

Executive Summary

Safeguarding Adults Review - David (pseudonym)

2024

The Bolton Safeguarding Adult Board and the panel of the Safeguarding Adult Review would like to offer their sincere condolences to the family of David, who have lost their loved one in tragic circumstances.

They would like to place on record their sincere thanks to the daughter of David who contributed significantly to identify recommendations.

1. INTRODUCTION

- 1.1** Bolton Safeguarding Adults Board (BSAB) commissioned this review as it met the criteria of The Care Act 2014 which states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area 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.
- 1.2** The purpose of this review is to promote effective learning and action improvement to prevent future deaths or serious harm in the future. This can also be learnt from good practice. The aim is that lessons can be learned from the case and for those lessons to be applied in future cases.

2. OVERVIEW

- 2.1** David lived alone after separating from his partner and had a distant relationship with his children. He faced severe health issues, including strokes, spinal injury, and partial skull removal, and was diagnosed with depression, anxiety, ADHD, and a personality disorder. He also struggled with substance abuse and poor mobility. From 2019 onward, multiple agencies supported him with tenancy, health, and safeguarding needs, but his engagement was inconsistent due to drug use.
- 2.2** David was repeatedly victimised, experiencing assaults, cuckooing, and theft. Police recorded several crimes against him and made referrals to Adult Social Care, but follow-up was often minimal. He frequently sought help with food and financial issues, and agencies provided food parcels and advice. Despite interventions, he continued to face exploitation and abuse, including threats and physical harm from individuals staying in his home. His vulnerability worsened during COVID-19 lockdowns, and safeguarding plans were put in place but were not always effective.
- 2.3** Between 2022 and 2023, David had multiple hospital admissions for physical health problems and substance-related issues. He disclosed ongoing abuse and financial exploitation by a man named Carl, who later locked him in a flat for two weeks, assaulted him daily, and stole his money. David eventually escaped and reported the abuse, but the investigation was not progressed expeditiously. Safeguarding enquiries were opened but closed without thorough risk assessments or multi-agency conferences.
- 2.4** David's health deteriorated further, with repeated hospitalisations for infections and injuries linked to drug use. There were occasions where he was found disoriented, dirty, and without basic necessities. Despite numerous referrals and care plans, his situation remained unsafe. In March 2024, emergency services responded to reports of an overdose and later discovered David was deceased at Carl's address with extensive injuries consistent with prolonged abuse. Carl was arrested and remains on bail for murder pending forensic results.

- 2.5** This review examined multi-agency collaboration, safeguarding practices, and systemic challenges in supporting David, a vulnerable adult, between 2019 and 2024. While there was evidence of interaction between agencies such as Bolton at Home, the police, hospitals, and Adult Social Care, the overall approach lacked coordination. Referral pathways were in place, but agencies often worked in silos, relying on assumptions that others had acted. This resulted in missed opportunities for joint planning and safeguarding conferences, even after serious incidents like prolonged imprisonment and assault. Care plans were fragmented, and when short-term interventions ended, there was no structured step-down support, leaving gaps in care.
- 2.6** Professionals highlighted David's reluctance to engage limited options for intervention. However, executive functioning was never assessed or considered, despite clear indicators—such as his hospital self-discharge, substance misuse, and cognitive challenges following strokes. Barriers to collaboration included poor system connectivity and limited information sharing between health systems. Housing issues were repeatedly overlooked during hospital attendances, and substance misuse further restricted access to charitable support.
- 2.7** Agencies recognised the risks regarding cuckooing but responses were reactive and fragmented. No home visits or multi-agency plans were implemented, leaving David vulnerable to repeated exploitation. Research shows that individuals with substance misuse, disability, and social isolation—characteristics present in David's case—are prime targets for cuckooing. Differing priorities among agencies compounded the problem, with police focusing on criminal aspects and housing prioritising community impact. The absence of accurate local data and proactive engagement strategies further weakened the response.
- 2.8** Safeguarding assessments were inconsistent. Agencies responded promptly to basic needs, but they missed chances to exercise professional curiosity, such as entering the home during visits. Mental health assessments identified as necessary during hospital stays were never completed, and executive functioning assessments were not considered. Misunderstandings around GMP's "Care Plan" terminology may have created an assumption that they had responsibility for his care. Research emphasises that safeguarding should focus on an individual's ability to protect themselves, not just their decision-making capacity.
- 2.9** Systemically, Bolton is developing the BARM framework to manage high-risk cases outside statutory processes, aiming for proactive intervention rather than crisis management. Discharge planning for self-discharging patients also requires improvement, despite existing SOPs outlining communication standards.

3. CONCLUSION

- 3.1 David had several health issues which impacted on his mobility and although deemed to have capacity in the absence of unsuccessful attempts at an assessment, his executive functioning was not considered even though he displayed behaviour on more than one occasion that evidences he was not capable of making decisions that would keep him safe. This is balanced with the occasions when he disclosed criminal offences that had been committed to professionals against him.
- 3.2 The immediate response to adults in crisis within the Bolton area is effective which was displayed by financial and food support, the response by NWS in either transportation or arrangement of transportation to hospital and subsequent relevant referrals. ASC opened two s42 enquiries, with the first in 2023 closed due to him being in hospital and the risk being mitigated following a home visit where he stated he was on his way out so they didn't enter his home.
- 3.3 Although there is good evidence of bi-directional collaborative working and referring to agencies, there is a lack of multi-agency information sharing through conferences which is required for multi-complex individuals such as David so that the safeguarding plans and longer-term management plans can be made holistically with input from specialisms across the agencies that are required.
- 3.4 It has been highlighted by professionals during this review that a barrier to this is the Chairing of these meetings and the lead agency for oversight thereafter due to demand and capacity issues. This is an area that BSAB need to review and identify either as an ongoing functionality to integrate this process into or identify funding streams to create a function that could enable this.
- 3.5 Although the BARM process will be an extremely vital function to those who it is currently proposed to support, it would not currently support those who have been reduced in risk from high to medium yet are at risk of returning to high risk without any on-going support being provided. (Recommendation refers)
- 3.6 There was good recognition and recording of the circumstances of David being identified as cuckooing as seen on referrals but there is little evidence of agencies actually entering his home to be able to ascertain his living conditions and be fully informed to risk assess in relation to cuckooing.
- 3.7 When care and support needs are not met under The Care Act 2014, this does not mean that the individual does not have vulnerabilities. David had a number of aspects that made him vulnerable and open to exploitation and although he obtained good support from agencies when in crisis that would bring him to a stable position, this meant that he was then closed to that ongoing support and would then deteriorate again and the process would have to then begin from the same point as before. This has been described as the 'grey area' by professionals and means that the individual, in this case, David, is on a rollercoaster, whereby he receives a lot of support from multiple agencies all at one time and can begin to feel better and stronger, then the support stops and he is left to try and maintain that status by himself which he is unable to do as his vulnerabilities are still present. This can be harmful to the emotions of the individual and also causes intense demand on agencies in specific periods causing duplication of work already completed.

- 3.8** Once the intense response to crisis has been completed and the individual no longer meets care and support needs, an overview support mechanism for the longer term that would evade a downward spiral is required. (Recommendation refers)
- 3.9** Executive functioning is something that has come to the fore in the past few years but is not necessarily fully understood by those not trained within this area. It is not to be used for instances where the person is deemed to have mental capacity but makes poor choices due to the abuse of substances for example. A consultant psychiatrist (and nurses on the mental health liaison team) would always consider and take into account executive functioning when conducting any mental health assessment but this is not routinely recorded which then causes issues on review as it appears absent. A medical professional on a general ward would not be able to assess executive functioning. (Recommendation refers)

4. RECOMMENDATIONS

1. **ASC to review the BARM proposal prior to ratification to ensure it includes processes for safeguarding measures similar to those highlighted within this review, once the immediate response in crisis has been addressed.**

This is to establish the extensity of support that it will be able to provide and whether additional functionality can be added or a separate source of process is required.

2. **Promotion of the Neighbourhood Multi-Disciplinary Team is required with communication to professionals across Bolton for wider understanding of their capabilities and mechanisms for referral.**

This facility to provide support was not widely known amongst professionals conducting this review and is a resource that can alleviate capacity issues and provide and overarching responsibility for collaborated working in relevant cases.

3. **Greater Manchester Police (and other agencies if relevant) to consider whether the phrase of 'care plan' remains the correct terminology to ensure it reflects its purpose.**

This will ensure there is no confusion or assumptions that direct care is being provided.

4. **BSAB to compose local cuckooing guidelines that dovetail into the National cuckooing guidelines for instances when cuckooing is identified and it is not perceived that an Organised Crime Group is involved. Guidance should also include good practice around non-engagement.**

This will provide guidance of a process to be followed to avoid agencies referring on without any positive action and to ensure safeguarding measures are put in place and the individual is seen rather than remote communication that if not responded to, leads to the closure of the file.

5. **BSAB should formalise reporting of all cuckooing within the Bolton area to establish it's prevalence so that an informed multi-agency approach and safeguarding measures can be implemented.**

At this time, the review highlighted that Bolton are unaware of the depth of the cuckooing issue within their area due to lack of data collation.

6. **GMMH to ensure discharge planning meetings are coordinated for complex cases allowing a multi-agency approach to support safer discharge. Assessment of executive functioning can be considered as part of these meetings with the appropriate assessor delegated the task (for example, psychiatrist, Speech and Language Therapist, Occupational Therapist etc.)**

This is due to David not receiving an executing functioning assessment post-stroke, despite multiple indicators.

7. **GMMH to audit practice for patients who leave prior to being assessed to ensure staff are following the Standard Operational Procedures correctly.**

David's discharge plan was not implemented due to early self-discharge.

8. **GMMH to audit documentation practices and ensure care plans are completed and communicated clearly to patients and families.**

The family found incomplete documentation from GMMH's Home-Based Treatment Team in David's home.

APPENDIX

Glossary

ASC – Adult Social Care

BARM – Bolton At Risk Management

BSAB – Bolton Safeguarding Adult Board

GMMH – Greater Manchester Mental Health

GMP – Greater Manchester Police

GP – General Practitioner (Doctor)

IOPC – Independent Office Police Complaints

MASH – Multi-Agency safeguarding Hub

NWAS – North West Ambulance Service

OCG – Organised Crime Group

SAR – Safeguarding Adult Review