Safeguarding Adult Review

DAVID

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This report belongs to Bury Integrated Safeguarding Partnership (BISP)

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1 Introduction

1.1 This SAR is in respect of 50-year-old male to be known as David[1]. David was found murdered in his own home. He had been beaten and items had been taken from his property.

1.2 At a meeting in May 2019, Bury Safegaurding Adults Partnership (BSAP) agreed that the criteria[2] for a Safeguarding Adult Review (SAR) had been met and that a SAR should be commissioned to promote an effective learning and improvement plan. The persons present (hereafter known as the Panel) identified that lessons could be learnt regarding the way that agencies work together, to reduce the risk of abuse and neglect.

1.3 The purpose of this review is therefore to consider what lessons can be learned to guide better future practice and to focus on opportunities for improvement within systems. It is not the purpose of this review to scrutinise the actions of, or apportion blame to, agencies or individuals. The review process has unavoidably been worked with the benefit of hindsight, but the report has attempted to minimise any influence of outcome bias.

Process

[1] It is important to protect the identity of the subject of the report; the pseudonym David has been chosen for this review

[2] Section 44, the Care Act 2014 stipulates that Safeguarding Adult Boards must arrange a SAR when an adult in its area with care and support needs 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.

1.4 In June 2019 an independent reviewer was appointed and in October practitioners, managers and agency safeguarding leads attended a one-day learning event, where the perspectives and opinions of all those involved at the time were discussed and evaluated. Due to unforeseen circumstances the reviewer was unable to complete the report and BISP appointed a new lead reviewer[3] in February 2020. The new reviewer used previous agency reports provided for the initial screening process, chronologies, and summaries of the discussions had at the learning event, to form the foundation of this report. Additional information from agencies regarding their reflection of practice and their analysis was obtained by means of further agency reports and communicating directly with the practitioners and their managers. The lead reviewer and the panel considered draft reports and all members made an invaluable contribution to the process and learning of the review. A copy of the draft report was sent to the attendees of the learning event for them to confirm that it was an accurate reflection of their involvement.

1.5 The panel convened on a further occasion (by video link due to Covid-19 restrictions) to consider recommendations and how learning could be shared with relevant practitioners and agencies. A final draft was shared electronically and considered by all in advance of the virtual extraordinary meeting with the BISP strategy group in May 2020 where the review was presented.

Timescale and Enquiry

1.6 The timescale that the review is to consider is from 1.12.17 until 12.2.19. There is some relevant information about David prior to this timescale, and this is summarised in this report due to it having a relevance on later practice.

1.7 The review sought to understand the following Key Lines of Enquiry

- How effective was agencies communication and co-ordination of their involvement with David?
- Was safeguarding considered by any service and how was this progressed?
- What support was provided to David to manage his circumstances and how was his non-engagement with opt in services managed?
- What was known about other people accessing David's property and how did agencies respond?

Family involvement

1.8 Family engagement is invaluable to the review and BISP would like to thank David's mother for her contribution and for speaking with the initial lead reviewer.

1.9 Only information that is relevant to the learning established in this review is disclosed, other information about David or the people around him is not.

Parallel investigations

[3] The lead reviewer appointed was Allison Sandiford. She is an experienced reviewer and is entirely independent of the BISP.

1.10 The SAR process did not progress until the criminal investigation was complete in August 2019. Four males respectively pleaded guilty in the Crown Court to crimes relating to David's death. The crimes were murder, manslaughter, robbery and attempting to pervert the course of Justice. The judge sentenced all four to prison on the grounds that the murder and other crimes had been for personal gain.

1.11 One of the perpetrators has been subject to a Serious Further Offence (SFO) review by the National Probation Service. This process looks at learning specific to the perpetrator and the probation service. It was established within the SFO process that no one working with the perpetrator had any knowledge of him taking advantage of David and therefore none of the learning is linked to this review.

1.12 The review, although an independent process undertaken on behalf of the BISP, was thoughtful of the ongoing Coronial decision as to whether an inquest would be reopened, or the findings of the criminal court accepted.

2 Background

2.1 David was raised in Greater Manchester. Little is known about his childhood, but his parents separated when he was young. He was part of a large blended family and there is record of him stating that he was a victim of familial abuse as a child. David was a talented artist and maintained an interest in drawing and sketching. He had hopes of selling his work and going back to college.

2.2 David led a chaotic lifestyle. He suffered with his mental health and as he got older, he started to misuse substances and alcohol. As an adult David reported that he only remained in contact with a couple of his siblings and his father. He had two children of his own but was mostly estranged from them.

3 Brief Synopsis of Events

3.1 Having returned to Bury from a neighbouring locality David presented to housing as homeless in December 2017. He was found temporary accommodation but in February 2018, following the death of his father, his mental health had deteriorated to the extent that he was admitted onto the mental health ward under section 2 of the Mental Health Act[4] where he stayed for twelve days.

3.2 In June 2018 David gained his own tenancy. Within a month, a domestic incident between him and his girlfriend was reported at the address and home conditions were noted to be deteriorating. David admitted daily amphetamine use and disclosed concerns of being at risk of physical abuse from a group of adults. Agencies continued to offer David support, but his engagement was sporadic.

3.3 In November 2018 David was again admitted onto the mental health ward. Upon discharge, 6 days later a nurse recorded that David's self-care was poor and that he was at risk of self-neglect and vulnerable to exploitation. Professionals continued to signpost and offer support for his substance misuse and poor mental health, but his engagement remained poor.

[4] Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.

3.4 In February 2019 he was found deceased at his home address.

4 Analysis of the Key Lines of Enquiry

The following agencies and teams have been considered within the analysis of this review:

The Agencies and Teams	Acronym
Adult Social Care	ASC
Community Mental Health Team (Pennine Care NHS Foundation Trust)	CMHT
Home Treatment Team (Pennine Care NHS Foundation Trust)	HTT
Six Town Housing	STH
Greater Manchester Police	GMP
General Practitioner	GP
Criminal Justice Mental Health Team (Pennine Care NHS Foundation Trust)	CJMHT
Access and Crisis Team (Pennine Care NHS Foundation Trust)	A&C
Rapid, Assessment, Interface and Discharge team (now known as Liaison Mental Health Service, Pennine Care NHS Foundation Trust)	RAID
National Probation Service	NPS
Community Rehabilitation Company	CRC

How effective was agencies communication and co-ordination of their involvement with David? Was safeguarding considered by any service and how was this progressed?

4.1 At the beginning of the review's timeline David presented as homeless after moving back into the area from elsewhere, and an assessment of need was undertaken by ASC. It is not standard practice for workers to attempt contact with professionals from a previous area, but its value should be considered on a case by case basis. There is no record of this having been done in this case and it has not been possible to establish why as the practitioners are no longer in post. The assessment was completed in January 2018 and the case transferred to the locality team. In February 2018, three days after the passing of his father, David was admitted onto the mental health ward under section 2 of the Mental Health Act 2007, he was described as presenting as 'highly agitated with delusional and disordered thought'. A Trust Approved Risk Assessment (TARA) was completed and identified that David was agitated as he suspected his family of having taken money from him. The assessment also noted that he had previously neglected himself and had been exploited by others who had used his flat as a place to hang-out and deal drugs.

The ward advised ASC that David had been placed under a section 2 and ASC demonstrated good practice by asking the ward for further detail. ASC was informed that the ward had not made a referral to CMHT as the admission was thought to be as a result of drug use rather than mental illness. However, ASC made its own referral to CMHT the following day but was advised that due to him being safe in hospital, David would not meet their criteria.

4.2 The ward holds weekly multi-disciplinary reviews to discuss the progress of patients and plan for discharge. Following a period of medication-free assessment where David had become more settled and presented as euthymic, he was deemed fit for discharge from the section 2. David was granted leave but failed to return and he was located at his sister's house by the police but refused to go back. Subsequently the ward discharged him in his absence two weeks later and advised ASC. This communication is good practice, but it would have been helpful if ASC had been updated of David leaving the ward of his own accord three weeks earlier. Upon discharge a ward will usually liaise with partner agencies and anyone involved in a patient's care but on this occasion, there is no evidence of contact being made with any other agency. As David had informed the ward that he was living in temporary accommodation, it would have been good practice to inform housing of the discharge. Sharing of information such as this would be easier if agencies had access to each other's electronic information and records, but this is a complicated issue affected by confidentiality and incompatible systems. What is clear is that when professionals from different agencies can view an individual's involvement with another service, inter agency communication vastly improves, which in turn can assist with assessments and interventions regarding support. The lack of communication between the ward and ASC when David effectively discharged himself, left him living in temporary accommodation for a period of time with no mental health support or social worker. The ward did not re-refer him into CMHT as there had been no evidence of psychiatric or depressive symptoms following the section 2. His acute presentation was deemed to have been related to the loss of his father and his amphetamine use.

4.3 The discharge plan was formulated three weeks after David had left the ward of his own accord and it is not documented in the records how it was communicated to David. The plan was thorough and included a 7 day follow up from HTT[5], self-referrals to Healthy Minds and the drugs team and if in crisis, an instruction to contact his GP or attend A&E. However, David did not sign the plan and there is nothing to evidence that he was aware of it although the ward has recorded that he had been provided with a Healthy Minds booklet during an inpatient review and that

[5] The Home Treatment Teams provide an alternative to inpatient care by offering short-term intensive community support. In addition to supporting clients who are at risk of admission into a hospital the HTT supports discharge from wards. Where there is no other team involved with the client, the HTT will complete a seven day follow up and the client will be offered support if required. In the absence of a client putting themselves or another at risk, the HTT will accept that a client may not wish to accept the support. The allocated practitioner will attempt to see the client within 72 hours of discharge but if initial attempts are unsuccessful, will continue to do so for the full seven days. If no contact has been made after the seven days then staff must complete a breech report and if there are concerns, must also consider a concern for welfare with the police.

self-referrals had been discussed. HTT having recognised that David was unaware of the discharge plan, planned to cold call. The team made six phone calls and attended his address on one occasion but could not make any contact with him. Ten days after formal discharge the HTT aborted further contact attempts after conversation with the resettlement team had established that David had been seen by them and had been fine. David's discharge lacked the framework and leadership that would have been provided had he been under secondary mental health services[6], and met the criteria for a Care Programme Approach (CPA). In the absence of a CPA his only monitored contact with another mental health professional was a ward discharge appointment with a consultant psychiatrist scheduled for seven weeks' time. He did not attend this appointment nor make contact during the 14 day 'opt in' period and was subsequently discharged from mental health services in May. This 'opt in' procedure is the same regardless of a service user's circumstances and the review would question whether further attempts to engage a patient could be made based upon a risk assessment of an individual's circumstances.

4.4 A safeguarding concern should be raised when a person has reasonable cause to think that an adult with needs for care and support, is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves because of those needs. In July 2018, the police raised a safeguarding concern to Bury council following a domestic incident that had occurred at David's address in which David was recorded as the victim. The girlfriend was removed from the address and David was advised to call the police if there were any further issues. The attending officer demonstrated good practice by raising the concern as she was worried that David had needs due to his mental health and substance misuse and considered that he would benefit from support. The concern was closed after the Connect and Direct hub[7] screened the referral and it was deemed that David did not meet the criteria for a section 42[8] assessment as he was accessing support through STH and was being managed by the community hub (hereafter known as the hub). The principle of the hub is to help individuals in crisis to rebalance their lives prior to the need to access statutory services. Cases are referred by any agency (with consent) and multi-agency teams meet weekly and work collectively to support the individual.

4.5 A month later STH raised a safeguarding concern that reported that David had said he was at risk of financial and physical abuse from a group of adults and that he felt isolated and was self-medicating with amphetamine. STH had noted that his property was untidy and there were needles on the floor. The officer advised David to tidy up and to contact the police if he was in any danger. The concern noted that the housing officer had shared the concerns with GMP but GMP have no record of this. David did not respond to a letter sent by ASC asking that he make

[6] Secondary care services are those which you generally need a referral from a GP to use (such as hospitals or community mental health teams).

[7] The Connect and Direct 'Hub' has the responsibility for recording and triaging safeguarding concerns.

[8] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

contact and no further concerns were received so the referral was closed after six weeks, noting that David remained an ongoing case at the hub and that police and housing remained involved. This closure was despite contact with David, during the timescale that the concern was open, having been very difficult; two days after David had made the disclosure, he attended the housing offices, but all subsequent home visits by the housing officer were unsuccessful and on each occasion the officer was unable to gain a reply. It was decided at a hub meeting in September that the housing officer would visit the address of a known associate of David's in the hope of locating him and this is where he was eventually spoken to, five weeks after the initial concern. David then allowed STH access to his property the following day but ceased to engage thereafter until he visited their offices in November 2018.

4.6 None of the referrals made to ASC during the course of the review were dealt with as a section 42 Care Act enquiry. National Research conducted in 2017 by SCIE[9] found that a number of organisations were confused by the inconsistency between local authorities, and also workers within the same authority, when deciding whether to carry out a section 42 safeguarding enquiry. This uncertainty leaves agencies unsure about how to proceed a concern and lacking in confidence when considering whether to challenge a decision. There is nothing to suggest that any referring agency in this review considered challenging any of the decisions made by ASC regarding David, but it is unclear whether they were provided with, or requested, feedback. A visible feedback process is essential for continuous clarity to both referrers and referees and one should always be in place. A good feedback procedure should include an initial acknowledgement of a referral having been made and be followed, within an agreed set timescale, with an update. In addition to the transparency, a practice such as this has the benefit of reducing the amount of correspondence that a referral team will receive as referees will not need to chase feedback.

4.7 Consistency and clear updates are imperative to safeguarding and during the process of this review ASC identified that there was improvement to be made regarding how safeguarding concerns were responded to. A subsequent period of consultation resulted in the introduction of a specialist safeguarding team which went live in May 2019, to promote a standardised response to safeguarding concerns. The team now screens all potential safeguarding cases with the exception of those allocated to the older people's mental health team, the community mental health team and the learning disabilities team. Upon receipt of a referral the team will decide whether the criteria are met and progress it in accordance with safeguarding procedures. This team will continue to interact with the community hubs when required but all of the referrals received in David's case were closed with the rational that he was under the radar of the community hub. This would suggest that it is possible that prior to the implementation of this team, there was an over reliance upon the hub to manage a case.

[9] Social Care Institute for Excellence: Safeguarding Adults: Highlights September 2017

4.8 The review has recognised that many joint agency visits to David were arranged as a result of hub intervention and there is evidence of good information sharing and regular communication amongst the range of agencies working together under the auspice of the community hub. David first became known to the hub when his home conditions began to deteriorate in May 2018, and subsequent concerns were brought by other agencies regarding his behaviours and poor engagement. Consequently, David was discussed at approximately twenty meetings. Members of the review panel have questioned how the hub engaged with agencies not located within the building and the hub has reported that separate conversations were held with key partners as and when required. For example, conversations were held with mental health professionals to discuss historic information held within their systems and to discuss concerns regarding David's presentation and resulted in further joint agency visits.

4.9 No strategy meetings convened to discuss David as the hub meetings were thought to have been sufficient. In the absence of strategy meetings, the hub needed to provide the framework for the coordination of actions and provide the multi-agency agreement to act as a team around David. It does have a common approach of retaining minutes of all of the meetings and the actions determined, but better practice could be achieved with a more robust action management system where updates could be centrally recorded and monitored within the hubs operating structure. If, as in this case, there is little progress, the case could then be escalated to other safeguarding channels to prevent the problem revolving around the hub agencies without solution. Given the reliance that has developed upon the hub this is particularly important.

4.10 The final concern raised for David occurred only weeks prior to his tragic death after he had threatened to shoot himself as he left the job centre. The police attended his address and established that there had been a problem with his benefit money but that it had now been sorted. The officer gained David's consent to share his information in an attempt to get him further support, but the public protection investigation unit did not review the case until after David had sadly passed away and subsequently this concern was not shared with other agencies. The case was marked as being of 'medium risk' but waited 16 days for review due to particularly high queues. Had the case been reviewed prior to David's death, referrals would have been completed to ASC and mental health services. It is also likely that a strategy meeting would have been requested with partner agencies and intelligence placed on the police systems.

Learning:

- There needs to be a clear pathway between ASC and MH services upon admission and discharge on MH wards where their communication is appropriate.
- Referring agencies need to be aware of what actions result from their referral and must follow up if no feedback is received.
- The use of 'opt in' practices should be considered in line with a service user's

circumstances.

- Community hub information must be shared effectively to allow all agencies to record, respond and consider concerns and a model of thresholds should be available to all professionals to assist with when to refer to ASC/safeguarding.

What support was provided to David to manage his circumstances and how was his non-engagement with opt in services managed?

4.11 It is common for people to experience problems with their mental health and substance abuse at the same time. Research shows that mental health problems are experienced by the majority of drug users (70%) and alcohol users (86%) in community substance misuse treatment[10]. The root cause of David's circumstances was his inability to abstain from substance use and address his subsequent mental illness. All agencies agreed unanimously that he required support to do both of these things. Whilst other agencies dipped in and out of David's life, housing was consistent, and the agency made several attempts to engage David with support networks to improve his lifestyle and address his mental health.

4.12 In July 2018 following the domestic incident STH referred David for tenancy sustainment which is a service to help complex and vulnerable tenants sustain their tenancies. The service can help with managing finances, maintaining property conditions, and accessing other support for drug and alcohol abuse, mental health problems, general health concerns and domestic abuse. A sustainment officer attended David's address on seven occasions to complete an assessment of his needs, but David was not present. The officer also attempted to contact David by telephone and text, but he did not respond to messages. In September, the officer managed a successful joint visit to David with the housing advisor. David had a visitor at his address whom he introduced as his nephew and his presence prevented a full assessment being completed at that time, but David did agree to the officer making further contact with him. Unfortunately, David failed to respond to succeeding contact attempts and the needs assessment could not be completed. Subsequently no action plan was created for him. The sustainment officer recognised that the hub was involved and kept them updated at weekly meetings.

4.13 David continued to mostly thwart professionals attempts to support him, and his situation appears to have steadily deteriorated until he presented at the housing offices in a poor state at the beginning of November 2018. He said that he had not eaten for two days, wanted to get clean and had stopped taking amphetamine. He had not taken any medication for months and was hearing voices. David was provided with food and an appointment was scheduled for him to see his GP later in the week. Housing informed the hub of his presentation and a Police Community Support Officer (PCSO) subsequently attended David's address on a follow up visit. The PCSO was concerned about David's mental health, but its deterioration was not

[10] Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313 2 Delgadillo J, Godfrey C, Gilbody S and Payne S (2012) Depression, anxiety and comorbid substance use: association patterns in outpatient addictions treatment. Mental Health and Substance Use Vol. 6, Iss 1, 2013.

to the extent that it warranted police powers and so accordingly the officer contacted the CJMHT, who shared the concern with A&C[11]. A&C said that David had been offered their support as they had received a concern for him about his relationship breakdown following the domestic incident, but he had not engaged. Their plan was to write with advice, but the case was about to be closed. There is nothing documented within the A&C record that evidences further attempts to engage him.

4.14 David was not under the care of the CMHT but a police sergeant from the hub conducted a joint follow up visit with them the following day. This was appropriate as it is a responsibility of the CMHT to duty call when there are concerns. David still presented as mentally unwell and paranoid, but his mental health was not deemed complex or serious enough to meet the criteria for secondary care services[12] and therefore CMHT advised that he see his GP and self-refer to Healthy Minds and One Recovery. There is no record of David self-referring to either support team, neither did he attend the doctor's appointment that housing had arranged for him. Professionals tried to see David at home several times over the next few weeks, but he did not answer the door when they visited.

4.15 At the end of the month a PCSO and CJMHT conducted a successful joint visit and found David at home with an unidentified female and a dog. David was in an injured state and mentally unwell. He said that the injury was the result of a cycling accident and he agreed to go to the hospital. Whilst there David saw the RAID team as he was having suicidal thoughts and thoughts of hurting others. He was admitted onto the mental health ward but following review a week later, was considered fit and stable enough for discharge. Although his discharge summary advises that he was deemed to be at risk of self-neglect no safeguarding referral was considered. Upon discharge CJMHT were informed by the ward that David intended to present at One Recovery and that he would receive seven day follow up from the HTT. HTT made three attempts to contact David by telephone but he did not respond to messages. On day four HTT contacted One Recovery who informed them that David was declining input with services. The HTT manager agreed that the follow up was complete and no further contact attempts were made.

4.16 The review has recognised that support was offered to David on multiple occasions and that his circumstances were manageable with this support. However, his problems became unmanageable as a result of his non-engagement. Non-engagement is common amongst people who are struggling with an addiction as drugs can damage the decision-making part of the brain located in the brain's prefrontal cortex. Therefore, an individual who develops an addiction may not be aware that their behaviour is problematic and may be in denial and hostile to support. The ward discharge paperwork suggests that their staff recognised that

[11] The referral pathway for Secondary mental health services in Bury is via the Access and Crisis team.

[12] The adult community mental health service provides a range of support options to service users aged 16-65 with severe and enduring mental health problems who have complex needs and present significant levels of risk to themselves or others including individuals

David was struggling as it highlighted his risk of self-neglect and also noted that his self-care was poor. Despite this, a safeguarding concern was not raised, and he was discharged in the belief that his discharge would enable him to obtain the relevant support for himself.

4.17 It is a concern that when professionals recognised that David's non-engagement and self-neglect were rendering his circumstances unmanageable, his lifestyle was 'accepted' and support continued down the self-referral route even though this route is reliant upon a patient's motivation to get help. Self-referral has the advantage of opening up pathways, but a disadvantage is that some people might overuse the service and others might not use it all. David fell into the latter category and sadly it is too late for him to help us to understand why. Data used to collect information for surveys[13] looking at why people do not approach their GP with mental health problems concluded that many believe that they do not need help or that no one can help them. Although these surveys were specifically about why people did not visit their GP's, the logic can be applied to all methods of support. Gatekeeping mechanisms would be helpful to monitor people who have been advised to self-refer but choose not to, as these people often become 'at risk' as a result of their own actions and choices.

4.18 Adult safeguarding is about preventing and responding to all concerns of abuse, harm, or neglect of adults, and all of the organisations in Bury are asked to adopt The Bury Safeguarding Adults Inter-Agency Policy & Procedures[14]. The policy aims to prevent and reduce the risk of significant harm to 'adults at risk' from abuse or other types of exploitation, whilst supporting them in maintaining control over their lives.

4.19 It is acknowledged that there are several forms of abuse or neglect, and the Care Act 2014 guidance lists self-neglect as one of them. Although there is no specific definition of self-neglect, examples provided include lack of self-care, poor personal hygiene, and a failure to access services. These examples are expanded upon in The Skills for Care research[15] which identifies three distinct areas that are characteristic of self-neglect:

- Lack of self-care - this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or well-being.

- Lack of care of one's environment - this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment.

- Refusal of assistance that might alleviate these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment.

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[13] Meltzer H, Bebbington P, Brugha T, Warrell M, Jenkins R, Lewis G. The reluctance to seek treatment for neurotic disorders. J Mental Health 2000; 9: 319–27 Meltzer H, Gill B, Petticrew M, Hinds K. *OPCS* Surveys of Psychiatric Morbidity. Report 2. Physical Complaints, Use of Services and Treatment of Adults with Psychiatric Disorders. *London: HMSO, 1996*

[14] https://search3.openobjects.com/mediamanager/bury/directory/files/bury_safeguarding_adults_inter_agency_policy_and_procedures_2017.pdf

[15] https://www.skillsforcare.org.uk/Documents/Topics/Self-care/Self-neglect-scoping-study.pdf

4.20 When we consider this framework against David's unkempt appearance, non-compliance with medications, deteriorating home conditions and non-engagement with support interventions, there is little doubt that he was suffering self-neglect.

4.21 One of the biggest challenges in adult safeguarding is securing the wellbeing of an adult whose risk arises from self-neglect as opposed to a risk arising from a third party, particularly where they do not wish to engage. Having recognised that David was at risk of self-neglect it was vital that his situation was communicated to other agencies effectively to ensure that all of the partner agencies could prioritise a response. The reviewer has not found a self-neglect strategy within BISP, but such a framework would provide a guide to assist all Bury partner agencies to respond when concerns of self-neglect have been identified. Self-neglect may not always prompt a section 42 enquiry unless there is a serious risk to the health and wellbeing of an individual but interventions on self-neglect can often be decided under a more appropriate part of the Care Act which focusses on assessment, planning, information and advice, and prevention. An assessment should always be made on a case by case basis.

4.22 A further challenge with establishing self-neglect is that practitioners have to consider whether David was choosing to live this way or whether he lacked capacity to make good decisions about his own wellbeing and care for himself. This results in human right dilemmas for practitioners, as they attempt to balance an individual's right to privacy with their own duty of care to safeguard. One cannot presume that because David made decisions that another person might consider reckless, he did not have capacity. The question of capacity is complex and is subject to being influenced by others personal and cultural values but The Mental Capacity Act (MCA) has a test to help a professional assess whether a person lacks capacity. It is important that assessments remain balanced between the individual's viewpoint, and the professional's duty, but the test consists of two stages. Firstly, there must be proof that an individual has an illness or injury that affects the way his or her brain or mind works - this can include symptoms caused by drugs and alcohol. And secondly, it must affect the individual so much that he or she is unable to make a specific decision at a certain time. The review has not identified any case notes that reflect any assessment of David's capacity, but it is clear from the information provided that professionals had considered it. Good practice would be to document these decisions and to record the conclusions of assessment.

4.23 If David had been found to lack capacity, the Mental Capacity Act would have provided a statutory framework for decisions to be made on his behalf, but David was considered by all professionals involved to have mental capacity meaning he was assessed as having the ability to make his own decisions and choices. As a result, all interventions with David needed to be with his consent and continuous engagement and this may have complicated the options of actions available. The exception to this was when a decision was made on David's behalf regarding his admission onto the mental health ward under Section 2 of the Mental Health Act but

immediately following this his ability to make good decisions and to engage was relied upon again when ASC wrote to David to ask whether he still wanted their support. This letter included the caveat that if he did not respond within 14 days his case to social care would be closed. David did not respond and therefore the case was closed. Supporting people who are difficult to engage is a skill and is not uncommon. The new specialist safeguarding team has recognised that this is not an appropriate response to a safeguarding referral, and this practice has now been replaced with a procedure that includes home visit attempts and a risk assessment prior to closure. Contact will also be made with other services involved.

4.24 As previously mentioned this review recognises that within these complexities of self-neglect, professionals have taken positive actions to try and support David in the form of self-referrals and housing support. But the review has identified a further opportunity when David could have been assessed and agencies could have intervened when he disengagement with his GP: Despite being diagnosed with epilepsy David had a history of not attending GP appointments and not taking medication, however in December 2018 he was seen at the practice where he discussed his low mood and drug use. He was given a week's supply of sleeping tablets and advised to self-refer to healthy minds. Following this appointment David did not respond to telephone contacts or attend an appointment that had been arranged for January. The GP may not have recognised the full picture of the concerns developing around David as the practice had only received routine notifications when David had been in receipt of acute health services. Had the GP been aware of the concerns raised by other agencies, David's non-engagement and lack of attendance at his appointment, may have generated a different response - at the time, there was no formal policy in general practice to be followed when adults 'did not attend' their appointments but new guidance is currently in draft form for consideration. The review recognises that it is not routine practice for ASC to contact a GP upon receiving a referral but a two-way communication between ASC and a GP is always beneficial and can be done easily if a patient gives consent. In this case it would have assisted to monitor the support being offered to David and there is nothing to suggest that David would not have consented to this information being shared.

4.25 In 2017 an Inter-Agency Risk Management (IARM) protocol was piloted for adults in Bury who were deemed to have capacity but were at risk of causing serious harm or death to themselves or others through either risky behaviour or a refusal to engage with support services. Following the trial, the Adult Safeguarding Board continued to discuss management of the protocol but due to the structural changes of the joint boards taking precedence at meetings held thereafter, the protocol was not launched. The review has considered whether David's reluctance to engage with professionals would have meant that his case would have fallen within the remit of the IARM. If it had, his case would have been led and managed by the lead agency identifying the need to initiate it, possibly housing in this case. David's consent would have been encouraged but not necessary and a meeting would have been held within five working days of the decision to proceed having been

made. All agencies involved with David and those whose services it was felt could benefit David, would have been invited to attend and assist with the creation of an action/protection plan. David, having been subject to the IARM process would have been held on a Risk Register which would allow the safeguarding board to oversee and guide his case. Although the review recognises that it is a matter of conjecture as to whether David would have fitted the IARM criteria and also that this procedure would not have foreseen or prevented the tragic outcome of this case, it would have provided a clear record of who was involved and what actions had been taken. It would also have assisted professionals to measure the risks to David and would have offered a clear lead, which would have been hugely beneficial when you consider the wide range of mental health support services that are available and their complexity of remits and thresholds.

Learning:

- There must be clear pathways and processes between ASC and MH services to support adults who do not engage with services and are deemed to be at risk of abuse or neglect.
- The IARM policy should be reconsidered or a new multi-agency protocol for adults deemed to have capacity but at risk of neglect of abuse should be devised.
- There must be clear guidance for all agencies on how to support adults who do not engage with services and are deemed to be at risk of self-neglect.
- A decision regarding an assessment of mental capacity being undertaken and any result must be documented to improve information sharing and ensure that all professionals understand the risk that a vulnerable adult in their area faces.

What was known about other people accessing David's property and how did agencies respond?

4.26 David disclosed preceding exploitation at a previous flat he had lived in when completing the TARA in February 2018 prior to his admission onto the mental health ward. The TARA forms part of the assessment process and would have been a collaborative process between David as the service user and the assessor. Practitioners encourage the patient to sign the form to evidence that the content has been shared with them but on this occasion, David did not sign. The review has not been able to establish why but it was likely due to David's presentation at the time. It would have been good practice to explore the previous exploitation further with David when he was presenting as euthymic whilst on the ward and then consideration could have been given as to whether the issue was historic or unresolved and needed to be shared with other agencies.

4.27 As discussed at paragraph 4.4, David had disclosed to STH during a home visit that he was having issues with some individuals and that he was at risk of abuse. David did not give much information and did not feel able to name any of the individuals but the information that he had provided, was in line with good practice, shared by

means of a safeguarding referral. In addition, David was told to contact the police using 999 if he was in danger. The current housing policy is to make the police aware of the concerns but at the time this was done by means of informing the community hub during a weekly meeting. Better practice would be to report the disclosure directly to the police immediately. Following David's disclosure housing made several attempts to make further contact him and discuss his allegations, but he was not at home. When the housing officer did have successful contact, the allegation of the abuse was not referred to. Nor did David respond to any contact made with him by ASC and they closed the case after six weeks.

4.28 The STH officer reported that he disclosed David's comments regarding physical abuse from other adults into the next hub meeting. The minutes of the meeting note an allegation made by David of financial abuse from his family, but do not refer to any physical abuse from other adults. In the absence of these concerns being recorded, a response was not formulated and followed. This highlights the importance of concise minutes and the need for the minutes to be distributed promptly alongside a request for all participants to confirm that their input into a meeting has been understood and recorded accurately. Had the physical abuse concern been recorded it could have prompted a further multi-agency meeting which would have ensured that every agency had the full picture of what David was alleging and who he was associating with. A lack of thoroughness at this time led to a missed opportunity to try and understand what was happening in David's life and his relationships. His disclosure, when taken on its own, can be described as low-level but it may have been part of a bigger emerging situation. If such individual reports are responded to robustly there is less chance of them escalating in severity. Circulation of David's disclosure amongst other local community hubs and agencies such as NPS and CRC would have allowed other professionals to demonstrate professional curiosity and consider known associates of David's and any risks that those associates were known to pose.

4.29 Had the disclosure been immediately reported to the police by housing or later via the hub, it would have been recorded on the police system and a resource may have been deployed to gain further information, at the very least the information would have been recorded on the intelligence system. It is possible that David would not have consented to the police being informed but support workers can, in some circumstances, report a crime on behalf of a victim.

4.30 In October 2018 David contacted the police to report a street robbery. He disclosed the name of the offender and detailed how he knew him. David did not wish to support any police investigation and the matter was closed with no further action. The individual named is not one of the convicted perpetrators involved in David's murder and had the police have considered this robbery in line with the disclosure of financial abuse, no connection may have been identified. However, David's lack of support for police investigations evidences his vulnerability and inability to recognise or address the risks he was presented with and further curiosity at this time could have proved valuable.

4.31 It is very possible that David had become the victim of cuckooing. This refers to the befriending of vulnerable people, typically with learning difficulties, mental illness, or addiction issues, by others, so that they can use their homes to keep and sell drugs or conduct other criminal activities. The scale of cuckooing is unclear, but in 2018 Commander Simon Bray, the National Police Chiefs' Council lead on drugs, said the number of people having their houses taken over could be in the thousands[16]. This review has not been given any information that would evidence that the perpetrators were using David's address for any criminal activities, but it is clear that David, having been robbed and murdered by people he associated with, who he had allowed into his property, was a victim of mate crime. There is no statutory definition of mate crime in the UK, but it is commonly defined as exploitation, abuse, or theft from any person at risk from those they consider to be their friends. Those that commit such abuse or theft are often referred to as 'fake friends'[17]. David was deemed to have the mental capacity to make his own choices, but his drug abuse and mental illness may have prevented him from identifying and addressing the abusive behaviours of the people around him that he thought of as friends. The Association for Real Change (ARC) Safety Net project[18] was set up in 2009 to research the issue of mate crime, raise awareness, and deliver training. As ARC members shared testimonies the project became aware of the extent of mate crime and the vulnerability of the victims. The project argued that when people cannot, or will not, see the crimes to which they are subjected, it is up to the people around them to do so and to take decisive action.

4.32 The very nature of mate crime means that self-reported mate crime will be low as the victims see the perpetrators as friends. This makes it hard for a professional to spot this type of crime. Protecting vulnerable people is very reliant upon security systems and support workers building good relationships and conducting unannounced visits. Mate crime can only be addressed by educating professionals, possible victims, and members of the community and by increasing their awareness.

Learning:

- Professional curiosity is crucial when safeguarding a vulnerable adult.
- Staff working with vulnerable adults must recognise, understand and be aware of the impact of cuckooing and mate crime.
- Professionals should always give careful consideration as to whether they should report a crime, or anything that they suspect to be a crime, to the police and/or make a safeguarding referral, even if the client does not give consent.
- Clear guidance is required to help practitioners manage the risks of cuckooing and mate crime.

[16] https://www.policeprofessional.com/news/rise-in-cuckooing-cases-as-county-lines-gangs-thrive/
[17] https://www.manchestersafeguardingpartnership.co.uk/resource/mate-crime-advice/
[18] http://arcuk.org.uk/realchangechallenges/files/2013/10/RCC-Mate-crime-PCJA.pdf

5 Conclusion and recommendations

5.1 David was a vulnerable adult who was unable to abstain from misusing substances and whose mental health suffered. This was the root of David being vulnerable to exploitation and the review does not consider that agencies could have done anything to prevent this. David was deemed to have mental capacity and therefore his engagement was crucial to all intervention. The community hub was central to the support offered to David and as a result, many professionals advised David of the support available to him to help him change his lifestyle. David did not engage, and his situation deteriorated.

5.2 David neglected himself and associated with people who did not have his best interests at heart. He was a victim of domestic violence and he disclosed that he was at risk from some of his associates. David did not feel able to provide professionals with the names of these associates and this omission hindered agencies assisting him further. He was murdered in his own home for gain by people who were known to him.

5.3 Although there is evidence of good multi-agency working overall, learning has been identified about the way that agencies worked together in David's case. They were specifically in regard to agencies understanding self-neglect, supporting adults deemed to have capacity but at risk of neglect or abuse, and recognising cuckooing and mate crime.

5.4 Much good practice[19] has been identified during panel discussions regarding this case. Including:

- It is clear that David was difficult to keep in contact with and the persistence of the housing officer to attend his address reflects his good practice.
- The officer who attended the domestic incident was thorough in raising a safeguarding concern due to concerns regarding David's vulnerability.
- The decision made within a hub meeting to visit the address of an associate of David's in order to locate him after visits to his home address had proved unsuccessful, demonstrated good providence.
- STH referral for tenancy sustainment was prompt when concerns were raised regarding David's ability to manage his tenancy.
- The Police Sergeant taking David to hospital when he presented with injuries resulting from an accident on his bike, was exemplary action.

5.5 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning in this case. For example, ASC have introduced the specialist safeguarding team to screen safeguarding referrals and a formal policy for general practice to follow when adults 'do not attend' their appointments, is currently in draft form.

[19] Good practice in this report includes both expected practice and what is done beyond what is expected.

5.6 The review requires that the further recommendations for the safeguarding partnership are made, to ensure that any areas identified as being of concern are addressed.

Recommendation 1:

BISP to recognise and address the multiplicity of mental health pathways that work within a complex model that is confusing for both practitioners and the users.

Recommendation 2:

BISP to revise and review the use of opt-in/self-referral services, and consider whether they are fit for purpose, particularly in relation to people who are reluctant to engage with services.

Recommendation 3:

BISP to review or reformulate the role and remit of the community hubs and ensure that training is available to help practitioners to, understand safeguarding thresholds, apply multi-agency protocols, and refer people in need appropriately.

Recommendation 4:

BISP to ensure that all agencies understand and use a self-neglect policy - to be addressed in training and supervision.

Recommendation 5:

BISP should review/consider a multi-agency protocol for adults deemed to have capacity but who are at high risk of neglect or abuse.

Recommendation 6:

BISP to ensure that training is available for all agencies to help practitioners to recognise, understand and address cuckooing/mate crime and to be confident in reporting crimes to the police on behalf of a client, when appropriate.