Safeguarding Adult Review (SAR) 'Michelle' 7 Minute Briefing

Who was Michelle

Michelle was a 56-year-old woman of White Irish ethnicity who lived in Dagenham. She was described by her half-sister as vibrant, passionate about rap music and poetry and deeply attached to her dog and goldfish. Michelle had a close relationship with her father. She was known to mental health services for many years. Despite her own challenges, she had a desire to help others.

The full report can be found here:
Safeguarding Adult Review Reports

Michelle's Experiences

Michelle died in hospital on 16 December 2022 from multi-organ failure, neutropenic sepsis, pancytopenia, intravenous drug use. Michelle also suffered from personality disorder. In childhood Michelle experienced sexual abuse, physical violence, substance misuse from age 8, and was placed in local authority care. In adulthood Michelle faced multiple exclusion homelessness, chronic mental and physical health issues, domestic abuse, and exploitation. She was a known sex worker with a number of arrests and had a history of self-neglect and substance misuse. Michelle lived in squalid conditions, often slept rough, and was repeatedly hospitalised. A number of safeguarding concerns were raised however her care and support was fragmented.

Key Findings

Safeguarding Failures: 17 safeguarding concerns were raised by the Police, only four led to Section 42 enquiries, none under self-neglect.

Mental Capacity Assessments: Over-reliance on the assumption of capacity despite clear signs of cognitive impairment and trauma.

Housing Conditions: Michelle's home was described as uninhabitable, with infestations and structural issues.

Recommendations

- Consideration of a system-wide work around the impact of childhood adversity and homelessness.
- Scoping of local multi-agency best practice guidance in working with people experiencing multiple Exclusion Homelessness (MEH).
- People experiencing MEH to have in place, timely, person centred, integrated care plans with regular reviews and risk management.
- Implementation of hoarding and self-neglect guidance.
- Learning opportunities across the partnership for professionals around the concept of functional capacity.
- Measuring the impact of reviews.
- Multi-agency hospital discharge planning.
- Auditing and learning from safeguarding concerns.
- Victim support and perpetrator management.
- Implementation of trauma informed approaches.

Recommendations

- Medication compliance monitoring.
- Review of the Allocations Policy and Management Transfer Policy.
- Training around exploitation and domestic abuse.
- Supervision to support the workforce to understand protected characteristics.
- Effective transition planning across key workers.

Key Findings

Multi-Agency Co-ordination: There was a lack of integrated care planning and communication between agencies.

Discriminatory Attitudes: Michelle's had complex needs and there may have been unconscious bias and a lack of trauma-informed practice.

There is a strong correlation between adverse childhood experiences and multiple exclusion homelessness.

Michelle's care lacked a person-centred integrated approach.

Mental capacity assessments were insufficiently robust, overlooking the impact of trauma, substance misuse and exploitation.

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