

Overview report on the death of Mr M

Executive summary

1 Background

- 1.1 Mr M was a White British man from Rochdale, and was 57 years old at the time of his death. He had a long history of alcohol misuse, and following various accidents when intoxicated, suffered a brain injury in 2005. This left him with epilepsy, for which he required anti-convulsant medication. He underwent a period of inpatient neuro-rehabilitation in 2005/6, and on discharge, while he was noted still to be misusing alcohol, he was deemed to have capacity to make decisions, to recognise legal boundaries, and to be capable of independent living.
- 1.2 Prior to the brain injury, Mr M had been arrested in relation to a sexual assault on a minor, and in May 2006 he was found guilty and received a prison sentence. He was made subject to sex offender notification requirements for life. He was released from prison in April 2009 and then was re-imprisoned in July 2012 for breaching his Sexual Offences Prevention Order (SOPO).
- 1.3 He was released on 31st May 2013. He was homeless on release, and was subject to MAPPA processes as he was deemed to be at a high risk of re-offending.
- 1.4 Finding appropriate accommodation for Mr M was very difficult because of his offending profile, and because of his unwillingness to address his alcohol misuse. His alcohol use increased his risk of having epileptic fits, which led to injuries and confusion, as well as increasing his propensity both to offend and to disclose his offending to others.
- 1.5 Initially, the option of an out of borough therapeutic placement was considered but Mr M failed to meet funding criteria. It was then agreed that a self-contained flat would be the best option for him, with support from Adult Preventative Services. These properties are not easy to find in Rochdale, especially given the restrictions imposed by his sex offender status.
- 1.6 After 3 weeks of homelessness, Mr M was found accommodation in a guest house in North Manchester. This seemed to lead to general improvement and a reduced risk but unfortunately he was evicted in the middle of August, following his disclosure of his status to other residents, and some concerns in relation to comments he made regarding a 17 year old boy. He was rehoused in a Guest House in Tameside. There were a number of concerns relating to this guest house, not least that previously a sex offender had been seriously assaulted while living there.

- 1.7 Mr M continued to misuse alcohol and had a number of episodes of going missing. He remained subject to MAPPA procedures and efforts to rehouse him continued. Support services from two voluntary organisations assisted Mr M with managing his money, retaining his tenancy, and supporting his independent living. Mr M refused to engage with any alcohol services and continued to drink heavily.
- 1.8 As time went on, the workers expressed increasing concerns about Mr M's safety in the guest house, as there were suspicions that he was being both physically and financially abused, and that the other residents were aware of his offending history.
- 1.9 In January 2014, an appropriate property was identified and plans were made for Mr M to move. He was deemed to be at reduced risk and the MAPPA meetings were downgraded to lead professionals meetings.
- 1.10 On 7th February 2014, a safeguarding referral was made to Rochdale Adult Care by one of the voluntary organisations working with Mr M. On 10th February 2014, this referral was sent on to Tameside Adult Care, as Mr M was a Tameside resident. Discussions ensued between Tameside and Rochdale on 12th/13th February but no clarity on who would lead the case was established, with Tameside assuming that Rochdale would take the lead, and Rochdale mislaying the paperwork. In the event neither agency took any further action, and the voluntary sector organisation did not follow up when the client had not been seen.
- 1.11 There was a lead professionals meeting on 27th February. This concerned itself in the main with Mr M's planned move into his new accommodation and the safeguarding referral was not discussed. On 1st March there was a fire at the guest house and Mr M was found dead.

1.12 Summary of the issues presented by Mr M

- He had capacity to make decisions, to recognise legal boundaries, and to be capable of independent living.
- He posed a risk to himself and a risk to others.
- He had no family or friends able to support him.
- It was felt that he could not be left to fend for himself because of his pattern of offending.
- He was very difficult to house, because of his offending profile.
- He lacked insight into the impact of his alcohol use and did not want to address this.
- His needs were assessed as 'low level' and therefore many specialist services were not available to him. However, he appears to have been functioning less

well than the assessment of his needs would predict, which seems to have led to difficulties for universal services.

- This, coupled with the fact that he had a brain Injury, seems to have led many *professionals to expect that if he was offered further specialist assessments, an appropriate service or funding route would emerge.*

2. Lessons Learned

2.1 Failure in pre-release planning. There was insufficient planning prior to Mr M's release from prison on 31st May 2013. In particular, there should have been far more focus on finding Mr M accommodation before he was released from prison, and in describing precisely the risk he posed to himself, to members of the public, and to professionals, and how this risk should be managed.

Recommendation: Pre-discharge planning must be undertaken in a timely manner and must include engagement with any services that the person is likely to need on release

2.2 Misunderstanding of the role of the MAPPA process

2.2.1 The MAPPA process is designed to manage the risk an offender poses to the public. In this case, it appears that there were unrealistic expectations of the MAPPA process, and that it was expected to cover case planning and strategy as well as risk management. This does not appear to have been discussed overtly and possibly led to misunderstandings and misapprehensions among professionals about their (and others') roles.

2.2.2 MAPPA meetings in such cases needs to be supplemented by case planning/case management, with an identified lead professional to co-ordinate the care plan. This person could have ensured that there was an effective strategy in place to manage Mr M's needs and to identify and co-ordinate the support available from the different agencies.

2.2.3 It is clear from the chronology that the mismatch between the risk he posed, his level of functioning, and his assessed level of need was of great concern to the professionals involved in this case. The label 'brain injury' seems to have led people to assume that Mr M had a need for, or would be eligible for, specialist services. This may have had the effect of distracting staff from the need to engage universal services (such as primary health care) effectively, or of giving sufficient attention to the clear risk that his alcohol use presented. Having a lead professional overseeing the case should ensure that a more holistic approach is taken, that there is are opportunities for open discussion, and that decisions are properly recorded and acted upon.

2.2.4 To summarise: it would be beneficial to

- **Identify a lead professional, to take a strategic overview and co-ordinate the case**
- **Be clear about the role and remit of people on the group**
- **Be clear about what is agreed and why**
- **Make sure the group agrees a strategy and focus as well as actions**
- **Ensure that there are effective risk assessments in place, updated as required**
- **Recognise when risks might increase and act accordingly**

2.3 Housing Arrangements

2.3.1 Much of the difficulty in providing suitable housing for Mr M was due to his offending behaviour as any housing near schools or play areas was advised against by the police, as was housing where there would be vulnerable young people living or visiting regularly. A risk assessment of the specific danger that Mr M posed might have enabled a wider choice of housing locations to be considered.

2.3.2 There was a failure to assess the specific risks, both to him and to others, that were caused by Mr M's placement at the guest house in Tameside. At the time of his placement in this guest house in August 2013 a number of concerns were raised about its suitability, but no risk assessment was undertaken. Given that Mr M was frequently missing, it was also not a successful placement in terms of enabling professionals to keep track of him.

2.3.3 Furthermore, there was evidence from the start that there was a potential for him to be abused in this setting, and as time went by there was increasing evidence that Mr M was being abused, both physically and financially. The urgency of the need to remove him from the guest house was not recognised or acted on.

2.3.4 The very specific risk he might face from residents once it was known he was moving into independent accommodation appears not to have been discussed and no plan to mitigate this was made

Recommendation: In this case, consideration should have been given to moving Mr M from the guest house even if this was not directly into independent living. More generally, where there is an urgency to find safe accommodation, consideration should be given to whether it is possible for an individual or family to move into an identified property before the repairs are finished.

2.4 The effectiveness of the support package and the relationship between specialist, targeted and universal services

- 2.4.1 Overall, there was a lack of evaluation and monitoring of the support package. There do not seem to have been clear goals set, other than to assist in finding Mr M appropriate housing, and to ensure that Mr M was supported to maintain his tenancy. The impact of Mr M's failure to engage with aspects of the care package does not seem to have been addressed.
- 2.4.2 The role of alcohol seems to have been viewed as a secondary issue to housing in this case, meaning that it lacked sufficient focussed attention. A number of agencies could have worked more effectively together to encourage Mr M to consider his drinking and to challenge his complacency on the subject. The serious problems that were caused by Mr M's drinking were well recognised at the start of the case. It was for this reason that substance abuse support was included in the care package for Mr M. However, Mr M's refusal to engage with discussions regarding his alcohol use meant that this element of his care package seemed to get dropped but the implications of this work not being undertaken do not seem to have been discussed.
- 2.4.3 There was little evidence of effective engagement with other universal or preventative services such as primary care or alcohol and substance misuse services. While partner agencies were keen to ensure that Mr M was registered with a GP and had access to prescriptions for his anti-convulsant medication, there seemed to be very limited engagement with the GP. Given that Mr M consistently failed to meet the criteria for specialist services, and given the gatekeeping role of the GP in relation to referrals for both primary and secondary care services, it is disappointing that so little effort was made to engage the GP practice.
- 2.4.4 This failure to engage the GP with the case may have contributed to their decision to remove Mr M from their list (because he was living in Tameside), and their failure to inform any of the agencies working with Mr M of this decision. While the GP practice was legally entitled to remove Mr M from their list, the potential implications of removing a vulnerable patient without notifying the new area do not appear to have been considered in this case.

Recommendations: that care packages should be regularly reviewed and that significant deviations from agreed plans should be reported and appropriately resolved.

That there needs to be a better understanding among agencies and workers of the relationship between specialist and secondary care services, and primary

care/universal/ preventative services. This applies particularly to external agencies' understanding of health services.

2.5 The quality of the safeguarding support offered to Mr M throughout the review period

- 2.5.1 There appeared to be some misunderstandings and misapprehensions about how actions should be progressed in this case. Some agencies appear to have seen the route for raising safeguarding concerns as either via the MAPPA meetings or the GMP SOMU. It is clear from the notes of the case that neither MAPPA nor the SOMU saw it as their role to translate these concerns into formal referrals to adult safeguarding.
- 2.5.2 While Mr M was living at GH2, there were misunderstandings about the role of another resident, who presented himself as the 'manager' of the home. While he was known not to have any such role, over time he became actively involved in the case. This was not appropriate and may have added to the risk to Mr M.
- 2.5.3 Once it appeared that suitable accommodation had been (or was about to be) identified for Mr M, agencies appear to have become overoptimistic about Mr M's prospects. Agencies need to be alert to the increased risk at times of change, and the MAPPA meeting on 6th January 2014, and the lead professionals' meeting on 27th February, instead of focusing largely on the plans for managing Mr M's move and support arrangements, should have also spent some time considering how to keep him safe until the move was completed.
- 2.5.4 With hindsight, it seems that a formal safeguarding referral should have been made before 7th February 2014. By 13th January there certainly seem to have been sufficient concerns for a referral to have been made. Again, whether this would have changed the outcome in this case is debatable, as it is not clear that Mr M would have accepted alternative accommodation, especially if it limited his drinking.
- 2.5.5 When the referral was made, on 7th February, despite discussions between the referring agency, Tameside and Rochdale MBCs, no further action was taken by either Tameside or Rochdale in relation to this referral, and the referring agency did not follow up their referral. All three agencies have policies and procedures for referrals and this failure by all three agencies was caused by human error.
- 2.5.6 There was an opportunity for the safeguarding referral to be discussed at the professionals' meeting on 27th February, but this was missed, due to this meeting focussing on the proposed move. The referral should have been discussed at this meeting.

Recommendation: There needs to be a reminder to all agencies of their responsibilities in relation to reporting safeguarding concerns, and also to following up any such reports.

3. Conclusions

- 3.1 Mr M was a very difficult man to help and there was evidence of very good work from a number of agencies, many of whom went beyond what could reasonably have been expected.
- 3.2 The poor planning prior to Mr M's discharge from prison put agencies at a disadvantage. Additionally, because Mr M had capacity to make choices, it was not possible for agencies to intervene when these choices were ones that led to increased risk for Mr M. For example, on one occasion, Mr M was offered immediate alternative accommodation because of the perceived risk at the guest house; he turned this down because it was in a dry house.
- 3.3 Mr M's brain injury served as a distraction in some instances, leading agencies to make continued requests for specialist assessments. This time might have been better spent in developing effective engagement from primary care, universal and targeted services.
- 3.4 Better case management, a more co-ordinated and focused approach to Mr M's alcohol use, and more rigorous risk assessments might have changed the outcome in this case, although Mr M, with his habit of disclosing his offences, was likely to have remained at a high risk from others.