Briefing Document for Mathew

Salford Safeguarding Adults Board

This short briefing summarises the key themes and lessons to be learnt following a Safeguarding Adults Review (SAR) undertaken by Salford Safeguarding Adults Board (SSAB).

ABOUT THE ADULT

Mathew was known to several agencies throughout his adulthood due to his personal challenges with drug addiction and managing his mental health.

Mathew had a long criminal history for a variety of crimes.

Mathew had a long-term partner who is the mother of his 2 children; the relationship was described as 'on and off' for a number of years. At the time of the fatal incident, they were not in a relationship.

The couple were discussed at Multi Agency Risk Assessment Conference (MARAC). The purpose of the MARAC is to reduce the risk of death or serious harms to victims/survivors of domestic abuse Towards the latter stages of his life, Mathew had been arrested for a domestic incident which resulted in bail conditions that prevented him returning to the local area, where his children lived with their mother.

Mathew was known to Mental Health Services and had a number of short stays as an inpatient

In the final year of his life, Mathew made several attempts to take his own life and experienced a period of homelessness. Short term accommodation was offered but these didn't work due to them being located outside of the Salford area.

On the day of the fatal incident, Mathew was being offered a property.

WHAT HAPPENED?

Mathew took his own life on 09/11/2020 on a railway and died as a result of his injuries.

REASON FOR THE REVIEW

A Safeguarding Adult Board (SAB) **must** arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

Safeguarding Adults Boards **may** arrange for a SAR in any other situation involving an adult in its area with needs for care and support.

The purpose of a SAR is to establish whether lessons can be learnt from something that's happened and the circumstances with the aim of improving practice or the way in which agencies and professionals work together to safeguard adults. The review also aims to identify areas of good practice and what works well.

The Safeguarding Adult Review Panel considered the details provided on the referral and decided that the criteria had been met for a discretionary SAR.

KEY LEARNING FROM THE REVIEW

Mental Health and Substance Misuse

Mathew appears to have struggled with his mental health throughout his childhood into his adulthood which has impacted and affected many aspects of his life including his relationships both with his family and partners and his ability to be a parent. Mathew did try to engage with services but unfortunately this was not consistent, so Mathew continued to have a chaotic lifestyle and there were times when professionals felt that Mathew 'disguised compliance'. It has been acknowledged by family and professionals that Mathew would tell them information to paint a picture that things were perhaps better than they actually were.

The review has identified that there needs to be a better understanding around disguised compliance.

Raising awareness around disguised compliance will improved and enhance the importance of 'working together', improve communication between agencies and will highlight the importance of having a strong multi-agency approach to ensure intervention is strength based and person-centred.

It is evident from the information provided throughout this review that Mathew needed support as an adult in his own right but also as a parent.

The vision for Salford Clinical Commissioning Group (Salford CCG) which is aligned with the vision of the Salford Locality Plan is for Salford people to start, live and age well.

A new service has been developed called 'Living Well' after it was recognised there was a gap in the primary care provision, it aims to work with people who are not meeting the criteria for the Care Programme Approach through Community Mental Health Teams but need support to manage their daily challenges.

The Living Well model was set up in 2019 and was piloted in the Broughton area, the pilot has been deemed successful, and the model has started to be rolled out across Salford.

Unfortunately, and sadly this model did not come in time to support Mathew.

Adults experiencing homelessness

Mathew did experience 'homelessness' in the last 12 months of his life. Attempts were made to allocate Mathew a property. The challenges around adults having access to suitable property is a national issue rather than a local one due to the national shortage of social housing. However, it was recognised that the multi-agency approach could be strengthened within Salford to ensure Housing Services are not totally dependent on the adult providing all the information which can inform decisions and identify areas of needs.

Domestic Abuse within relationships.

There was evidence that there was domestic abuse within the relationship between Mathew and his partner. From the information presented to the review, it appears that the correct policy and procedures were followed by agencies.

An area of assurance for the Salford Safeguarding Adult Board (SSAB) is to understand more about the function of Multi Agency Risk Assessment Conference (MARAC). The purpose of the MARAC is to reduce the risk of death or serious harms to victims/survivors of domestic abuse. Mathew and his partner were referred to MARAC, however, it is not clear from the information provided to the review what actions were agreed and how effective the discussions at MARAC were to reduce any identified risks.

Role of a father

Mathew appears to have had a volatile relationship with his ex-partner. This appeared to have put additional strain on his mental health because he wanted to be a father to his children but managing the parental responsibilities and his own chaotic lifestyle clearly had an impact on his ability to remain well.

It is important for professionals to recognise the needs of the children, but the needs of the parents should also be recognised equally for both mother and father as part of a whole family approach. There is evidence that there was lot of intervention with the family, but it has been acknowledged that the needs of Mathew, as an adult and as a father were not always recognised.

Recognising signs of self-neglect

There is evidence that Mathew did self-neglect in the sense he struggled with his mental health and drug addiction and lived a very chaotic lifestyle and, professionals didn't appear to consider the Salford Self-Neglect Policy. It may not have changed the outcome for Mathew, but it would have promoted and encouraged professionals to engage in a multi-

agency discussion, sharing of information, risk management and ensure a joined-up approach to case management.

Working Together

Multi-agency working enables different services and professionals to join forces to try and prevent incidents and risks escalating. It is an effective way of supporting adults and families who have additional needs and helps to secure positive outcomes. Working in collaboration is essential if individuals are to be offered support in a timely manner. Effective multi-agency working is acknowledged to be a challenge on a day-to-day basis, but it is also essential.

It is evident that Mathew was signposted and engaged with a number of different services and professionals were in contact with Mathew but there appeared to be a lack of consistency in multi-agency working and communication between partner agencies.

There was evidence of good practice on occasions where information was being shared between agencies but there was a lack of co-ordination regarding risk management, more so when there was increasing incidents when Mathew tried to take his own life.

Escalation of concerns within agencies.

There was a varied approach in respect of escalation within single agencies when there was a deterioration in Mathew's general health and wellbeing. There is a sense that agencies mainly worked in isolation.

Missed opportunities to raised Adult Safeguarding S42 procedures

It appears there were missed opportunities to raise safeguarding concerns regarding the deterioration in Mathew's mental health, and the increased risk of him trying to take his own life. This may not have changed the outcome for Mathew but raising the concerns through the safeguarding process would have promoted the multi-agency discussion, risk management and proactive protection planning to ensure every possible action had been taken to minimise the risk Mathew posed to himself and also others.

The impact the pandemic of COVID-19 had on how Mathew was able to access support/services.

The pandemic would have clearly had an impact on Mathew's daily life and lifestyle choices, as it did everyone. However, it appears that Mathew still had access to support and services but just in a different way due to the National Government Guidelines.

WHAT ARE WE GOING TO DO?

- The SSAB will seek assurance on the areas of key learning from this review to ensure there has been learning and positive change from Mathew's review.
- Share communication of the review and ensure wider learning from partner agencies.

SIGNPOSTING AND RESOURCES

If you are concerned about an adult who may be at risk or is suffering from harm, abuse or neglect (including self-neglect) then please report it to ensure the adult gets the rights support. Please do not hesitate to **report your concerns.**

If you are worried about the welfare or safety of a child, it is very important that you **report your concerns.**

If you feel worried about your own or someone's mental health you should talk to someone. Call your GP surgery and arrange to speak to someone immediately.

Shining a Light on Suicide aims to brings suicide out of the dark in Greater Manchester because it affects many people. Whether you're feeling suicidal, worried someone else is, or have lost someone to suicide, you're not alone. Whatever you're going through, we'll help you get the advice and support you need.

MIND In Salford is an independent, user focused charity providing quality services to make a positive difference to the Mental Health of the people of Salford.

Samaritans – whatever you're going through, a Samaritan will face it with you. We're here 24 hours a day, 365 days a year – call 116 123 for free.

Salford Thrive – offer free online training supporting children and young people's emotional health and wellbeing

Salford Thrive Directory has been developed to support anyone working or volunteering with children and young people (0-25 years). The directory will help you access useful information about different types of resources and services.

Suicide: Let's Talk – It can be hard to know how to support someone who you think might be feeling suicidal. **Zero Suicide Alliance** have created fee online training that will give you the skills you need to help someone who is struggling with suicidal thoughts. Please be aware that this training may be challenging for some people. Make sure you have someone you can talk to if you need to.

The confidential **Greater Manchester Bereavement Service** is there to listen and help find the right support for anyone bereaved. The service includes dedicated suicide bereavement practitioners (phone 0161 983 0902 weekdays or **see here**). Staff should share this with anyone they know who is bereaved. Families bereaved by suicide should also be given the booklet **'Help is at Hand'**

NEXT STEPS – WE ASK THAT YOU

- Share the briefing document within your own agencies, within your local teams and share with individuals who you may feel will benefit from the learning from this review.
- Make yourself familiar with the training and additional resources referenced above.
- If you feel you need further information regarding the Salford Adult Safeguarding Adult Board (SSAB), Salford Safeguarding Children Partnership (SSCP) or the Community Safety Partnership (CSP), please visit Partnerships in Salford webpage which will direct you to the individual Boards and Partnership.

Learning has been shared with all agencies involves a robust Action Plan developed to address the key themes and learning which will be monitored on a regular basis.

The SSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned and areas of good practice from this case and other SARs in the system in due course.

For more information visit our website https://safeguardingadults.salford.gov.uk/