A Safeguarding Adult Review (SAR) commissioned under

The Care Act 2014

‘Sam’

Overview Report

December 2023

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1 Context and circumstances of the SAR

1. Our deep and heartfelt sympathies go to Sam's family[1] and in particular his brother and other siblings and children. Sam was sadly found deceased close to his property in early June 2022. Sam, and his older brother who spoke to the reviewer during the SAR, were particularly close to each other since their childhood and had contact with each other by phone three or four times a week and each would visit the other regularly.

2. This is a mandatory SAR about a 51-year-old, Sam, who moved to Sheffield in 2013 from Gloucestershire where he had lived in a hostel. Housing records say that this was for about three years although Sam's brother thought it had been a much shorter time. According to housing records in Sheffield, Sam already had a friend in Sheffield with whom he stayed when he first arrived in the city. Sam was white British and English-speaking. He was born and grew up in south London. His mum died when he was about four years old. His brother and sister still live in London. He has two sons (now young adults 19 and 21 respectively) through a marriage that ended suddenly after about 12 years. Sam was in regular employment during the marriage and was working as a manager/supervisor in a retail park. According to Sam's brother, the end of Sam's marriage was a shock and unexpected and it was soon after that Sam left his job and moved to another part of the country to make a fresh start. He initially went to Cambridgeshire but left after a matter of weeks to go to Gloucestershire. Sam's brother says that Sam did not know anybody in either area before going. By the time he had arrived in Sheffield looking for work in the building and construction industry, he was drinking a lot of alcohol. He told the housing service about this and suffering depression when he registered for accommodation. His brother says that Sam had an interest in gardening and landscaping work and effectively hired himself out as a self-employed contractor while in Gloucestershire. Sam never worked after he arrived in Sheffield. An assessment by an alcohol liaison nurse in 2019 when Sam was in the hospital included a record of Sam having family living in another part of the country. More information about Sam has only become known to services in Sheffield since the SAR and is in itself an important lesson from this SAR.

3. The circumstances of Sam's death and the contact different services had with him at various times since early 2018 provide a reasonable cause for looking at how partners and other people with relevant functions worked together to safeguard Sam before his death. In such circumstances, the Safeguarding Adult Board (SAB) should always

[1] Pseudonym used for Sam.

conduct a review of the involvement of agencies and professionals associated with an adult at risk.

4. The purpose of SARs is described in the statutory guidance as to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”. This mandatory review under the Care Act and associated guidance was because Sam was an adult at risk and was living in neglected circumstances when he died.

5. For clarity, the use of acronyms is kept to a minimum. Family members are referred to by their relationship with Sam. Professionals are referred to by their job titles or roles such as neighbourhood officer, GP, nurse, or police officer.

6. Details about the organisations that provided information and participated in the review are included in an appendix.

2 Overview of information

7. Sam had the sole tenancy of a flat provided by the local authority in an area with a high concentration of social housing and significant deprivation[2]. Sam’s flat is believed to have been used by close associates of people engaged in anti-social and criminal activity. Sam had become socially withdrawn, and depressed and had developed an alcohol dependency over several years.

8. Sam faced multiple risks. He was at risk from self-neglect and from his dependent use of alcohol, poor health, and risk from exploitation. This does not mean that Sam had chosen a lifestyle. The term self-neglect can mistakenly be understood to suggest that Sam had made a decision not to look after himself and his health and these were things that he could, if he had chosen, have changed. As will become clearer in this report it was much more a reflection of emotional distress and trauma that was hidden and not understood well enough at the time. People who have been hurt by others can shrink away from people to prevent further harm. If the perception is that services pose a risk, then they will shy away from services. The adult safeguarding challenge is to address the cause of self-neglect (what happened to this particular person). Understanding for example trauma and how it affects a person like Sam is a fundamental area of learning explored in this SAR. None of the services had enough details about Sam’s life and therefore a sufficiently informed understanding of whether he had care and support needs or the interplay of factors contributing to risk. Understanding a person’s experience is the key to formulating and understanding potential solutions that also depend on developing a trusting relationship to

[2] According to ONS the area is amongst the fifth (16.2 per cent) most deprived English post codes.

develop confidence in accepting support from trauma-informed professionals.

9. Sam had been targeted by people seeking to control his home in connection with drugs. Cuckooing is increasingly recognised as a conscious strategy associated with organised criminal activity which exploits people who are at risk or vulnerable in their communities. It is predatory and manipulative behaviour. It is often targeted at people with a disability but as occurred in Sam's case, it can be used against individuals who are easy targets because of their social isolation and/or difficulties with their health or substance use. It is a type of crime that rarely involves the takeover of a home by force or violence but instead begins with befriending and feeding on a victim's vulnerabilities. Victims, including Sam, are often known to a range of different services and this is highlighted in the local work through initiatives like the Changing Futures cuckooing project in Sheffield.

10. Victims of cuckooing are often reluctant to inform others about what is happening or to involve agencies such as the police for several reasons that can include being cut off from a supply of drugs or fearing eviction or reprisals rendering them "complicit victims" who will not make formal statements and will not testify in criminal or other processes.

11. Sam's emotional and physical health had been poor, and his use of alcohol was a likely factor in his premature death at 51 years of age. He died from sertraline toxicity in combination with alcoholic ketoacidosis and hypothermia. He had alcoholic cirrhosis of the liver and coronary artery atheroma.

12. Sam was not diagnosed with any mental disorder or illness and there is no information or evidence that Sam had a learning, mental or physical difficulty or disability. Sam's brother does not think Sam had a disability. Regular heavy drinking is linked to symptoms of low mood and depression and the American Psychiatric Association includes alcohol abuse and alcohol dependence into a disorder called alcohol use disorder (AUD)[3]; alcohol dependence is classified by WHO (World Health Organisation) as a mental and behavioural disorder (F10)[4] in its clinical descriptors and diagnostic guidelines. In the UK the use of alcohol or drugs is not, by itself, regarded clinically as a disorder or disability of the mind (although the effects of such use may be).

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[3] https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-use-disorder-comparison-between-dsm#:~:text=DSM%E2%80%935%20integrates%20the%20two,%2C%20and%20severe%20sub%2Dclassifications.

[4] https://www.who.int/publications/i/item/9241544228

Dependence on alcohol and drugs is regarded as a mental disorder[5] consistent with international classifications.

13. The Department for Work and Pensions (DWP) administered a claim for employment and support allowance (ESA) and Sam was in a support group for his health issues which included the use of drugs and alcohol. ESA is a benefit for people with a disability or health condition that affects how much they can work. DWP had information that Sam experienced blackouts and had problems with his leg and hand as well as visual difficulties. He was placed in a support group in 2014; this did not involve any ongoing requirement to attend or participate in any work or training-related activity.

14. The day before Sam died the police had conducted a welfare visit to talk with Sam. It was a member of the public who requested that Yorkshire Ambulance Service (YAS) attend because of the concerns about the deteriorating extent of his self-neglect and poor physical condition. Despite advice from paramedics who attended, Sam declined to be taken to the hospital and as he left the ambulance, he fell sustaining an injury to his head. A bandage was applied by a paramedic, but Sam continued to refuse any further medical treatment.

15. Later the same evening Sam was found by a member of the public on his hands and knees on the pavement; there was no ambulance available to attend immediately due to other urgent requests for service and deployment. By the time an ambulance was available Sam had left the reported location. It was the following day that Sam was found deceased.

16. There were persistent concerns about Sam, particularly since January 2019. The police had recorded 15 investigations where Sam was a victim of crime, or concerns and the police had sent vulnerable adult referrals, the last being on the day before Sam died[6]. There had been other safeguarding concerns recorded by other services.

17. Sam lived in the same flat since 2013. He told the housing service about his difficulties with alcohol and low mood when he sought help with accommodation after arriving in the city. A code (A for awareness) was added to his records. He was a tenant who needed support to hold on to his tenancy up until his death.

18. His use of alcohol brought him into contact with different services. In March 2014 he fractured his cheekbone when he fell. Later in 2014, the police responded to a physical altercation involving Sam and another

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[5] https://www.legislation.gov.uk/ukpga/2007/12/notes/division/6/1/1/4 Mental Health Act 2007 Explanatory Notes Part 1 Section 3 (25)

[6] The police form uses the term vulnerable adult rather than adult at risk.

male. There were also reports of arguments with the tenants of another flat. In April 2015 Sam told police officers that he was an alcoholic and had borderline schizophrenia. The police made a vulnerable adult (VA) referral to adult social care. It was the first occasion when the police recorded concerns that Sam was at risk of being cuckooed to either use his home as a drug den or a source for dealing on the estate although did not define it as cuckooing.

19. In 2014 Sam first visited a local drop-in place for people who have problematic substance use and/or have become homeless and Sam became friends with another regular visitor to the centre. Sam's friend died in August 2021 and Sam had not been seen at the centre for several months before he died.

20. In mid-October 2018 Sam attended his GP surgery complaining of swelling to his neck and pain to the left side of his face. The GP contacted the ENT (Ear, Nose and Throat) registrar at Sheffield Teaching Hospital NHS FT (STH NHS FT), who agreed for Sam to be seen as a ward attender on the head and neck ward at the Royal Hallamshire Hospital the following day, for further investigations to take place into the origin of the swelling. Sam attended and on initial investigation, it was suggested that he should be admitted to the ward for treatment with intravenous (IV) antibiotics, to reduce the swelling in his neck and for ongoing monitoring. Sam declined treatment and returned home. He was advised to return to the ward immediately if the swelling increased or if he experienced problems with his breathing. An appointment was arranged to review the swelling two days later.

21. Sam was admitted as an emergency having become very unwell. He required surgery (excision and drainage) for an infected abscess in his cheek which he fractured in a fall from a wall in a local park and his swelling in the neck had increased. The surgery was delayed from the 20th of October 2018; Sam wanted to discharge himself, but the staff managed to persuade him to remain in the hospital; his abscess was excised and drained the following day and a biopsy was taken. He was treated with antibiotics and prescribed dexamethasone for his impetigo. He was discharged home on 23rd October 2018 with further oral antibiotics. An outpatient appointment was requested with oral and maxillofacial surgery (dentistry), once Sam's histology results were ready. Sam did not attend the outpatient follow-up appointments which were notified to his GP in letters also sent to Sam in February 2019. Routine blood tests indicated abnormal liver function which had normalised while Sam was in the hospital (and not drinking alcohol).

22. Two days after Sam was discharged from the hospital, he reported being assaulted by a female at his home who he had asked to leave. The police responded taking an account from Sam and the female. Sam described how he had asked her to leave his home, but she had refused

and had threatened to get people to attack him. Sam did not want to make a formal complaint but wanted the unidentified woman removed from his property. She was arrested for being drunk and disorderly and was issued with a penalty notice for disorder.

23. In mid-December 2018 Sam contacted the police to report a party and loud noise including screaming and shouting from a neighbouring property. The call handler who took the call recorded that Sam's behaviour was quite erratic getting very angry and then becoming calm and felt that he was vulnerable. He was reluctant to give his name or address and did not want officers to visit his home. Sam explained to the police officer who phoned him that he had complained to the council and described having depression and regular blackouts. Sam did not want to make a complaint about his neighbours or provide further detail and there was no further action.

24. Sam contacted the police in January 2019 to report an ongoing issue with a neighbouring property; Sam did not want to make a formal complaint.

25. In mid-June 2019 a third-party report to the police described concerns about Sam. The referrer had visited Sam who was no longer in the flat, but his door was answered by two people who were involved with the local drug network and the referrer was concerned that Sam was being manipulated. The report was followed up by a telephone call to Sam who could be heard being instructed about what to say by other people. An officer visited the flat, but Sam was unwilling to allow the officers to enter, and he asserted that the two people were there at his invitation. Sam told the police officer that he was lending money and was able to tell the person to leave. This was accepted and there was no further follow-up. Sam contacted the housing service in July 2019 to make a complaint about the same neighbour.

26. In late September 2019, the neighbourhood housing officer visited Sam at home for the annual tenant visit; One of the two adults who had been the subject of earlier concerns in June 2019 had also been present. Sam was seen to be withdrawn and he eventually asked to speak to the neighbourhood officer privately when he disclosed, he did not want the person at the address and that money was being taken from him. Sam described how a recent benefit payment had been used to clear a debt at a local shop where his account had been used by other people claiming they were purchasing alcohol on his behalf. He said that he had no food and was going to visit his GP to ask for help in getting a food parcel.

27. Sam's appearance and disclosures caused the neighbourhood housing officer to complete a concern for safety report to the police who completed a welfare check with Sam. He told the police officers that he

voluntarily lent money to a named female, but he did not feel exploited. No Offences were disclosed about Sam; he described drug dealing in the area and an intelligence report was subsequently processed. The police advised the neighbourhood housing officer to refer their concerns to adult social care (ASC).

28. After a discussion with ASC, it was agreed that Sam's problems related to his substance misuse and that the police and housing were aware of the exploitative behaviour of the person at Sam's home.

29. A referral was sent to SHSC via email by the neighbourhood housing office as well as a copy being sent from ASC having noted that Sam was open to that service. The referral was sent eight days after the original referral and was not triaged for a further three days. According to SHSC, the safeguarding concerns included cuckooing and financial and psychological abuse. It was noted that the housing service was continuing to work with Sam to ensure Sam did not lose his tenancy. Sam was advised to contact his GP for a referral to substance misuse services. This is an example of where a case management approach to dealing with a referral was unable to respond more appropriately and is explored as learning later in the report.

30. The SPA (single point of access) attempted to contact Sam on the 7th of October 2019 on the day the referral was triaged and passed on to the SPA. Sam did not answer the call or respond to the voicemail message. Further contact was attempted the following day without success. The plan had been to assess Sam's social care needs and a possible referral to local alcohol services. A voicemail and text message were left for Sam to contact the SPA. The referral; was closed three days later in the absence of any contact or response.

31. In October 2019 Sam was admitted as an emergency patient to the critical care unit (CCU) presenting with confusion and jaundice. The day before he had consulted the GP who had wanted to arrange Sam's admission to the hospital because of signs of liver failure which he had declined. Sam was diagnosed with e-coli, sepsis, aspiration pneumonia and acute hepatitis linked to alcohol use. Sam was also observed to have a "mild seizure"; this was a one-off seizure, and he was referred to the neurologist who deemed Sam safe to be discharged and for him to be referred to the First Fit Clinic which Sam declined. He was in the hospital for a month until late November 2019 when he discharged himself against medical advice. While in the hospital the police were contacted by the neighbourhood officer who informed them that Sam was in the hospital and was worried that a female had a key to his property and he did not want her at his home. Police found the female and took possession of Sam's key.

32. It was while Sam was an in-patient at the hospital that an alcohol liaison nurse talked to him about his history. This is the only recorded occasion of a social history being sought by a professional from Sam about his earlier life and a discussion about difficulties indicating trauma such as losing his mum when he was four years old. He said that he was from Croydon, he was a builder and had two brothers and a sister; it was understood by the nurse that the brother had been visiting Sam in the hospital (identity not recorded, but this was his older brother who was spoken to as part of this review). Sam had been drinking alcohol daily for 15 years since his marriage broke up followed by divorce. He drank from early in the morning until late evening consuming about three litres of cider (7.5% ABV). He described no occasions of abstinence other than when he had been in the hospital. Sam said that he had contact briefly with the alcohol service in 2012 (before he arrived in Sheffield) but did not want to be re-referred to a service. Sam said he was keen to move to another part of Sheffield to be nearer a friend (in Crosspool) and was bidding on properties. At the time of the assessment, the nurse was unaware of any safeguarding concerns and Sam did not disclose any.

33. The nurse subsequently reviewed Sam's records and noted the safeguarding concerns. When the nurse spoke with Sam to ascertain his views, wishes and feelings about what he wanted to happen in response to the concerns Sam said he was keen to move to another part of Sheffield to be nearer a friend (in Crosspool) and was bidding on properties. Sam asserted that he could defend himself against potential perpetrators and prevent them from entering his home. When the nurse spoke with the neighbourhood housing office, they were told that Sam was being supported in trying to move nearer to his friend. The neighbourhood officer was advised to explore with Sam a referral to a local provider of recovery-focused accommodation. The nurse updated the risk assessment and sent a copy to the GP. There is no record of subsequent discussions with Sam about this after leaving the hospital. The hospitalisation could have been an opportunity for the formulation of a more coordinated response with Sam and is discussed for learning later in the report.

34. In January 2020 Sam contacted the police to report being assaulted by a female barging into his flat. An officer attended and Sam said he did not want to make a formal complaint. It was recorded as Assault occasioning actual bodily harm (AOABH). The female was arrested and interviewed and denied any offences and was released and the matter was filed. This incident may have been part of the cuckooing but was not identified as such based on the information and no other safeguarding discussion or action is recorded. This is explored for learning later in the report.

35. The Covid lockdown meant that there was less direct contact with the GP and the housing annual tenancy visit was completed remotely. There

were also housing welfare telephone calls during which Sam said he was being supported by friends.

36. In August 2020 Sam was served with a community protection notice[7] for being drunk and disorderly, allowing vulnerable people to use his property to engage in harmful behaviour and causing noise and unreasonable behaviour.

37. In early September 2020, a community social worker (ASC) attempted to contact Sam but was unable to get through when the number did not work. There is no other detail about the circumstances of the attempted contact in the case note but inquiries by the Individual Management Review (IMR) author found information in a spreadsheet that was separate from the main system. This recorded that a referral from the housing service identified Sam as having addiction and benefit problems; he was reported to be interested in having advice about alcohol support groups. When the telephone call did not work, a letter was sent to Sam (although there is no file copy on the system or to say what the letter included). There was no response, and the referral was closed.

38. In March 2021 Sam told the police that a male had been shouting threats through his letterbox. Officers visited but Sam did not want to make a complaint and the male was not located.

39. In May 2021 the police completed an S-DASH (non-domestic stalking and harassment risk assessment) with Sam after he reported being visited by a male who had kicked and damaged his door. He reported that the male was visiting regularly. The assessment was completed in line with Home Office guidelines (HOCR) for the recording of harassment after multiple incidents. Officers did not identify any other corroborating evidence and the assessment and report were filed when there was no response by Sam to the follow-up contact.

40. A week later the neighbourhood officer asked the police to complete a welfare check. The housing officer had spoken to a neighbour and friend of Sam who was staying with him. The housing officer reported that

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[7] Community protection notices (CPNs) are designed to stop a person aged 16 or over, business or organisation committing antisocial behaviour (ASB) which spoils the community's quality of life. This can include offences such as noise nuisance, eyesore rubbish on private land and antisocial behaviour. A CPN can be issued by council officers, police officers, police community support officers (PCSOs) or social landlords, if designated by the council. Grounds for issuing a CPN include instances in which an individual's behaviour: has a detrimental effect on the quality of life of those in the locality is unreasonable and is of a persistent nature. Before a CPN can be issued, the person, business or organisation suspected of causing the problem must be given a written warning stating that a community protection notice will be issued unless their conduct changes and ceases to have a detrimental effect on the community. The warning must also detail that a breach of a CPN is a criminal offence.

during the conversation she could hear two females shouting abuse down the phone at her. The housing officer said that Sam and his friend were vulnerable to being used and intimidated by people going to the property. Police officers visited the address and spoke with Sam, He allowed them to search his address, but no females were present. Sam informed officers that he was happy when one of the females attended but when both were there, he wasn't happy. The information disclosed by Sam did not suggest that any offences had been committed or that there were any requirements for referrals to support services. The matter was filed.

41. The neighbourhood officer discussed concerns for Sam with the safer neighbourhood team in late May 2021 and how Sam was being drawn into worrying behaviour with vulnerable people by a female. Two properties neighbouring Sam were closed down with closure orders[8] and Sam was warned he could face similar consequences if he did not stop people using his home as an alternative. The reliance on using enforcement action is discussed as part of the learning later in the report.

42. Sam's friend died in 2021.

43. In June 2021 Sam contacted police stating that a man would not leave his address and had threatened to strangle him, he later said the man had left but was shouting and swearing outside. Later, a third party made a call to the police reporting a male in the street was throwing bricks at a flat window and shouting threats to stab someone. Officers attended but the male had left the scene, Sam advised he did not want to make a formal complaint and that he just wanted the man to leave the area. Officers searched for a male to no avail. As no damage was observed to Sam's property the matter was filed.

44. In July 2021 there was further report to the police of a male going to Sam's flat. Sam declined to make a formal complaint or to attend a station appointment. There was a further incident involving reports of a female victim of domestic abuse seeking refuge in Sam's home (who was not the perpetrator). The police response to the reports resulted in a DVPO (domestic violence protection order) being issued against the perpetrator; this had implications for Sam in terms of potential repercussions given the perpetrator was part of the group attempting to cuckoo him.

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[8] The process to close premises comprises two stages; the issuing of a closure notice followed by the issuing of a closure order. A closure notice prohibits access to the premises for the period specified in the notice. Only the police or a local authority can initiate the process to close premises which are causing antisocial behaviour, if they reasonably believe that there is, or is likely to be either: a nuisance to members of the public disorder relating to the premises and in its vicinity. In addition, the notice must be necessary to prevent occurrence or re-occurrence of the nuisance or disorder.

45. A referral was made to adult social care services by the police which reported concerns about Sam's physical safety and emotional health, his use of substances and being targeted by other people in the community. The ASC record of the referral includes information that the police had been called to the property when the male had threatened to petrol-bomb Sam's home. ASC recorded that the police had made a safeguarding referral that included emotional and financial abuse but this had not been confirmed. ASC concluded that the concerns were about people staying at Sam's home who were "not supposed to be there". A First Contact worker spoke with Sam and concluded that he had "no social care needs" and therefore closed the referral after passing the referral to SHSC. The police were informed that SHSC mental health services would be contacted as Sam was known to that service.

46. The referral arrived with SHSC six days after the original referral and was managed by the safeguarding team in SHSC (rather than the SPA in 2019 due to changes in the process). It was triaged six days later, on the 5th of August 2021. The SHSC safeguarding triage team completed an SBAR assessment[9]. The team had taken over responsibility for reviewing safeguarding concerns from the SPA (single point of access). It concluded that there was no evidence that Sam was unable to protect himself and determined that "the legal criteria for a safeguarding referral was not met". The police confirmed that one possible perpetrator had been arrested. The assessment concluded that Sam was able to protect himself and that "legal criteria were not met" (it is assumed this is a reference to the Care Act). It noted that Sam required support with his use of alcohol. A letter was sent to Sam with advice and information about support services. A copy of the letter does not appear to have been sent to the GP. Sam was not open to any SHSC services.

47. The housing service and police both had reports of anti-social behaviour (ASB) involving two women who were frequently visiting Sam's flat.

48. In September 2021 Sam was seen by the GP with an eye injury and a bruised shoulder although he did not follow up on the GP's advice to go to the hospital. He also missed routine appointments for blood tests and vaccination.

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[9] The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition.

S = Situation (a concise statement of the problem)
B = Background (pertinent and brief information related to the situation)
A = Assessment (analysis and considerations of options — what you found/think)
R = Recommendation (action requested/recommended — what you want)

49. In late January 2022, the police responded to an emergency call reporting that Sam had been locked into his flat by a male who would not let him leave and had taken over his home. Sam was found in a very intoxicated condition and denied that he was being held against his will but disclosed that he had been slapped in the face. In a subsequent victim statement Sam stated that *"following this incident I feel extremely vulnerable and scared of him. I feel like he is now taking advantage of me. I have bad health as it is, and he has made it even worse. My anxiety is now a lot worse, and I feel down in general. I do not want to leave my flat as he has knocked my confidence. I would wish for him to not be able to come near my flat again as I am scared he will try and enter and force me to let him stay and that he may also assault me again".*

50. The suspect was interviewed but denied any offences. The investigation was reviewed by an evidential review officer who decided that due to insufficient evidence, the file was closed. There is no evidence that actions in the investigation plan such as house-to-house enquiries were completed. Two potential witnesses recorded in the file were not asked to make statements. The decision-making in terms of progressing an investigation of crime and raising safeguarding concerns about Sam are explored in learning later in the report.

51. In early March 2022, a GP visited Sam at his home for an assessment of an "acute presentation" and provided treatment for a chest infection. Sam was seen with two unidentified adults present, one of whom had called for the GP contact. They were noted to be intoxicated. Features of liver disease were observed on examination of Sam and a brief review of his mood was completed although no further detail is included. The GP was able to talk with Sam alone and in private to offer him the opportunity to raise concerns about his well-being and safety. Concerns that were recorded by the GP included hammer marks to the front door, and vomit on a mattress and bedroom floor. On direct questioning, Sam replied that he felt safe in his flat. There was a discussion about his benefits and general financial situation. Although immediate treatment was provided there was no escalation of safeguarding concerns either in terms of a discussion at the practice or raising a referral. This is explored as learning later in the report.

52. In early June 2022, a police officer visited Sam in the late afternoon to check on his welfare he was described as looking the worse for wear. The visit was prompted because the officer had not seen Sam for several months. His home smelt of alcohol and he looked unkempt he had drops of blood on his sleeve which he said were from a spot on his chin. The police officer made a referral to ASC the same day (Wednesday) via email which coincided with the additional Jubilee Bank Holiday weekend. The information was not processed by ASC until the following Monday by which time Sam had died. It also meant that when the police notified

the out-of-hours team of Sam's death the following day there was no record of the referral in the system.

53. The referral was made to ASC by the officer to "highlight a potentially gradual decline of health and welfare of Sam due to his actions and the encouragement/coercion of others. To look at various interventions by support agencies to prevent another tragedy through self-neglect and influence by other parties. In particular the female has been described as having leech-type behaviour towards people and moving on when they do not have anything further to offer."

54. The officer also noted on the referral that female 1 had previously been issued with a community protection notice[10] about two addresses (one of which was that of Sam) in 2020. The notice had expired on 30th July 2020 so no actions could be taken by the attending officers relating to this. The officer also submitted an intelligence report relating to the females at the address and the concerns for Sam.

55. The YAS contact with Sam was on the same day that the police officer made a welfare visit when Sam had collapsed in the street close to his home. A hypoglycaemic episode was diagnosed. Sam stated he had not eaten that day (Wednesday) due to not being paid until Friday. He refused transport to the hospital as his main concern was getting home. The ambulance crew advised him this could be sorted later but he still refused. Sam fell backwards and hit his head, but still refused to be assessed or transported. A referral to ASC was sent as Sam was neglecting his own medical and health needs. The crew was unable to assess his home living conditions. This referral was also not loaded onto the system until the following Monday.

56. A call was made later the same evening as the YAS had seen Sam; a member of the public had found him on the ground. The YAS were unable to allocate an ambulance due to other calls that were graded at more urgent levels. When an ambulance could be deployed Sam was not in the reported location.

3 Legal framework, research, and national learning relevant to the review

57. The Care Act 2014 (CA) statutory guidance includes self-neglect as a category under adult safeguarding. The number of adults who self-

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[10] Community protection notices (CPNs) under the Anti-Social Behaviour, Crime and Policing Act 2014 are designed to stop a person aged 16 or over, business or organisation committing antisocial behaviour (ASB) which spoils the community's quality of life. This can include offences such as noise nuisance, eyesore rubbish on private land and antisocial behaviour. A CPN can be issued by council officers, police officers, police community support officers (PCSOs) or social landlords, if designated by the council.

neglect is increasing in England and continues to rise due to demographic changes[11].

58. The Care Act 2014 (CA) requires the local authority to assess anyone who appears to require care and support regardless of their eligibility for state-funded care. The assessment must focus on the needs of the person how they impact their well-being and the outcomes they want to achieve. There were several occasions when a CA referral could have been made by health professionals.

59. The CA imposes a duty on the local authority to make statutory safeguarding enquiries where an adult with care and support needs is believed to be experiencing or is at risk of abuse or neglect including self-neglect. The CA (s6) also requires the local authority and relevant agencies to work in partnership and to cooperate generally. Health and social care organisations are legally compelled to cooperate on cases of self-neglect which require a safeguarding response. An assessment of mental capacity is likely to be a key determinant in decision-making about how to respond.

60. This SAR highlights how the term self-neglect or self-harm can be unhelpful and effectively mask the nature and level of risk associated with care and support needs such as represented by Sam's circumstances.

61. Sam's physical health and emotional well-being had been cumulatively and adversely affected over several years. Relationship breakdown was a significant and largely unknown factor in Sam's life. Research literature consistently describes how a relationship breakdown is a major factor in men self-harming and experiencing poor mental health. Researchers describe the protective value of the social bond in the form of work and family life and how these serve to give a sense of purpose and belonging but when they unravel can stop being a source of protection and become a source of risk[12].

62. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life-threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being.

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[11] Safeguarding statistics (NHS Digital, 2021) show that local authorities in England completed nearly 13,000 S42 enquiries in the year 2020/21, where self-neglect was the primary issue, a 26 per cent increase from the previous year.

[12] Shiner, M., Scourfield, J., Fincham, B. and Langer, S. (2009) When things fall apart: Gender and suicide across the life course. Social Science and Medicine, 69: 738-746

63. Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

64. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and well-being.

65. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?' or 'How do we stop their unwise or risky behaviour?'

66. A person-centred, relationship-based approach remains central to establishing trust, appreciating the reasons behind self-neglect, exploring perspectives and preferred options, offering support and wherever possible coordinating and negotiating interventions. A Changing Futures report in September 2022 in Sheffield highlighted that establishing trust between a person receiving support and the person providing it was paramount in securing engagement[13].

67. Professional curiosity helps prevent professionals from making assumptions about what is happening in a person's life, and how and why they make decisions[14]. A common assumption is that people automatically have the capacity and are in a position to make choices about their lives. The powerful influences that may have affected behaviour, childhood or adult trauma, addiction, shame about environment and circumstances, grief about increasing disability, and fear of loss of control, are often not recorded as occurred with Sam and are therefore not considered. Apart from the alcohol liaison nurse, there was little or no exploration of Sam's life experiences. A focus on threshold-related decisions as occurred in this case about responding to a referral can prevent any opportunity to begin a process of sufficiently curious enquiry.

68. The use of various legal powers such as the CA, Mental Capacity Act 2005 (MCA) and Mental Health Act (MHA)[15] is discussed in the guide

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[13] Changing Futures – Learning Report – Personalised Engagement Approaches September 2022

[14] Thacker, H; Anka, A; Penhale, B (2019) Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014 The Journal of Adult Protection Vol. 21 No. 5 2019, pp. 252-267

[15]Mental Health Act

by Alcohol Change UK[16]. Undertaking mental capacity assessments with dependent drinkers poses a very specific challenge. Approximately 50 per cent of dependent drinkers have frontal lobe damage as a result of brain injury. In the general population, the figure is only 8.5 per cent. The frontal lobe is the behavioural centre of the brain which has a key role in impulse control. Many patients with frontal lobe damage are wrongly considered to have capacity because, in a simple assessment environment, they know the correct things to say and do. When they need to act upon that knowledge in the complex setting of the real world they are driven by impulse and, therefore, can no longer weigh up options[17].

69. The Mental Capacity Act 2005 applies to people with a range of circumstances including mental impairments due to the symptoms of alcohol or drug use. The Code of Practice describes mental disorder as "any disorder or disability of the mind" (2.4) and clinically recognised conditions which could fall within the Act's definition of mental disorder include "Mental and behaviour disorders caused by psychoactive substances" (2.5).

70. Although dependence itself is not a mental disorder, conditions which arise from alcohol use could be considered mental disorders. This is confirmed in sections 2.9-2.10 of the Code of Practice.

71. A focus on a person having decisional capacity, will not understand the person's ability to carry out their decision (executive capacity) and what prevents them from doing this. It will not help understand why the person will continue to neglect themselves and will limit the practitioner's confidence in using professional curiosity and respectful challenge. When responding to adults who self-neglect an MCA assessment of their mental capacity to make their own decisions is a critical factor in determining the outcomes for the person.

72. The compulsion associated with addictive behaviour can be seen as overriding someone's understanding of information about the impact of their drinking and implying a lack of capacity. Executive capacity should be included explicitly in assessments, linked to the person's ability to use and weigh information. Case law (London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)) has demonstrated that a chronically dependent drinker can be viewed as lacking the capacity for decisions about his care. The question is, therefore, what are the circumstances

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[16] https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers
[17] https://www.basw.co.uk/resources/repairing-shattered-lives-brain-injury-and-its-implications-criminal-justice
Professor Ken Wilson provides invaluable insights into the impact of alcohol related brain damage and mental capacity in this video: https://vimeo.com/259124220.

that chronic, dependent drinkers cannot make key decisions about e.g., their care, treatment or living conditions?[18]

73. An MCA assessment should therefore include the impact of trauma on executive brain function. Part of the capacity assessment is to determine whether the person is able or unable to employ the skills of self-care (S4.21 MCA codes of practice). A record of an MCA should demonstrate that a person is able or unable to employ self-care skills. Consideration is then given as to whether the reason that the person cannot maintain self-care skills is a result of trauma, anxiety, mental ill health, or other impairment of, or disturbance in the functioning of the mind or brain.

74. The Mental Capacity Act 2005 provides the legal framework for assessing whether adults have the mental capacity to make their own decisions and decide how to proceed when they are unable to. The MCA says that a person is unable to make a particular decision if they cannot do one or more of the following four things:
    a) Understand the information given to them.
    b) Retain that information long enough to be able to make a decision.
    c) Weigh up the information available to make a decision.
    d) Communicate their decision; this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

75. A lack of mental capacity can be temporary or enduring and relates to a particular decision at a point in time; it can be due to:
    a) a stroke or brain injury;
    b) a mental health problem;
    c) dementia;
    d) a learning disability;
    e) confusion, drowsiness or unconsciousness because of an illness or the treatment for it; or
    f) substance misuse.

76. The MCA also requires any decision or action taken for or on behalf of a person who lacks the capacity to be in that person's best interest. The law gives a checklist of key factors which must be considered when working out what is in the best interests of a person who lacks capacity.

77. The MCA applies to situations where a person may be unable to make a particular decision at a particular time because their mind or brain is affected, for instance, by the effects of alcohol or drugs. For example, a person such as Sam may at times lack the capacity to make some major decisions, for instance about specific medical treatment, but this does

[18] LB of Tower Hamlets v PB [2020] EWCOP 34

not mean that they cannot decide what to eat, wear and do each day. In other words, it is not about a general or global capacity to make decisions.

78. Cuckooing refers to an individual or group of people targeting another person to take over their home. It is often associated with organised criminals who target people who are socially isolated and at risk of exploitation. It is a form of exploitation that is often wrongly interpreted as “bad lifestyle choices” or “falling in with the wrong crowd”. Common risk factors for cuckooing to happen include social isolation of the person being cuckooed living alone in an area of multiple deprivation and having limited social support. The combination of isolation, loneliness and predatory relationships creates the conditions for an adult to be exploited and at risk of emotional, physical, sexual, and financial abuse.

79. Cuckooing is a complex form of abuse that can involve different typologies with one common purpose[19]. The dominant narrative is the “parasitic nest invasion” where an adult at risk is targeted by perpetrators who “befriend” and quickly gain access to the property to sell drugs, store weapons or steal goods. In “quasi-cuckooing” local drug users may be initially willing to have perpetrators in their homes in return for free drugs. These relationships become violent and exploitative very quickly resulting in the victim becoming indebted. Another typology is “coupling” where a member of an organised crime group (OCG) develops a sexual relationship with the victim. This model is akin to domestic abuse dominated by a coercive controlling relationship where the victim's home is taken over. Young particularly female victims have also been sexually exploited as part of the OCG activity.

80. A further model of cuckooing identified in the research is not associated with OCG activity but is “localised cuckooing”. This is exploitation by members of a local community to use a victim’s home for “recreational reasons” such as drinking, drug taking or sometimes storing and distributing stolen goods. This form of cuckooing is not orchestrated by OCG activity but is criminal and anti-social behaviour that is exploiting an adult at risk.

81. How professionals such as police, health, housing, anti-social behaviour teams, and social care define, process, and understand information is critical to the effective safeguarding of an adult at risk. If it is seen as a mutual relationship rather than exploitative, the response will focus on enforcement and sanction as occurred with Sam.

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[19] Spicer, J., L. Moyle, and R. Coomber. 2020. “The Variable and Evolving Nature of “Cuckooing” as a Form of Criminal Exploitation in Street Level Drug Markets.” Trends in Organized Crime 23 (4): 301–323. doi:10.1007/s12117-019-09368-5.

82. Sam did not have a disability but the form of exploitation that he suffered has implications for how people with a disability living alone in communities of multiple disadvantages are protected from this form of exploitation that has also been mislabelled as "mate crime"[20].

83. Victims of cuckooing such as Sam can be reluctant to inform anybody else or seek the help of agencies for a variety of reasons. In most cases they may have difficulty understanding that they are the victims in an exploitative relationship; be unsure about what support is available or not have the type of support that is effective; fear eviction and loss of their home; be dependent upon having drugs supplied to them; intimidation using any means necessary and effective to keep them silent and acquiescent; be traumatised by what has happened to them and magnifying previous traumatic experiences. Professional curiosity helps prevent professionals from making assumptions about what is happening in a person's life, and how and why they make decisions[21].

84. Undue influence is another factor that is explored later in the report.

85. The Dame Carol Black report[22] concluded that public provision concerning substance misuse is not fit for purpose. Amongst its findings and recommendations, it urges the government to reverse its disinvestment in treatment and recovery services and provide the resources and whole system approach that provides people with somewhere to live and something meaningful to do. It recognises that addiction is a chronic health condition requiring long-term follow-up and emphasises the importance of greater coordination at national and local levels. It observes that prevention is ultimately more cost-effective and that trauma and/or mental ill-health are drivers of much addiction, with the consequence that commissioners of substance misuse and secondary mental health services must ensure that individuals do not fall through the cracks. Within that context, any local improvement is highly dependent upon the national commitment that is long-term and meaningful.

4 Summary of learning

86. Sam's death was premature and occurred in neglected conditions despite contact with different services over several years and requires

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[20] Doherty, G. 2020. "Prejudice, Friendship and the Abuse of Disabled People: An Exploration into the Concept of Exploitative Familiarity ("Mate Crime")." Disability & Society 35 (9): 1457–1482. doi:10.1080/09687599.2019.1688646.
[21] Thacker, H; Anka, A; Penhale, B (2019) Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014 The Journal of Adult Protection Vol. 21 No. 5 2019, pp. 252-267
[22] Black, C. (2021) Review of Drugs, Part 2, Prevention, Treatment and Recovery. London: The Stationery Office.

an account of whether there are lessons about how services responded to any care and support needs along with safeguarding concerns.

87. There are examples of professionals trying to help Sam from as far back as 2013 when neighbourhood officers were signposting Sam to support services. The GP practice which serves an area with high levels of complex and homeless patients never closed its doors during Covid recognising some patients could not access health care through remote consultations. The GP made a home visit to Sam in March 2022 in response to concerns about his non-attendance for the previous follow-up to health concerns. Individual police officers contacted other services including ASC in response to concerns about Sam's vulnerability. There were examples of housing and police officers working together and individual officers tried to have private one-to-one conversations with Sam when other people were found in his home. The panel agreed that although there are other examples of good individual agency practice these did not result in the level of multi-agency response that could have been more effective.

88. Although a person may retain the mental capacity and have the right to make unwise decisions the duty of care still requires professionals to explore why unwise decisions are being made and what can be done to help a person who is self-neglecting and reluctant to engage with support; it requires developing a relationship. It will generally require multi-agency discussion rather than unilateral decision-making by one person or service.

89. This SAR highlights how the term self-neglect or self-harm can be unhelpful and effectively mask the nature and level of risk associated with care and support needs such as represented by Sam's circumstances.

90. For example, the use of criminal justice frameworks and anti-social behaviour measures to respond to behaviour that is effectively a coping mechanism developed over many years to live with trauma and loss, risks blaming the person rather than framing more constructive and effective responses. What happens for example when significant life events have affected a person so much that they are unable and incapable of dealing with the emotional pain without the use of survival mechanisms to get through the day-to-day? Drinking alcohol, not becoming attached to people, and feeling safer in the open rather than within enclosed spaces which featured in Sam's story begins to make sense. The fact that so little was known about Sam by any of the services is an important lesson. Understanding that trauma to describe adverse life experiences and the emotional and psychological impact include loss (of relationships), bereavement, poverty, discrimination, abuse, neglect,

loss of power or control, and loss of physical or mental well-being that affects self-confidence and self-esteem[23].

91. If practitioners focus on the label of self-neglect or substance misuse for example, then they will focus on a solution to stop the self-harm or to prevent the substance misuse. This means that agencies are focussing on removing the very coping mechanisms keeping people safe from the real drivers of risk (trauma, loss, bereavement, social isolation, fear, and poverty) that cause mental and physical ill health. The coping mechanisms may have become part of the problem, but to a person like Sam, they are survival strategies that have kept them going for several years. People who have been hurt by people shrink away from people to prevent further harm. If the perception is that services pose a risk, then they will shy away from services. The safeguarding challenge is to address the cause of self-neglect (what is the person's story and what has happened to them). Understanding trauma and how it affects a person is the key. Relying on legal enforcement has limited utility in these circumstances.

92. Similarly, the impact on self-confidence and self-esteem combined with entrenched coping mechanisms that include the use of substances renders a person such as Sam vulnerable to crimes such as cuckooing. If cuckooing is seen as a person making the wrong choices (about allowing people into their home for example) it leads to people thinking the strategy is to give them clear words of advice backed up by threats of legal sanctions. It will be largely ineffectual and exacerbate what is already a complex and entrenched situation.

93. Some changes to the way services work in Sheffield would probably have improved the opportunities to help Sam. The MASH (multi-agency safeguarding hub/team) launched in April 2023 involving social care, health and police with other services provides a daily opportunity to identify adults at risk and develop a plan of action. The local authority has resumed responsibility for managing and responding to referrals under the Care Act (which had been delegated to the SHSC). These changes in themselves cannot create the conditions for ensuring more effective responses in the future.

94. Cuckooing is not an offence or included as a defined form of abuse in national guidance. The police are the only service to have a definition of cuckooing which describes it as "*the practice where drug dealers take over the property of a vulnerable person and use it as a place to run their business"*. The definition goes on to say that victims are *vulnerable and often fearful of going to the police and worry they may be incriminated*.

[23] https://www.scie.org.uk/files/self-neglect/policy-practice/self-neglect_general_briefing.pdf

95. The police and housing service attempted to stop the behaviour that was causing distress and disturbance to the community through the use of anti-social behaviour measures. The police were the service that had the most contact and information about Sam and although passed on concerns about Sam's welfare, closed off sustained interventions in the face of victims and witnesses being reluctant to give statements.

96. None of the services saw Sam as an adult at risk of abuse represented by cuckooing and neglect which were primarily processed as Sam not making wise choices. The alcohol liaison nurse was the single professional to whom Sam spoke about his background story and the circumstances that led to him being in Sheffield. However, important information about how quickly Sam's life changed has only become clearer in discussion with Sam's brother as part of the SAR. This absence of curiosity and inquiry or the use of a more trauma-informed approach[24] deprived the people trying to help Sam of an understanding of how and why he was unlikely to make the kind of changes that they tried to help him achieve through a mixture of advice, signposting, and sanctions.

97. There are services in Sheffield that were not used; this may have been a combination of a lack of knowledge about relevant services and understanding the need for an approach that can recognise and overcome the barriers facing people like Sam who have trauma-related difficulties that do not focus on trauma-related difficulties.

98. All of the services were aware of Sam's use of alcohol and how it was a risk to his health and put him at risk when people used his home. Health professionals tried to encourage Sam to accept health care especially when he became dangerously ill and required in-patient care at the hospital. Housing and police worked to address concerns about Sam's welfare which included how anti-social behaviour could be stopped. Well-intentioned though the approach was by all of the services, they all focussed on the difficulties and problems rather than what lay beyond them.

99. All of the interventions assumed that Sam had the capacity and ability to take control of his circumstances, to follow or comply with the advice and on occasion enforce. It was assumed he was making choices about who was in his home and that his use of substances was a lifestyle consciously chosen. The impact of Sam's chronic and long-term use of

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[24] Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'

alcohol and its impact on his ability to process and understand risk was not recognised.

100. Sheffield, in line with many other areas in England, has a multi-agency neglect pathway[25] which includes a vulnerable risk management model (VARMM) and complex case management (CMM) pathway for working with adults who can make decisions for themselves but are at risk of harm through self-neglect, risk-taking or chaotic behaviour/lifestyle and refusal of services. The VARMM is the process for responding to safeguarding concerns including self-neglect. The only service to make any reference to the self-neglect policy or pathways was the NHS South Yorkshire Integrated Care Board (SY ICB) although the police used the vulnerable adult notifications on more than one occasion to record their concerns about Sam.

101. The pathway is generally intended to be used when the safety of an adult with mental capacity is at risk for example from;

a) Serious harm or death by self-neglect, fire, deteriorating health condition, nonengagement with services or where an adult is targeted by a local community, is subjected to hate crime, anti-social behaviour or sexual violence - and they do not meet the criteria for safeguarding (serious harm means death or injury, whether physical or psychological, which is life-threatening and/or traumatic and which is viewed to be imminent or likely to occur in the future)
b) There is a potential risk to the health and safety of others in the community. This could be due to fire risk, cuckooing, drug dealing, hate crime and other crimes committed which could make others feel unsafe in the area; environmental health concerns such as vermin, excess rubbish and unsanitary conditions and any other issues which could impact the health and safety of neighbours, visitors, the wider community, or professionals who need to enter the property to provide a service.
c) There are high levels of concern from partner agencies.

102. The pathway is accessed in Sheffield through a safeguarding referral being raised with the local authority's adult social care (ASC) First Contact Team and is processed through three stages. The initial stage is for the referral to be screened through a process of information

[25] https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures/multi-agency-self-neglect-policy-and-practice-guidance-including-varm-and-ccm

gathering that includes establishing what risk exists and whether it is immediate. ASC decide when adequate information has been gathered and if the Care Act criteria are not met (s42) (1) the referral can be closed with feedback to the referrer about managing ongoing concerns and or signposting to other services. The CA applies to people who have problems with alcohol and the term self-neglect as a form of neglect abuse encompasses many people in these circumstances. Cuckooing is not a category of abuse included in the CA or the associated guidance. In this case, when a referral was made it was not clear what enquiries were made and none resulted in the referral being processed further than signposting.

103. There were four referrals from 2019 until the day that Sam died. Although the first referral in September 2019 included information about Sam being exploited financially the circumstances were put down to his use of alcohol and the information was passed to the SPA under the delegated arrangements that operated at the time when services were already in contact with a person. The SPA attempted telephone contact and Sam did not pick up from the voicemail or subsequent text and the referral was closed. Two months later the alcohol liaison nurse completed the history with Sam who was in the hospital as a result of an alcohol-related illness. The nurse was not aware of the recent safeguarding referral from housing that had described Sam's financial exploitation. The nurse spoke with the housing neighbourhood team about Sam's wish to be housed in another part of the city closer to a friend. The safeguarding team in SHSC processed the referral from the police in July 2021 about financial exploitation. The referral was closed without further enquiries on the basis that the police were already dealing with concerns.

104. The second referral to ASC First Contact a year later in September 2020 was closed without enquiries. The third referral from the police in July 2021 described Sam being targeted and safeguarding concerns about emotional and financial abuse. The referral was also passed to the mental health service. A fourth referral was made just before Sam died following the police welfare visit.

105. The introduction of the MASH in April 2023 is now seen as an integral part of the initial enquiry process although is not a substitute for completing enquiries.

106. Level 2 of the pathway is an agreement for the most appropriate agency to offer a further response which can include the use of the complex case management pathway.

107. Level 3 of the pathway is the use of the VARMM which can only be accessed if and when the initial 2 stages are not able or appropriate to offer a response.

108. Neither the safeguarding policy nor the risk assessment matrix includes any mention of cuckooing as a potential form of abuse or safeguarding concern.

109. The housing service describes having experienced officers who can recognise vulnerable tenants and have a good awareness of people presenting a risk to others but do not have the toolkit to manage those complex circumstances. Safeguarding response to groups of adults at risk represents a contextual safeguarding issue. Contextual safeguarding is an approach (not a model) that has been developed to respond to older children at risk from sources of abuse that are outside of their family relationships. It is an approach that seeks to target the context in which the abuse occurs, to address it through the lens of person-centred welfare as opposed to just a crime reduction or community safety strategy and to develop partnerships with key stakeholders. Expecting the victims of ASB and cuckooing to give evidence and be a party to legal action is unlikely to be effective. An adult at risk of being exploited requires an effective safeguarding response rather than relying on a justice system solution alone.

110. Sam's health was adversely affected by his use of alcohol and required GP and hospital care following accidents and illness. His brother described Sam's dislike of hospitals; Sam's reluctance to go to the hospital was evident in his non-attendance at outpatient appointments or allowing the YAS to take him to the hospital when he had injured his head. He also discharged himself against medical advice.

111. The issue of mental capacity and best interest is an issue highlighted regularly in SARs involving issues of self-neglect. The best interest is the statutory requirement that if a person intends to decide on behalf of another person, they must, first of all, determine whether that person has mental capacity. All of the services believed that Sam had mental capacity and saw no reason to consider that Sam was unable to make any specific decision. Arguably Sam made some decisions that were not wise and did not serve his best interest, but this is not in itself evidence of not having the capacity for specific decisions. Given the tragic circumstances under which Sam died, the panel discussed the response to Sam in the hours before he died. The YAS had no power to compel Sam to travel to the hospital. The circumstances of the YAS response are subject to an internal serious incident investigation.

112. The MCA can be used with people impaired by alcohol (and drugs). Although there is little detailed guidance the concept of executive function[26] has value and relevance. However, use of the MCA should be

[26] Executive function is a set of cognitive skills that are needed for self-control and managing behaviours. Executive function is an umbrella term used to describe a set of mental skills that

used as a last resort in making any decision on behalf of a person and specifically excludes people who are solely dependent on alcohol. The Mental Capacity Act sets out a two-stage test. The first is to determine if the person has an impairment of, or a disturbance in the functioning of, the mind or brain". The person does not have to have a diagnosis. The Mental Capacity Act asks for evidence if it is believed that the person has an "an impairment of, or a disturbance in the functioning of, the mind or brain". For example, the impact of using substances can be considered. Evidence for this can be taken from existing records or diagnoses, and personal knowledge of the person, or it might be based on observations and information given by others. Although a person might be confused the cause may not be known at that time. The assessor is required to record reasonable evidence that the person has an impairment or disturbance. Evidence could refer to:

113. The question of undue influence in the context of personal welfare decisions can arise in the context of the MCA or under the court's inherent jurisdiction over vulnerable adults and in the context of financial affairs. To paraphrase Lord Donaldson does a person mean what they say or are they merely saying it for a quiet life, to satisfy someone else or the advice and persuasion is such that they are no longer able to think and decide for themselves[27]? Undue influence, a psychological process by which a person's free will and judgment are supplanted by another is also a legal principle that is applied where agreements or contracts have been unfairly made. Undue influence arises where a relationship exists between two parties where there is "trust and confidence, reliance, dependence or vulnerability on the one hand and ascendancy, domination or control on the other" (Royal Bank of Scotland Plc v Etridge (No 2) [2002] 2 AC 773 at [11]).

114. Undue influence is broken into two legal classes:

a) Actual undue influence is where the wrongdoer exerts undue influence on the other person to enter into a transaction;
b) Presumed undue influence is where there was a relationship of trust and confidence between a vulnerable person and the wrongdoer, which is of such a nature that it is fair to presume that the wrongdoer abused the relationship in procuring the person to enter into a particular transaction.

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are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions. Professionals assessing capacity in this patient group are faced with a number of obstacles that make determination of capacity more challenging. This can have significant implications because failing to carry out a sufficiently thorough capacity assessment in these situations can expose a vulnerable person to substantial risk.

[27] Re T (Adult: Refusal of Treatment) [1993] Fam 95(CA), at 113 per Lord Donaldson

115. Although none of the professionals may have had cause to consider whether they should override any of Sam's decisions there were multiple occasions when it would have been potentially helpful to consider if Sam was the victim of undue influence and by implication what consequences that had for how Sam's views, wishes and feelings were being considered and risk assessments completed. However, undue influence is not identified as a safeguarding issue in national guidance or local safeguarding policy and guidance. If a person is a victim of cuckooing and undue influence it cannot be the case that they are then made responsible for the circumstances they find themselves in and being sanctioned when the abuse continues.

116. One of the GPs knew Sam well and was able to respond when his health deviated from its usual baseline involving depression and long-term alcohol use. The reception staff knew Sam and helped him to access help during the Covid lockdown. Although the GP Practice does not have a formal *did not attend* (DNA) policy they were active in following up on failed appointments. The practice also has six-weekly multidisciplinary team discussions about patients with the most complex needs or known vulnerabilities. Sam was not on the list which reflected the information the practice had at the time. Although the practice had one safeguarding notification (October 2019) this was not coded in the patient records. The GP practice was not aware of all the safeguarding issues that the SAR has collated.

117. The absence of a holistic assessment meant that none of the single agencies and respective professionals was in a position to understand the nature of risk and develop more effective interventions. The reason this did not happen is a combination of the capacity and resources of single professionals and services, the application of threshold criteria and the working practices of individuals and services. The focus was on responding to anti-social behaviour and crime prevention including the use of closure notices; when referrals were made to ASC there was no enquiry with services and each agency worked within their parallel disciplines; this encourages a response to concerns that will not understand cumulative and underlying patterns.

118. Until the SAR there had been no discussion with the local centre that Sam had used for social contact and support.

119. South Yorkshire Police (SYP) has implemented procedural instructions relating specifically to self-neglect. This is to enable frontline officers to recognise the signs of self-neglect and provide instruction on the response expected. SYP also has a single point of reference for partner agency self-neglect & hoarding policies, on the forces' intranet protecting vulnerable people's portal. The portal also contains information regarding relevant support services. It is maintained and regularly updated.

120. SYP has improved the vulnerability question sets required on all referrals to partner agencies. This is to improve officers' understanding of the signs of vulnerabilities and recognise these, information sharing with partner agencies, improve recording and enable a far more effective and efficient manner to conduct research.

121. The College of Policing launched a toolkit for tackling Anti-Social Behaviour. The toolkit will help support SYP officers and staff with evidence-based techniques for tackling ASB and case studies of successful approaches around the country. The toolkit has been publicised across SYP and there is an expectation that all relevant officers/staff will utilise this.

122. Public provision nationally concerning substance misuse is not fit for purpose suffering from disinvestment in treatment and recovery services which require a whole system approach; trauma and/or mental ill-health are drivers of much addiction, with the consequence that commissioners of substance misuse and secondary mental health services must ensure that individuals do not fall through the cracks. Within that context, any local improvement is highly dependent upon the national commitment that is long-term and meaningful.

5 Developing the learning from the SAR

123. Areas for development from the review include:

a) Chronic dependent drinking that results in higher levels of risk to self or others and its long-term negative impact comes within the scope of CA definitions of an adult at risk and the associated duties to make enquiries and conduct assessments; evidence of self-neglect, being subject to and at risk of abuse from others through cuckooing and the use of emergency services were visible markers of risk in this case; assessment of risk needs to also consider service refusal;
b) The absence of CA inquiries as part of referral responses was influenced in part by interpreting behaviour as lifestyle choices; assuming an ability to understand and take positive decisions and the adverse impact of alcohol abuse on executive function undermined more concerted effective help;
c) Legally and professionally informed assessment, including MCA, MHA and CA with dependent drinkers present specific challenges due to the high incidence of brain injury compared to the general population and in particular, are more vulnerable to impulse and less able to weigh up options;

d) Adults at risk through dependent drinking and cuckooing are more likely to be helped by community-based and non-statutory services that can be curious, persistent and offer meaningful relationship building, can help reduce harm and understand how to follow motivational and trauma-informed practice; these are likely to require more specialist professional skills than for example a neighbourhood or police officer; the importance of purposeful concerned curiosity and interest in a person's life story and understanding of trauma-informed care and response when presented with evidence of self-neglect within the context of empathetic persistence, skilled questioning and building a relationship; substance misuse services were recommissioned with a new provider in 2022;
e) A common professional multi-agency understanding of cuckooing is important including guidance in adult safeguarding pathways and protocols; the absence of national guidance in this matter is noted;
f) Achieving a balance between an individual's autonomy and the professional's duty of care; multi-agency meetings (never used with Sam) can be crucial to discussing differences of opinion between professionals, using adult safeguarding principles, evaluating preventive or risk mitigation options, and avoiding defensive or authoritarian practice that undermines engagement;
g) Ensuring that CA referrals are processed and triaged in a timely way including out-of-hours and public holidays; internal audits by adult social care are taking place; MASH processes and CA inquiries should involve GP services;
h) Risks associated with reliance on case management responses and application of legalistic thresholds before initial enquiries are complete:
i) Recognition of undue influence as a safeguarding concern deserves explanation and description in safeguarding policies;
j) Use of discretionary person-centred reasonable adjustments for people who are not disabled but face barriers in using services; this has application in how did not attend appointments are followed up, discharge planning, providing additional information when making referrals;

6 Recommendations

1. A local multi-agency group with senior representation from key agencies should be responsible for ensuring that chronic, highly vulnerable, dependent drinkers are protected and supported by the appropriate use of legal powers highlighted in this SAR and linked to other city initiatives such as Changing Futures. The responsibility could be located in the Sheffield Adults Safeguarding Partnership Board (SASPB), the Health and Well-being Board or Community Safety Partnership.
2. The SASPB should seek assurance and understanding from commissioners about the suitability, availability, and capacity of local services to the group of higher-risk adults with higher dependence on alcohol and/or drugs, following the recommissioning of services in Sheffield, recognising the challenges nationally set out Dame Carol Black's report.
3. The SASPB should seek assurance from the new provider of how they are building assertive services based on relationship building, harm reduction and motivational intervention, evidenced through six monthly reports to the Quality and Performance subgroup.
4. The SASPB should support the new provider by promoting awareness of services and referral pathways and engaging the new provider in the work of the safeguarding partnership including the Annual Safeguarding Self-Assessment Audit and Assurance Meetings.
5. The SASPB should commission a task and finish group to review the policy and practice arrangements for safeguarding adults at risk and vulnerable to cuckooing and specify that all instances of cuckooing are notified to the Adult MASH.
6. The SASPB should ensure that local safeguarding policy and protocols include a definition of cuckooing as a form of abuse and should be promoted through local awareness-raising activity.
7. The SASPB should ensure that local training and professional development promoting appropriate expertise in conducting assessments and applying legislation to the group of high-risk adults where there is a higher dependence on alcohol and/or drugs.
8. The SASPB's annual report should include reporting on the safeguarding of chronically dependent drinkers at high risk of harm and the local inter-agency safeguarding response to cuckooing.
9. The South Yorkshire Police should ensure that an effective system of recording instances of cuckooing is developed that can flag risk and vulnerability for investigative and intelligence purposes.
10. The SASPB should require partner agencies to report on how they promote and advise staff to follow the local self-neglect policy for adults at risk.

11. The SASPB should require each partner agency to ensure they have put in place policy and operational protocols for recording incidents of cuckooing and action to be taken including referral to the Adult MASH.

7 Recommendations and actions that have already been taken by individual agencies.

Sheffield City Council Housing and Neighbourhoods Services

1. To discuss with the legal team what the threshold for supporting court action is and explore alternative methods for ASB.
2. To deliver bespoke training to the area identified with lots of vulnerable tenants.
3. MASH - to inform neighbourhood officers of the new procedure.

Sheffield Place NHS South Yorkshire Integrated Care Board (SY ICB)

1. The GP practice will update and share best practice about the Was Not Brought policy.
2. The GP Practice will formalise into policy and practice guidance the use of the usual GP approach for complex patients.
3. Consider all notifications of a safeguarding concern to be a significant event and thus need to be discussed at the practice meeting.
4. The SY ICB will provide a lessons learned briefing for GP practices in the city to raise awareness of the SASPB self-neglect policy and its use in primary care and include the good practice and exemplar methods of supporting complex patients.
5. The practice will raise awareness of the SASPB Self-Neglect Policy and how to use it in the context of their practice.

Sheffield Teaching Hospitals NHS Foundation Trust (STH NHS FT)

1. To further promote Professional Curiosity amongst clinical staff at Charles Clifford Dental Hospital.
2. To promote the DNA/WNB Policy

Agencies that provided information to the SAR

The following services provided information:

a) Adult Social Care First Contact service
b) Department for Work and Pensions (DWP)
c) Sheffield Health and Social Care Foundation Trust (SHSC)
d) Sheffield City Council Housing and Neighbourhoods Service

e) Sheffield Place NHS South Yorkshire Integrated Care Board (SY ICB); Sam was registered with the same GP practice from October 2012 until his death; his first appointment was in 2018.
f) Sheffield Teaching Hospitals NHS Foundation Trust (STH NHS FT)
g) South Yorkshire Police (SYP)
h) Yorkshire Ambulance Service (YAS)

Details of the independent author and statement of independence

Peter Maddocks was the independent reviewer He has not been employed by any of the services contributing to this review and is not related to any person who is employed in a local service or has an elected position in the city.

Acronyms

Acronym	Full Name
ASB	Anti-Social Behaviour
ASC	Adult Social Care
DVPO	Domestic Violence Protection Order
DWP	Department of Work and Pensions
CA	Care Act
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
OCG	Organised Crime Group
SY ICB	Sheffield Place NHS South Yorkshire Integrated Care Board
SAR	Safeguarding Adult Review
SAB	Safeguarding Adult Board
SASPB	Sheffield Adult Safeguarding Partnership Board
SBAR assessment	Situation-Background-Assessment-Recommendation
S-DASH	Non-domestic Stalking and Harassment Risk Assessment
SHSC	Sheffield Health and Social Care Foundation Trust
SPA	Single Point of Access
STH NHS FT	Sheffield Teaching Hospitals NHS Foundation Trust
SYP	South Yorkshire Police
YAS	Yorkshire Ambulance Service
VA referral	Vulnerable Adult referral
VARMM and CCM	Vulnerable Adult Risk Management Model and Complex Case Management