Safeguarding Adults Review – Adult F

1.0 Introduction

1.1 Adult F was found deceased in her flat in September 2022. Her cause of death was pneumonia. She was a White British woman aged 51 and lived alone. She had learning difficulties[1] and appeared to have been assessed for learning disability[2] several years earlier, but it has not been possible to confirm any diagnosis. There had been longstanding concerns about the impact of alcohol dependency on her mental and physical health. She also had a hearing impairment. She had been supported for many years by her mother, whose home she visited on a daily basis. However, her mother's capability to support her daughter had been affected by her (mother's) own health needs. Partner agencies became increasingly concerned that Adult F was neglecting herself whilst declining offers of support and in the months prior to her death three safeguarding concerns were received by Adult Social Care.

1.2 Calderdale Safeguarding Adults Board decided to commission a Safeguarding Adults Review (SAR), following a referral from Adult F's housing provider Together Housing, on the grounds that self-neglect appeared to have been a significant factor in Adult F's death and there were concerns about how partner agencies had worked together to safeguard her.

1.3 Calderdale Safeguarding Adults Board commissioned David Mellor to conduct the SAR. He is a retired chief officer of police, a former Safeguarding Adults Board chair and has 12 year's experience of conducting SARs and other statutory reviews. He has no connection to services in Calderdale.

1.4 The SAR has been advised that no inquest took place and that Adult F's case is now closed to the Coroner.

1.5 Calderdale Safeguarding Adults Board wishes to express its heartfelt condolences to Adult's F's family and friends.

2.0 Terms of Reference

2.1 The SAR has focussed primarily on the period from March 2020 until Adult F's death in September 2022 although Adult F's contact with agencies prior to March 2020 has been considered where relevant.

2.2 The SAR has explored learning in the following areas:

[1] A person with a learning difficulty may be described as having specific problems processing certain forms of information.

[2] The Department of Health defines a learning disability as "a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning), which started before adulthood".

- Explore the way in which professionals responded to challenges experienced in engaging with Adult F and explore the extent to which agencies made reasonable adjustments in respect of Adult F's learning difficulties and hearing loss.

- Explore the extent to which professionals understood the dynamics of the relationship between Adult F and her mother. Did Adult F consent to her mother engaging with professionals on her behalf? Explore the response of agencies to Adult F's mother's needs as her daughter's carer.

- To what extent did professionals consider Adult F's mental capacity to make specific decisions including decisions to decline care and support.

- Explore the extent to which practice was trauma informed and took account of Adult F's history, in particular the removal of her children and the impact this may have had on her mental health and wellbeing and her relationship with professionals.

- Explore agency assessment of and responses to Adult F's alcohol consumption.

- Explore agency responses to safeguarding adult concerns, in particular indications of self-neglect. Were responses to self-neglect consistent with local guidance? Explore the extent to which the principles of making safeguarding personal were applied.

- Explore agency response to self-harming behaviour and expressions of hopelessness.

- Explore the extent to which professional concerns about Adult F were escalated. Given the complexities of the case, how did agencies and practitioners use supervision and reflection? Explore the extent to which case closure decisions were informed by current needs and risks.

- Explore the impact of Covid-19 on both Adult F and her mother as Adult F's carer.

3.0 Chronology of key events

3.1 As a human being with hopes, fears, wishes and feelings, Adult F is largely invisible to this SAR. Insofar as the review understands her life at all, it understands her primarily through her encounters with professionals at times when she was often

worried, fearful and confused and also through information provided by her mother with whom professionals invariably communicated when they experienced difficulties in engaging with Adult F. Adult F was born in 1970 and she was the mother of four children born between 1988 and 1998. Her first child was born when Adult F would have been 17 or 18 years old. The Police attended a number of domestic abuse incidents involving Adult F and her partner – and father of the children - in which no offences were recorded and no further action taken except for one occasion when her partner was arrested to prevent a breach of the peace. Police attendance at a domestic abuse incident in September 2001 appears to have precipitated the removal of her children from her care. The Police documented that living conditions had deteriorated, that there was excrement 'all over' the house and that Adult F 'clearly cannot cope'. There were no significant findings arising from the child protection medical examinations of the children conducted at that time other than that the youngest child – then around 3 years of age – was under weight. There is no mention of the father of the children in the Police record of this incident. Adult F's elder two children were cared for by her mother under a Residence Order[3] and the younger two children were placed for adoption. Adult F would have been in her early thirties when her children were removed from her care.

3.2 Adult F had learning difficulties and there is a reference to a 2006 learning disability assessment in her medical records but it has not been possible to confirm any diagnosis. She was on the learning disability register of her GP practice. Her hearing was impaired which created some verbal communication challenges. There were also longstanding concerns about the impact of alcohol dependency on her mental and physical health and she was diagnosed with liver disease in 2007 or 2008. Concerns also arose about her general physical health including evidence of very low weight. Adult F seemed very reliant on her mother for support particularly in managing her finances, the provision of meals and support to attend appointments. However, her mother's capacity to support Adult F appears to have been affected by her (mother's) long term progressive neurological condition. Her mother may have had other additional needs associated with aging.

3.3 Adult F's mother decided not to contribute to this SAR because she understandably could not face discussing the events leading up to her daughter's death at a time when she had recently experienced two further close family bereavements. However, her mother had already provided an outline of Adult F's life in numerous contacts with professionals. Adult F's mother said that her daughter had experienced a difficult childhood, Adult F's husband had been abusive, she had suffered a traumatic assault from a subsequent partner and as a result she had a

[3] Residence Orders were made under Section 8 of the Children's Act 1989 and was an Order which settled the arrangements to be made as to the person with whom a child is to live. Residence Orders were replaced by Child Arrangement Orders (Children and Families Act 2014). Adult F's mother would have had parental responsibility for the two elder children.

general mistrust of men and ‘didn’t like authority figures’ – which is why her mother said that Adult F refused help. Adult F’s mother said that she managed her daughter’s benefits to prevent her spending all her money on alcohol. Her mother said that Adult F had few hobbies but enjoyed reading and had few friends but talked to people when ‘out and about’. From the only conversation of substance with Adult F documented by a professional during the period on which this SAR primarily focusses (a home visit by a social worker on 15th November 2021) Adult F appeared to value her independence and seemed very reluctant to accept support from professionals. The social worker documented that Adult F clearly perceived social workers as people who placed people in care homes and said that she did not need a social worker as she didn’t want to go into care. It seems reasonable to assume that the earlier removal of her children may have contributed to this view of social workers. Adult F appeared to struggle to address her relationship with alcohol. Although her flat was noted to be in a ‘poor state’ during this visit there were indications that she may have tidied up in preparation for the visit which indicated that she may have been anxious to present the impression that she was coping more effectively than was actually the case.

3.4 The medical cause of Adult F’s death at the age of 51 was pneumonia but key factors which may have contributed to her premature death appear to have been her social isolation, the difficulties experienced by agencies in engaging with her, her long term use of alcohol and her neglect of her self-care and care of her home environment. Almost a decade and a half before Adult F’s death, her mother shared with professionals that Adult F had ‘given up’ and was ‘slowly dying’.

3.5 Following the removal of her children, there was an interval of several years during which agencies appear to have had little contact with Adult F. From around 2007 she lived at her mother’s address, where Adult F’s two elder children also resided. In January 2008 Adult F’s mother contacted Children’s Social Care to inform them that Adult F had recently been admitted to hospital due to ‘alcoholism’ and that the hospital staff had advised that Adult F could not live on her own. During her contact with Children’s Social Care, Adult F’s mother said that her daughter would not admit that she had a problem ‘even though she is so far down the line’. Children’s Social Care - whose response to her mother’s concerns is not known – recorded no further case notes in respect of Adult F after this time.

3.6 Between November 2008 and May 2009 Adult F attended Calderdale Royal Hospital on four occasions following what were documented to be intentional overdoses. No acute mental health concerns were identified. She was advised to self-refer to Calderdale Substance Misuse Services (CSMS) on each occasion but declined to do so.

3.7 During 2008 and 2009 the Police began attending incidents at Adult F's mother's address in which Adult F was arrested to prevent a breach of the peace following arguments with her mother whilst she (Adult F) was under the influence of alcohol. During one of the incidents Adult F was documented to have threatened to self-harm by cutting herself with a knife and on a later occasion cut her arm with a knife.

3.8 In July 2015 the Police were contacted by the caretaker of a flat in which Adult F had been temporarily placed by Calderdale Council Housing Options team pending a homelessness assessment. The caretaker reported that Adult F had disclosed that she had been raped. The Police located Adult F who confirmed her rape disclosure although the account she provided was said to be not 'coherent' and it was noted that she had been drinking alcohol. A suspect was traced who stated that consensual sexual activity had taken place but not intercourse. The Police took no further action due to having insufficient evidence to proceed.

3.9 During 2015 the Police had attended a further eight incidents at Adult F's mother's address which indicated that her relationship with her mother was coming under increasing strain as a result of Adult F's alcohol consumption. From 4th August until 8th October 2015 Adult F stayed in Calderdale Council homeless accommodation to which she had been moved after her disclosure of rape (Paragraph 3.8). Adult F then moved to a women's hostel in Huddersfield for a time. Calderdale Council's Housing Options team had sent a KeyChoice[4] Support Assessment to Together Housing in support of a housing application from Adult F on 26th August 2015. The assessment stated that she had lived with her mother, who had a long term progressive neurological condition, for 10 years but she could no longer 'cope with her daughter's behaviour'. The assessment added that her mother continued to play a supportive role and Adult F saw her daily. Her vulnerabilities were stated to be partial deafness and alcohol consumption – which was said to be her main issue. She was said to 'make herself vulnerable' through drinking – which was affecting her physical and mental health but that she did not perceive this to be a problem. The assessment stated that Adult F would eventually need to address her drinking. She was also said to have problems with personal hygiene and diet. It was stated that she would need help to budget appropriately, and it was noted that her benefits were currently paid into her mother's bank account. It was said that she was used to having her mother to tell her what to do and to 'keep her in line'. There were said to be no anti-social behaviour issues, although she had presented to the concierge regularly overnight although she had not presented a risk to staff or other residents in her homeless accommodation. It was acknowledged that she had not

[4] KeyChoice is a Choice Based Letting system used for letting properties in Calderdale. The scheme simplifies the way in which people apply for a home, as it takes into account the date of their membership and personal circumstances. It also gives people a variety of properties to choose from, with comprehensive information about the properties to rent.

had a tenancy for 10 years. Adult F said that she did not need pre-tenancy help. The assessment stated that Adult F's support needs at that time were 'significant'.

3.10 The support worker from the Council temporary accommodation and support service planned to support Adult F in her tenancy for up to six months or until SmartMove[5] assumed responsibility for supporting Adult F. The SAR has been advised of the support provided by the temporary accommodation and support service. SmartMove support would be daily for the first two weeks and weekly thereafter. Typically, the support offered would be to set up utilities, help to apply for grants for furniture, GP registration and help to understand the tenancy agreement. The support could also have included help to access support from local agencies and to ensure support was in place for the longer term. The housing related support SmartMove were contracted to provide at that time also included referrals to other agencies such as mental health services. The content, length and intensity of the support provided to Adult F to help her settle into her tenancy is not known. Calderdale Council Housing Options have advised the SAR that they retain records for 7 years only and SmartMove's responsibilities have since been taken over by a different organisation. It was noted that Adult F would also be receiving daily support from her mother.

3.11 Adult F's tenancy with Together Housing began on 26th October 2015. The Police were called to fifteen incidents at Adult F's tenancy between November 2015 and March 2016. Many of the calls were to support the Ambulance service who responded to several calls from Adult F. This series of calls resulted in Adult F being conveyed to hospital on two occasions. Adult F was often described as intoxicated. The Ambulance service contacted the Police to discuss the large number of phone calls they had been receiving from Adult F but the issue was taken no further after calls from Adult F ceased.

3.12 Between May 2016 and June 2017 the Police were called to nineteen incidents at Adult F's mother's address in which her mother reported that Adult F was causing a disturbance whilst intoxicated. On several occasions the Police arrested Adult F and placed her before the Court. The Court Manager subsequently wrote to the Police to ask them to consider alternative methods of dealing with Adult F rather than continually placing her before the Court for a breach of the peace. The Court Manager went on to suggest that Adult F's mother consider a Non-Molestation Order.[6] The Police had opened a 'Repeat Domestic Violence Occurrence' in July

[5] At that time SmartMove provided support to people who were homeless or at risk of losing a tenancy. The support previously provided by SmartMove is now provided by Happy Days.

[6] A non-molestation order is typically issued to prohibit an abuser from using or threatening physical violence, intimidating, harassing, pestering or communicating with the victim. An order could prevent the abuser coming within a certain distance of the victim, their home address or even attending their place of work. A non-molestation order can protect a person against behaviour that by itself may not be a criminal offence or in situations where the police have responded to a 999 call but then taken the view that there is insufficient

2016 which was endorsed to the effect that efforts would be made to persuade Adult F's mother to apply for a Restraining Order[7] or a Non-Molestation Order.

3.13 During 2017 Adult F was convicted of a public order offence relating to an incident at her mother's address and was made subject to a Restraining Order which stated that she was not to harass or threaten her mother or cause damage to her mother's property and to only attend her mother's property when sober. Adult F was subsequently arrested on one occasion for breaching the Order in respect of which her mother did not wish to make a statement. There were no further reported incidents after June 2017 and over the following two years Adult F appears to have had little contact with agencies which may indicate that she became more settled in her tenancy and that her visits to her mother's address became less problematic.

3.14 During September 2019 Adult F first came to the notice of Together Housing for anti-social behaviour (ASB) which consisted mainly of noise nuisance primarily during the night hours when her TV was played loudly, she was said to be banging on neighbour's doors, and loud banging noises were emanating from her property as a result of 'stomping around' and moving furniture. Together Housing opened an ASB case. They documented Adult F's vulnerabilities to be hearing impairment, poor eyesight, poor mobility and that she was heavy drinker. Together Housing worked with the neighbours who had made the complaints, Adult F's mother and Adult F to resolve the issues and adopted a broadly supportive – as opposed to enforcement oriented - approach. Measures were put in place to reduce noise such as carpeting and Adult F was offered hearing loops and door closers. Together Housing has advised the SAR that it is unclear whether conversations took place directly with Adult F. Their contact appeared to primarily be with her mother. Together Housing considered the ASB case to have been resolved by September 2020.

2020

3.15 On 23rd March 2020 the first Covid-19 lockdown commenced and partner agencies made significant adjustments to the way in which they delivered services in response to the unprecedented challenges arising from the pandemic. Adult F's neighbours informed Together Housing that she was visiting her mother daily in contravention of Covid-19 restrictions.

3.16 Between 11th and 19th May 2020 Adult F made twenty two 999 calls to the Ambulance service and at least ten 999 calls to the Police. The calls were made during the night and Adult F frequently struggled to remember her address and

evidence to charge the abuser with a criminal offence such as assault. If a non-molestation order is in place, then the police can arrest the abuser for the offence of breaching that order.

[7] Restraining orders may be made on conviction or acquittal for any criminal offence. These orders are intended to be preventative and protective. The guiding principle is that there must be a need for the order to protect a person or persons. A restraining order is therefore preventative, not punitive.

postcode. She often had difficulty hearing the call taker, saying she was 'really deaf', and her TV was often heard playing loudly in the background. She often seemed confused and possibly affected by alcohol. The apparent purpose of the calls was to say that she was feeling unwell and she was often advised to contact NHS 111. On one occasion she said that she had broken her pelvis, although she was observed to be mobilising well when an ambulance later attended her home address. Ambulances were deployed on four occasions in all and Adult F generally appeared to be very reluctant to admit the crews into her home, engage with them or accept assessments. On all four occasions Adult F was discharged by the Ambulance crews without treatment or being conveyed to a hospital.

3.17 Adult F did not give clear reasons for calling the Police although she made reference to disputes with neighbours over noise issues which she said were preventing her from getting to sleep. The Police attended on one occasion in response to Adult F's concerns about a broken window – which the Police concluded had been damaged accidentally and suggested she contact the local authority to arrange boarding up/repair. During the calls, there were indications of low mood in that she said that she was 'past caring' and that the noise from her neighbour's dog made her feel like killing herself. On one occasion Adult F seemed worried that the Ambulance service would let her mother know that she had been ringing the service.

3.18 After 19th May 2020 Adult F had one further contact with the Police prior to her death and did not call the Ambulance service for nearly a year.

3.19 On 28th May 2020 Adult F's GP practice phoned her to arrange the annual health check she was offered as she was on the GP practice's learning disability register[8]. Adult F said that she only felt able to attend the appointment with her mother who she said was currently shielding as a result of the pandemic. It was agreed to postpone the appointment until Adult F's mother was available to attend with her.

3.20 On 12th June 2020 Adult F's GP practice was informed of the large number of 999 calls Adult F made to the Ambulance service and observed that the calls appeared to be 'anxiety related' and contacted the adult learning disability health service to check whether Adult F had a learning disability diagnosis. The GP practice was advised that it was unclear whether Adult F had a diagnosis but the learning disability service said they would be happy to discuss Adult F with the community matron – to whom the GP practice referred her. The community matron then consulted the learning disability service which advised her to seek the consent of Adult F for a referral to the latter service. No referral was made by the community matron who established that Adult F had had no 'social services' input since 2016

[8] People with a learning disability often have poorer physical and mental health than other people. An annual health check can improve people's health by spotting problems earlier.

and had not seen her GP since 2018. From her GP records the community matron established that Adult F had 'no long term conditions', no repeat medication and a history of learning disability, alcoholism and deafness. The community matron spoke to Adult F's mother who said that her daughter 'would not consent or engage with health professionals and had not been agreeable to referrals/medication for a number of years'. Adult F's mother said she had taken her daughter's phone off her 'due to repeated 999 calls'. There is no indication that any risks associated with this approach to preventing Adult F making inappropriate use of the 999 system was challenged.

3.21 The community matron subsequently discharged Adult F from the service as an 'inappropriate referral' on the ground that Adult F did not have a long term physical health need. The community matron considered referring Adult F to the high intensity user group (HIUG)[9] but Adult F was considered not to meet the criteria. At that time a High Intensity User was defined as a frequent user of YAS, or they had attended Hospital A&E 5 or more times in one calendar month or 12 times in 3 consecutive months. The SAR has been informed that at that time there was no dedicated HIUG lead and so the service was being covered by the community matrons who are assigned to GP practices but at that time many of them had been redeployed due to the pandemic.

3.22 On 7th October 2020 a practice nurse from Adult F's GP practice conducted a learning disability review of Adult F via a phone call with her mother. Her mother said that Adult F lived alone and was 'not allowed' a phone due to her repeated 999 calls. She said that Adult F continued to drink heavily – 7-9 units per day – although she only drank in the evenings 'now' but sometimes became verbally aggressive after drinking alcohol. She said that her daughter was incontinent of urine but was 'in denial' about this and refused to wear continence pads. Adult F's mother described herself as 'housebound' but she said that she managed her daughter's money and used it to pay her bills. A friend did the shopping for both mother and daughter and took Adult F's shopping to her. Adult F's mother said that her daughter had few hobbies but enjoyed reading and had few friends but talked to people when 'out and about'. She also mentioned that Adult F's children had been removed from her care.

3.23 The second national Covid-19 lockdown commenced on 5th November 2020.

2021

[9] The High Intensity User Group at the Calderdale & Huddersfield NHS Foundation Trust (CHFT) is a multidisciplinary group covering both Calderdale and Huddersfield. The group works with service users who are frequently attending A&E or calling 999. They are a consent-based service and look to work with service users to ensure that the appropriate support is offered.

3.24 The third national Covid-19 lockdown commenced on 6th January 2021 and restrictions began to be eased on a stepped basis between 8th March 2021 and July 2021.

3.25 On 21st April 2021 Together Housing raised a cause for concern after a neighbour complained about the sound of screaming and shouting from Adult F's flat during the nights. A neighbourhood officer spoke to Adult F's mother, as communication with Adult F was said to be challenging. Her mother said that she would speak to Adult F. She disclosed a change in Adult F's routine. Her usual routine had been to go to her mother's house daily, arriving late afternoon but she had recently been arriving around 8.15pm and staying for only an hour. The neighbourhood officer discussed the case with a manager on the same date who asked whether self-neglect was an issue. The neighbourhood officer felt that the condition of her property was 'just unclean' and that it did not constitute a level of self-neglect which would justify a safeguarding referral. Adult F was documented to be a 'non-conformer' who had 'really good' support from her mother. Together Housing noted that Adult F had had no heating or hot water since 8th March 2021 as she 'won't stay in for the repair appointment'. It is not known how long Adult F was without heating or hot water.

3.26 On 11th May 2021 the Together Housing neighbourhood officer contacted Adult F's mother who said that she had spoken to her daughter who had denied responsibility for the noise. Her mother expressed concern about the state of Adult F's flat which she said she had not visited for twelve months.

3.27 During the early hours of 17th May 2021 Adult F made a large number of 999 calls to the Ambulance service saying that she was struggling to breathe. She appeared to be intoxicated. Attempts to clinically assess her over the phone were unsuccessful and so an ambulance went to her address and conveyed her to hospital for further assessment. Empty cider bottles were noted in her flat. Adult F was admitted to the Hospital A&E with swollen glands and 'complaining of weight loss'. She was reviewed by medics and discharged home in an NHS funded taxi. The hospital also documented that Adult F was anxious about a 'benefits interview' (see next paragraph).

3.28 Later that day the Department for Work and Pensions (DWP) carried out a medical assessment of Adult F by phone and documented that Adult F relied on her family and her mother, was alcohol dependent, experienced depression, suicidal thoughts, musculoskeletal problems, had impaired hearing, visual problems and had urinary incontinence.

3.29 During the early hours of 12th June 2021 the Police were contacted by one of Adult F's neighbours who reported that Adult F had 'hammered' on their door several times, visibly distressed and asked them to contact the Police as she felt unwell. The

Police gained access to Adult F's flat - with the assistance of Together Housing - where she was complaining of chest and abdominal pains and appeared confused. The Police requested the attendance of the Ambulance service which was unable to respond promptly because of critical demand levels and so the Police transported Adult F to Calderdale Royal Hospital A&E where she was assessed and discharged later the same day. A safeguarding risk arising from self-neglect was documented in Adult F's hospital records but no referrals were made to other services or a safeguarding concern raised with the local authority and she was discharged without the offer of advice or support in relation to her alcohol consumption. The SAR has been advised that the most likely explanation for these missed opportunities was human error. Adult F's GP practice was notified by letter which contained no advice in relation to the need for GP follow up.

3.30 Together Housing became aware of the 12th June 2021 Hospital attendance because two days later (14th June 2021) the neighbourhood officer phoned Adult F's mother to discuss the incident. Her mother said that Adult F had obtained money from somewhere and 'got really drunk'. She added that Adult F's drinking was causing her to have fits and she said that the Police were very concerned that Adult F was 'very underweight', adding that her daughter was 'skeletal'. (There is no reference to concern about Adult F's weight in the Police incident record). The neighbourhood officer suggested that Together Housing could support Adult F to a GP appointment but her mother said she thought her daughter would not agree to this. The neighbourhood officer discussed Adult F's capacity with her mother who said that her understanding was that her daughter had the capacity to make her own decisions. During the conversation her mother said she was frightened about what would happen to Adult F when she (mother) died. Together Housing opened an internal safeguarding concern. Together Housing were also considering a referral to Gateway to Care[10] at that time.

3.31 The Together Housing neighbourhood officer made further calls to Adult F's mother during June and July 2021 but no direct contact was made with Adult F. Her mother said that she was being 'very strict' with Adult F's money to try and prevent her drinking to excess. The neighbourhood officer offered to visit Adult F at her mother's house but this suggestion was declined by her mother who said that Adult F 'doesn't do well when being asked questions or (when) communicating with someone other than her mother'. The neighbourhood officer also suggested Calderdale Deaf Club. The possibility of Adult F moving closer to her mother's address was also discussed. Her mother continued to state that her daughter would be unlikely to accept the offers of support the neighbourhood officer suggested, describing Adult F as 'like a little child who doesn't like being told off'.

[10] Gateway to Care is the first point of contact for adult social care which offers practical information and advice to help people live independently at home.

3.32 On 7th July 2021 Adult F's mother wrote to the DWP requesting to be appointed as her daughter's appointee in respect of the payment of her benefits. The DWP has no record of this request being actioned or of any follow up from Adult F's mother. (If Adult F's benefits continued to be paid into her mother's bank account as they were at the time her Together Housing tenancy began, then this may explain why her mother did not follow up her initial letter to DWP).

3.33 Together Housing made further calls to Adult F's mother during August and September 2021. Her mother expressed concern about Adult F being underweight and not having her Covid-19 vaccinations.

3.34 On 1st October 2021 Adult F was admitted to Calderdale Hospital after a witnessed fall from a bus during which she hit her head. She was assisted to stand by bystanders. She denied consuming alcohol although a smell of alcohol was apparent. She was found to have hyponatraemia[11] and hypokalaemia[12] due to reduced oral intake. When her mother contacted the ward and expressed concern about her daughter not eating, she was assured that the hospital planned to refer Adult F to a dietician, but this did not happen. The SAR has been advised that the most likely explanation for this omission is human error.

3.35 Adult F's mother contacted Together Housing to advise them that she (her daughter) had been admitted to hospital. She said that Adult F had not been eating – and weighed no more than six stones – and had been drinking excessively. She added that she had been to her daughter's flat and that it was in a 'disgusting state' in that she had been using one of the kitchen drawers as an ashtray. In response the neighborhood officer rang the hospital to advocate for Adult F and was advised that she 'could not be forced to do anything she did not want to do'. The neighbourhood officer also shared information with the hospital about Adult F's needs. Adult F was discharged home on 12th October 2021. She was offered 'social services' support which she declined. Her GP practice was informed and advised to prescribe Thiamine[13] tablets. These were added to her repeat prescription but never issued as the system is reliant on patients requesting their repeat medication.

3.36 On 14th October 2021 Together Housing consulted their safeguarding team following which Together Housing sent their first safeguarding concern to Gateway to Care due to Adult F's risk to self and others (fire safety), the difficulties experienced in engaging with her, her fluctuating care and support needs – which were stated to

[11] Hyponatraemia is a low level of sodium in the blood.

[12] Hypokalaemia means low potassium.

[13] Thiamine can be used to treat or prevent vitamin B deficiency. Thiamine helps to turn food into energy and to keep the nervous system healthy. The body is not able to make thiamine for itself but the body can usually get all the thiamine needed from food.

be hearing loss and alcohol dependency - and her inability to protect herself from risk. The referral from Together Housing also explained that Adult F was supported by her mother and that this was proving difficult for her mother as she was elderly. It was also noted that she (Adult F's mother) was highly distressed and didn't know where else to go for help. A referral to the Fire and Rescue Service (FRS) was also made. Fire safety adaptations were to be considered including flashing/vibrating smoke alarms given Adult F's hearing impairment. Direct communication was to be made with Adult F in writing and via a physical welfare check. Tenancy breach letters were to be considered if access was denied. If the referral was not accepted by Adult Social Care a multi-agency meeting was to be arranged to ask for guidance and help. If Adult Social Care were unable to assist, a referral to Together Housing's independent living team would be considered although the SAR has been advised that Adult F would not have been eligible for this as the independent living team supports people aged 60 and above.

3.37 On the same date (14th October 2021) the Together Housing safeguarding concern was sent from Gateway to the Adult Social Care all age disability team (AADT). There was then a delay in responding to the safeguarding alert. A factor which may have contributed to this delay was that the safeguarding alert stated that Adult F was in hospital when in fact she had been discharged.

3.38 On 10th November 2021 a FRS prevention officer visited Adult F at her home address having made an appointment via her mother. The risks identified from this visit included Adult F's hearing impairment, her 'possible excessive alcohol use (discarded cider bottles were noted on the floor), unsafe smoking (burn marks noted and cigarette ends discarded in the fireplace), 'low engagement' with night routine and escape plan advice, crime prevention concerns (front door left unlocked) and the fact that Adult F had no phone. Safety advice was given, two smoke detectors and a heat detector were installed and relevant advice leaflets were left. Smoking cessation advice was also offered and declined.

3.39 On 11th November 2021 the FRS submitted a safeguarding referral to Gateway in which concern was expressed about Adult F looking undernourished and dishevelled and about the discarded alcohol bottles in the property. On the same date the FRS prevention officer spoke to the Together Housing neighbourhood officer and shared concerns about Adult F self-neglecting, adding that she was 'extremely thin'.

3.40 Together Housing had sent an email to Gateway to check on the progress of the safeguarding referral on 28th October 2021 but there is no indication that they received a reply. They made a further enquiry on 12th November 2021 and spoke to an AADT social worker who then emailed an advanced practitioner following which a duty visit was arranged. The FRS safeguarding concern was also received by the AADT on 12th November 2021.

3.41 An AADT duty social worker visited Adult F at home on 15th November 2021 and was admitted. The social worker noted the flat to be in a poor state with broken furniture and cigarettes on the floor. She saw no evidence of alcohol bottles. She noted that Adult F appeared very thin but she said that she visited her mother's home for meals most days and said that she was having a supermarket delivery. The recent FRS visit was discussed with Adult F who said that, as she had experienced a house fire many years previously, she was aware of the need to extinguish her cigarettes. The social worker felt that Adult F had some learning difficulties although she had been unable to confirm a learning disability diagnosis from previous case notes. The social worker felt that Adult F's primary need appeared to be around her mental health and alcohol dependency.

3.42 Adult F declined the offer of support from the social worker – including tenancy support - although she appeared to equate 'support' with being placed in a care home. The social worker felt that Adult F had capacity to consent to support and that she would need to seek advice on the question of whether she could progress the safeguarding concerns without Adult F's consent. The social worker felt that Adult F's tenancy was at risk if she could not keep her flat 'up to standard'.

3.43 The social worker also spoke to Adult F's mother who said that her daughter had experienced a difficult childhood, an abusive husband, her four children had been taken into care due to neglect, had suffered a traumatic assault from her last partner (the SAR has received no information about this assault) and as a result 'didn't like men - including repair men' and 'didn't like authority figures' – which is why she refused help. Adult F's mother went on to say that she managed her daughter's benefits to prevent her spending all of her money on alcohol, provided her with meals and accompanied her to health appointments. Her mother added that she had her own health issues following her diagnosis with a long term progressive neurological condition.

3.44 The social worker planned to liaise with Together Housing but there is no indication that this was actioned. Together Housing made several attempts to ascertain the outcome of the social worker's visit before the notes of the social worker's 15th November 2021 visit were verbally shared with them on 25th November 2021. The social worker sought advice from management, asking 'at what point do social workers intervene even when someone is telling us to go away'. The social worker received advice and the consequent plan was to make a further home visit to Adult F in company with Together Housing and a BSL[14] interpreter. This second home visit, not including a BSL interpreter on this occasion, was planned for 4th January 2022.

[14] British Sign Language.

2022

3.45 On 4th January 2022 an AADT duty social worker and the Together Housing neighbourhood officer attempted a home visit to Adult F but received no reply after several minutes of loud knocking despite indications that she was at home. Adult F had been informed in advance that the visit would be taking place. Together Housing documented that a further attempt would be made to carry out the joint home visit in two weeks' time, but Adult Social Care has no record of any further follow up plan or action.

3.46 The Together Housing neighbourhood officer continued to attempt solo home visits to Adult F during January 2022 but received no reply. The neighbourhood officer sought advice from the Together Housing safeguarding team which advised (on 27th January 2022) that the internal safeguarding concern should remain open given Adult F's vulnerability, her ability to manage her tenancy and the difficulties her mother faced in supporting Adult F due to her own health needs. Adult Social Care were documented to have 'withdrawn' -although this appears to have been an assumption rather than a documented decision – and Adult F was also documented to have decided not to engage with Adult Social Care.

3.47 The Together Housing neighbourhood officer continued to attempt home visits to Adult F when in the area and management oversight of the case also continued. On 8th March 2022 Together Housing closed the internal safeguarding case after further discussion with their safeguarding team. It was documented that there had been 'no further concerns' or any updates or contacts from Adult Social Care following Together Housing's first safeguarding referral.

3.48 During the early hours of 14th April 2022 Adult F called the Ambulance service via 999 from a neighbour's phone. Adult F said that she was 'in pain'. The male neighbour said that Adult F had woken him up and asked him to ring 999. During the call he became distressed and said that he no longer wanted to help Adult F as he had his own problems. The call handler advised the neighbour to advise Adult F to contact 111 for further assistance. There is no indication that Adult F did so.

3.49 On 29th July 2022 the Together Housing repairs team visited Adult F to repair her leaking toilet and raised an internal cause for concern relating to how she was living and looking after herself. Her property condition was noted to be 'poor' and photographs were taken.

3.50 Following this cause for concern being raised internally, on 1st August 2022 Together Housing made a second safeguarding referral to Gateway to Care in respect of Adult F which stated that when her property was accessed to repair a leak, she showed signs of self-neglect, appeared very confused and struggled to understand what was happening. Photographs of the property condition were

attached. As was the case with the first referral, the second referral also stated that Adult F's mother had a long term progressive neurological condition and could not provide support to her daughter.

3.51 An AADT duty social worker screened the referral and also reviewed the previous two safeguarding referrals submitted by Together Housing in October 2021 and the FRS in November 2021. A joint visit with the BSL interpreting service was arranged for 8th August 2022 when no reply was obtained. During the period prior to the visit the Together Housing neighbourhood officer and their job share colleague had been attempting to obtain an update on the progress of the Together Housing safeguarding concern via a number of calls to Adult Social Care without success. On the day of the home visit Adult Social Care were unable to contact the Together Housing neighbourhood officer although Together Housing have advised the SAR they have no record of Adult Social Care attempting to contact them. The AADT social worker obtained management agreement to phone Adult F's mother who said that Adult F was deaf, depressed and alcoholic but went on to say that she did not feel that they needed any support. She said that Adult F visited her every evening and she provided her daughter with a meal.

3.52 Together Housing continued to try and obtain an update on their 1st August 2022 safeguarding referral and on 15th August 2022 received an email from Adult Social Care informing them of the 8th August 2022 visit and the subsequent contact with Adult F's mother and noting that it had not been possible to speak to Adult F or ascertain whether she had eligible care and support needs. A joint AADT/Together Housing visit to Adult F was proposed. Together Housing had some difficulty in obtaining a telephone contact for the AADT duty worker but when phone contact was achieved the Together Housing neighbourhood officer explained that a joint AADT/Together Housing visit had been tried and had not succeeded in the past. Involving the Police was also under consideration although it was felt that the Police would not be able to justify entry to Adult F's flat on welfare grounds as it was assumed that she continued to visit her mother's address on a daily basis. Together Housing advised that they were considering seeking a Court Order 'to empty the property' but this would take time to obtain. The AADT social worker said that she felt that Adult F's case needed to be allocated for a longer piece of work to be attempted.

3.53 On 19th August 2022 the Together Housing neighbourhood officer phoned Adult F's mother to update her on the safeguarding referral. During the conversation her mother said that Adult F 'hated' 'social services' because they 'took her children from her'. Her mother acknowledged that Adult F 'would be all the better' if she would accept help as she was skeletal, had an enlarged liver and was an alcoholic. Her mother talked about the possibility of Adult F moving into sheltered housing where she would be 'looked after'.

3.54 After consulting with the AADT safeguarding lead, on 25th August 2020 the AADT social worker advised Together Housing that Adult F's mother was to be involved in the next home visit as it was thought that Adult F was more likely to open the door and admit professionals if her mother was present. The Together Housing neighbourhood officer was asked to liaise with the AADT duty social worker for the following week (week commencing Tuesday 30th August 2022 – Monday 29th was a public holiday) who would collect Adult F's mother and drive her to her daughter's address. The visit would take place in the late afternoon as Adult F was known to sleep during the day. Together Housing expressed reservations that a joint visit could 'overload' Adult F and cause her anxiety but the plan to arrange a joint visit involving Adult F's mother was agreed.

3.55 On Wednesday 31st August 2022 the AADT duty social worker phoned Adult F's mother to discuss the pending visit. Her mother said that Adult F had not visited her until 11.45pm the day before and appeared dishevelled – wearing one slipper and one shoe – had presented as disorientated and ate nothing and took no food home. It was arranged that the AADT duty social worker would pick up Adult F's mother from her home address and drive her to Adult F's home the following day - Thursday 1st September 2022.

3.56 The home visit to Adult F did not take place as planned on Thursday 1st September 2022 due to pressures on the duty team.

3.57 On Friday 2nd September 2022 the AADT duty social worker attempted the home visit to Adult F. The social worker was unable to locate Adult F's mother's address and so visited Adult F's address unaccompanied but received no reply. However, by this time Adult F had cancelled the 2nd September 2022 home visit as she said that she had cleaned her flat in preparation for the 1st September 2022 visit.

3.58 On Sunday 4th September 2022 Adult F's mother went to her daughter's address as she had not visited her mother's address the previous evening. She found Adult F on the floor not breathing and unresponsive. She contacted the Ambulance service. The paramedics who attended confirmed death and noted the presence of rigor mortis which signified that Adult F's death had occurred between 2 and 24 hours previously.

4.0 Views of Adult F's family

4.1 Adult F's mother was invited to contribute to the SAR, but she decided not to do so. There is no obligation on family members to contribute to a SAR. Prior to writing to Adult F's mother, contact was made with her GP who confirmed her diagnosis and advised that, in his professional opinion, she would be able to fully contribute to the SAR, should she wish to do so. The independent reviewer then wrote to Adult F's

mother before following up with a telephone call. Adult F's mother said that she had recently suffered two further family bereavements and felt that discussing her daughter's death would make it more difficult for her to cope with the more recent bereavements. When asked if she would like to be contacted again when the SAR was complete, she again declined. Adult F's mother's wishes have been respected.

5.0 Analysis

5.1 In this section of the report each of the key lines of enquiry will be addressed in turn.

Explore the way in which professionals responded to challenges experienced in engaging with Adult F and explore the extent to which agencies made reasonable adjustments in respect of Adult F's learning difficulties and hearing loss.

Engaging with Adult F

5.2 The pattern of professionals accepting that Adult F's mother could speak on her daughter's behalf became firmly established as the 'default' option. For example, the GP practice nurse conducted a learning disability review of Adult F via a phone call with her mother (Paragraph 3.22).

5.3 The SAR has received no indication that Adult F consented to her mother making decisions on her behalf or acting as her advocate when agencies needed to contact Adult F. However, there were some occasions on which agencies considered the issue of Adult F's consent before contacting her mother. For example, Together Housing sent letters for Adult F via her mother's address at Adult F's request and recorded her consent to do so and on another occasion Adult Social Care management approval was obtained by the AADT duty social worker to contact Adult F's mother without consent – to arrange for her mother to accompany the social worker to the September 2022 home visit at a time when there were heightened concerns about Adult F (Paragraph 3.52).

5.4 Whilst contacting Adult F's mother, Together Housing staff also continued to attempt direct contact with Adult F. They also hoped that building a positive relationship with Adult F's mother could help them to eventually engage directly with Adult F herself. There are clear examples of this approach in the chronology of key events (Paragraph 3.31) but over time they became over reliant on Adult F's mother to pass on information to, or to provide information about, Adult F and the relationship between the Together Housing neighbourhood officer and Adult F's mother became primarily concerned with providing support to Adult F's mother as a mother who was worried about her adult child.

5.5 Overall, partner agencies repeatedly contacted Adult F's mother on her daughter's behalf without explicit consent from Adult F. This was done with good intentions and was a pragmatic solution to the challenges professionals experienced in engaging with Adult F, but the availability and accessibility of Adult F's mother meant that professionals began to contact her mother as a 'first' as opposed to a 'last resort' and thus avoided consideration of courses of action which could have created opportunities for Adult F to engage with services. Professionals never documented any doubt that Adult F lacked mental capacity to consent to contact being made with her mother on her behalf and so Adult F's consent should have been sought. Using Adult F's mother as the default option for communicating with or about Adult F also reinforced her isolation, her lack of independence and meant that Adult F was rarely observed.

Recommendation 1

That when Calderdale Safeguarding Adults Board disseminates the learning from this Safeguarding Adults Review, it highlights the importance of obtaining the consent of an adult to contact a family member or third party to advocate on their behalf as the best option whilst recognising the benefit of working with family members such as Adult F's mother to try and improve professional engagement with her daughter. The adverse impacts on Adult F arising from professionals defaulting to contact with her mother should also be highlighted.

5.6 Adult F's mother also informally acted as Adult F's appointee for benefits. There seemed to be an acceptance of this and there is no indication that professionals considered making checks with the DWP. Adult F's mother attempted to put her role as her daughter's appointee on a formal footing in July 2021 but the DWP has no record of this request being actioned or of any follow up from Adult F's mother (Paragraph 3.32). The DWP has advised this SAR that they are conducting a 'full review' in relation to actions taken in respect of appointees and that their learning from Adult F's case may contribute to the case for change. The Safeguarding Adults Board may wish to request the DWP to share the findings of their review of appointee arrangements with them, given the connections sometimes found between appointee arrangements and financial exploitation (There is no indication of financial exploitation in this case).

5.7 Adult F's mother appeared to keep a tight rein on her daughter's money – apparently in order to reduce the amount of disposable income Adult F had to spend on alcohol. This approach did not appear to be successful given the frequency with which Adult F presented as intoxicated – although her very low weight may have meant that she became intoxicated after drinking a smaller amount of alcohol. Tightly controlling Adult F's expenditure may have had unintended negative effects such as limiting her ability to manage her finances independently and may also have limited her ability to purchase other items she needed.

5.8 Adult F had lengthy periods without a phone which risked her being unable to make or receive calls from practitioners. Her mother removed Adult F's phone from her following the large number of 999 calls Adult F made to the Police and Ambulance service in May 2020 (Paragraphs 3.28-3.29). This went apparently unquestioned and unchallenged by professionals who became aware (Paragraphs 3.32 and 3.34). It seems possible that her mother may also have removed Adult F's phone from her during a later period as the FRS noted that she had no phone in November 2021 (Paragraph 3.38) and in April 2022 Adult F needed the help of a neighbour to contact the ambulance service via the 999 system (Paragraph 3.48). It is entirely possible that there are alternative explanations for Adult F's regular lack of access to a phone.

5.9 The removal of her daughter's phone could have been viewed as controlling behaviour by her mother in that as well as isolating her from support and making it more difficult to summon help in an emergency, it reinforced Adult F's dependence on her mother and also her mother's role as 'gatekeeper'.

Reasonable adjustments

5.10 Adult F had learning difficulties although there is a reference to a 2006 learning disability assessment in her medical records (she would have been 36 in 2006) but it has not been possible to confirm any diagnosis. She was on the learning disability register of her GP practice (Paragraph 3.4).

5.11 Adult F's hearing was impaired which created some verbal communication challenges. YAS has advised the SAR the 999/111 service regularly communicates with service users who live with a hearing impairment via the Relay UK[15] service. Relay UK connects people using a textphone, through operators 24 hours a day. However, YAS also advised that in certain situations, including where alcohol is a factor, Relay UK may not be an appropriate solution and 111/999 call handlers are taught techniques at their initial training to lower their tone and speak slowly and clearly to aid callers who are finding the call challenging. The Adult Social Care proposal to involve the BSL interpreter could be considered to have been a 'reasonable adjustment' although there is no indication from either Adult F's medical or Adult Social Care records that Adult F was familiar with BSL. It is noted that out of 12 million UK residents who are deaf or hard of hearing, there are 151,000 BSL users. Professionals could have asked Adult F or her mother how best to communicate with her.

5.12 When Adult F disclosed a rape in July 2015 (Paragraph 3.8) reasonable adjustments do not appear to have been made. A person with learning difficulties or

[15] Details of Relay UK can be found at https://www.relayuk.bt.com/

learning disability who discloses a sexual offence might well provide an account which lacked coherence, particularly if they had been drinking alcohol. Adult F's hearing was also impaired. The Police have reviewed their investigation of Adult F's disclosure of rape and advised the SAR that the detectives to whom the case was allocated visited Adult F on a number of occasions and quickly identified and interviewed the suspect. Communication with Adult F was noted to be 'difficult' but there appears to have been no consideration of the support of an independent sexual violence advisor (ISVA)[16] or other advocate or referral to the Kirklees, Calderdale and Wakefield Rape and Sexual Abuse Centre (RASAC).

5.13 The police service nationally has recognised the need to improve the quality of rape investigations and increase the number of successful prosecutions (1). Of particular relevance to this SAR are the findings of a 2021 Joint Thematic Inspection of the Police and Crown Prosecution Service's response to rape, particularly that some victims with protected characteristics[17] may face greater barriers when reporting rape offences (2), that there were inconsistent levels of referrals to support services, and especially in the effective involvement of ISVAs (3) and that victims of rape are more likely to continue to engage with the police and support an investigation when an ISVA is involved (4).

5.14 The SAR has been advised of Operation Soteria Bluestone, which is a national Home Office funded research and change programme, which brings together police forces with academics and policy leads to use evidence and new insight to enable forces to transform their response to rape and serious sexual offences (RASSO) (5). The ultimate product from the programme is the development of a national operating model for RASSO to be used by all 43 Home Office police forces.

5.15 The SAR has been advised that in Calderdale a dedicated Detective Inspector-led Adult Protection Team was established in October 2023. Their primary role is to investigate RASSO and safeguard vulnerable adults. The Police have advised the SAR that they are very confident that had Adult F disclosed the rape today, the Police would have better engaged with support services which may have helped them to obtain an account from her.

5.16 Although Adult F's rape disclosure was made in July 2015 the importance of providing effective support to victims of rape with protected characteristics remains

[16] Independent Sexual Violence Advisers (ISVAs) play an important role in providing specialist tailored support to victims and survivors of sexual violence. An ISVA is an adviser who works with people who have experienced rape and sexual assault, irrespective of whether they have reported to the police. The nature of the support that an ISVA provides will vary from case to case and will depend on the needs of the individual and their particular circumstances.

[17] The characteristics that are protected by the Equality Act 2010 are age, disability, gender reassignment, marriage or civil partnership (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation. (Adult F may have been considered to have a disability because of her hearing loss and learning difficulties/learning disability).

of the utmost importance and so it is recommended that the Safeguarding Adults Board requests a progress report from West Yorkshire Police in respect of the Adult Protection Team in Calderdale and that the report should focus in particular on the support provided to rape victims with the protected characteristics of learning disability/difficulties and hearing impairment.

Recommendation 2

That Calderdale Safeguarding Adults Board requests a progress report from West Yorkshire Police in respect of the Adult Protection Team in Calderdale and that the report should focus in particular on the support provided to rape victims with the protected characteristics of learning disability/difficulties and hearing impairment.

5.17 Following discharge from Hospital on 12th October 2021 Adult F's GP practice was advised to prescribe Thiamine[18] tablets. These were added to her repeat prescription but never issued (Paragraph 3.36). Responsibility for ordering her Thiamine tablets by repeat prescription rested with Adult F. At the practitioner learning event Adult F's GP said that it would be a 'mammoth job' for the GP practice to monitor the extent to which vulnerable patients were ordering and collecting medication. However, such monitoring by GP practices could be construed as a reasonable adjustment and would also be consistent with the Care Act prevention principle that it is better to take action before harm occurs (6). The Named Safeguarding GP's advice has been sought on the likely impact of Adult F not taking her prescribed Thiamine medication. The advice is that Thiamine is typically prescribed in respect of long term excessive alcohol use where Thiamine is thought to be neuroprotective (protects against the risk of nerve degeneration) or alternatively when a patient is suffering from malnutrition and refeeding syndrome[19]. The Named Safeguarding GP went on to say that Thiamine is often mentioned in the literature in relation to these two clinical scenarios but there is little consensus about what is an optimum dose or length of treatment. The Named GP added that in their experience it was not uncommon for patients prescribed Thiamine not to request it or, if dispensed, not to take it. It should also be noted that taking prescribed Thiamine could reduce the risk of Wernicke-Korsakoff Syndrome.[20]

[18] Thiamine can be used to treat or prevent vitamin B deficiency. Thiamine helps to turn food into energy and to keep the nervous system healthy. The body is not able to make thiamine for itself but the body can usually get all the thiamine needed from food.

[19] Refeeding is potentially a fatal condition defined by severe electrolyte and fluid shifts as a result of a rapid reintroduction of nutrition after a period of inadequate nutritional intake.

[20] Wernicke-Korsakoff syndrome is a neurological disorder caused by the lack of Thiamine. The disorder includes Wernicke encephalopathy and Korsakoff amnesic syndrome which are not different conditions but different stages of the same disease (Wernicke-Korsakoff syndrome). The disorder's main features are problems in acquiring new information or establishing new memories, and in retrieving previous memories. The syndrome may result from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders and the effects of chemotherapy.

Recommendation 3

That Calderdale Safeguarding Adults Board requests the NHS West Yorkshire Integrated Care Board to work with Calderdale GP Practices to develop pathways which enable reasonable adjustments to be made where patients on their learning disability registers experience difficulties in ordering and collecting prescribed medication.

5.18 The SAR has been advised that GP practices now have care co-ordinators and some GP practices hold adult at risk meetings which may help to pick up on patients in vulnerable circumstances who are not ordering their medication. However, at the practitioner learning event Adult F's GP reflected that at the GP practice's adult at risk meetings they tend to focus on adults they see regularly and therefore know quite well. The GP felt that they needed to be better at flagging concern about people with vulnerabilities they don't see. This seems to be quite a pertinent observation on which the Safeguarding Adults Board may wish to highlight when the learning is disseminated from this SAR.

Recommendation 4

That Calderdale Safeguarding Adults Board requests the NHS West Yorkshire Integrated Care Board to work with Adult F's GP Practice to develop a pathway which highlights patients on the GP Practice's learning disability register who:
(i) have not attended or been brought to their annual health check and
(ii) there is also information which indicates risk of harm to the patient,
so that such patients can be discussed at the GP Practice's adult at risk meetings. If it is possible for Adult F's GP Practice to develop such a pathway, the NHS West Yorkshire Integrated Care Board may wish to share this more widely with Calderdale GP practices as good practice.

5.19 Although the FRS identified that Adult F was 'hard of hearing' there is no indication that flashing/vibrating smoke alarms were fitted given Adult F's hearing impairment (Paragraph 3.37). The FRS has informed the SAR of the advice leaflets shared with Adult F although there is no indication that easy read versions may have been considered to be necessary for Adult F.

Recommendation 5

That Calderdale Safeguarding Adults Board requests West Yorkshire Fire and Rescue Service (Calderdale District) to advise them of the reasonable adjustments they take to ensure that adults with learning disability/learning difficulty are provided with information and support which meets their needs.

Explore the extent to which professionals understood the dynamics of the relationship between Adult F and her mother and explore the response of agencies to Adult F's mother's needs as her daughter's carer.

5.20 As previously stated Adult F seemed very reliant on her mother for support particularly in managing her finances, the provision of meals and support to attend appointments. This state of affairs appeared to be of longstanding.

5.21 Adult F's mother assumed the role of gatekeeper to services for her daughter. Professionals may have been dissuaded from making referrals by Adult F's mother invariably stating that her daughter would not accept support. This may well have been an accurate picture of her daughter's wishes and is consistent with Adult F previously declining support from alcohol services (Paragraph 3.6) and declining tenancy related support when seen by the social worker on 15th November 2021 (Paragraph 3.42). The dynamic of mother repeatedly declining support on her daughter's behalf meant that professionals were unable to ascertain whether Adult F may have reconsidered her stance and may have been ready to accept support.

5.22 There is little indication that professionals fully explored the dynamics of Adult F's relationship with her mother. Generally, her mother was seen as a parent who had provided extremely valuable and much needed support to her daughter over much of her daughter's adult life. The only example of a professional observing their relationship and documenting that observation is in a Children's Social Care note which is undated but could be from 2008. It stated that "Mother presented as very overpowering during the meeting and it was difficult for Adult F to express her own wishes and feelings" and "during the conversation Adult F became very destressed due to her mother's behaviour. Adult F presents as a pleasant lady who is longing to be independent of her mother." The possibility that Adult F's mothers support for her daughter may contain elements of controlling behaviour – for example by removing Adult F's mobile phone from her – went otherwise unexplored by professionals.

5.23 At the practitioner learning event the comment was made that "we lost who Adult F was and it became more about her mother". The lack of professional contact with Adult F meant that her wishes and feelings could only be obtained from her mother whose views of her daughter appeared to be fixed and pessimistic. The lack of professional contact with Adult F also prevented consideration of her mental capacity.

Adult F's mother's needs as a carer

5.24 The impact on Adult F's mother of providing quite intensive daily support to Adult F should not be under-estimated. As Adult F entered her fifties, her mother was supporting her in her early seventies having been diagnosed with a long term progressive neurological condition in her late fifties (Paragraph 3.8). During a 2021

conversation with Together Housing her mother said she was frightened about what would happen to Adult F when she (mother) died (Paragraph 3.30).

5.25 Adult F's mother had also assumed responsibility for parenting Adult F's two elder children at a time in her life when she was probably not expecting to parent children and adolescents once again – from around 2001 until 2012 (from her early fifties until her early sixties). Adult F's mother reported two assaults by Adult F's second child (Paragraph 3.9) and was also considered to be the victim in many incidents of familial domestic abuse in which Adult F was regarded as the perpetrator of domestic abuse when she became abusive after consuming alcohol.

5.26 However, there is no record of Adult F's mother being offered a Carer's Assessment. The Care Act 2014 substantially replaced and consolidated existing legislation for carers and those they support. The Act introduced parity of esteem between carers and service users, strengthened carer's rights to an assessment of need and placed a new duty on local authorities to fund support for carers 'eligible needs'. Had a Carer's Assessment been offered and carried out it may have helped professionals to better understand the dynamics of the relationship between mother and daughter and may have clarified Adult F's mother needs and any risks she may have faced.

5.27 The most evident opportunities to suggest a Carer's Assessment arose at the time the AADT social worker contacted Adult F's mother after making a home visit to Adult F in November 2021 (Paragraph 3.43) and as part of Adult Social Care's screening following receipt of Together Housing's second safeguarding referral in August 2022. The independent reviewer was of the view that Adult F's caring responsibilities could have prompted an earlier offer of support to Adult F's mother, particularly during the period when the Together Housing neighbourhood officer was developing a very positive link with Adult F's mother between June and November 2021. However, the collective view of the Panel is that as both of Together Housing's safeguarding referrals included details about Adult F's mother's needs and the fact that she was struggling to cope, this should have led Adult Social Care to consider Adult F's mother's needs/carers assessment rather than Together Housing's neighbourhood officers. It is not known whether Adult F's mother was coded as a carer in her GP records as it was not considered proportionate to request access to Adult F's mother's health records for the purposes of the SAR. The SAR Panel felt that a likely barrier to recognising Adult F's mother as her daughter's carer may have been because of Adult F's status as a middle aged woman with her own general needs tenancy and the fact that the support she was receiving was from her mother who lived elsewhere. The SAR Panel felt that it was important for professionals to appreciate that informal caring relationships could take a variety of forms.

5.28 The Calderdale Carers Strategy and Action Plan 2022-2027 (7) includes the objective to 'improve information, advice and guidance for carers – to reach those we

currently do not reach'. The objective includes supporting carers to recognise themselves as carers so that they can receive support at an earlier stage. It is not known whether Adult F's mother saw herself as her daughter's carer although she frequently described the support she provided to Adult F to professionals. The Carers Strategy envisages the development of a multi-agency communication plan, an aim of which will be to consider the different types of carers – the importance of which is emphasised by the learning from this SAR.

Recommendation 6

When Calderdale Safeguarding Adults Board disseminates the learning from this SAR, that Adult F's mother's role as her daughter's carer is highlighted as well as the fact that professionals from a range of agencies did not recognise her mother as Adult F's carer. There may also be merit in sharing the learning from this SAR in relation to the lack of recognition of Adult F's mother as her daughter's carer with the Calderdale Cares Partnership.

To what extent did professionals consider Adult F's mental capacity to make specific decisions including decisions to decline care and support.

5.29 Whilst there were longstanding concerns about the impact of alcohol dependency on Adult F's mental and physical health, the SAR has received no indication that there was any professional consideration of the impact of her alcohol use on her cognitive abilities, the impact of her frequent intoxication or the impact of her learning difficulties on her mental capacity to make decisions about her care and support needs.

5.30 As previously stated, the lack of in-person contact with Adult F limited professional opportunities to assess her mental capacity to make decisions about her care and support needs. The Mental Capacity Act states that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. The firmly established default position of contacting Adult F's mother to ascertain her daughter's wishes meant that there was insufficient professional attention paid to supporting Adult F to communicate her wishes and feelings.

5.31 The question of whether Adult F had the capacity to consent to having her phone removed - an action which could deny her access to medical care and other services and contribute to social isolation – did not appear to be explored by professionals who became aware of this.

5.32 Her capacity to consent to the management of her money by her mother was not ascertained by the DWP or any professional in contact with Adult F.

5.33 As previously stated, the possibility that Adult F's mothers support for her daughter may contain elements of controlling behaviour went largely unexplored by professionals. Therefore the impact of any controlling behaviour on Adult F's scope for making decisions was not considered, principally because the indications of controlling behaviour by her mother do not appear to have been recognised.

5.34 However, the AADT duty social worker who responded to the first two safeguarding concerns had a substantial conversation with Adult F and she felt that Adult F had capacity to consent to support and that she (the social worker) would need to seek advice on the question of whether she could progress the safeguarding concerns without Adult F's consent (Paragraph 3.42). However, Adult F appeared to equate the offer of support with being placed in a care home which raises the question of whether Adult F fully understand the information shared with her in relation to the offer of support and may therefore have lacked capacity to make decisions in relation to her care and support needs.

5.35 The interaction between the AADT duty social worker and Adult F may also have been a missed opportunity to consider Adult F's executive function. Executive function relates to the ability to put into practice knowledge and information about a decision 'in the moment' that a decision or action is required. It is a clinical term and relates to a set of cognitive skills pertaining to working memory, planning, attention focus, remembering instructions, self-control and juggling multiple tasks (8). An Association of Directors of Adult Social Services (ADASS) (South West) thematic review of mental capacity issues arising from Safeguarding Adults Reviews (SAR) noted that in one of the SARs reviewed, the expressed opinions of the individual at the heart of the review differed from their observed behaviour yet no mental capacity assessment took place (9). Arguably, Adult F's stated perception that as she had experienced a house fire many years previously she therefore knew how to safely make sure her cigarettes were fully extinguished was at variance with her observed behaviour in that the FRS prevention officer found unsafe smoking (burn marks noted and cigarette ends discarded in the fireplace and 'low engagement' with night routine and escape plan advice) (Paragraph 3.38). The FRS fire prevention officer also observed that Adult F 'seems to just drop her cigarettes anywhere in the lounge'.

5.36 One of the largest areas of practice concern highlighted by the above mentioned ADASS (South West) thematic review was practitioners finding it difficult to work with and understand executive function and how to assess mental capacity with individuals with potential executive dysfunction. This included the specific impacts that some contexts and conditions have on executive function such as self-neglect and substance misuse (10). Given the possible missed opportunity to note the variance between Adult F's stated awareness of fire safety and her observed behaviour - and consequently consider Adult F's executive capacity, it is

recommended that this area of learning should inform mental capacity training in Calderdale.

Recommendation 7

That Calderdale Safeguarding Adults Board ensures that the learning from this Safeguarding Adults Review in relation to executive functioning, specifically the importance of noticing any variance between a person's stated awareness of an issue and their observed behaviour in relation to that issue, informs the local Mental Capacity Act training provided in Calderdale.

5.37 It is noted that more substantial doubts about Adult F's mental capacity emerged in the month or so prior to her death. Together Housing's second safeguarding concern stated that she appeared very confused and struggled to understand what was happening when her property was accessed to repair a leak from her toilet (Paragraph 3.51).

5.38 Closely allied to mental capacity is the issue of consent and one of the key dilemmas associated with lack of consent was succinctly articulated by the AADT social worker who visited Adult F in November 2021 in response to the first and second safeguarding referrals. The question posed to her managers by the social worker at that time was 'at what point do social workers intervene even when someone is telling us to go away' (Paragraph 3.44). It is not known whether the absence of consent was a factor in Adult Social Care not progressing the Section 42 Safeguarding Enquiry beyond the social worker's home visit, contact with Adult F's mother and the unsuccessful follow-up home visit, but it may have been. The West Yorkshire Integrated Care Board (ICB) is represented on the SAR Panel by the Designated Nurse for Safeguarding Adults, who is in the process of preparing a paper on what he perceives to be a prevailing culture in Calderdale in which there appears to be a tendency not to progress safeguarding referrals where there is an absence of consent despite the fact that Section 42 of the Care Act 2014 does not state that a Safeguarding Enquiry may only be undertaken with the person's consent. The Designated Nurse's view is that it is necessary to have a partnership agreement to better inform multi-agency understanding of this issue - which sets out approaches to take in the absence of consent to safeguarding referrals - otherwise there is a risk that professionals will not engage with people who are at risk due to lack of consent. The Recovery Steps manager who contributed to this SAR felt that professionals needed to adopt a more creative approach to overcoming an absence of consent by, for example, asking Adult F if they could bring a someone along from Recovery Steps to a visit or meeting with her.

Recommendation 8

That Calderdale Safeguarding Adults Board is invited to note the professional concern which arose in Adult F's case over the ability to proceed with a Section 42 Safeguarding Enquiry in the absence of Adult F's consent and that the learning arising from this Safeguarding Adults Review in this regard should inform future discussions in respect of proceeding with Safeguarding Enquiries in the absence of consent.

Explore agency responses to safeguarding adult concerns, in particular indications of self-neglect. Were responses to self-neglect consistent with local guidance? Explore the extent to which the principles of making safeguarding personal were applied.
Safeguarding

5.39 When Together Housing raised the first safeguarding concern in October 2021 there was a delay in Adult Social Care (AADT) responding to the concern, although the safeguarding concern stated that Adult F was in hospital when in fact she had been discharged. Adult Social Care did not appear to be responsive to Together Housing's attempts to follow up and check on the progress of the safeguarding concern. It appeared to take two follow up calls from Together Housing and the second safeguarding concern from the FRS to prompt a response in the form of a duty visit. Nor does the Adult Social Care chronology provide any information about any fact finding, assessment of the safeguarding concern and whether it was considered if the criteria for conducting a Section 42 Safeguarding Enquiry had been met.

5.40 The AADT duty social worker's home visit was successful in that the social worker managed to have a substantial in-person conversation with Adult F, gather valuable information and form a view about Adult F's capacity. This was the most significant in-person contact any professional had with Adult F during the period on which the SAR focusses.

5.41 Whilst it is appreciated that the system for responding to safeguarding concerns has since changed, and continues to evolve, the Adult Social Care response to the safeguarding concerns raised by Together Housing and the Fire and Rescue Service in October and November 2021 appears to have ended without any risk assessment, formal closure, review or management oversight.

5.42 The August 2022 safeguarding concern from Together Housing was again responded to by an AADT duty social worker. Together Housing again experienced some difficulty in eliciting information from Adult Social Care about the progress of the safeguarding concern but once they had been provided with a telephone contact for the AADT duty social worker, communication improved significantly. Involving Adult F's mother in the home visit appeared to improve the chances of gaining access. However, there was quite a long delay from the point at which the

safeguarding concern was received (2nd August 2022) and the home visit being attempted (2nd September 2022). This may be partly a hindsight observation but there were indications that Adult F's presentation had begun to deteriorate markedly which may have indicated a more urgent response.

Recommendation 9

Although the Safeguarding Adults Review has been advised that Adult Social Care's process for responding to safeguarding concerns has changed since the three safeguarding concerns were received in respect of Adult F, it is recommended that Calderdale Safeguarding Adults Board obtains assurance in respect of the key learning points arising from the response of Adult Social Care to the safeguarding concerns, specifically:

- *the delay in responding to the first and second safeguarding concerns raised by Together Housing and the difficulties Together Housing experienced in seeking updates on the progression of the safeguarding concerns from Adult Social Care,*
- *the lack of fact finding in response to the first (Together Housing) and second (Fire and Rescue Service) safeguarding concerns, particularly the absence of any contact with Adult F's GP Practice, and*
- *the absence of any progress in relation to the first and second safeguarding concerns following the home visit by the AADT duty social worker on 15th November 2021. When a second home visit went unanswered Adult Social Care's progression of the safeguarding concerns appeared to simply cease without any risk assessment, protection plan, review, management oversight or formal closure and*
- *the effectiveness of management oversight arrangements.*

Self-Neglect

5.43 In order to draw out further learning from the extent to which self-neglect was identified as a concern in respect of Adult F, the SAR will consider insights derived from the body of research on self-neglect conducted over the past decade by Braye, Preston-Shoot and Orr (11) (12) (13).

5.44 The self-neglect research emphasises the importance of paying attention to key transition points. Although several years prior to Adult F's death, a very important transition point was Adult F's transfer from homeless accommodation into her own general needs tenancy in November 2015. It was appropriate for Adult F to be supported to obtain her own tenancy after around a decade of living with her mother. The KeyChoice Support assessment completed at that time stated that Adult F's support needs were 'significant', although it was noted that she would also be receiving daily support from her mother. (Paragraphs 3.14 and 3.14)

5.45 The support worker from the Council temporary accommodation and support service and SmartMove was also to provide support to help Adult F to settle into her tenancy. The support which may have been offered to Adult F is described in Paragraph 3.14, although the content, length and intensity of the tenancy support provided to Adult F at that time is not known.

5.46 The KeyChoice Support Assessment addressed many key issues but understated others, although it is accepted that the assessment was primarily informed by Adult F's stay in Calderdale Council homeless accommodation when Adult F appears to have presented as fairly stable. At the time of this assessment there was quite strong evidence of self-neglect. Partner agencies may have been less aware of self-neglect at that time and responses to self-neglect may have been less well developed.

5.47 That Adult F may not have been fully prepared for an independent tenancy at the time she moved into the Together Housing flat is indicated by the fifteen incidents attended by the Police and Ambulance service during the first five months of her tenancy which related primarily to concerns about her mental health and reports of anti-social behaviour and alcohol misuse (Paragraph 3.11).

5.48 It is not known if Together Housing, Calderdale Temporary Accommodation and Support or SmartMove were informed of any of these incidents. Adult F appears to have become more settled in her tenancy thereafter as from June 2017 until May 2019 – a period of almost two years – she appears to have had little contact with agencies and her visits to her mother's address appear to have become less problematic. However, Adult F's transition into her own general needs tenancy was a very challenging time for her and the impression gained from a distance of several years - and without access to all records of the support provided to Adult F at that time – is that information sharing between all the agencies which were in contact with Adult F during the first five months of her tenancy could have been improved.

Recommendation 10

That Calderdale Safeguarding Adults Board seeks assurance from Calderdale Council Housing Options and the providers of housing locally in relation to the support provided to people such as Adult F who have substantial needs and face challenges in adjusting to a general needs tenancy for the first time or after a lengthy interval since their last tenancy.

5.49 Returning to the self-neglect research completed by Braye, Preston-Shoot and Orr, this research found no single overarching explanatory model for self-neglect, observing that causation is associated with physical health issues, mental health issues, substance misuse and psycho-social factors. Exploring 'psycho-social factors' further, the self-neglect research draws attention to 'diminished social

networks', 'limited economic resources' and 'personality traits including 'traumatic histories/life-changing events' and 'perceived self-efficacy.[21] Adult F appeared to have become very socially isolated, her access to her benefits was tightly controlled by her mother and there were a number of events in her life which could have caused trauma. From the direct interactions between Adult F and professionals it appears that she presented as perceiving herself as having self-efficacy at times (fire safety) whilst at other times she appeared to feel that she needed help (999 calls to Police and Ambulance) but struggled to articulate her needs clearly.

5.50 The self-neglect research also emphasises the importance of a relational approach in order to help professionals 'find the person'. Professionals never really had the opportunity to 'find the person' in Adult F's case although the AADT social worker who responded to the third and final safeguarding concern acknowledged that Adult F's case needed to be allocated for a longer piece of work to be attempted (Paragraph 3.53)

5.51 From the point at which the GP practice nurse conducted a learning disability review of Adult F in October 2020 (Paragraph 3.22), the evidence of self-neglect was very prominent. At the time of that review Adult F was said to be drinking heavily, to be incontinent of urine but to refuse to wear continence pads and to be socially isolated. (A referral to social prescribing could have been considered in respect of the latter issue.)

5.52 Calderdale Hospital documented a safeguarding risk arising from self-neglect during Adult F's June 2021 attendance (Paragraph 3.29) and her October 2021 admission (Paragraph 3.36) but no safeguarding concerns were raised which was a missed opportunity. The SAR Panel questioned whether there are any particular barriers to hospital staff acting on self-neglect concerns. It is acknowledged that during a hospital admission a patient's presentation may well improve and in Adult F's case she would not have access to alcohol, however, for any improvement in health arising from such a hospital admission to be sustained post-discharge, some form of support would likely be needed. The SAR Panel also acknowledged that at the time of this hospital attendance by Adult F, Calderdale Hospital continued to manage significant pressures associated with the Covid -19 pandemic.

Recommendation 11

That Calderdale Safeguarding Adults Board seeks assurance from Calderdale and Huddersfield NHS Foundation Trust in respect of the effectiveness of the action taken when a safeguarding risk arising from a patient's self-neglect is recognised by hospital staff, including assessment and any onward referral.

[21] A person's belief that they can be successful when carrying out a particular task.

5.53 The Calderdale guidance on self-neglect – which the SAR has been advised has been updated since the time of the safeguarding concerns raised in respect of Adult F -emphasises the importance of a robust risk assessment, preferably multi-agency, which includes the views of the adult and their informal networks of support. The guidance states that the risk assessment might cover capacity and consent; indications of mental health issues; the level of risk to the persons physical health; the level of risk to their overall wellbeing; effects on other people's health and wellbeing; serious risk of fire; serious environmental risk e.g. destruction or partial destruction of accommodation. There is no indication that any such risk assessment took place following Adult Social Care's receipt of the safeguarding referrals from Together Housing and the Fire and Rescue Service in October and November 2021 which would be expected practice. However, the independent reviewer takes the view that it shouldn't be necessary to formally raise a safeguarding concern in order to complete a multi-agency risk assessment. West Yorkshire Integrated Care Board has requested the SAR report to highlight that when someone is making risky decisions then a mental capacity assessment must be more detailed and documented, rather than relying on the presumption of capacity. This is a valid point but, as stated above, in Adult F's case the key opportunity to assess the risks she faced from self-neglect was missed.

Recommendation 12

When the learning from this Safeguarding Adults Review is disseminated, that Calderdale Safeguarding Adults Board highlights the importance of conducting a multi-agency risk assessment to inform options for the future support of a person who at risk from self-neglect.

5.54 Looking back at the escalating concerns about Adult F's self-neglect there appears to have been a strong case for arranging for Adult F to have a medical assessment. Her low weight, indications of malnourishment and skeletal appearance were commented upon by several professionals and her mother. No medical assessment took place other than during her hospital admission in October 2021, although on that occasion a planned dietician referral was overlooked. Factors which may have acted as barriers to the need for a medical assessment being recognised include the following:

- Her GP practice appears to have had no contact with Adult F since May 2020. The last measurement of Adult F's weight was an estimate of 51kg provided by her mother in October 2020 which was very similar to the previous 2016 recording of her weight.

- Her GP practice does not appear to have been contacted in respect of the three safeguarding concerns.

- When she was discharged from hospital in October 2021 the notification to the GP did not mention low weight as an issue. Adult F's GP attended the practitioner learning event and said that hospital discharge letters often contain very little detail.
- Concerns about Adult F's weight were included in both the Together Housing and FRS safeguarding concerns submitted in October and November 2021 respectively. At the practitioner learning event it was suggested that 'health' and 'safeguarding' routes are separate pathways for Gateway to direct referrals and that once a referral is directed down the 'safeguarding route' by Gateway, there a risk that the person's physical health needs might be overlooked. However, when poor physical health is identified in a safeguarding concern in relation to self-neglect then this should be addressed through a multi-agency safeguarding response. However, it shouldn't need a safeguarding concern to be raised for a person to receive a medical assessment and Adult F had been admitted to hospital for almost two weeks in October 2021 when she would have been medically assessed.

- Together Housing felt that they were not in a strong position to request a medical assessment for a resident as they would not normally know which GP practice a resident was registered with although the neighbourhood officer offered to help Adult F contact her GP.

Explore agency response to self-harming behaviour and expressions of hopelessness.

5.55 The sequence of intentional overdoses by Adult F over a relatively short period took place 15 years ago (Paragraph 3.6). The position now is that, as then, the patient would be referred to the mental health liaison team. Where there are repeat attendances a referral to the high intensity user group (HIUG) could be considered (See Paragraph 5.72 below). Additionally the Calderdale and Huddersfield NHS Foundation Trust (CHFT) now has a Nurse Consultant for Mental Health. CHFT has also recently reviewed the Missing Person policy with West Yorkshire Police and this now includes a RAG rated risk assessment to identify the level of risk should a patient leave the hospital without a mental health review.

5.56 Adult F's mother said that her daughter had 'given up' and was 'slowly dying' in 2008. This SAR raises the question of when a person is seriously self-neglecting and declining offers of support, whether professionals should more actively explore suicidal ideation with the person.

Recommendation 13

That Calderdale Safeguarding Adults Board should reflect on the learning arising from this Safeguarding Adults Review and partners should consider the question of

whether there is a case for elevating serious self-neglect as an issue where professionals should explore suicidal ideation with the person as they would do if the person had self-harmed.

Explore the extent to which practice was trauma informed[22] and took account of Adult F's history, in particular the removal of her children and the impact this may have had on her mental health and wellbeing and her relationship with professionals.

5.57 Adult F was the mother of four children who were removed from her care, apparently on the grounds of parental neglect. Any trauma experienced as a result of the removal of her children may have been mitigated by the fact that Adult F's elder two children were cared for by her mother under a Residence Order and Adult F lived with her mother for 8/10 years prior to 2015 so would have lived in the same house as her two elder children. It is not known whether she was involved in their upbringing. The Adult Social Care chronology states that a child of Adult F still living with Adult F's mother did not accept Adult F as his mother or speak to her.

5.58 Although the research literature is limited, it demonstrates that the removal of a child from the mother (at birth) can be 'acutely traumatic' and has a 'far reaching impact' (14). Women from whom their children have been removed at birth described it as 'deeply distressing and de-humanising' with shame and stigma also present (15). One study posited the construct of 'disenfranchised grief' which captures the lack of social acceptance of this particular form of grief when a child is removed at birth (16).(Adult F's children were not removed from her care at birth).

5.59 There is some evidence that the removal of her children may have affected Adult F's view of professionals, in particular social workers, and contributed to her reluctance to engage with services. Her mother said that Adult F 'hated' 'social services' because they 'took her children from her' (Paragraph 3.54) and when Adult F declined the offer of support from the social worker in November 2021, she appeared to equate the support offered with being placed in a care home (Paragraph 3.42).

5.60 It is not known whether Adult F's long term consumption of alcohol was related in any way to the removal of her children. This seems likely, although Adult F did not cite this as an issue which triggered any of her series of intentional overdoses during

[22] Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing.

2008 and 2009 (Paragraph 3.6), which would have been 4 to 5 years after the formal removal of her children from her care.

5.61 It is not known whether Adult F was offered support when her children were removed. The SAR has been advised of Change Together – a service for women in Calderdale – which offers a bespoke service including 1:1 / group work for women who have had children removed from their care. The support provided by Change Together is aimed at 'moving women on', focussing on a range of needs past, present and future including loss, anger, substance misuse, mental health issues, domestic abuse, self-esteem and confidence building. The service also refers to helping women to heal, to recover a sense of self and identity and move their life forward before thinking about becoming a parent again. Change Together is a Calderdale Council commissioned service.

Recommendation 14

That Calderdale Safeguarding Adults Board shares the learning from the Safeguarding Adults Review with Change Together, particularly the potential long term impacts on parents of the removal of their children including alcohol misuse and self-neglect.

5.62 In addition to the removal of her children Adult F's mother said that her daughter had a difficult childhood, that her husband had been abusive and that she had suffered a traumatic assault from her last partner. Additionally, Adult F disclosed a rape to the Police in 2015 and told the social worker she saw in November 2021 that she had experienced a house fire.

5.63 The social worker who saw Adult F in November 2021 was able to gather much of this information from speaking to Adult F's mother (Paragraph 3.43) but there is no indication that this information and her mother's view that Adult F did not respond well to authority figures led to the adoption of a trauma-informed approach thereafter. The lack of a coordinated multi-agency response to Adult F's safeguarding needs appears to have been a key factor in the lack of consideration of a trauma-informed approach. Other reviews have been undertaken in Calderdale which have highlighted trauma and Calderdale is part of the West Yorkshire Trauma Adversity Resilience Group which has a joint ambition to work together with people with lived experience to ensure West Yorkshire is a trauma informed and responsive system by 2030 (17).

Explore agency assessment of and responses to Adult F's alcohol consumption.

5.64 There were longstanding concerns about the impact of alcohol dependency on Adult F's mental and physical health and she was diagnosed with liver disease in

2007 or 2008. Adult F was frequently noted to be intoxicated when she came into contact with agencies, and she had sequences of alcohol related hospital admissions or attendances in 2008/2009 and in 2021.

5.65 However, there is a lack of clarity over the amount of alcohol Adult F was consuming or how she was obtaining it, given the apparent limits placed on her benefits. She appeared to believe that her use of alcohol was not problematic (KeyChoice Support Assessment completed in 2015). Adult F frequently declined referral or self-referral to Recovery Steps and the service has no record of providing any service to her.

5.66 There were also concerns about her general physical health which may have interacted negatively with her alcohol use such as very low weight – which may have resulted in her becoming intoxicated on lower levels of alcohol consumption – and her hyponatraemia and hypokalaemia due to reduced oral intake.

5.67 At the manager learning event it was stated that there are many people like Adult F living in Calderdale whose alcohol use is extremely problematic. The most recent figures the SAR has been able to access (2012/2013) stated that Calderdale:

- had a significantly worse rate of alcohol related harm hospital stays for adults than the average for England,
- has the worst mortality rate in the region for females aged under-75 with liver disease and
- is significantly higher than the England average for Alcohol Specific Hospital admissions for males, females and those under 18; alcohol related Hospital admissions for males and females; admission episodes for alcohol related conditions; binge drinking (percentage of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session); employees in bars (as a percentage of all in employment).

5.68 It was estimated that there are 9049 higher risk drinkers in Calderdale. It is assumed that Adult F would have been classed as a higher risk drinker although there is a lack of clarity over the amount of alcohol Adult F was actually consuming.

5.69 Recovery Steps have contributed to this SAR and acknowledge that they only engage with a relatively small number of dependent drinkers and they are constantly exploring ways of improving this engagement. This is a national challenge. NHS England state that some estimates indicate that less than 20% of alcohol dependent people are accessing treatment, leading to late presentations through emergency care, creating demand for more specialist – and costly – NHS care (18). Recovery Steps advised the SAR that had Adult F been willing to engage with them they would have adopted a harm reduction approach, focussing on small steps such as advising

her to switch to drinks with a lower alcohol content and improving her nutritional intake. Recovery Steps also felt that had any professional managed to engage with Adult F then they could have asked her if they could bring someone along from Recovery Steps to the next meeting. They acknowledged that their liaison with the hospital could be better and advised that Recovery Steps had recently appointed a hospital liaison officer to begin to address this issue. It may be worthy of note that NHS England have improved the quality of alcohol related care in hospitals by establishing Alcohol Care Teams on a trial basis in a number of hospitals which had succeeded in significantly reducing A&E attendances, bed days, re-admissions and ambulance call outs. Over the next 5 years hospitals with the highest rate of alcohol dependence related admissions will be supported to establish Alcohol Care Teams (19). It is not known whether Calderdale Royal Hospital will be one of the hospitals identified.

5.70 Developing Recovery Step's point about opportunities to engage with people through their prior contact with other services, there may have been other opportunities to encourage Adult F to self-refer to Recovery steps such as the multiple arrests made by the Police following incidents at her mother's address when Adult F was under the influence of alcohol. In regularly arresting Adult F to prevent a breach of the peace and detaining her in a cell overnight before placing her before the Court – and continuing to do so after the Court Manager asked them to consider more imaginative options - the impression gained is that at that time Adult F may have been regarded as a 'troublesome drunk'. The Police deal with a large number of people when they are affected by alcohol. The SAR has been advised that Police Officers do have some training and awareness of the support services available and have workers from Liaison and Diversion who work within their custody suites and are able to signpost arrested people to support services. It is noted that the FRS prevention officer offered Adult F smoking cessation advice. Could they also offer advice on seeking help with alcohol given that a high percentage of fire fatalities in the home involve drink or drug related behaviour? (Paragraph 3.38)

5.71 Adult F's mother could have been offered a referral to Recovery Steps as a family member affected by Adult F's alcohol use. Her mother said that she attempted to restrict her daughter's consumption of alcohol through tightly controlling her finances. Her mother may have benefitted from advice from Recovery Steps who have a 'concerned others' offer to family members which is delivered via groupwork, 1:1 and telephone support. They are currently supporting around 30 family members on the 'concerned other's programme.

Recommendation 15

That Calderdale Safeguarding Adults Board request Recovery Steps to provide advice to partner agencies who come into contact with people who may be misusing alcohol so that the staff of relevant partner agencies are sufficiently well informed to

advise about the local support available, how to access it and encourage the person to self-refer. Recovery Steps should also be requested to highlight to partner agencies the support available for family members affected by someone else's drinking.

Explore the extent to which professional concerns about Adult F were escalated. Given the complexities of the case, how did agencies and practitioners use supervision and reflection? Explore the extent to which case closure decisions were informed by current needs and risks.

Escalation

5.72 In June 2020 the community matron considered referring Adult F to the high intensity user group (HIUG) but Adult F did not meet the criteria (Paragraph 3.21). As stated, the High Intensity User Group at the Calderdale & Huddersfield NHS Foundation Trust (CHFT) is a multidisciplinary group covering both Calderdale and Huddersfield. The SAR has been advised that the HIUG referral criteria have been reviewed and are now as follows:

- any adult who has had either 4 or more attendances to A&E or calls to YAS in a calendar month period,
- has complex health needs and
- has 'safeguarding issues'.

Although Adult F's sequence of hospital attendances - 3 occasions between 17th May and 1st October 2021 (Paragraphs 3.27, 3.29, 3.34) would not have met the first bullet point of the revised criteria for a HIUG referral, she could have been referred to the HIUG on the grounds of 'safeguarding issues'. The SAR has been advised that 'safeguarding issues' are not further defined as the intention is to allow professionals to exercise professional judgement in deciding whether or not to refer someone to the HIUG on the grounds of 'safeguarding issues'.

5.73 Given the difficulty agencies experienced in engaging Adult F in-person, during these 3 attendances including one 12 day admission, Calderdale Hospital had greater opportunity than other professionals in contact with Adult F to attempt to build trust with her and encourage her to access support. Having said this, it is assumed that during her admission Adult F would have been seen by a large number of clinical and non-clinical staff.

5.74 Since Adult F's series of hospital attendances in 2021, CHFT has introduced a Complex Needs MDT, the (non-exhaustive) criteria of which are as follows:

- Patient presents with complex needs that the ward team would like additional MDT support to manage the situation at ward level.
- Increased incidents of agitation which may or may not have required the use of PRN medication.

- Increased need to call security for assistance.
- Standard interprofessional working arrangements have not managed the situation and expertise is required to review the case/situation.
- Complex discharge issues requiring safeguarding/legal/MDT support to the ward team/discharge team.
- If the ward assess and document that the level of risk has escalated or has the potential to escalate, with the patient, and concerns are raised about the safety of the patient, other patients, visitors and staff.

5.75 When speaking to Calderdale professionals in connection with this Safeguarding Adults Review it has become abundantly clear that the learning from 'Burnt Bridges?', a Calderdale Safeguarding Adults Board commissioned thematic review into the deaths of five men on the streets of Halifax during Winter 2018/19 is having a profound impact on professional culture and practice in Calderdale. 'Burnt Bridges' refers to an expression used on numerous occasions by professionals who contributed to that review and is often used to describe how someone might intentionally set out to destroy their opportunities or reputation, behave offensively or not comply with rules – particularly in relation to their perceived ability to maintain a home.

5.76 Learning themes from 'Burnt Bridges?' which are of particular relevance to agency contact with Adult F are the possible presence of trauma in her life, the need to prevent people with multiple and complex needs becoming disengaged from services and the need to recognise that support to sustain a tenancy is not the sole responsibility of one agency.

5.77 One of the tangible outcomes of 'Burnt Bridges' is the MEAM (Making Every Adult Matter) multi-disciplinary meeting process, also referred to by some professionals as the 'Complex Lives' MDT. The aim of this intervention is to maximise support for people with complex and multiple needs, maximising on system-wide resources and the sharing of information. The criteria for referral are people with complex needs who are falling through gaps between services and systems who meet 3 or more of the following criteria:

- Unstable housing
- Substance misuse
- Contact with the criminal justice system
- Mental ill health
- Domestic abuse

The MEAM MDT adopts a flexible approach to considering the following additional clinical and social risks:

- Learning/intellectual disability
- Traumatic head injuries

- Care leavers

The MEAM MDT also recognises that Black and Asian Minority Ethnic Groups and Women may be underrepresented in the criteria set out above.

Full MEAM MDT meetings take place on a Friday. These meetings have full agendas and so there may only be time for a short solution focussed discussion of individual cases leading to ongoing work outside the meeting. Separate individually focussed meetings can be arranged when presenting a new case or for particularly complex cases.

5.78 Adult F was not referred to the MEAM MDT. The period during which concerns were increasing in relation to Adult F – May 2021 until September 2022 – may have occurred prior to the MEAM MDT process becoming fully embedded. However, applying the MEAM MDT criteria to Adult F, a referral could have been considered on the grounds of 'unstable housing' (the AADT social worker was concerned that Adult F's tenancy may be at risk), 'substance misuse' (long term alcohol misuse), 'contact with the criminal justice system' (although her substantial contact with the criminal justice system was mainly during earlier years) and mental ill health (no diagnosis although prolonged alcohol misuse may have begun to affect her cognitive abilities) and 'learning/intellectual disability (no confirmed learning disability diagnosis although she was on her GP Practice learning disability register).

5.79 There was an opportunity for Together Housing to formally escalate Adult F's case to a Senior Manager in Adult Social Care using the multi-agency Escalation Procedures following the apparent withdrawal of Adult Social Care after the unsuccessful attempt to visit Adult F at home on 4th January 2022 (Paragraph 3.46). The SAR has been advised that the issue of Escalation Procedures not being invoked has often been highlighted in previous statutory reviews. This is also the experience of the independent reviewer. The typical response has been for the relevant partnership board to promote or re-promote the Procedures. Together Housing has advised the SAR that they have been working to build the confidence of their staff to make use of internal and multi-agency Escalation Procedures.

5.80 It may be worthy of note that the 2022 Annual Review of child safeguarding practice review (CSPR) reports included the following message for practice:

'All safeguarding agencies need to promote cultures that give their staff the confidence to ask questions. Staff need to be able to both give and receive challenge and work together to resolve professional differences' (20)

Whilst this message for practice was addressed to safeguarding children professionals, it is of equal relevance for safeguarding adults professionals.

5.81 An important word in this message for practice is ‘culture’. Organisational culture is often defined as the set of values, beliefs, attitudes, systems, and rules that outline and influence employee behaviour within an organisation. It is therefore suggested that in addition to re-promoting the Escalation Procedures, the Safeguarding Adults Board considers how to promote a culture in which professionals perceive challenge and escalation as a positive intervention which serves to promote the safety and wellbeing of adults at risk of abuse and/or neglect.. Changing organisational culture can be challenging but steps which could be considered include monitoring the use of the Escalation Procedures on the basis that ‘what gets measured, gets done’, positive reinforcement by praising the use of the policy by professionals and agencies operating in a manner which indicates that not only are they open to challenge but that they actively welcome it.

Recommendation 16

That Calderdale Safeguarding Adults Board further promotes their Escalation Procedures and also considers how to promote a culture in which professionals perceive challenge and escalation as a positive intervention to promote the safety and wellbeing of adults at risk of abuse and/or neglect.

Supervision

5.82 The Together Housing neighbourhood officers had access to supervision in the form of oversight of the case although the author of the Together Housing chronology observed that management oversight could have been more frequent. The neighbourhood officers also had access to valuable advice from Together Housing’s safeguarding team.

5.83 The AADT duty social worker who responded to the first two safeguarding concerns raised by Together Housing and the FRS had access to advice and guidance from supervision although it would have been helpful if the managerial response to the social worker’s request for guidance on the following question had been documented: ‘At what point do social workers intervene even when someone is telling us to go away’.

5.84 The AADT duty social worker who responded to the subsequent Together Housing safeguarding concern also had access to managerial advice and consultation with the AADT Safeguarding Lead.

Case closure

5.85 As previously stated, there is no indication that Adult Social Care formally closed Adult F’s case after the second home visit on 4th January 2022 (Paragraph 3.45) but there is no indication that any further action was taken. The case appeared

to have been closed through inaction. This issue is the subject of Recommendation 9.

5.86 On 8th March 2022 Together Housing closed the internal safeguarding case after further discussion with their safeguarding team. It was documented that there had been 'no further concerns' (Paragraph 3.47). However, there was no indication that anything had changed for Adult F following the internal safeguarding case opened by Together Housing and the two safeguarding concerns raised by Together Housing and the Fire and Rescue Service. Together Housing note that they did keep Adult F's case open for two months after Adult Social Care ceased their response to the safeguarding concerns submitted by Together Housing and the FRS. Together Housing also advise that prior to case closure their procedures require that all cases are discussed with the line manager and advice sought from their safeguarding team if necessary; if the manager feels that the case shouldn't be closed then they will advise on the further action to be taken or agree closure and document the rationale. The SAR Panel felt that this was really good practice by Together Housing and suggested that partner agencies should consider adopting or incorporating this approach to case closure into their policy and procedures.

5.87 Together Housing appear to have been left to largely carry the risks to which Adult F was exposed. However, at the point of proposed case closure by Together Housing, there was an opportunity for a multi-agency discussion to assess risk and consider whether agencies had individually and collectively exhausted their options for offering support to Adult F. There was also an opportunity for Together Housing to have considered escalating their concerns about Adult F after Adult Social Care appear to withdraw from further action in response to Together Housing's first safeguarding referral. It is noted that Together Housing referred Adult F for a Safeguarding Adults Review following her death, rather than any of the statutory agencies involved in her case.

Explore the impact of Covid-19 on both Adult F and her mother as Adult F's carer.

5.88 During the first Covid-19 lockdown, Adult F's neighbours informed Together Housing that she was visiting her mother daily in contravention of Covid-19 restrictions. Given the importance of her daily visits to her mother's address, it is understandable Adult F would have been prepared to continue visiting her mother daily. This emphasises how challenging it was for vulnerable people to comply with the lockdown restrictions. It is not known how Adult F travelled to her mother's address during the lockdown periods. If she used public transport then this may have been less available to her.

5.89 Adult F's mother, who was said to have been shielding, may have been exposed to increased risk from Covid-19 from her daughter's visits. Her mother later

advised Together Housing that a neighbour was purchasing groceries for her and Adult F and delivering them to both women's addresses.

5.90 It is not known whether Adult F or her mother would have met the criteria for additional support during the pandemic. Being on her GP Practice's learning disability register would not have automatically entitled her to support from the local authority during the pandemic.

5.91 Adult F's GP practice suggested that her frequent use of the 999 system to contact the Police and ambulance service during May 2020 (Paragraph 3.16) may have been an anxiety response to the pandemic. This may have been a reasonable interpretation of Adult F's behaviour as she had previously contacted the Ambulance service via the 999 system multiple times when anxious about a forthcoming DWP interview.

5.92 Adult F declined her annual GP health check on 28th May 2020 as her mother was unable to accompany her because she was shielding as a result of the pandemic (Paragraph 3.19).

5.93 Adult F's mother expressed concern that her daughter had not had a her Covid-19 vaccinations. The SAR Panel has been advised that there was a huge amount of work done with people with a learning disability to vaccinate this group, including special clinics with individualised plans. When people attended these clinics they also received information and support around the restrictions. The ICB produced guidance on vaccinations for people where mental capacity was an issue and this was widely circulated with Care Homes and GP practices being targeted specifically.

5.94 It is not known whether the pandemic affected Adult F's alcohol consumption. Research suggests that drinking may have become more entrenched for some people during the pandemic although Adult F's alcohol consumption already appeared entrenched. One wonders whether the subsequent concerns about Adult F's malnourishment may have had their origin in the pandemic lockdowns when she may not have been able to visit her mother so regularly for meals.

5.95 The Ambulance service was unable to attend Adult F's address on one occasion due to 'critical demand levels' – a situation which may have been affected by the additional pressures of the pandemic (paragraph 3.29).

Good practice

- Both the YAS and Police call takers responded to the large number of 999 calls made by Adult F during May 2020 with patience and compassion despite

the fact that she appeared to be regularly misusing the 999 system (Paragraphs 3.16 and 3.17).

- On 12th June 2021 the Police transported Adult F to hospital when the Ambulance service was unable to do so because of critical demand levels (Paragraph 3.29).

- On 14th October 2021 Together Housing consulted their safeguarding team and developed a comprehensive plan in response to escalating concerns about Adult F. The plan included a safeguarding referral, a referral to the Fire and Rescue Service and contingency plans should the safeguarding referral not be accepted (Paragraph 3.37).

- Generally, Together Housing front line neighbourhood officers adopted a commendably persistent, flexible, compassionate and supportive approach, advocated for Adult F during her October 2021 hospital admission and attempted to engage constructively with Adult Social Care.

- The Together Housing neighbourhood officer rang the hospital during Adult F's October 2021 admission to advocate for Adult F and also shared information with the hospital about Adult F's needs including her hearing impairment (Paragraph 3.35).

- The Together Housing approach to case closure; - prior to case closure their procedures require that all cases are discussed with the line manager and advice sought from their safeguarding team if necessary; if the manager feels that the case shouldn't be closed then they will advise on the further action to be taken or agree closure and document the rationale.

6.0 List of Recommendations

Recommendation 1

That when Calderdale Safeguarding Adults Board disseminates the learning from this Safeguarding Adults Review, it highlights the importance of obtaining the consent of an adult to contact a family member or third party to advocate on their behalf as the best option whilst recognising the benefit of working with family members such as Adult F's mother to try and improve professional engagement with her daughter. The adverse impacts on Adult F arising from professionals defaulting to contact with her mother should also be highlighted.

Recommendation 2

That Calderdale Safeguarding Adults Board requests a progress report from West Yorkshire Police in respect of the Adult Protection Team in Calderdale and that the report should focus in particular on the support provided to rape victims with the protected characteristics of learning disability/difficulties and hearing impairment.

Recommendation 3

That Calderdale Safeguarding Adults Board requests the NHS West Yorkshire Integrated Care Board to work with Calderdale GP Practices to develop pathways which enable reasonable adjustments to be made where patients on their learning disability registers experience difficulties in ordering and collecting prescribed medication.

Recommendation 4

That Calderdale Safeguarding Adults Board requests the NHS West Yorkshire Integrated Care Board to work with Adult F's GP Practice to develop a pathway which highlights patients on the GP Practice's learning disability register who:
(i) have not attended or been brought to their annual health check and
(ii) there is also information which indicates risk of harm to the patient,
so that such patients can be discussed at the GP Practice's vulnerable adult meetings. If it is possible for Adult F's GP Practice to develop such a pathway, the NHS West Yorkshire Integrated Care Board may wish to share this more widely with Calderdale GP practices as good practice.

Recommendation 5

That Calderdale Safeguarding Adults Board requests West Yorkshire Fire and Rescue Service (Calderdale District) to advise them of the reasonable adjustments

they take to ensure that adults with learning disability/learning difficulty are provided with information and support which meets their needs.

Recommendation 6

When Calderdale Safeguarding Adults Board disseminates the learning from this SAR, that Adult F's mother's role as her daughter's carer is highlighted as well as the fact that professionals from a range of agencies did not recognise her mother as Adult F's carer. There may also be merit in sharing the learning from this SAR in relation to the lack of recognition of Adult F's mother as her daughter's carer with the Calderdale Cares Partnership. When the learning from this Safeguarding Adults Review is disseminated, that Calderdale Safeguarding Adults Board highlights the importance of conducting a multi-agency risk assessment to inform options for the future support of a person who at risk from self-neglect.

Recommendation 7

That Calderdale Safeguarding Adults Board ensures that the learning from this Safeguarding Adults Review in relation to executive functioning, specifically the importance of noticing any variance between a person's stated awareness of an issue and their observed behaviour in relation to that issue, informs the local Mental Capacity Act training provided in Calderdale.

Recommendation 8

That Calderdale Safeguarding Adults Board is invited to note the professional concern which arose in Adult F's case over the ability to proceed with a Section 42 Safeguarding Enquiry in the absence of Adult F's consent and that the learning arising from this Safeguarding Adults Review in this regard should inform future discussions in respect of proceeding with Safeguarding Enquiries in the absence of consent.

Recommendation 9

Although the Safeguarding Adults Review has been advised that Adult Social Care's process for responding to safeguarding concerns has changed since the three safeguarding concerns were received in respect of Adult F, it is recommended that Calderdale Safeguarding Adults Board obtains assurance in respect of the key learning points arising from the response of Adult Social Care to the safeguarding concerns, specifically:

- *the delay in responding to the first and second safeguarding concerns raised by Together Housing and the difficulties Together Housing experienced in seeking updates on the progression of the safeguarding concerns from Adult Social Care,*

- *the lack of fact finding in response to the first (Together Housing) and second (Fire and Rescue Service) safeguarding concerns, particularly the absence of any contact with Adult F's GP Practice, and*
- *the absence of any progress in relation to the first and second safeguarding concerns following the home visit by the AADT duty social worker on 15th November 2021. When a second home visit went unanswered Adult Social Care's progression of the safeguarding concerns appeared to simply cease without any risk assessment, protection plan, review, management oversight or formal closure.*

Recommendation 10

That Calderdale Safeguarding Adults Board seeks assurance from Calderdale Council Housing Options and the providers of housing locally in relation to the support provided to people such as Adult F who have substantial needs and face challenges in adjusting to a general needs tenancy for the first time or after a lengthy interval since their last tenancy.

Recommendation 11

That Calderdale Safeguarding Adults Board seeks assurance from Calderdale and Huddersfield NHS Foundation Trust in respect of the effectiveness of the action taken when a safeguarding risk arising from a patient's self-neglect is recognised by hospital staff, including assessment and any onward referral.

Recommendation 12 (now incorporated into Recommendation 6)

When the learning from this Safeguarding Adults Review is disseminated, that Calderdale Safeguarding Adults Board highlights the importance of conducting a multi-agency risk assessment to inform options for the future support of a person who at risk from self-neglect.

Recommendation 13

That Calderdale Safeguarding Adults Board should reflect on the learning arising from this Safeguarding Adults Review and partners should consider the question of whether there is a case for elevating serious self-neglect as an issue where professionals should explore suicidal ideation with the person as they would do if the person had self-harmed.

Recommendation 14

That Calderdale Safeguarding Adults Board shares the learning from the Safeguarding Adults Review with Change Together, particularly the potential long

term impacts on parents of the removal of their children including alcohol misuse and self-neglect.

Recommendation 15

That Calderdale Safeguarding Adults Board request Recovery Steps to provide advice to partner agencies who come into contact with people who may be misusing alcohol so that the staff of relevant partner agencies are sufficiently well informed to advise about the local support available, how to access it and encourage the person to self-refer. Recovery Steps should also be requested to highlight to partner agencies the support available for family members affected by someone else's drinking.

Recommendation 16

That Calderdale Safeguarding Adults Board further promotes their Escalation Procedures and also considers how to promote a culture in which professionals perceive challenge and escalation as a positive intervention to promote the safety and wellbeing of adults at risk of abuse and/or neglect.

References

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Appendix A

Process by which safeguarding adults review (SAR) conducted.

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Membership of the SAR Panel:

Lorraine Andrew - Service Manager, Prevention & Early Help and Safeguarding Lead, Calderdale Adult Social Care.
Julia Caldwell - Business Manager, Calderdale Safeguarding Children Partnership and Safeguarding Adults Board.
Michael Cox – Detective Chief Inspector, West Yorkshire Police.
Emma Cox – Associate Director, Nursing quality and Professionals, South West Yorkshire Partnership NHS Foundation Trust.
Alison Edwards – Head of Safeguarding, Calderdale and Huddersfield NHS Foundation Trust.
Sally Fletcher – Learning and Improvement Officer, Calderdale Safeguarding Partnerships.
Julie Hartley - Serious Incident Review Co-ordinator, Calderdale Safeguarding Adults Board
Catherine Holliday – Named Nurse for Safeguarding, Yorkshire Ambulance Service.
Nicola Kyser-Forrest – Homelessness Manager, Calderdale Housing Options.
Sue Lewis – Strategic Lead, Together Housing Zoe Aspinall – Safeguarding Manager, Together Housing
David Mellor - Independent Reviewer
Gemma Stead - Safeguarding Manager, Adult Services and Well-Being, Calderdale Adult Social Care.
Luke Turnbull - Designated Nurse, Safeguarding Adults, Calderdale Cares Partnership, West Yorkshire Integrated Care Board.

Chronologies which described and analysed relevant contacts with Adult F were completed by the following agencies:

- Calderdale Council Adult Social Care
- Calderdale and Huddersfield NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Together Housing
- West Yorkshire Integrated Care Board.
- West Yorkshire Police
- Yorkshire Ambulance Service

Additionally a short report was provided by Calderdale Council Housing Options.

The chronologies were analysed and issues were identified to explore with managers and practitioners at two learning events facilitated by the lead reviewer.

As stated earlier in the report, Adult F's mother decided not to contribute to the SAR.

The independent reviewer developed a series of draft reports which reflected the chronologies, the contributions of practitioners and managers who attended the learning events, a conversation with a manager from Calderdale Recovery Steps and the views of SAR Panel members.

The report was further developed into a final version and will be presented to Calderdale Safeguarding Adults Board.