Sandwell
Safeguarding
Adults
Board

Learning Brief
Thematic Safeguarding Adults Review: 'Morgan'

The Review

The Care Act 2014 requires Safeguarding Adults Boards to arrange a Safeguarding Adults Review if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. Sandwell SAB concluded that the circumstances surrounding the deaths of both Morgan and another case, that of Kim, met the mandatory criteria for undertaking a SAR under Section 44 of The Care Act 2014. Commonalities existed in the two cases (e.g. they both revolved around self-neglect and substance misuse), therefore the SAB decided to undertake a thematic review.

Background

Morgan died at home at the age of 70 when his tracheostomy had become blocked; this had been the main reason for frequent admissions to hospital in the latter stages of his life. He also had heart and other long-standing physical health problems but there were also concerns about self-neglect of personal care and his living environment.

Morgan is reported to have described himself as dependent on alcohol. However, the picture of Morgan's alcohol misuse provided by different agencies is contradictory. He lived in a flat which was described as having beer cans and rubbish all over the floor. He was noted to sit on one chair because there were belongings all over the others. At times, because he was not topping up his meters, he was found to be living in the cold and the dark.

Morgan had been known to Adult Social Care since 2010 and information highlights financial exploitation as far back as 2012. West Midlands Police recorded in 2014 that he was a "vulnerable adult". He had twice been the victim of serious assault from his son. In 2019 he was in hospital for two weeks following one of these assaults.

Arguably, the biggest challenge with Morgan was that, despite contact with multiple agencies, he could be hard to engage into constructive interventions. Morgan received domiciliary care, but he frequently did not answer the door to care workers or said that he was about to leave when they arrived. He was often out and consistently denied any need for help. On at least two occasions Morgan refused to comply with medical interventions; on other occasions he was recorded as not taking medication regularly.

In Morgan's case there were two safeguarding referrals between December 2018 and his death. However, at least seven points can be identified at which safeguarding referrals could have been submitted but were not. There is no evidence of a formal mental capacity assessment having been undertaken. At times it appears that capacity was assumed rather than assessed and there were points at which a capacity assessment should have been considered but was not.

Morgan’s care raises concerns about risk assessment and risk management. For example, it is unclear whether the information provided around the assault by his son was explored further and if any other agencies had been made aware of the incident. Certainly, this serious incident did not have the type of impact on agency interventions that might have been expected. There is no evidence that this was viewed as domestic violence, that a DASH risk assessment was completed, or that the case was considered by MARAC.

The last months of Morgan’s life were lived under the restrictions imposed by the first Covid-19 lockdown. Morgan’s chronology highlights three instances when there were contact issues due to restrictions on personal visits.

Key Messages to Front Line Practitioners

1. All frontline services should use robust alcohol screening tools such as the AUDIT tool to identify and record the level of alcohol related risk for clients.
2. Frontline professionals also require training in best practice in working with chronic, change resistant and dependent drinkers and drug misusers.
3. Professionals should ensure that they are using professional curiosity to understand the complex backgrounds and needs of people like Morgan.
4. Professionals need guidance on “What works with hard to engage clients”.
5. Best practice with clients like Morgan will require a response that is built on assertive outreach.
6. Continued failure to engage by complex clients requires escalation. This may be through standard agency management processes but clients like Morgan will benefit from escalation to multi-agency management.

Key Messages for Management and Strategic Development

1. Health and social care commissioners should consider an expansion of local assertive outreach capacity to people who are vulnerable to abuse, neglect and exploitation, and substance misusers in the area.
2. Health and social care commissioners should ensure that there is a clear pathway for the multi-agency management of complex clients which makes use of the network of existing multi-agency groups in Sandwell.
3. SSAB should lead the development of local procedures that guide professionals on how to respond to clients that are hard to engage but are very vulnerable or pose significant risks. These procedures should include a structure for determining the level of vulnerability associated with a client, which will then guide the level of persistence that is used to follow-up these individuals. The procedures should include the need to escalate those who are more vulnerable to abuse, neglect and/or exploitation and coercion, and/or hard to engage, to a local multi-agency forum for joint management.

Family input

NB The review had no contact with Morgan’s family