Trafford Strategic Safeguarding Partnership

Local Safeguarding Adult Review: 'Mike'

1 Introduction:

Mike was a 35-year-old male who died in the Trafford Council area in August 2023. He died from stab wounds which appeared to have been self-inflected. Mike had struggled with his mental health for several years; he accessed private support for psychosis during his twenties but did not become known to mental health services in Greater Manchester until 2020.

Mike was under the care of various city councils at times and spent several months abroad. Whilst in Gibraltar he became mentally unwell and returned to the UK. His flatmate sought help from several agencies during the 24-hour period prior to Mike's death but was unable to obtain support for him.

2 Key Findings:

There was evidence of some examples of good practice:

- The ongoing pilot scheme under which mental health practitioners from GMMH work in the NWAS Emergency Operations Centre.
- The Salford GP provided excellent continuity of care to Mike.
- The role played by the Greater Manchester Mental Health Tactical Advice Service (MHTAS) in advising the officers dealing with the incident which led to Mike being detained under the Mental Health Act in 2021.
- Once appointed, the Salford CMHT care co-ordinator engaged effectively with Mike.

3 Recommendations:

Trafford Strategic Safeguarding Partnership (TSSP) should:

1: Obtain assurance from Greater Manchester Mental Health (GMMH) NHS Foundation Trust (FT) that staff comply with the policy of notifying a patient's 'carer' within 24 hours of admission under the Mental Health Act.

2: Obtain assurance from GMMH that people admitted to hospital under the Mental Health Act are supported to access independent mental health advocate support.

3: Request GMMH share their revised repatriation policy with the TSSP to allow them to scrutinise the policy to checked for enhanced arrangements for repatriation.

4 Recommendations *(continued)*:

TSSP should:

4: Write to the Gibraltar Health Authority (GHA) to share this SAR and invite GHA to reciprocate by sharing the outcome of their investigation with TSSP when complete.

5: Write to the NHS Greater Manchester (GM) Integrated Care Board (ICB) to ask that all GP practices in GM consider any risks and consult other services the patient is in contact with before finalising a decision to remove a patient from the GP practice list because they reside out of the area covered by that specific practice.

5 Recommendations *(continued)*:

TSSP should:

6: Write to the NHS GM ICB to highlight the importance of all GM GP practices having a process to identify vulnerabilities/risks affecting new patients and prioritise an in-person consultation where necessary.

7: Ensure information about the rights of a 'nearest relative' to request a Mental Health assessment is accessible to members of the public and that relevant professionals have an awareness of this right so that they can provide appropriate advice to members of the public.

6 Recommendations *(continued)*:

TSSP should:

8: Review Trafford's 'front door' approach to responding to people presenting with suicidal ideation, so that the learning informs the draft Trafford Suicide Response guidance.

9: Seek assurance that clear communication to practitioners will be shared about how RCRP will work in future alongside clear pathways established.

10: Share this SAR so that further consideration may be given to developing strategies to support people who experience mental health problems in the workplace.

7 Resources for Further Leaning:

Identify 3 changes in your future practice influenced by the learning from this review.

- Access the full published report here: (traffordsafeguardingpartnership.org.uk)
- Access the video learning briefing on our Trafford Strategic Safeguarding Partnership – YouTube.