Richmond and Wandsworth Safeguarding Adults Board Safeguarding Adult Review - Michael recording script

Michael was a talented musician and artist who lived alone. He had experienced poor mental health over many years, with a diagnosis of schizoaffective disorder which was complicated by the use of controlled drugs. Michael had frequent admissions to hospital and had been supported by Mental Health Services over many years. Michael had a long history of inconsistent engagement with the professionals supporting him and with his treatment.

In March 2019 Michael was discharged from hospital and returned home, supported with a Care Plan (Care Plan Approach) and a Community Treatment Order (CTO). Michal was also supported by Adult Social Care which commissioned a cleaning service to support his independent living. During subsequent months Michael disengaged from services and was last seen by professionals in September. In December his family expressed concerns that they hadn't been able to contact him. The following January Michael was reported to the police as a missing person and was found deceased at his home.

The subsequent police investigation determined that Michael had been murdered by a member of a 'County Lines' drugs network, which had begun exploiting him during the previous summer. They had used his home to supply controlled drugs – a type of criminality often termed 'Cuckooing'. This typically involves the home of a vulnerable person being taken over for criminal activity.

So, what did the review find?

1. There was a need for Person Focussed Care Planning

As a result of Michael's past history, professionals had an expectation that he would not engage with his care plan or engage with drug and alcohol services. This led to planning focussing on how to manage the risk of anticipated disengagement, rather than on finding ways to work with Michael in a way that would support his overall wellbeing. This missed an opportunity to look deeper into his life and help him to build positive relationships through the interests which were important to him.

Being unable to develop a positive working relationship with Michael prevented professionals from understanding what was happening in his life, including the identification of his increasing drug use and the criminal exploitation that he was exposed to.

2. The need for Multi-Agency Planning

Michael's care plan was developed by the mental health services in a single agency approach. This meant that the information held by other agencies was not shared or considered. It also led to agencies working independently of each other. Coordinating the work of key agencies may have resulted in a more comprehensive and effective safeguarding plan.

During care plan reviews, the mental health team were not aware of new information that had been gained by other agencies from their ongoing involvement with Michael. A regular multi-agency review would have helped to ensure that information was shared and risk

appropriately considered. This would have helped to build an insight into Michael's life, ensuring that the context of events was fully understood by all.

As Michael disengaged from services, professionals could have been more robust in managing the escalation of risk. There were missed opportunities to make referrals to established forums such as the Adults at Risk process and the Community Multi Agency Risk Assessment Conference.

As concerns about Michael's welfare increased the police were asked to conduct a 'welfare check'. The information provided to the police did not outline an immediate risk to Michael's safety and therefore the request was declined in accordance with police policy and procedure.

3. The need to understand 'Cuckooing' and Criminal Exploitation

Despite the safeguarding board's guidance on recognising the signs of cuckooing, this issue was not widely understood and the risk to Michael was not identified. Furthermore, a coordinated partnership response to this type of criminal exploitation does not exist in South West London.

4. Community Treatment Order Processes

Despite concerns about Michael's engagement with his treatment, a decision was taken to discharge his Community Treatment Order at the first formal review. The decision was taken by a consultant who had not previously met Michael and the rationale did not reflect his short- or long-term clinical history. The discharge of the CTO led Michael to completely disengage from services and to stop taking his medication.

Whilst colleagues from the mental health team were consulted in this decision, a record of their views and representations was not recorded. Despite professionals not agreeing with the decision, it was not challenged.

Professionals from other agencies were not consulted and upon discharge a disengagement management plan was not considered.

What lessons can we learn?

1. We need to use Person Centred Approaches to Safeguarding

One of the key principles underpinning adult safeguarding is 'making safeguarding personal'. Professionals should seek to fully understand what is happening in a person's life and what is important to them. This will help to increase engagement and put people at the heart of decision making. This is particularly important with those who are hard to reach or reluctant to engage.

To support the development of safeguarding plans and the work of professionals, effective pathways of support should exist and be properly commissioned. This will provide a range of services to be considered in the safeguarding plan.

2. We need to use Multi-Agency Planning

The safeguarding partnership has an excellent 'multi-agency planning framework', which has been developed to support safeguarding carried out in a non-statutory setting. Professionals

should read this and use the principles within it for any safeguarding plans which they lead, regardless of purpose or complexity.

And in complex cases, key agencies should always be involved from the outset to share information and to develop a partnership safeguarding plan. The lead agency should hold others to account for delivering actions and there should be regular reviews which all agencies contribute to.

As risk increases then safeguarding activity should be escalated. Doing ‘more of the same’ is unlikely to make a difference and a more robust response should follow. Consideration should be given to making safeguarding referrals through established processes – for example a safeguarding adult referral.

The police will only conduct welfare checks where there is an immediate risk to the persons safety. If you ask the police to conduct a check, then clearly articulate why there is an immediate risk and what you have already done to try and address it. If there is not an immediate risk, but you feel a partnership approach would be beneficial, then consider contacting the police safeguarding teams.

3. We need to Understand ‘Cuckooing’ Criminal Exploitation

Cuckooing is a term used to describe a practice where a person’s home is taken over and used to facilitate criminal activity, most frequently in relation to the illegal supply of drugs. People are normally victimised due to their vulnerability, with poor mental health and drug addiction being significant risk factors.

When working with vulnerable people who use drugs, consider the risks of exploitation and look out for the signs. The safeguarding partnership has an excellent information leaflet for practitioners on this.

4. We can also learn about Community Treatment Order Processes

During a CTO review it is essential to capture and detail the views of the other professionals working with the vulnerable person, including the views of partner agencies involved in the safeguarding plan.

Good practice should consider undertaking more than one review prior to discharging a CTO and upon discharge a disengagement management plan should be put into place.

A culture of professional challenge is essential to effective safeguarding. Professionals should be encouraged to challenge a decision which they feel may have a detrimental impact.