Strengthening Practice

Safeguarding Adults Rapid Review – Gayle22

Executive Summary

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1. Executive Summary

1.1 Background and context for the review

The Manchester Safeguarding Partnership (MSP) commissioned this Strengthening Practice Safeguarding Adults Rapid Review in November 2021, with a view to understanding and learning from the circumstances surrounding the care of a female adult with care and support needs, who died in 2020 aged early 50's. Gayle was living with morbid obesity, which presented significant challenges to her mobility and independence. This health condition was continually seen in a context of long-term, extreme personal self-neglect, significant environmental neglect of her home, which she shared with her younger adult brother at the time of her death, and continued refusal of most services or other forms of support.

Gayle had been known to the Manchester health and social care system and social housing (at this home address) since the early 2000's. The contact with her across roughly an 18-year period between 2002-2020, is typified by a repeated pattern of referral into Adult Social Care by a number of different agencies, primarily social housing, but also the North-West Ambulance Service (NWAS), Greater Manchester Police (GMP) and the Greater Manchester Fire and Rescue Service (GMFRS). These repeat referrals were punctuated by 3 lengthy gaps in any substantial contact with services, varying from 14 months prior to her death, up to 2 – 2.5 years at other times.

Although there is no evidence that services understood this at the time of their interactions with Gayle, it can be seen from historical information in the primary care record that Gayle had been taken into care as a child at around the age of 9, along with her other siblings, following child protection proceedings due to abuse and/or neglect. These records also indicate that Gayle had developed childhood obesity by the time she was 15, whilst she was living in a children's care home.

During the time-period of this review, another safeguarding case was considered by the Adult Practice Review Panel which also involved a female adult who was living with morbid obesity and other co-morbidities. There were similarities in these two cases, especially in relation to the pattern of care and support needs of an adult living with morbid obesity, the co-occurrence of morbid obesity with self-neglect/persistent refusal of care and support, and recognising the vulnerability and risk profile of adults who are living with morbid obesity.

The relevant features of this second case have therefore also been taken account of in the recommendations in this review that relate to morbid obesity.

1.2 The rapid review process

The review process was based on the Social Care Institute for Excellence (SCIE) rapid review methodology, with a view to achieving a swifter turnaround of safeguarding learning, especially in light of the pressures and constraints created by the Covid-19 pandemic. The review was completed during approximately a 4 month period and consisted of the following elements:

- Provision of a case chronology, from which the independent reviewer developed key lines of enquiry (KLOE) for discussion
- Individual agency meetings and record checks to discuss the KLOE
- Production of an early analysis report, discussed at the Adult Practice Review Panel
- A joint, structured multi-agency practice discussion to discuss in detail the most pertinent episodes of contact with services and the service responses (c. Spring 2013, Winter 2015 and Autumn 2018)
- Production of an accessible executive summary style report, discussed at the Adult Practice Review Panel

Although an extended family member was invited to speak to the independent reviewer, no response was received on this occasion. However, the case notes and additional information provided by several agencies helped to shed light on the circumstances of the case from the point of view of Dean, Gayle's adult younger brother and carer. The chronology and case notes also document Gayle's own self-stated reasons for refusing help and support from others, which help to give an insight into her state of mind and motivations, especially in the final period of contact in Autumn 2018, prior to her death.

1.3 Overview of the case and care scenario

Gayle sadly died in her early 50's, 2 days after admission to hospital early in 2020. An ambulance was called to her home address by her adult younger brother Dean and her family carer, who had a joint tenancy with Gayle at the address. Dean reported that Gayle had fallen 5-6 days prior and had been in roughly the same position since that time. There is evidence that Dean had tried to lift and reposition Gayle, but as she was living with a morbid level of obesity, it had not been possible for him to lift her off the floor onto a chair or the bed.

When the ambulance crew attended the scene, they found Gayle in a chronic and serious state of neglect. The home was in a very dirty and neglected condition, with mice/rat droppings seen on the floor, and there are wider reports of waste hoarding at the property. The ambulance crew took special measures and advice before attempting to provide care to Gayle, as she was confused and considered to be

critically ill, and in particular to plan how to safely lift her from the difficult position she was in, to transport her to hospital. The ambulance crew noted that Gayle had severe ammonia burns and parasites were visible in the skin damage / wounds on her body. She was also observed to have signs of sepsis, and severe necrosis and gangrene to her left foot and lower leg.

It was later confirmed in hospital that she had necrosis in both feet and due to her very critically ill state it was judged that she would not survive any form of surgery or transportation to receive specialist care at another hospital. Gayle sadly died two days after admission. Notes record that a post mortem concluded Gayle's cause of death as 1a. Pneumonia, 1b. Morbid Obesity and Gangrenous left foot and 2. Diabetes Mellitus Ischaemic Heart.

Although it may not have been explicitly known to colleagues involved in Gayle's care or those involved in the wider care scenario around her brother, historical information contained in the primary care record indicate that both Gayle and Dean had been the subject of child protection proceedings in another Greater Manchester borough. As a result, both were placed in care as children. Whilst Gayle had gone on to have children of her own, sadly they were also taken into care or adopted due to neglect. Gayle reported that she stayed in touch with two of her children, mainly via Facebook.

Prior to her death, Gayle had been known to Adult Social Care since June 2002 when a referral appears to have been made concerning her care and support needs, potentially following a period of rough sleeping. The case notes suggest that she had also been known to a housing provider prior to this time, but specific details are limited. Following the closure of Gayle's case by Adult Social Care in March 2003, she became a joint tenant with her brother Dean of a flat with a social housing provider in April 2003. Case notes indicate that Gayle's and Dean's father also came to live with them at the address until his death in Summer 2012. It was at this address that Gayle remained living with her brother until her death in early 2020.

In January 2004, Gayle registered with a local medical practice and remained so until the time of her death. It appears that Dean also registered with the same practice in the same year but was deducted from the patient list in 2010. Dean was therefore not registered with a GP between July 2010 and February 2020 and it has not been possible to ascertain the reason for his removal from the GP patient list in 2010.

The case chronology shows a pattern of engagement with the family over the c.18 year period from 2002 – 2020, which is typified by a repeated pattern of referral into Adult Social Care, mainly but not exclusively by the social housing provider, followed by case closure. These often frequent episodes of contact are punctuated by 3 long gaps, where there appear to have been only limited touch-points with the GP or the housing provider, with relatively limited intervention. These lengthy gaps in contact,

and therefore an absence of care and support for Gayle and Dean, occurred between:

- July 2013 – November 2015, at which time a safeguarding referral had been raised by GMFRS due to the likely fire risk at the property
- c. December 2015 – April 2018, at which point Dean sought help from the housing benefit service as he had reached a point of financial crisis, which resulted in a referral to Adult Social Care and then onto a housing support worker
- November/December 2018 up to the time of Gayle's death in 2020.

At least 10 separate referrals by the social housing provider to Adult Social Care were made between April 2003 and c. Spring 2013, but Gayle's case was closed after the Community Care assessment (sometimes due to ineligibility for social care support) and any initial intervention, which was typically a crisis clean or the provision of some small aids to daily living. Within this period, NWAS and GMP independently made safeguarding / care referrals in August 2012. It is considered likely that the timing of these referrals may be linked to agency presence at the property in relation to the death of Gayle's father.

Throughout this 10 year period Gayle and Dean are noted to be living in unsanitary conditions, which appears to have included a lack of attention to their own hygiene, appearance, nutritional and wider health needs. It is not clear if there were specific signs of waste hoarding at the property throughout this time period, but case notes document that the housing provider was made aware of the extent of the issues at the property, including extensive rubbish bags, refuse, flies and vermin inside the home, in May 2010. The longstanding nature of the situation is confirmed in a case note of a conversation in October 2018, which documents that the medical practice had been aware of Gayle's long-term chronic neglect.

Discussions with agency leads and the provision of additional information in the course of this review process, some of which included self-reporting by Dean, suggests that Gayle in particular was very suspicious and wary of external input or support from public services and often directly rejected support, including home maintenance - or did so *indirectly* by not answering the door or phone, or being evasive about her circumstances or needs for example. The chronology indicates on several occasions that Gayle stated that she did not like accepting help and was likely to view this as 'interference'. There is evidence that Dean was often asked by Gayle not to call anyone for help, and this appeared to be the case even in the weeks leading up to her death, following her fall and the very serious state of her feet and leg wounds.

A significant point and missed opportunity to intervene in Gayle's care and support, was the closure of Gayle's case by Adult Social Care in July 2013, following a referral in February 2013. This is considered significant because it was documented in the social care assessment that Gayle had substantial FACS-eligible needs, but that she had also appeared to make a 'lifestyle choice' to live that way. However, before the case was closed, the housing provider is also documented as informing

social care that Gayle and Dean did not appear to have the skills and knowledge to independently manage a tenancy or their health and hygiene.

Following this there is around a 2-year gap in contact with the family over which time, and continuing through to Gayle's death, it would seem that that Gayle's considerable deterioration in health had been largely hidden from the view of services due to the relatively minimal levels of contact with the family, despite their extreme living conditions and circumstances. There were two further points in late 2015 and Autumn 2018 when greater levels of agency contact with the family were prompted by safeguarding referrals.

In December 2015, separate home visits were completed by the GP, and adult social care accompanied by a fire officer. Family history and a wide range of health needs were noted as being discussed in the GP home visit, but suggestions of help were largely declined. The conclusion of the social worker was that Gayle had capacity to make her own decisions about her care and support, which limited social care intervention.

In Autumn 2018, the final period of concerted contact with Gayle before her death, there was a safeguarding referral which resulted in what appears to have been a thorough Adult MASH (multi-agency safeguarding hub) enquiry into the family's circumstances and adult social care history. This concluded with a risk assessment, which identified 3 main safeguarding risks, which were Gayle's ongoing risk of self-neglect, the decline in her health and social isolation. The Adult MASH also recommended a full Care Act assessment and in the instance of this being refused, either a Care Act Section 11 'no refusals' assessment, or if GL was deemed to have capacity to make her own decisions, to consider diverting the case into the high risk protocol.

During October 2018 the social worker allocated to Gayle's case completed two home visits and after the second is documented as being very concerned about Gayle's presentation. The social worker requested a visit by District Nursing due to concerns about the wound on Gayle's foot and the risk of sepsis. The following day a joint visit was made to Gayle by the social worker and the district nurse and although Gayle was reported as being resistant to the presence of the District Nurse, she did allow her foot wound to be dressed but refused any more visits. The same day, another joint visit was undertaken with a senior social worker specifically to assess Gayle's mental capacity to make decisions about her social care and support needs. The conclusion was that Gayle did have capacity to refuse support.

Although it is noted in the case chronology that it was intended for adult social care to continue to work with Gayle at the family's pace following these visits, and there had been discussion with the GP about Gayle's situation being monitored due to the circumstances, the case was closed at the end of November 2018 as her lack of consent to a care package or other forms of support were judged to be made with capacity, which prevented Adult Social Care from intervening. There is no record of any further contact by community or primary healthcare services with Gayle beyond December 2018.

Although the Adult MASH recommended the need to hold a multi-agency meeting and the allocated social worker is documented as sharing this view, there is no evidence that either an MDT, a referral to active case management, or use of the high risk protocol/managing high risk together pathway were used in practice to find a way forward to address Gayle's self-evident health and support needs.

1.4 The key themes under consideration

8 initial key lines of enquiry were discussed with the safeguarding agency leads. These were:

1. When (if at all) was a family history taken/known in relation to Gayle? To what extent is it normal practice now to understand an adult's history and what would this usually cover?
2. Was Dean's ability, capacity or appropriateness to be a care-giver questioned by practitioners in contact with the family in 2015 or 2018, given the condition that Gayle was regularly found in and an evident lack of attention to basic human needs; and/or when Dean's potential mental health issues / learning disability were raised by several agency safeguarding referrals during 2012 (NWAS, GMP) and 2015 (GMFR) and in GP notes in December 2015.
3. Were any detailed assessments of Gayle's mental capacity made and are these recorded?
4. How does/can a practitioner (then or now) make an objective assessment about the extent to which someone's living conditions represent an immediate or cumulative avoidable harm?
5. When services are supporting people with a level of obesity that significantly reduces their ability to live independently, mobilise, undertake personal care, attend to wider health needs etc is there any local/professional good practice guidance available to practitioners?
6. Is there a clear rationale for why this families' case was not left open to services or regularly followed-up, given the severity of the living conditions, the documented 'chronic neglect' and the volume of referrals/safeguarding concerns raised?
7. Was a multi-agency meeting initiated at any point to discuss the circumstances of this family? Is there a recorded explanation of why / why not?
8. In your review of this case on behalf of your agency, what do you perceive to have been the biggest barriers to escalating this family's case so that it received further organisational or multi-agency scrutiny/discussion?

Based on these initial KLOEs and following discussion with the agency leads in the first stage of the review, 5 key themes of interest around safeguarding practice were generated by the independent reviewer:

- The relevance of family history and previous life course events in adult safeguarding
- The management of long-term self-neglect
- Decision-making and recording around mental capacity
- The plausibility of an adult with additional needs as a family carer
- Morbid obesity as a safeguarding risk factor

1.5 Practice learning points

Key learning points from the review are highlighted below, collated under the 5 themes that the review considered. Although they are based on this particularly complex and extreme case of personal and environmental self-neglect, they are considered to reflect general good practice in working with adults with care and support needs who may be showing signs of self-neglecting behaviour, with or without morbid obesity.

The relevance of family history and previous life course events in adult safeguarding

- In complex cases, including those that involve apparent self-neglect, work sensitively and compassionately with the adult to understand the life course factors that may play a part in their presenting behaviour or mindset
- Record significant disclosures about past adverse experiences (for example, abuse, neglect, exposure to domestic violence), or relevant family and medical history, in digital case notes and records so that colleagues are aware of the information in future referrals and casework
- In safeguarding investigations, ensure that all relevant social and clinical care history is shared to fully inform practitioners' understanding of the case and the judgement of risk

The management of long-term self-neglect

- Avoid characterising persistent self-neglect as a 'lifestyle choice'
- Seek support to manage or escalate complex and enduring cases of self-neglect, using 'business as usual' routes such as:
    - management advice and/or supervisory support
    - call a multi-disciplinary team meeting to discuss the case and agree respective agency roles, including a safeguarding lead
    - agree a robust process and timeframe to review the case and determine further action needed

- Note that any agency can call a multi-disciplinary team meeting if they consider that the circumstances of a case and the level of concern/risk warrant it
- Explicitly consider using psychologically-informed and relational practice, alongside strengths-based practice, when supporting adults who show persistent self-neglecting or other complex behaviour
- Consider carefully with the adult the factors that may be causing or contributing to their inability or unwillingness to self-care, including practical, physical, motivational, emotional or psychological causes
- Complete a global mental capacity assessment which takes into account executive functioning i.e. the ability or motivation of the adult with care and support needs to organise themselves to follow professional/medical advice, initiate a plan of action, or control their behaviour etc
- Where an Adult MASH safeguarding investigation is completed, practitioners in the community should clearly document any rationale for not following the safeguarding risk assessment and recommendations made by the Adult MASH
- Apply the Managing High Risk Together Pathway in cases where risks persist and require a high risk strategy to manage them
- When routine and escalated courses of action have been applied, seek legal advice to discuss what options remain to safeguard the adult with care and support needs

Decision-making and recording around mental capacity

- Do not conflate a positive decision around mental capacity with a decision to close the case or with no need to follow-up – decisions about case closure and any follow-up required should be considered *independently* in light of all the circumstances of the case and with due regard to the significance of the presenting safeguarding risks and how they can be managed
- Collaborate with other agencies to develop a risk management plan for adults with care and support needs who decline help *with* capacity, and who demonstrate ongoing self-neglect
- The mental capacity judgements of one agency should not be automatically adopted by all agencies - decisions around mental capacity should be made independently by the expert/practitioner and relate specifically to the presenting field of need e.g. care needs / medical or clinical needs / housing needs
- Historic agency perceptions of mental capacity are not sufficient to judge ‘in the moment’ mental capacity
- When assessing mental capacity, take into account executive functioning i.e. the ability or motivation of the adult with care and support needs to organise themselves to follow professional/medical advice, initiate a plan of action, or control their behaviour etc

- Seek management advice, supervisory support or specialist advice in relation to mental capacity in complex and/or enduring cases of self-neglect
- Systematically and clearly record in case notes the factors that are considered when making decisions around mental capacity

The plausibility of an adult with additional needs as a family carer

- Avoid making assumptions about family care arrangements, including the ability or willingness of other family members to provide care
- Where there are concerns about the mental or emotional health and/or the cognitive or functional ability of an adult to provide informal care to an adult with care and support needs, practitioners should carefully test out the ability, understanding, experience and confidence of the individual to undertake the caring role
- Refer family members who are providing care for a carers assessment to enable and signpost them to access practical, emotional and financial support
- Seek management advice and/or supervisory support if there are concerns about the ability of the family member to provide the type, level or frequency of the care needed by the adult with care and support needs, to avoid unintentional neglect and/or an escalation of risk

Morbid obesity as an adult safeguarding risk factor

- Recognise that adults living with morbid obesity are very likely to have health, care and support needs relating to some of the following factors:
    - an increased risk of other life-limiting health conditions in particular type 2 diabetes, heart disease, stroke and some types of cancer
    - poor mobilisation
    - falls and an inability to independently lift once fallen
    - physical immobility that may affect independent living, including cooking, cleaning and personal care
    - poor psychological health and wellbeing, which may be linked to the effects of social isolation, as well as factors like low self-esteem
- Be aware that safeguarding risks associated with morbid obesity *alongside self-neglect* may lead to the onset or exacerbation of life-limiting co-morbidities such as diabetes or cardio-vascular disease
- Be aware that long-term morbid obesity, which may start in childhood and extend into adulthood, can be associated with adverse experiences and traumatic events in childhood

1.6 Summarising commentary

Throughout this independent review is has been repeatedly confirmed that the combination of *ongoing and extreme* personal and environmental self-neglect in this case, alongside a firm reluctance to accept support, is seen relatively rarely in adults with care and support needs in the Manchester area. This is not to say that self-neglect is uncommon, but that it is unusual to see it in this form. This leads to a natural question of why successive professionals involved in the case over a period of nearly 20 years did not intervene more robustly or ensure ongoing oversight of the family, when the self-neglect was so self-evident and extreme.

It has not been possible to resolve this important question in the course of the review, but agency leads were specifically encouraged to reflect on this in discussion with the independent reviewer. Some of the hypotheses discussed included:

- Is self-neglect consistently recognised and do practitioners have the underpinning skills and knowledge to consider the safeguarding implications of short, medium and long-term self-neglect?
- Do practitioners and managers understand and know how to rigorously apply the levers that are available to them to manage the risks associated with very challenging and ongoing cases of self-neglect?
- Were practitioners who knew the family desensitised to the conditions in which Gayle was living and her continual refusal of support?
- Did a form of collective 'groupthink' develop amongst professionals, driven by the difficulty and seeming intractability of the scenario?
- Was it difficult for professionals to relate to the situation in front of them, or draw on other similar professional experience, to therefore have self-confidence in how to work with Gayle and feel that they could have a positive impact on the situation?

A further apparent barrier in professionals' approach was having sufficient interest in or curiosity to understand how this very extreme and unusual scenario had developed. This appears to have at least partially been driven by a lack of information on or attention to Gayle's personal and family history, the most significant elements of which were available within health records. This is coupled with an apparent reluctance by professionals and practitioners to ask or seek to understand.

Had Gayle's extremely sad, complex and difficult personal history been known about, it could have provided a more nuanced and refreshed understanding of her situation, which may have reframed the way colleagues approached working with her. Instead, there seems to have been an underlying view that the way she was

living was a lifestyle choice and this view seemed to tacitly persist through to the final period of contact with her in 2018.

Although the key events of this case pre-date Manchester Safeguarding Partnership's publication of its self-neglect resources in 2019 and new insights around executive function have emerged since that time, the review explored the likelihood of self-neglect being misidentified as a 'lifestyle choice' *now*. Colleagues who participated in the multi-agency practice discussion felt that this thinking probably remained influential at a practice level. Attributing complex, unusual behaviour including self-neglect to a lifestyle decision is unhelpful and tends towards blaming the individual, whilst also distracting from the underlying emotional and psychological drivers of self-neglect. It is important that this is clarified in the MSP's self-neglect resources and any training.

On a similar theme, morbid obesity is also often regarded simplistically as a diet and physical activity imbalance, although for many adults who are overweight or obese, this is likely to be the root cause. However, when *morbid obesity* is seen in the context of complex behaviour and self-neglect, it is important that there is a shift in contemporary practice and thinking across health, social care and wider services, which actively recognises the very real care and support needs of adults living with morbid obesity, and the safeguarding risk associated with self-neglect alongside the already life-limiting co-morbidities related to morbid obesity.

Finally, one of the defining features of this case was the weak application of mental capacity assessment (MCA) and the misappropriation of a positive MCA assessment to close a case or cease follow up. The Adult Practice Review Panel helpfully noted that mental capacity assessment is often perceived as having a binary yes/no outcome, when in the real-world the decision is actually much more complex and nuanced, particularly in cases of self-neglect. A number of the agency discussions also reflected the ongoing challenges of embedding best MCA practice across the public-facing workforce. These insights indicate a need to jointly review the availability and quality of MCA training and continuing professional development provided by agencies across the Manchester Safeguarding Partnership and ensure that it evolves to address the practice challenges of working with self-neglect and assessing executive function.

1.7 Recommendations

The following themed recommendations focus attention on system-level issues that are relevant to all safeguarding partners and wider organisations and are designed to support the development of solutions to some of the practice issues seen in this Safeguarding Adults Review.

There are no specific recommendations that relate to the issue of the plausibility of an adult with additional needs as a family carer. This is because a comprehensive range of recommendations around carer support and good practice have been

flagged and actioned following the recent Carers Thematic Learning Review, published by the Manchester Safeguarding Partnership in January 2022: https://www.manchestersafeguardingpartnership.co.uk/wp-content/uploads/2016/08/2022-01-20-MSP-Carers-Thematic-Learning-Review-Executive-Summary.pdf

The key messages from this review in relation to supporting family carers mirror those in the Carers Thematic Learning Review – to ensure the carer is recognised and appropriately supported in all routine contact with agencies, and through carer assessment and by signposting into specialist information and advice. These are all opportunities to identify and address concerns about the capacity or ability of the carer to meet the needs of the adult with care and support needs and are approaches that would have also been appropriate courses of action in this case.

Life course perspectives on safeguarding adults

1. The Manchester Safeguarding Partnership Agency Safeguarding Leads should consider collaboratively developing guidance that supports practitioners to use simple, relational and conversational methods to gather family and personal history *directly* from adults who are showing self-neglecting or other complex behaviour
2. The Manchester Safeguarding Partnership should seek assurance from the statutory partners and wider organisations with safeguarding responsibilities that they have in place the necessary guidance or frameworks that support practitioners to confidently record and share relevant historic or sensitive information between agencies - in line with the Care Act and GDPR - in order to effectively support and safeguard adults with care and support needs
3. The Manchester Safeguarding Partners should build on current trauma-informed practice and developments by considering the feasibility of a broader offer of trauma-based psychologist 'consultancy' for practitioners who are working with very complex and enduring cases of adult self-neglect or complex behaviour

Self-neglect and mental capacity

The MSP should:

4. Review and update the Manchester Safeguarding Partnership self-neglect toolkit and practice resources generally, and specifically to:
    - Reinforce the message that the case of an adult with care and support needs should not be automatically closed or not followed up, purely on the basis of a decision that they *have* mental capacity
    - Challenge the characterisation and perception of persistent, serious self-neglect as a 'lifestyle choice'
    - Provide additional guidance to support contextually relevant decision-making in cases of severe personal or environmental self-

neglect/hoarding, especially when supporting adults who have serious underlying health conditions

- Raise awareness of:
    a. the link between the development of morbid obesity with adverse experiences in childhood
    b. the safeguarding implications of self-neglect alongside adult morbid obesity

5. Proactively explore with practitioners across different professions and organisations what are the barriers to consistent and sound mental capacity practice in cases of self-neglect, including the use of 'business as usual' support such as seeking management advice or supervision support, as well as specific provisions such as the Managing High Risk Together Pathway
6. Reinforce at a managerial level the importance of offering appropriate levels of oversight and support to recently qualified or relatively inexperienced colleagues who are allocated cases featuring complex behaviour and/or self-neglect
7. a) Explore the feasibility of jointly commissioning an online combined MCA and self-neglect (including executive decision and function) learning module, which supports best integrated care practice across social care, health and housing

   b) Consider mandating annual combined MCA and self-neglect online training (as in a.) for public-facing health and social care practitioners
8. Reinforce the importance of independent mental capacity judgements by agencies involved in complex cases of self-neglect, to ensure that professional assessments are specific to the presenting field of need e.g. care needs / medical or clinical needs / housing needs

Promoting understanding of morbid obesity as a safeguarding risk factor

9. Over the medium-term, the Manchester Safeguarding Partnership should work towards collating in one place a set of relevant online resources that support best practice in the integrated health, social and psychological care and support of adults living with morbid obesity – which is easily accessible and promoted to all partners and practitioners