

Overview Report

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.

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PREFACE

Section 44 of the Care Act 2014 places a statutory requirement on the Bolton Safeguarding Adults Board to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Bolton Safeguarding Adults Board the power to commission a SAR into any other case:

‘A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

- a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
- b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect..., or
- c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

- a) identifying the lessons to be learnt from the adult's case, and
- b) applying those lessons to future cases.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

All Bolton Safeguarding Adults Board members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice (“tell it like it is”).

1. INTRODUCTION

Purpose of the review

- 1.1 David was a white, British male who was 37 years old when he was found dead at the home of a male named Carl, who was, at the time, wanted by the police in relation to an assault on David. At the time of his death, David had a multitude of injuries on each part of his body alongside pre-existing conditions, however, the injuries on their own were sufficient to cause his death.
- 1.2 In April 2024, the Bolton Safeguarding Adults Board (BSAB) commissioned a Safeguarding Adults Review (SAR) under s.44 as they felt it met the mandatory criteria due to evidence of neglect and abuse.
- 1.3 This review is to examine system findings, to better understand the learning that can be taken from David's experiences and strengthen safeguarding systems for those in the future who find themselves in similar circumstances.
- 1.4 Carl has subsequently been convicted of David's murder.

Scope of the review

- 1.5 A Terms of Reference (TOR) was agreed and the focus was on events from 2018 onwards that involved David, agency contact with him during that time, and services that were available to him.
- 1.6 Within this framework, key lines of enquiry were:
 - Was there good evidence of collaborative working across agencies and how effective was this?
 - Do professionals in Bolton have an understanding and knowledge surrounding cuckooing?
 - Were agency assessments conducted appropriately: were they shared across agencies and was practice consistent with making safeguarding personal?
- 1.7 Good practice as well as learning should be shared to assist professionals in the future.

Methodology

- 1.8 Initial scoping was completed and it was apparent that David had a lot of contact with a number of agencies over an extended period of time. Further information was requested in more depth surrounding the areas of the Terms of Reference and then a tabletop event took place where each agency was represented in person and a debate was held to identify learning, gaps in provisions and barriers to both agencies and those in need of support. The following agencies contributed to the review:
 - Adult Social Care (ASC)
 - Probation Service
 - Greater Manchester Police
 - Bolton Adult Safeguarding Board
 - Housing options

- Bolton Foundation Trust
- NHS Greater Manchester ICB – Bolton locality
- Bolton Metropolitan Borough Council
- Bolton at Home
- GMMH
- NHS GM ICB – GP Practice

1.9 The review used the signs of safety methodology when looking at the key themes asking the questions:

- What went well?
- What could have been done better?
- How can we do it better?
- What is the learning and how can we embed this into practice?

1.10 The family were represented within this review by David's daughter, Sophie, as his Next of Kin. It was agreed between the Author and Sophie that David's son was too young to approach and she would speak on the family's behalf.

1.11 Pseudonyms were used within this report to anonymise individuals and provide confidentiality. These were chosen together by the Author and Sophie.

1.12 All panel members and Sophie had sight of this report and its findings prior to finalisation and submission to BSAB.

National and local Policy context

1.13 Since 2015, s42 Care Act extended previous adult safeguarding policy expectations to 'alert' local authorities of any safeguarding risks. Now all 'relevant partners'¹ are expected to cooperate with the local authority in the exercise of their safeguarding function to prevent abuse and neglect, recognise, report and respond appropriately when abuse or neglect occurs. The Care and Support guidance also set clear safeguarding obligations for professionals, providers, commissioners, and regulators to meet expectations to work collaboratively in response to safeguarding concerns.

1.14 The recent national SAR analysis report² identified 60% of SARs published between 2019 - 23 featured presentations of self-neglect. A further 5% explored criminal exploitation- both were features in David's case. A key improvement priority arising from the national report was for SARs to build on previously completed reviews, including those undertaken locally.

¹ defined by s6(7) Care Act 2014 and including police, NHS bodies, the DWP, prisons and probation services.

² Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: <https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2019-march-2023-executive-summary>.

- 1.15** The Greater Manchester Safeguarding Adults Board have provided guidance in 2021³ of how to conduct SARs in their county and BSAB acknowledge that they have not received referrals in order to commission SARs as a matter of course previously but intend to build upon the findings of both this review and the previous published review 'Nancy' in 2022 in which some of the 'key themes' are similar to those explored within this review.

2. SUMMARY OF THE FACTS

David

- 2.1** David lived alone in a 'Bolton at Home' accommodation having separated from his long-term partner and mother of his children, five years previously. He has two children in which his daughter Sophie, described their relationship with their father in the last few years as sporadic and distant but they would always speak if they met each other whilst out and about.
- 2.2** David had experienced a number of health issues. He had part of his skull removed as part of a medical procedure and suffered a double stroke and a spinal injury. David was referred to the Mental Health Team on 20th May 2019 as he had been formally diagnosed with depression, anxiety, ADHD and a personality disorder and was also a known drug user. Medical notes in 2019 state that he had no use of his left arm and poor mobility.
- 2.3** David was supported at the commencement of his tenancy in 2019 until March 2021 by Bolton at Home with general tenancy needs.

Combined chronology of David's experience and responses

- 2.4** David was registered with his GP practice from 2016. David was first known as a victim to Greater Manchester Police (GMP) in 2020. During that year, GMP recorded six separate crimes against David including burglary and assault. The police made a referral to Adult Social Care (ASC) in relation to Cuckooing at the end of 2020 and repeated this two months later in February 2021. On both occasions, ASC attempted to contact David, on the first occasion by email and on the second occasion by welfare letter and received no reply with no follow-up attempted.
- 2.5** David had phoned the Police stating he let a friend stay for a few nights and now he thinks things are missing from his house and thinks his friend might have taken them. His mother had also contacted the police as David had been assaulted regularly by the perpetrator. David stated he did not want Police to take any action for fear of repercussions from the perpetrator and wanted officers to speak to Bolton at home for a move to be facilitated.
- 2.6** Bolton at Home (B@H) had recorded disclosures made several times of assault and cuckooing, with David often refusing to report to Police, however, he did so once he

³ GM-SAB-Safeguarding-Adult-Review-Guidance.pdf

felt safe and the perpetrator had been removed from the premises. Work was undertaken to support David in these issues from B@H Support Team, Neighbourhood Safety Team, and UCAN, alongside GMP, BMBC Adult Safeguarding contacted during that time with concerns for his vulnerabilities. The perpetrator was arrested several months later when David saw him in town and called the police.

- 2.7** Bolton at Home have a number of UCAN centres across Bolton, embedded within communities that provide practical support for those in need of use of technology, housing issues and money matters, health and wellbeing and other areas. David had also rung his General Practitioner (GP) in a distressed state in relation to a young man in his address refusing to leave and had been so for 8-9 months. A referral was forwarded to ASC who spoke to him on the phone and were informed by David that he had been assaulted by the persons family and had spoken to his housing provider in relation to a move. He had been informed that he would need to have an accommodation swap with another tenant (social housing) with the same type of accommodation. Bolton were in National lockdown due to Covid 19 at this time and a protection plan was put in place by ASC although it was recorded that the risk had been removed due to the passing of the young man. There is nothing in the information provided to the review to suggest that the police were involved or aware of this incident.
- 2.8** Incidents continued to be reported to the police in 2022, with damage being caused to David's window and him reporting bullying that caused him distress in the January, but he did not wish to support a police prosecution. He directly contacted ASC on two occasions requesting financial support. On the first occasion, he was contacted within 24 hours and the Early Intervention team delivered food parcels to his home with an offer of support to obtain gas which he declined. On the second occasion, a week later, he was referred to the Food Bank services, money skills team and his GP as there were wider concerns identified around drug use and lack of financial management as his persistent drug use and accessing food banks on a regular basis had caused an issue with him accessing further support from charitable services.
- 2.9** Less than two months later, whilst in hospital, he was referred to the admission avoidance team (NHS led service) stating that support was needed for David on his discharge. He then reported to the police that offenders had broken into his home and caused extensive damage, leaving items of drug use and stealing his television and Xbox. The offenders were not identified and the crime was closed.
- 2.10** David was again an inpatient in August 2022 and had contact with the Salford Mental Health Liaison Service (GMMH) and was open to the Achieve Service at that time but was only seen on one occasion as he did not attend offered appointments, was difficult to contact and was eventually closed to the service. He was discharged from hospital having been assessed as not needing a package of care. Records show he had again disclosed people staying at his home in which he felt unsafe and wanted to move.
- 2.11** Between 04/04/22 and 13/06/23, significant multi-agency work was carried out between Bolton at Home, the Community Learning Disability Team and Independent Living Service to assist in the cleaning of his property, food parcels, money skills, referring him to the Tenancy Sustainment Team and assisting him with his activities of daily living. David continued to use substances during this period which made his engagement fluctuate which resulted in him agreeing a course of action and then

changing his mind. On 13/06/23, he was found to not have eligible Care Act needs and all referrals required had been completed and he was therefore closed to the Community Learning Disability Team.

- 2.12** In July 2023, David was referred to psychology which is under GMMH, which was his first referral since 2020. This was due to a worsening mood and anxiety over the past two months and he was struggling with motivation. His physical health was a concern but he was engaging with his GP. He requested an increase in Diazepam but was refused due to his history of substance abuse and it was noted that he may benefit from a therapeutic approach due to his low mood but it does not appear that this took place.
- 2.13** Over the next couple of months, David came to the attention of a number of agencies. David reported an incident to the police in which he had received threats but would not disclose by whom. The police made referrals to the Emergency Intervention Team (EIT - ASC) and Achieve substance services (GMMH) as he was struggling to go out or carry heavy items due to a recent back injury. He had no-one to support him and his flat was dirty with no food in the fridge and was not eating properly.
- 2.14** In August, David had a fall which led to back pain and subsequently, he called an ambulance a week later. It was established that he had attended Bolton Hospital the day previously but left when he was informed to attend Salford Royal Foundation Trust (part of the Northern Care Alliance – NCA). He disclosed to the crew that he had been befriended by a male named Carl who had been taking money from him. Carl had initially been present but left halfway through the assessment and it was then the disclosure was made. He stated that Carl had originally offered him help and allowed him to stay at his house to try and get him off drugs. Over the last two months, Carl had been taking money from David and when he refused to pay him, Carl would threaten and assault David. Due to this, David had been struggling to find money for food and to pay for gas. The crew recorded this information on their system which is accessible to Salford Royal Foundation Trust (NCA) and arranged a funded taxi to transport him to Salford Royal Foundation Trust (NCA) hospital.
- 2.15** The hospital referred the concerns to ASC surrounding cuckooing, physical abuse and theft and a S.42 enquiry commenced. David was re-admitted to hospital on a number of occasions over the following months. Multi – agency work was undertaken between the Safeguarding Adults Team, the Integrated Discharge Team at the hospital, the police, Bolton at Home and VSCE organisations with David being consulted and spoken to throughout. The concerns he had raised were mitigated and he was returned as per his wishes and facilitated by Bolton at Home changing the locks, with his ward setting up online shopping for David and ensuring he had food when discharged and the police checking the property to ensure Carl was not there.
- 2.16** Whilst in hospital, attempts were made to complete a Mental Health Assessment with David as GMMH had received a referral for a Mental Health Assessment due to David's suicidal thought, but this was not completed due to either refusal or him not being on the ward at the time the Doctor attended. Issues arose with David frequently being off the ward and concerns over drug paraphernalia being found in his room, causing a police search as he was injecting a needle into his groin. There were no concerns identified relating to David's mental capacity (2005) to make informed decisions.

- 2.17** At the beginning of September, whilst still in hospital, David suffered a double stroke in which he was given a Craniotomy and was transferred to Royal Bolton hospital for ongoing stroke rehabilitation. He had still not been reviewed by the Mental Health Liaison Team. It was believed that he had been taking crack and heroin in the hospital toilets.
- 2.18** David had been discharged from psychology at the beginning of August due to no response to screening or follow up letters, although it is not known if he received these. The ambulance service (NWS) attended calls relating to David on numerous occasions throughout the times he had been discharged from hospital. It was discussed that formal support would not be appropriate from ASC as David did not have eligible support needs under the Care Act.
- 2.19** In November 2023, the police were called to a Tesco pharmacist as David arrived to collect medication and was acting disorientated and unsteady on his feet looking dirty and lethargic. Police records state that David accepted a referral back to Achieve. The call was passed from the police to the ambulance service (NWS) and NWS returned him home in a taxi with a referral made to Early Adult Help Service which was then undertaken by the Early Intervention Team (ASC).
- 2.20** The referral stated that David had told members of the public that he was being mistreated by someone living with him. Local Tesco staff mentioned that "he visited often with a gentleman who apparently treats him "like a dog". David told Tesco staff that this gentleman has taken over his flat and when they are there, he has to stay in his room. He also said they take his money and make him ring round for food parcels and money." Several attempts to contact David were made by ASC EDT (Emergency Duty Team) to no avail.
- 2.21** A Care Act 2014, section 42 safeguarding enquiry was completed under the category of emotional, psychological, physical, financial and material abuse. He was visited by two social workers four days later after several unsuccessful attempts to contact him. They met David who stated he was on his way out and was well.
- 2.22** The police had six care plans, one for each incident that was recorded between 2020 and 2024 with more recent care plans relating to David looking dishevelled and disorientated. He had been discharged from hospital and stated he had lost his front door keys. His clothing was dirty and appeared to have blood on them and he appeared to have soiled himself. He was in a poor state and said he was going to return to hospital.
- 2.23** David spent January 2024 in hospital due to an abscess in his groin caused by injecting himself. He had lost his keys and was unable to get into his property and asked for some help at home, so he was provided with the Bolton at Home maintenance number and allowed to use the phone and a referral for support at home was made. Two days after discharge, the police were called as David was found in his hospital gown appearing dirty and soiled in the town centre. He had not gone home due to having no keys and had stayed at a friends' where the house was in a poor state. He was fed by the Salvation Army and then transported to hospital. Within the space of a few days, David had fallen and banged his head, returning to the Accident and Emergency department (A & E) and disclosed to Bolton at Home that he was being bullied and

threatened by residents in his block of flats. A query was sent to the Bolton Local Authority safeguarding Team to see if this could be explored in the community.

- 2.24** David had several admissions to hospital prior to his death to treat multiple physical health issues. He attended both Salford Royal hospital and Bolton Foundation Trust hospital and had five attendances to A & E dating from 31/12/2023 to 22/02/24.
- 2.25** On 22nd February 2024, David attended the UCAN centre as he didn't know where else to go and subsequently reported to the police once he had been transported to hospital, that he had been held, locked in a flat for fourteen days by a male named Carl. He had known him for about twenty years having met through friend of a friend. Carl had told David he would give him something to eat and a nice hot bath after his flat had been broken into and he couldn't live there anymore due to damage that had been caused there.
- 2.26** Whilst at Carl's, David's money had been taken off him and had been beaten up regularly. Carl wouldn't let David leave as he had to wait until 26th February 2024 to pay him money from his benefits. He would keep beating David and he would have nothing to eat. David stated he would have a few sips of water when he had been to the toilet. However, he later stated he had access to the fridge in the kitchen. Carl would make up things that were not true just to 'go off at him' and he couldn't get out of the flat as he kept the door locked. He made David sleep on the floor or on the couch. Carl would sleep in his bed in his bedroom.
- 2.27** The only person that had been in the flat in those 14 days has been Carl. He made David ring up telephone banking on Monday and transfer £170. The account was Carl's mum's account. He told David that he owed his mum money.
- 2.28** One morning, Carl woke up and the heating was on. He thought it had been on all night and used all his gas. He thought David had put it on and he ended up getting assaulted for this. He told David that he doesn't mind the heating on, but he didn't like the lying. David ended up admitting to things that he hadn't done just to try to avoid being hit.
- 2.29** He would punch David every day in the face, head, body, ribs, kidneys. The injuries to his face happened a couple of days prior. He also had bruising to his right arm around 6 inches from his elbow, that was caused by a piece of wood, like a bed slat.
- 2.30** On the average day, Carl would be there most of the time. David would be lying on his bed watching TV, and he would be doing the same. When he was aggressive, he threatened David saying that he was going to do things like chop him up and stab him in the eye. Not much else would happen apart from Carl going to the chemist at around 14:30hrs to pick up his medication for drugs.
- 2.31** David had seen an opportunity to leave the flat on the 22nd of February 2024 and got out as quickly as he could as Carl was still in bed asleep.
- 2.32** Nobody had known where David was, and he doesn't have anyone else. He told the police he had a flat and still had the keys to the flat, but it needed work doing and he stated he couldn't go back there. The Police placed Carl as 'locate trace' and did not progress the investigation.
- 2.33** NWAS attended with staff from Bolton at Home present and he was taken to Royal Bolton Hospital. David left the hospital the following day without being discharged.

Bolton at Home held a cross-service review meeting to discuss concerns for David due to his unknown whereabouts. It was then that it was agreed that when he was found, a decision would need to be made in regard to temporary accommodation.

- 2.34** Referrals were made to ASC in relation to cuckooing and physical assault and a s42 enquiry was opened. Safeguarding Adults conducted a welfare visit and liaised with the police. In February 2024, ASC attended his address and spoke to him outside momentarily but did not return to explore concerns raised by staff at the food store when he was found in his hospital gown. ASC then closed the s42 enquiry without a multi-agency conference, a repeat visit or sufficient information gained to accurately risk assess.
- 2.35** In March 2024 a 999 call to NWS reporting a male had taken an overdose in which they were unable to find the address provided (incorrect address given potentially by Carl) and the incident closed. The safeguarding team made numerous attempts over the week to ascertain if he had been seen by agencies. Three days later, NWS received a further 999 call was made reporting a deceased male who was later identified to be David who had visible injuries. NWS contacted the police and the address, which was Carl's home address was treated as a crime scene. Carl was arrested. He has since been convicted of David's murder.
- 2.36** A forensic post-mortem took place and it was found that David had injuries both externally and internally to all parts of his body and it was felt that he may have been deceased for a couple of days prior to discovery. Some of the injuries found correlate with David's disclosure as outlined at 2.29 of this report.

3. ANALYSIS AND CONCLUSION

3.1 Is their evidence of collaborative working across agencies and how effective was this?

- 3.1.1** Collaborative working between agencies has been identified and should be recognised, evidenced with Bolton at home having interactions with the police, Royal Bolton hospital and Adult Social Services from 2019 through to 2024.
- 3.1.2** Pathways for referrals are evident and have been made on each occasion that David disclosed incidents or concerns to agencies. Referrals were made to ASC on a number of occasions by differing agencies leading to s42 investigations. Following the disclosure of a serious assault and being kept imprisoned for fourteen days on 22/02/24, there was evidence of bi- agency conversations but no coordinated involvement and no MDT or safeguarding conference took place for a holistic and multi-agency approach. David's whereabouts was unknown to some agencies yet known to Bolton at Home but no discussion took place in a multi-agency forum for information to be shared and coordinated. This would have also clarified the situation regarding access to the property.
- 3.1.3** He had left hospital prior to being formally discharged and it was voiced that although referrals are completed, there is a lack of understanding of the difference between 'he doesn't want to go home' as opposed to 'he can't go home'. It is possible that assumptions were made as to whether he was in the care of another service. Also,

assumptions that other agencies would have made a referral and therefore, each agency relying on another to the extent that no referral is made by an agency are all apparent.

- 3.1.4** Care plans were not multi agency and therefore each agency were working in silo the majority of the time and when the short-term intervention ended, there was a gap with no-one to step-down a level to although he still had needs.
- 3.1.5** Professionals felt that the biggest issue was that David would not engage with services and that if there is nothing to say that a person lacks capacity, then there are few options available to change their circumstances. Executive functioning was not considered even though David presented on multiple occasions with multi complex needs as although he knew how to get help, he went to the UCAN centre instead of the police, had a history of drug abuse, strokes and use of ADHD medication and remained in a hospital gown days after discharging himself. Professionals felt that this was an area that could have been explored with a psychologist from the stroke team making an assessment around executive functioning whilst David was in hospital, but this did not happen and a professionals meeting was not held. It was felt that this was a learning issue.
- 3.1.6** Barriers to collaborative working were identified in the form of staff at hospitals not having access or connection to any information held on other health systems which reduces the amount of information available in order to appropriately risk assess prior to discharge. On each occasion of his five attendances at A & E, there were no referrals made in relation to his accommodation problems to any housing department. However, there were occasions where referrals were made to the Adult Safeguarding Team and/or contact made to ensure previous referrals had been received and were being responded to.
- 3.1.7** Due to David's persistent substance use and accessing food banks on a regular basis, ASC state that this caused issues with obtaining further support from charitable services.

System findings

- 3.1.8** Bolton's Community NHS services and Adult Social Care teams are organised into 6 multi-disciplinary neighbourhood teams with each neighbourhood covering a population of 30-58,000 people. There is a Neighbourhood Multi-disciplinary Team (MDT) meeting in each neighbourhood fortnightly in which any organisation can refer a person who they think requires wider support than they alone can offer but may not be aware of which service is the most suitable and therefore cannot make a direct referral.
- 3.1.9** From this meeting, a plan is devised for the person referred with documented actions for the professionals who are identified as being able to offer support. Neither Community Mental Health teams or drug and alcohol services regularly attend these meetings at present and there can be a gap in allocating a key worker if the person is younger and/or complex. Other areas have specific teams that specifically do this work.

- 3.1.10** During the tabletop event, there was a lack of knowledge amongst professionals of either the neighbourhood teams per se or the capabilities of the teams.
(Recommendation refers - 2)

3.2 Do professionals in Bolton have an understanding and knowledge surrounding cuckooing?

- 3.2.1** David first reported a person in his home who had been there for some time and refusing to leave in 2020. This was recorded by Greater Manchester Police under criminal offences in which David did not support a criminal prosecution, and they were therefore not progressed. The police made a referral to ASC that David may be a victim of cuckooing to which a telephone call was made but was unsuccessful and the file was closed. This was during Covid 19 and no further action was taken by either the police or ASC.
- 3.2.2** David's mother reported similar circumstances in 2021 in which the police attended, spoke to David at his door in which he showed fear, and when the perpetrator came to the door and was aggressive, he was removed from the location. A referral was made to ASC in which they emailed David and sent him a welfare letter due to him having no phone. No further action was taken and, on both occasions, no home visit was completed to ascertain risk and appropriate safeguarding measures.
- 3.2.3** Research into preventing cuckooing victimisation⁴ identified primary targets for cuckooing perpetrators are those who suffer from alcohol or drug dependency, physical disability, mental health or learning disability, frequently they live in socially deprived neighbourhoods. In addition, numerous other risk factors include history of care, present or prior neglect, physical or sexual abuse, financial or housing insecurity or homelessness, social isolation and/or lack of support network, neurodiversity or brain disorder and connections to other vulnerable groups or those involved in street gangs or county lines activity. Many of these indicators of multiple disadvantage featured in David's experiences.
- 3.2.4** Although this research is in relation to identifying Organised Crime Groups, it relates to David's circumstances of being 'befriended' by Carl who has honed manipulation skills over time resulting in a complex interpersonal relationship whereby the victim may be unaware they are exploited and speak of 'friends'. They are therefore usually reluctant to engage with police and safeguarding agencies either because they don't want to undermine what they perceive as a relationship, or they fear retribution or both.

⁴ Undertaken by Dr Laura Bainbridge and Dr Amy Loughery University of Leeds, 2024, available at: [https://essl.leeds.ac.uk/downloads/download/244/understanding-and-preventing-cuckooing-victimisation-dr-laura-bainbridge-and-dr-amy-loughery-university-of Leeds](https://essl.leeds.ac.uk/downloads/download/244/understanding-and-preventing-cuckooing-victimisation-dr-laura-bainbridge-and-dr-amy-loughery-university-of-Leeds)

3.2.5 Rose Broad's research into multi-agency responses to cuckooing⁵ explored common barriers to developing a 'community of practice'⁶. Her work highlighted that although police, housing, health and social care all had underlying public sector duties to safeguarding and promote equality of opportunity, the agencies have differing priorities when responding to cuckooing. Police will, understandably, focus on criminal responses. Housing staff's priority is the impact for other residents, reflecting the limitations of their powers only to intervene if behaviours have wider public health or safety ramifications. Social care participants within her research also reported challenges where the perception was one of a dysfunctional relationship rather than a clear victim- offender paradigm. Broad identified that the differing priorities could make it difficult to establish a community of practice as it wasn't always apparent who should take ownership of the problem and who should be part of any community of practice or team around the person.

System findings

- 3.2.6** Responses to cuckooing are fragmented, reactive and too heavily focused on criminal or civil sanctions. The process of referrals to the police and them being the lead agency in relation to cuckooing from Organised Crime Groups is known to all agencies. The Police in these circumstances are re-active to the situation and in cases of cuckooing of an individual in the circumstances of David, whereby one individual or more is exploiting him for their own gain, pro-active work by front-line professionals who are more likely to have contact and a relationship with David should be progressed.
- 3.2.7** Agencies did identify the circumstances of David as cuckooing but there was no multi-agency consultation, plan or response in the absence of an identified process which left David susceptible to further cuckooing as was identified in this review and on records.
- 3.2.8** Entry into David's home may have identified safeguarding measures that could have been implemented and challenges with re-housing David due to lack of available alternative accommodation prevented him from moving away from a location that was known to be targeted.
- 3.2.9** Data collation on cuckooing within Bolton is only held by the police and recorded in relation to County Lines and Organised Crime and therefore is not an accurate representation of the cuckooing situation within the Bolton area. (**Recommendation refers - 5**)

⁵ This research focused on processes and practice across Greater Manchester Authority, and reported at a Symposium on the 03.05.23 and available at: https://essl.leeds.ac.uk/downloads/download/217/communities_of_practice_in_multi-agency_responses_to_cuckooing

⁶ Defined by Wenger (2009) as 'groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly'.

3.3 Were agency assessments conducted appropriately: were they shared across agencies and was practice consistent with making safeguarding personal?

- 3.3.1** There is evidence of a response to David's needs and requests within 24 hours of being contacted with ASC and local charities supplying food parcels and financial support
- 3.3.2** ASC attended the home address of David for two separate s42 enquiries but did not enter the home on either occasion. Although there are no powers of entry to look inside the home, professionals can often gain access with conversation and these were missed opportunities to show professional curiosity to expand on the information already disclosed.
- 3.3.3** The GMP term Care Plan is an electronic record which cannot easily be amended, it would need re-coding within GMP's computer system. The term was built into the computer system in 2019 and is used for all 10 districts across GMP. Having reviewed this case, it is accepted there has potentially been a misinterpretation or misunderstanding of the GMP term 'Care Plan' by some partners. Therefore, the SCRT made enquiries with each district safeguarding team asking whether there have previously been similar queries raised by partners; however, this appears to be an isolated case and there is a well-established understanding across the GM regarding the GMP term "care plan". The term care plan reflects care planning completed by GMP which is the recording of information where there have been concerns for a person's welfare and to keep a record of when and where referrals are made to the appropriate external agencies who provide the necessary level of care. ([Recommendation refers - 3](#))
- 3.3.4** During his lengthy stay in both the Royal Bolton Hospital and Salford Royal hospital in 2023, it is recorded that several attempts to assess David's mental health were made but were not completed due to him either not being on the ward, the doctor being called away or David not consenting. The fact that it was clearly identified that he required this assessment should mean that all efforts to complete this within the months period he was an inpatient should have been utilised.
- 3.3.5** Due to David's medical history, his drug use and his repeated disclosures of how he was being exploited, following his stroke, an executive function assessment should have been considered and completed by the stroke psychologist but there is no record of this being contemplated. This would have assisted with support being provided even if David refused to engage.

System findings

- 3.3.6** Research findings into self-neglect⁷ warn practitioners that they should explore the person's ability to protect themselves. This is important in the context of safeguarding functions because it is the 'ability to protect themselves' rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing. The 'wellbeing principle' includes a focus on personal dignity, choice and control, but there 'is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round'. Equal weight should be attributed to duties to protect health, remove risks of abuse or neglect alongside respecting choice and control. Professional judgement is needed in such situations; practitioners must balance natural instincts to intervene with obligations (under s1 Care Act) to safeguard or promote independence with the need to respect autonomy and develop a relationship of trust.
- 3.3.7** The BSAB are currently developing a shared multi-agency framework, BARM (Bolton Adult Risk Management) to assist in managing cases involving adults where there are a level of high risk and the circumstances 'sit outside' of the statutory adult framework. It supports case discussion where no multi-agency case discussion and risk management process exists and is in addition to existing multi-agency processes.
- 3.3.8** An adult is believed to be 'at risk' when they are unable or unwilling to provide adequate care for themselves and:
- Are unable to obtain necessary care to meet their needs; and/or
 - Are unable to make reasonable or informed decisions due to mental health issues, a learning disability, or an acquired brain injury; and/or
 - Are unable to protect themselves adequately against potential exploitation or abuse; and/or
 - Have refused essential services without which their health and safety needs cannot be met but lack the insight to recognise this.
- 3.3.9** The BARM framework is a proactive approach, focusing on prevention and early intervention rather than crisis management. Observations were made that there would be capacity issues within this process and the criteria that David met would not automatically fall within the criteria of the BARM.
- 3.3.10** The framework is to support agencies and practitioners where it is clearly evidenced the individual has capacity under the Mental Capacity Act. BARM is not a replacement for single agency risk management or pre-existing multi-agency discussion processes.
- 3.3.11** The framework will be used in situations where an adult is living with a level of risk that is not currently managed under existing multi-agency arrangements or other processes and the individual continues to make serious, unwise choices, putting themselves

⁷ For example, Bray, Orr and Preston-Shoot (2015) 'Serious case review findings on the challenges of self-neglect: Indicators of good practice' Journal of adult protection 17,2, 75-87

and/or others at risk and where the multi-agency collaboration feels they have exhausted all options and legal duties open to their organisations.

3.3.12 The purpose of any meeting will be to review that all appropriate and reasonable efforts have been exhausted and offer advice and recommendations.

3.3.13 Concerns from the panel were voiced in relation to David self-discharging from hospital and whether the discharge plan would be effective in these incidents. There is a ratified Mental Health Liaison Standard Operational Procedure (due to be reviewed April 2027) that clearly sets out the expectation of MHLT if a patient leaves prior to being assessed. Communication standards are clearly set out in the SOP which are explained in the following paragraph.

3.3.14 At the point of discharge from the service, a discharge letter is sent to the patients GP and all relevant professionals involved (with the patient's consent) within 24 hours of discharge from ED and 7 days from acute wards. Individuals are offered a copy of their discharge letter addressed to their General Practitioner (GP). If this offer is declined, the refusal should be documented.

The letter includes the plan for:

- On-going care in the community/aftercare arrangements.
- Crisis and contingency arrangements including details of who to contact.
- Medication, including monitoring arrangements.
- Details of when, where and who will follow up with the patient as appropriate.

3.3.15 Additionally, if the acute side were concerned that a patient self-discharges & they have concerns about a person's MH, then medical staff could enact a 5 (2).
(Recommendation refers)

3.4 Family observations

3.4.1 Sophie describes her Dad as stubborn and states that for him to attend the UCAN centre to ask for help must have meant that he was in serious trouble.

3.4.2 Sophie forwarded the author photographs of documentation that she found in her Dad's home following his death. They related to a Home-based Treatment Team service user pack which included an Occupational Diary and a safety plan booklet provided by Greater Manchester Mental Health. On reviewing these documents, Sophie identified that very few entries, if any meaningful entries at all had been made and questioned the Author as to what home care had been provided to her Dad on his discharge from hospital following his double stroke as the documentation was not completed and she felt that it appeared no support had been provided.

- 3.4.3** The Author forwarded these documents to BSAB who made relevant enquiries with Greater Manchester Mental Health, Bolton NHS Foundation Trust and Achieve.
- 3.4.4** A discharge plan had been in place for his formal discharge from hospital on 02/11/24 in which the neighbourhood safety officer and the police would meet him to change the locks to his address. A food hamper would have been provided to him on the ward and a student from Occupational Therapy supported David to do an online food shop and purchase a microwave prior to his discharge. No further active therapy was required.
- 3.4.5** Occupational Therapy had expressed concerns raised by the MDT that David did not know where his electricity key was and that he could maybe do with support on discharge with a social worker examining whether he could be referred to the early intervention team. David left the ward on the 01/11/24 prior to the plan being commenced and it was therefore not completed.

3.5 Conclusion

- 3.5.1** 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.
- 3.5.2** 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 to 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.
- 3.5.3** 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.
- 3.5.4** It has been highlighted by professionals during this review that a barrier to this is the chairing responsibilities for 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.
- 3.5.5** 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)

- 3.5.6** 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.
- 3.5.7** 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.
- 3.5.8** 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](#))
- 3.5.9** 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