Trafford Strategic Safeguarding Partnership

SAR MM overview report.

October 2021

MM pen picture

MM was 39 years old at the time of her death. She lived with her partner and her child (now an adult) and lived in close proximity to another family member.

MM's physical and mental health was poor and she had a history of exposure to traumatic events that impacted her well-being as an adult.

She experienced difficulties in relation to alcohol consumption and despite severe physical impacts resulting from this, MM found it difficult to reduce her consumption or remain abstinent from alcohol.

She did not engage with medical treatment, this may have been because she was unable to manage communications from medical services, or because she was self-neglecting. The impact of this lack of engagement was that MM's physical and mental health continued to decline throughout her adult life.

During the last year of her life MM had very limited mobility which exacerbated her poor physical health.

The adults who lived with and close to MM also experienced health and well-being issues and were each, in their own way vulnerable, making it difficult for them to provide care for MM. It is not clear whether MM's decision-making in relation to treatment and care was compromised by her mental and physical health or whether this was explored by professionals.

MM's child was subject to exploitation and became involved in associated anti-social behaviour. MM's home was targeted by exploiters thereby increasing her own and her family's vulnerabilities.

It appears that agencies worked to support the family however there was no nominated lead professional or agency to coordinate multi-agency involvement and respond to whole family dynamics and co-dependencies.

Lessons Learnt

1. **Primary care safeguarding responsibility**. The GP should have taken a more proactive role in ensuring the safeguarding of MM and her family. It was not sufficient to identify risk, make a referral and not to follow that up with further enquiry and if necessary support, to ensure the family unit and particularly MM was safeguarded and protected from neglect/self-neglect

2. **Enhancing the chances of home detox success**. Home detox courses are far more likely to have successful outcomes if the client has a package of support at home that supports the detox programme. The home detox programme should not be seen in isolation as an intervention but should be regarded as a programme required to be supported by other interventions to enhance chances of success. These interventions would typically be to do with client motivation and trauma informed support.

3. **Agencies do not understand the need of support in home detox.** Where home detox is offered as a potential treatment agencies need to work together to support and enhance home stability and have a trauma informed approach to contact with the service user. Such a partnership approach can be used to manage and mitigate risk and enhance client success.

4. **Consideration of the impact of detox on a person's physical and mental health and potential for relapse.** Safe detox should only be supported or facilitated in conjunction with substance misuse services. Their specialist approach will involve a contextual understanding of the person relative to their history, their family, their community and their motivation. Such specialist support will inform and enhance the effectiveness of other supporting partners.

5. **Lack of professional curiosity by Adult Social Care (ASC) upon receipt of the GP letter indicating that MM was going to attempt home detox.** The vague nature of the GPs letter to Social Care required further professional enquiry as to the support that surrounded this treatment and the likely impact on safeguarding for all vulnerable members of the family. In

particular it was not clear who was responsible for what aspects of this intervention.

6. **Housing providers should remain open minded as to the causes of a client's ill-health**. Assumptions are easy to make about unwise decision making in relation to chronic alcohol abuse and ill health, the possibility of other abuse, neglect or self-neglect as impacting on MM's health was likely, but was never examined by colleagues in housing. Best practice would be to rule out other forms of causative abuse that might impact on health.

7. **Housing providers have a general responsibility to consider a tenant's mental capacity under the requirements of the Mental Capacity Act 2005**. Where mental capacity is a believed by the housing provider to be a consideration in relation to specific tenancy issues that are being considered, then advice and guidance should be sought from the Local Authority, which may include considerations of assessment.

8. **Review and amend the safeguarding referral form into Adult Social Care.** A safeguarding referral form that focussed on the needs, expectations and outcomes required by the person, and considered advocacy, safeguarding to date and risk assessment would help ensure an appropriate response from Adult Social Care.

9. **A broader understanding of what constitutes domestic abuse is required from agencies.** The extent to which MM failed to have any control over aspects of her life is suggestive of domestic abuse coercion and control. Where this is recognised as a risk it can be mitigated and managed. Enhanced understanding and training in this area would allow practitioners to recognise the potential for such less obvious forms of domestically derived abuse.

10. **Adult Social Care to review the understanding amongst its professionals as to who is eligible for safeguarding support.** Under S42 Care Act 2014 paragraph 5 identifies that MM was eligible for adult social care which is defined as including:

11. ‘all forms of personal care and other practical assistance for individuals who, by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.’

12. Therefore she was also eligible for safeguarding support, this is at odds with the responding social worker who concluded that mm had no ‘care or support needs at that time’. A person does not need to be eligible for Local Authority services to be eligible for safeguarding. Care and support needs refer to any care and support needs including self-neglect and substance misuse.

13. **Screening team to receive further training about disguised compliance**. . Disguised compliance should be routinely considered where there are concerns about self-neglect. Professional curiosity requires that information provided may not be accepted at face value.

14. **The need to hold an MDT, professionals or strategy meeting.** This was a complex case that required the enhanced information sharing and understanding / allocation of responsibilities that a multi-agency meeting would have facilitated.

15. **All agencies to share the responsibility of leading the enquiry process including the strategy meeting to coordinate enquiries.** The TSSP should promote the principle that a practical consequence of safeguarding being ‘everyone’s’ responsibility is that agencies other than Adult Social Care are required to identify when an MDT is required and are responsible for conducting one. Recognising when agencies other than the Local Authority are best placed to coordinate enquiry processes ensures the sustainability of proportionate responses to safeguarding concerns raised.

16. **A safeguarding lead should have been identified as a result of an MDT.** Without such a defined area of responsibility it is not possible to ensure safeguarding fundamentals (E.g. Capacity assessments, and the ruling in/out of types of abuse.)

17. **Too little is understood by practitioners about how an assessment of capacity is affected by the executive functioning of the mind.** The impact of trauma on the executive functioning of the mind is now well understood. This understanding needs to be incorporated into assessments of capacity because of its impact on the weighing of individual judgements around welfare.

18. **Where there is an option of 'opt in' for Health services and a failure to respond is an indication of 'opting out', there must be a pro-active determination that an individual has opted out in a fully informed manner.** As well as the obvious physical and mental health problems that MM was suffering she was also significantly disadvantaged by her reading ability, thus her likelihood of accessing an 'opt in' service was likely to be disproportionately low.

19. **MM discharged herself from hospital against medical advice, she was deemed to be capacitous against a backdrop of significant evidence regarding her mental health problems, despite this there was still a responsibility on the acute setting, to manage her safeguarding through referral to other agencies.** An appreciation of this ongoing duty of care is a core principle of safeguarding and should underpin actions even where a patient self-discharges contrary to medical advice.

20. **The gravity of the decisions made by MM that might be considered unwise and the ample evidence that an impairment of the mind or brain might be an issue meant that an assessment of capacity was a requirement.** It was therefore not reasonable to continue to engage the principle of 'an assumption of capacity' in these circumstances because of the abundance of evidence to the contrary that suggested the need to assess. An assessment of capacity was not only required under the Mental Capacity Act but would have been highly expedient for those agencies wishing to exhibit the justification associated with a defensible decision model

21. **Children's services involvement in MM's family-the need to access all available information to support accurate assessments and to refer**

safeguarding concerns for adults. MM's son was subject to Child Protection and later Child in need. There is evidence that a more accurate assessment of MM's capacity to care for her son would have been made if Children's services had facilitated the sharing of information by other agencies already engaged with MM. Children's services recorded in their records the decline of MM's health and apparent increasing neglect/self-neglect.

22. **The Care Act 2014 requires that all agencies ensure the safety and wellbeing of the whole family**. Children's services have statutory duties to safeguard adults in the same way that adult services have duties to safeguard children. A safeguarding adult referral should have been made in respect of MM when concerns were identified, in line with Trafford Strategic Safeguarding Partnership policies and procedures.

23. **There were occasions throughout the involvement of Children's services where it would have been questionable whether MM had capacity to consent to elements of any child protection plan or child in need plan.** Parental responsibility comes into question where MM might have lacked capacity to provide consent. There is no evidence that Children's services have considered MM's capacity with respect to decisions she was being asked to make about her son's care.

24. **Housing Agency involvement and responsibilities.** There is evidence that where safeguarding concerns were being dealt with by the housing agency, such safeguarding concerns were not adequately understood or supervised by staff in a managerial capacity, with a view to whether a referral to other agencies was required. Also there was no understanding of the need by housing staff to undertake capacity assessments in relevant circumstances or indeed the training and skills to carry out such assessments.

25. **The overall responsibility under the Mental Capacity Act to undertake capacity assessments and the need for multi-agency meetings**. As has been noted throughout this report the over reliance on an assumption of capacity in the face of evidence to the contrary seems to have prejudiced the care and safeguarding outcomes for MM.

26. **Self-neglect presents a situation where the impact of trauma on a person's ability to self-care must be considered and ruled out as part of any enquiry.** Such trauma informed approaches are becoming regarded as essential to the understanding of why individuals self-neglect because of its impact on executive functioning of the brain. Where there is concern about a person's capacity to make care decisions, as a result of the executive functioning of the brain being affected by trauma, and / or where there are concerns about the impact of substance misuse on the brain function, capacity assessments must be employed.

27. **If at any point a safeguarding multi-agency meeting had been held, then these capacity assessments might have determined whether MM was being neglected, was self-neglecting (Intentionally) or responding to trauma (Unintentionally).** A safeguarding plan would identify capacity assessments required and which agencies were required to conduct them. The safeguarding enquiry process includes establishing a person's capacity to make certain decisions, or decline care, services or treatment and agencies would be held accountable for these assessments.