# SAFEGUARDING ADULT REVIEW
OVERVIEW REPORT

in the case of

Peter

## Acknowledgements

The coordination of this review has been assisted greatly by the SAR panel with their local, professional and organisational knowledge. It has also been assisted by the chronology authors in the work they undertook and analysis they provided of their agency.

The practitioners who attended the learning event are also thanked for their valuable contributions and discussion.

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## 1. Introduction

1.1 This review seeks to identify the learning opportunities resulting from the death of Peter. Any Safeguarding Adults Review (SAR) has a tragic loss or significant harm at the heart of it and this review remains focused on the person at the centre of it, Peter.

1.2 At the time of his death Peter was 66 years of age, he had held a tenancy since 2016, when it was handed to him on the death of his father. There was evidence dating back sometime that Peter misused substances and as a result that he associated with other persons who did the same

1.3 Part of the role of this review will be to consider Peter's own vulnerabilities and to see whether his vulnerability was exploited by others. Over a long period of time there was a particular person, Mark, who was at times described by both himself and Peter as Peter's carer. Mark had a significant history of criminal convictions, including drug related offences. Concerns were raised that Mark was exploiting Peter, as were others who frequented Peter's address. This exploitation of a vulnerable person, particularly by moving into their address has been referred to as 'cuckooing'[1] and more recently as home invasion. This activity is often linked to the supply of class A drugs by persons involved in drug supply routes referred to as County Lines[2]. There was evidence of persons involved in this type of offending exploiting Peter.

1.4 In October 2021, emergency services were called to Peter's address on the report of a person having stabbed himself in the chest. The person was found to be Peter and he was pronounced as being deceased at the scene. Two males, one of them being Mark, were initially investigated as being involved in Peter's death. The investigation concluded that there were no other persons involved the death and a police report has been submitted to HM Coroner on this basis.

[1] Cuckooing, National Crime Agency - A common feature in county lines drug supply is the exploitation of young and vulnerable people. The dealers will frequently target children and adults - often with mental health or addiction problems - to act as drug runners or move cash so they can stay under the radar of law enforcement. In some cases, the dealers will take over a local property, normally belonging to a vulnerable person, and use it to operate their criminal activity from. This is known as cuckooing.

[2] County Lines, National Crime Agency - County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs.

## 2. Methodology and terms of reference

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally
- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults partnership in Worcestershire to improve its services and prevent abuse and neglect in the future.
- Agree how this learning will be acted on, and what is expected to change as a result.
- Identify any issues for multi or single agency policies and procedures.
- Publish a summary report, which is available to the public.

2.2 The Worcestershire Safeguarding Adult Board (WSAB) Case Review Group undertook a Rapid Review on this case in relation to the referral for a SAR and for a Domestic Homicide Review[3] (DHR). The sub-group was constituted from agencies with responsibility to make determination on the necessity of a SAR and a DHR. After due consideration the subgroup reached the decision that the case did not meet the criteria for a DHR, the Home Office have been advised of this decision. The subgroup unanimously agreed that the case warranted a SAR.

2.3 Each agency identified as being involved was requested to provide information and chronology detailing their involvement. Practitioners who were involved in the case were invited to take part in a reflective discussion event. The discussion from these events is reflected throughout the report.

2.4 Scoping was provided by the below agencies:-

- West Mercia Police (WMP)
- Worcestershire Acute Health NHS Trust (WAHT)
- Worcestershire County Council Adult Social Care (WCC ASC)
- Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG) on behalf of the GP practice
- Cranstoun Drug Services
- Bromsgove and Redditch District Councils
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)

[3] Domestic Homicide Review - section 9(3) of the Domestic Violence, Crime and Victims Act 2004 states: domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

- National Probation Service (NPS)
- West Midlands Ambulance Service (WMAS)
- Department of Work and Pensions (DWP)

2.5 Terms of reference for the review were agreed. The terms of reference identified the focus of the review will be the period 1st July 2020 to the date of Peter's death in October 2021.

The areas identified by the panel for consideration were:

- Were Peter's care and support needs assessed and was the relationship with Mark understood by agencies?
- Did agencies effectively share information?
- Was there effective consideration of home invasion and what was done to mitigate risk to Peter?
- To identify and highlight for learning purposes any areas which are considered to be good practice.

## 3. Background

3.1 At the time of his death Peter had a single tenancy on his property. The tenancy was passed to him in 2016, after his father died, for whom Peter had been a carer. Peter had a small family, whom he did not have much contact with, but spoke fondly about. Some agencies got to know Peter well and spent time with him. They would describe him as a genuinely nice man who engaged well with them but was lonely. This view was reflected by his neighbours, who liked Peter but were concerned by some of the persons who visited him.

3.2 A greater insight into Peter as a person was gained from discussion with his family. They had been close but in more recent times they had become estranged. The reason for this was over Peter's relationship with his associate Mark. Peter had lived with varying levels of addiction to both alcohol and drugs for many years but after the death of his father had started to refrain from any substance misuse. When Peter formed a relationship with Mark his family recognised that this presented a real risk to Peter, and they strongly advised against it. When they were unable to influence this decision, for the sake of their own health and wellbeing they felt, reluctantly, they had to remove themselves from the situation.

3.3 Peter had limited mobility and was a wheelchair user. He had been a long-term heroin user and many of his associates were involved in drug use. For around 18 months prior to his death Peter had been a close associate of Mark. The relationship with Mark was not fully understood but Peter on occasions referred to him as his carer and being as close to him as a 'brother'. Mark, and on occasions other persons, were regular visitors to Peter's address and this was a cause of concern to both Peter's neighbours and some of the agencies involved with him. Mark had a significant criminal history, including drugs offences and it was this which caused concerns as to whether Peter was being exploited.

3.4 The family describe a sense of helplessness in a situation where they felt that Peter was being drawn into a situation which would lead to a decline in his health but were unable to influence this. As Peter would not accept support, they were unable identify any agency to highlight their concerns to who could or would assist in these circumstances.

## 4. Narrative chronology

4.1 The concerns from neighbours started to be voiced in July 2020, they reported that there was increasing anti-social behaviour and that more persons seemed to be staying overnight at Peter's property and there was evidence of the use of drugs. It should be remembered that the national lockdown for the covid pandemic started in March 2020, and the associated restrictions were implemented and altered as time progressed according to the risk presented by the pandemic.

4.2 As a result of the reports the housing officer visited in August 2020, and although they were not given access to the property, they noted that there were other persons present. Peter agreed that he was struggling to pay his rent and consented to getting support to managing his finances and working with the Financial Inclusion Team. The housing officer discussed a referral with Adult Social Care (ASC) but was told that a referral could not be made as Peter had not given consent for the referral. There is no record of this conversation within ASC records. ASC did undertake to speak to the GP and police but the housing officer did not return to get this consent.

4.3 In September 2020, police received a report that Peter had been assaulted in his home. Police attended and saw that Peter had a cut to his lip. Mark was present at the address, but Peter maintained to officers that there had not been an assault and the injury had been caused by an accident. Although the officers believed that Peter had been assaulted, he would not assist this and therefore no action could be taken. At this stage, there were no referrals made to other agencies.

4.4 During early September 2020, there were further concerns raised by neighbours regarding the number of visitors to the address. The financial inclusion officer contacted Peter to try to support him with his finances. Peter stated that he spent money daily on cigarettes and alcohol. The officer was able to discuss the possibility of support for his alcohol use, but Peter declined this. The officer also explored whether Peter was being subjected to financial abuse, which he denied although he did disclose his bank card had been stolen and used without his consent. Peter stated he was going to report this to police, but it would appear no report was made.

4.5 This visit was followed up a week later with a joint visit by the housing officer and police. Entry to the property was not gained but it was observed that the house was cluttered and damaged. Mark was present at the address and claimed that he was staying there as his own property was in a state of disrepair.

4.6 At the beginning of October 2020, there was an incident where damage was caused to Peter's property by another male who broke a window by throwing a brick and is recorded as making threats and demanding money from Peter. Initially Peter agreed to make a statement to support a prosecution but later declined to do this. Although this

matter was appropriately recorded by police no further action was taken due to a lack of witness support.

4.7 At the beginning of December 2020, police visited Peter's address and found two males present from the West Midlands area who were known for the organised supply of heroin. There was evidence of drug dealing from the premises. The two males were arrested. Peter was initially arrested but did not enter custody and was interviewed regarding the men using his property. Peter revealed that having been invited in the men refused to leave.

4.8 It was recognised that Peter was vulnerable, and the resulting action was appropriate. The police put in place a Risk Management Plan (RMP), which entails the police visiting the address on a regular basis. This included joint action with the housing officer and a 'cuckooing' agreement was put in place. This agreement was signed by Peter and made an agreement that he would work with police and housing to stop persons who may be exploiting him visiting his address. This agreement was supported by regular visits by police and housing and signage at the address to inform others that an agreement was in place.

4.9 The RMP and agreement resulted in Peter being visited, mainly by police every 2-7 days. Peter seemed to welcome this support and it is clear that a good rapport was formed with Peter. On occasions other persons were found at the address, but this was recorded and the opportunity to probe their presence and whether Peter consented to their presence. Regular visits were made and recorded up until April 2021.There is good evidence in the records that the police made regular enquiry with Peter regarding the drug support he was receiving and whether he felt this was sufficient.

4.10 In mid-April 2021, neighbours reported to police concerns regarding Mark's relationship with Peter, as they had heard Peter being shouted at. Peter had also been seen hiding cash outside of his address as he felt Mark might take it. Soon after this Peter informed the police that Mark was now registered as his carer. Department of Work and Pensions (DWP) records show that a carers allowance was made to Mark in respect of Peter from January 2021, this was backdated to September 2020. Peter also mentioned to his GP that he had a 24-hour carer and has had this support for the past 19 months.

4.11 At the end of April 2021, Peter attended the substance misuse service offices and self-referred into treatment. It was noted that Peter's previous treatment episode with the service had been terminated due to Peter's non-engagement. The on-going attempted contact with Peter was either by phone or letter. There was a successful call at the end of May 2021 where Peter discussed drug use and the risk of overdose.

4.12 The joint approach between police and housing continued in May 2021, where Peter's case was discussed at a regularly convened ASB/safeguarding meeting. It was agreed at this meeting that a Community Protection Warning Notice[4] (CPWN) would be issued to

[4] Community Protection Warning (CPW) – s 43 Anti-social Behaviour, Crime and Policing Act 2014 - An authorised person may issue a community protection notice to an individual aged 16 or over, or a body, if

Mark to protect Peter from cuckooing. A joint visit was undertaken to issue the CPWN but after conversation with Peter it was established that he considered Mark as his carer and wished for him to be present at his address. Therefore, in accordance with Peter's wishes a CPWN was not issued.

4.13 At the beginning of June 2021, both police and housing were concerned about the appropriateness of Mark being a registered carer and as a result made enquiries with the benefits office. It is believed that this was the Local Authority benefits office as opposed to DWP.

4.14 In mid-June 2021, the substance misuse service undertook an assessment of Peter, he disclosed using alcohol, heroin and crack cocaine. He had abstained for 5 years but re-lapsed two years previously. He disclosed using substances to manage his physical pain. He disclosed mobility issues and that his mobility scooter was broken, and he could not use it. He stated that he had a carer. Under safeguarding it was recorded that there were no concerns identified or disclosed. There were no referrals or liaison with other organisations involved with Peter. Peter was seen by the service again at the end of June 2021 and a further history was taken. Peter further disclosed that he had been previously 'cuckooed' and the police visited him regularly. At this stage Peter stated that he had no debts to drug dealers. Peter agreed to commence methadone and a follow up meeting was planned. There was liaison at this stage with police and confirmation that there was no cuckooing now taking place.

4.15 From July to September 2021, Peter's case was discussed at the joint police/housing meeting. As time progressed it was clear that the RMP and cuckooing agreement were having a positive effect with a decrease in ASB and associated reports. Peter's contact with the substance misuse service was limited mostly to text and telephone call with signposting to debt management services and support with food vouchers. In July and August 2021, Peter informed the service that he was not using heroin anymore.

4.16 In mid-October 2021, Peter self-presented at hospital with what he reported as a self-harm wound to his neck. Peter stated that he felt low due to money concerns, he stated that he was 'ten grand' in debt. He was seen and treated for his wound which he described as a cry for help and was seen by a mental health nurse. Peter admitted being a heroin user and using it daily. He was described as being future orientated and presented a low risk for suicide. Information was forwarded to Cranstoun. There is no indication of any referrals to other agencies.

4.17 Fours days later the police carried out a routine RMP visit to Peter and he disclosed the visit to hospital and harm that he caused to himself. There was no indication that the information was shared with the Harm Assessment Unit (HAU) for consideration of contact with ASC. Later the same day emergency services were called to Peter's address on the report that he had self-harmed by stabbing himself in the chest. After providing

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satisfied on reasonable grounds that—(a) the conduct of the individual or body is having a detrimental effect, of a persistent or continuing nature, on the quality of life of those in the locality, and (b)the conduct is unreasonable.

emergency treatment and resuscitation the ambulance staff verified that Peter was deceased.

## 5. Analysis of involvement

### 5.1 Were Peter's care and support needs assessed and was the relationship with Mark understood by agencies?

### Was consideration given to safeguarding Peter and were appropriate agencies involved?

5.1.1 Where it appears to a Local Authority that a person has care and support needs the Local Authority must assess whether the person does have care and support needs and what those needs are.[5] The eligibility criteria of the care act states that Local Authorities must consider whether the person's care and support needs arise from, or are related to, a physical or mental impairment which includes substance misuse.

5.1.2 The Care Act also sets out the wellbeing principle. The Care Act Statutory Guidance states that wellbeing is a broad concept but includes protection from abuse and neglect, control by the individual over day to day, social and economic wellbeing and suitability of living accommodation. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person[6].

5.1.3 Housing records indicate a referral was made to Adult Social Care (ASC) in August 2020, when a housing officer made contact. It is recorded ASC informed the housing officer that as consent for the referral had not been gained from Peter the matter could not be taken forward. This is disputed by ASC as they have no record of this conversation. At the time of this referral the housing officer had received consent for his case to be discussed with the Financial Inclusion Team, who would support Peter with his rent arrears. It would seem from this consent Peter did want support and if asked may well have consented to support from ASC. Following this response from ASC the necessary consent should have been sought, which would have allowed ASC to assess Peter's care and support needs.

5.1.4 There is no doubt that the police and housing officers worked closely and well with Peter and this is discussed in more detail in the next section. The monthly meeting looked at safeguarding as well as the issues of anti-social behaviour. Part of the consideration of this meeting could have been referrals to ASC for a carer assessment for Mark, this may have assisted in a greater understanding of his role, had it been agreed.

This could have been undertaken with Peter's consent or if this was not forthcoming on the basis of the appropriate level of concern, that he was at risk or abuse or neglect.[7]

[5] Section 9, Care Act 2014
[6] Care and Support Statutory Guidance,2014, Department of Health
[7] Section 11, Care Act 2014

5.1.5 Peter self-referred to the substance misuse service in April 2021, this must have been a significant point for Peter for him to reach out for support. Shortly before this on a police visit Peter had discussed his use of heroin and where he could get support, indicating at this time that he was open to engagement. There are records of sustained attempts by the substance misuse service to contact Peter but mainly by text and letter and as a result there was not an assessment until two months later. This period of time is significant, and consideration needs to be given to how, when a person self refers to the service, a more immediate response can be achieved to seize the opportunity which is presented.

5.1.6 In October 2021, Peter presented with a self-harm wound to his neck. He disclosed that he was feeling low due to money problems and disclosed owing a substantial sum of money as a drug debt. He said that his self-harm was a cry for help. Peter was assessed by a mental health worker and as part of the discussion he said that he did not trust his GP, there is no record of this being explored further. His risks associated with his mental health were assessed using a web-based assessment tool (GRIST) and he was deemed to be low risk of suicide and that the self-harming was a maladaptive coping mechanism to social stresses. It was recognised that Peter was a heroin user and receiving treatment from Cranstoun. Peter was discharged to the care of his GP. There is no record of contact or discussion with the GP.

5.1.7 At this point there could have been more professional curiosity into Peter's situation and the concerns that he was expressing.

5.1.8 Peter self-referred to the substance misuse service in April 2021, this must have been a significant point for Peter for him to reach out for support. Shortly before this on a police visit Peter had discussed his use of heroin and where he could get support, indicating at this time that he was open to engagement. There are records of sustained attempts by the substance misuse service to contact Peter but mainly by text and letter and as a result there was not an assessment until two months later. This period of time is significant, and consideration needs to be given to how, when a person self refers to the service, a more immediate response can be achieved to seize the opportunity which is presented.

**Learning: -** Although there were concerns regarding Peter and how his situation and circumstances presented a risk to him there was a lack of referral to ASC regarding safeguarding concerns and consideration of potential self-neglect. This was primarily due to them being managed through the RMP and monthly ASB meetings.

There must be a tipping point for a person seeking support for substance misuse and that where a person recognises that they need support and seek that support the response needs to be dynamic and pro-active to exploit the opportunity presented by the client.

When Peter did present with self-harm shortly before his death there could have been a more enquiring approach and consideration to sharing concerns with other agencies.

### Recommendation 1

Worcestershire Acute Health NHS Trust should ensure that staff exercise appropriate professional curiosity when persons present with self-harm injuries and that consideration is given, depending on presenting circumstances, to raising a safeguarding concern.

### Recommendation 2

Cranstoun (substance misuse service) should consider how a more immediate response can be achieved to assessing clients who self-refer to the service.

### Recommendation 3

Cranstoun (substance misuse service) should ensure that consideration is given to potential safeguarding concerns and liaison with other services when assessing clients.

## 5.2 Was there effective consideration of cuckooing (home invasion) and what was done to mitigate risk to Peter?

### Did agencies effectively share information

5.2.1 In this case there is good evidence that Peter was vulnerable to exploitation in the form of cuckooing. All the guidance on dealing with this type of activity suggests that a multi-agency approach is adopted. Peter was particularly vulnerable to this activity. He was lonely and wanted company. His mobility was limited, and he required support with this. He was a heroin user and required money for drugs to feed his habit.

5.2.2 There is evidence of more informal exploitation with a number of persons staying with Peter at various stages. There was a long-term relationship with Mark who he described as his carer and on one occasion as being as close to him as a brother. There is also evidence of Peter being targeting by those involved in the organised supply of class A drugs when two males linked to this activity were arrested from his home address in September 2020. An indication of the prevalence of cuckooing nationally was revealed during the National County Lines intensification week which took place during in October 2021 – targeting drug traffickers who often recruit children and vulnerable adults to supply drugs across the country resulted in 894 cuckooed addresses being visited[8].

5.2.3 From July to September 2020, housing and police received complaints regarding the visitors to Peter's address and the anti-social behaviour that resulted from this. When two males were found at the address with evidence of then dealing heroin, appropriate action was taken. The police put in place a Risk Management Plan (RMP) and with housing jointly put in place a cuckooing agreement.

5.2.4 The police RMP entailed regular visits to Peter's home address, this allowed officers to get to know Peter well and to engage with him. It is clear from the records and reflections from some of the officers involved that Peter welcomed this support. The police monitored and dealt with visitors to Peter's address. There is also evidence that the police understood

[8] Cuckooing - The case for strengthening the law against slavery in the home, November 2021 – The Centre for Social Justice

and sought to support Peter in the main cause of his vulnerability, his reliance on and use of heroin. The police encouraged and sought to facilitate engagement with drug services.

5.2.5 The RMP also supported the cuckooing agreement with Peter. This initiative entailed Peter signing an agreement that he would work with housing and police to restrict access to his property by those seeking to use it for drug dealing or other illegal activity. The initiative also involves deploying signage to indicate that the agreement is in place. This seeks to deter those who would exploit Peter and allows Peter to rely on the agreement to better resist approaches from those seeking to exploit him.

5.2.6 Both the RMP and cuckooing agreement were coordinated by monthly housing/police meetings where Peter's case and similar cases were discussed. When reflecting on this meeting housing and police agreed that it could be enhanced by the regular attendance of Cranstoun, and any other agencies engaged in the case.

5.2.7 Overall the activity in relations to cuckooing has to be viewed as innovative and sustained good practice. There was evidence that the activity was having an impact with a reduction of unwanted visitors to Peter's address and a reduction in anti-social behaviour.

5.2.8 The more difficult issue to address was the relationship Peter had with Mark. This lasted over a significant period of time. Mark was described by Peter as his carer and Mark had been receiving a carer allowance for performing this role. Agencies' supporting Peter had concerns over the suitability over Mark as a carer and recognised that he could be exploiting the relationship. There was evidence that this was a reality with Peter seen hiding money from Mark and reports of Mark verbally abusing Peter. There was clear consideration of how this may be addressed. There was an attempt to use legislation (CPWN) to restrict Mark's access, but this was resisted by Peter. Mark had the status as a carer with DWP. Attempts were also made to highlight these concerns, but these proved unsuccessful due to a lack of understanding of the process of providing carer support and the agencies involved.

5.2.9 The agencies who knew Peter well believe that Peter would have been unlikely to accept other support and Mark was able to meet his specific needs, namely the provision of what he considered most important in his life, heroin. Agencies were aware of the relationship with Mark and had well founded concerns, they sought to address it and manage the risk it presented but Peter's reliance on Mark made this difficult. The suitability of Mark as a recipient of carers allowance is discussed at section 1.

**Learning: -** The RMP is seen as good practice that was seen to be having an impact for Peter, particularly when combined with the cuckooing policy. The multi-agency reflective discussion noted that the cuckooing is not active in all areas and this good practice should be shared. Where there is an RMP in place other agencies should seek to use this as a foundation for other means of support (Self Neglect and Hoarding Policy and CARM). Other agencies utilising and supporting an RMP has been noted in other local Worcestershire reviews.[9] Where there are monthly ASB/Safeguarding meetings agencies that have a significant role with the user cohort should attend the meetings.

[9] SAR David, 2018, Worcestershire Safeguarding Adults' Board

### Recommendation 4

The Worcestershire Safeguarding Adults' Board should work with Community Safety Partnerships to promote what cuckooing is and how it can be dealt with by using the cuckooing policy and a multi-agency approach.

### Recommendation 5

Where multi- agency meetings are being convened to support complex cases, all agencies involved with that person should be involved.

## 5. Conclusions

There were concerns raised by people who knew Peter and some of the agencies that he was involved in regarding some people taking advantage of his vulnerability. This was certainly the case with some of the persons who were arrested from his address, but the case was not so clear with his associate Mark who he tended to rely on.

The Police and Housing put good measures in place to address the risk to Peter and to address some of the behaviour which was a result of some of the associations that Peter had formed. Peter welcomed this support and there is evidence that he reached out for support to address his long standing misuse of drugs. Unfortunately, the desire for support was not sustained by Peter and his engagement was variable. The discussions for this review did highlight that a more immediate and face to face approach benefitted Peter.

As with many complex issues there is a real benefit in maintaining a multi-agency approach, in part this was adopted by the police and housing with the ASB and safeguarding meetings but it would have added value if the substance misuse provider was also able to attend to coordinate the information and approach.

## 6. Recommendations

### Recommendation 1

Worcestershire Acute Health NHS Trust should ensure that staff exercise appropriate professional curiosity when persons present with self-harm injuries and that consideration is given, where appropriate, to raising a safeguarding concern.

### Recommendation 2

Cranstoun (substance misuse service) should consider how a more immediate response can be achieved to assessing clients who self-refer to the service.

### Recommendation 3

Cranstoun (substance misuse service) should ensure that consideration is given to potential safeguarding concerns and liaison with other services when assessing clients.

## Recommendation 4

The Worcestershire Safeguarding Adults' Board should work with Community Safety Partnerships to promote what cuckooing is and how it can be dealt with by using the cuckooing policy and a multi-agency approach.

## Recommendation 5

Where multi- agency meetings are being convened to support complex cases, all agencies involved with that person should be involved

## Appendix A

## Rapid Review SAR – Worcester Safeguarding Adult Board – Peter

## BACKGROUND

A Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

- there is reasonable cause for concern about how the SAB, members of it
- or other persons with relevant functions worked together to safeguard the adult

the adult has died, and

the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

This case was initially referred for both a Safeguarding Adult Review (SAR) and a Domestic Homicide Review (DHR). The panel considered criteria for both reviews and decided that it did not meet the criteria for a DHR but should proceed as a SAR.

## CIRCUMSTANCES

The subject of this review is Peter.
Peter had a significant history with police both as a victim and an offender.
He had an ongoing relationship with a male, Mark. This relationship was at times described as being a caring role with Mark caring for Peter.
Peter and others who frequented Peter's property were suspected of dealing class A drugs from the property and that they were exploiting Peter for the purposes of this.
Peter's neighbours had reported concerns regarding persons frequenting his address and housing had been involved over concerns of anti-social behaviour.
Police and housing worked together to address the anti-social behaviour and the concerns over Peter being exploited.

On 19th October 2021, emergency services were called to Peter's home address on the report of a man having stabbed himself in the chest. Paramedics declared Peter deceased at the scene. Mark was at the address together with another man who were both arrested on suspicion of murder.
Police enquiries have since established a hypothesis that the fatal injury sustained by Peter was caused by himself and will be submitting a report to HM Coroner on that basis.

**SUBJECT**

| Name | Date of birth | Date of death |
|---|---|---|
| Peter | November 1954 | October 2021 |

**METHODOLOGY**
This review will build on the scoping from the rapid review process and enhance this by the author undertaking agency interviews as required. Proportionate and strength-based review, using chronologies and practitioner events to enable analysis of events, interactions and plans afoot to identify learning opportunities regarding good practice to be shared and areas for improvement. These events may be supported by 1:1 interviews with key practitioners where it is felt it will enhance the learning opportunities of the review.

**CHRONOLOGIES PROVIDED BY:**

1. **West Mercia Police (WMP)**
2. **Worcestershire Acute Health NHS Trust (WAHT)**
3. **Worcester County Council Adult Social Care (WCC ASC)**
4. **Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG) on behalf of the GP**
5. **Cranstoun**
6. **Bromsgrove and Redditch District Councils**
7. **Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)**
8. **National Probation Service (NPS)**
9. **West Midlands Ambulance Service (WMAS)**

**TERMS OF REFERENCE**
<u>Areas of consideration</u>

1) Were Peter's care and support needs assessed and was the relationship with Mark understood by agencies?
2) Did agencies effectively share information?
3) Was there effective consideration of cuckooing (home invasion) and what was done to mitigate risk to Peter?
4) Was consideration given to safeguarding Peter and were appropriate agencies involved?
5) Was Peter appropriately supported for his substance misuse?

6) To identify and highlight for learning purposes any areas which are considered to be good practice.

## TIMESCALE

This case includes a significant history, which is important to understand the context and cumulative effect.

The review will focus on the period 1st July 2020 to the date of Peter's death 19th October 2021.

Agencies will also be asked to consider the significance of any events outside of this timeframe which add context to or assist the learning process.

## SIGNIFICANT PERSONS

Relevant family members, and any other important personal network will be informed what the Safeguarding Adult Review is for, how it will work, what the parameters are and how they can engage in the review.

## PRACTITIONER EVENT

To be facilitated by Report Author. To generate learning arising from the themes present in the Chronology.

## PARALELL PROCEEDINGS

HM Coroner is undertaking an inquest. There is ongoing communication between the Safeguarding Board and Coroner's office.

## PUBLISHING

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.