City and Hackney Safeguarding Adults Board

Safeguarding adults review - MS

1) Safeguarding Adults Review

The MS SAR was commissioned by the City and Hackney Safeguarding Adults Board (CHSAB) in December 2019. The Care Act 2014 (s44) requires that SARs are conducted where an adult i) died or suffered serious harm, ii) it is suspected or known that it was due to abuse or neglect and iii) there is concern that agencies could have worked better to protect the adult from harm.

The MS SAR focuses on the complex safeguarding issues that can occur when someone is experiencing multi-exclusionary homelessness. In this case, rough sleeping combined with substance misuse, self-neglect and limited mental capacity.

2) Background

MS was a Turkish (Kurdish) male, aged 63-years old with a history of homelessness, self-neglect and substance abuse. MS was sadly found dead at a bus stop in Stoke Newington, which he frequently stayed at during periods of homelessness. MS was ruled to have died of natural causes. Prior to his death, he had recently been evicted from a residential home and whilst he had been offered alternative accommodation he refused this.

A number of professionals were involved in MS's care, and had sought to help him into secure accommodation and with his health needs. Unfortunately no effective means of resolving MS's situation were found before his death.

3) Person-centred care for people with learning disabilities

A lack of multi-agency working and coordination was identified, with no agency or professional taking the lead for MS's care. Professionals can lack confidence in establishing ownership in cases where the needs of the individual are highly complex. However, evidence suggests that allocating a lead agency or professional in such cases is an effective way to help identify a workable solution to support the individual in the long-term.

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4) Mental Capacity

Sadly there were a lack of mental capacity assessments undertaken for MS and it was assumed that he had capacity throughout his engagement with professionals. This highlights the importance of continuing to assess an individual's capacity throughout engagement.

This is especially important in cases where the individual may be self-neglecting or have a history of substance misuse, and their capacity may fluctuate or be impaired as a result of this. Where professionals are unable to make a clear decision they should feel empowered to escalate the case or make a referral to the Court of Protection.

5) Understanding MS lived experience

A key theme throughout the SAR was around our knowledge of MS's life and past experiences. There remains a gap in what we know about MS and how his past may have shaped his behaviour prior to his death.

It is crucial that practitioners take steps to understand the history of the individual, such as their culture and past traumas as it can help build a better understanding of how to provide effective support. In this case, there was no advocacy or interpreter offered to support him and this may have helped him express his wishes and engage with practitioners more effectively.

6) Legal literacy

Unfortunately assessments of MS's needs did not lead to care and support provision or a s42 safeguarding enquiry. There is an indication that sometimes practitioners make assumptions about a rough sleeper and may miss signs that support is needed, for example all rough sleepers self-neglect. It is important that practitioners are aware of legislation that exists to support rough sleepers and seek legal advice in high risk cases.

7) Summary of recommendations

The Review identified 12 recommendations to take forward, these include:

- Seeking assurance around the use of interpreters and advocacy
- Reviewing the structure of multi-agency meetings for people experiencing homelessness to ensure that there is a structured approach to engagement with services users

- Audit mental capacity decision making for substance misuse or homelessness cases and how we need to support staff in their understanding around this
- Revise and publicise the escalation policy for high risk cases
- Review the best ways to ensure practitioners maintain their legal literacy