Safeguarding Adult Review

Henry

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1. Introduction

Section 44 of the Care Act 2014 requires that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when certain criteria are met.

These are:

- When an adult in its area dies as a result of abuse or neglect, whether known or suspected, or has not died, but the SAB suspects that the adult has experienced serious abuse or neglect, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

SARs are required to reflect the six safeguarding adult principles of the Care Act 2014. These are **empowerment, prevention, proportionality, protection, partnership** and **accountability**.

The aim of a SAR is to identify any lessons that would improve the safety and wellbeing of adults with care and support needs, and where possible, to provide a legacy to the person and/or their family and friends and to the practitioners and agencies involved.

There should be clear objectives for the SAR in order to achieve these aims.

Through a shared commitment to openness and reflective learning, the SAR should provide an opportunity to reach an understanding of the facts **(what happened)**, provide an analysis and findings **(why did it happen)** and provide recommendations where relevant to improve services and reduce a risk of repeated circumstances.

The intended outcome of the SAR is a shared action plan to address the recommendations where relevant **(what will happen next)**.

2. Acknowledgements

This SAR was commissioned following the death of Henry, who died in his late fifties in January 2023.

It is acknowledged that the reasons behind this report mean that a family and friends have lost someone dear to them and that their grief is likely to be compounded by how Henry died. The reasons why this report exists are undoubtedly profoundly difficult for those closest to Henry. We therefore convey our condolences and deep sorrow for the loss of Henry and for the circumstances in which he died.

We would also like to acknowledge that individual staff and leaders in agencies working alongside people with care and support needs can be affected too, when there are poor outcomes for people they are working with. This can also have a lasting impact on staff involved.

All representatives from the agencies involved with this SAR showed professionalism, and a genuine desire to learn from Henry's sad death. We therefore extend our thanks to all those who gave of their time and offered their reflections, positive engagement and showed their commitment to identify any learning opportunities.

This review has identified some good local practice and offers some recommendations for the SAB and system partners to consider. It is important to note from the outset that there were no apparent single or multi-agency omissions or practice errors that might have led to Henry's untimely death.

Through an independent lens, this SAR has identified some of the key challenges faced by agencies at the time and in the current climate, when supporting adults like Henry, who have complex and changing needs. By reflecting back at past experience it is hoped that there can be learning for the future.

We also hope that this piece of work has been experienced as being co-produced, offering those contacted by the SAB team or directly by the Reviewers, the opportunity to be heard, to contribute and to share views constructively.

We are also grateful to the SAB team for their support with the co-ordination of this review and for supporting the facilitation of it.

3. Circumstances Leading to the Review

On 3rd January 2023 Surrey Police Officers and Paramedics attended Henry's home address following concerns raised by Raven Housing Trust, Adult Social Care and Henry's mother. Henry was found to be unable to mobilise, was unkempt, in a dirty unclean environment and was sitting in his own faeces, with pots of excrement around him. There was drug equipment around but no drugs evident. Paramedics were concerned that Henry was under the influence of drugs (heroin). Henry was taken to hospital but sadly went into cardiac arrest whilst on the journey and required resuscitation. On arrival at hospital Henry's clinical plan was for end-of-life care due to his poor state of health. Henry sadly died on 5th January 2023.

Following Henry's death professionals reflected that there were potential questions about abuse and/or neglect and opportunities for learning for the agencies who had been in contact with Henry.

A Section 42 Care Act 2014 adult safeguarding enquiry was subsequently opened and a decision taken at the closure of the enquiry on 13th March 2023 that there should be a referral made to the Surrey SAB for consideration for a SAR to be carried out. The records state that the rationale for this decision is:

Duty met: Person has died due to abuse or neglect and there is cause for concern about working together.

Delegated responsibility for making decisions in relation to SARs in Surrey is given to the SAB Safeguarding Adults Review (SAR) Decision Group.

In response to the referral, there was a view reached that the SAR criteria were met and that there was an opportunity to learn from the circumstances of Henry's death about the way in which agencies had worked together.

4. About Henry

Henry was brought up in a supportive family alongside his two brothers and a sister. He was living with the history of abuse and trauma having been raped as a young adult and was also the victim of a violent attack in late 2013.

Henry was unemployed and was financially dependent on benefits. He experienced unstable housing and was living in a property owned by Raven Housing Trust. In the later years he was unable to leave the property due to it being on the third or fourth floor with no lift, so did not access the community independently.

Henry had a number of health conditions including being HIV positive, and having Hepatitis C. It is understood Henry had a mental health diagnosis of paranoid personality disorder and experienced physical disabilities, including poor mobility, a history of falls and used a wheelchair.

Henry was both an alleged victim and an alleged perpetrator, he had come to the attention of the Police, suspected of committing drug offences. Henry had spent time in prison for an offence of arson.

Henry was a smoker, drank large quantities of alcohol daily and was reported to be taking cannabis, which his mother says was for pain relief. It is reported that periods of his life were characterised by taking other drugs, although the extent to which he was using drugs towards the end of his life is unknown. He was understood to be taking methadone which is used to treat heroin dependence. It is alleged that Henry was being cuckooed[1] by someone or more than one person known to him in the months and possibly longer prior to his death.

5. Engagement of Family

Henry's mother was contacted by the SSAB team and offered the opportunity of being involved in the SAR. She did not wish to participate directly but gave the SSAB team a detailed account of Henry and her experience.

She recalled how Henry had always been a sociable chap who was handsome, just like her husband. Henry loved collecting unusual spiders and had a collection of tarantulas. Henry had been an outdoors person – he loved rock climbing when he was younger. Henry had visited Germany to do an apprenticeship in cabinet making before working for the Post Office.

Henry's mother said he would let anyone into his flat without a thought which left the family afraid.

Henry could be violent but mostly with words. She knew that Henry would say he didn't need help, and he would be taken at face value.

[1] Cuckooing is a term used to describe activity where a criminal, or criminal gangs, exploit vulnerable people.

Henry's mother praised the response by the Police and Council saying that the Police were so 'lovely and really wanted to help.' She also described Henry's GP as 'going above and beyond' to support her and Henry.

She said that she does not want other people exploited like Henry was, she described having 'such a lovely early life together' and hopes for some closure through receiving this report.

6. Review Process

6.1 Themes Identified

The following key themes form a thread through the analysis, findings and recommendations in this report.

Vulnerability/ Risk

This includes:

- Understanding how people with multiple and complex needs are supported to identify and meet their care and support needs, in particular in relation to their living conditions and housing needs.
- An evaluation of how effectively agencies identify vulnerable individuals who are at risk from others and work proactively together to address or reduce risks posed by others.
- Consideration of how cuckooing is identified; assessments undertaken by professionals and how risks associated with cuckooing are managed.
- An assessment of how agencies identify and assess people at risk of self-neglect, how decisions are made regarding intervention and support, especially when someone is reluctant to co-operate and how risks associated with self-neglect are managed.

Information Sharing, Co-operation and Partnership Working

This includes:

- An evaluation of how agencies share information and agree plans to improve the support to people with multiple and complex needs.
- Whether there are effective communication and co-ordination mechanisms between health, social care, police, housing and other relevant agencies.
- An understanding of what is available to agencies to help them to collaborate to address safeguarding risks, cuckooing and self-neglect.
- An assessment of what policies, protocols and guidance are in place to support agencies to work as a team around the person and whether there are any gaps or areas of improvement to support agencies with information sharing and partnership working.

Access To and Provision of Services

This includes:

- An evaluation of available services.
- Consideration of how agencies connect and collaborate to support people who may not recognise they are being abused and how decisions are made, especially when individuals refuse help.

- An evaluation of what support is available and how services work with individuals who have multiple and complex needs and have experienced significant trauma.

6.2 Review Methodology

The methodology used for this review involved four key stages:

Stage One - A scoping exercise to understand Henry's contact with agencies across Surrey between 1st January 2020 and 5th January 2023. More detailed scoping information was then provided by all agencies Henry was known to.

Stage Two - An evaluation and analysis of the scoping information was carried out to review the contact with Henry and through developing a combined chronology of agency involvement.

Stage Three - A facilitated workshop was held to support agency representatives to work together, to understand each other's role in respect of contact with Henry and to engage in groupwork. The groupwork was centred around an analysis of the support offered to Henry and to reflect on system working, whether there were any missed opportunities and to identify any new learning opportunities.

Stage Four - There was then follow up with the agencies that were unable to attend the workshop, so they had the chance to contribute to the SAR process and there was one follow on meeting with Raven Housing to clarify a key point.

In advance of the workshop all participants were asked to consider the following key question:

Should a similar situation occur, what learning can be drawn from the experiences of the past, to improve the way in which support is provided and to reduce any barriers to providing more effective care and support?

6.3 Agency Involvement

Scoping was undertaken with the following agencies and a summary of involvement is provided below:

Agency Details	Nature of Involvement
Adult Social Care (social services for adults)	Referred to ASC, by GP in August 2020 due to falls. Referral responded to by an Occupational Therapist (OT) who made a referral to the wheelchair service and referred to social care colleagues. Henry was contacted the following day and declined input. Henry was spoken to again later in August, as he was requesting OT assessment to support rehousing. His GP made a further referral in January 2022 re mobility and falls concerns and was signposted to the Falls Team. A contact was also received in January 2022 about cuckooing.

	Henry was referred again to ASC in December 2022, an assessment took place on 3rd January 2023.
Surrey Police	Previous contact was in 2014 following the assault. Henry was next referred to Police in March 2020 due to suspicions of drug dealing. There was no further Police involvement.
Primary Care (GP)	Henry was in regular and frequent contact with his GP.
Raven Housing Trust (Housing provider)	Henry was a longstanding tenant of Raven Housing Trust (RHT) prior to 2013 and remained a tenant until he died.
First Community Health (Community Nursing, Falls Team, Urgent Community Response)	Referred to Falls Team in August 2020, seen for a face-to-face assessment in September 2020 and followed up in February 2021. Referred again in February 2022, seen by OT from Falls Team. Final referral for Urgent Response Team in December 2022, responded to within 2 hours and referred on to the Community Nursing Team who remained in contact until final admission.
Catalyst (Outreach Project specialising in mental health and cuckooing support)	Referral from Raven Housing Trust on 19th October 2021 due to a suspicion of cuckooing, followed up through a joint visit with Raven Housing Trust on 27th October 2021. Closed following this visit. No further involvement.
SECAmb (Ambulance Service)	One contact only on 3rd January 2023 when taken to hospital.
Surrey and Sussex Healthcare NHS Trust	Emergency Department attendance on 3rd January 2023. Prior to this, four attendances between 2013 and 2016 for shortness of breath, chest infection and related to the assault.
Reigate and Banstead Borough Council (Council with housing and community safety responsibilities)	Raven Housing Trust is commissioned by Reigate and Banstead. Referred to CHARMM in November 2021, discharged in February 2022.
Royal Surrey Hospital, Frimley Hospital, Ashford and St Peter's Hospitals, Epsom and St Hellier University Hospitals (NHS hospitals)	Henry had no contacts.
CSH Surrey (community healthcare)	Henry had no contacts.
HCRG Care Group (a private provider of health and care services)	Henry had no contacts.

7. Key Facts

The main focus of this SAR was the period from October 2021 when Raven Housing Trust raised concerns about cuckooing and/or drug dealing. However, a summary of involvement prior to this time was also considered, to support with the historical context.

Background

It is understood that in December 2013, Henry's flat was broken into, and he was subjected to a violent attack with an iron bar. He sustained spinal and brain injuries as a result and experienced long term physical impact.

In **March 2020** the Police received information that Henry was involved in drug dealing from his home and was being cuckooed by London based drug dealers. This did not progress to the investigation stage.

Henry's GP made a referral to Adult Social Care in **August 2020** following Henry falling at home. Henry was spoken to by an OT who made a referral to the wheelchair service, once it was established that Henry lived alone in a fourth floor flat and was housebound, unable to access the community without a wheelchair.

At the time, Henry was also spoken to by the Adult Social Care Locality Team by telephone. Henry confirmed he was receiving food parcels and hot meals from the local hub. The outcome of the conversation was that Henry was eating regularly, can wash and dress and wishes to remain independent, he does not feel he requires carers to provide any support.

Later in **August 2020** Henry contacted Raven Housing Trust to discuss a move to the ground floor as his health was declining. He was advised to apply to Reigate and Banstead Borough Council for a transfer and that information from his GP may help in support.

In response, Henry's GP made a referral for an OT assessment to support with rehousing. He was assessed by a Physiotherapist (First Community Health) who identified that Henry falls regularly. Equipment was provided and an exercise routine, it was also noted that Henry was an alcoholic who drinks 4-5 cans of beer and a quarter of a bottle of whisky each day.

In **December 2020** Henry called Raven Housing Trust as his wheelchair had been 'stickered' in a communal area and was told that communal areas must be kept clear for fire safety purposes. He also had a telephone consultation with his surgery pharmacist, for a medication review.

In **February 2021** Henry was followed up by the Falls Team. He reported that he is managing well, getting in and out of the bath was a struggle but he did not feel he needed any equipment. Henry said he had not fallen lately, was finding the equipment helpful and had been doing the exercises going up and down stairs. He agreed to be discharged from the service.

In **July 2021** Henry had a telephone consultation with his GP as his foot was swollen, he requested pain relief but declined an in-person appointment. He also contacted Raven Housing Trust in **July 2021** due to a lack of heating and hot water and this issue was transferred to engineers to visit.

Later in **July 2021** Henry's mother called Raven Housing, asking for a transfer to a ground floor due to health conditions. Henry's mother was advised that a transfer would need to be requested via Reigate and Banstead Borough Council and that some medical evidence would be of help.

Events from October 2021

On **18th October 2021** Raven Housing Trust contacted Police and Catalyst for any information as they had received a report of possible cuckooing and/or drug dealing from Henry's home. He was referred to Community Harm and Risk Management (CHARMM) for partner input. It is noted that these concerns of possible cuckooing had been raised previously over the years.

On **26th October 2021** Henry phoned Raven Housing Trust after receiving a letter sent to all flats in the block about drugs and anti-social behaviour. Henry advised he does not use drugs and is immobile.

A rep from the Specialist Outreach Team at Catalyst visited Henry with the Tenancy Enforcement Officer from Raven Housing Trust on **27th October 2021**. Henry was adamant he was not being cuckooed and that the person visiting was a friend. Raven Housing cleaners were asked to monitor any smell of drugs when cleaning the block.

On **25th November 2021** Henry was discussed at CHARMM as a new nomination. He was noted as low risk as Henry does not attend the hub or mix within the community. The minutes state that Henry is a drug dealer in his flat and has had disabilities in the past. Henry was added to the ongoing cases agenda as a low case risk.

On **12th January 2022** Henry was referred to Adult Social Care by his GP due to mobility/falls concerns. Henry's GP was advised by the OT to re-refer to the Falls Team. This referral was made and the Falls Team contacted Henry as a result on **14th January 2022**, he confirmed that he had fallen twice recently and asked for an OT assessment to assess his needs and the suitability of his housing as he wanted to be re-housed. Henry reported having difficulty moving around, he is crawling or using crutches and is unable to leave his flat due to living on the third floor with no lift. He said he was feeling trapped.

A follow-up appointment was booked for **1st February 2022**. During this visit it was noted that the flat and Henry were unkempt. Henry said that he has a carer who helps him with shopping and housework and that he drinks as many beers as he is able to during the day, but it does not affect his balance. The outcome of the visit was that Henry requires a referral to social services OTs to start the process of rehousing. It has not been possible to find any evidence of follow up after this visit.

On **27th January 2022** Henry was again discussed at CHARMM. It was noted that Henry was a potential cuckooing victim of a female, CCTV was implemented on 26th January 2022 to see who is coming in and out of the flat. There were reports of a cannabis odour and of the female coming and going at bizarre times of the day. It was noted that the case would remain open to CHARMM as a low risk.

On **24th February 2022** Henry was again discussed at CHARMM. The minutes state that Henry was a possible victim of cuckooing and that he was keen to move to a ground floor flat. Reports had stopped since the communal doors had been fixed, and CCTV had now been in place for a while. The same female was noted as the alleged perpetrator and as there had been no further complaints for a while Henry was removed from the agenda.

Henry called Raven Housing Trust on **3rd March 2022** asking about a move to the ground floor, it was agreed that he would be referred to the Digital Inclusion Officer who could help him register his request with Reigate and Banstead Borough Council.

On **1st April 2022** (and later on 23rd May 2022 and 7th September 2022) Henry made calls to Raven Housing Trust re the intercom not working, which resulted in problems when letting in carers. This was escalated to relevant team, and internal checks to contractors to ensure work was completed.

On **6th September 2022** Henry reported that he lost rent card.

On **15th September 2022** Henry's mother called Raven Housing Trust to let them know she and the family had spent time cleaning Henry's home. She was advised unfortunately there was no authority to discuss his tenancy with them, a form was sent to Henry to give consent to share information with his mother which he returned on 23rd September 2022.

On **23rd December 2022** Henry's GP visited him and spoke to his mother who was concerned about worsening oedema and reduced mobility. A referral was made to Urgent Care Response (UCR) and was accepted for a 2-hour response. Henry was then visited daily, and antibiotics were started by his GP. There was a query about how Henry would obtain these, and the GP confirmed they would contact his mother to discuss.

Henry's mother also contacted UCR and Raven Housing Trust herself on **23rd December 2022** saying that she had tried to contact social services and housing but was limited in what she could do to help as she was disabled and had not been able to visit Henry at home for three months. Her grandson and his wife had told her Henry was in a bad way. Raven Housing advised that the Tenancy Officer would contact Henry and an appointment was made for a visit on 3rd January 2023.

On **24th December 2022** during the UCR visit although observations were in the normal range, Henry's feet were in a poor state, with a possible fungal infection, his

toes were also ischaemic[2] and necrotic[3]. There was a healing pressure ulcer on his sacrum.

There were concerns about self-neglect as a result of this visit and referrals were made to Adult Social Care for assessment, a safeguarding referral was completed and referrals made to District Nursing and Community Matron for ongoing input. The referral to Adult Social Care was responded to on 28th December 2022 following it being sent to the Mental Health East Team and Reigate and Banstead Locality Team.

Henry was contacted by telephone on **Christmas Eve** by UCR where he reported he was feeling ok; he was informed the Community Nursing Team would be visiting the next day. The Community Nursing Team visited on **Christmas Day 2022** which resulted in an escalation discussion with the Clinical Team Lead and an urgent podiatry review was requested. Henry remained in a poor state of health, and it was difficult to assess Henry well due to poor lighting and space. He was moving around using furniture to keep upright and was in a lot of discomfort and pain which was not being eased by the pressure relieving seat pad. There were also no improvements to the condition of his flat.

On **28th December 2022** Henry's GP made a referral to the social prescribing team and vascular team and UCR also referred Henry to the Community Matron to review co-morbidities. Also on this day, the First Community Adult Safeguarding Lead queried with the Clinical Assessor what type of referral had been made to Adult Social Care (a safeguarding referral to the Multi-Agency Safeguarding Hub (MASH) or a referral for care and support needs assessment) and asked if support with alcohol misuse had been discussed and offered. They also recommended a Fire Safety check. The next day the Clinical Assessor returned the call and explained that both a safeguarding concern had been raised with MASH and also a referral was made in respect of Henry's care and support needs. The Safeguarding Lead agreed to follow up with the District Nurse in respect of alcohol support services and a fire safety check.

Further contacts were made with Henry from Adult Social Care on **28th December 2022**. He was contacted by both the Mental Health Central Duty Team and the Reigate and Banstead Locality Team in response to the same contact (referrals made on 24th December 2022 by UCR). During the call with the Mental Health Central Duty Team Henry confirmed that he had mobility issues and had not been out of his flat for 2 years. The outcome of the conversation was that the contact would be assigned to the Mental Health Locality Team for a Section 9 Care Act 2014 assessment (adult social care/OT). However, the contact was closed as a duplicate with an outcome of information/advice given.

The same contact was responded to by the Reigate and Banstead Locality Team who offered a welfare visit which was declined by Henry. The following day he did accept

[2] Ischaemic means diminished blood supply causing a shortage of oxygen
[3] Necrotic means the premature death of cells in bodily tissue

the offer of a Section 9 Care Act 2014 assessment which was booked at his request for the 3rd January 2023.

On **29th December 2022** Henry reported that his kitchen light was faulty.

The District Nurse phoned Henry on **30th December 2022** to arrange a time to visit. He declined, as stated he was unable to get to the door as no-one was with him at home. He asked that the District Nurse visit him on 3rd January 2022.

Henry was then visited in the morning of **3rd January 2023** by two nurses for planned wound care. They were unable to assess Henry's sacrum as he was unable to weight bear and could not move. He had used a saucepan to empty his bladder which the nurses emptied. The nurse updated Henry's GP with his condition.

Around 12:30 on **3rd January 2023** Henry was called by the Podiatrist team administrator to make a high-risk appointment for that afternoon (this was in response to the urgent request). Henry advised that he couldn't get out of the chair and would not be able to attend, the Podiatrist reviewed the photographs provided by the nursing team and contacted Henry to tell him that he needed to attend hospital, if he couldn't get a lift to Accident and Emergency (A&E) he should call 999.

On the same day the District Nurse spoke to the Duty GP to report continued concerns about Henry's state of health. The GP informed that Henry was being seen by Adult Social Care later in the day and she would let Henry's own GP know so a home visit could be arranged later in the week.

Later on, **3rd January 2023** a home visit was completed by the Tenancy Support Officer and Adult Social Care to complete an assessment. A male was present who Henry referred to as his nephew. Henry's health had deteriorated, and he was unable to move or weight bear. The property was in a very poor state with numerous risks including faeces around the floor, cigarette burn marks, mould and burnt food present.

The Police were called by the Tenancy Support Worker and Adult Social Care rep due to concerns about cuckooing. The Police attended and an ambulance was called at 6.15pm.

Henry was subsequently taken to hospital by ambulance but was unwell in transit and suffered a cardiac arrest. When he arrived at A&E Henry was found to have bilateral gangrenous infected ischemic legs[4] which were found to be occluded from the aorta.[5] Henry's clinical management plan was for end-of-life care based on his multiple co-morbidities and poor condition.

On **4th January 2023** the Police visited Henry's mother to ask her if she had any knowledge of Henry being cuckooed. Whilst there the male that had been seen at Henry's flat on the previous day arrived and assaulted one of the Police Officers. Catalyst contacted the Surrey and Sussex HealthCare Trust Safeguarding Team on

[4] Serious condition where a loss of blood causes body tissue to die and a type of pressure ulcer.
[5] Catastrophic vascular condition

4th January 2023 to discuss concerns with regards cuckooing. Henry's mother shared with the Police that the male was known by a different name which she shared.

During the morning of **5th January 2023** Henry passed away.

8. Analysis of Key Facts

8.1 Overview

The Reviewers understand that intervening in the lives of adults with multiple complex needs and who may be at risk can be challenging; especially when balancing the principles of choice, control, autonomy, and protection. Intervention is usually only possible with the consent and co-operation of individuals. If intervention is taken by public services in the absence of the co-operation of individuals it can only be where there is a legal gateway to do so. The Police have coercive enforcement powers but in the main most other agencies have to rely on participation and any support directed by the person.

Henry was an adult who was living in the community with no formal support network. He was under the care of primary NHS services, alongside his housing support.

Although Henry referred to 'carers' but there was no formal package of care in place.

A significant issue for Henry seems to be the accessibility of his housing. Despite many conversations and communication about a move to a ground floor property this review has not been able to establish why this was not arranged and if Henry would have been deemed a priority for alternative accommodation. Unfortunately, we were not able to obtain any information from Reigate and Banstead Borough Council to answer this query to establish what actions if any took place to facilitate a move.

Much of the communication related to a requested move was directed at Raven Housing Trust, who were the landlord and not responsible for housing allocation decisions. Each time Raven Housing Trust were contacted they redirected Henry and his mother to the Borough Council as it is the Council who assess housing applications, not the supported housing provider.

Raven Housing Trust are only able to facilitate management moves in specified circumstances where there is significant harm occurring or fear of loss of life (such as a situation of domestic violence). The Raven Housing Trust rep explained in our meetings that management moves cannot be used to address medical conditions.

Although there was one Police referral back in 2020 it was not possible to progress with this any further due to the quality and reliability of the information received.

8.2 Vulnerability/ Risk

Henry's lifestyle of the harmful use of alcohol, smoking and use of drugs is likely to have had a chronic impact on his health over many years.

Whilst we would identify Henry as having care and support needs it is unclear whether Henry would have considered himself to have care and support needs and whether

he would have considered different lifestyle choices to improve his quality of life. It is also unclear whether he was motivated to reduce or cease his misuse of substances. There were occasions where Henry was offered formal support, but he declined.

What is evident is that his housing situation was clearly a barrier to an improved quality of life, access to the community and the potential of fresh air and exercise – all of which improve the life chances of people with complex medical conditions.

Henry's circumstances meant he was reliant on others for food and provisions, and it is unclear what support was being provided to Henry.

Whilst there are grounds to suspect that Henry was self-neglecting this had not been established through any formal process. Henry was not formally assessed by ASC until right at the end of his life in relation to care and support needs. Therefore, no judgements were made in relation to his mental capacity around his lifestyle choices and whether any intervention might have been possible at an earlier stage.

The Mental Capacity Act 2005, Section 1, requires that capacity is assumed, unless it is established that a person lacks the capacity to make a particular decision.

It is clear from the Falls Team visit on 1st February 2022 that Henry's quality of life and living circumstances were poor when he described feeling trapped and unable to access the community due to his housing situation. His property is described as unkempt on this visit, which then became a common theme throughout contacts that followed. From the records there would appear to be a missed opportunity around the time this visit took place as there had also been a contact recorded by ASC on 27th January 2022 in relation to cuckooing.

However, it is important to remember, as is the case with SARs, that we now have the benefit of hindsight.

Had an outcome of the visit or the contact with ASC prompted a more formal Care Act 2014 safeguarding response it is impossible to know what course this might have taken and what choices Henry would have made in relation to participation. However, had concerns been 'named' as safeguarding concerns (be they in relation to possible self-neglect) this might have prompted a more formal assessment and offers of support.

Henry also denied that he was being cuckooed and described his associates as 'carers' or sometimes friends.

There are many references made to Henry possibly being cuckooed but this was not formally investigated by the Police, so was still a suspicion, rather than being confirmed. Cuckooing is a crime, with the most common form being where drug dealers take control of the victim's home and use the premises to store, prepare or distribute drugs, often as part of county lines networks.

The National County Lines Coordination Centre has identified a number of specific heightened risk factors that make people vulnerable to cuckooing:

- Lack of safe/stable home environment
- Social isolation or social difficulties
- Economic deprivation
- Insecure accommodation status
- Physical or learning disability
- Mental ill health
- Substance misuse.

This review has established that agencies did recognise community safety risks that Henry may be exposed to and for this reason he was discussed at the Community Harm and Risk Management Meeting (CHARMM) on more than one occasion between November 2021 and February 2022.

CHARMM is described as a multi-agency information sharing arrangement related to community safety used in Surrey.

8.3 Referral Criteria

A victim and/or perpetrator can be referred to the Community Harm and Risk Management Meeting where:

- A case has not been resolved despite action already taken and is having a negative impact on a victim(s), household and/or wider community
- There have been several incidents by the same perpetrator on the same victim(s) in the last 6 months and they are increasing in severity and frequency
- The victim(s) and/or perpetrator are vulnerable, or at risk to either themselves or others
- The case is complex and requires a multi-agency response
- The case does not fall under the remit of another specific group or panel.

CHARMM was described by the agencies contributing to this review, as a forum to discuss risks to Henry as a potential victim. It is noted in the CHARMM minutes of February 2022 that Henry is possibly the victim of cuckooing (one female's name noted) but that reports had stopped since the communal doors have been fixed, and CCTV is in place for a time as well. Henry had been deemed a low risk and was removed from the agenda as there had been no further complaints from tenants. He was not subsequently discussed again.

The Police representative we spoke to in relation to this review explained that CHARMM is an effective information sharing forum that allows for discussion about people posing a risk or being vulnerable in their own right.

At the Learning Event participants (some of which had worked elsewhere) spoke about the benefits of having a formal multi-agency risk management framework. These are commonplace in some areas and are often referred to as Multi-agency Risk Management Frameworks (MARM).

8.4 Information Sharing, Co-operation and Partnership Working

This review has not identified any specific issues about the co-operation and partnership working between agencies.

We consider that agencies had a good understanding of each other's roles and remits and appropriate referrals were made across agencies. There was proactive action taken by Raven Housing Trust to refer to Catalyst and also Henry's GP was working hard to support him with his health needs.

8.5 Access To and Provision of Services

The following provides a precis and evaluation of the involvement of agencies.

GP involvement: Henry was largely supported by universal services with his GP being the primary source of support. There was frequent communication between Henry and his GP surgery, including medication reviews, vaccinations and the active engagement of community secondary health services. His mother was complimentary about the GP, describing them as 'going above and beyond.'

Housing support: Raven Housing Trust provided consistent tenancy support to Henry and were in regular contact with him.

Adult Social Care: Henry was referred to ASC in late December 2022, a matter of days before he died. The opportunity for intervention by ASC was therefore limited, as Henry had not been previously assessed by them.

Substance Misuse support: it does not appear that Henry requested any support with substance misuse and there is note of this being offered to him by the Catalyst worker who visited. This was declined by Henry.

Police involvement: Henry was in contact with the Police in 2014 after the violent attack. Following this the next contact was in 2020 when although there were indications of possible cuckooing the information was not sufficiently reliable for the Police to take any action. Henry was never spoken to by the Police, nor did he directly contact the Police to make any specific allegations.

Specialist Cuckooing support: this was offered to Henry on one occasion by Catalyst back in October 2021 following a referral by Raven Housing Trust. A joint home visit was completed, and Henry was adamant that he was not being cuckooed and the person visiting was a friend. He also said he would not let anyone into his flat to sell drugs and was able to say no to people coming in.

Community Support: the health teams support in the community for Henry was very responsive and appropriate escalation took place.

9. Key Findings

9.1 Summary

One of the principle findings of this review has been in relation to the decision making to undertake a SAR.

The Section 42 enquiry which took place after Henry died resulted in the SAR referral. The enquiry concluded that Henry had died due to abuse or neglect and there was cause for concern about working together. However, it was not clear what evidence was drawn upon to reach this conclusion. In the Section 42 enquiry report viewed by the Reviewers stating that Henry died due to abuse or neglect, it is also not clear if the view reached was that Henry was experiencing abuse or neglect by agencies, his associates (abuse or neglect by a third party) or if this referred to self-neglect. We will take each of these forms of abuse or neglect in turn.

The Care Act 2014 makes provision for abuse or neglect by organisations, agencies or individuals in positions of trust or providing services to adults with care and support needs to be categorised as **neglect** or **acts of omissions**. An act of omission in safeguarding refers to a failure to take appropriate action when needed to protect a vulnerable individual. Examples of neglect and acts of omission include ignoring medical, emotional or physical needs, failure to provide access to appropriate health, care and support services, withholding the necessities of life including medication, adequate nutrition and heating.

In the months leading to Henry's death, he was not in receipt of a formal care package and was being supported mostly by NHS services, alongside his housing support. The Section 42 enquiry that took place did not specifically explore or evaluate the role of agencies supporting Henry to determine whether or not they were acting in a way that would constitute neglect or acts of omission. This review has in fact found the contrary - Henry's GP and UCR were providing a responsive service to him. The Reviewers do not consider that the threshold is met to deduce that Henry was being neglected by any of the agencies he was known to and we have not seen any evidence in this review of any neglect by organisations which would constitute acts of omission.

In terms of possible abuse or neglect by the associates / friends / carers known to Henry, we have not been able to establish through this review that there was anything known or investigated about whether there was perpetrated harm to Henry by a third party. It is therefore only speculation, and no conclusions can be drawn.

Thirdly, it was also not possible to explore self-neglect with Henry, since he had died by the time the enquiry was commenced. Self-neglect can of course be considered in the context of safeguarding, but this was never formally assessed or discussed with Henry, as far as we have been able to find out.

The final consideration for whether SAR criteria are met is that there are concerns about the way in which agencies were working together. In terms of whether there were concerns about multi-agency working in this review, we have not identified any systemic issues in how the multi-disciplinary team were working to support Henry. The conclusion reached is that Henry's case reflects wider challenges regarding system working such as demand and capacity and the challenges faced by working with people with multiple and complex needs, co-morbidities and engaging in harmful behaviours.

Ideally, SARs should be commissioned and undertaken in a timely way, to ensure learning is identified and acted upon swiftly. There has been a delay in this SAR being completed. A further finding is therefore the missed opportunity to maximise learning in a timely way to ensure maximum value from the SAR process.

9.2 Good Practice

The Community Nursing Team, Urgent Response Team, GP and Raven Housing Trust deserve recognition for the way in which they supported Henry.

Record keeping is also noted to be very thorough and detailed by First Community Health. At a time when there is often reduced capacity over the Christmas period the team provided a good standard of support to Henry when he was referred to them in December 2022.

9.3 Safeguarding Principles

The six safeguarding principles are useful to summarise when applied to this review.

Empowerment - People being supported and encouraged to make their own decisions and informed consent.	The clearest voice Henry expressed was in relation to his housing needs. There would appear to have been a missed opportunity to work with Henry to achieve this goal of a move to a ground floor property.
Prevention - It is better to take action before harm occurs.	Agencies applied prevention principles, identifying the risk of continued deterioration in Henry's health. Community nursing increased frequency of visits to review and monitor the situation.
Proportionality - The least intrusive response appropriate to the risk presented.	There is sense that because Henry was not offered interventions through a safeguarding lens there may have been missed opportunities to offer a more proactive response, appropriate to the presenting risks.
Protection - Support and representation for those in greatest need.	It was not identified that Henry needed protection from any abuse or neglect.
Partnership - Local solution through services working with their communities.	Communities have a part to play in preventing, detecting and reporting abuse and neglect.
Accountability - Accountability and transparency in safeguarding practice.	Appropriate escalation was evidenced, particularly by NHS services in respect of Henry's deteriorating health and the serious medical issues he was experiencing.

9.4 Points of Learning

The term cuckooing was used in relation to Henry's circumstances, with reference made on at least six occasions. Cuckooing is a form of criminal exploitation in which criminal gangs target vulnerable people to use their homes as a base from which to deal drugs. The vulnerable person is often coerced into allowing their property to be used for this purpose through the offer of 'free' drugs. The cuckooed person may then be forced to deal drugs to pay off the 'free' drugs they were initially given in a practice known as 'debt bondage'. The person being cuckooed will often be reluctant to raise concerns for fear of reprisals and violence. Perpetrators of cuckooing prey on people who have vulnerabilities. Many of the signs of cuckooing look like anti-social behaviour and may present in this way.

Whilst there was reference to Henry experiencing cuckooing there was no evidence from Surrey Police to support this view. There is a question as to whether following the concern of cuckooing being raised at the CHARMM meetings on 27th January 2022 and 24th February 2022 that the multi-agency meeting should have considered / determined what actions would need to be taken to establish some facts about these concerns. The CHARMM minutes state that Catalyst (a specialist cuckooing organisation) would make contact. It has been confirmed by Catalyst that they did make contact with Henry and were unable to establish any evidence that he was being exploited by a gang dealing drugs. So, there is an unanswered question as to whether he may have been exploited by friends that Henry was allowing to use his flat or whether there could have been mate crime taking place.

A further learning point, which has now been addressed through the Serious Incident Policy in 2024, is in relation to the practice of undertaking s42 enquiries when someone has died. Sadly, it is not possible to safeguard someone after they have died so other processes are more helpful to address learning. The introduction of the Serious Incident Policy within Adult Social Care is a positive change and allows for more appropriate pathways to be considered / followed in the local authority. However, when applying the SAR criteria, it would be helpful to establish what other processes might be followed.

There is a point of learning about the value of seeing people in their own home environment. Whilst telephone support is valuable and time effective there is a sense that Henry was able to provide a more positive picture of his circumstances when contacted by telephone. Since the Covid-19 pandemic all services now operate slightly differently which has undoubtedly brought the benefit of greater use of technology. However, there is also value in seeing people for face-to-face visits and assessments. The 2020 referral to the Local Authority by the GP requesting OT assessment and the referral to the falls team, and mention of suicidal thoughts may have been more appropriately responded to with an offer of a home visit and a full assessment. However, this may not have been accepted by Henry.

When Henry referred to having ‘carers’ this was taken at face value and there may have been a bias, or an assumption made that Henry was in receipt of formal care. Nonetheless, a carer is anyone, including children and adults who look after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addition and cannot cope without their support. The extent to which Henry’s ‘carers’ were acting in his best interest is debatable and unknown.

There is another point of learning about identifying ‘carers’ and determining who might be defined as carers. Given that Henry mentioned ‘carers’ there is possibly some learning about professional curiosity that, if applied, might have enabled professionals to explore what he meant when he used the term.

There may also have been a missed opportunity to identify Henry's mother as a carer. Back in 2020 Henry was described as housebound and that his mother could no longer continue supporting him, it may have been helpful for a carers assessment to be offered at this time.

The cause of Henry's death is recorded as natural. There is a sense that Henry's social circumstances, lifestyle and living environment were most likely contributing to his chronic and long-term health difficulties coupled with the cognitive impairment, experienced as a result of the attack in 2013. Henry was most likely living in deprivation for many years prior to his death.

It is possible that the Christmas and New Year period had a bearing on the responsiveness of agencies, particularly ASC, when the safeguarding referral and the referral for a needs assessment were made in late December 2022. However, the response was still made within a few days, with an assessment arranged for 3rd January 2023. During this time Henry did also decline a welfare visit, which might have been an additional opportunity to intervene.

At the Learning Event participants identified a point of learning about applying Section 11 of the Care Act 2014 as Henry's situation seemed to resonate with some of the professionals who attended. Section 11 relates to refusal of assessments and the role a local authority may take when an adult refuses a care needs assessment.

10. Conclusion

In summary, this review has not established conclusively that Henry was the victim of abuse and / or neglect. The lapse of time and the lack of any formal safeguarding or other exploratory process whilst Henry was alive has meant that it has not been possible to confirm or deny this.

The review, however, has enabled agencies to reflect on the care and support afforded to Henry and to identify some areas of good practice, alongside some points of learning.

There has been no evidence found to suggest that the role of agencies in any way contributed to Henry's early death. What is clear when considering the wider determinants of health, is that Henry was likely to have had a reduced life expectancy for a number of reasons including being in poor health for a long time, his lifestyle and living conditions.

The following recommendations are made in the spirit of reflection and may already be considerations the SAB are progressing, given the time lapse since the period of time being considered by this review.

11. Recommendations

Recommendation 1

It is recommended that the SAB ensures the Section 44 Care Act 2014 SAR criteria are applied in full when deciding whether to commission an independent SAR.

Rationale – Statutory SARs should be reserved for situations where there is evidence or a high suspicion of abuse or neglect directly related to death or serious harm, and crucially, where there are significant concerns about the way in which agencies have worked together to protect the person from abuse or neglect.

The April 2017 – March 2019 Analysis of SARs (published by the Local Government Association) identified inconsistencies and concerns regarding SAR processes, including SAR decision making, and that the law requires decision making to be reasonable, lawful and rationale.

The current Safeguarding Adults Review Decision Group, decision making template could be reviewed to provide more prompts for the Learning and Review Group to consider, when making statutory or discretionary SAR decisions.

Recommendation 2

It is recommended that the SAB consider a multi-agency framework for learning together from situations where there is learning for more than one agency.

Rationale – this could provide a proportionate and timelier vehicle for continuous improvement and increase the opportunity to understand experiences in the context of the systems in which they occur, in order to prevent reoccurrence.

The NHS introduced a new Patient Safety Incident Response Framework in 2022, some of the tools used in this framework such as After-Action Reviews (AARs) or Learning on One Page (LOOPS) could be usefully applied to a broader multi-agency context. Some of these tools are very useful to support teams to reflect on incidents in a proportionate way, soon after they occur.

Recommendation 3

It is recommended that the SAB consider introducing a Multi-agency Risk Management Framework (MARM).

Rationale – A MARM can be a useful framework where partner agencies work together to identify, assess and manage risk to people where other statutory frameworks do not apply or are not effective.

Many SABs have introduced multi-agency risk management frameworks – local examples include Hampshire, Dorset, Oxfordshire, Richmond and Wandsworth

Should this recommendation be taken forward, this would present an ideal opportunity to review the interface with other community safety processes and how information is shared in other frameworks such as CHARMM to ensure there is alignment, rather than duplication.

Recommendation 4

It is recommended that the SAB consider a workstream in its next business planning cycle to promote the recognition and understanding of cuckooing.

Rationale: This review could therefore be used as a catalyst for raising awareness of cuckooing and provide a legacy to Henry.

The Leicester/Leicestershire & Rutland SAB has a specific guide on cuckooing, together with legal definitions which the SAB may wish to consider in developing their toolkit. This may be helpful for the Surrey SAB to refer to.