to prison. The care co-ordinator told those in the meeting that Mr. D was worried that due to the incidents he may be asked to leave Moor View. The panel acknowledged that this would have been a difficult conversation for Mr. D in a room full of professionals and that there were staff members who had been involved in the incident present in the meeting. The panel felt that their attendance at that meeting was not appropriate.

6.1.24 The Social Worker discussed with Mr. D the options available, including moving to a different placement and a change in the level of support to enable him to be more independent. Mr. D agreed to wear/use his epilepsy pendant so staff could support him if he had a seizure. It was agreed that staff would hold onto knives and potential hazardous items until the bail conditions were lifted. It should be noted that the removal of these items was not part of the

bail conditions and reference their removal in this manner was misleading and could have added to the worries of Mr. D.

6.1.25 Mr. D expressed ongoing stress and worries about his bail conditions to different people. Although risk assessments were updated and measures preventing/managing the risks, the stress due to the bail conditions was not fully explored in the risk assessment.

Event 3

6.1.26 The information regarding the extent of Mr. D's needs, requirements and risks to self and others were not shared in with Together Housing Association as part of the housing application which followed a homeless assessment by the Council's Housing options team. Nor were the full circumstances surrounding the recent attack on a member of staff shared. Practitioners expressed their concerns during the practitioner event that this information should have been shared from the outset as part of the original application and that they could have worked with professionals in assessing the risks and identifying suitable accommodation.

Event 4

6.1.27 There was a lot happening during this time period that impacted on Mr. D. He had recently been diagnosed with osteoarthritis. He was experiencing difficulties in swallowing, for which he was receiving support. Mr. D expressed concerns about the criminal investigation and bail conditions, which included his fears that he may go to prison and the ongoing move. Mr. D's occupancy was still subject of review and the application for alternative accommodation was still being progressed. Mr. D did not verbally express any suicidal thoughts; however, he was prone to spontaneous actions which were thought to be as a response of stress. Mr. D's care co-ordinator stated that he felt that there had been a breakdown of the relationship between Mr. D and Moor View at this time, and there remained a conflict of interest in that the staff who were supporting him, had been involved in the management of the incident in June 2020.

6.1.28 Mr. D's mental health was stable during the first half of the month; however, between 15 and 17 November he appeared to be very unsettled. Staff provided support and contact was made with the crisis team and CMHT. Mr. D was refusing to take his medication. No mental health assessment was completed. On 17 November, an additional member of staff was brought into the night service. Over the following days Mr. D engaged well with staff and spent some time in the main house socialising with other tenants. Mr. D was still subject of bail conditions at this time, one of which was not enter the main building, and therefore this was a breach of those conditions, and could have created confusion for Mr. D. Following a visit by the care co-ordinator on 19

November it was agreed that self-medication would commence from 23 November.

Summary

6.1.29 There were several incidents where the risk Mr. D presented to himself, and others significantly increased. These incidents required a multi-agency response in terms of dealing with and reviewing agencies response. There were opportunities for other agencies to have been involved in this process to help inform risk assessments. This would have provided an opportunity for agencies to reflect on the case, and the restraints within the bail conditions, and withdrawal of services as to how these impacted on Mr. D and others involved in his care and residency. When there was a disagreement amongst agencies, there was no evidence of agencies working together to resolve these matters.

6.1.30 The restrictions that were in place, which led to an increase in stress to Mr. D were also in addition to the restrictions in place due to the Covid-19 pandemic. It was not clear from agency records that any one agency had a clear understanding of all the risk factors that were impacting on Mr. D at this time, with agency's only responding to those areas that were relevant for their agency. There was conflicting understanding amongst some agencies as to the sharing and receiving of care plans that the SAR panel has not been able to resolve.

6.1.31 Whilst it was predictable that Mr. D would have times of crisis the SAR panel determined that the staff at Moor View were influenced by the incident from June 2020, in relation to how they responded to further incidents with Mr. D. The SAR panel saw limited evidence as to how staff had addressed Mr. D's behaviour prior to implementing the crisis plan. The use of a formal Psychiatric review or an assessment under the Mental Health Act to review the circumstances, did not seem to have been fully considered in light of the difficulties experienced. It was acknowledged that the incident in June had been more extreme and escalated more quickly than previous incidents. A coordinated multi-agency response that took account of the change may have been more effective.

6.2 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?

6.2.1 Mr. D had been a resident at Moor View since 2014. The panel heard that he lived independently in a self-contained bungalow which was aside from the main building. Mr. D had access to the main building as and when required. Mr. D was described as settled and content with his living arrangements. This latter arrangement was impacted following the bail conditions that had been imposed in June 2020.

6.2.2 At 1800hrs on 21 September 2020, Mr. D was served a notice by Moor View to vacate his accommodation by 19 October 2020. Records held by Moor View stated that Mr. D was informed that this was due to changes in the planned service provision by Richmond Fellowship. Mr. D's care co-ordinator was informed the same day via email. The notice should have been given to the CCG (CHC) as the placement was commissioned by them.

6.2.3 At the practitioner event, Richmond Fellowship stated that the change in their service provision had been a consideration for some time and that plans to implement the changes sooner had been hindered due to the Covid-19 pandemic. The independent report commissioned by Richmond Fellowship following the death of Mr. D stated - 'In Mr. D's case a decision was made to implement these plans earlier due to the behaviour of Mr. D. This could indicate there was an element of punishing Mr. D for his behaviour by bringing the ending of his tenancy forward'. Richmond Fellowship have informed the review that they have found no evidence to support that this was the motivation for action.

6.2.4 The Operations Manager, Mental Health and Learning Disability from the CHC told the Independent Chair that the plans had been to change the service provision from a Registered Care Home with Nursing to a service with a clear rehabilitation focus to meet local needs. This had been planned for about four years, with multi-agency planning in place, but this had been delayed due to poor performance of Moor View and poor CQC inspections. Although there was an impact from Covid-19, some existing Moor View service users had already moved to other more appropriate long-term services.

6.2.5 There was mention in the Multi-Disciplinary Team meeting in August 2020 of consideration of serving the notice on Mr. D at that time; however, whilst this did not take place, neither was Mr. D informed that there was to be a change to Moor View's service provision. During the practitioner event the care co-ordinator and Social Worker stated that they felt pressured, once Mr. D had been told; to identify an alternative accommodation for him. They stated that whilst extensions were granted by Moor View these were still challenging timescales for them to manage. This was an opportune time to have considered a multi-agency co-ordinated response.

6.2.6 On 25 September 2020 Moor View sent an email to Housing Options that Mr. D had been served a 28-day notice. The application came via Housing Options team and was then assessed via a homeless assessment. There was limited information within the email, which prompted a housing advisor to contact Moor View to obtain further information prior to an assessment. The Housing Advisor was told that if accommodation was not secured for Mr. D after the 28 days then he would need to leave the property. This would have meant that Mr. D would have been homeless. The Housing Advisor was also told by Moor View that Mr. D could live independently but would need a support package that his care co-ordinator would need to arrange. At this point Moor View were told by the Housing Advisor that the care co-ordinator could make a referral to Housing Support Team. The timing of the application did not allow Mr. D much time to seek alternative suitable accommodation. The information provided by Moor View was incorrect as Mr. D could not have been made homeless as it was the CCG who were responsible for funding the placement for Mr. D and the CCG were not given prior notice of the decision to serve a 28-day notice. Mr. D could have been provided with a bespoke package to live in the community which would have had to have been agreed following detailed assessment and multi-agency discussions before any subsequent move.

6.2.7 Whilst information was shared following contact from the Housing Advisor, the full extent of Mr. D's needs and his vulnerabilities, the risk that he presented to himself and others, including the assault and ongoing investigation was not shared at this point. Together Housing Association informed the review that with any applicant who has complex needs and requires care/support it would be expected that information is proactively shared by other agencies, both as part of the homeless assessment and with Together Housing Association as the potential landlord and via structured multi agency discussions, including risk assessments and care/support planning and to determine the most appropriate solution/options in relation to future accommodation. This has been identified as an area of learning. [Recommendation 1]

6.2.8 Together Housing Association stated information should have been forthcoming and shared from the outset and collated within the homelessness assessment. In addition, housing should have been involved in multiagency discussions; however, in the absence of that happening, indicators relating to vulnerability and complexity should have been spotted from the outset of the application being received and advice sought, rather than at the point a property became available, as happened in this case. Had this been identified earlier it would have prompted Lettings Coordinators to determine that further information was needed to support the application including arrangements that were to be put into place to support Mr. D to manage to live independently and sustain his tenancy. This has been identified as an

area of learning for Together Housing Association and Calderdale Metropolitan Council Housing.

6.2.9 There was limited recording as to whether Mr. D was kept updated about developments in relation to the application. Mr. D was supported by a Housing Support Worker who supported him with bidding. There were times when Mr. D was first in the queue for a property and on another occasion, he was fifth in the queue.

6.2.10 By November the prospect of Mr. D moving on from Moor View would now have been very 'real', as this was frequently being discussed alongside preparing for independence with medication. Mr. D had expressed a wish throughout this process that he remained close to his mother.

6.2.11 On 24 November 2020, a further extension was granted until the end of the year, whilst this may have alleviated the immediate pressure, Mr. D was still being required to leave his accommodation in a short period of time.

6.2.12 The review found that there was no record of a multi-agency decision regarding the appropriateness of Mr. D potentially moving into ordinary housing. It appeared that this route was being progressed in the absence of more appropriate rehousing options, including another supported housing or care home setting. The review has seen no information as to any risk assessments and plans to ensure the safety of Mr. D and others, including his ability to manage in independent accommodation. Together Housing Association were not asked to attend a meeting with agencies to discuss accommodation options. The panel agreed that having a multi-agency meeting and including Together Housing Association would have allowed for a jointly co-ordinated response to have taken place, with clear information sharing of the complexity and vulnerabilities of the case. This has been identified as an area of learning. [Recommendation 1]

6.2.13 The review has highlighted that housing processes need to be more joined up between Housing Options and Together Housing Association Lettings team, and with other key housing teams. This would strengthen the sharing and assessment of information, clarify expectations relating to information-sharing and requirements, sharing of concerns and also to strengthen the collective housing "voice" as part of a wider multi-agency team. The case also highlights that housing colleagues need to be recognised as key partners and that their involvement is essential to multi-agency planning for those who require housing and have complex needs and vulnerabilities. [See 9.2]

6.2.14 Throughout the completion of this review there were differing views amongst agencies and Practitioners as to the 'status' and 'role' of Moor View in terms of their service delivery. Information submitted to the review and discussions held included quotes that Moor View was – 'a Care Home', 'Supported Living

Accommodation' and 'Nursing Home'. On discussing this further it was identified that Professionals did not truly understand what these definitions meant for service delivery and residents. This has been identified as an area of learning and a relevant recommendation made. [Recommendation 4]

6.2.15 Richmond Fellowship informed the review that at the time of Mr. D's death there was no service level agreement in place with the CHC, as the contract had expired a few years earlier. The CCG, in contrast, stated that there had been a service level agreement in place since 2014, which outlined the service commissioned and that this never expired. The CCG had an overarching NHS contract with Richmond Fellowship up until 30 June 2020 (extended for 3 months due to Covid – 19), following which the CCG set up a new contract from 1 July 2020 to 30 September 2022, in line with all CHC providers in Calderdale. A signed copy was not received until 15 January 2021. Whilst Moor View is no longer in existence the SAR panel have identified an area of learning and have made a recommendation for the CCG to provide assurances and evidence to the SAB that contractual arrangements are up to date and in place. [Recommendation 5]

6.3. Were safeguarding incidents identified? Were these reported/referred effectively? Was the response to the safeguarding reports effective?

6.3.1 Safeguarding concerns were raised to the Local Authority Safeguarding Team by Moor View following events in June and August 2020. In June, the concerns were accepted for further enquiries and a safeguarding strategy meeting was to be arranged due to the deterioration of Mr. D's mental health. Moor View stated to the Local Authority Safeguarding Team that they had followed the care plan in place for managing the deterioration before the incident occurred. The Local Authority Safeguarding Team made further contact with Moor View and other professionals involved with Mr. D.
The care co-ordinator stated that the crisis plan was robust, that Mr. D's presentation was behavioural, and the crisis plan did not need to be amended further. This view was re-affirmed by the care co-ordinator during the practitioner event. It was requested that the crisis plan, and behavioural plan be sent to the Local Authority Safeguarding Team.

6.3.2 Records show that attempts were made to arrange a strategy meeting, but this did not take place. There then followed the further incident on 14 August 2020. The second safeguarding alert was received by Local Authority Safeguarding Team on 17 August, who requested that care plans be submitted to show how the risk was being managed and that checks outlined in the crisis plan were being followed. Information was shared with

Emergency Duty Team and Moor View were advised to contact Out of Hours if required.

6.3.3 On 26 August the Local Authority Safeguarding Team held a discussion around how increased contact from Moor View could potentially increase the risk for Mr. D with regards to the risk to himself and others, and that the therapeutic relationship may have broken down, (e.g. on recent self-harm attempts he had contacted his mother rather than staff). Consideration was made of the viability of placement for Mr. D and whether this could be adapted e.g., a more 'arms-length' approach with mental health/emotional support provided outside of Moor View (Nightline, Mental Health Support Line), with suggestion being put to the CCG. There was no record of the CCG being informed of this suggestion.

6.3.4 The Local Authority Safeguarding Team liaised with Moor View, care co-ordinator and mental health lead and it was agreed that Mr. D's bail conditions, updated dual crisis plan for postictal psychosis and behaviour would be shared. In addition, the Local Authority Safeguarding Team were informed in the meeting that had been held the previous week that Richmond Fellowship were looking into possibility of Mr. D's move to a more independent tenancy in his bungalow, and the Social Worker was completing a care needs assessment. The Local Authority Safeguarding Team were informed that a further meeting would take place in September to discuss risk management at the time, which would take account of the possible outcomes for Mr. D and the risk he may pose to others and himself. This was due to take place near to Mr. D's bail date; however, the bail date was later cancelled and extended until February 2021. There is no record that a Care Act assessment was completed prior to Mr. D's death. There is no record that a further multi-disciplinary team meeting was held.

6.3.5 On 24 January 2020, the Care Quality Commission (CGQ) published a report into Moor View following an inspection undertaken in November 2019 with an overall rating of - 'requires improvement'. The below details the individual ratings –

- Is this service safe? – requires improvement
- Is this service effective? – requires improvement
- Is this service caring? – requires improvement
- Is this service responsive? – requires improvement
- Is this service well led? – inadequate

The report details the following in the overall summary -

'Although there was evidence of some improvement in the service, we found some aspects of the running of the service and the person-centred approach

were still not meeting regulations. Information about safeguarding concerns was inconsistently managed and there had not been enough progress in improving the approach to care planning and delivery. The provider was still not able to demonstrate how they were providing meaningful rehabilitation and recovery in line with the service aims. There was some improvement in the assessment and management of risk, however further work was still needed. Staff recruitment practices and the management of medicines were now safe. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were offered choice, however some further improvement was needed to people's care plans in relation to choices they may wish to make'.

6.3.6 In addition to the above in 2018 Moor View had been given a Notice of Proposal, issued by the CQC. The content of this was successfully challenged by Richmond Fellowship and the notice was dropped. On 13 June 2019 Moor View was rated inadequate. On 16 October, the Local Authority Safeguarding Team received a copy of the report completed by Richmond Fellowship following the incident in June 2020 and closed the case. Whilst the ratings showed an improvement since 2018, and the report from Richmond Fellowship identified learning, the panel agreed that further action should have been taken by the Local Authority Safeguarding Team in response to the safeguarding alerts.

6.4 How were Mr. D's wishes and feelings about his accommodation needs, care and treatment included in care planning? Were they any gaps?

6.4.1 The care co-ordinator did not feel that the voice of Mr. D was heard by other agencies involved in his care. This included the decision making to end his placement, how this was communicated to him, and consideration of the impact that this would have on Mr. D. The care co-ordinator was very clear in their view that the care co-ordinator should have been used to help support Mr. D at the time of receipt of the notice. This has been addressed in 6.2.

6.4.2 There was evidence of the care co-ordinator working with the Social Worker to enquire about Mr. D's wishes and feelings. Mr. D regularly informed professionals of his concerns surrounding his bail conditions and the possible outcome of the criminal investigation. Whilst it is not routine for the Police to consider the wishes and feelings of the perpetrator when imposing bail conditions, in this case, given Mr. D's vulnerabilities the panel agreed that the decision and impact that these conditions imposed on Mr. D could have

been considered in a multi-agency context prior to being imposed, had resourcing and timing within the law allowed.

6.4.3 The bail conditions placed significant restrictions on Mr. D and prevented him from accessing support in the main building, if required. During the practitioner's event, it was acknowledged by staff that consideration should have been given to approaching the Police to consider a variation in the conditions, that still allowed safeguarding measures to be implemented but allowed for Mr. D to be able to access support and engagement with staff. An example was given that by placing his food and medication at this door led to the de-skilling of Mr. D in relation to being able to care for himself. Another example was provided that the removal of sharp instruments and hazardous substances was linked with his bail conditions, but the actual conditions did not stipulate the removal of these items. Mr. D lived in a self-contained bungalow, there had been no evidence of self-neglect. It was reported that he managed to look after his flat, keeping it clean. These decisions were made without consultation with Mr. D. This has been identified as an area of learning and a relevant recommendation made. [Recommendation 3]

6.4.4 Mr. D wished to be placed in accommodation that wouldn't be a geographical barrier to seeing his Mother. It was known that his Mother was a protective factor in his life, whom he spoke too daily. Mr. D had expressed a wish not to be placed in independent accommodation. Whilst these factors were known by some agencies, it is evident that this information was not shared as part of the initial housing application, despite these being significant factors in his life.

6.4.5 When Mr. D attended the multi-disciplinary team meeting in August 2020, he had received no prior notification to allow him to prepare, yet he was expected to speak openly and freely in a room of professionals, some of whom had been involved in the incident in June 2020, but were now involved in discussions and decision making about him. This was escalated as poor practice at the time following feedback to the CCG from the care co-ordinator and escalated to the Regional Manager at Richmond Fellowship. The SAR panel were informed that similar experiences had occurred with other service users and indicated a lack of knowledge and poor practice from the home manager who was lacking in confidence, which was exacerbated by feeling powerless to bring about positive change.

6.4.6 The decision to serve notice was made by the Area Manager who was an impartial party and had not been impacted by the incident in June. The decision to go down the homeless route was not the most appropriate course of action, but it seemed to have been driven out of desperation and concern that Moor View could not keep Mr. D safe having felt that they had exhausted all other avenues. The review were informed by Richmond Fellowship that the move on of the other residents was handled in the same way as for Mr. D and

he was not treated differently to other residents; however, the review have seen no evidence that other residents were being moved on through the homeless route.

6.4.7 Mr. D's occupancy at Moor View was not understood by Professionals. The review saw evidence of his occupancy being referred to under differing terms, and this caused confusion amongst agency engagement and during the review process. The SAR panel agreed that a person's occupancy needed to be clearly documented within agency records, along with information for Professionals to help them understand these definitions and legal requirements. This has been identified as an area of learning. [Recommendation 4]

6.4.8 The SAR panel agreed that it was important for those agencies who commission residential services to ensure that contractual arrangements clearly document the occupancy and how these impact on their responsibility, as commissioners, when considering a move of placements or terms of service provision. This has been identified as an area of learning. [Recommendation 5]

6.4.9 Mr. D's care plan dated July 2020 details Mr. D's wishes and feeling in relation to his physical and mental health, living arrangements and his feelings following the incident in June 2020. The plan records Mr. D's fears that he may not be allowed to continue to live at Moor View as a consequence of the incident in June. The plan covers the impact of the bail conditions on Mr. D and states –

'It would seem that the impact of these restrictions are creating a situation that is directly in contradiction to the rehabilitative goals identified in his care plan and the overall ethos of Moor View. He has become more dependent upon the service and less independent'.

6.4.10 The plan concludes with the following summary under the section 'What needs to happen and who will do it? –

'Mr. D wishes to remain living in his current accommodation at Moor View, and as this assessment has highlighted, his needs can be met by the support team on site, as they are in a position to offer 24 hour care that is flexible and responsive to his changeable needs.

The way in which care is being provided requires review as does consideration of whether Mr. D's needs for support could be met in another setting, where his need for autonomy with access to increased support could be provided on a flexible basis. However, it is important to reiterate that Mr. D does not want to move and his mother also fears for his safety were he to be offered accommodation that did not have such ready access to a high level of

care, when he needs it'. Whilst the Care Act Assessment identifies areas that need to be addressed – i.e. impact of the restriction due to the bail conditions, review of the care being provided, and access to support, it is not recorded as to who will take those areas forward.

6.4.11 The details within the plan regarding Mr. D's needs to be able to access support in alternative accommodation where not shared or known by Together Housing during their involvement in September 2020.

6.5. What was the impact on the Covid pandemic on Mr. D? Was this adequately recognised and responded to by services?

6.5.1 The Covid-19 pandemic had a significant impact on Mr. D as it prevented him from having face to face contact with his Mother for a significant period of time. This lack of contact was during key events subject to this review, including his arrest following an assault on a staff member. Mr. D's Mother was a protective factor in his life, and this lack of contact will have caused him a considerable amount of distress. Whist it was recorded that Mr. D did have daily telephone contact with his Mother, the impact of him having no face to face contact, and the restrictions in place with his bail conditions meant that other support networks available to him had been withdrawn. There was no record as to how these factors, which clearly impacted on Mr. D, were considered or how they were being managed.

6.5.2 Whilst the CCG (CHC) contacted all service users remotely on a monthly basis during the Covid-19 pandemic. At the time, the CCG was instructed by NHS England to take this risk based approach to face to face contact, which the CCG followed. There was no record of any direct contact with Mr. D. Contact was made with Moor View. The CCG staff making the calls followed a script, which instructed them to speak to the service user where possible; however, service users would often not come to the phone unless there were other concerns. When this occurred, the worker would accept an update from providers. The purpose of the calls was to identify any service user at high risk. Priority was given to people living in own homes at risk of isolation or domiciliary/nursing provider failure, covid infection and associated risks. Mr. D was in 24/7 care with a care co-ordinator, case manager and Social Worker input and was therefore deemed to be low risk. The Social Worker and care co-ordinator were in regular contact with Mr. D. The CCG had raised several concerns to Richmond Fellowship some of which were service user specific. It was appropriate that Mr. D had regular contact with his care co-ordinator whom he trusted and had a positive communicative relationship with. The care co-ordinator would have received supervision and support from their manager. The manager attended the mental health panel, held at

that time bi-weekly. The panel was a multi- agency panel, where concerns regarding a service provider or individual service user could be shared. Moor View was a regular agenda item for updates in addition to CCG led contracts and improvement meetings with Richmond Fellowship at that time. The CCG (CHC) relied on the care co-ordinator and Social Worker to manage any communication that was required.

6.5.3 Mr. D's care co-ordinator did attend face to face meetings with Mr D, as it was felt that this was the most appropriate method of contact for Mr. D as virtual meetings would not be effective or were Mr. D's preference of contact. The panel recognised this as good practice.

6.6 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.

6.6.1 The Covid-19 pandemic had a massive impact on the GP practice; however, there is no evidence that this negatively impacted on the service provided to Mr. D. There was a video consultation with Mr. D during this time, which may have been carried out in person had this occurred outside of the pandemic. There is no record that the use of an online consultation had any negative impact on Mr. D.

6.6.2 Front line staff were in place alongside agency nurses and recovery workers at Moor View. There was a gap in higher management due to the area manager leaving in April 2020. This was addressed with remote cover until a replacement was in post from September 2020. The SAR panel were informed that the last CQC inspection had identified issues with the leadership of the service specifically regarding the Registered Manager, which were addressed through capability procedures and support from central teams

6.6.3 West Yorkshire Police were unable to respond to a request for help from Moor View in the early hours of 17 June 2020 due to the availability of resources who were engaged on other priority calls. The Police were informed that Moor View had also requested an ambulance to attend, with a view to taking Mr. D to an acute mental health unit, with the role of the Police to assist if Mr. D became violent. The Police received a number of further calls during the night from Moor View informing them that the ambulance was at the premises. None of the calls indicated an increase in the risk or threat of violence from Mr. D towards himself or others and the incident was closed with no unit attending. The Police response to calls received later on that day have been addressed in 6.1. There were no issues in relation to capacity or resources on these later calls for service.

6.7 What learning has your agency identified and what is the plan for turning that learning into practice?

6.7.1 The following learning has been identified by individual agencies during the completion of this review.

Calderdale and Huddersfield NHS Foundation Trust

6.7.2 CHFT to explore the use of advanced management plans (plans supported with a patient flag) which can be based on multi-disciplinary information sharing for high risk and complex patients.

To reinforce information gathering/sharing from other health sources (e.g. community and mental health) when a person with complex needs attends CHFT.

NHS Calderdale Clinical Commissioning Group (Continuing Health Care)

6.7.3 There must be a clear process agreed between commissioners and providers if service changes are planned, this process should be adhered to by all parties . Communication must be maintained by each party throughout this process.

As part of any planned service change assessments must be made of the impact for individuals including any potential risks/impacts and assurance required that the service can continue to meet the individuals identified needs.

In the event of any significant incident the provider should ensure that care plans and risk assessments are updated. The case manager will initiate an early review of the individual and ensure that relevant plans and actions are in place.

Calderdale Metropolitan Borough Council, Adult Social Care

6.7.4 The communication with community staff and their continued input with the placement and management of their respective teams, worked well.

A learning outcome and discussions taken forward is not to relay on the interdependency between Health and Social care teams and at all stages joint visits and assessments should be made.

To look at and review the escalation process from Local Authority frontline professionals to management where a serious event has occurred and management to take forward jointly with other lead agencies involved within the process. This to be managed through supervision of Mental Health staff within the Local Authority.

The outcome of the SAR to be used and discussed as a reflective session within the Local Authority Mental Health social work teams and Approved Mental Health professionals' forums to inform practice and to encourage discussion on practice and what could have been done better whilst acknowledging the good practice also.

6.7.5 A number of agency discussions were held between the Local Authority, SWYFT and the CCG to review events and practice issues.

There were very full and comprehensive case recordings on the Local Authority computer system to take forward the issue of access to other agency data bases as part of a wider multiple agency forum and information sharing process.

NHS Calderdale Clinical Commissioning Group (GP)

6.7.6 Identified no learning from this review.

Richmond Fellowship

6.7.7 Richmond Fellowship commissioned two investigations, one following the incident on 17 June and an external investigation following the death of Mr. D. A service improvement plan was put in place to ensure recommendations were implemented. CQC best practice workshops were held to capture and share learning.

6.7.8 Richmond Fellowship have put in place a Service Improvement Governance Group which meets fortnightly to support the early identification of any emerging concerns and to monitor progress against improvement plans and share best practice.

6.7.9 There were differing perceptions of what each agency's roles and responsibilities were. These assumptions and expectations need to be explicitly stated to avoid the breakdown in relationships which can occur as a result.

6.7.10 A full review of training has been undertaken to ensure this aligns with the Care Certificate requirements, to ensure recovery workers are equipped with the skills and knowledge to support clients with challenging mental and physical health needs. Ongoing development needs for managers and recovery workers are reviewed in each supervision session and via our appraisal process. Training will include multiagency working for our managers to ensure multi agency care/support plans are agreed and fit for purpose

6.7.11 Clarity will be sought about the service model being commissioned, with commissioners and our business development and operational team, at the

onset of the contract to ensure a clear understanding of expectations and responsibilities for service delivery and outcomes. Parameters will also outline the requirements for CMT/CCO responses to crisis situations, mental health assessments, to record meetings and outcomes in a timely, transparent and professional way, in order to develop and strengthen partnership/multi-agency working

6.7.12 A learning event will be held with our board following the outcome of the SAR to reflect on the learning from both this event and the wider experience of Moor View.

South West Yorkshire Partnership NHS Foundation Trust

6.7.13 Identified learning as to how the SWYPFT practitioner was supported and if there were future incidents with other service users with similar issues and for access to the SWYPFT Safeguarding team to offer support, advice regarding safeguarding supervision and possible escalation if required

6.7.14 There was positive evidence throughout Mr. D's electronic notes of support from SWYPFT practitioner and the use of the advocacy and support whilst Mr D was at the Police station. This included reassurance provided to Mr. D throughout the process and with his Mother.

6.7.15 For staff to consider environmental and social stressors as part of risk assessment and care planning.

6.7.16 To review SWYPFT reporting mechanisms for violence and aggression- incidents that are not directed at SWYPFT employees and consider how this is responded to as part of risk assessment and care planning.

Together Housing Association and CMBC Housing

6.7.17 Guidance should be sought by staff from their managers when dealing with applications where there are indicators of complex needs/vulnerabilities when an application is received, including via a homeless assessment, e.g. Housing options advisors (CMBC) and Lettings advisors (Together Housing).

6.7.18 Whilst information was requested at the point that Mr. D's bid for a property was successful, this should have already been provided to Together Housing via CMBC coordinating information as part of the homelessness assessment and via housing's inclusion in multiagency meetings; however, in the absence of that happening, and there are concerns about an application being more complex then this could have been requested earlier in the application process.

6.7.19 There was too much emphasis on the process and missing the point re the whole end-to-end process (from when notice was served then the CMBC

homeless assessment) to application to Together Housing Association. The focus needs to be on ensuring that adequate and appropriate information is provided to Housing and that housing is involved in multi-agency discussions and planning to determine suitable options and arrangements in place to support an application to manage to sustain their tenancy and live safety.

6.7.20 The following will take place to address the learning –

- To review arrangements in place within the Together Housing Association Lettings team re assessing applications i.e., spotting indicators re vulnerabilities/complex needs and seeking guidance.
- To review the end-to-end housing application process with CMBC Housing Options team relating to applicants with complex needs and or vulnerabilities including the timing of tenancy sustainability assessments.
- To strengthen arrangements and confidence of managers to request a multi-agency meeting and to escalate and challenge if a multi-agency approach is not being followed for applicants with complex needs.

West Yorkshire Police

6.7.21 Calderdale District will communicate anonymised learning derived from the analysis of police engagement with Mr D to all staff by way of a lessons learned presentation to patrol and specialist staff as part of the District's scheduled training rota which will highlight correct processes and responses in respect of:

- The recording of crime complaints in order to comply with NCRS as disseminated by the FCMU and OFCR;
- The creation and proper use of Credible Evidence Packs and Problem Solving occurrences in respect of the repeat receipt of unfounded complaints;
- The appropriate use of Niche Section 136 and Mental Health Concern occurrences where persons are detained or voluntarily assisted to places of safety and the requirement to additionally record Niche crime offence occurrences where offences are also disclosed;
- That the rationale for decisions made should be clearly recorded on logs or occurrences for example decisions not to detain a person under the Mental Health Act or record apparently disclosed criminal offences;
- When considering the release of a detainee to a mental health setting on police bail there must be liaison with the care provider to ensure that this is an appropriate return and that all safety planning has been undertaken and implemented and that this liaison is fully recorded on police databases;

- To reiterate the requirements of the Victims Charter.
- Case study to be shared with staff at training school and included on internal websites. An audit will be undertaken on the numbers of staff who have received the input.

7. Diversity

7.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

7.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

7.3 Mr. D had a complex physical and mental health history. Mr. D had osteoarthritis affecting his hip and at the time of his death was awaiting investigation into scarring on his larynx. Mr. D felt his mobility and incontinence were significant barriers. Mr. D had a history of multiple suicide attempts and self-harm.

7.4 Mr. D had temporal lobe epilepsy and was prescribed anti-epileptic medication. Mr. D had a diagnosis of Postictal Psychosis and Personality Disorder. He had also been diagnosed with paranoid schizophrenia. Mr. D's condition was predominantly, concordant with medication. Mr. D had previously been detained under Section 2 Mental Health Act 1983. Mr. D was supported by SWYPFT Calderdale Mental Health Community Team up until the time of his death. Mr. D's physical and mental health needs required him to have continued multi-disciplinary support.

8. Conclusions

8.1 Mr. D died in the autumn of 2020. An inquest concluded that Mr. D's death was suicide.

8.2 In the months prior to his death Mr. D had assaulted a member of staff from his Registered Care Home with a knife and been arrested. Mr. D was later released with bail conditions that restricted his access to support or contact with residents within the Registered Care Home. In the summer of 2020, Mr. D had attempted to take his own life. In September, Mr. D had been served a notice to vacate his property.

8.3 These events presented a time of anxiety and worry for Mr. D with the outcome of these events not being known. Mr. D told professionals of his fear surrounding the criminal investigation, and that he may receive a custodial sentence. Whilst Mr. D's tenancy continued to be extended beyond the agreed deadlines, this did not provide any certainty to Mr. D who was still awaiting an agreement in terms of his future accommodation and support provision.

8.4 Mr. D was very close to his Mother. He would speak with her daily and regularly meet with her. Not being able to see his Mother, either due to a custodial sentence or the location of a new accommodation, increased his concerns. The restrictions in place due to Covid-19 pandemic meant that Mr. D was unable to meet with his mother, the impact of which cannot be underestimated as this was very unsettling and distressing for Mr. D. Mr. D was not in control of any of these factors affecting his life and was reliant on the professionals that he was engaged with to help and guide him through this time.

8.5 The serving of the notice was undertaken in isolation of any independent support being provided to Mr. D. There was no evidence that multi-agency discussions and planning had taken place before the decision had been made to end Mr. D's placement. Full information in relation to Mr. D's needs and risks were not shared during the housing application process. This resulted in significant issues in the housing application process, with decisions on suitable accommodation having to be made in response to the limited information received.

8.6 There was a period, when the Area Manager was not in post and cover was provided by an Area Manager from another part of the organisation. Whilst not based in Yorkshire the Area Manager did spend 2-3 days a week at Moor View. On two occasions, safeguarding alerts were raised by the staff at Moor View, however, their concerns appeared to be minimised with limited action and intervention taking place. When staff requested Police assistance in response to Mr. D's volatile presentation, they were either unable to attend or when they did their response was below the minimum expected standards.

8.7 Mr. D repeatedly told professionals about his anxiety and worries for the future, yet decisions were being made by agencies working in isolation and without the inclusion of Mr. D. On the one occasion that Mr. D was part of a multi-agency meeting, he had been given very short notice to attend and prepare. The meeting was also attended by professionals who had been involved in the incident in June 2020 when Mr. D had assaulted a member of staff, therefore potentially placing additional stress on Mr. D to speak openly and freely.

8.8 Relationships had broken down between Mr. D and Moor View staff, which would have been difficult for both Mr. D and staff. Richmond Fellowship had undertaken a desk top review and identified learning in June 2020; however the identified learning was not placed into an action plan or monitored through Service Governance Group.

9. SAR Panel Learning

9.1 Individual agencies involved in this review have identified learning for their respective agencies. A summary of this learning is detailed at 6.7. This section will detail the strategic learning for Calderdale Safeguarding Adult Board, and not repeat learning already identified for agencies involved in the review.

9.2. **Multi-agency working**

9.2.1 There were missed opportunities both at a strategic and operational level for agencies to have worked together effectively to manage the deterioration in Mr. D's mental health and case management. Multi-agency working was the over-arching pinnacle of learning on this case.

9.2.2 The incident in June had escalated more quickly than previous incidents and whilst Mr. D's condition had deteriorated, the crisis plan, and multi-agency response remained the same. The review identified the importance of all relevant agencies being involved in meetings/discussions where decisions are being made around the risk management of an individual as this will allow for relevant information to be shared and to inform discussions on risk assessment and management.

9.2.3 There had been plans in place to change the model at Moor View for over four years; however, this was delayed due to the CQC inspection. Improvement plans have to be jointly owned by the provider and the commissioner with the support of other agencies working together.

9.2.4 There were significant gaps in agency representation during the decision making process around the options of available and appropriate alternative

accommodation for Mr. D. All relevant agencies should be represented and considered as part of multi-agency meetings to allow for decisions to be made on an informed basis, which take account of any identified needs around complexity or vulnerability.

9.2.5 Moor View did not receive copies of Mr. D's discharge summary from hospital. CHFT told the review that it would have been useful to have received the minutes of the risk assessment meetings so that staff had a broader understanding of Mr. D's circumstances during attendance at hospital. The sharing of information between partner agencies, is a key factor in enhancing and supporting multi-agency working.

9.2.6 The multi-agency working did not clearly articulate how and when information was to be shared amongst agencies, to support in the move of Mr. D and risk management.

9.3 Escalation

9.3.1 There was evidence of agency disagreement in relation to the roles and responsibilities of those agencies involved. Agency records were conflicting as to whether relevant plans had been shared. At no stage were the difference of opinions resolved. There are processes in place to allow agencies to work together to resolve multi-agency disputes, which should have been considered in this case. Had this taken place it would have allowed for agencies to have a clear and documented record around care and crisis plans, and the expectation of agencies involved in the case.

9.3.2 Mr. D's level of risk had increased, and his mental health had deteriorated. Staff at Moor View were struggling to manage the situation, they reported their concerns, but told the review that they felt they were not responded to, which left them to manage the risks and Mr. D's presentation alone. The review agreed that there were opportunities for Moor View to have considered escalating their concerns and the response from partner agencies.

9.4 Terminology

9.4.1 For agencies to be able to work effectively together there needs to be a common understanding and access to information on relevant terminology which will help to inform Professional's knowledge around key definitions where they are working with individuals who are in receipt of services including residential accommodation. It is important that this information includes details on roles, remits and what these mean for service users. In October 2015 the CQC issued guidance which provides useful information on regulated activities for providers[12]. .

[12] 'Guidance on regulated activities for providers of supported living and extra care housing'

9.4.2 The review agreed that there was learning in relation to Professionals understanding of the different terminology in relation to a Mental Health Act assessment and an assessment of an individual's mental health. This included where there is a perceived difference of opinion between agencies as to the relevance and evidence that an assessment is required.

9.5 **Person centred decision making**

9.5.1 It is important that where decisions are made that impact on an individual, then where appropriate, those decisions are taken in consultation with the individual concerned, along with appropriate advocacy and support. All decision making should be centred around the person, the risks they pose to themselves and others, taking account of the impact that the decisions may have on their needs and access to services.

9.6 **Contractual arrangements**

9.6.1 There was conflicting information on the existence of the upto date contractual arrangements in place between the CCG and Richmond Fellowship. It is important that contractual arrangements are upto date and reflect the expectations of all parties in terms of service provision and understand around occupancy. This should include the termination of services and placements.

10. Recommendations

10.1 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 co-ordinated response. The evidence should be supported with examples of when the processes have been used.

10.2 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.

10.3 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 centred around the individual, and that those decisions clearly document the individual's involvement in the decision making process. Anonymised examples should be provided.

10.4 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.

10.5 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.

Appendix A

Panel Members

Name	Role	Agency
Stuart Bainbridge	Detective Chief Inspector	West Yorkshire Police
Tracey Bell		Richmond Fellowship
Michelle Boon	Operations Manager, Mental Health and Learning Disability	NHS Calderdale Clinical Commissioning Group
Karen Burke	Named Professional For Adult Safeguarding	Calderdale and Huddersfield NHS Foundation Trust
Julia Caldwell MA	Safeguarding Partnerships Manager Domestic Homicide Review Lead	Safeguarding Children Partnership Safeguarding Adults Board
Emma Cox	Assistant director of nursing, quality and professions	South West Yorkshire Partnership NHS Foundation Trust
Carol Ellwood-Clarke	Independent Chair and Author	
Julie Hartley	Serious Incident Review Co-ordinator	Calderdale Safeguarding Children Partnership and Calderdale Safeguarding Adults Board
Terence (Terry) Hevicon-Nixon	Operations Manager	All Age Disability Service/ Mental Health Social Work/AMHP Lead /Approved Mental Health Practitioner Adult Services and Wellbeing
Jodie Morley		Richmond Fellowship
Sue Lewis	Head of Supported Housing	Together Housing Association
Robert Templeton	Director of Operations	Recovery Focus (inc. Richmond Fellowship)
Luke Turnbull	Designated Nurse Safeguarding Adults	NHS Calderdale Clinical Commissioning Group (part of the shared safeguarding team with

		NHS Kirklees Clinical Commissioning Group)
Heidi Wilson	Strategic Housing Delivery Manager	Calderdale Council Housing Services