Safeguarding Adult Review

Overview Report into the circumstances surrounding the death of Michael

Independent Reviewer: Stella Smith

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Contents

Preface

The Keeping Bristol Safe Partnership extends its sincere condolences to Michael's* family. It also extends thanks to Michael's mother who kindly provided valuable information and an insight into Michael's life which ensured he was at the heart of this review.

This Safeguarding Adult Review would not have been possible to undertake without the contributions, open reflection, information and insight supplied by safeguarding partners and agencies who provided care and support for Michael. This helped to identify shared learning and to define the recommendations for improvement.

The input and professional support provided by the Keeping Bristol Safe Partnership Safeguarding Adults Review Team has been greatly valued and appreciated.

*Michael is a pseudonym chosen by his mother.

1. Introduction

Section 44 of the Care Act 2014 places a duty on Safeguarding Adults Boards to arrange a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. A SAR promotes learning and identifies improvements to prevent future death or serious harm occurring again. A SAR does not seek to lay blame; it is an opportunity to consider together what happened and what could have been done differently.

Michael[a] was a White British man who was 44 when he died in September 2024. The cause of death was recorded as drowning in his bath following an epileptic seizure. Michael had early trauma arising from an accident in childhood which left him with a brain injury and frequent epileptic seizures. He could not sustain employment, became dependent on drugs and was targeted, exploited and abused by others.

A SAR was commissioned by the Keeping Bristol Safe Partnership (KBSP) as it was thought that there was evidence that services could have worked together more effectively to protect Michael. An independent lead reviewer was appointed and a SAR panel of partner representatives was established; the panel was chaired by the lead reviewer.

The SAR draws on significant events, in the two years up to the time of Michael's death in September 2024, with some additional information about his childhood and the challenges he experienced which impacted on his adult life.

The engagement and inclusion of Michael's mother, safeguarding partners and practitioners and the exploration of different perspectives informs the SAR.

The SAR report sets out the Terms of Reference (ToR) and the identified areas of focus to be addressed which are:

- safeguarding practice, including risk assessment and mental capacity assessment.
- cuckooing and exploitation.
- self-neglect.
- partnerships and collaboration.

The SAR methodology draws out the legal context, references relevant research and the evidence base regarding effective clinical/professional practice. It compares and contrasts this with the practice findings. Operational and wider strategic systems and factors that influenced practice and professional response are critically analysed to inform learning,

The SAR looks at how partner organisations have responded since Michael's death and what has changed and is changing. It identifies recurring themes from local and national SARs and highlights resources that may be helpful for practice

[a] Michael is a pseudonym chosen by his mother.

development. SAR Quality Markers underpin the SAR to ensure that it is robust, consistent and most importantly person centred[b].

2. SAR Terms of Reference (ToR) and Methodology

2.1 A SAR panel, chaired by the independent lead reviewer, was established. Panel members had a key role and professional responsibility within the statutory review process.

2.2 The following agencies provided chronology information to inform the SAR and made up the panel membership for this review. The panel also formulated the ToR.

- Avon and Somerset Police
- Avon and Wiltshire Mental Health Partnership Trust
- Bristol, North Somerset and South Gloucestershire Integrated Care Board.
- Bristol City Council - Adult Social Care.
- The Probation Service.
- In Hope, The Wild Goose drop in centre.
- North Bristol NHS Trust.
- Second Step: Mental Health Charity and Housing Support Service.
- South Western Ambulance Service Trust.
- University Hospitals Bristol and Weston NHS Trust.

2.3 The ToR sets out the legal context of the SAR, its purpose, key areas of focus, family involvement, panel membership, media and communications, agreement and periodic review.

2.3.1 The proposed areas of focus are**:**

1. Safeguarding practice, including engagement with family, risk assessment, mental capacity assessment and safety planning.
2. Cuckooing and exploitation.
3. Multi-agency work with adults who are experiencing self-neglect.
4. Multi-agency partnership and collaboration including sharing information.

2.4 The SAR Methodology

2.4.1 The SAR panel agreed that gathering chronological information over a two year time period prior and up to the time of Michael's death would be proportionate and enable focus on key events and relatively current organisational practice. The SAR does reference some key events outside of this period to inform on Michael's adverse childhood experiences and the impact of his early brain injury on his adult life.

The SAR quality marker 9 guides practice on the chronology time frame:

The Safeguarding Adult Review (SAR) gains a sufficient range and quality of information and input, to determine the relevant objective facts, to 'stand in the

[b] List of 15 Safeguarding Adult Reviews Quality Markers - SCIE

shoes' and 'get inside the heads' of those involved and to grasp the way that single and multi-agency/professional practice is shaped both by work environments and conditions, and by social and organisational factors.

2.4.2 The SAR methodology looks at each area of focus and:

- Considers the legal context and reference relevant research and wider evidence base regarding effective clinical/professional practice and compare this with the practice findings.
- Critically analyses the key findings and identify learning including enablers and barriers to practice.
- Considers the wider strategic context and organisational systems and factors that influenced the practice and professional response.
- Focuses on recurring themes from SARs, both locally and nationally.
- Highlights learning points and consider actions taken and changes made (and developing/proposed) within the partner organisations.
- Identifies recommendations and provide references and helpful resources.

2.4.3 The Partner Learning Event

This event is a fundamental part of the SAR as it enables non-judgmental discussion and reflection about practice enablers and challenges at the time. The discussion will inform the SAR and promote growth in understanding and appreciation of different partner perspectives.

2.4.4 Family Contact and Making Safeguarding Personal

Michael's family will be advised about the SAR purpose and method and how they wish to be involved. Family views will be compassionately sought and provide insight into Michael as a person. He will be at the heart of this review, his life, experiences and challenges will inform analysis and review of practice.

The reviewer had contact with Michael's mother in an initial telephone call and explained the purpose of the SAR. Michael's mother shared information about her son's childhood, the traumatic time following his accident and the impact that his brain injury had on his life.

In follow up telephone calls, Michael's mother shared with the reviewer that she had recently lost her sister and that this compounded her grief. She expressed anxiety about the pending inquest for Michael and told the reviewer about her close bond with and support from Michael's brother who was attending the inquest with her. The reviewer asked if Michael's brother or his sister would like to talk to her and be involved in the SAR as well.

Michael's mother chose the pseudonym Michael for the SAR as this was reflective of her son's love of Michael Jackson's music. She said that her other son and daughter had chosen not to be involved in the SAR. Michael's mother talked further about her son and daughter and her grandchildren and the help she had from her supportive husband. The reviewer and Michael's mother built up a good rapport. She was updated on the progress of the SAR and had reviewed the draft report and gave her feedback to the reviewer. This has been incorporated into the draft report.

2.4.5 Parallel Processes

The SAR will include reference to parallel processes namely the coroner's inquest outcome and the housing support agency internal review.

3. Michael

Michael was in a car accident when he was seven years old. He was in intensive care and suffered brain damage. Michael had a long period of rehabilitation following his accident and learned to walk again, though he was left with severe epilepsy and frequent seizures.

Michael's mother said that he did not receive any specialist educational help at school. She said that Michael liked music and dancing, especially to Michael Jackson's songs. He was an outdoor person who loved animals. He had a pet cockerel. Michael's mother reflected that 'he didn't have children and would have liked to have had a steady girlfriend; he would have been loyal'. Michael had two brothers and a sister.

Michael found it difficult to hold down employment because of his frequent seizures. His memory was poor and he was very forgetful. His mother said that 'Michael was his own person and was lucky to be alive after his accident. He was not stupid; he was nobody's fool'. Michael's mother was concerned that he had got into bad company, she felt that he was exploited and people took advantage of him and that 'he didn't think before he acted'.

Michael's mother is grieving for the loss of her son and she wanted to highlight in the review that family involvement and being part of a team working together to support family members in distress is very important. She feels that had she been included there may have been a different outcome. She also felt that if Michael had been supported to have a fresh start away from the people who were exploiting him, in different and more supported accommodation, that he would still be here today.

Michael became dependent on alcohol and drugs. He lived in accommodation that provided a high level of tenancy support. He was, at times, aggressive and abusive to others and had served time in prison for assault. In the two years prior to his death, Michael was subject to a probation order, which was regularly breached due to non-attendance at appointments. His complex needs that were related to brain injury, such as memory problems and erratic and impulsive behaviours, meant that he was unable to reliably attend appointments or undertake any rehabilitative work to prevent re-offending.

Michael was very vulnerable to exploitation and coercion by others. There was a network of professionals and services working to support him including housing/key worker support, Police, Probation, Adult Social Care (ASC), Home Care, GP, Community Health, Acute Hospitals and a community charity drop in support and recovery service. A full list of the agencies involved, and their roles can be found in section 2 of this report, the SAR Terms of Reference. People who were supporting Michael cared about him and, at times, built up rapport with him.

Michael was financially, physically and emotionally abused by others over a sustained period of time. A safeguarding safety plan was in place and reduced some of the risks but not to a level to keep him safe from harm. Towards the end of his life, Michael was assaulted and threatened by a female who had moved into his home. She was present when he died and initially was arrested for his murder and later released on police bail. A post mortem and inquest concluded that Michael had died as a result of drowning following an epileptic seizure.

Michael's keyworkers worked with him consistently and in a caring, responsive way. They supported him to attend his probation and medical appointments and informally advocated for him on many occasions. The extensive chronology and care notes highlight their support for Michael as did the community charity In Hope who offered Michael a place of sanctuary when he needed advice, food, support and a safe place to vent his frustration and anxiety.

3.1 Summary of Chronology Information

The extensive summary of chronology information is indicative of the many incidents and, concerns about Michael and significant key events. Detailed discussion, critical analysis and learning are explored in Section 4 of this report. Information is drawn from a wide range of sources including Michael's mother, a practitioner learning event, partner agency discussion, chronologies and records. Michael's keyworker, referred to in the chronology, was part of the Second Step[c] supported housing team.

January 2022: A My Team Around Me[d] (MTAM) meeting was held which was led by ASC and involved Michael and key partners. The meeting was held to discuss with Michael the escalating concerns around risks to him, including frequent physical assaults from others known to him, emotional abuse and financial exploitation leaving him with no money for food or electricity. It was noted that there had been four previous safeguarding enquiries which concluded with the risks being reduced but not removed.

The meeting concluded with a revised safety plan and noted that some partners expressed that accommodation with a higher level of support for Michael would be the best option. It was agreed that a mental capacity assessment regarding Michael's decision making about where he lived would be completed. It was noted that Michael agreed with and consented to the safety plan.

June 2022: A mental capacity assessment was completed by ASC regarding Michael's decision making regarding 'whether or not to engage in move on support from his current accommodation'. It concluded that he had 'the capacity to decide whether to engage with support to find accommodation'.

7th September 2022: Michael said he had been violently assaulted by another resident of the flats where he lived. At this time, there was concern about his frequent seizures which was referred to his GP.

[c] About Second Step Bristol | A Leading Mental Health Charity
[d] My Team Around Me

12th September 2022: Michael was sentenced to a two year community order for an assault on an Emergency Worker. Attached to this order were rehabilitation activity requirement (RAR) days. Michael was supervised by a Probation Officer. It was later recognised by the courts that the order was unworkable because of Michael's cognitive functioning and, at times, erratic and impulsive behaviour, rendered him unable to complete RAR activities and reliably attend appointments. The Probation Service commissioned a personal wellbeing service to work with Michael, and this was unsuccessful. The court order was eventually changed to a financial penalty.

It was noted in the chronology that unsuitable community orders were recommended on two occasions. Michael's health and care needs, impeding his ability to reasonably and successfully engage with probation orders, were not taken into account.

13th September 2022: A safeguarding referral was received by ASC regarding an assault on Michael by another resident. He was noted to have been 'punched in the face and was dizzy and vomiting'. He was assessed by the GP.

14th September 2022: The methodist church homeless hub informed Michael that he was banned for 12 months for racist abuse. On the same day, the Police were called regarding an alleged assault on Michael from another resident. It is noted in the chronology that a police risk assessment should have been completed and ASC notified.

16th September 2022: There is reference to Michael being concerned that he hadn't received his benefit payment. He was informed that his money was 'placed into an appointeeship'. It is noted in records that a mental capacity assessment in November 2021, concluded that Michael did not have capacity to make decisions on how his finances are managed and appointeeship of his benefits by the Council was to be put in place.

20th September 2022: Michael was seen by his GP; he was drowsy and there was concern about him not eating and an increase in seizures. He was sent to hospital and admission was proposed which he refused. There were differing views on Michael's mental capacity to make this decision, no recorded assessment was completed and no information given on how the dissenting views were resolved. It is noted in the chronology that there was a missed opportunity to refer to the hospital safeguarding team. Michael self-discharged against medical advice.

At this time, it is recorded that Michael was distressed about his new financial appointeeship and called the Police as he thinks his money was being stolen.

27th September 2022: Michael's keyworker notes that he was racially abusing other tenants.

6th October 2022: Michael attended the hospital Emergency Department (ED) with an extensive head wound sustained in a fall after smoking crack cocaine; he seemed confused/drowsy. Concerns were raised about his epilepsy management. The chronology reflects that as this was the third presentation of Michael to ED in 2 weeks, a safeguarding concern should have been raised to ASC.

11th October 2022: ASC and Police notes report that Michael told police officers that he was frustrated about his appointeeship and finances and threatened to stab his social worker. A risk flag was added to the ASC notes and joint visits were recommended.

18th October 2022: Safeguarding enquiry closed. The concerns raised were assault on Michael and financial exploitation from others. A safety plan is put in place involving the hate crime service, the drug and alcohol team, ASC, voluntary sector agencies, Police, health and commissioned support.

19th October 2022: The housing provider record their intention to pursue an eviction with Michael and to help him find accommodation. The reason given was his repeated breaches of the tenancy agreement.

24th October 2022: ASC record that a housing focused meeting was held to discuss accommodation options for Michael. There is partner reflection of a missed opportunity to consider his executive functioning[e] in relation to his decision making about his place of residence.

8th November 2022: The GP notes concerns about Michael's health, increased seizures, shortness of breath when walking, incontinence with seizures and swelling of a testicle. Michael was seen by the GP, and an antibiotic cream was given for a skin infection. There is no record of discussion regarding the other health issues.

9th November 2022: Michael meets with his social worker to discuss the management of his money. It is noted that he seemed to understand.

18th November 2022: ASC notes the completion of a Mental Capacity Assessment regarding Michael's decision making on place of residence. Michael was deemed to have capacity.

23rd November 2022: Michael's GP has a telephone discussion with him noted as regarding his 'psychotic disorder'. It was noted that his mental health was stable with no new concerns.

30th November 2022: ASC notes that a support plan was put in place – four hours a week with two support workers to support Michael with budgeting and social activities and to help him manage risks.

30th November 2022: Michael is assaulted by another tenant; he told his keyworker that he felt 'bullied and unsafe' in his accommodation. The incident was reported to the Police.

13th December 2022: Michael told his keyworker that he had two seizures that week and wasn't taking his medication properly. He said he was 'starving and had no money'. He was advised to go to a food bank. It is noted that Michael was regularly reporting threats of assault and actual assaults.

2023

[e] Executive dysfunction | Headway

3rd January 2023: Michael's keyworker notes that he is not feeling well, he has no money for food and is forgetting to take his medication.

17th January 2023: Recorded by ASC, the forensic Community Learning Disability Team are not accepting Michael for a service as he does not have a learning disability – he has an acquired brain injury. A review of the risk screening tool is noted which details identified risks relating to Michael's residence, his behaviour and behaviour of others towards him and a risk to life when having a bath due to seizures. There is reflection in the chronology that the risk tool does not gather views of Michael or look at monitoring risk management/reduction.

19th January 2023: Michael had a seizure on the bus and was intoxicated; he was admitted to hospital. He was aggressive on the ward and his behaviour became out of control. Michael punched his fist into a trolley, threw objects and equipment around, and a metal water bottle had injured a member of staff. He was agitated and he said he was upset about the door being locked. Michael was noted as having the capacity to make a decision on leaving hospital, and he was escorted off site by the security staff.

23rd January 2023: Michael's social worker requested an internal investigation as he had reported physical abuse towards him from hospital staff. The hospital reported that Trust policies were followed, including a High Impact User Personal Support Plan[f] regarding behaviour escalation and incident reporting.

27th January 2023: Michael was reported to be having increased seizures. His money was going into his bank account at midnight and was spent by the time support workers could assist with money management.

2nd February 2023: ASC record notification that Michael was deemed not suitable for community supported housing and that rehousing should take place through the homeless pathway.

4th February 2023: Michael was charged with assault on an emergency worker.

27th February 2023: Hospital notes record that Michael presented at ED with shortness of breath. It was recorded that his PSP, in place since 2018, stated that Michael was at risk of financial, physical and emotional abuse from a friend and that he was to be referred to the psychiatric team if there was deterioration in mental health and an increase in risks. The PSP advised on the completion of mental capacity assessments related to unsafe discharge and to report incidents in line with the Trust protocol.

[f] Supporting high impact users to reduce demand for emergency care - The Health Innovation Network The High Intensity Users (HIUs) team triage and prioritise patients based on multiple factors. Once prioritised, patients are contacted and asked to contribute to a Personal Support Plan (PSP). The Plan is then used by members of staff in the ED to provide a consistent approach to assessment and management, and a multidisciplinary team supports to address any underlying issues through a holistic approach.

20th March 2023: Police notes record that Michael was assaulted in the street by a group of drug users; he was seen in the ED. A police risk assessment was completed[g] and rated Red and referred to the Police Lighthouse Safeguarding Unit (LSU) who referred on to ASC. There were concerns about Michael's vulnerabilities and his reliance on food banks; he did not have a working fridge. It was reported that Michael was not understanding the correspondence coming through his door, and had missed a bail appointment.

23rd March 2023: A professionals meeting was held and led by ASC as there was concern about Michael's financial management. Money was going into his account at night and being spent quickly; this was a known risk. The reflection commentary noted that 'the financial protection plan put in place to reduce destitution was making Michael a target for financial abuse'. It was later agreed that the care support agency would have a pre-payment top up card to buy food and essentials for Michael to reduce the risk.

4th April 2023: Michael continues to be without a phone which was vital for his prompts about medications and probation and medical appointments. There was confusion regarding which agency was dealing with this.

26th April 2023: The care support agency report that a woman was found asleep in Michael's flat and that several people had been there the night before. There was evidence of drug use.

9th May 2023: Michael's keyworker notes her concern about his non-attendance at probation and potentially being returned to court. She advocates for Michael in a police interview regarding the assault on a hospital nurse and records her understanding of the impact of his brain injury and Michael's memory problems.

10th May 2023: It was reported that a care agency worker was assaulted by Michael as he wanted to have possession of the pre-payment top up card. There were no injuries to the support worker. Michael was reported to be angry and accused the care worker of opening his mail without permission and taking his money. He had made a racially abusive comment. An incident form was completed though there was no evidence of any action taken. Michael was increasingly agitated about money and noted to not understand the reason for financial appointeeship.

17th May 2023: The police investigation into Michael's assault on an emergency worker is noted as requiring medical information about his memory loss and confusion following a seizure. The Police needed this corroborating and wanted to have Michael's consent.

9th June 2023: It is recorded that there was a burglary; a man had damaged Michael's door and let himself into his flat. The man was found asleep on the sofa; Police were called and no charges brought, a BRAG was completed and it would

[g] The Blue, Red, Amber, Green (BRAG) risk assessment is completed by attending police officers for anyone who has been or is believed to be at risk of harm, abuse, or exploitation or who is or may be, in need of support or intervention.

have been appropriate to forward this to ASC for their information and to ensure that they were fully informed about the incident.

21st June 2023: It was reported that a woman who Michael did not know was staying in his flat. He said that he wanted her to leave and was confused about who she was.

23rd June 2023: ASC notes record that Michael had a discussion with his social worker about a potential supported place with 24 hour support. He refused to consider this.

30th July 2023: Police were called as Michael was the victim of a burglary. Michael said his TV, money, clothes and phone had been stolen and the front door smashed in. Michael is reported to be regularly losing things such as his electric key and his door key. He said that he was feeling threatened and intimidated. A police risk assessment was completed and rated Amber. There was a referral from the LSU to ASC expressing concern that Michael was unsafe living in his accommodation. This was noted as being recorded as an ASC contact rather than a safeguarding referral.

30th August 2023: Michael's bank card and pin are reported as being stolen by the woman staying with him. He was supported by police officers to take action and change his bank card. A banning order was put on this person and a safeguarding referral was made to ASC; this did not progress as it was deemed sufficient that action had been taken.

7th September 2023: A safeguarding referral was made by Michael's keyworker to ASC about Female 1[h] exploiting Michael.

21st September 2023: A police risk assessment was completed and rated Amber. Female 1 assaulted Michael in his flat, and concerns were raised that Michael was a victim of cuckooing and exploited by others. He declined to give a statement, and no further action was taken or discussion with ASC held.

26th September 2023: Michael's keyworker records that he was saying that he felt bullied and controlled by people in his flat.

28th September 2023: ASC safeguarding enquiry opened, following referral from police regarding suspected cuckooing and exploitation. Michael is thought to be influenced by a Female 2 and forced to handover money or drugs. There is reflection in the chronology that there was a missed opportunity at this point to complete a mental capacity assessment to determine Michael's decision making regarding protecting himself from harm.

3rd October 2023: Michael experienced further seizures and pneumonia. He was referred to the specialist epilepsy team for seizure management and medications review.

5th October 2023: Michael's keyworker advised ASC that he did not have the ability to exercise judgement on what visitors he had in his flat and that the visitors had

[h] Females known to Michael are designated with a number rather than an initial for anonymised reference.

increased. This informed Michael's safety plan and a further mental capacity assessment which took place in December 2023.

19th October 2023: Police record a burglary of Michael's flat and his vulnerability. ASC were informed and Michael's keyworker was alerted that he had no food in the fridge or cupboards.

Police record the discussion with Michael's keyworker that they feel that his mental health is deteriorating and that there are increasing safeguarding concerns.

20th October 2023: Michael's keyworker made a safeguarding referral to ASC as he seemed disorientated and was not recognising him. The loss of memory very concerning. ASC note that this concern was added to the ongoing safeguarding enquiry.

23rd October 2023: The ambulance service made a safeguarding referral to ASC. Michael had called an ambulance, but when the service called back, an unknown female answered and then discontinued the call. This concern was added by ASC to the ongoing safeguarding enquiry as it was thought to have provided evidence of exploitation and coercion of Michael by others.

23rd October 2023: Michael's keyworker called Care Direct to report concerns they had had about his mental health and his deteriorating memory.

It is reported that the mental health service tried to contact Michael and when there was no response from him, they had sent a letter to his GP. The chronology entry commentary reflects the absence of mental health team discussion; there was no liaison back with Michael's keyworker and no reason given for the decision to close.

At this time, there were escalating concerns regarding Michael's self-neglect, increased drug use, memory loss, people coming and going to his flat, not taking his medication, collapse, seizures, and increased police concerns.

26th October 2023: Michael's keyworker notes her concerns as he said to her 'I am dying'. There were possessions in his flat that were not his and he didn't seem to know where he was.

30th October 2023: Michael went to ED with an injury to his elbow. Female 3, known to Michael, had thrown an ashtray at him; she had wanted money from him. Female 3 had also introduced a man called 'muscles' who was a threatening presence. Michael's keyworker told the hospital doctor that they had increasing concerns about his mental capacity and safety at home. Michael was deemed to have capacity to self-discharge.

2nd November 2023: Michael's keyworker notifies the Bristol City Council (BCC) finance team that Michael has a personal bank account as well as a benefits account. His debit card can draw on both and the personal account is overdrawn by over three hundred pounds. The records are unclear how this situation was rectified.

6th November 2023: Michael's GP notes an email was received from a social worker regarding a request for a mental capacity assessment. It was unclear what was

being asked, e.g. the specific decision to be assessed. There was no follow up discussion.

7th November 2023: Michael's keyworker alerts ASC of their concerns: he has high support needs, memory loss, unwanted visitors and he had been recently assaulted. The need for a mental capacity assessment around Michael's decision making regarding keeping himself safe was highlighted. There was an accumulating high number of incidents.

28th November 2023: Police were called and it was reported that a female was wanting to sell drugs from Michael's property. Michael was reported to have been beaten up and assaulted. There is no referral onwards to ASC.

5th December 2023: A safeguarding strategy meeting was held and noted that risks to Michael were escalating. Agreed actions included providing advocacy for him, completing a best interest decision regarding money management, to review the mental capacity assessment in regard to Michael's choice of accommodation and to complete a re-assessment to increase support.

5th December 2023: A mental capacity assessment was completed and was recorded as being on the same day as the safeguarding strategy meeting. It concluded that 'due to a cognitive impairment, Michael is unable to weigh up and use the information required to decide how to maintain his safety in relation to abuse from others. Michael is able to understand and for a short period retain that he has experienced abuse but is unable to use this information to enact his decisions to keep himself safe'.

13th December 2023: A safeguarding referral to ASC from the ambulance service was raised regarding concerns about coercion of Michael by a female and the condition of his flat. The referral was noted as a review request rather than a safeguarding alert, and there was a reflective comment raising an issue of the 'normalisation' of events with Michael as they were so frequent.

13th December 2023: GP notes record that they are aware of females in Michael's flat who he didn't trust. The GP requested a review of medication appointment, and a text was sent to Michael but recorded as not being delivered. It is unclear what action was taken.

2024

February 2024: There were ongoing concerns: Michael was becoming abusive to staff, he had further seizures, the ambulance crew raised safeguarding concerns and there was no food in his flat.

5th March 2024: Michael is sentenced to a 12 month community order for assault on an emergency worker. The Probation Service resets Michael's 20 RAR days.

There is a noted increase at this time of people trying to get Michael to withdraw money from cashpoints and access his flat. This was witnessed by support staff. Michael is noted as being 'nervous and fearful'. He didn't want the Police involved.

22nd April 2024: Michael's keyworker recorded that Female 4 was staying in his flat which was a tenancy breach. Michael was making intermittent accusations against her and the keyworker made a safeguarding referral to ASC about Female 4's coercion. Agreed actions recorded were to continue the search for supported living with care for Michael.

1st May 2024: A new social worker is allocated to work with Michael.

15th May 2024: Michael is assaulted at a cashpoint by two males who threw him to the ground, cutting his head. Police raised concerns to ASC.

6th June 2024: Michael's keyworker reports a female to be a constant presence. He says that she hits him and brings unknown males into the property and she is threatening and unpredictable. Michael wants support staff to remove her from the flat.

A possible supported residence for Michael that offers specialist care is identified by his keyworker and discussed with his social worker.

27th June 2024: Michael's keyworker reports another unknown female in his flat and that she had given access to other people. Michael did not want to discuss this further.

12th July 2024: Michael's keyworker records contact from his mother who was concerned that she hadn't heard from him. She was told of the support he received and it was agreed that her contact number could be shared with the social worker.

17th July 2024: A safeguarding strategy meeting was held and it was agreed that a mental capacity assessment regarding Michael's decision making on inviting visitors to his flat needed to be undertaken. There is a reflective comment in the chronology that there is no reference in the discussion to the previous mental capacity assessment approved in February 2024 which concluded that Michael did not have capacity to make decisions about keeping himself safe.

8th August 2024: There are continuing concerns about Michael being a victim of cuckooing. ASC notes record that a safeguarding strategy meeting was held and it was agreed to increase Michael's care to daily, using a different provider, and to seek accommodation options There is reference to 'the need to apply to the Court of Protection for an order'.

18th August 2024: Police record that Michael is assaulted by Female 4 and punched in the head multiple times. She and another male threw a table at him. Female 4 was arrested and charged with assault and also for being in possession of Class A drugs. Michael was admitted to hospital, treated for his injuries and he self-discharged. Police note that they spoke to Michael's social worker about the assault and a joint visit was arranged to meet with Michael on 6th September.

19th August 2024: Michael's keyworker made a referral to the Anti-Social Behaviour (ASB) Multi-Agency Management (MAM) Group.

21st August 2024: Second Step noted that they tried to contact Michael's social worker to report that he had been assaulted by female 4. An email was also sent to

say that the Police had entered Michael's flat and had arrested Female 4 and that Second Step were seeking an injunction against Female 4 from entering the property. The social worker picked up the message on their return from leave on the 28th August 2024. The ASC partner reflected in the chronology whether a more robust cover for the social worker when on leave could have helped with a more coordinated approach to this increase in risk.

28th August 2024: An Anti-Social Behaviour/Multi-Agency Risk Management (ASB/MARM) meeting was held. Michael was noted as being new to the list. It was agreed that his keyworker would compile a list of concerns and incidents for a vulnerable adult case conference.

28th August 2024: ASC case records note that Michael's social worker requested a police officer to make a safeguarding referral regarding the assault on Michael by Female 4 on 18th August 2024.

3rd September 2024: ASC received a safeguarding referral from the police, and this was noted by an ASC partner as a significant delay as the assault to Michael was on 18th August 2024. This was categorised as a request for an unplanned review rather than a safeguarding concern which would have been in line with ASC safeguarding procedures.

Michael's keyworker notes that he is refusing to admit the new care provider into his flat and that there is a need for handover regarding payment cards, food provision, the pending eviction and the ban on visitors.

4th September 2024: The police are called to Michael's flat. It was reported in police records that Female 4 was at Michael's flat and went to sleep at midnight. When she woke up at 3am, she had found Michael face down in the bath. It is recorded that Female 4 pulled Michael out of the bath before walking to an address to try and find his ex-partner. Unable to find the address, she returned 45 minutes later, and knocked on a neighbour's door and asked them to call an ambulance. An investigation was undertaken by the police and Female 4 was arrested for murder. The Coroner's report provided the cause of death as 'Drowning in the context of post traumatic epilepsy and recent cocaine use'. Therefore, the investigation was no longer treated as murder and closed.

4. SAR Areas of Focus

4.1 Safeguarding Practice, Risk Assessment and Mental Capacity Assessment

The Legal Context

Section 42 (S42) of the Care Act 2014 sets out local authorities' duty to make safeguarding enquiries: A S42(2) enquiry can take many forms by conforming to the six key safeguarding adults principles and Making Safeguarding Personal. An individual does not have to be eligible for care and support under the Care and

Support Eligibility Regulations [3] for a safeguarding concern to be raised or for the local authority S42 duty to apply.

Practice Guidance

Revisiting Safeguarding Practice[i] sets out the roles and responsibilities and practice principles that are integral to safeguarding adults. The six principles of Adult Safeguarding are embedded in the Care Act (2014) and apply to all health and care settings. They are:

Empowerment: Understanding lived experience and supporting and encouraging people to be involved in their care wherever possible.
Prevention: Taking action before harm occurs.
Proportionality: Responding in a way that is appropriate to the risk presented.
Protection: Providing support and representation.
Partnership: Services working together and with their communities.
Accountability: Ensuring responsibility for protecting and supporting adults when abuse happens.

4.1.2. Safeguarding Practice: Key Findings

4.1.2.1 Safeguarding Concerns

There were multiple safeguarding concerns and referrals to ASC over the two year period prior to Michael's death. The concerns included physical abuse and assaults on Michael, exploitation by others, cuckooing[j], coercion and control and financial abuse. Professionals meetings and safeguarding strategy meetings were held with a sub-section of partner representation.

Michael experienced self-neglect and had serious physical health issues. Many of the concerns raised were related to uncontrolled epileptic seizures arising from medication management issues and self-neglect. This is further detailed in section 4.3. of this report.

Concerns of a similar nature were repeatedly recurring and not being resolved. The Housing Support Service noted in their internal review, following Michael's death, that there was 'limited awareness about the many incidents and concerns about Michael as they did not reach the threshold for escalation'. There was no cumulative view of incidents until two months before Michael's death when brought to the attention of the ASB/MARM multi-agency forum.

The extensive chronological information highlights that Michael was exposed to frequent abuse and exploitation and was significantly at risk. Professionals working with Michael were exposed to risk of assault and threats of violence from him. He had seriously assaulted hospital staff and there are reported threats of violence from Michael towards support staff.

[i] revisiting-safeguarding-practice.pdf (publishing.service.gov.uk)
[j] What is Cuckooing? – Preventing and Disrupting Cuckooing Victimisation

An ASC partner reflected in the ASC chronology that there were instances of safeguarding referrals being delayed, safeguarding concerns being wrongly categorised and not progressed. There are also instances of concerns being added to an ongoing safeguarding enquiry losing momentum and specific consideration of the particular circumstances of each concern.

The ASC partner hypothesised in the ASC chronology of events that the instances described, which are detailed in the summary chronology in Section 3.1 of this report, could potentially 'indicate a normalisation' of events which is a known response and risk to professionals being overwhelmed and fatigued by the sheer volume of incidents[k]. Other factors, such as work pressures and overload, were highlighted by practitioners at the SAR learning event as having an impact on the response to some safeguarding concerns and on their emotional wellbeing.

4.1.2.2 Making Safeguarding Personal

The Care Act 2014 emphasises the importance of Making Safeguarding Personal. It means that the safeguarding process should be 'person led, and outcomes focused'. Safeguarding should be underpinned by principles of engagement in conversation with the person 'about how best to respond to the safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety' (Appendix 1 Care Act Statutory Guidance 14.15).

The MTAM approach was introduced in 2022. It is a whole system, person centred and inclusive way of working with people experiencing multiple disadvantage who require multi-agency support.

My Team Around Me (MTAM[l]) is a way of working that aims to build a 'one-team' approach for people who are supported by multiple services. Each team works towards four key objectives:

Client-led: Enabling multi-agency groups to work in a person-centred and trauma-informed way.
Shared accountability: Collective safety and support planning, sharing tasks, risk, and resources.
Service continuity: Staying involved in a one-team approach particularly during transitions, making collaborative, preventative, and restorative approaches.
Innovative practice: Person-centred, trauma-informed and positive risk-taking solutions are enabled.

Initially Michael engaged with the MTAM approach, although the momentum was not sustained. This could have been because the approach was at an early stage of implementation or because Michael did not have family members or an advocate to support him in engaging with the meeting. There are just two references in the collated agency chronology of contact with Michael's mother who had told the reviewer that she would have wanted to have more contact with her son and to be

[k] Why Wellbeing Matters in Safeguarding - Ann Craft Trust
[l] My Team Around Me — Changing Futures Bristol

included in efforts to keep him safe, she felt that this would have made a positive difference.

Making Safeguarding Personal principles and ways of working that were inclusive, built up trust and rapport with Michael were evident at times:

- A Police Community Support Officer (PCSO) built rapport with Michael and helped him understand that people were exploiting him.
- Partners highlighted that there had been a productive MTAM meeting with Michael present. The team had shared and discussed their concerns with Michael, and he had responded well to this approach.
- One partner said that she was motivated to keep going because she saw a glimmer of hope and believed in the possibility of change for Michael; more engagement with him was leading to a better rapport.
- When Michael was given clear information, for example about advocacy and how it would support him to express his views, he had responded positively.

4.1.2.3 Safeguarding Collaboration

Partners highlighted at the SAR learning event that at times they felt isolated and would have welcomed a more joined up safeguarding partnership approach. Michael's GP was invited but was unable to attend safeguarding strategy meetings and overall the absence of health partner involvement limited collaboration and potential access to health and mental health input and services.

Michael could have been more effectively safeguarded if the MTAM collaborative and inclusive approach had continued as Michael had responded well to this personalised and appreciative way of working. Engaging family support, in particular from Michael's mother, and introducing specialist brain injury services, such as Headway to inform practice, would have been of benefit.

4.1.3 Risk Assessment and Safety Planning

There were risks to Michael and risks to staff working to support him.

There were three safety and support plans for Michael:

- A High Impact User Personal Support Plan (PSP). This plan was used by members of hospital staff. It identified risk to Michael and to hospital staff, offered guidance on appropriate response with an overall objective of enabling a consistent and holistic approach.
- A Safeguarding Safety Plan, referenced in the chronology in January 2022, following the MTAM meeting and updated on the ASC data system in October 2022 and November 2024 following the closure of safeguarding enquiries.
- A Second Step Safety and Inclusion plan which was in place to be able to think about Michael's individual needs and how staff can safely work with him to prevent mental health issues from worsening.

Michael had multiple attendances in the hospital ED and PSP guidance on appropriate response was not always followed, for example, staff were advised to

complete a mental capacity assessment if Michael wanted to self-discharge and there is little evidence of assessments being completed.

The ASC led safeguarding safety plans detailed risk assessments and risk management plans though these tended to be high level and lacking clear timelines and dates for review. Risks of physical, emotional and financial abuse to Michael were identified, though safety action plans were not always followed through. For example, an action noted in December 2023 was to discuss with Michael the appointment of an advocate. There is reference in the chronology information of discussion of advocacy with Michael and that he was open to this concept once the purpose had been explained to him. However, a referral for an advocate for Michael was not actioned and this was a missed opportunity.

ASC risk screening tools and reviews were completed in line with safeguarding policy, though this was noted in the chronology information as being a system trigger to review rather than an opportunity for risk discussion or consideration of risk management/reduction.

Partners at the SAR learning event commented that a known risk was Michael having a seizure whilst bathing, and that drowning in the bath following a seizure was, in part, the cause of his death. The question arose why Michael was in accommodation that had a bath. This risk, which was not taken into account when Michael first took up residence in his flat in 2018, could have been re-visited during the housing provider and social worker conversations with Michael regarding options for alternative accommodation.

4.1.3.1 Risks to Staff

There were known risks to staff; Michael had previously assaulted hospital staff and this was noted in his PSP as being mainly post-seizure and under substances. Staff would see Michael in pairs, often with body cameras and were advised to call hospital security and, if needed, the police to provide protection.

Michael threatened violence towards social workers and care workers, and the risk was mitigated by two people visiting at any one time, as well as alerts being placed on Michael's care records.

SAR partners considered the impact of mental stress on staff working in circumstances where there are threats of violence against them and they are continually trying to support people, like Michael, who were suffering regular and continuing abuse. This has an impact on wellbeing at work and more overt recognition and inclusion of this in safety planning would be of benefit. The Ann Craft Trust[m] provides useful resources on safeguarding mental health at work.

4.1.3.2 ASC Risk Enablement Tools

[m] Safeguarding Your Mental Health at Work - Ann Craft Trust

In December 2024, the ASC Bristol Decision Support Tools were created in collaboration with the Keeping Bristol Safe Partnership (KBSP) with a focus on risk enablement and Making Safeguarding Personal approaches in support of safeguarding practice. The tools support professional curiosity in the context of everyday practice promoting better outcomes for people exposed to safeguarding risk.

4.1.4 Mental Capacity Assessment

Recent guidance issued by the Office of the Public Guardian, Making Decisions: a guide for people who work in health and social care[n] informs and guides health and social care practice in the application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

The Mental Capacity Act created the role of an Independent Mental Capacity Advocate (IMCA) to represent and support people who may lack capacity and have no one else to support them. An IMCA becomes involved if there are decisions to be made regarding serious medical treatment or a long term move to alternative accommodation.

It is recorded that during the review period, Michael had four mental capacity assessments; three were completed by ASC and one was completed by ED hospital staff. There are references to Michael having capacity to self-discharge from ED but no assessment information.

The first mental capacity assessment was completed by ASC in November 2021 to determine Michael's ability to make decisions regarding and managing his own finances. It concluded that Michael did not have capacity to make decisions about financial matters and was at risk of financial abuse. Financial appointeeship was put in place for Michael and to some extent regulated, though this did not address the key risks and issues and the many fluctuations in payments were disruptive. Michael was able to access some money making him a continuing target for financial abuse and he was frequently without money for food, heating and a mobile phone which was essential for prompts for his medication and appointments and for communication with him.

The second mental capacity assessment was completed by ASC in June 2022 regarding Michael's ability to manage his tenancy. The mental capacity assessment focused on Michael's ability to consider housing options and make decisions about alternative accommodation. The outcome of this assessment was that Michael did have capacity to appreciate and decide upon different housing options. The assessment process could have included consideration of Michael's appreciation and insight into the risks he was exposed to in his current tenancy and his decision making about maintaining his safety. Risks to Michael continued to escalate and over the next eighteen months incidents of physical, financial and emotional abuse increased as did occurrences of people invading his home.

[n] Making decisions. A guide for people who work in health and social care : helping people who are unable to make some decisions for themselves :: Office of the Public Guardian 2009 :: OBNB, the Open British National Bibliography

The third mental capacity assessment was completed by ASC in December 2023 and concluded that due to cognitive impairment, Michael was unable to weigh up and use the information required to decide how to maintain his safety in relation to abuse from others. The outcome stated that 'Michael is able to understand and for a short period retain that he has experienced abuse but is unable to use this information to enact his decisions to keep himself safe'. There was a two month delay awaiting authorisation, a departure from internal ASC procedure, and no follow up actions or transfer of this information in the handover to Michael's new social worker. This led to no consideration of best interest decision making for Michael and no appointment of an IMCA.[o]

There is a record of one mental capacity assessments being completed in the ED in October 2023 when Michael needed antibiotic treatment for an infection. There was limited information on the assessment form, and the outcome was unclear and confusing stating that Michael had capacity and also an 'ongoing lack of capacity unlikely to improve/change imminently'.

SAR Partners reflected that it would have been helpful if there had been a recognised process in place to share the mental capacity assessment outcomes as this would have informed a more collaborative and coordinated approach to safety planning for Michael. A process in place would also have mitigated the risk of mental capacity assessments not being acted upon.

4.1.4.1 Emergency Care

There are numerous references to Michael's attendance in ED following seizures, falls/collapse and assault. As referenced, a PSP was in place for Michael to give guidance to staff on managing distress and risk when he was in ED or admitted to hospital. The plan references appropriate support including that staff should 'complete a capacity assessment if Michael wishes to self-discharge' and to complete a safeguarding referral if there are concerns about his presentation as he is at risk of financial, physical and emotional abuse'. The plan was not followed in that Michael was assumed to have mental capacity to make the decision to self-discharge on numerous occasions.

Partner feedback highlights the challenges in assessing mental capacity in an ED environment. The Royal College of Emergency Medicine (RCEM) gives recommendations and guidance for practice on mental capacity assessments in emergency settings and provides a useful checklist and flowchart that can be used in practice.[p]

RCEM Summary of recommendations:

• All Emergency Department (ED) doctors should understand the Mental Capacity Act (MCA) and be trained to be comfortable assessing a patient's capacity.

[o] What do IMCAs do and who should get an IMCA? - SCIE.
[p] RCEM_Mental_Capacity_Act_in_EM_Practice-Feb_2017_V2-Copy.pdf

• ED nurses should be trained to make a brief assessment of a patient's capacity to decide to leave the ED as part of their initial assessment of a patient.
• Difficult decisions about a patient's capacity should be shared with a senior doctor.
• If a patient is prevented from leaving the ED because they do not have the capacity to decide to leave, the means used to keep them must be proportionate to the risk to the patient.
• If a patient has a mental health problem that is diminishing their capacity, then they should be assessed under the Mental Health Act (MHA). In these circumstances, the MHA is more appropriate than the MCA.
• Common law powers can be used in areas not covered by MHA or MCA or when there is no opportunity to form a judgement about patient's mental capacity or mental state in situations where urgent intervention is needed to avert serious consequences. This power is short and lasts only until crisis subsides.

There is a reference in the chronology information to a difference of opinion between a nurse and a doctor regarding Michael's mental capacity to self-discharge, though there is no documentation of assessment or exploration of this conflicting issue. A partner reflected that this could have been because it was very difficult at times to complete a mental capacity assessment with Michael as he was frequently under the influence of substances causing him to be confused and rendering any assessment unreliable.

University Hospitals Bristol and Weston NHS Trust (UHBW) partners highlight that there have been a number of change initiatives to improve mental capacity assessment training and learning opportunities for hospital staff. There is a new and specific MCA training package that sits separately to safeguarding as a statutory/mandatory training package, quick reference guides and a webinar on how to complete a mental capacity assessment. Further details can be found in Section 5 of this report, 'What's Changed and Changing'.

4.1.4.2 Emergency Planning

Partners in the ambulance service highlighted the challenges experienced when tending to Michael, sometimes in the early hours of the morning when he had suffered a seizure or related to an injury sustained due to an altercation or through intoxication. There is ever increasing complexity of demand on the ambulance services[q] and that shared multi-agency care plans outlining each agency involvement, risks and strategies would be of great benefit.

A partner reflected that care plans such as these could be kept at a person's house and would be invaluable to ambulance crews who may attend late at night and have no real awareness of what is happening for the person. The MTAM resources include a collective safety plan[r] which could be usefully used in this context.

Further, partners could consider the development of emergency care plans that can be kept at home and also held on data systems. Inclusion North's Stop People Dying

[q] urgent and emergency care and the threat to ambulance services

[r] MTAM Collective Safety Plan

Too Young Group has developed useful resources, such as guidance on emergency plans.[s]

4.1.4.3 Substance Use

The British Association of Social Work briefing on mental capacity assessment and substance use comments:

People who use substances are often reluctant to engage with services and may also live chaotic life styles which make this engagement more difficult. Existing services are frequently not resourced to provide the level of intensive support that might have a significant impact on their wellbeing. Like much social work, the key skills here are about the building of empathic and trusting relationships and establishing a comprehensive picture through the assessment process. Working with and through the complexities of understanding the functions, nature and consequences of someone else's alcohol and drug use and its relationship with any capacity considerations takes time.[t]

Michael had a diagnosed psychotic disorder and a brain injury and was long term substance user. This combination made him highly susceptible to risk. He did not receive support from the mental health services and there was no active drug and alcohol services involvement in the period of this review.

A Safeguarding Adult Review conducted by the Hertfordshire Safeguarding Adults Board (SAB) in 2024 focused on the issue of mental capacity assessment and substance use and highlighted that there is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability which in turn impacts on mental capacity.

The SAR author reflects that 'people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.[u]

4.1.5 Reflection

1. Overall, there was limited exploration of Michael's executive functioning given the impact of his brain injury and long term substance use. 'Executive function is the name for a collection of thinking skills that are used when solving problems, making decisions, planning and completing tasks, and reflecting on our activity. Impairment of executive functions is common after acquired brain injury and has a profound effect'.[v]

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[s] Your Guide To Emergency Care Plans Inclusion North's Stop People Dying Too Young Group, the North East and North Cumbria Learning Disability Network, the NHS North East and North Cumbria Clinical Networks and the Integrated Care System.

[t] BASW briefing

[u] 'Alex' SAR

[v] Executive dysfunction | Headway

2. There was no apparent shared strategy, including skills required and methods of working with people who had experienced a brain injury and this would have brought clear direction for and guidance to practice. There was reference to an Occupational Therapy report which provided guidance on working with Michael; this information was not widely cascaded.

3. An ASC partner reflected that whilst the financial protection plan was put in place to reduce risk to Michael, the regular payments into his account at night appears to 'have increased his attraction as a target for potential abuse and made it harder for support workers to encourage budgeting and spending on essentials'. In March 2023, the chronology summary details that a professionals meeting was held and led by ASC as there was concern about Michael's financial management. It was agreed that the care agency that supported Michael would have a pre-payment top up card to buy food and essentials for him.

At the time of writing this report, the reviewer has been unable to source the details of the financial protection plan.

4. There was a missed opportunity to address a core issue which was Michael's appreciation of the risks he was exposed to whilst residing in his flat. Some partners expressed at a safeguarding strategy meeting in 2022 that Michael would be better supported and protected in a specialist setting. One practitioner reflected that it would have been a challenge to secure a high level of resource for Michael because his needs were not clearly understood. This raises the questions:

- Was specialist advice sufficiently sought to ensure that Michael's needs were clearly identified? A referral was made to the mental health services by his keyworker but he did not respond to attempts to contact him and the referral was closed.
- Was Michael's early trauma associated with the impact of his brain injury sufficiently understood?
- Would involvement of Michael's family have made a difference? Their inclusion may have enabled him to connect with people who cared for him and enabled people supporting him to better understand his early life.

5. Following the mental capacity assessment in December 2023 that concluded Michael did not have capacity to make decisions about keeping himself safe, best interest decisions could have been considered together with the appointment of an IMCA and potentially an application to the Court of Protection[w]. A query arises as to why the mental capacity assessment was not picked up via the social care data system or in the handover to the new social worker. It was as though it had never taken place and this is a cause for concern.

6. Assumptions were made that Michael had mental capacity to self-discharge from hospital when admission and treatment, including specialist assessment, was required. Partners noted that there was a lack of staff confidence in completing

[w] Court of Protection - GOV.UK

mental capacity assessments and that this was heightened by Michael's altered mental state due to substance misuse.

7. A shared multi-agency safety plan, potentially combined with an emergency plan, discussed with Michael and available at his home, would have been helpful. The plan would have been an opportunity to include Michael in his safety planning, possibly with support from an advocate or trusted person, and would have assisted ambulance crews and other partners needing to access information in an emergency.

Recommendation 1: Safeguarding Safety Planning

The Keeping Adults Safe (KAS) Board should seek assurance that:

- Safeguarding safety planning is guided by Making Safeguarding Personal principles and enables inclusion of the person and, with their agreement, family and trusted others who should all be part of the team.
- Safety planning is collaborative and involves all key partners.
- If there are numerous agency safety plans for adults that are at risk that they are shared. Consideration should be given to the development of a multi-agency risk assessment and management plan to promote a shared and collaborative approach.[x]
- Safety action plans identify actions, responsibilities, timescales and dates for review.
- Safety plans include risk assessment for staff and identify actions to be taken to mitigate risk and channels of support.

Recommendation 2: Emergency Planning

ASC and Health partners should consider using the referenced resources to develop a template for a shared safety and emergency plan that can be developed together with the person and kept visibly in their home to be available in case of emergency.

Recommendation 3: Personal Support Plans (PSPs): UHBW

UHBW should review the effectiveness of PSPs; (for example through practice audits) to:

- Ensure that the advice and guidance is being followed.
- That there are documented records referencing actions taken in line with the PSP and any reasons for variation from it.

Recommendation 4: Mental Capacity Assessment: Adult Social Care

ASC should review the three mental capacity assessments undertaken with Michael, as detailed in this SAR, and ensure that the learning from this review guides future practice and system wide learning and development. The review should include:

[x] Multi-Agency-Risk-Management-Guidance-for-Professionals-Compressed.pdf

- Financial protection planning in relation to best interest decisions for the Council to take on financial appointeeship.
- Defining the decisions to be made and ensuring that theses capture the reason for a mental capacity assessment.
- The reasons for the lack of follow up of a mental capacity assessment outcome that was at a critical point in safety planning and acquiring advocacy for Michael.

Recommendation 5: Mental Capacity Act (MCA) Training

The KAS Board should seek assurance that:

- Agencies make more support available to their staff for carrying out mental capacity assessments.
- Training and learning opportunities should include specific reference to the effects of substance use informed by research and evidence based practice.
- Regular audits of practice are periodically completed by statutory partners to provide assurance about the impact of training and that mental capacity assessments are being undertaken appropriately. The information could be coordinated in the safeguarding performance data and presented to the SAB periodically.

Recommendation 6: Advocacy

ASC and Health partners should ensure that there is appropriate and available advocacy representation in accordance with The Care Act, Making Safeguarding Personal Principles and the Mental Capacity Act. Evidence of its presence, promotion and accessibility to be shared with the SAB to ensure that safeguarding is personalised and inclusive.

Recommendation 7: Legal Literacy

For the SAB statutory partners to consider how best to ensure that practitioners access legal literacy learning opportunities to promote understanding of legal frameworks, codes of practice and duties and powers to intervene when required to mitigate risk and prevent harm. This could reference the findings from this SAR and include reference to the Care Act 2014, the Mental Capacity Act 2005 and application to the Court of Protection.

4.2 Cuckooing and Exploitation

Cuckooing is named after the nest-stealing practice of wild cuckoos. It is a form of criminal exploitation where people are coerced, controlled, or intimidated into sharing, providing or offering up their accommodation to criminals. Victims of cuckooing may not always recognise that their relationship with the perpetrator is exploitative.

Cuckooing is not currently an offence and as such there is no specific category of crime, or data entry field on police systems. It may be recorded under a number of recordable offences such as drugs offences, fraud or violence against the person.

The Legal Context

The introduction of new legislation the Crime and Policing Bill will make cuckooing a criminal offence. To support implementation of the offence and strengthen the wider response to cuckooing, the government will publish guidance for police and other operational partners. The guidance will help improve identification of cuckooing and support professionals to take effective action against perpetrators and identify the best pathways to support and safeguard victims.

4.2.1 Practice Guidance

Supporting victims who have been groomed may pose a significant challenge. The Cuckooing Research and Prevention network, which works closely with West Yorkshire police and other partners, has produced many resources including a toolkit for professionals that offers practice guidance for common challenges.[y]

Professionals should seek cuckooing information and resources to improve awareness and understanding of the issue. The KBSP cuckooing protocol was established in November 2024 following a SAR for Adult R. The focus of this review looked at the following safeguarding themes: cuckooing, systemic responses to repeated patterns of victimisation, how agencies recognise and support protective factors, and how systems can help adults with care and support needs to protect themselves from risk and exploitation.

4.2.2 Key Findings

Throughout 2022, it is noted that Michael had altercations with others and was angry and frustrated that he wasn't in control of his own money. The money he had was either stolen as he was a regular target of financial abuse, or spent on drugs. Michael was sometimes without food and electricity. From April 2023, the risks escalated and it was noted by housing support staff and other residents that many people were entering Michael's flat without his permission and using and dealing drugs.

The police issued banning orders, for example on a female who had assaulted Michael in his home in August 2023. However the chronology references that despite the ban, the female continued to invade Michael's home where she continued to assault him. It was proving impossible to enforce bans on people as Michael was being coerced and under pressure to let them into his home.

It was recorded that at times Michael appeared bewildered, fearful and anxious. He wanted support staff to ask people to leave his flat and appeared to be frightened of any retribution.

Police officers were called on numerous occasions and identified that Michael was a victim of cuckooing. The chronology information details risk assessments completed by police officers. Safeguarding concerns were raised and there was discussion

[y] Preventing and Disrupting Cuckooing Victimisation: Professional Toolkit | School of Law | University of Leeds

between Michael and his social worker about alternative housing accommodation with a high level of support. Michael consistently refused to consider this; at times he said the people coming to his home were his friends, and at other times he asked for support for them to leave. Michael was unwilling to make any statements to police officers making it hard to remove people from his flat. He was fearful of reprisal.

It was a challenge to help Michael and to manage the escalating situation. Police officers found drug paraphernalia in his home and made some arrests and referred to ASC as a safeguarding concern. As previously discussed, there was a missed opportunity to act on a mental capacity assessment outcome that Michael was not able to make decisions about keeping himself safe. This would likely have resulted in an IMCA being appointed, discussion and a possible referral to the Court of Protection. Ultimately Michael remained a victim of abuse and exploitation until his death.

The incidents of cuckooing and assault on Michael were so prolific that he was referred by his keyworker to the ASB/MARM in August 2024, a month prior to his death. However, it was acknowledged by SAR partners that this referral could have happened earlier; the ASB/MARM has been established for many years.

The ASB/MARM is a multi-agency forum chaired by the ASB Team to coordinate responses to persistent or complex ASB cases. It brings together the police, local authority, housing providers and partner agencies to share information, assess risk and agree suitable interventions or safeguarding measures. The process is well embedded across all Neighbourhood Police Teams and has been operating effectively for several years.

A meeting was held on 2nd September 2024 and the outcome was a recommendation for escalation to a Vulnerable Adults Case Conference. A Community Protection Warning was drafted but not served due to Michael's subsequent death.

4.2.3 Reflection

An ASB/MARM referral at an earlier stage would have led to escalation, case conference, increased multi-agency wide awareness and shared and resourced safety planning for Michael.

Police partners commented that awareness of the ASB/MARM process is maintained through partnership meetings, internal briefings and joint working arrangements. External partners are typically introduced via their collaboration with Neighbourhood Police Teams (NPTs) and encouraged to refer directly to the ASB Team. Initial identification and escalation sits with NPTs or housing providers, and the ASB Team relies on these frontline agencies for tasking and referral once patterns of behaviour emerge.

Best practice informed by evidence based research highlights that the victim may be reluctant to disclose information and recommends that there should be identification of the most appropriate professional or advocate. Ideally, this should be someone who the victim trusts. There was no engagement of a trusted person or advocate to

speak with Michael. There were few attempts to engage with family members who potentially could have been influential in a risk management and safety plan.

Although there were references in the chronology summary of other residents in the flats where Michael lived as being at risk of exploitation and cuckooing, this was not raised in the safeguarding notes and safety plan. There was little evidence of a joined up safeguarding approach or enquiry to collate all known incidents and manage this in a more holistic and strategic way. The internal Housing Support review highlights that there were some staff changes which impacted on leadership and a service improvement plan is now in place.

At the time of Michael's death, the KBSP Cuckooing Protocol had been recently introduced, though was not embedded. There are now training resources and public information on hate and mate crime on the KBSP website. There is scope to develop an engaging KBSP cuckooing strategy that draws on practice models, toolkits and other resources that are further detailed in Section 9 of this report, 'Resources'.

In 2024, Avon and Somerset Police adopted Operation Trespass. This is a national initiative to tackle cuckooing, where people's homes are taken over by exploitative drug networks.

The operation draws on best practice from forces such as Merseyside and Essex to standardise the identification, recording and management of cuckooing incidents. Operation Trespass is further detailed in Section 5 of this report, 'What's Changed/Changing'.

The KBSP hosted a learning event for a related SAR referral where the police are presenting to partners about evidence led prosecutions with regards to cuckooing. This will highlight the opportunity for any professional to provide the police with statements if they or others witness incidents, or if the victim discloses an incident, about cuckooing even if the victim is unable or unwilling to report it. This can support prosecution via Hearsay Evidence gateways. Michael was unwilling to press charges against those who were financially exploiting him and invading his home for fear of reprisals. Hearsay evidence given to the police may have led to more effective action being taken to prosecute those responsible.

Findings of an extensive research project completed by the University of Leeds concludes:

'that cuckooing is a highly predatory and exploitative practice that poses a significant danger to vulnerable members of society. Tackling cuckooing requires a multi-agency response designed to safeguard (potential) victims and prosecute perpetrators'.

Recommendation 8: Cuckooing

The KBSP Policy and Projects Officer to review and update the KBSP Cuckooing protocol to include the learning from this review, and national SARs and from the cuckooing professionals toolkit and resources that are referenced in Section 9 of this report.

4.3 Self-Neglect

Self-neglect is one of the key challenges in adult care. There are many reasons as to why an adult may not engage with a service including lack of trust, fear, loss of control and past trauma.

Legal Context

The Care Act 2014 gives a broad definition of adults in need of care and support and clearly articulates duties towards them. Safeguarding Adults Boards (SABs) have a statutory objective to help and protect adults with care and support needs who are experiencing, or at risk of, abuse and neglect and are unable (as a result of those needs) to protect themselves.

The statutory guidance to the Care Act (Department of Health and Social Care, 2020) includes self-neglect within the list of circumstances that constitute abuse and neglect, thus locating it firmly within SABs' remit.

4.3.1 Key Findings

Michael had a chaotic lifestyle involving drug dependency and this led to neglect of his health. He had an erratic pattern of taking prescribed anti-epilepsy medication which resulted in seizures, falls, injuries and multiple attendances in ED. The chronology information details Michael's numerous attendances in ED following seizures, though the only reference to specialist assessment is in October 2023 when it was noted that he was referred to the specialist epilepsy team for seizure management and medication review. There is no documented outcome of this review or advice given to the GP or any other people supporting Michael.

Michael's GP said that when he had a period of relative stability and wasn't using substances, his seizures were less frequent. She said that Michael had a mistrust of the epilepsy medication which could have been a contributory reason to why he did not take it. There is no evidence that this was ever explored with him either in recent years or in his younger days when his mother told the reviewer that Michael suffered bullying because of his disability. He was unable to work because of frequent seizures and this had a significant impact on his wellbeing and life chances.

Michael was frequently reported as being unwell; he suffered pneumonia and other health issues arising from poor nutrition. He spent most of his money on drugs and it was noted at times that he said he 'was starving' and said to his keyworker 'I'm dying' and was very distressed.

Michael frequently missed his probation appointments, despite best efforts from support staff to alert him, attend with him and encourage him to use techniques such as setting up alerts on his phone. He missed GP appointments which were often re-arranged several times. There was a reliance on the medical practice on calling Michael or sending texts which were often not received because of his phone not being in use. There was little communication between the GP and Michael's keyworker and this would have been of benefit.

Michael lived in basic conditions; the possessions he had were frequently stolen from him or he lost them. His brain injury, past and present trauma and non-engagement with support led to self-neglect.

4.3.2 Reflection

The term self-neglect can be construed as unhelpful as it risks blaming the person. Self-neglect is not a lifestyle choice; it is often associated with trauma, loss and deteriorating mental and physical health. The trauma Michael experienced following the serious accident he had, combined with cognitive deficits and substance use, had a negative impact on his wellbeing.

Evidence Based practice guidance[z] suggests that effective practice is person centred and respectful, develops trusting relationships, promotes working in partnership and is non-judgmental.

A health partner reflected that discussion with Michael about the best ways to communicate with him, including gaining his consent to make contact with his keyworker if necessary, had had a positive impact. There are noted times when Michael responded well to personal respect and being treated like an adult, for example in the MTAM meeting and when advocacy was clearly explained to him.

Partners noted at the SAR learning event that Michael was very conscious of being treated like a child and 'infantilised' rather than an adult, and this was compounded by feelings of loss of control, for example over his money being managed for him. Michael is reported to have been, quite rightly, enraged by a care worker opening his correspondence without asking him, and every incident like this compounded the damage to his self-esteem that had built up over many years of coping with a profound, yet largely unrecognised, cognitive disability.

Adopting a trauma informed practice approach, recognising Michael's adverse childhood experiences combined with sensitive and informed ways of working with him to build his self-esteem, would have been of great benefit. Helping people who are self-neglecting is most effective when there is multi-agency partnership planning and an informed practice approach in place.

People working to support Michael were aware of the challenges he experienced - to care for himself, his significant memory loss, missed appointments, lack of response to correspondence and non-engagement with services. Some steps were taken to try to mitigate the risks of self-neglect:

- The care agency had a pre-paid card to buy food for Michael - however, this became an issue as he did not understand the need for financial protection and as discussed likely reduced his self-esteem causing him to be angry and frustrated.
- Alerts on Michael's phone to remind of appointments - however, this became an issue when Michael lost his phone or had his phone stolen.

[z] working_with_people_who_self-neglect_pt_web.pdf

- The care agency pick up of medication - however, this became an issue if the care staff rota changed for any reason.

A University Of Bristol Social Policy Report published in October 2022[aa] explored what SARs can tell us about how to improve adult safeguarding in England, with a focus on mental capacity and self-neglect. Six SARs published in England in 2020 were analysed. The brief presents key findings and recommendations to improve future policy and practice for adult social work.

The report found that:
a) People experiencing self-neglect are more at risk if professionals fail to assess mental capacity.
b) Safeguarding processes failed to protect people with capacity.
c) Mental Capacity Assessments lacked nuance and scope in that they did not capture:
- Complex and traumatic life experiences.
- Substance misuse.
- Executive functioning/decision making – includes the planning, initiation, organisations, weighing up of options and carrying out of tasks.
- The notion of 'choice'.

d) The study found that professionals lack confidence in assessing capacity.
e) The study makes a range of recommendations for practitioners, managers and policy makers.

4.4 Information Sharing, Partnerships and Collaboration

The Legal Context.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

Sections 6 and 7 of the Care Act 2014 set out when local authorities and relevant partners must work cooperatively with each other; when local authorities must cooperate with other appropriate people or bodies; and that local authority officers from different services in the same authority must work cooperatively.

The local authority has the lead responsibility for safeguarding adults with care and support needs, and the police and the NHS also have clear safeguarding duties under the Care Act 2014. There are often different geographical boundaries and IT systems and this can make sharing information between partners complex in practice.

The Social Care Institute for Excellence Adult Safeguarding Partner Collaboration and information Sharing Guidance analyses some of the challenges faces by SABs and partner agencies and offers guidance for practice.[bb]

[aa] Mental Capacity, Self-Neglect, and Adult Safeguarding Practices: Evidence Synthesis and Agenda for Change | Policy Bristol | University of Bristol
[bb] Safeguarding adults: sharing information - SCIE

4.4.1 Key Findings

Information sharing with Michael was fragmented and often unclear. His communication needs and understanding of information was likely impaired as a result of his brain injury and cognitive functioning. Michael was invited to meetings and information was shared with him, though there was no indication that this was in a planned and accessible way. There was no evidence of a strategy or informed practice approach underpinning communication and sharing information with Michael.

There was an absence of health partners meeting with other multi-agency partners to discuss known concerns about Michael. There were protocols in place to manage his abusive and aggressive behaviour to hospital staff. Attempts to seek specialist support, for example from the alcohol specialist nurse and the epilepsy specialist team, did not influence multi-agency practice and ways of working with Michael.

In general, there was good sharing of information between the police, ASC and Second Step. There was a missed opportunity for the police to share with partners information about Female 4 who was living in Michael's flat. She was a known perpetrator of violence and exploitation towards men. There have been significant improvements to the police recording of safeguarding concerns, sharing of information with partners and staff training. This is further detailed in Section 5 of this report.

Michael's keyworker was very proactive in trying to bring partners together to discuss escalating risks and concerns. Latterly, she was made aware via the police of the ASB/MARM forum as a route towards finding a way to help Michael move forwards and secure more intensive support and suitable accommodation.

4.4.2 Reflection

A practice approach and clear methods to communicate with Michael and share information with him and across the multi-agency partnership would have been helpful. With his permission, Michael's family members could have been involved in a MTAM meeting which may have been inclusive and helpful.

Earlier escalation of the accumulating risks and concerns about Michael would have ensured multi agency management discussion and safety planning. There were instances of professionals meetings and some information sharing but this did not include all partners.

The outcomes from professionals meetings were insufficiently communicated and roles, responsibilities, agreed actions and timescales were unclear from the records.

There were channels for multi-agency discussion and case conference which were not taken up until the month prior to Michael's death. This is reflective of a rather fragmented approach to the coordination of support for him and incidents being seen as separate occurrences rather than viewed as accumulated risk and escalated accordingly.

An ambulance service partner reflected that there is no IT system for specifically sharing information. Connecting Care is a portal where information from primarily health and social care agencies is uploaded and can be 'read from' but not 'written to'.

The KBSP has information sharing agreements and guidance in place that sets out the principles and legal context of information sharing and governance. The main and recurring issues across national SARs, which is acknowledged by the KBSP, is the often uncoordinated sharing of relevant information between partners and the absence of shared data systems that support coordinated activity across the multi-disciplinary partnerships.

5. What's Changed and Changing

The Partner Learning Event was instrumental in engaging practitioners and managers to reflect and directly contribute to the learning process. The review has identified the following changes since Michael's death and areas that are changing.

Avon and Wiltshire Mental Health Partnership (AWP)

The triage team now have a Standard Operating Procedure which states that someone highlighted with a significant risk and a mental health risk who does not attend would be offered a further three assessments as well as liaison with the referrer and family.

Horizons Bristol

A drug and alcohol service called Horizons was launched on 1st April 2025. The service provides a wide range of services that are appropriate and accessible for the people that need them. Horizons is a collaboration between nine community organisations, offering inclusive and accessible support to help anyone in Bristol make informed choices about their wellbeing. Horizons works closely with commissioners, GPs, clinicians and communities, providing alcohol and substance use support for adults and young people.

Second Step Supported Housing and High Support Accommodation Service

- Both teams have a more stable staff team, with experienced support workers and a new Team Manager.
- Internal quality and performance processes have been reviewed and changed to allow for greater oversight and scrutiny. Regular reports are also submitted to the senior leadership team and the Board.
- There is a broad, overall service improvement plan including actions based on the internal reviews recommendations.

My Team Around Me (MTAM)

The MTAM approach has been adopted. Whilst there had been no official training at that time of Michael's circumstances, Changing Futures have now delivered training across the sector. The MTAM approach provides a framework for practitioners to be

able to call for multi-agency meetings with inclusion or voice of the person. A partner reflected that it is hard to get all partners around the table and sustain over a long period. Partners are trying to embed the approach.

The approach is similar to AWP's Your Team, Your Conversation, Your Plan.

GP/Medical Practice

The GP practice are involved in a project called 'Deep End' practice where practices in deprived areas can share learning. This has funded two practitioners to carry out a health inequalities fellowship to a) create micro teams to share learning in a small group of GPs and b) to create a drop-in clinic in the practice.

BCC Adult Social Care

- The local authority's safeguarding model has changed and now sits within the specialist safeguarding team. There is now separate oversight to gain more consistency over risk and to share learning.
- The Mental Capacity lead has refreshed the training and the MTAM approach has been implemented.

Trauma Informed Practice.

A set of principles for Trauma Informed Practice have been developed and these are being embedded in policy and practice across the area:

A trauma-informed Integrated Care System has evolved over the past four years, building knowledge of trauma and adversity into services and systems, promoting recovery, and preventing further harm. Trauma Informed practice is now included in the overarching strategy for the Integrated Care System. A Trauma Informed Practice Framework has been developed as an accessible resource for local organisations. The Framework draws on national and international best practice and input from local organisations and people with lived experience of trauma and adversity.[cc]

Avon and Somerset Police

The police have launched an operational model called Operation Trespass to roll out cuckooing awareness and training to all beat teams. This is not fully embedded yet. The awareness and training will focus on Bristol-based cuckooing and home takeovers as a local issue.

The initiative provides a structured menu of tactical options for policing and partner agencies, including:

- Overt visits and warnings by uniformed officers or Police Community Support Officers.
- Joint housing/police tenancy interventions.

[cc] Principles for Trauma Informed Practice

- Targeted welfare visits and intelligence gathering.
- Warrants, arrests, and closure orders.
- Target-hardening measures and safeguarding actions.
- Deployment of a communications toolkit (leaflets, posters, public awareness materials).

Much work has been completed during 2025 with regards to the referral mechanism within the police BRAG (Blue Red Amber Green) which is how police record safeguarding concerns and share with partners. The process has been revamped with a more detailed question set depending on whether it is a child or adult and there are automated bots that work in the background to identify NICHE reports depending on the record type that require a BRAG.

Specific training to all front line staff has been undertaken during 2025 to increase the awareness and understanding of the need to share concerns with Children's services or ASC.

Mental Capacity Assessment (MCA) Training in Acute Hospitals

New Initiatives and resources will sit across both NBT and UHBW as both Acute Trusts are merging in 2026 as the Bristol NHS Group.

There is a new MCA training package that sits separately to Safeguarding as a statutory/mandatory training package. There are also grab guides-quick reference guides. There is a Webinar available to staff on how to complete an MCA assessment

This year (2025) there is a new intranet with improved functionality and accessibility with more visual guides.

The Director for Safeguarding is undertaking a group initiative to highlight the issue of MCA practice and ensure there is accountability throughout all leadership teams and executive oversight as a legal requirement for practice.

There will be numerous messages across different mediums:

- FAQs.
- Links to resources.
- Video messages.
- Two new MCA webpages.
- MCA will be highlighted in Group CEOs messages about MCA being the responsibility of everyone (likely in the new year).

The above will be a fixture on the 'Trusts' landing pages and refreshed repeatedly as a rolling program.

The Named Professional for Adult Safeguarding is the MCA Lead for the Trust.

Once the new initiatives are in place they will aim to set up more robust audits of the MCA assessments across the Trust to provide more assurance and support.

The staff numbers within both NBT and UHBW acute trusts are in the high thousands, so consistency is by default, often difficult because of the competing clinical priorities particularly in very busy ED departments and often confidence in the process can be an obstacle. However, the aim is to get a clearer message out to the clinical divisions about the importance of the use and evidence of completing MCAs and the responsibility of both nursing and medical staff to complete and document assessments, along with the rationale, in the electronic hospital records.

6. Recurring Themes

6.1 The areas of focus that are discussed within this SAR are identified as being highly prominent in the Second National Analysis of Safeguarding Adult Reviews: April 2019 - March 2023.[dd]

Self-neglect featured in **60%** of the sample of 652 reviews. This is a 15% increase from the first national analysis and indicates that self-neglect is a growing national concern. Poor use of safeguarding pathways and shortcomings in risk assessment and management were highlighted in **82%** of the stratified sample of 229 SAR reports. Attention to mental capacity was missing or inadequate in **58%** of the stratified sample of 229 SAR reports.

6.2 A review of past local SARs highlights that there are areas of focus, learning and practice improvement recommendations which resonate with this SAR including:

- Trauma Informed Practice
- Substance Use
- Multi-Agency Collaboration
- Mental capacity assessment including reference to the High Impact User Personal Support Plan and
- Cuckooing and exploitation
- Financial Abuse
- Self-neglect
- Advocacy

The SAR Lily published in 2025 had very similar recommendations to this SAR:

- KBSP to review how effectively trauma informed practice (including support systems for staff) is embedded.
- Partners to ensure that guidance and training for staff includes when to question and assess mental capacity including the use of legal processes, such as referral to the Court of Protection and when to use them.
- Partners to ensure that multi-agency self-neglect protocols and processes are available, that staff are aware of them, they include substance use and associated behaviours in the definition of self-neglect and that they prompt multi-agency information sharing, risk assessment and decision making.

[dd] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association

There is reference to changes in practice regarding the High Impact User Personal Support Plan which applies to hospital staff and a standard operating procedure when staff have doubts about mental capacity, and a person wishes to self-discharge. The procedure is to assess mental capacity as part of the discharge process and clinicians must note that they have acknowledged the plan and any reasons for variation from it. This procedure was not followed with Michael who also had a High Impact User Personal Support Plan in place.

The identification of recurring issues and ensuring that that learning, and improvement plans are regularly reviewed would be of benefit to ensure timeliness of response to agreed actions. The recurrence of similar issues indicates that learning is not always being embedded.

7. Conclusions

7.1 The SAR about Michaell has focused on his life and experiences and has drawn on sources of information and insight from family members, agency chronologies and discussions with practitioners and managers. The SAR is underpinned by the SAR Quality Markers which have guided every stage of the SAR from setting up to the completion of the report and its recommendations.

7.2 The SAR panel agreed the SAR areas of focus, namely Safeguarding Practice, Cuckooing/Home Takeover and Adult Exploitation, Self-Neglect and Information Sharing, Partnerships and Collaboration. The methodology considered the legal context and duties for each area of focus, as well as relevant current research and best practice principles and guidance. The findings and analysis of events in each area of focus is compared and contrasted with best practice to assist learning and recommendations.

7.3. A key theme was the protection of Michael from the abuse he was experiencing from others and the learning and reflection on both the operational and systemic factors that influenced practice and the professional response. There was a particular focus on mental capacity assessment and the impact of brain injury and sustained substance use on executive functioning and decision making. The challenges are acknowledged and this SAR brings learning and thought to overcoming barriers to effective practice.

7.4 There is a focus on recurring themes, both nationally and locally as informed by the second national analysis of SARs report (2019-2023) and from previous KBSP SARs.

7.5 There have been positive changes made. Building in assurance that the changes being made are not only effective but also coordinated across agencies wherever possible to support collaboration will be of benefit..

8. Recommendations

Recommendation 1: Safeguarding Safety Planning

The Keeping Adults Safe (KAS) Board should seek assurance that:

- Safeguarding safety planning is guided by Making Safeguarding Personal principles and enables inclusion of the person and, with their agreement, family and trusted others who should all be part of the team.
- Safety planning is collaborative and involves all key partners.
- If there are numerous agency safety plans for adults that are at risk that they are shared. Consideration should be given to the development of a multi-agency risk assessment and management plan to promote a shared and collaborative approach.
- Safety action plans identify actions, responsibilities, timescales and dates for review.
- Safety plans include risk assessment for staff and identify actions to be taken to mitigate risk and channels of support.

Recommendation 2: Emergency Planning

ASC and Health partners should consider using the referenced resources to develop a template for a shared safety and emergency plan that can be developed together with the person and kept visibly in their home to be available in case of emergency.

Recommendation 3: Personal Support Plans (PSPs): UHBW

UHBW should review the effectiveness of PSPs; (for example through practice audits) to:

- Ensure that the advice and guidance is being followed.
- That there are documented records referencing actions taken in line with the PSP and any reasons for variation from it.

Recommendation 4: Mental Capacity Assessment: Adult Social Care

ASC should review the three mental capacity assessments undertaken with Michael, as detailed in this SAR, and ensure that the learning from this review guides future practice and system wide learning and development. The review should include:

- Financial protection planning in relation to best interest decisions for the Council to take on financial appointeeship.
- Defining the decisions to be made and ensuring that theses capture the reason for a mental capacity assessment.
- The reasons for the lack of follow up of a mental capacity assessment outcome that was at a critical point in safety planning and acquiring advocacy for Michael.

Recommendation 5: Mental Capacity Act (MCA) Training

The KAS Board should seek assurance that:

- Partner agencies make more support available to their staff for carrying out mental capacity assessments.
- Training and learning opportunities should include specific reference to the effects of substance use informed by research and evidence based practice.
- Regular audits of practice are periodically completed by statutory partners to provide assurance about the impact of training and that mental capacity assessments are being undertaken appropriately. The information could be coordinated in the safeguarding performance data and presented to the SAB periodically.

Recommendation 6: Advocacy

ASC and Health partners should ensure that there is appropriate and available advocacy representation in accordance with the Care Act, Making Safeguarding Personal Principles and the Mental Capacity Act. Evidence of its presence, promotion and accessibility to be shared with the SAB to ensure that safeguarding is personalised and inclusive.

Recommendation 7: Legal Literacy

For the SAB statutory partners to consider how best to ensure that practitioners access legal literacy learning opportunities to promote understanding of legal frameworks, codes of practice and duties and powers to intervene when required to mitigate risk and prevent harm. This could reference the findings from this SAR and include reference to the Care Act 2014, the Mental Capacity Act 2005 and application to the Court of Protection.

Recommendation 8: Cuckooing

The KBSP Policy and Projects Officer to review and update the KBSP Cuckooing protocol to include the learning from this review, and national SARs and from the cuckooing professionals toolkit and resources that are referenced in section 9 of this report.

9. Resources

Safeguarding Your Mental Health at Work - Ann Craft Trust
Mind have created resources to support the mental health of people working in the emergency services, such as the police, fire, search and rescue and the ambulance service.

- NCVO have created practical tips for self-care when working in safeguarding.
- The NHS have launched ‘Your Mind Plan’ which asks you five questions about your mental health to provide you with bespoke advice.
- Access our resources to enable you to create a safer culture within your sport and activity club or within your organisation.
- Mind have a free helpline service that you can access online or via telephone if you want to speak to someone in confidence about your mental health.

- Check out our guidance for self-care when working from home.
- If you are a manager, read Mind's guide to supporting staff with mental health challenges.
- Bupa have highlighted some practical tips for looking after your mental health at work.

Preventing and Disrupting Cuckooing Victimisation: Professional Toolkit | School of Law | University of Leeds

Your guide to Emergency Health Care Plans Your Guide To Emergency Care Plans

Planners and Checklists - Headway

RCEM_Mental_Capacity_Act_in_EM_Practice-Feb_2017_V2-Copy.pdf

executive-functioning-grab-sheet-mca-guidance_v10_apr2021.pdf (lancashiresafeguarding.org.uk)

revisiting-safeguarding-practice.pdf (publishing.service.gov.uk)

RCEM_Mental_Capacity_Act_in_EM_Practice-Feb_2017_V2-Copy.pdf

MTAM Collective Safety Plan

Preventing and Disrupting Cuckooing Victimisation: Professional Toolkit | School of Law | University of Leeds

working_with_people_who_self-neglect_pt_web.pdf

Safeguarding adults: sharing information - SCIE

Multi-Agency-Risk-Management-Guidance-for-Professionals-Compressed.pdf

10. Acronyms

ASB – Anti-Social Behaviour.

ASC – Adult Social Care.

BCC Bristol City Council.

BRAG Risk Assessment – Blue - not at risk of abuse or neglect and able to protect themselves, Red - at risk of abuse or neglect and unable to protect themselves, Amber - possibly at risk of abuse or neglect and unable to protect themselves and Green - possibly at risk of abuse or neglect and able to protect themselves.

AWP – Avon and Wiltshire Mental Health Partnership.

ED – Emergency Department.

IMCA – Independent Medical Capacity Advocate.

LSU – Lighthouse Safeguarding Unit.

MARM – Multi Agency Risk Management.

MDT – Multi-Disciplinary Team.

NBT – North Bristol Trust.

NPTs – Neighbourhood Police Teams.

PSP – Personal Support Plan.

RAR – Rehabilitation activity requirement.

SAR – Safeguarding Adult Review.

ToR – Terms of Reference.

UHBW – University Hospital Bristol and Weston NHS Foundation Trust.

END