Safeguarding Adult Review

[Michael]

Commissioned By:	Richmond and Wandsworth Safeguarding Adults Board
Lead Reviewer and Author:	Mark Power (Mark Power Safeguarding)

Contents

1. Introduction

In June 2020, the Richmond and Wandsworth Safeguarding Adults Board scrutinised the case of Michael who had been found deceased at his home in January 2020. His death was the result of a homicide, having been the victim of criminal exploitation by a County Lines criminal drugs network[1]. Michael was known to a number of services and was being supported at the time of his death.

The safeguarding board recognised the potential for improving the way agencies worked together to safeguard adults at risk and commissioned this Safeguarding Adults Review[2]. An independent author was appointed to work with the safeguarding partners to review practice and use the experiences of Michael to:

- Identify potential improvements in order to safeguard and promote the welfare of adults at risk.
- Support the development of safeguarding practice and services.

A number of agencies participated and key thematic areas offering the potential to improve outcomes were identified, outlined in this report as follows:

a) Multi-agency planning and the commissioning of services – Section 5.
b) Understanding criminal exploitation – Section 6.
c) Community Treatment Orders – Section 7.

2. Methodology

An independent lead reviewer was appointed to work alongside a panel of local professionals to undertake the review. Chronologies and single organisation reviews were provided by each agency, analysing practice events and considering how changes to practice may deliver future improvement. The Mental Health Services provided a comprehensive Root Cause Analysis.

Practitioners and senior representatives from each agency met for a further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for consideration by the safeguarding board. Michael's family was provided the opportunity to be involved in the review, but were unable to. His mother, who knew his circumstances best, was unable to contribute due to her health.

Terms of reference were provided by the safeguarding board, identifying the following research questions:

- How professionals understand their role in protecting vulnerable people who also use substances from criminal exploitation.
- How effectively organisations work together to support people with complex needs.

This report outlines the recommendations in a concise format. It is written with the intention of publication and as such does not contain information which may identify those involved. The detailed analysis of events and the evidence underpinning this report are held in additional documents retained by the safeguarding board.

[1]County Lines Explanation - https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines

[2] Explanation and purpose of a review - https://sabrichmondandwandsworth.org.uk/safeguarding-adult-reviews

3. Michael - An Overview

Michael was a talented musician and artist, who had lived alone for many years. He had a long history of poor mental health and at the time of his death was being supported by the Mental Health Trust. He had been known to its Recovery and Support Team for over twenty years, having a diagnosis of schizoaffective disorder complicated by the use of controlled drugs.

Michael had a long history of poor engagement with the services and professionals supporting him. He had a reluctance to take his medication, was inconsistent in attending appointments, and did not like to allow professionals into his home. He had been admitted to hospital on twenty three occasions (since 2001) and following discharge had a history of relapse and repeated admission. His mother had provided him constant support and maintained excellent communication with the services working with him, however at the time of his death she was herself vulnerable. She was elderly and suffered from poor health.

Michael was known to the Metropolitan Police, which over a long period had received an extensive number of reports involving him. These included reports of anti-social behaviour connected to a long standing dispute with a neighbour[3] and which had resulted in him being the recent victim of violence.

On the 22nd March 2019, Michael was discharged from his most recent hospital admission under a Community Treatment Order (CTO)[4]. He was supported by the Mental Health Trust's Recovery and Support Team, in addition to Adult Social Care[5]. In September 2019 his CTO was discharged and his engagement with services diminished. In December 2019 Michael's mother raised concerns that she had not seen him for some time and on the 2nd January 2020 reported him to the police as a missing person. Michael was later found deceased in his home.

The police investigation determined that Michael was likely to have been the victim of criminal exploitation during the summer of 2019 and up until the point of his death. Members of a County Lines network had used his premises to supply controlled drugs, in criminality which is commonly known as 'Cuckooing'[6].

4. Key Practice Events

a) Prior to Michael's hospital discharge on the 22nd March 2019, a planning meeting was attended by both the Mental Health Trust and Adult Social Care. This identified that the support of drug and alcohol services would be a key issue for Michael and should form part of his ongoing care plan.

b) To support his discharge a care plan was developed under the Care Programme Approach[7], led by the Mental Health Trust Care Coordinator. This was however a single agency plan and did not

[3] First incident of ASB recorded by the Housing Services in 2002 – reported by the neighbour.

[4] CTO - https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/community-treatment-orders

[5] The Mental Health Social Care Team.

[6] Cuckooing Explanation - https://crimestoppers-uk.org/campaigns-media/news/2018/mar/let-s-stop-cuckooing

[7] A framework for multi-agency care planning - https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa

involve the Drug and Alcohol services as recommended and as required under the Trust's Dual Diagnosis policy[8]. The care plan did not identify the risk of criminal exploitation.

c) Adult Social Care appointed a Social Care Assessor to support Michael in his return home. This included the commissioning of a cleaning service to support his living arrangements. Whilst there was a good working relationship between professionals, each agency worked independently as opposed to collaborating in a formal multi-agency care plan.

d) Following his discharge, Michael did not attend his first 48 hour review appointment. This was the start of a pattern of missed appointments and the inconsistent taking of his prescribed medication (Depot Injection[9]). Michael had told professionals that he did not want the medication and only took it as it was a condition of his CTO.

e) In May 2019 the police attended an incident at Michael's home in relation to the long standing dispute with his neighbour. This had resulted in Michael being assaulted and his flat damaged. A safeguarding referral was not submitted by the Police, however Michael did inform his Care Coordinator of the incident.

f) In September 2019 a consultant psychiatrist discharged Michael's CTO, providing a rationale that he had engaged well with his medication and support services. This was despite clear evidence to the contrary. Following the removal of the CTO Michael stopped taking his medication and disengaged from support services.

g) In a six week period from late August 2019, the police received two reports about the illegal supply of controlled drugs from Michael's flat. As these had not been corroborated no further action was taken. Safeguarding referrals were not submitted and the agencies supporting Michael were unaware of the reports. At this time Michael's mother had reported concerns to the Mental Health Trust that he may have returned to drug use.

h) In November 2019 the police received an emergency call from Michael to say that a male had forced his way into his flat and threatened to kill his cat. The police attended and determined that it was an argument between two friends about who was to use the last of their drugs. No safeguarding referrals were submitted and partnership agencies were unaware of the incident.

i) On the 13th December 2019, Michael's mother reported concerns to the Mental Health Trust that she had not seen him for some time and was worried about his safety. The care coordinator attended his address and after receiving no reply requested the Police to conduct a welfare check. This was declined in accordance with policy, as the report did not indicate any immediate risk to his safety. The Police provided advice that his Mother should report him missing if concerns existed. This was done on the 2nd January 2020 and after forcing entry into the flat Michael was found deceased.

5. Multi-Agency Planning and Commissioning of Services

5.1 Overview

Throughout the review it was identified that whilst individual professionals were committed in supporting Michael, there was a consistent lack of multi-agency coordination. This greatly affected the efficacy of his initial care plan and meant that changing events in his life were not identified and responded to. Whilst arrangements exist for the development and review of multi-agency planning[10], Michael's plan was developed in a single agency approach. The involvement of key partners at an early stage would have had the benefit of effective information sharing, the joint

[8] For persons with co-existing mental health illness and substance misuse difficulties.

[9] Antipsychotic medication.

[10] Care Planning Approach (CPA) framework and Section 117 of the Mental Health Act.

assessment of risk, and using the capabilities of different agencies to create a comprehensive safeguarding plan. Whilst the care plan was reviewed regularly by the Mental Health Trust, it did not have the benefit of emerging information known to other agencies.

Prior to Michael's discharge from hospital it was recognised that drug and alcohol services would be key to his care plan, but this was not included. Having examined the underlying reasons, the review panel felt that this was due to a bias held by professionals. Michael had a history of not engaging with substance misuse services and it is probable that an assumption existed that he would not on this occasion. Rather than focussing on finding ways to increase his engagement, plans focussed on trying to manage an expected disengagement from services.

A person centred approach[11] to safeguarding may have offered the potential for improved outcomes, looking deeper into his life to identify what was important to him and using these things to help build positive personal relationships. This may have helped to improve his wellbeing, whilst building engagement with professionals and allowing a greater insight into his life. Taking time to understand the underlying issues with his neighbour dispute and helping him to address these should also have been important. One of the key risks of criminal exploitation is a lack of positive relationships in a vulnerable person's life and seeking to address this would have helped to reduce this risk.

Involving the local policing team in the safeguarding planning could have added great value. Developing an understanding of Michael could have helped local staff to understand the context of the drug supply intelligence and the incidents reported at this home. This may have led to a more comprehensive response and the engagement of partners. The local policing commander chairs the CMARAC[12], a partnership forum to manage and resolve high risk cases of anti-social behaviour. This may have helped to address the neighbourhood dispute whilst further safeguarding Michael.

In 2020, the safeguarding board introduced new procedures for the multi-agency assessment and management of risk[13]. This provides guidance for high risk cases managed outside of statutory safeguarding arrangements, embracing a person centred approach and following the 'Making Safeguarding Personal' principles. Whilst this is not intended to support cases such as Michael's, had its principles been followed then it would have provided the basis for improved planning.

In January 2021, the safeguarding board completed a safeguarding review in relation to a homicide that occurred in 2017. This identified issues similar to Michael's case, such as the joined up approach to managing risk and the unconscious bias of staff when dealing with people who are reluctant to engage with services.

If the efficacy of safeguarding people with complex lives is to be improved, then a new strategy for partnership safeguarding will be needed. The basis of which should be to develop a partnership vision as to how the quality of engagement can be improved through a contextual approach.

It is recommended that the current management of risk framework is expanded to form the basis of a new strategy for partnership safeguarding and that this applies to safeguarding in all settings, whether completed under a statutory framework or other process. The remainder of this report

[11] https://www.scie.org.uk/prevention/choice/person-centred-care

[12] Community Multi-Agency Risk Assessment Conference

[13] Multi-agency Risk Assessment Framework 2019-2020

section provides guidance as to what should be considered in any new strategy and includes the following key issues identified during the review:

5.2 Person centred approach
5.3 Multi-agency planning framework
5.4 Commissioning services
5.5 Police safeguarding structures
5.6 Disengagement of service users

5.2 Person Centred Approach to Safeguarding

One of the key principles underpinning adult safeguarding is 'making safeguarding personal'. Putting the person at the heart of decision making and activity. This applies to all safeguarding, regardless of the complexity and risk level of a specific case.

A person centred approach should underpin any new partnership strategy, encouraging professionals to fully understand what is happening in the person's life and considering their wishes in the development of a safeguarding plan. The quality of plans should be assessed on this principle and it should form the basis of supervision sessions and the review of plans.

5.3 Multi-Agency Planning Framework

A diverse range of agencies involved at the outset of planning adds a richness to the assessment of risk and the quality of plans. It further provides the opportunity for professionals to challenge each other and for the development of increased professional curiosity. In the majority of complex cases the three key statutory partners (Police, Local Authority, Health) will all be involved in the person's life and have an important role in the planning process.

It is recommended that a planning framework is developed as part of the new strategy and that the statutory partners form the foundation of new partnership arrangements, supported by other key agencies. The current management of risk framework would be a useful starting point, which could be expanded for use in all complex cases. Any new framework may wish to consider:

- A commitment from the three statutory partners to support the new arrangements with a contribution to initial planning meetings.
- That other agencies having a role in a person's life should be included within the planning and review process, including involvement from General Practitioners.
- Guidance for professionals in the development of partnership plans and how a lead agency should hold others to account in their delivery and review.
- Guidance as to how existing partnership forums may be used to assist in planning and the management of changing risk. For example the CMARAC and the Safeguarding Adults Referral process.

5.4 Commissioning Services

Once a set of key principles has been set, the partnership may then identify the pathways of support required and ensure that services are properly commissioned, including the necessary funding and resources. A range of services available for immediate deployment will support professionals in their engagement with adults at risk and provide a range of options for consideration in the safeguarding plan. In Michael's case the only service considered was a cleaning provider. This took five months to commission, having the potential to impact upon his wellbeing and also his confidence in the professionals supporting him. Whilst developing a range of commissioned services the following should be considered.

- The commissioning of mainstream services frequently required. To prevent delay in their deployment and to allow the development of a workforce that understands safeguarding principles.
- Involvement of the third sector to create a 'toolkit' of services, which may be used in response to the assessment of personal need.
- How services are deployed and involved as an integral part of the safeguarding plan.

5.5 Police Safeguarding Structures

During the review it was identified that further clarity was needed in how to engage the police in adult safeguarding. Whilst specialist staff are located across London, police structures are not understood by the different agencies and professionals do not know how to identify and engage with the relevant policing team. Specialist staff are located in the Multi-Agency Safeguarding Hubs (MASH) across London and would be a perfect point of initial access. This would provide a 'front door' which is easily understood by other agencies, whilst providing a consistent point of access not affected by staff changes.

It is recommended that the Metropolitan Police consider how partner agencies engage with adult safeguarding staff, and how a single point of access could facilitate further engagement with the safer neighbourhood and other specialist teams. It would be beneficial to ensure that these arrangements are published with each of the adult safeguarding boards across London.

5.6 Disengagement of Service Users

The Mental Health Trust has a recently updated Clinical Disengagement Policy, providing detailed guidance for the management of risk to patients who disengage from services. The review panel highlighted this as good practice and something that did not exist in many other agencies and services.

The policy also provides guidance as to when it is proportionate to report a cause for concern to the police and to request a 'welfare check'. It provides further guidance as to what information should be presented in any report. This complements the policy used by the police service and should help eliminate confusion which existed amongst professionals over the process. A wider understanding of the role of police 'welfare checks' is required across a number of agencies.

There would be great value in encompassing aspects of the disengagement policy into a new planning framework, including an understanding of the police role and how to engage them in 'welfare checks'.

Recommendation 1:	*A new partnership strategy should be developed for a person centred approach to safeguarding and for the multi-agency planning of high risk or complex cases. This should include the commissioning of services and the development of a multi-agency planning framework.*

Recommendation 2:	*The Metropolitan Police should clarify its process for engagement in relation to adult safeguarding cases and publish contact arrangements with all Borough Safeguarding Adults Boards.*

6. Understanding Criminal Exploitation

Cuckooing is a term used to describe a practice where a person's home is taken over and used to facilitate criminal activity. This is often to facilitate the supply of controlled drugs by organised drug networks, as in Michael's case, however it may also relate to other criminal acts. People are normally victimised due to their vulnerability, with poor mental health and drug addiction being significant risk factors. During the last eighteen months the Housing Partnership has experienced twenty cases within the properties they manage.

The safeguarding board has recently produced an excellent leaflet for practitioners explaining how to recognise the signs of cuckooing and how to make a referral in relation to it. A number of the risk factors explained in this leaflet appeared in Michael's case, however the risk was not identified either at the creation of the care plan or during subsequent reviews. The review panel found that awareness of cuckooing across the partnership was limited and that this was an area that should be further developed.

Whilst making the referral for this safeguarding review, the Metropolitan Police outlined that there was a lack of a coordinated response to the issue of cuckooing within the Basic Command Unit (BCU). This highlights that the need to develop a cuckooing strategy extends wider than Richmond and Wandsworth.

It is recommended that the safeguarding partnerships across South West London develop a harm reduction strategy in relation to 'cuckooing'. The strategy may wish to consider:

a) Training for professionals and members of the private and voluntary sectors who are involved in safeguarding and care planning.

b) How vulnerable people at risk of exploitation are identified and engaged with to reduce their risk.

c) Public awareness to increase reporting of possible criminality. This may consider using the existing 'Crimestoppers' information campaign[14].

d) How police enforcement integrates with partnership safeguarding plans.

e) How a new strategy is considered within the Metropolitan Police homicide prevention strategy.

Recommendation 3:	*The Safeguarding Adult Partnerships across South West London should develop a 'Cuckooing' criminal exploitation harm reduction strategy.*

7. Mental Health CTO Process

From the outset Michael was reluctant to engage with his CTO. He was inconsistent in attending his appointments and was reluctant to take his medication. He made an early application for the CTO to be discharged, however did not attend the First Tier Tribunal Hearing which took place on the 1st July 2019. The hearing panel upheld his CTO due to his history of disengagement and non-concordance with treatment when a previous CTO had been discharged. Following this decision Michael continued to miss appointments and told staff that he only consented to his Depot injection as it was a condition of the CTO.

[14] https://crimestoppers-uk.org/campaigns-media/campaigns/tackling-cuckooing-and-county-lines-drug-networks

On the 18th September Michael attended his first formal CPA review, held with a Consultant Psychiatrist whom he had not seen before. A decision was taken to discharge the CTO as he was assessed to be concordant with his medication and presented as stable. Following this decision Michael disengaged from services and stopped taking his medication. The removal of the CTO was a significant factor in reducing the ability of professionals to safeguard Michael.

Policy and procedures exist to ensure that during a review, the views of other professionals involved in the care plan are sought and that clinical history is considered. In this case it is difficult to see how this could have resulted in the subsequent decision. Notes show that the views of health care professionals were sought, however there is no record as to what views had been presented. There was also no record as to how his clinical history had been considered in the decision. Furthermore there was no evidence of this decision being challenged by other professionals, which may have been expected in a culture of healthy professional challenge.

The consultant involved in this decision was new to the Recovery Team, working in a short term 'locum' placement. The team had faced staffing shortages and had undergone a period of staff change. This situation has recently improved with new permanent positions, however the likelihood of future temporary positions being used in the Health Trust is high. For this reason it is essential that clear clinical guidance exists to support future decision making and to encourage a culture of healthy professional challenge. It is recommended that the Mental Health Trust issues new clinical guidance for the reviews of Community Treatment Orders and that this should include:

- The importance of discussion in multi-discipline meetings prior to a CTO discharge and that the views presented by professionals should be detailed in the decision rationale.
- That good practice should consider undertaking more than one review prior to discharging a CTO and that upon discharge a disengagement management plan should be put into place.
- A process encouraging members of the mental health teams to professionally challenge a decision which they feel to have a detrimental impact upon safeguarding.

Recommendation 4:	*The Mental Health Trust produces new clinical guidance for the review and discharge of Community Treatment Orders.*

8. Conclusion and Summary of Recommendations

8.1. Concluding Comments

The key learning from this review is the need to develop a person centred approach to safeguarding and to improve procedures for multi-agency planning and review. The Richmond and Wandsworth Safeguarding Adults Board should now consider the recommendations outlined in this report and how they intend to deliver improvements to safeguarding practice. In addition to addressing the multi-agency recommendations it should hold individual agencies to account for delivering the single agency recommendations.

8.2 Summary of Recommendations

Recommendation 1:	A new partnership strategy should be developed for a person centred approach to safeguarding and for the multi-agency planning of high risk or complex cases. This should include the commissioning of services and the development of a multi-agency planning framework.

Recommendation 2:	The Metropolitan Police should clarify its process for engagement in relation to adult safeguarding cases and publish contact arrangements with all Borough Safeguarding Adults Boards.
Recommendation 3:	The Safeguarding Adult Partnerships across South West London should develop a 'Cuckooing' criminal exploitation harm reduction strategy.
Recommendation 4:	The Mental Health Trust produces new clinical guidance for the review and discharge of Community Treatment Orders.