LONDON BOROUGH OF CAMDEN SAFEGUARDING ADULTS PARTNERSHIP BOARD SAFEGUARDING ADULT REVIEW MATTHEW 2023

Review Report by David Mellor

Camden Safeguarding Adults Partnership Board

Safeguarding Adults Review in respect of 'Matthew'

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1.0 Introduction

1.1 This Safeguarding Adults Review was commissioned following the death of Matthew (a pseudonym), whose body was discovered in his flat in the London Borough of Camden on 27th August 2020. Matthew was a White British male and was 47 years old at the time of his death. The last professional contact with him took place six days earlier. During 2018 concerns arose that Matthew may be a victim of 'cuckooing' and a Closure Order was obtained in 2019 which prohibited access to his flat for three months. Application was made to extend the Closure Order but this was unsuccessful. Matthew had been supported to relocate to a hostel in the London Borough of Hackney and returned to his flat once the Closure Order expired. After Matthew's return to the flat there were further incidents of anti-social behaviour and possible drug dealing which may have been indications of cuckooing and a further Closure Order was being progressed in the period prior to Matthew's sudden death.

1.2 A safeguarding concern raised shortly before Matthew's body was discovered was subject to a Section 42 Safeguarding Enquiry. A Safeguarding Adults Planning meeting took place on 5th November 2020 and a Safeguarding Adults Outcome meeting was held on 28th January 2021. Following the latter meeting a referral for a Safeguarding Adults Review was made.

1.3 On 21st April 2021 Camden Safeguarding Adults Partnership Board (SAPB) decided to conduct a Safeguarding Adults Review (SAR) on the grounds that Matthew appeared to be a person with care and support needs who had died, it was suspected that he had suffered abuse as a result of cuckooing which may have contributed to his death and there was concern that partner agencies could have worked more effectively to protect him. SAPB initially decided to conduct a SAR consisting primarily of a facilitated workshop event but after further consideration, it was decided to commission a SAR in which an 'investigative' approach would be adopted.

1.4 David Mellor was appointed as independent reviewer for the SAR on 13th October 2021. He is a retired chief officer of police and has ten years' experience of conducting statutory reviews. He has no connection to any agency in Camden. The process by which the SAR was conducted is shown in Appendix A.

1.5 An inquest took place on 8th January 2021 which concluded that the cause of Matthew's death was 'unascertained'. The Coroner was unable to reach a more definitive conclusion because of the time which had elapsed between death and the discovery of his body.

1.6 Camden Safeguarding Adults Partnership Board wish to express sincere condolences to Matthew's family and friends.

2.0 Terms of Reference

2.1 The period covered by the SAR is from June 2018 until Matthew's death in August 2020. Significant events which took place outside of these dates have also been included.

2.2 The following key lines of enquiry have been explored by this SAR:

- The effectiveness of the single and multi-agency response to 'cuckooing' in this case.
- The effectiveness of efforts to safeguard Mathew.
- The application of the Mental Capacity Act in this case and 'cuckooing' cases generally.
- The extent to which a person-centred approach was adopted in this case and the extent to which Matthew's 'voice' was heard.
- The extent to which all legal remedies were considered and applied.
- The overall effectiveness of multi-agency collaboration and information sharing in this case.

2.3 It is also intended that the learning from this SAR will inform the development of a comprehensive multi-agency approach to the growing problem of cuckooing in Camden.

3.0 Synopsis

3.1 What is known about Matthew's life has been pieced together from what he disclosed to professionals. His sister initially agreed to contribute to the review but subsequently decided against this. Matthew appeared to have a mutually supportive relationship with his sister and stayed with her for a period in the summer of 2018 when the concerns that he was a victim of cuckooing were prominent. He appeared to have become estranged from his mother, who passed away some months after Matthew's death. Housing records indicate that Matthew disclosed that his father had died from an overdose. It is not known when this happened or how close Matthew's relationship with his father was. Matthew is known to have had a son who Housing records state he was 'unable to see'. This record appears to date from around 2004 when Matthew would have been in his early thirties and experiencing accommodation instability which may have made regular contact with his son challenging. The only other agency record which refers to Matthew's son is a telephone contact with Camden Specialist Drug Services (CSDS) in April 2020 in which he said that he and his son had reconnected (No further details). Very little is known about Matthew's intimate relationships although he introduced a male who was staying in his flat in late 2018 to professionals as his partner. Matthew was described as exceptionally talented at art although there are no further details of this. Unfortunately, the SAR has been unable to ascertain what really mattered in life to Matthew.

3.2 Matthew had a long history of contact with drug misuse services, disclosing using drugs from the age of eleven. He also had contact with mental health services in respect of depression and had a history of suicidal ideation and attempts to take his own life. He was diagnosed with chronic obstructive pulmonary disease (COPD). He was also diagnosed with ADHD whilst serving a prison sentence and was prescribed ADHD medication which was later stopped after he reported suicidal thoughts. No alternative ADHD medication was said to have been available at that time. Matthew does not appear to have been in employment for a number of years. Housing records documented Matthew saying he would never be able to work because he'd become institutionalised through time spent in care and periods in prison. However, Housing records indicate that he took on positions of responsibility whilst in prison. Nothing further is known about any periods in the care of the local authority as a child or young person. Little is known about his periods of imprisonment and for what offences he was sentenced other than a sentence of two and a half years for causing actual bodily harm in 2011. Housing records indicate that Matthew had previously been considered to present a high risk to staff and other vulnerable residents. The National Probation Service have advised this review that their last period of supervision of Matthew ended in April 2013. He was in receipt of Disability Living Allowance (DLA) at one time. This benefit is now only paid

to children and people born before 1948. It is not known if Matthew transitioned to the Personal Independence Payment (PIP). He was also in receipt of Employment and Support Allowance (ESA).

3.3 He had a number of council tenancies from the age of 21. One tenancy ended with eviction and another was surrendered when he was sentenced to a period of imprisonment for the actual bodily harm offence referred to in the previous paragraph. There were issues of noise and anti-social behaviour associated with one of his tenancies. Difficulty was experienced in finding him a hostel placement after he assaulted a worker in a hostel following a prison sentence and was recalled to prison. There are also references to street homelessness in Matthew's records. Matthew subsequently had a successful placement in supported accommodation where he was described as polite and considerate to others. It appears that he may have benefitted from support from his sister during this period who was documented to live nearby. His tenancy in the flat in which cuckooing subsequently took place began in November 2015. The assessment which informed this decision concluded that the tenancy was the most appropriate option, provided it went alongside care and treatment from drug services, support with his mental health and floating support. At the time this tenancy began he was receiving treatment from Camden Specialist Drug Services (CSDS) and was being prescribed daily supervised methadone (daily supervised consumption by the pharmacy) and diazepam to take away. He also collected five other medicines on a weekly basis which were prescribed by his GP.

2018

3.4 In January 2018 Camden Tenancy Services spoke to Matthew about his rent arrears which had been a persistent problem and he disclosed that he spent all his income on crack (£30-£40 daily) and had not been eating as he had no money for food. He was given food bank vouchers.

3.5 Later the same month Camden Tenancy Services were made aware of complaints about loud music coming from Matthew's flat. When spoken to Matthew denied that the loud music emanated from his flat. This appears to have been the first complaint of this nature during Matthew's tenancy.

3.6 On 13th February 2018 a CSDS multi-disciplinary team (MDT) meeting discussed recent information received by a 'response worker' which related to Matthew allowing drugs to be sold from his flat (no further details).

3.7 On 15th March 2018 Matthew disclosed to his CSDS keyworker that drug dealers had taken over his flat and that he was being supplied with free crack. He said that

he had recently asked them to leave, which they did, although he added that he owed them £200. Since then they had been phoning him constantly for money, but they had made no threats. He added that he had changed his mobile phone as a result (CSDS had been unable to contact him on his usual mobile number). Matthew reported that if he felt at risk he would discuss this further. The keyworker advised Matthew to contact the police if he felt in any danger.

3.8 When he saw his CSDS keyworker later the same month Matthew said that he was currently not in danger as 'the boys that took over his flat had been sent to prison'.

3.9 During April 2018 the Tenants Association for the flats in which Matthew lived raised concerns with the Kentish Town Safer Neighbourhood Panel over possible misuse of Matthew's flat for the sale of drugs. Camden Tenancy Services were made aware.

3.10 On 16th May 2018 a drugs warrant was executed by the Met Police at Matthew's address and he was arrested and charged with possession with intent to supply heroin, crack cocaine and cannabis. He was the only person present. Drugs and drugs paraphernalia were seized.

3.11 Later in the month Matthew told his CSDS keyworker that the police had 'raided his property for drugs and a murder enquiry' and that he had been arrested for possession of drugs. (The chronology submitted by the Met Police to this SAR confirms that a warrant issued under the Misuse of Drugs Act had been executed at Matthew's flat and a large quantity of cannabis and suspected Class A controlled drug was found and Matthew arrested and later charged with possession with intent to supply heroin, crack cocaine and cannabis). He also told his keyworker that the 'young boys' who had been using his flat to sell drugs have been remanded in custody for murder and that he had been given the option of testifying against them or going to prison for possession of drugs. He reported having suicidal thoughts although he had not made any plans. He described feeling trapped with no way out. He also said that he felt he was at risk if he talked to the police. The keyworker encouraged Matthew to contact his solicitor urgently. Matthew was discussed at the CSDS MDT held on 29th May 2018 when it was planned to 'complete a safeguarding referral' which was documented to have been completed at the next CSDS MDT held on 12th June 2018 but there it is unclear to whom the safeguarding referral was made and there is no indication of any outcome from the referral.

3.12 On 6th June 2018 Matthew had an unscheduled meeting with his CSDS keyworker during which he said that the drug dealers were not currently staying in his flat but had been leaving 'illicit substances' in his property and 'threatening his

family'. He indicated that his awareness of the murder the dealers were accused or suspected of put him at risk. He continued to refuse to contact the police. The keyworker informed Matthew that 'a safeguarding would be opened' and if he changed his mind about making a report to the police, CSDS could provide 'support around safeguarding'. The keyworker later discussed Matthew with the CSDS safeguarding lead when it was documented that Matthew reported that he 'did not feel he is at initial harm'. It is unclear precisely what was meant by this phrase. Matthew was to be encouraged to contact Crime Stoppers to make an anonymous report about the drug dealers who had been visiting his flat. The CSDS MDT noted the ongoing risks to Matthew including the risk of deteriorating mental health.

3.13 On 12th July 2018 Matthew phoned CSDS in a distressed state to say that he was being bullied by people who were coming to his flat and 'using illicit substances'. He added that he had been threatened by an individual involved in the murder case. A crisis plan was discussed with Matthew including crisis and emergency phone numbers. He also shared his new phone number.

3.14 On 31st July 2018 Matthew told his CSDS keyworker that he had not had any contact with boys, however he said that he was mostly staying with his sister because the young drug dealers who had harassed him previously had been visiting his flat demanding money. By the end of August 2018, Matthew said that he had returned to his flat.

3.15 CSDS offered Matthew a meeting with the CSDS safeguarding lead to consider requesting a transfer of address from the local authority and to further encourage Matthew to contact the police. The meeting took place on 13th September 2018 but Matthew declined to discuss the drug dealers visiting his flat, saying that he was in withdrawal due to missing his methadone the previous day.

3.16 On 26th September 2018 CSDS referred Matthew for floating support with his agreement and the following day floating support advised Camden Tenancy Services that Matthew had told them that his flat had been taken over by drug dealers in early July, that they had threatened him when he asked them to leave and he was scared to report the matter to the police. Floating support suggested placing Matthew in temporary accommodation for his safety.

3.17 On 2nd October 2018 CSDS liaised with Camden Tenancy Support after obtaining Matthew's consent. On the same date Community Safety contacted Adult Social Care MASH to advise that Matthew's address had been 'taken over as a drugs address'. The MASH conduct network checks which established that CSDS was the only agency currently working with Matthew.

3.18 The following day Camden Tenancy Support spoke to Matthew and offered him temporary accommodation along with storage for his possessions. Matthew's GP practice was informed.

3.19 On 5th October 2018 Camden Tenancy Services and Community Safety visited Matthew at his flat. Another male was present who Matthew introduced as his partner. The partner said that he had recently been released from prison and was staying over with him because he was concerned about him. Matthew said that a group of men had begun visiting his flat 'last summer' and after their visits became more regular, he was forced to let them have the flat. They began leaving drugs in his flat and dealing 'out of the back window'. He went on to say that the men were not currently staying with him, that three of them had been arrested for a 'triple murder' and that since the police raid they had stopped coming as much. Camden Tenancy Services planned to register Matthew for a property move, which would entail staying in temporary accommodation in the first instance, probably out of Borough.

3.20 On 8th October 2018 the community safety officer who had visited Matthew 3 days earlier, saw him and his partner injecting crack behind a local library and asked them to leave the area. This gave rise to some uncertainty on behalf of tenancy services and community safety over the extent of Matthew's vulnerability and the suspicion that he may be presenting as more vulnerable than he actually was.

3.21 On 17th October 2018 a network meeting (also described as a safeguarding meeting) took place to discuss Matthew. It was agreed that Housing/Community Safety would proceed with a full Closure Order with a view to supporting Matthew into the Pathways programme*, that CSDS would shorten his prescription to weekly in order to see him more frequently to 'keep an eye on him and his safety' (however, they continued to see Matthew fortnightly), Housing/Community Safety would arrange to meet with Matthew to discuss next steps and complete safety planning with him including changing his locks. A referral to the Community MARAC (Multi-Agency Risk Assessment Conference) was considered but there is no indication that this took place. The Met Police were to be made aware and asked to share intelligence if this was legally possible.

*It is understood that if Matthew had entered the Pathways programme he would have initially moved into supported accommodation until such time as he was able to manage an independent tenancy again.

3.22 During a meeting with his CSDS keyworker later in October 2018, Matthew disclosed that he had 'hurt' one of the people visiting his flat with an iron bar, adding that he had 'totally flipped'. At his next CSDS appointment in early November 2018

he presented with a severe swelling to his right eye and said he had 'got into a fight'. He said he had been to hospital A&E but had left without being seen. He was advised to return to A&E or visit his GP. There is no indication that he contacted his GP.

3.23 During November and December 2018 complaints were received from neighbours about visitors to Matthew's flat. One neighbour reported being regularly disturbed by visitors to Matthew's flat throughout the night and said that they felt intimidated by Matthew 'and his associates' and declined to become involved in any action against him.

2019

3.24 On 1st February 2019 a further network/safeguarding meeting took place. Matthew's CSDS keyworker had invited him to the meeting as she had mistakenly understood the meeting to be primarily focussed on creating a safety plan for Matthew. The Met Police were present and arrested Matthew for hiding or disposing of weapons used in a murder. The CSDS keyworker expressed concern over Matthew's arrest at a meeting to which her service had invited Matthew because of the potential impact this could have on his trust in CSDS. Plans to obtain a Closure Order, relocate Matthew to temporary accommodation and rehouse him via the Pathway scheme were discussed as was a proposal to apply for possession of his flat if the Closure Order was obtained. Floating support advised the meeting that they would not be allocating a support worker to Matthew because they felt that he presented a significant risk to others.

3.25 On 19th February 2019 a Closure Order consultation meeting took place at which it was agreed that a Closure Order would be pursued. LBC legal services became involved. 'Mental health services' were to be made aware of the possibility that Matthew could be placed in temporary accommodation. CSDS were unable to attend or send a report.

3.26 Also during February 2019 Matthew was seen by his GP when he reported a cough and was worried he might have pneumonia again. The GP noted significant weight loss and follow up chest x-ray and blood tests were arranged. However, Matthew did not have the tests completed or attend a follow up GP appointment.

3.27 On 7th March 2019 a further Closure Order consultation meeting took place at which it was decided to delay applying for a Closure Order as the police advised that Matthew was shortly to be tried for assisting an offender, which was part of a wider murder trial. Legal Services planned to share the information collected so far with a

barrister. A report from CSDS would be required as well as details of complaints from neighbours.

3.28 On 11th March 2019 CSDS supplied a letter in respect of Matthew which stated that he was in treatment for complex mental health/substance misuse issues, that he had significant symptoms of anxiety, panic attacks, ADHD, Bipolar Disorder and PTSD, that he had a significant history of self-harm and attempts to take his own life. The letter went on to state that Matthew had a history of poly-drug use to manage his mental health symptoms, adding that he had an extended period of abstinence following his release from prison in 2013 but had relapsed in 2018 due to reportedly being targeted by drug dealers who were harassing him. The letter further stated that a capacity assessment had not been conducted but that CSDS believed him to be vulnerable due to his mental health and previous risk history. The risks to Matthew were stated to be accidental overdose, relapsing mental state, self-harm and increase in suicidal ideation and physical health deterioration.

3.29 On 2nd May 2019 the Closure Order was served on Matthew, who said he was surprised as he was being cuckooed. The following day, the Judge adjourned the Closure Order hearing until 10th May 2019 to allow Matthew the opportunity to seek legal advice.

3.30 On 7th May 2019 Matthew reported increasing suicidal ideation, feeling overwhelmed, hopelessness and loneliness to CSDS. 'Forensic' and housing issues were documented to be the triggers for these feelings. CSDS contacted Matthew's solicitor. Later the same day Matthew attended the Royal Free Hospital and was assessed by the Mental Health Liaison Team. He presented with a growing conviction that he wanted to end his life by taking an overdose or hanging himself in the context of losing his flat, a court case for his part in a murder and escalating drug use. These factors were documented to be exacerbated by a move to a different part of London where he felt he would lack support networks. The MHLT recommended informal admission to hospital. However, he was subsequently considered not to meet the criteria for hospital admission as it was felt that Matthew would benefit from Crisis Resolution Team (CRT) support in the community where the CRT could liaise closely with CSDS.

3.31 On 10th May 2019 the Closure Order was granted under which Matthew was required to vacate his property by 2pm on 14th May 2019. The Order was to remain in place for 3 months. LBC Legal requested Housing to refer Matthew to the Vulnerability Panel to consider whether possession proceedings were justified in accordance with LBC's Public Sector Equality Duty. If possession proceedings went ahead this would entail serving a Notice Seeking Possession (NOSP). Additionally,

LBC Legal planned to consider the question of whether LBC should make an application to extend the Closure Order in due course.

3.32 On 15th May 2019 Matthew moved to the Shuttleworth Hostel in Hackney, where a room had been reserved for him by Camden's Temporary Accommodation Team. He initially went to the wrong hostel and ended up having to sleep on the street. CSDS facilitated a call to the correct hostel and escorted him to the bus stop and gave him exact details of the Hostel address. He was transferred to a pharmacy and a GP practice in Hackney but continued to receive treatment from CSDS.

3.33 Matthew had little engagement with the Camden Crisis Resolution Team and was transferred to Hackney Home Treatment Team (HTT) who subsequently discharged him following limited engagement.

3.34 On 8th July 2019 the Vulnerability Panel* considered Matthew and endorsed proceeding with possession proceedings alongside Matthew's surrender of his tenancy to enter the Pathway scheme if he agreed to do so. Possession proceedings were considered likely to persuade Matthew to surrender his tenancy.

*The Vulnerability Panel is a multi-agency panel which scrutinises possession proceedings where there is vulnerability. Adult Social Care are not represented on the Panel. It also advises on the management of complex cases which may generate recommendations for additional support, supported housing, sheltered housing or other transfers. All other options should have already been tried with the Panel considered to be a last resort. The Panel meets monthly and the parent body is Camden Council Supporting Communities Directorate.

3.35 By 24th July 2019 it had been decided to seek to extend the Closure Order when it expired in August 2019. On 7th August 2019 the barrister advising LBC advised that they had to have reasonable grounds to make application to extend the Closure Order, and the barrister questioned whether the witness statements previously obtained were sufficient given there had been no further incidents and there was no information about Matthew's current circumstances. The barrister advised that given the Magistrates Court's reputation for leniency and the possibility of Matthew being represented, LBC 'may not be able to get past technical difficulties'.

3.36 On 9th August 2019 the application to extend the Closure Order did not go before the Court as the LBC application was 'not made by way of complaint'. Therefore the Closure Order was not extended. Matthew was advised of the expiry of the Closure Order but requested not to return to his flat until the secure metal door had been removed from the property.

3.37 During his time in the Hackney hostel, Matthew continued to attend meetings with his CSDS keyworker. He reported feeling negative about the hostel environment and was concerned that he would not be able to return to his flat. On one occasion he took a pair of scissors out of his bag and said he wanted to 'slash himself up'. He declined A&E attendance or engagement with HTT. Lack of access to prescribed medication for a number of days following his change of GP may have been a factor in Matthew's distress. When it appeared that he would be unable to return to his flat, this affected his mood but he was documented to be acceptant of this although he was unhappy at the prospect of spending a further three months in the Hackney hostel when an extension of the Closure Order was under consideration.

3.38 Matthew left the Hostel in Hackney and returned to his flat on 14th August 2019. His CSDS key worker had a 'brief discussion around safeguarding himself from his flat being taken over again'. Matthew said he will not let anyone visit him. The provider of the Hackney Hostel has advised the SAR that no issues arose during Matthew's stay other than one minor violation of house rules. Matthew disclosed to his keyworker that he had been attacked by another resident and fought back with an iron bar. Matthew was encouraged to report the incident to the police which he declined to do.

3.39 It was decided to monitor Matthew and if the nuisance/complaints started up again, an application for a new Closure Order could be made. In the meantime possession proceedings were to be commenced.

3.40 During September and October 2019 complaints of noise (primarily loud music) began again. Case notes reflect that the strategy at this time was to try to encourage Matthew to agree to surrender his tenancy and enter supported housing as an alternative to possession proceedings. Matthew had requested a review of the decision to pursue mandatory possession.

3.41 During October 2019 Matthew told his CSDS that he had had no further visits from the young people who took over his flat and that he felt safe at home.

3.42 During December 2019 a neighbour, who had previously made complaints about Matthew, reported that he was still regularly playing excessively loud music, associates of his had been banging his window loudly in the back passage, and he was still taking 'young lads' into his flat as before. It was said that there was often a strong smell of cannabis emanating from the property.

2020

3.43 During January and February 2020 further complaints of anti-social behaviour related to Matthew's flat were received including a GP letter on behalf of a patient who said that the noise emanating from Matthew's property on a daily basis was causing their patient's mental health to deteriorate. LBC began considering a mandatory possession of Matthew's flat. CSDS were consulted and advised that they were surprised to hear this as Matthew was looking well and reporting 'zero activity' in his flat and that he was enjoying the peace and quiet. When his CSDS key worker advised Matthew that his tenancy may be at risk, he stated that he had had no visitors for several months.

3.44 In early March 2020 Matthew told his CSDS key worker that he feared that his neighbours were building a case to obtain his eviction and became tearful at the prospect of losing his home. He said he had begun self-isolating in his flat because of the pandemic. The first England lockdown began on 23rd March 2020.

3.45 From 7th April 2020 Matthew began collecting methadone and diazepam from the pharmacy twice weekly instead of the previous daily supervised consumption of methadone ceased. Matthew's COPD placed him at greater risk from Covid-19 therefore justifying a reduction in his visits to the pharmacy. His methadone dosage had been gradually reduced from 100ml daily to 85ml daily.

3.46 CSDS began contacting patients by telephone and struggled to make contact with Matthew over the following months. His CSDS key worker was only able to speak to him by phone on two occasions following the start of the national lockdown on 23rd March 2020.

3.47 Following the onset of the pandemic, possession proceedings were halted until May 2021.

3.48 Complaints were received from neighbours in May and June 2020 in relation to noise, loud music, drug dealing and different groups of people visiting Matthew's flat in contravention of Covid-19 restrictions. One neighbour expressed the view that Matthew was 'getting away with it' as 'no one was paying attention'**.**

3.49 By early August 2020 the Closure Order process was re-commenced. Community Safety advised Matthew's keyworker and asked her not to inform Matthew due to concerns in respect of his safety as a previous victim of cuckooing. It was documented that there was evidence that his flat had been 'taken over' again and that there was possible cuckooing. CSDS advised that they had had very limited contact with Matthew since the Covid-19 lockdown began.

3.50 It had been intended to apply for the Closure Order on 21st August 2020 but the Met Police were unable to commit to involvement in the process because of operational pressures and the listing of the Closure Order application was delayed until early September 2020.

3.51 Matthew was last seen by the pharmacy on Friday 21st August 2020 when he was advised that he would need to attend CSDS premises on Monday 24th August 2020 to collect his prescription. Matthew also phoned CSDS reception staff on the same day and confirmed that he would attend on 24th August 2020. This arrangement was made so that CSDS could see him and ask him about what was happening in his flat, in particular whether he was being cuckooed and whether 'he would like a safeguarding to be opened for him'.

3.52 Matthew did not attend his appointment with CSDS on Monday 24th August 2020. After Matthew's keyworker consulted with her manager and a Trust service safeguarding adults manager (SAM) the following day, she contacted Community Safety on Wednesday 26th August 2020 to express concern that Matthew had not attended his appointment with CSDS two days earlier. A safeguarding concern was raised on the grounds that Matthew was 'at risk from cuckooing' which CSDS have advised this SAR was a 'miscommunication'. CSDS have also advised this SAR that there was a meeting between CSDS and Community Safety on Wednesday 26th August 2020. There was considerable email communication between partner agencies on that date but it is unclear from the records whether a meeting actually took place or not.

3.53 On Thursday 27th August 2020 CSDS requested the Met Police carry out a welfare check and Matthew's body was found lying on his bed. It appeared that he had been deceased for some time. At the subsequent inquest a witness statement from one of Matthew's neighbours stated that Matthew's flat had been uncharacteristically quiet from Friday 21st August 2020.

3.54 The Closure Order was granted by the Court on 4th September 2020.

3.55 The safeguarding concern raised the day before Matthew's body was discovered was subject to a Section 42 Safeguarding Enquiry and a Safeguarding Adults Planning meeting took place on 5th November 2020 and a Safeguarding Adults Outcome meeting was held on 28th January 2021. Following the latter meeting a referral for a Safeguarding Adults Review was made.

4.0 Contribution of Matthew's family

4.1 Matthew's sister initially agreed to contribute to the review but wished to locate notes she had written about Matthew's contact with agencies before providing her account. After being unable to locate her notes, she decided not to contribute further. She said that she had suffered three deaths in the family, including Matthew's, during the past two years and was worried that she would 'become muddled' without her notes.

4.2 However, during her initial telephone conversation with the independent reviewer, the sister made the following brief comments:

4.3 She said that some men who had been involved in murders locally, turned up at his flat and asked him to hide the weapons they had used. She said that the men were 'horrid people' and implied that her brother had little choice but to comply with their demands.

4.4 She said that Matthew was a drug addict but that she had never seen anyone 'go downhill' so quickly. It is unclear when she felt that her brother had started to go 'downhill' but it appeared she was linking her brother's deterioration to the period when the men she believed to have been involved in the murders were visiting his flat.

4.5 She strongly felt that Matthew shouldn't have been allowed to go back to his flat after the Closure Order expired and that having returned to the flat, no safety net was put in place for him.

4.6 It is unfortunate that it was not possible to have a more detailed conversation with Matthew's sister and explore issues more thoroughly and also obtain some insights into Matthew as a person, but there is no obligation on family members to contribute to a Safeguarding Adults Review.

4.7 When the Safeguarding Adults Review was concluded, Matthew's sister was asked if she would wish to read and comment on the final SAR report. She agreed to this and a copy of the SAR report was mailed her. She subsequently provided written feedback as well as accepting the SAR report recommendations.

5.0 Analysis

In this section of the report each of the terms of reference questions will be answered in turn.

The effectiveness of the single and multi-agency response to 'cuckooing' in this case.

5.1 Matthew first disclosed that he may be a victim of cuckooing to his CSDS keyworker on 15th March 2018. (CSDS have advised this review that the term 'cuckooing' was not used by Matthew or CSDS staff when documenting the concerns he reported during that period) The keyworker documented that drug dealers had taken over his flat and were supplying him with free crack cocaine. Matthew went on to say that the drug dealers had left his flat at his request, but they had since been phoning him constantly in respect of debt of £200 he had incurred which had led him to change his mobile phone.

5.2 The CSDS response was to advise Matthew to contact the police if he felt he was in danger. It is not known how aware the CSDS keyworker was of the dynamics of cuckooing but cuckooing guidance for professionals suggests that the victim may be worried about going to the police for fear of being suspected of drug dealing or membership of the gang which has taken over their home, or fear of repercussions from the gang and fear of losing their tenancy. Camden's current cuckooing guidance – which was first drawn up January 2020 – includes a comprehensive section on 'Reasons individuals may not report cuckooing'. There is no indication that Matthew took the CSDS advice and contacted the police. The advice contained in this cuckooing guidance was not available to CSDS staff at the time Matthew began reporting his concerns.

5.3 The CSDS did not contact any other agency about Matthew's disclosure of cuckooing for over six months (March to September 2018). (CSDS point out that no services contacted CSDS during this period either – which is a point brought out in Paragraphs 5.10 and 5.11) Early sharing of information is regarded as vital to an effective response to cuckooing. One consequence of this was that during this period CSDS was completely reliant on self-reported information from Matthew. Given that Matthew may have been under duress from the individuals who had taken over his flat. The CSDS did not appear to consider that this might be what the current Camden cuckooing guidance describes as a 'rehearsed statement' which he might have been pressurised to make.

5.4 By May 2018 Matthew disclosed that the 'young boys' who had been using his flat to sell drugs had been remanded in custody for murder and that he had been

given the option of testifying against them or going to prison for possession of drugs. He reported having suicidal thoughts although he had not made any plans. He described feeling trapped with no way out. Matthew's perception that he was faced with a choice of either imprisonment for possession of drugs or the potentially dangerous repercussions of testifying against people who had been charged with murder may, or may not, have been accurate but it was clearly a perception that weighed heavily on him and had led to suicidal thoughts.

5.5 Despite the escalating risks which Matthew faced, the CSDS approach continued to place the onus on Matthew to extricate himself from the situation. CSDS continued to encourage him to contact the police or, as time went by, to contact Crime Stoppers which would in theory allow him to report the matter anonymously – although he would presumably have needed to identify the address where the cuckooing was taking place – and to contact his solicitor. During August 2018, Matthew took the initiative and removed himself from his flat and went to stay with his sister for a time. However, CSDS did discuss a crisis plan with Matthew including crisis and emergency phone numbers. He also shared his new phone number at that time.

5.6 CSDS involved the service's safeguarding lead which led to consideration of more appropriate options such as encouraging Matthew to request a transfer of address from the local authority and the involvement of the safeguarding lead appears to have prompted contact with partner agencies – Floating Support, Camden Tenancy Services and Community Safety in late September/early October 2018. The CSDS chronology submitted to this review emphasised that the contact with Floating Support and Camden Tenancy Services were with Matthew's consent. There is no indication that a lack of consent from Matthew had prevented earlier contact with these agencies, but it may have been a factor which influenced the approach adopted by CSDS.

5.7 The London Multi-Agency Safeguarding Policy and Procedures which apply to all London Boroughs including Camden sets out the approach to be adopted when adults are reluctant to give their consent to the sharing of safeguarding information, including the circumstances when professionals can reasonably override such a decision, which include:

- emergency or life-threatening situations which may warrant the sharing of relevant information with the emergency services without consent,
- other people are, or may be, at risk, including children,
- sharing the information could prevent a serious crime,
- a serious crime has been committed
- the risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference (MARAC) referral

5.8 If CSDS did not share information with partner agencies because Mathew did not initially consent, it is not clear from the chronology submitted to this SAR whether they considered the circumstances in which they may be justified in overriding a lack of consent. It is noted that consent is not referred to in the Camden cuckooing guidance. It may be of value to illustrate how the guidance on overriding consent could apply to cuckooing cases.

Recommendation 1

Given that a victim of cuckooing is likely to be subject to exploitation and may be under duress, it is recommended that a section on consent and the circumstances in which it is possible to override absence of consent in cuckooing cases, is included in the Camden Cuckooing Guidance.

5.9 During the period in which CSDS were attempting to support Matthew as a single agency, the cuckooing concerns were discussed at CSDS MDT on several occasions. It is noted that the MDT did not appear to be a very effective forum for discussing the cuckooing concerns. Several actions were proposed but there was no sense of any coherent plan being developed and the MDT appeared to accept assurances that a safeguarding referral had been made when there is no indication that this was the case.

5.10 During this same six month period in which the CSDS attempted to manage the risks to Matthew without making contact with any partner agency, other agencies were also becoming aware of concerns which could have indicated cuckooing:

- Camden Tenancy Services became aware that Matthew reported being unable to purchase food because he was spending £30-40 daily on crack cocaine in January 2018, received complaints of loud music coming from Matthew's flat the following month and were made aware of concerns raised by the Tenants Association over possible misuse of Matthew's flat for the sale of drugs in April 2018. Several of the 'signs to look out for' included in the Camden cuckooing policy were apparent at this stage including 'lack of funds and no food in the house', 'an increase in anti-social behaviour in and around the property' and 'complaints from neighbours regarding drugs and/or alcohol'.

- The Met Police executed a warrant under the Misuse of Drugs Act at Matthew's flat on 16th May 2018 and arrested him for possession with intent to supply heroin, crack cocaine and cannabis. It is understood that there was no one else in the flat at the time. The Met Police chronology provides no

information about the persons arrested and charged with murder who appear to have been amongst those who took over Matthew's flat, so it is not known whether the Met Police had reason to suspect that Matthew was a victim of cuckooing at that time. From the information they have shared with this SAR, it appears that they primarily perceived Matthew to be an offender rather than a victim at that time. From the information provided it is not possible to form a view about whether the people involved in cuckooing Matthew's flat were also behaving in a similar manner in other properties locally and whether the Met Police were aware of this.

5.11 Multi-agency working began in earnest from October 2018 and the MASH was advised that Matthew's flat 'had been taken over as a drugs address'. The MASH involvement at that point was limited to network checks which confirmed that CSDS was the only agency currently working with Matthew. In these circumstances it is assumed that the MASH would have concluded that as the London Borough of Camden (LBC) had a Section 75 partnership agreement with Camden and Islington NHS Foundation Trust (C&I) under which appropriately trained managers within the Trust can act on behalf of the local authority to undertake safeguarding duties, that CSDS – as part of C&I – would lead on any adult safeguarding issues arising from the apparent cuckooing of Matthew.

5.12 Matthew was visited by Camden Tenancy Services and Community Safety and his account of what had been taking place obtained. He was offered temporary accommodation and storage for his belongings by Camden Tenancy Services which it is assumed he declined, possibly because this would have involved Matthew initially moving to temporary accommodation out of borough.

5.13 The first multi-agency meeting took place later in October 2018 where it was agreed to proceed with a full Closure Order with a view to supporting Matthew into the Pathways programme. Meantime safety planning was to be discussed with Matthew by Camden Tenancy Services and Community Safety and it was agreed that CSDS would arrange to see Matthew weekly rather than fortnightly although there is no indication that CSDS actioned this. A referral to the Community MARAC (Multi-Agency Risk Assessment Conference) was considered but did not take place. In Camden the Community MARAC considers complex and/or high risk cases of anti-social behaviour (ASB) and hate crime. Information is shared on a monthly basis between various stakeholders which directs risk planning, risk management, and effective problem solving across partnerships. The practitioner learning event arranged to inform this SAR heard that the Community MARAC was no longer considered a suitable forum to discuss cuckooing cases as they were very complex cases in which it was challenging to assess risk and that the victims were not always perceived as seeking help. By this stage Camden Tenancy Services and Community

Safety had begun to suspect that Matthew was presenting as being more vulnerable than he actually was. The issue of gaining an holistic understanding of the vulnerability of a victim of cuckooing will be discussed later in this report.

5.14 The Chair of the Camden Community MARAC has advised this SAR that cuckooing cases continue to be referred to the Community MARAC and she could not recall any cuckooing cases being rejected at the screening meeting which precedes the full Community MARAC meeting. She added that cuckooing cases can be very complex and sometimes a multi-agency meeting might be held to discuss a cuckooing case outside the Community MARAC where it is only possible to allocate 15-20 minutes to discuss new referrals and around 10 minutes to review previously considered referrals because of the number of referrals received.

5.15 The Camden Cuckooing Guidance states that cuckooing cases may be referred to the Community MARAC or the High Risk Panel to 'support with multi-agency working'. The High Risk Panel provides a multi-agency way of supporting individuals with complex needs presenting with high risk in order to secure positive and person-centred outcomes. The Chair of the Camden Community MARAC expressed some unease about the option of referring complex cuckooing cases to either the Community MARAC or the High Risk Panel – which she said had a stronger housing focus - on the grounds of possible confusion over which pathway to use, duplication and a possible lack of consistency of approach. She said that she planned to discuss this matter with the Chair of the High Risk Panel.

5.16 It seems a little unusual to have the option of referring complex cuckooing cases to two strategic risk management fora. It is unclear what the rationale for this situation is, but it would seem timely for the rationale for being able to refer to either Community MARAC or the High Risk Panel to be reviewed. It is therefore recommended that the rationale for being able to refer complex cuckooing cases to either the Community MARAC or the High Risk Panel is reviewed. Camden Safeguarding Adults Partnership Board may be best placed to bring together the relevant stakeholders to resolve this issue.

Recommendation 2

That Camden Safeguarding Adults Partnership Board bring together relevant stakeholders to review the rationale for being able to refer complex cuckooing cases to either the Community MARAC or the High Risk Panel.

5.17 The Met Police did not attend this first October 2018 multi-agency meeting and were to be asked to feedback intelligence where this was legally possible. The lack of involvement of the Met Police at this stage meant that partners were not fully

aware of the risks faced by Matthew from the people who had been visiting his flat who had since been charged with murders or their associates and nor was it possible to fully assess the risks to professionals visiting Matthew's flat.

5.18 Notwithstanding the multi-agency approach adopted from late September/early October 2018, CSDS do not appear to have shared with partner agencies the fact that when Matthew met his keyworker on 7th November 2018 he had a severe swelling to his right eye which he said was the result of 'getting into a fight'.

5.19 The second multi-agency meeting did not take place until February 2019 – over three months after the first meeting. The reason for the length of this interval is unknown. A Closure Order consultation meeting followed later in February 2019. At this meeting it was confirmed that a Closure Order would be pursued, although these plans were later temporarily put on hold at the request of the Met Police as Matthew was due to be tried for assisting an offender, which was part of a wider murder trial.

5.20 Although there seemed to be quite a strong focus on the Closure Order process, the Closure Order consultation meeting requested a report from CSDS which provided details of his history, diagnoses, the care and treatment provided and the current risks to Matthew which included accidental overdose, relapsing mental state, self-harm and increase in suicidal ideation and physical health deterioration. The risks appeared to be born out when Matthew presented to CSDS and then the Hospital Mental Health Liaison Team with suicidal ideation after the Closure Order was served on him early May 2019. The extent to which these risks and their subsequent manifestation informed decisions in respect of the Closure Order is unclear. There is no indication that any delay in enforcing the Closure Order was considered.

5.21 It is therefore recommended that Camden Safeguarding Adults Partnership obtains assurance that sufficient weight is given to the mental and physical health of the occupants of properties in respect of which a Closure Order is being pursued.

Recommendation 3

That Camden Safeguarding Adults Partnership seeks assurance from the London Borough of Camden Community Safety Department that sufficient weight is given to the mental and physical health of the occupants of properties in respect of which a Closure Order is being pursued.

5.22 Matthew vacated his flat and moved to Shuttleworth Hostel in Hackney on 15th May 2019. Transitions involving vulnerable adults invariably carry risk. The risks to

Matthew were mitigated by his continuing contact with CSDS – which was the agency which knew him best and in which he appeared to place a good deal of trust. Support in respect of his recently deteriorating mental health needs transferred from Camden Crisis Resolution Team to Hackney Home Treatment Team. He was also temporarily transferred to a GP practice and a pharmacy in Hackney which led to some initial problems with continuity of medication. However, the loss of support networks, including his Camden GP practice and pharmacy where he was well known, may have generated feelings of isolation and loneliness. Additionally, the SAR was advised by the manager of the Shuttleworth Hostel that they received no information about Matthew from Camden Housing other than his name. She said that it was standard practice to receive no information about the person's needs or any risks to themselves or others. She added that the Hostel ask new residents if they have any support needs but there is no obligation on them to disclose these. Additionally, Matthew spent the first night after he left his flat sleeping on the street as he initially went to the wrong hostel.

5.23 At the time he transferred to Shuttleworth Hostel, Matthew had recently presented with suicidal ideation, he was using crack cocaine which was said to be escalating and he had been a victim of cuckooing by people who had been charged with murders. Additionally, CSDS had recently assessed him as being at risk of accidental overdose, relapsing mental state, self-harm and increase in suicidal ideation and physical health deterioration.

5.24 The SAR has been advised that there would be two key steps in the process of placing Matthew in the Shuttleworth Hostel. Firstly the Neighbourhood Housing Office identifies a need for temporary accommodation. The Neighbourhood Housing Office then asks the Temporary Accommodation Group to identify a placement from the supply that is available on that day. The SAR has been advised that sometimes there is no temporary accommodation availability and housing officers then ring round hotels with a purchase card. Understandably there appears to be a strong focus on sourcing temporary accommodation against very tight timescales from the supply of temporary accommodation available. On the basis of the lack of information shared with the Shuttleworth Hostel about Matthew's quite complex needs, there appears to be a much less strong focus on sharing information about any support needs the person being placed may have.

5.25 Clearly Shuttleworth Hostel needed sufficient information to support Matthew adequately. It is therefore recommended that Camden Housing review the process by which council tenants such as Matthew are placed in temporary accommodation to identify how information about the person's support needs can be legally shared with the providers of temporary accommodation in order to ensure the transfer is

safe and the accommodation provider has sufficient information to provide adequate support.

Recommendation 4

That the London Borough of Camden Housing review the process by which council tenants such as Matthew are placed in temporary accommodation to identify how information about the person's support needs can be legally shared with the providers of temporary accommodation in order to ensure the transfer is safe and the accommodation provider has sufficient information to provide adequate support.

Consideration

Camden Safeguarding Adults Partnership Board may wish to ask how LBC Housing assure themselves that hostel accommodation is safe and appropriate. This query is prompted by media reporting of deaths in Shuttleworth Hostel rather than information shared by agencies with this SAR and therefore this is presented as a 'consideration' rather than a recommendation to the Board.

5.26 On 8th July 2019 (almost two months after Matthew left his flat following the grant of the Closure Order) Matthew was considered by the Vulnerability Panel which endorsed progressing possession proceedings alongside Matthew's surrender of his tenancy to enter the Pathway scheme if he agreed to do so. Possession proceedings were considered likely to persuade Matthew to surrender his tenancy. As previously stated, the SAR has been advised that Adult Social Care are not represented on the Vulnerability Panel. As previously stated, the Vulnerability Panel is a multi-agency panel which scrutinises possession proceedings where there is vulnerability. It also advises on the management of complex cases which may generate recommendations for additional support, supported housing, sheltered housing or other transfers. There would be benefit in Adult Social Care being represented on the Vulnerability Panel in order to contribute to as holistic as possible a view being taken of the person's needs. (It is not known whether the risks to Matthew highlighted by CSDS and his presentation immediately prior to leaving his flat two months earlier were shared with the Vulnerability Panel).

Recommendation 5

That Camden Safeguarding Adults Partnership Board write to Camden Council Supporting Communities Directorate, which is the parent body of the Vulnerability Panel, to request that Adult Social Care are represented on the Vulnerability Panel in view of the learning from this Safeguarding Adults Review.

5.27 The agencies involved were confident that an application to extend the Closure Order by a further three months would succeed, giving sufficient time to accomplish the plan agreed at the Vulnerability Panel. However, the doubts about whether the application would succeed expressed by the barrister advising LBC casts doubt on whether professional confidence in securing an extension to the Closure Order was fully justified. In the event, no extension was granted and Matthew returned to his flat three months after he left it. There was no plan for this contingency.

5.28 However, the immediate issue which required to be addressed was whether it was safe for Matthew to return to the flat. There is no evidence that a risk assessment was carried out and the extent of safety planning appeared to be a 'brief discussion around safeguarding himself from his flat being taken over again' the CSDS had with Matthew. The lack of a risk assessment and other than minimal safety planning were key omissions by all services (CSDS). It is not known what percentage of victims of cuckooing return to their homes after voluntarily transferring to temporary accommodation or moving out following the grant of a Closure Order, but prior to the victim of cuckooing returning to the property where the cuckooing had taken place, a multi-agency risk assessment should be conducted, and a safety/protection plan put in place. The multi-agency risk assessment should be co-ordinated by London Borough of Camden Housing. Camden's Cuckooing Guidance will need to be updated to reflect this requirement. Camden Housing advise that evaluating risk to a resident in the council's stock returning from temporary accommodation to a home where there appeared to have been cuckooing is standard practice, although no evidence that a risk assessment was conducted by Camden Housing prior to Matthews's return to the flat has been shared with this SAR. Camden Housing also point out that cuckooing is not limited to the Council's housing stock – which constitutes less than a third of the accommodation in the borough. In cases of cuckooing which do not relate to the London Borough of Camden's Housing staff, ensuring a multi-agency risk assessment and a safety/ protection plan will therefore be a joint responsibility for the agencies involved.

Recommendation 6

That, prior to the victim of cuckooing returning to the property where the cuckooing had previously taken place, a risk assessment should be conducted, and a safety/protection plan put in place. The risk assessment should be a multi-agency risk assessment and should be co-ordinated by London Borough of Camden Housing. Camden's Cuckooing Guidance should be updated to reflect this requirement.

5.29 It seems clear that Matthew valued his tenancy, wished to return to the flat and was delighted when he was able to do so. He reported being unhappy in

Shuttleworth Hostel and early in his time there took a pair of scissors out of his bag and told his CSDS keyworker that he wanted to 'slash himself up'. However, his return appeared likely to expose himself to the risks he had previously experienced and he was likely to face some hostility from other residents who may have been hoping that he would not return. It would have been beneficial if a professional had had a conversation with Matthew about his tenancy and discussed what was best for him so that he could make an informed choice.

5.30 Complaints from neighbours began within weeks of Matthew's return and continued in the months leading up to the onset of the pandemic. Some indications of cuckooing came to notice including 'young lads' being in the flat and some evidence of people seeking drugs by banging the window loudly in the rear passage from where drug dealing had taken place previously. Matthew expressed no concerns about cuckooing to his CSDS keyworker and told her that there had been 'zero activity' at the flat and that he was enjoying the peace and quiet. This version of events was at odds with the escalating complaints from neighbours. Matthew may have concluded that sharing accurate information with CSDS about what was happening in his flat could put his tenancy at further risk.

5.31 LBC responded to the complaints from neighbours by reconsidering the mandatory possession of Matthew's flat although possession proceedings were temporarily halted following the onset of the pandemic. The Coronavirus Act 2020 increased the notice periods landlords were required to provide to tenants when seeking possession of a residential property between 26 March 2020 and 30 September 2021 (1). Between 1 June 2021 and 30 September 2021, notice periods were required to be at least four months except in the most serious cases such as egregious rent arrears or anti-social behaviour.

5.32 However, further complaints were received from Matthew's neighbours in May and June 2020 in relation to noise, loud music, drug dealing and different groups of people visiting Matthew's flat in contravention of Covid-19 restrictions. The Closure Order process was re-commenced in August 2020 and it had initially been intended to apply for the Order on 21st August 2020, although this was slightly delayed because the Met Police were fully committed to other demands at that time.

5.33 Matthew's contact with CSDS had been very limited since the onset of the pandemic but they were asked to arrange to see him in-person apparently to ascertain what was happening in his flat. His non-attendance at this appointment with CSDS led to concerns being raised about Matthew's safety and the arrangement of the police welfare check which led to the discovery of his body.

5.34 The circumstances in which the 2020 Closure Order was progressed were very different from when the May 2019 Closure Order was obtained. The pandemic had severely limited Matthew's contact with the CSDS and other agencies. However, little seemed to have been learned from the experience of the May 2019 Closure Order. Whilst applying for a further Closure Order in August 2020 appeared to be fully justified by the complaints from residents, the risks to Matthew did not appear to be explored or considered. The cause of Matthew's death is unascertained but it is worth pointing out that prior to the May 2019 Closure Order being obtained CSDS had advised that Matthew was at risk of accidental overdose, relapsing mental state, self-harm and increase in suicidal ideation and physical health deterioration.

5.35 It is not known whether Matthew was aware that the Closure Order process had recommenced at the time of his death. CSDS had been asked not to inform him by Community Safety. However, in March 2020 he had told his CSDS keyworker that he feared that his neighbours were building a case to obtain his eviction and became tearful at the prospect of losing his home.

5.36 It is concerning that the 2020 Closure Order process appeared to be well advanced without any assessment of the impact on Matthew having been ascertained. It is recommended that where a Closure Order is being considered, current information about the any vulnerabilities affecting the tenant subject to the Closure Order should be obtained.

Recommendation 7

That Camden Safeguarding Adults Partnership Board seeks assurance from the London Borough of Camden Community Safety Department that when a Closure Order is being considered, current information about any vulnerabilities affecting the tenant subject to the Closure Order should be obtained.

5.37 Matthew's disclosure that the people who took over his flat were providing him with crack cocaine which may initially have been 'free of charge' but for which a debt may later have been claimed to be owed, giving the people who took over his flat leverage over Matthew. It is worthy of note that concern has been expressed about an apparent increase in the use of crack cocaine and the impact of this on society. Public Health England (PHE) and the Home Office conducted an enquiry into the increased use of crack cocaine and published their findings in 2019 (2). Amongst the findings which may be of relevance to this SAR are the views of treatment workers and service users spoken to by the enquiry who believed that crack use was responsible for causing mental health problems, paranoia and the tendency to make users more aggressive.

The effectiveness of efforts to safeguard 'Mathew'.

5.38 During the period from March to September 2018 Matthew appeared to be in a very vulnerable position and CSDS would have been fully justified in making safeguarding referrals at several points during this period. There were repeated concerns that he was being exploited by people visiting his flat, that these people may have 'taken over' his flat, that this was exposing him to a range of risks of harm. There was also evidence of self-neglect due to spending most of his income on drugs leaving little for food (In February 2019 his GP noted 'significant weight loss').

5.39 It is clear that CSDS planned to complete a safeguarding referral but there is no indication that this happened.

5.40 There is no indication that cuckooing was 'named' in the CSDS records of their contact with Matthew during 2018 which suggests that, at that time, there may have been a lack of awareness of cuckooing, including the complex dynamics of this form of criminal exploitation. It is not known if there was a cuckooing policy in Camden at that time although, as stated the current Camden Cuckooing Guidance dates only from January 2020.

5.41 Cuckooing is not specifically referred to in the London Multi-Agency Safeguarding Policy and Procedures which apply to all London Boroughs including Camden. The London Multi-Agency Policy and Procedures - which were published in August 2016 and revised in April 2019 - stress the importance of recognising that exploitation is a common theme in nearly all types of abuse and neglect. The policy and procedures identify four categories of sources of risk, one of which is 'community based risk' - which the policy states to include issues such as so called 'mate crime', anti-social behaviour and gang-related issues. Cuckooing is clearly an example of a 'community based risk'. It is assumed that the policy and procedures were written prior to cuckooing becoming such a pressing issue in Camden and elsewhere but it is recommended that the London multi-agency safeguarding policy and procedures are refreshed to include appropriate references to cuckooing. This would also help to draw attention to the fact that cuckooing is a safeguarding issue.

Recommendation 8

That Camden Safeguarding Adults Partnership Board requests that the London Multi-Agency Safeguarding Policy and Procedures are refreshed to include appropriate references to cuckooing. Camden Safeguarding Adults Partnership Board may also wish to promote the London Multi-Agency Safeguarding Policy and Procedures.

5.42 The London Borough of Camden (LBC) and Camden and Islington NHS Foundation Trust (C&I) have a longstanding partnership agreement under Section 75 of the NHS Act 2006 under which appropriately trained managers within the Trust can act on behalf of the Local Authority to undertake adult safeguarding duties. Where this is done, the legal responsibility for safeguarding remains with the Local Authority.

5.43 During the period in which Matthew was believed to be a victim of cuckooing (March 2018 to May 2019) these arrangements did not appear to be working effectively. In particular, CSDS were not recording safeguarding entries on LBC's MOSAIC information system, or only making limited entries - because of longstanding difficulties all C&I staff had in accessing MOSAIC, which is hosted within LBC's IT system. Additionally, insufficient resources appear to have been allocated to safeguarding adult manager roles at that time.

5.44 The SAR has been advised that in 2017 the Section 75 agreement was reviewed in order to consider how to strengthen LBC oversight of the local authority responsibilities undertaken in partnership with C&I and to improve recording and performance in respect of safeguarding. Changes arising from the review included revised arrangements for the deployment of social work staff into C&I and a change in leadership arrangements for social care with the creation of a new role of Head of Social Work in Mental Health (HoSWMH).

5.45 LBC then commissioned an independent review to look at effectiveness of these revised arrangements which took place between November 2019 and January 2020. This independent review identified the need to *inject some pace into* implementation of the 2017 review and identified a number of areas requiring focussed attention, including action to improve governance around the Section 75 agreement, strengthening shared leadership, providing greater clarity on a number of roles and responsibilities and continuing to progress professionally aligned working. Safeguarding was identified as an area of concern by the independent review, although progress was noted in recording – where it had been agreed that safeguarding entries would be recorded on the C&I Carenotes patient information system and data extracted by LBC – and in joint working – in that there was now appreciation of each other's roles between the ASC MASH and the senior service manager responsible for the first point of contact into C&I. The independent review had been advised of planned safeguarding practice audits which the review supported, suggesting a baseline audit followed by a revisit audit six months later to demonstrate improvements in practice.

5.46 The SAR independent reviewer has spoken to the Head of Integrated Learning Disability Services & interim Head of Mental Health Social Work in LBC Adult Social

Care who advised that although progress in responding to some areas of the 2019/2020 independent review of the Section 75 partnership agreement had been delayed because of the pandemic, the initial audit of recording of safeguarding entries on Carenotes had found that the volume of safeguarding recorded had increased significantly although there was room for improvement in the quality of recording, that there is evidence of the involvement of safeguarding adult managers in decision making and evidence of good practice. Some more changes were also due to be made to the safeguarding workflow in Carenotes.

5.47 The CSDS has advised this SAR that they have increased the number of safeguarding adults manager's within the overall service and that the two social workers within the CSDS team are also now involved in reviewing all the Merlin reports and safeguarding concerns which are referred into, and raised within, the service and provide advice and complete Section 42 enquires accordingly.

5.48 It is clear that much progress has been achieved in improving the effectiveness and the recording of safeguarding since the CSDS response to Matthew in 2018/2019. However, it is recommended that Camden Safeguarding Adults Partnership Board seeks assurance that the quality of management oversight of safeguarding issues provided by C&I safeguarding adults managers is of a good standard and that safeguarding adults inquiry officers and safeguarding adults managers have access to SAPB training in order to fully understand their role. The SAR has been advised that C&I staff are unable to access the LBC learning and development portal unless LBC pay an additional licence fee of £120 per person. This is a prohibitive cost given the number of C&I staff who need to access the SAPB training. The SAR has been advised that a solution has been found to this problem in that C+I has agreed to both fund and commission SAM and inquiry officer training for all of their relevant staff and will commission identical courses from the same training company that LBC use so that C&I staff are able to access identical training. Additionally LBC has agreed to release some training slots booked with the training provider to C+I, in order to accelerate the training.

Recommendation 9

That Camden Safeguarding Adults Partnership Board seeks assurance from the Camden and Islington NHS Foundation Trust that the quality of management oversight of safeguarding issues provided by C&I safeguarding adults managers is of a good standard.

Recommendation 10

That Camden Safeguarding Adults Partnership Board seeks assurance from the Camden and Islington NHS Foundation Trust that the training needs of their safeguarding adults inquiry officers and safeguarding adults managers will be met within an acceptable timescale.

5.49 The Camden Cuckooing Guidance does not reflect the extent to which C&I manage safeguarding issues 'in-house' in accordance with the aforementioned Section 75 partnership agreement and so it is recommended that the process to be followed when cuckooing gives rise to safeguarding concerns in C&I is also included in the Camden Cuckooing Guidance.

Recommendation 11

That the process to be followed in the Camden and Islington NHS Foundation Trust when cuckooing gives rise to safeguarding concerns is also included in the Camden cuckooing Guidance.

The application of the Mental Capacity Act in this case and 'cuckooing' cases generally.

5.50 CSDS did not doubt Matthew's capacity although in the letter they prepared to inform the May 2019 Closure Order process, they stated that a capacity assessment had not been conducted. However, a prior capacity assessment had been conducted in June 2018 which had concluded that Matthew demonstrated clear capacity to make decisions in respect of his physical and mental health at that time.

5.51 When assessed by the Mental Health Liaison Team at the Royal Free Hospital on 7th May 2019, Matthew was documented to understand, retain and weigh up information and could repeat it back as part of his deliberation about his treatment needs.

5.52 The Camden Cuckooing Guidance states that assessment of the individual's mental capacity and their need for advocacy would also be considered, adding that referrals will be made for a Care Act advocate or Independent Mental Capacity Advocate, if required.

5.53 The Mental Capacity Act (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational

or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices'. The Code of Practice suggests issues worthy of further investigation might include whether the person is 'easily influenced by undue pressure' (3).

5.54 Matthew may have been influenced by 'undue pressure' by the men who appear to have taken over his flat for a period in 2018. The extent to which this could have affected his decision making does not appear to have been considered by any agency in contact with him at that time. It is therefore recommended that when the learning from this SAR is disseminated, Camden Safeguarding Adults Partnership Board ensures that the potential impact of 'undue pressure' on the decision making of victims of cuckooing is included in learning and development relating to the Mental Capacity Act. Developing a scenario which examines the impact of 'undue pressure' on Mental Capacity could be of particular value.

Recommendation 12

That when the learning from this SAR is disseminated, Camden Safeguarding Adults Partnership Board ensures that the potential impact of 'undue pressure' on the decision making of victims of cuckooing is included in learning and development relating to the Mental Capacity Act. Developing a scenario which examines the impact of 'undue pressure' on Mental Capacity could be of particular value.

The extent to which a person-centred approach was adopted in this case and the extent to which 'Matthew's' 'voice' was heard.

5.55 A victim of any form of criminal exploitation, including cuckooing, may not always appreciate they are being exploited and they may behave in ways which are not seen as being compatible with being a victim. However, those engaged in the exploitative behaviour exercise power over them in a relationship which is not equal.

5.56 Victims of cuckooing can often be perceived as offenders or perpetrators of anti-social behaviour which may mask their vulnerability to an extent. Professionals from different agencies appeared to perceive Matthew in different ways. The Met Police appear to have seen him primarily as an offender, and on one occasion they lawfully arrested him at a multi-agency meeting to which he was mistakenly invited. Camden Housing Services had an understandable focus on the impact of his behaviour on other tenants although the valuable information they were able to elicit from Matthew about his life indicates that they also saw him 'in the round', whilst Community Safety suspected that Matthew may have been presenting as more vulnerable than he actually was. CSDS perceived Matthew to be a victim and sought

to adopt a person-centred approach at all times (The SAR has been advised of a 'Team Around Me' person centred and strengths-based conference approach which is currently being rolled out by Fulfilling Lives in Islington and Camden (FLIC). This appears to be a particularly valuable approach to understanding a client's aspirations and attempting to unblock issues which may be 'getting in the way'.)

5.57 Matthew does not always appear to have been honest in his dealings with agencies. As stated he appeared very committed to retaining his tenancy although he may have lacked insight or empathy into the impact on his neighbours of what was taking place in his flat.

5.58 It is important that professionals from various disciplines do not set too high a bar for their expectations of victim behaviour when it is suspected that they may be being criminally exploited. It is possible that he may have perceived the need to present unequivocally as a victim at times in order to gain the support of agencies who he felt were likely to perceive him in a less sympathetic light.

5.59 During the manager's learning event arranged to inform this SAR, the Closure Order approach adopted in this case was challenged and the question was raised as to whether supporting Matthew to remain in his flat would have been a more 'person-centred' – and possibly more effective – approach.

5.60 If it had been possible to support Matthew to remain in his flat in May 2019 then the deterioration in his mental health which occurred at that time might have been avoided and he would have continued to access local support networks including his GP and pharmacy, both of which knew him quite well. Focussing on supporting Matthew to remain would have avoided the 'move the problem' approach, which in Matthew's case achieved a brief period of no doubt welcome respite for his neighbours but little more than that.

5.61 However, for Matthew to remain in his flat would have required quite intensive support which could have exposed professionals to unacceptable levels of risk from the people who had taken over his flat and their associates and may have been unlikely to have been possible without confidence from the police that they would be able to arrest and detain the alleged perpetrators. Additionally, doubts had arisen over Matthew's ability to maintain an independent tenancy and the Vulnerability Panel had reached the conclusion that he would benefit from a further period in supported accommodation before a further independent tenancy was considered again.

5.62 Overall, the decision to seek a Closure Order or gain Matthew's agreement to a temporary move away from his flat appeared to be justified by the level of risk he

faced from the people who had taken over his flat and their associates, the level of disturbance and intimidation suffered by his neighbours and the risks to professionals from those involved in the cuckooing – some of whom faced charges of murder – and their associates.

5.63 However, there would be value in making the consideration of the option of supporting the victim of cuckooing to remain in their home more explicit in the Camden Cuckooing Guidance. The Guidance certainly implies that supporting the victim to remain in their property is an option in the section 'What to do if you suspect a person is being targeted' but where the options of temporary accommodation and Closure Orders are discussed in the Guidance, it would be of value to stress the importance of also considering supporting the person to remain in their home.

5.64 There is no indication that any agency in contact with Matthew during the period under review considered whether an assessment of his care and support needs was appropriate although Camden Housing, supported by the Vulnerability Panel, carefully considered next steps for Matthew and concluded that he would benefit from supported housing. It seems likely that Matthew had unassessed care and support needs which may have become more apparent if the 'Well-Being' principle of the Care Act had been considered. Well-Being is broadly defined by the Care Act and may relate to any of the following:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society (4)

Recommendation 13

That the section of the Camden Cuckooing Guidance in which the options of temporary accommodation and Closure Orders are discussed stresses the importance of also considering supporting the person to remain in their home.

The extent to which all legal remedies were considered and applied.

5.65 This question has been addressed in the section of this report which considered the Closure Orders and other legal remedies (Paragraphs 5.1 – 5.35).

The overall effectiveness of multi-agency collaboration and information sharing in this case.

5.66 Overall, Camden Tenancy Services, Community Safety and LBC Legal worked effectively together. They appeared to be accustomed to collaborating with each other. These agencies were less successful at working with CSDS who struggled to attend all meetings and appeared to regard the multi-agency meetings to be principally about evicting Matthew from his flat. At times there appeared to be a stronger focus on legal process issues than on the risks to Matthew. Although the multi-agency meetings were described by some agencies as safeguarding meetings, consideration of safeguarding duties did not appear to be prominent and it is unclear of the extent to which partners understood the delegated responsibilities for safeguarding which resided with CSDS. The Met Police appeared to largely adopt the role of consultee and enforcement of the Closure Order rather than active partner in the multi-agency process. It was unclear to what extent partners adopted a strategic overview of all cuckooing activity the principal offenders may have been engaged in.

The impact of Covid-19 restrictions on 'Matthew' and the agencies in contact with him.

5.67 The onset of the Pandemic and the introduction of the first England lockdown had a significant impact on professional contact with Matthew.

5.68 CSDS began offering primarily telephone contact with clients. This significantly reduced the service's contact with Matthew as they struggled to make contact with him by telephone. This had been a recurrent issue with Matthew, particularly during the first period of cuckooing from March 2018 when he had changed his phone because of the frequency with which the people who had previously taken over his flat were ringing him to pressure him into paying a £200 debt. There is no indication that CSDS considered the risk that Matthew - as a previous victim of cuckooing – may be isolated from sources of professional help and support if they attempted to communicate exclusively with him by telephone. Nor is there any indication that CSDS reviewed this method of communicating with Matthew when their contact with him diminished so markedly from April 2020 onwards.

Improvements which have taken place since the death of Matthew

5.69 At the manager and practitioner learning events arranged to inform this SAR, several participants commented upon the steps taken to improve the single and

multi-agency response to cuckooing including the Met Police cuckooing tracker which enables many of the risks faced by a victim of cuckooing to be monitored. As stated the London Borough of Camden published valuable cuckooing guidance in January 2020.

5.70 Camden Specialist Drug Services (CSDS) wish to draw attention to the following changes they have made:

- Safeguarding concerns are now recorded directly on to Carenotes.

- When a CSDS client is temporarily housed out of the borough, CSDS liaise with other boroughs to inform them of any cuckooing concerns.

- When Merlin reports are received these are now routinely added to Carenotes and responded to with service users.

- CSDS have increased the number of SAM's within the overall service. Additionally, the two social workers within the CSDS team are also now involved in reviewing all the Merlin reports and safeguarding concerns that are referred into the service and are raised within the service and provide advice and complete S42(2) enquires accordingly.

- CSDS now has safeguarding MDT meetings for staff to be able to raise new concerns with SAMs, social workers and managers for review. There are also continuous opportunities for concerns to be raised outside of this meeting with managers and/or SAMs.

- The trust safeguarding hub provide a weekly drop in forum for staff to discuss any safeguarding concerns. In addition support and advice are also available outside of the forum.

- CSDS has close relationships and good communication with ASB police, community safety officers and safer neighbourhood teams.

- A C&I Trust wide learning event on cuckooing took place in April 2021 which all staff were invited to and a number of SMS staff accessed and learning cascaded to the team.

- There is attendance by SMS SAM's at the borough wide safeguarding learning and development quarterly groups; Trusts safeguarding SAM interface monthly meetings; quarterly safeguarding in the adult pathway meetings and

the quarterly meetings between adult social care, MASH and SMS interface meetings.

- CSDS has access to legal support via Release for clients, which SMS staff are aware of how to access for service users.

Good practice

5.71 When Matthew initially went to the wrong hostel and ended up having to sleep on the street, CSDS facilitated a call to the correct hostel and escorted him to the bus stop and gave him exact details of the Hostel address.

5.72 The Section 42 safeguarding enquiry, which was initiated shortly before Matthew's body was found and which continued after his death and led directly to the referral for a SAR to be completed, was thorough and inclusive.

6.0 List of Recommendations

Recommendation 1

Given that a victim of cuckooing is likely to be subject to exploitation and may be under duress, it is recommended that a section on consent and the circumstances in which it is possible to override absence of consent in cuckooing cases, is included in the Camden Cuckooing Guidance.

Recommendation 2

That Camden Safeguarding Adults Partnership Board bring together relevant stakeholders to review the rationale for being able to refer complex cuckooing cases to either the Community MARAC or the High Pick Panel.

Recommendation 3

That Camden Safeguarding Adults Partnership seeks assurance from the London Borough of Camden Community Safety Department that sufficient weight is given to the mental and physical health of the occupants of properties in respect of which a Closure Order is being pursued.

Recommendation 4

That the London Borough of Camden Housing review the process by which council tenants such as Matthew are placed in temporary accommodation to identify how information about the person's support needs can be legally shared with the providers of temporary accommodation in order to ensure the transfer is safe and the accommodation provider has sufficient information to provide adequate support.

Consideration

Camden Safeguarding Adults Partnership Board may wish to ask how LBC Housing assure themselves that hostel accommodation is safe and appropriate? This query is prompted by media reporting of deaths in Shuttleworth Hostel rather than information shared by agencies with this SAR and therefore this is presented as a 'consideration' rather than a recommendation to the Board.

Recommendation 5

That Camden Safeguarding Adults Partnership Board write to Camden Council Supporting Communities Directorate, which is the parent body of the Vulnerability Panel, to request that Adult Social Care are represented on the Vulnerability Panel in view of the learning from this Safeguarding Adults Review.

Recommendation 6

That, prior to the victim of cuckooing returning to the property where the cuckooing had previously taken place, a risk assessment should be conducted, and a safety/protection plan put in place. The risk assessment should be a multi-agency risk assessment and should be co-ordinated by London Borough of Camden Housing. Camden's Cuckooing Guidance should be updated to reflect this requirement.

Recommendation 7

That Camden Safeguarding Adults Partnership Board seeks assurance from the London Borough of Camden Community Safety Department that when a Closure Order is being considered, current information about any vulnerabilities affecting the tenant subject to the Closure Order should be obtained.

Recommendation 8

That Camden Safeguarding Adults Partnership Board requests that the London Multi-Agency Safeguarding Policy and Procedures are refreshed to include appropriate references to cuckooing. Camden Safeguarding Adults Partnership Board may also wish to promote the London Multi-Agency Safeguarding Policy and Procedures.

Recommendation 9

That Camden Safeguarding Adults Partnership Board seeks assurance from the Camden and Islington NHS Foundation Trust that the quality of management oversight of safeguarding issues provided by C&I safeguarding adults managers is of a good standard.

Recommendation 10

That Camden Safeguarding Adults Partnership Board seeks assurance from the Camden and Islington NHS Foundation Trust that the training needs of their safeguarding adults inquiry officers and safeguarding adults managers will be met within an acceptable timescale.

Recommendation 11

That the process to be followed in the Camden and Islington NHS Foundation Trust when cuckooing gives rise to safeguarding concerns is also included in the Camden cuckooing Guidance.

Recommendation 12

That when the learning from this SAR is disseminated, Camden Safeguarding Adults Partnership Board ensures that the potential impact of 'undue pressure' on the decision making of victims of cuckooing is included in learning and development relating to the Mental Capacity Act. Developing a scenario which examines the impact of 'undue pressure' on Mental Capacity could be of particular value.

Recommendation 13

That the section of the Camden Cuckooing Guidance in which the options of temporary accommodation and Closure Orders are discussed also stress the importance of also considering supporting the person to remain in their home.

References:

(1) Retrieved from https://www.gov.uk/government/publications/covid-19-and-renting-guidance-for-landlords-tenants-and-local-authorities/coronavirus-covid-19-guidance-for-landlords-and-tenants#section1

(2) Retrieved from https://www.gov.uk/government/publications/crack-cocaine-increase-inquiry-findings/increase-in-crack-cocaine-use-inquiry-summary-of-findings

(3) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

(4) Retrieved fromhttps://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Appendix A

Process by which the SAR was conducted

Camden Safeguarding Adults Partnership Board has four broad options (Options A-D) when deciding which methodology to choose to conduct a SAR. The Partnership Board initially chose option B – 'Learning Together' for this SAR. The 'Learning Together' option envisages that the SAR will be lead reviewer-led, supported by a case group, involvement of practitioners/the adult – if not deceased/family via the case group and 1:1 conversations, no single-agency management reports, narratives of multi-agency perspectives rather than chronologies and the aim of identifying underlying patterns which support good practice and create unsafe conditions.

The methodology ultimately agreed to complete the SAR departed from Option B to an extent. Whilst agencies were not requested to provide single agency management reports, they were requested to provide enhanced* chronologies and 1:1 conversations with practitioners were considered impractical given the range of practitioners and managers who had been involved with Matthew. It was therefore decided to facilitate two learning events for practitioners and managers. An independent reviewer was appointed, and his work was overseen by a case group consisting of the Independent Chair of the Safeguarding Adults Partnership Board and the two co-chairs of the Board's Safeguarding Adults Review Sub Group.

*The chronology template was enhanced to provide additional guidance on the issues which colleagues completing the chronology were asked to comment upon.

Enhanced chronologies were submitted by the following agencies:

- Camden & Islington NHS Foundation Trust (Camden Specialist Drug Services)
- GP Practice
- London Borough of Camden Adult Social Care (Multi-Agency Safeguarding Hub)
- London Borough of Camden Community Safety and Public Protection
- London Borough of Camden Housing Services
- London Borough of Camden Landlord Services
- London Borough of Camden Legal Services
- London Fire Brigade
- Metropolitan Police
- Pharmacy

The independent reviewer wrote a concise case summary which was derived from the combined chronologies. This case summary was circulated to colleagues attending the separate practitioner and manager learning events which were very well attended.

Matthew's sister had initially indicated a wish to contribute to the SAR but ultimately decided not to do so. There is no obligation on family members to contribute to a SAR. However, in a preliminary conversation with the independent reviewer she made some initial comments which have been included in the SAR report.

The independent reviewer conducted follow up conversations with the manager of the Camden MASH in order to better understand the Safeguarding Enquiry commenced shortly before the discovery of Matthew's body, with the Head of Integrated Learning Disability Services & interim Head of Mental Health Social Work in LBC Adult Social Care to better understand the work undertaken to enhance the implementation and monitoring of the Section 75 agreement between the London Borough of Camden and Camden and Islington NHS Foundation Trust and with the Chair of the Camden Community MARAC.

The first draft of the SAR report was presented to representatives of the agencies which contributed to the review. Following the helpful feedback received from that group a second draft was prepared and presented to senior managers from the agencies which contributed to the review. Following their helpful feedback a third draft report was prepared. The third draft was discussed with senior management of the Camden and Islington NHS Foundation Trust before this final SAR report was written and presented to Camden Safeguarding Adults Partnership Board.

Glossary

Best Interests - if a person has been assessed as lacking mental capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Cuckooing is a form of criminal exploitation. It is the term used when a person alleged to be causing harm uses the house of an adult at risk for movement of cash proceeds, to store and/or supply drugs, weapons and other criminal activities.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to take action themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

Section 42 Care Act 2014 Enquiry by local authority
This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-Neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings, lack of self-care to an extent that it threatens personal health and safety, inability to avoid harm as a result of self-neglect, unwillingness to seek help or access services to meet health and social care needs and includes behaviour such as hoarding.