Safeguarding Adult Review: Michael

Executive Summary

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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 doesn't seek to lay blame but promotes learning, reflection and working together to understand what happened, what could have been done differently and forging a shared partnership commitment to change and improvement.

Michael[1] was a White British man who was 44 when he died in September 2024. The cause of death was 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 epilepsy. He was unable to 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 agency representatives was established.

The SAR draws mainly on significant events in the two years up to the time of Michael's death. Michael's family were contacted and advised about the SAR purpose and method and their views were compassionately sought and provided valuable insight. Michael's mother spoke to the independent reviewer on a number of occasions and she shared information about Michael's childhood and the challenges he experienced which impacted on his adult life.

Michael is at the heart of this review; his life, experiences and challenges informs the analysis of practice and the wider system context leading up to and at the time of his death.

This Executive Summary of the full SAR report includes a precis of the review findings, key learning points and recommendations. The detailed terms of reference and SAR methodology can be found in the full report.

The independent reviewer and SAR panel wish to express sincere condolences to Michael's family. They would like to thank Michael's mother, safeguarding partners, practitioners and managers and the KBSP safeguarding adults review team for their valued support, reflections and contributions.

Michael

Michael was in a car accident when he was seven years old. He was in intensive care and suffered a severe brain injury. Michael had a long period of rehabilitation following his accident but was left with significant disability which had a profound effect on his life.

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

In his adult life, Michael found it difficult to hold down employment. He suffered frequent seizures and his memory was poor. Michael's mother was concerned that he had got into bad company, and she felt that he was exploited and people he associated with took advantage of him.

Michael became dependent on alcohol and drugs. He lived in accommodation that provided a high level of tenancy support. Michael was, at times, aggressive and abusive to others and had served time in prison for assault. In the two years prior to his death, he was subject to a probation order, however his complex needs related to his brain injury meant that he was unable to reliably attend appointments or to undertake any rehabilitative work preventing re-offending.

Michael had frequent attendance at the Emergency Department (ED) arising from seizures and intoxication. His intake of epilepsy medication was erratic and this led to uncontrolled seizures and often falls. He had poor nutrition and neglected his health.

Michael was very vulnerable to exploitation and coercion by others and was financially, physically and emotionally abused over a sustained period of time. There was a network of professionals and services working to support him. A safeguarding safety plan and other risk management plans were in place and reduced some of the risks to Michael 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. The Coroner's report concluded that Michael had died from drowning in his bath following an epileptic seizure.

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 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.

2. SAR Areas of Focus

2.1 Safeguarding Practice, Risk Assessment and Mental Capacity Assessment

2.1.1 Safeguarding Practice – Key Findings

There were multiple safeguarding concerns and referrals to Bristol City Council Adult Social Care (ASC) over the two year period prior to Michael's death. The concerns included physical abuse and assaults on Michael, exploitation by others, cuckooing[2], coercion and control and financial abuse. Concerns were raised about Michael's neglect of his own health and uncontrolled epileptic seizures arising from medication management issues.

[2] What is Cuckooing? – Preventing and Disrupting Cuckooing Victimisation

There were instances of safeguarding referrals being delayed and safeguarding concerns being wrongly categorised and not progressed. There were also instances of safeguarding concerns being added to an ongoing safeguarding enquiry losing momentum and specific consideration of the particular circumstances of each concern.

Practitioners at the SAR partner learning event highlighted factors including work pressures and overload as having an impact on the response to some safeguarding concerns and on their emotional wellbeing. Partners highlighted that at times they felt isolated and anxious and would have welcomed a more joined up safeguarding partnership approach.

Michael did not have family members or an advocate to support him in engaging with safeguarding meetings. There are just two references in the agency chronologies 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 included in efforts to keep him safe. There is reference in the chronology information to 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.

Making Safeguarding Personal principles and ways of working that were inclusive, built up trust and rapport with Michael were evident in practice. The extensive chronology and care notes highlight that housing support keyworkers worked with Michael consistently and in a caring, responsive way. A community charity offered Michael a place of sanctuary when he needed advice, food, support and a safe place to vent his frustration and anxiety. A police community support officer built up a good rapport with Michael and helped him to understand that he was a victim of exploitation by others.

Key Learning

The review identified that Michael could have been more effectively safeguarded if there had been a sustained collaborative and inclusive approach. The My Team Around Me approach (MTAM)[3] was in the early stages of implementation and to some extent was effective but it was not sustained. Michael responded well to a personalised and appreciative way of working. Engaging advocacy and family support, in particular from Michael's mother, would have increased support to Michael. Introducing specialist brain injury services, such as Headway to inform practice, would have been of benefit.

2.1.2 Risk Assessment and Safety Planning – Key Findings

The extensive chronological information, as detailed in the SAR report, 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 as he could be aggressive and make physical threats to staff particularly when under the influence of drugs.

[3] My Team Around Me — Changing Futures Bristol

There were three risk management and safety plans in place for Michael, a Hospital High Impact User Personal Support Plan (PSP), an ASC Safeguarding Safety Plan and a Housing Support Safety and Inclusion plan. Each plan highlighted Michael's individual needs, risk factors and guidance on appropriate response. The plans were not well coordinated and did not underpin a strategic approach to keeping Michael safe. The review found that guidance on appropriate response and safety actions plans were not always followed through. Further details can be found in the full SAR report.

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 the cause of his death. This risk, which was not taken into account when Michael first took up residence in his flat, could have been creatively re-visited during conversations with Michael regarding options for a move to alternative, safer and more supported accommodation.

Partners expressed at a safeguarding strategy meeting that Michael would be better supported and protected in a specialist setting. One practitioner reflected at the partner learning event that it would have been a challenge to secure a high level of resource for Michael because his needs were not clearly understood.

Key Learning

A shared multi-agency safety plan 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, ideally with support from an advocate, and would have assisted ambulance crews and other partners needing to access information in an emergency.

SAR partners considered the impact of mental stress on staff working in circumstances where there are threats of violence against them. 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[4] provides useful resources on safeguarding mental health at work

2.1.3 Mental Capacity Assessment – Key Findings

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

Overall, the mental capacity assessments and actions taken in response did not adequately protect Michael. The first, completed by ASC in November 2021, concluded that Michael did not have capacity to make decisions about financial matters and was at risk of financial abuse. The financial protection plan did not address the continuing risks to Michael.

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

The second, completed by ASC in June 2022, concluded that Michael had capacity to consider housing options and make decisions about alternative accommodation. This assessment did not address a core issue, that of Michael's capacity to make decisions regarding maintaining his safety in his current tenancy.

The third, completed by ASC in December 2023, concluded that Michael did not have the capacity to maintain his safety in relation to abuse from others. This outcome was not acted upon or referred to again following authorisation in February 2024. This was a critical oversight as the outcome could have initiated best interest decisions together with the appointment of an Independent Mental Capacity Advocate (IMCA)[5] and potentially an application to the Court of Protection[6]. The Court of Protection is a specialist court established under the Mental Capacity Act 2005, which makes decisions on behalf of those who lack the mental capacity to do so for themselves.

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. 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.

Key Learning

1. 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.[7]

2. Recent guidance issued by the Office of the Public Guardian, Making Decisions: a guide for people who work in health and social care[8] informs and guides health and social care practice in the application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

3. The Mental Capacity Act created the role of an 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.

[5] What do IMCAs do and who should get an IMCA? - SCIE
[6] Court of Protection - GOV.UK
[7] RCEM_Mental_Capacity_Act_in_EM_Practice-Feb_2017_V2-Copy.pdf
[8] 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

2.2 Cuckooing and Exploitation

Key Findings

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.

Throughout 2022, it is noted that Michael was a regular target of financial abuse and 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 and using and dealing drugs.

Police officers were called on numerous occasions and they completed risk assessments and identified that Michael was a victim of cuckooing. Safeguarding concerns were raised and there was discussion between Michael and his social worker about alternative housing accommodation with a higher level of support. Michael consistently refused to consider this, and at times he said the people coming to his home were his friends, and at other times he said he wanted them to leave.

It was proving very challenging to enforce police bans on certain individuals as Michael was being coerced and under pressure to let them into his home. It was recorded that at times Michael appeared bewildered and anxious. He wanted support staff to ask people to leave his flat and appeared to be frightened and was unwilling to make any statements to police officers, making it hard to remove people from his flat. He was fearful of reprisal.

The incidents of cuckooing and assault on Michael were so prolific that he was referred by his keyworker to the Anti-Social Behaviour/Multi-Agency Risk Management[9] (ASB/MARM) in August 2024, a month prior to his death. SAR partners reflected that this referral could have happened earlier and would have led to escalation, case conference, increased multi-agency wide awareness and shared and resourced safety planning for Michael.

There was no engagement of a trusted person or advocate to meet and build up rapport 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

[9] 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.

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 through a holistic and strategic approach.

Key Learning

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.[10]

Best practice informed by evidence based research highlights that victims of cuckooing may be reluctant to disclose information and recommends that there should be identification of the most appropriate professional or advocate.

There are training resources and public information on hate and mate crime on the KBSP website.[11]

2.3 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.

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.

Key Findings

Michael lived in basic conditions, and 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. He had an erratic pattern of taking his prescribed anti-epilepsy medication which resulted in seizures, falls, injuries and multiple attendances in ED.

Michael's GP 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. Michael 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 frequently missed probation and GP appointments despite best efforts from support staff to alert him, attend with him and encourage him to use techniques such as set up alerts on his phone. There was little

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

[11] Welcome to the Keeping Bristol Safe Partnership website.

communication between the GP and Michael's keyworker and this would have been of benefit.

People working to support Michael were aware of the challenges he experienced and some steps were taken to try to mitigate the risks of self-neglect, though there were issues, noted below, which impeded success:

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

Key Learning

1. SAR partners 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.

2. Evidence Based practice guidance[12] suggests that effective practice is person-centred and respectful, develops trusting relationships, promotes working in partnership and is non-judgmental. Helping people who are self-neglecting is most effective when there is multi-agency partnership planning and an informed practice approach in place.

3. 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.[13]

2.4 Information Sharing, Partnerships and Collaboration

Key Findings

There was no evidence of a strategy or informed practice approach underpinning communication and sharing information with Michael. A practice approach and clear methods to communicate with Michael and respectfully gain his agreement to share information with his mother and across the multi-agency partnership would have been helpful.

There was an absence of health partners meeting with other multi-agency partners to discuss known concerns about Michael. 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.

[12] working_with_people_who_self-neglect_pt_web.pdf
[13] Working definition of trauma-informed practice - GOV.UK

In general, there was evidence of good sharing of information between the police, ASC and Michael's keyworker. There was a missed opportunity for the police to share with Michael, and with partners, information about a female living in Michael's flat who was a known perpetrator of violence and exploitation towards men.

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 and incidents being seen as separate occurrences rather than viewed as accumulated risk and escalated accordingly.

The KBSP has information sharing agreements and guidance in place that sets out the principles and legal context of information sharing and governance. 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'. A recurring issue identified by the second national analysis of SARs 2019-23[14] 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.

Key Learning

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.[15]

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. SARs are pivotal in illuminating influences on practice and ultimately on outcomes for people who have, complex needs often arising from trauma and adversity.

The SAR has identified changes that have taken place since Michael's death and areas that are changing. The changes are detailed in the full SAR report. SAR Partner discussions and reflections highlighted a keen interest for change and a

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

[15] Safeguarding adults: sharing information - SCIE

desire for partners to work together more effectively and provide helpful direction for practice improvement.

This SAR will be an opportunity for the Keeping Adults Safe (KAS) Board to coordinate and effect system wide process and practice change and use the learning and recommendations to bring partners together.

6. Recurring Themes

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. The KBSP is therefore not alone in facing significant challenges in safeguarding practice. SARs across the country are highlighting similar themes and also examples of good practice, areas for improvement and useful resources.

A review of past local SARs highlights that there are findings which resonate with this SAR as detailed in the full report. Ensuring that recurring issues are identified and that learning, and improvement plans are regularly reviewed would be of benefit.

7. Conclusions

The SAR about Michael 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[16] which have guided every stage of the SAR from setting up to the completion of the report and its recommendations.

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 findings and analysis of events in each area of focus is compared and contrasted with best practice to assist learning and recommendations.

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.

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.

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

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

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): University Hospitals Bristol and Weston NHS Foundation Trust (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.

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