Salford Safeguarding Adults Board

Discretionary Safeguarding Adult Review (SAR)
In respect of
Mathew
Overview Statement

Family have requested that the name used is Mathew.

1. Introduction – reason for the review

The Care Act 2014 states that 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.

SABs **may** arrange for a SAR in any other situation involving an adult in its area with needs for care and support. SARs can inform adult safeguarding improvement. They can identify what is working well and can identify areas for development.

The purpose of a SAR is therefore to establish whether lessons can be learnt from the circumstances of the adult that may improve practice or the way in which agencies and professionals work together to safeguard adults.

The Salford Safeguarding Adult Board (SSAB) has had no direct involvement with Mathew. The SSAB only became aware of Mathew when a referral was received in November 2020, for the Safeguarding Adult Review Panel to consider whether a SAR should be arranged. Therefore, the only involvement the SSAB has had is to undertake a SAR following the fatal incident.

Salford SAB considers and screens all requests for a SAR upon receipt of a referral. In this instance a referral was received on 19th November 2020. Upon receipt of the referral, the SAB made arrangements to gather the necessary information upon which to make a decision to determine whether or not the criteria for a SAR were met.

An interagency SAR panel met on 15th December 2020 to consider the case and it was felt that the criteria for a mandatory SAR was not met because there was insufficient evidence to suggest that Mathew died of abuse or harm but, nevertheless, it felt that further investigation was needed to understand how agencies worked together and if any additional learning could be identified. As a result, a discretionary SAR was agreed.

The review commenced in January 2021 and the final report was completed in August 2021.

Key dates for the review process	
SAR referral received/referring agency	19/11/2020 by Greater Manchester Police
SAR decision	15/12/2020
Type of SAR	Discretionary
1st Multi Agency Review meeting	12/02/2021
Met with family	11/05/2021
Final Report completed:	19/07/2021
Date final report was shared with SAR Panel	25/08/2021
Full report submitted to the Coroner's Office	30/08/2021
Date briefing was published	October 2021
Link to the Briefing Document shared with the family	January 2022
Coroner Inquest held at HM Manchester South Office	17/01/2022

2. Methodology/Process of the review

- SAR referral was screened by Business Manager for the Salford SAB
- Single agency involvement was requested by all partner agencies involved with Mathew.
- A combined chronology was created which was presented to the Salford SAR panel.
- Decision was made at Salford SAR panel for a Discretionary SAR
- Multi Agency Review Meeting was held for all partner agencies to contribute to the review. Areas of learning and good practice was identified.
- Meeting held with family to invite them to contribute to the review and to understand more about Mathew.
- Full report was shared with the review group for wider comment and all representation at the review group have received a copy of the full report.
- Report presented to Salford SAR panel for comments and sign off.
- Final report has been shared with the Salford SAB Joint Independent Chairs.
- A decision has been made by the SSAB that the full report would not be published due to the sensitive information that would be disclosed. An overview statement will be published.
- Business Manager for the Safeguarding Adult Board met with family to provide feedback from the review and identified learning.
- Learning from the review is essential so a briefing document was developed which was published on the Salford SAB website. The briefing document can be disseminated and enable the learning to be shared across the workforce.
- The review group has created an action plan. The action plan and implementation will be monitored by the support team for the Salford SAB.
- Monthly updates will be given to the Salford SAR panel and quarterly updates will be given to the Salford SAB.

3. Partner agencies who provided information for the multi-agency review

- Salford Clinical Commissioning Group (CCG) - Primary Care (GP)
- Greater Manchester Mental Health (GMMH)

- Achieve (commissioned service via GMMH)
- Salford Royal Hospitals NHS Foundation Trust – Acute and community services
- ForHousing
- Supported Tenancy Team (Salford City Council)
- Greater Manchester Police (GMP)
- Community Rehabilitation Company (CRC)
- Salford Safeguarding Children Partnership (SSCP)
- Domestic Abuse Services – MARAC (Multi Agency Risk Assessment Conference)
- Salford Children Services (Salford City Council)
- Salford Health and Justice Services (Commissioned service within GMMH)
- MIND – Commissioned Advocacy Service
- SIDASS - Salford Independent Domestic Abuse Support Services
- Salford Royal Foundation Trust - Adult Social Care – adult social care had no involvement with Mathew, but they have been invited to the multi-agency meeting to understand and share any learning from the review.
- Northwest Ambulance Service (NWAS)

Salford Safeguarding Adult Board (SSAB) led on the review.

4. About Mathew

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

4.2. Mathew had a long criminal history for a variety of crimes. There have been occasions when Mathew served custodial sentences.

4.3. Mathew had a long-term partner, who is the mother of his 2 children.

4.4. The couple were discussed at Multi Agency Risk Assessment Conference (MARAC). 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.

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

4.6. 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 this didn't work due to them being located outside of the Salford area and he wanted to be closer to his family and children.

4.7. Sadly, on the day of the fatal incident, Mathew was being offered a property.

5. What happened?

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

6. Views of the family/friend/representative

6.1. The Business Manager for the Salford Safeguarding Adult Board met with M (mother), condolences were given. Covid precautions were put in place for a face-to-face visit.

6.2. The statutory duty of the Salford SAB and the purpose and process of the Safeguarding Adult Review (SAR) was explained. M said she wished she would have known about the Safeguarding Adult Board (SAB) earlier because she felt that there was a lot of learning that was needed from her son's death.

6.3. Following the home visit there was a telephone discussion with Mathew's sister on 28/07/2021 where additional information was provided.

Mathew's social history

6.4. Mathew's father died in 2004 of bowel cancer, they buried him on the day his parents would have been married for 32 years. Mathew really struggled with the death of his father, Mathew was in prison at the time of his passing, but the prison officers were really good with him and allowed him to visit his father in the chapel 'to say his goodbyes'.

6.5. M described Mathew as a 'jack the lad' but loveable with a big heart who would do anything for anyone.

6.6. Mathew has 4 adult siblings, he had a 5th sibling, but she sadly died at 2 weeks old.

6.7. Mathew's parents lived separately for over 20 years, but this worked for them.

6.8. M said that she had a very close relationship with her son.

6.9. M explained that Mathew struggled with his mental health since he was 4-5 years of age. She explained in those days there weren't any tests for ADHD. He always struggled in large groups; he went to a 'special school' when he was 13 years old which he loved because he was taught in smaller classes. Even as an adult he struggled with larger groups, he couldn't attend family gatherings because he would 'just start' so they would do separate parties for him and the children because he could cope with the smaller numbers.

6.10. Mathew loved his football from a young age, and he had trials with a local football club, his granddad took him to training but after he died there was no-one else to take him, so he had to stop going. Even though he had trials for another club in a nearby area he supported always supported Manchester United.

6.11. M said that Mathew loved his partner and their children, she felt reassured when Mathew was with his children because there was never any doubt that he would have hurt them or himself while they were together. The couple were not married. Mathew was 'in and out' of prison whilst they were in a relationship.

6.12. Family have been very supportive of Mathew throughout his life, but his sister explained that when he took 'street diazepam' this would have a direct impact on their relationship with him because his behaviour would change, and he wouldn't accept their support.

6.13. In the last 12 months of Mathew's life, he was registered as homeless. This caused additional stress for Mathew because he didn't have anywhere to settle or take his children.

6.14. Housing Services tried to find Mathew a property and he was offered a place in a hotel in Eccles. He stayed with M for a short period of time, but he didn't want to stay there because he thought if he did, he would never be offered a property of his own.

6.15. Mathew was then placed in shared accommodation which didn't work. He got into an argument with the other male that lived there. The police were called and the landlord 'kicked Mathew out'. Mathew really wanted to be close to his children by living in the same area but there were limited properties available. Mathew felt it got worse for him after bail conditions were given which prevented him going back into the area where his children lived.

6.16. M felt that Mathew 'screamed for help'. M said that they have requested Mathew's medical notes and it appears that he was diagnosed with a personality disorder in May 2020 which was increased to multiple personality disorder in July 2020. M advised that there is also information in his records that in 2007 Mathew was given a diagnosis of schizophrenia which she advised he was never treated for.

6.17. M explained that when Mathew was with his partner, he often had difficulty sleeping. She said that, he went to the doctors, but they didn't help him so he would often take 'street diazepam'.

6.18. M can't understand why no-one helped him especially when he tried to take his own life on so many occasions. M said his first attempt to take his own life was at the age of 13 years. This continued on and off through his life but the last 12 months he made frequent attempts including overdoses, trying to hang himself, taking himself to bridges and self-harming and he still didn't get any help.

6.19. He was on multiple medications. M explained that Mathew had no spleen as it was removed 17 years ago after he was attacked.

6.20. M spoke about the day of the fatal incident, she said she spoke to him at 6pm, he told her that he was going to get a takeaway. She said that he seemed to be okay and in good spirit, and he told his mum that he loved her.

6.21. M said that Mathew always told everyone who he was close with that he loved them; it was just something he always did. M said that it was funny at times because when you told him that you loved him back, he would continue to say it and it would continue back and forth for a few minutes. M said she would often say 'right I'm hanging up now'.

6.22. The funeral was held on 09/12/2020. The street was full of people who wanted to pay their respects.

6.23. M is struggling to come to terms with her son's death and feels angry because she feels that Mathew didn't get the support he needed with his mental health. M keeps reliving the day of the incident and imagines what happened at the time of the fatal incident. She also thinks about the 'poor driver' and how the incident must have affected them.

6.24. M spoke about the day she reported her son missing, she had a maternal instinct that 'something' was wrong. She explained that she read about the incident in the paper before she was told it was Mathew. She was then contacted the day after to formally identify him. She is hoping the inquest will answer some of the unanswered questions she has, she is keen to be able to attend the hearing.

6.25. M was asked how she felt agencies worked together, M felt that they didn't talk to each other.

6.26. M also felt that professionals 'judged' him, they didn't see him as a person who struggled with his mental health who loved his children. They saw him as a 'drug abuser with a criminal history'. M spoke about how she felt children's services never offered him support to be a father, the focus was on the mother and children, but he should have been seen as an equal.

6.27. The only advice Mathew would get was 'engage with Achieve'. M feels that Mathew did engage but from the statements the family have obtained it appears that appointments were offered, and Mathew didn't attend. Mathew's sister advised that Mathew would ring the day after asking when his appointment was, knowing it was the day before. M said that Mathew would often ring to speak to his worker and they wouldn't return his calls, it even resulted in his allocated worker being changed because he rang so frequently. Mathew used heroin from the age of 17 years, but he got himself off it without any support. Mathew would ask to go into rehabilitation, but it never happened. It appears from the information provided through the coronial process that Mathew did not attend the last appointment which was required to be referred for the detox programme.

6.28. Mathew's sister feels Mathew was inconsistent in what he told his allocated workers and what he told his family.

6.29. The family advised that the Drug and Alcohol, Service always said that they couldn't support him with his mental health and then mental health services weren't really helpful which resulted in Mathew using 'street diazepam'

6.30. M was asked what learning the Safeguarding Adult Board (SAB) needs to consider from Mathew's tragic death. M said;

- Professionals need to stop looking at the addiction first and see them as a person who needs support with their mental health, it will then be easier and more supportive for the person to try and stop their addiction.

- She feels children services need to take into account the needs of the father equally, and not just the mother and children.
- Agencies need to 'talk to each other' and 'work together'.

6.31. M did want to acknowledge the support Mathew was given by his Housing Officer, she described her as being 'brilliant with him'. M was asked why she felt this, what did she do that was different to any other professional involved in Mathew's care. M said 'it was simply that she listened to him'.

6.32. M was thanked for her time. It was agreed that the SAB Business Manager would return to update her with the outcome of the review.

6.33. As the Business Manager was leaving, M stopped her and said 'I always knew my son would never get old and he would take his own life, it was a matter of when, someone should have helped him'.

7. What was identified as worked well for Mathew

- There was evidence that on isolated occasions there was good communication between agencies.
- Policy and procedures were followed to ensure Domestic Abuse Stalking and Harassment (DASH) risk assessment was completed which then triggered the referral into Multi Agency Risk Assessment Conference (MARAC).
- Mathew had good working relationship with his allocated workers from Probation and Housing Services.
- There is evidence that appropriate referrals were made to external agencies.

8. Summary of the multi-agency discussion

The themes have been taken from the Terms of Reference for the review:

- **<u>Mental Health and Drug Addiction</u>**

8.1. There is evidence throughout the review that Mathew struggled with his mental health from childhood into his adulthood which impacted and affected many aspects of his life including his relationship with his partner and his ability to be a father to his children. It felt from the information provided that Mathew was proactive at times to seek support, he tried to engage with services but unfortunately this was not consistent, so Mathew continued to have a chaotic lifestyle and there were times when there was '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 were.

8.2. Disguised compliance means when an individual is appearing to co-operate with professionals in order to allay concern and stop professional engagement. The review has identified that there needs to be a better understanding across partner agencies regarding disguised compliance.

8.3. Raising awareness around disguised compliance will improved and enhance the importance of 'working together', improve communication between agencies and will strengthen the importance of having a strong multi-agency partnership to ensure a true strength based and person-centred approach can be delivered.

8.4. The Salford Locality Plan states that the vision is for Salford to be a place, regardless of their age where a person should be able to 'live well'. It is evident from the information provided that Mathew needed support as an adult in his own right but also as a parent. Mathew didn't meet the 'criteria' for the Care Programme Approach [a package of care, usually for people with more severe and enduring mental health problems] but he clearly struggled to manage his mental health / drug addiction.

8.5. This is an area that has already been recognised as a gap in Primary Care within Salford, as a result a new service has been developed called 'Living Well' and it aims to work with people who are not meeting the criteria for the Community Mental Health, Care Programme Approach 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.

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

8.7. Further information and assurance will be provided in the Salford SAB single and multi-agency action plan regarding this area of development.

- **Adults experiencing homelessness**

8.8. Mathew experienced 'homelessness' in the last 12 months of his life. From the information provided during the review, it appears that every attempt was made to allocate Mathew a property, but this wasn't successful due to the challenges as a result of the bail conditions he was given, a restraining order that was issued and a lack of available and suitable property. The issues around 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 the need for additional support.

- **Domestic Incidents within relationships.**

8.9. There is evidence that there were domestic incidents within the relationship between Mathew and his partner which on occasions resulted in the police being called. (There is no evidence that Mathew was physically abuse towards his partner.)

From the information presented to the review, it appears that the correct policy and procedures were followed by individual agencies. The couple were referred to Multi-Agency Risk Assessment Conference (MARAC) and his partner was referred to the appropriate support services.

- **How effective was the multi-agency discussion at Multi Agency Risk Assessment Conference (MARAC)?**

8.10. The purpose of the Multi Agency Risk Assessment Conference (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. This is an area of assurance for the Salford Safeguarding Adult Board to understand if there is any further learning that can be taken from this review.

- **The impact a breakdown of a long-term relationship has on adult**

8.11. Mathew appeared to have had a volatile relationship with his partner which resulted in them having a lot of arguments. This appeared to have put additional strain on his mental health. Mathew wanted to be a father to his children but managing the parental responsibilities, his mental health and having a chaotic lifestyle clearly had an impact on his ability to manage his mental health on a day-to-day basis.

- **The emotional impact on Mathew being able to maintain a relationship/contact with his children**

8.12. It is important to acknowledge that when support is provided by Children Services, the needs of the children are paramount, but it is important for the needs of the parents to be recognised and equally for both mother and father as part of a whole family approach.

8.13. There is evidence that there was lot of intervention with the family from Children's Services and support was provided, however the review recognised that the needs of Mathew, as a father and who was an adult who had his own needs for support wasn't always recognised and there wasn't always the right representation within meetings to support Mathew. Feedback from M is that she did not feel Mathew was supported as a father, he was just seen as a 'drug addict'.

- **Self-neglect**

8.14. There is evidence that Mathew did self-neglect in the sense he struggled with his mental health, his drug addiction and lived a very chaotic lifestyle and didn't always engage with services. It was felt that 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 more multi-agency discussions, sharing of information, multi-agency risk management and ensure a joined-up approach to support Mathew.

- **Working Together**

8.15. 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 help to secure improved

outcomes. Working in collaboration is essential if individuals are to be offered a range of support they require 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.

8.16. The review group agreed that this was the main area of learning in the review of Mathew. It is evident that Mathew was signposted to different agencies which he would start to engage with but there appeared to be a lack of agencies working in collaboration as part of a joined-up approach, information sharing to manage risks and communication between partner agencies.

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

- **Escalation within agencies.**

8.18. There were a variety of different approaches in respect of escalation of concerns within single agencies when there was a deterioration in Mathew's general health and wellbeing. The review group agreed that agencies mainly worked in isolation, so the escalated concerns were not shared across partner agencies. Again, it was recognised that the outcome for Mathew may not have changed but a multi-agency approach to risk management would have been beneficial to try and safeguard and prevent Mathew from further harm.

- **Missed opportunities to raised Safeguarding S42 procedures**

8.19. From the information and evidence collated throughout the review, there appeared to be missed opportunities to raise safeguarding concerns into adult services regarding the deterioration in Mathew's mental health, the increased risk of him trying to take his own life and the increase incidents of Mathew displaying volatile behaviour. The review cannot advise whether there would have been any change to the outcome but raising the concerns through the safeguarding process would have promoted the multi-agency discussion, multi-agency risk management and proactive protection planning to ensure every possible action was 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.**

8.20. 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 they were delivered in a different way which aligned with the National Government Guidelines issued at that time.

9. Author and Date discretionary review was completed

Jane Bowmer – Business Manager – Salford Safeguarding Adult Board

10. Date the Discretionary SAR is presented to the SAR Panel

Full report was signed off by the August SAR Panel – SAR panel members accepted the report.

The overview statement has been prepared for the purpose of sharing with the Coroner's Inquest and also for publication on the SSAB website.

Copy has been shared with the Joint Independent Chairs and the Director of Children and Adult Services

Action plan briefing document has been developed to promote wider learning.

11. Copy of the 7 min Briefing Document for publication.

https://safeguardingadults.salford.gov.uk/media/1276/final-mathew-briefing-document-sept-2021.pdf