

SAR S

November 2024

INDEPENDENT REVIEWER: PAUL NICHOLLS



Adult S

(This is the only known photo of Adult S)

Adult S was an engineer who grew up in Scotland. He lived in a one-bedroom Local Authority owned flat near the city centre.

He was described by those who knew him as an ‘interesting, quirky’ character, with **no family and a limited social circle**. He tended to share varying accounts of his personal history with different individuals, these inconsistencies often made it challenging to work with him.

He used non-prescription drugs to help him cope with his mental and debilitating physical health conditions and combat his loneliness.

Adult S **was described as a ‘kind man’**, which led to some local people to take advantage of him. They would spend a lot of time at his house, often to use drugs. This led Adult S to say he **‘felt unsafe at home’**, even though there was no evidence that he was physically threatened.

Some of the relationships he formed were described in the review into his death as **‘exploitative friendships’**.

Gerard Doherty (2020) described - *‘Exploitative familiarity’* [Prejudice, friendship and the abuse of disabled people: an exploration into the concept of exploitative familiarity \(‘mate crime’\): Disability & Society: Vol 35, No 9 \(tandfonline.com\)](#)



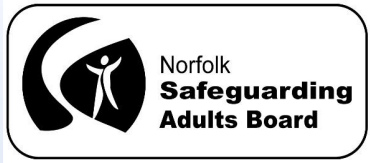
Adult S

Adult S frequently requested a move to another property as he felt this would resolve his problems. Some professionals felt the same. He was considered (by the Housing Provider) as a **'low priority'** due to his accommodation being classified by the Housing provider, as **'adequate for his current needs'**.

Adult S's neighbour and one very close friend J, worked closely with the reviewer and contributed to the report, giving us a **valuable insight** into Adult S life and sadly, the events leading up to his death. Adult S and J **supported and 'looked out'** for each other.

Meeting J enabled us to **understand some of the dynamics** around the people who associated with Adult S, and how they impacted on his life (and his passing). E.g., one friend tried to claim carers allowance without his knowledge. Another borrowed his car, then sold it, without Adult S knowing. Police investigated reports of theft from Adult S, but he was **reluctant to give evidence** and the investigation was closed.

J described the many professionals he observed working with Adult S. In his opinion, **'everyone tried their hardest to help him'**. Adult S was consistently described by partners as a **"willing recipient" of support**, which he actively sought. For example, in the 6 months before he died, Adult S went to his **GP 65 times**.



Adult S

Covid had a huge impact on Adult S. The charity support group, Menscraft, he attended once a week, closed. This adversely impacted his mental health and further increased his loneliness.

Between November 2021 and February 2022, three Multi-Agency Safeguarding Hub (**MASH**) referrals were made for Adult S due to suicidal ideation, overdoses, and concerns regarding his vulnerability to exploitation.

The Crisis Resolution and Home Treatment team recognised Adult S's **need for respite support** and arranged for Adult S to stay at a local mental health respite centre on two separate occasions in November 2021 and January 2022.

His neighbour described how Adult S '**absolutely loved**' being there and 'felt very happy and supported' whilst he was there.

A Care Act assessment was completed by an Assistant Practitioner, in Dec 2021. There was **no mention at this stage** of risks of exploitation of Adult S, despite three referrals in the previous two months.



Adult S

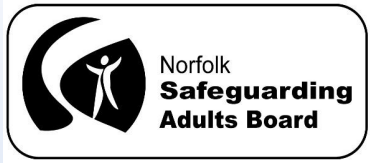
In early 2022 Adult S's **mental health deteriorated further**, he expressed suicidal thoughts and faced increasing difficulties with his personal care.

His GP **recommended a residential placement** or similar support, but Adult S was informed that he did not meet the criteria for supported accommodation, as concerns arose regarding potential risks to other residents due to his drug use.

In February 2022, he was admitted to the hospital following a **second suicide attempt**. It was recorded that Adult S '**lacked capacity**' in the discharge notes, but there was no evidence of an assessment taking place.

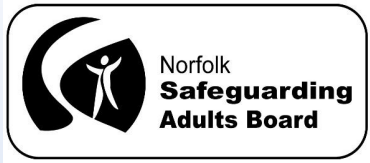
The **first multi-agency professional meeting** took place in February 2022. Police and Housing were not at the meeting.

Adult S died in March 2022 from **fatal opioid toxicity**. J was the only person who attended his funeral.



Do you have any questions?

What are your initial thoughts about Adult S and the risks and challenges he faced?



The five key lines of enquiry, agreed by the review team, in the review were :

- To explore the role of good practice by agencies, for example evidence of good multi-agency working.
- Were the multi-agency responses to the initial safeguarding concerns effective?
- How confident are staff from different agencies in identifying and understanding the **dynamics of adult exploitation** in particular County Lines, and knowing how to respond?
- Was there an effective multi-agency response to mental health concerns raised about Adult S safety?
- Did housing providers respond effectively to Adult S's safeguarding concerns?

The review took six months and there were **seven recommendations** . Today, we will focus on three.

Recommendation - Exploitative Friendships

There needs to be a greater understanding and attention given to the effects of “exploitative friendships” and coercion by acquaintances alongside the allegations of cuckooing. To have clarity of a person’s social network, loneliness and associated risks, drawing on the work done in other areas.

Most practitioners working with Adult S were aware of aspects of his exploitation and coercion by acquaintances, but it was not acknowledged in the Care Act assessment, a multi-disciplinary meeting and concerns **did not lead to a safeguarding enquiry**. It was recorded as ‘no evidence of cuckooing’.

The case was allocated to an Assistant Practitioner. It was felt during the review that the case should have been allocated to a Social Worker.

Adult S reluctance to give evidence hindered Police investigations.

There was a lack of **professional curiosity** regarding **financial exploitation** of Adult S which subsequently didn’t identify him as a **victim of exploitative friendships**, rather than ‘cuckooing’.

Recommendation - Exploitative Friendships (recent studies)

The variable and evolving nature of ‘cuckooing’ as a form of criminal exploitation in street level drug markets - Jack Spicer & Leah Moyle & Ross Coomber (2019).....*Social isolation was a significant factor ..What appeared to make victims/survivors structurally vulnerable was their **social positioning**: they become vulnerable because they are living alone and lonely, typically in poverty, with very few adult services to sustain them, and with a lack of **social connectivity to family and/or friendship networks**’.service providers and members of the community wrongly interpret warning signs of cuckooing as a sign that the person has ‘**fallen in with the wrong crowd**’ rather than identifying what is happening as exploitation.*

Stephen J. Macdonald, Catherine Donovan, John Clayton and Marc Husband (2021) - Disability & society - **Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation – a person often does not acknowledge that they are being exploited by the perpetrators; they see the perpetrators as friends, or potential intimate partners, and welcome them into their homes.**

Adult S formed acquaintances that he maybe wouldn’t have done if he had a wider social or family network, primarily to alleviate his loneliness. Adult S was reluctant to co-operate with Police when being financially abused by his acquaintances. Close acquaintances such a J were not consulted during assessments.

Recommendation – Multi Disciplinary Meetings

Practitioners are reminded that in complex cases, they are encouraged, at an early stage, to convene multi-disciplinary meetings. Every opportunity should be given to use multi-disciplinary team meetings and the appointment of a lead professional, particularly in cases involving risk factors around exploitation

There was **no Multi-Disciplinary Team** or Professionals meetings, prior to February 2022, with no single agency assuming a '**lead professional**' role. This would have helped prioritise appointments and support and ensure Adult S received the right intervention at the right time. When the meeting did take place, **key partners (particularly Housing) were not invited.**

This meant that important **information and risks were not shared** and there was no evidence of an outcome focused plan.

Recommendation - Housing

There needs to be greater oversight....from the housing providers to cases where an internal safeguarding concern has been raised. The council also needs to raise awareness amongst professionals of the eligibility for housing and how banding decisions are made and reviewed to enable all professionals to work together to manage expectations and needs of the person.

(Note – At the time of the review there were **4300 people on the housing register**, many of these are homeless, facing homelessness or living in conditions of severe housing need). There were **6 vacant properties** available at this time.

The housing provider held very limited records for Adult S, and there was no documented evidence of anti-social behavior at Adult S's location. Additionally, there was insufficient evidence of 'cuckooing' from the Police, despite their investigations. Social Care had also recorded that there was no evidence of 'cuckooing'.

An internal safeguarding concern had been raised by the housing provider, but no contact was made with Adult S.

Housing were not invited to the professionals meeting in Feb 2022, one month prior to Adult S passing.

Reflections on the case – **Learning points for consideration**

Do we fully understand and consider the effects of exploitative friendships?

- e.g. Selling of the car, claiming Carers Allowance without the persons knowledge.
- Did Adult S reluctance to give evidence affect outcomes?
- Did we fully understand the negative effects of social isolation and include these in assessments?

Do we take every opportunity to gather and share information amongst professionals?

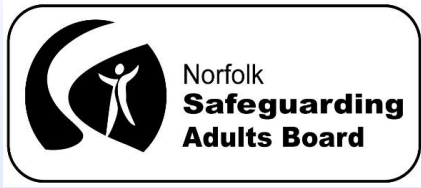
- Are early opportunities for multi-agency information sharing being utilised?
- Are key partners e.g. Housing, Police able to share information and inform an outcome focused plan?

Did we fully appreciate the pressures on Housing providers and their limited options

- Did some professionals assume that a move will solve the problem, without fully understanding the limited options available.

Do we fully understand the dynamics of the Social Network – ‘Tricky Friends’

- e.g. Could we have offered Neighbour J a ‘safe space’ to inform assessments – *‘Nobody listened to us’*
- [Tricky Friends animation | Norfolk Safeguarding Adults Board](#)



Happy to take questions.