



ROCHDALE BOROUGH SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW CONCERNING 'Tom'

OVERVIEW REPORT

Final

27.02.2017

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This report is the property of Rochdale Borough Safeguarding Adult Board (RBSAB).

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1. INTRODUCTION

1.1 The principal people referred to in this report are:

Tom	61 years	Victim	Male White British
Lynsey		Former partner of Tom	
Male A	42 years	Perpetrator	Male White British
Address One	Home Address of Tom and scene of homicide		

Note: Tom and Lynsey are pseudonyms.

- 1.2 This case is about Tom who was found dead at Address One on a day in spring 2016. Tom was a kind and caring man who once held a responsible position working within the charitable sector. Unfortunately, Tom began to misuse alcohol and his lifestyle changed. He lost his career, his long-term relationship ended and he began living on his own at Address One.
- 1.3 Tom began to associate with a group of men and women who had a similar lifestyle to his own and alcohol was a common bond. These people frequented Address One, some with the permission of Tom but others were not welcome and abused Tom's hospitality. There is evidence they stole personal possessions from him and money from his bank account.
- 1.4 Tom was well known to statutory and voluntary agencies. He was well liked by those professionals who dealt with him. However, Tom's lifestyle and the lifestyle of others who frequented Address One attracted notoriety. Agencies suspected Tom was being exploited by these associates; a safeguarding alert was made and two multi-agency strategy meetings were held.
- 1.5 Although some actions were taken by agencies, Tom was found dead by Lynsey. Greater Manchester Police launched a homicide enquiry and arrested Male A, a man who had recently started to frequent Address One. He was charged with Tom's murder and pleaded guilty when he appeared before a Crown Court in autumn 2016. Male A received a term of life imprisonment and must serve a minimum of 21 years in prison.
- 1.6 The police senior investigating officer said: "This was a senseless killing of a kind and generous, vulnerable man. The injuries inflicted by Male A were sadistic and unnecessary. Tom was a good man, but people took advantage of him. Male A was a violent individual and one of those people who took advantage of Tom's good nature and ultimately killed him".
- 1.7 Lynsey felt that the following quotation from Tom's funeral service was a good description of him;

'He was a talented, creative, decent, kind, gentle, stubborn, mischievous, generous, clever, articulate, colourful and extraordinary man who loved people and would go without himself to help others.'

2. ESTABLISHING THE SAFEGUARDING ADULT REVIEW

2.1 Decision Making

2.1.1 The Care Act 2014 [1st April 2015] introduced new responsibilities for local authorities and safeguarding adults' boards. S44 of that Act¹ requires a safeguarding adults' board to arrange for a review of a case involving an adult in its area with needs for care and support when certain criteria are met.

2.1.2 On 20.05.2016 the Rochdale Borough Adult Safeguarding Board RBSAB Safeguarding Adult Review Screening Panel met and agreed that the case met the criteria to commission a safeguarding adult review. The chair of the RBSAB agreed with this decision on 02.06.2016.

2.2 Safeguarding Adult Review Panel

2.2.1 David Hunter was appointed as the Independent Chair on 27 June 2016. He is an independent practitioner who has chaired and written previous adult safeguarding reviews and child serious case reviews, domestic homicide reviews and multi-agency public protection reviews. He has never been employed by any of the agencies involved with this Safeguarding Adult Review and was judged to have the experience and skills for the task. He was supported in the task by Paul Cheeseman, also an independent practitioner who was the author of the report.

2.2.2 The first of three panel meetings was held on 17.08.2016. One of these comprised a half day's systemic review. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

2.3 Panel Membership

2.3.2 The panel comprised representatives from agencies involved in the care of Tom and the investigation of the allegations. A list of panel members appears as Appendix B. A panel of key practitioners was assembled for the systemic review and the list of those members also appears at Appendix B.

2.4 The Safeguarding Review Process

¹ The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

2.4.1 The local process for conducting Safeguarding Adult Reviews (SAR) is set down in a protocol issued by Rochdale Borough Safeguarding Adults Board in October 2015 (amended April 2016). The method used for the SAR is described in more detail in section 5.1 post.

2.5 Agencies Submitting an Analysis of Key Events

2.5.1 The following agencies submitted information concerning key events;

- Rochdale Borough Council Adult Care and Support (RACS)
- Rochdale Boroughwide Housing (RBH)
- Greater Manchester Police (GMP)
- Petrus Community²
- Pathways³
- Stepping Stones⁴
- Pennine Acute Hospitals NHS Trust
- Heywood, Middleton & Rochdale Clinical Commissioning Group

2.6 Notifications and Involvement of Families

2.6.1 During the review process, meetings have taken place with Lynsey and with members of Tom's family (his sister, brother-in-law and niece a half-sister). The review panel were also provided with copies of Lynsey's statement provided to the homicide enquiry and both Lynsey and Tom's family provided copies of their victim impact statements⁵ which were read to the court when Male A was sentenced.

2.6.2 Lynsey and Tom's family provided important background information about Tom which is included within section three of this report. Lynsey and the family had the following questions they asked the review panel to consider;

1. When the three professionals made their last visit to address one, Male A was in the flat. The family believe he was in breach of his bail and there was a warrant for his arrest. Why was his background not checked?
2. Why did no professionals revisit Tom in the days after that joint visit?

² The Petrus Community is a registered charity and company limited by guarantee that provides residential and day support services for the homeless.

³ The commissioned alcohol and drug service for the area.

⁴ Provides Housing and Support in the area.

⁵ A victim impact statement is a written or oral statement made as part of the judicial legal process, which allows crime victims the opportunity to speak during the sentencing of their attacker or at subsequent parole hearings.

3. Why did none of the professionals contact Tom's family in Liverpool when trying to solve his problems?
4. Why weren't Lynsey's views sought when trying to persuade Tom to move from his flat?
5. Why did the court or judge that dealt with Male A grant him bail a few days before he killed Tom?

2.6.3 Lynsey and Tom's family were provided with copies of the report and their views were taken into account in preparing the final versions which were shared with them before publication.

2.7 Terms of Reference

2.7.1 The purpose of a Safeguarding Adult Review is neither to investigate nor to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- Review the effectiveness of procedures of both multi-agency and individual organisations;
- Inform and improve local inter-agency practice;
- Improve practice by acting on learning and developing best practice;
- Prepare or commission an overview which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future actions.

Timeframe under Review

2.7.2 This Safeguarding Adult Review covers the period between 02.12.2015 and the date of Tom's death.

3. BACKGROUND INFORMATION

A Pen Picture of Tom

- 3.1.1 Tom was born and raised in the Crosby area of Liverpool. Tom has a sister and four half-sisters. He was educated at a local primary school and at Liverpool Polytechnic. At one time he wanted to be a helicopter pilot however he went to work for a national food manufacturer instead. Eventually he moved to the Manchester area and attended college in Oldham. Tom's family say he was timid and could not see anything bad in people.
- 3.1.2 It was while he was in Oldham that Tom lost his father. His family say this marked the start of Tom's unhealthy relationship with alcohol. They say he would have been about twenty-seven years of age when this happened. Lynsey met Tom at a party in Manchester in 1977. She says he was a heavy drinker of alcohol when she met him. They formed a relationship to which they were both committed for the next twenty-seven years although they never married. The couple bought a house in Oldham where they lived. She says that Tom was a 'brilliant father figure' to her son. Tom did not have any children of his own.
- 3.1.3 Lynsey says Tom was an intelligent, creative and caring man. The family also echoed those thoughts. These facets of Tom's personality are something that is repeated by other people who knew Tom including many of the professionals who had contact with him. Tom had several jobs. In the 1970s he worked on adventure playgrounds before joining a local authority in the Manchester area and managing play centres for children. He then became the director of a Manchester charity that recycled and sourced materials for artwork, play and youth projects.
- 3.1.4 During his time with the charity Tom received a conviction for driving a motor vehicle while over the prescribed limit and received a twelve-month driving ban. In 1998 he was suspended from his job after being found drunk at his workplace. Lynsey said Tom was distressed and ashamed and this caused him to drink alcohol more heavily. He received a further conviction for driving a vehicle over the prescribed limit and was given a four-year driving ban and a community service order. The work based investigation concluded in 1999 and Tom then lost his job.
- 3.1.5 Lynsey says Tom's self-esteem was at an all-time low, he became extremely depressed and their relationship suffered. The couple separated and Lynsey took a tenancy at Address One. Eventually Tom moved into the address however Lynsey found it difficult to cope with Tom's addiction; Tom took over the tenancy in 2000 and Lynsey moved to a property in Yorkshire. The couple remained close; Tom visited Yorkshire and resided there for extended periods. Lynsey says she still loved Tom although she made it clear he needed to give up alcohol for good.

- 3.1.6 Tom's family say this was about the last time they saw Tom. His sister recalls having contact with Tom around 2000. She said he was drinking and she asked him to come and stay with her and her husband in Liverpool. He did not take up that offer and the family felt this was because Tom was a very proud person.
- 3.1.7 Tom undertook an alcohol detoxification programme and remained sober for three years. During this time became involved in creative projects at a local college and undertook training so that he could help people with restricted mobility on days out. Lynsey says he became very well known to older people in the area where they lived.
- 3.1.8 Sadly Tom started misusing alcohol again and Lynsey says his drinking 'spiralled out of control'. In 2013 the couple separated and Tom returned to Address One although they remained in regular contact. Lynsey says that Tom's caring nature meant that he often gave away things that were meant for him, for example food from a foodbank. Lynsey considered that because he was kind natured this made him vulnerable.
- 3.1.9 About twelve months before his death, Tom received a payment of seven thousand pounds from one of his pensions. Although Lynsey looked after some money for Tom, most of it (about four thousand pounds) was spent on drink by Tom. Around this time he formed a relationship with a woman in Rochdale. Tom told Lynsey this woman and her friends would purchase alcohol using his bank card. Lynsey felt that Tom was being exploited and she spoke to a social worker about her concerns.
- 3.1.10 Tom neglected his welfare and did not buy food. Lynsey bought food which she gave to Tom: he said this was pointless as the people he was associating with would take it. He said they were 'vultures'. Lynsey took comfort from the fact that Tom attended Petrus where he received support such as breakfast. Lynsey trusted Petrus and felt they would keep her updated about Tom and reassure her that Tom was safe and well.
- 3.1.11 In her statement to the police Lynsey outlined how Tom's misuse of alcohol impacted upon his health. He was a heavy smoker, very thin and frail and she felt that within the last year of his life there were signs that self-neglect had crept in. Tom also had some mental health issues and he was diagnosed with depression for which he took prescribed medication. He was also addicted to pain killers. Tom told Lynsey that he had been diagnosed with Korsakoff's syndrome⁶ because of his misuse of alcohol. There was no evidence from the medical information seen by the review panel that indicated to a formal diagnosis of this condition. In 2015 Tom fell into a bonfire sustaining burns that required him to spend ten days in hospital.

⁶ Korsakoff's syndrome is a form of Alcohol-related brain damage (ARBD). This is a brain disorder most commonly caused by regularly drinking too much alcohol over several years. Korsakoff's syndrome shares many characteristics with dementia.

- 3.1.12 Lynsey regularly visited Tom at Address One which she described as 'not a nice place to be in, it was dark, poor and dirty' however Tom declined her offers to clean it. Lynsey said there were often other people at the address and sometimes they would ask Tom for money. She saw a list of loans Tom had made to these people and some amounts were over £100. Tom told Lynsey that these people who visited his flat took his things. For example his record collection was taken and sold to a local shop and other personal items such as colouring books and knitted hats had been taken. Lynsey advised Tom to tell the police: he said he was not a grass and was afraid of a 'getting a kicking'.
- 3.1.13 Tom told Lynsey that he was scared of the people coming to Address One. He was distressed and would cry about how afraid he felt. Lynsey recognised that Tom was a vulnerable adult and it was these concerns and Tom's behaviour that caused her to speak to the Adult Safeguarding Team at Rochdale Council on 2.12.2015 to see if any help could be provided (see paragraph 4.1.3). Lynsey also spoke to the concierge at Address One and asked them not to let anyone in without checking with Tom first.
- 3.1.14 Shortly before he was killed, Tom was due to receive a substantial lump sum from a second pension. This required Tom to complete an application form. Lynsey said this was complex and she did not believe Tom had done this. She said he had a bad habit when intoxicated of telling everyone he encountered that he was going to receive a lot of money. Lynsey said she repeatedly told Tom not to do this as she was concerned he would attract attention from the wrong people and be exploited further.
- 3.1.15 Lynsey last saw Tom about three weeks before his death and she last spoke to him a few days later by telephone. Tom rang and said he needed some money as his bank card had been taken and £100 withdrawn from his account. Lynsey could hear someone in the background trying to rush him to end the conversation. Lynsey told Tom to report the matter to the police. A police officer later contacted Lynsey and gave her a crime number as a reference. She told the officer how worried she was about Tom and that she believed he was being exploited.
- 3.1.16 A few days after that telephone conversation Lynsey visited Address One and found the badly beaten body of Tom inside the flat. The police were alerted and a homicide enquiry was undertaken that resulted in the arrest and conviction of Male A. Lynsey later provided a victim impact statement to the police, a copy of which was supplied to the Safeguarding Adult Review. It is clear from this statement that Lynsey had suffered, and continues to suffer physically, emotionally and psychologically as the result of finding Tom's body and the circumstances in which he was killed. His family also felt emotionally close to Tom and are similarly distressed about his death and the way in which he was killed.

Background Information-Male A

- 3.1.17 There was little information available to the Safeguarding Adults Review Panel about the history and background of Male A. When he killed Tom, Male A was resident in supported accommodation in the Rochdale area.
- 3.1.18 When he appeared for sentencing for the murder of Tom, Male A was also sentenced for assaults on two other victims which took place in the Greater Manchester area. On 26.12.2015, Male A had assaulted a man in whose house he was staying in, causing the victim a black eye and a cut/bruise to his nose.
- 3.1.19 On 30.12.2015, whilst at another man's house, Male A had assaulted his next victim which caused a fracture to his nose and facial cuts and bruises. Due to his level of intoxication, Male A claimed to have virtually no recollection of either offence.
- 3.1.20 Male A had been remanded in custody for these offences and was released on conditional bail on 15.04.2016. Male A killed Tom sometime prior to 02.05.2016. When he was sentenced for the murder of Tom, Male A received sentences of 2 months and 18 months respectively to run concurrently for each of these offences.

4. SEQUENCE OF NOTABLE EVENTS

4.1 Introduction

4.1.1 For panel discussions, a tabular chronology was produced detailing over 128 professional contacts concerning Tom. It was felt that a repetition of that document within the report would overwhelm it and might obfuscate the key learning the panel wished to draw from its work.

4.1.2 Therefore, to improve clarity and focus the notable events have been condensed into tables. Table one details those events that occurred before the time frame of the review and table two details those events during the time frame of the review. Those events cross referenced within the table are analysed in more detail at section 5 of this report.

Table 1	
Date	Notable Events Before the Time Frame of the Review
Various Dates	There are entries recorded by the GP in the records outside the suggested timeframe. There is evidence of notifications of numerous attendances at A&E departments following alcohol related injuries.
July 2014	A safeguarding referral was made to Adult Care from his ex-partner Lynsey around Tom's drinking associates financially abusing him; however, over the summer of 2014 he declined support from Adult Care. Lynsey reported Tom had spent all his money which then negated the abuse.
Sept 2014	Lynsey contacted Adult Care again and reported that Tom was under pressure from the drinking gang to hand over money. It was noted that Petrus were involved in his case.
Nov 2014	A Social Worker visited Tom but he wasn't in. Following a letter from Adult Care, Tom came to the Council Offices at Riverside which led to a referral to Shelter for floating support.
March 2015	Adult Care closed the case.
May 2015	A new referral was received to Adult Care from Stepping Stones regarding Tom's vulnerability which led to a request to his GP for a dementia assessment. It was noted that other agencies were involved and he was choosing to socialise with other people who put him at risk
June 2015	His case was again closed to Adult Care.
July 2015	Stepping Stones report to Adult Care that Tom was discharged without an assessment. Adult Care agreed to complete an assessment. Assessment completed. No new needs from last assessment. Tom now has an allocated worker at Pathways who is looking at rehab / detox for him out of Rochdale, Tom is noted to be very keen to participate in this. He continues to self-neglect personal care tasks and meals however; he does not feel rehabilitation service is appropriate as he does not wish to wait in for carers. He accepts that he is still hoarding in his property. He has no intention to move and does not wish to consider sheltered accommodation. He reports he is still falling and has poor mobility, he states this is because of his alcoholism. Tom agreed to a GP medication review, a Mental Health review (low mood , anxiety), and a referral to Your Voice advocacy to support to

	appointments etc., as Stepping Stones cannot support with all appointments as he now has a lot at Wythenshawe hospital for his burns, and would forget to attend without support. He also agreed to a home fire services assessment due to risks about his property being cluttered, his smoking, drinking alcohol and sleeping on the settee. Tom agreed to continue to engage with alcohol services and stepping stones support so it was agreed that there was no further role for Adult Care once the referrals were made.
19 August 2015	GP recorded that Tom is receiving Detox and mixing with the wrong people.

Table 2		
Date	X-Ref to Section 5	Notable Events During the Time Frame of the Review
02/12/2015	Event 1 Section 5.2	KP1 from Stepping Stones makes an adult safeguarding referral about Tom.
07/12/2015		KP1 provided more information about Tom to RACS.
08/12/2015		Tom failed to attend an interview at a Housing Office.
08/12/2015		Letter hand delivered to Tom advising of continuing reports about nuisance.
10/12/2015	Event 2 Section 5.3	Final warning interview with Tom concerning anti-social behaviour at Address One.
16/12/2015		RBH joiners ushered from Address One by Tom when they attend to undertake work.
18/12/2015		KP6 visited Address One and spoke to Tom. He said individuals have been staying at his property against his will for approximately a month but these have now been removed following him contacting the police. Tom was quite irate and said he was not moving to other accommodation. Tom made threats about the people who had been staying at address one and said would arrange for these people to be killed.
02/01/2016	Event 3 Section 5.4	Tom was brought to accident and emergency at Royal Oldham Hospital by ambulance after a fall while intoxicated.
05/01/2016	Event 4 Section 5.5	First multi-agency strategy meeting held to discuss the concerns about Tom.
05/01/2016	Event 5 Section 5.6	KP5 and PC1 visited Address One and spoke with Tom. He was agitated as the conversation progressed and the officers came away.
06/01/2016		A pre-court intervention was arranged however Tom was too drunk to engage.
06/01/2016	Event 6 Section 5.7	Tom was brought to accident and emergency by ambulance after Tom was found on the floor of the Rochdale Bus Station with a cut to his eyebrow.
07/01/2016		An enforcement and income visit was made to Address One. Tom was not in and a calling card was left.
13/01/2016		KP6 visited Address One to conduct a welfare check and discuss Tom's attendance at a meeting the following day. Tom was not in. A note was posted informing of the visit and reminding him of the meeting.

14/01/2016		Tom failed to attend a meeting with council officers, and later, KP8.
14/01/2016		KP6 visited Address One, there was a note on the door addressed to a male name (not Male A) with mobile number to contact.
15/01/2016		A letter was sent by KP8 asking Tom to make another appointment to see her.
19/01/2016		A complaint was made by a neighbour regarding loud music and TV at Address One.
20/01/2016		KP8 spoke to Tom and gave him an appointment to see her on 27.01.16.
21/01/2016		A meeting is arranged for 28.01.16 to try and set up a repayment plan for rent arrears for Tom. He was asked to attend.
21/01/2016	Event 7 Section 5.8	PCSO1 Police submitted an intelligence report concerning a visit they made to Address One on 21.01.2016 and a conversation with Tom.
24/01/2016		GMP passed information to RBH that Tom had left Address One due to feeling unsafe.
25/01/2016		Info from Petrus – Tom had attended their office. Admitted he had had “idiots” in flat and stated he is sick of them. Stated he will engage with Pathways and rehab and wants to move out of the area.
27/01/2016		Tom did not attend appointment with KP8
28/01/2016	Event 8 Section 5.9	Tom visited Rochdale Council Offices for meeting with KP6. He was heavily intoxicated and had a facial injury. An ambulance was called and he was taken to hospital.
29/01/2016		KP6 informed KP8 that meeting above could not go ahead. KP8 wrote to Tom offering him another appointment.
09/02/2016	Event 9 Section 5.10	An application for Possession of Property for Address One has been made to the Courts.
11/02/2016		Tom did not attend an appointment with KP8. KP6 informed.
16/02/2016		KP1 sent e mail to KP6 advising that Tom attended Petrus today and appeared unwell, as well as being intoxicated. He expressed concerns and was very worried that unwanted persons were going to call on him later and want to stay at his flat. Tom did not give names. KP1 to contact police for welfare check.
19/02/2016	Event 10 Section 5.11	KP6 met with Tom at Petrus re housing situation, arrears and general circumstances. Tom refusing to move to supported accommodation and wants to remain at Address One.
19/02/2016		Joint meeting taken place with KP6, KP12 and Tom at Petrus to discuss his housing situation. Tom does not want to move and is aware of the situation and is willing to engage with RBH regarding the arrears. E-mail sent to RBH to update and make request for court proceedings to be delayed.
25/02/2016	Event 11 Section 5.12	KP5, KP2 & PCSO1 make evening visit to Address One and speak with Tom. One other male present (he was not named as Adult A).
02/03/2016		Info from concierge that Tom had written on front door with marker pen.
04/03/2016	Event 12 Section 5.13	Info from police. PCSO1 spoke to Tom about supported accommodation. He said he doesn't want it. Said he has

		two friends staying, a male and female (the male's name was not recorded as Male A).
08/03/2016		KP6 & KP12 visit address one and meet with Tom to discuss proposed meeting with KP13. Also at property was a woman. Tom described the couple currently staying with him as his friends and that he was happy with them at the property, he said they are preventing other "idiots" from attending.
08/03/2016		KP6 telephoned KP8 to report that Tom was drinking very heavily. She was informed that RACS, Petrus and RMBC are all working together to try and maintain the flat. KP8 wrote to Tom offering him another appointment for 17.03.16.
11/03/2016		Tom failed to attend Petrus yesterday as planned but he attended Riverside this morning to request to speak to KP6. He said he was unable to attend the meeting on 10/3/16 due to ill health. In relation to safeguarding Tom said the couple that have been staying at Address One have now moved out. He said there are no unwanted persons attending his property on a regular basis and that he feels safe in his flat, he mentioned the support he receives from the concierge and the police regarding this which he is grateful for. RBH informed and court proceedings will be delayed.
15/03/2016	Event 13 Section 5.14	Tom visited Petrus and completed Employment and Support Allowance Medical Questionnaire form. An appointment was made with Tom to complete an Income and Expenditure form.
16/03/2016	Event 14 Section 5.15	Tom attended an appointment with his GP and was encouraged to reduce alcohol intake.
17/03/2016		Tom did not attend his appointment with KP8. He was sent a letter asking him to call in to book another appointment.
21/03/2016	Event 15 Section 5.16	Tom attended appointment at Petrus regarding Employment and Support Allowance Medical Questionnaire and Sanctions.
22/03/2016	Event 16 Section 5.17	Tom attended an appointment with KP8 to discuss drinking. He disclosed theft of his bank card and money taken from his account.
23/03/2016	Event 17 Section 5.18	Second Strategy Meeting to discuss concerns regarding Tom. The meeting was told about the theft of money from Tom and that he was due to receive a large amount of money.
23/03/2016	Event 18 Section 5.19	Tom presented at Urgent Care Centre Rochdale Infirmary. He reported that he had fallen earlier that day but he couldn't recall when, neither could he remember any details with regards to the mechanism of the fall.
04/04/2016	Event 19 Section 5.20	CCTV staff email KP15 to advise that Tom is allowing "young people" into his flat.
05/04/2016		KP16 tried to contact Tom by telephone. Contact could not be made as his phone did not work. KP16 spoke to KP3 who said Tom continued to have people in his flat and was using alcohol. There is now a possession order on the property.
12/04/2016		KP1 called Tom to arrange appointment, No answer. Voicemail left.
13/04/2016		KP2 called Tom. No answer, voicemail left.
13/04/2016		KP6 rang KP8 to say police had been calling around to see

		Tom to discuss whether he wanted to report money being stolen from his account. He has never been in when they have called round. KP8 has an appointment with him tomorrow and will discuss then.
13/04/2016	Event 20 Section 5.21	KP3 attempted to locate Tom with regards court date and lack of engagement.
14/04/2016		Tom did not attend his appointment with KP8.
14/04/2016		KP2 completed unplanned visit to Address One. No answer.
18/04/2016		KP2 contacted KP12. Tom still does not have a payment plan in place for his arrears and service charges. RBH now seeking possession of Address One.
20/04/2016		KP1 completed unplanned visit to Address One. There was no answer and so a message was left requesting Tom to make contact if support still required and a referral for supported accommodation was needed.
20/04/2016		KP8 wrote to Tom asking him to get in touch to make another new appointment.
21/04/2016		PCSO2 sent e mail to KP6 informing him Tom reported his bank card stolen and a further £400 being taken. PCSO2 visited him and Tom did not want to provide names of provide names of suspects. PCSO2 discussed previous allegation of £250 being taken. Tom again was unable to provide relevant information. He was very concerned about being seen as a "grass". Tom said "the idiots have been round again and I've let them in".
26/04/2016		KP5 told KP3 they had not seen Tom for a while but he had been seen vomiting in the lift.
26/04/2016	Event 21 Section 5.22	Tom attended an appointment with Petrus regarding his private pension and money going missing from his bank account and to discuss up and coming Court appearance.
27/04/2016		Tom attended appointment with Petrus and contact was made with his bank.
28/04/2016	Event 22 Section 5.23	Tom visited the Hub in the company of Male A.
28/04/2016	Event 23 Section 5.24	KP5, KP2 and PCSO visit address one to carry out evening visit and speak with Tom and Male A.
28/04/2016		Turning Point sent letter to Tom requesting that should he require any further support to contact the service.
29/04/2016		KP8 tried to phone Tom today but his device was switched off. She texted him asking him to get back in touch
02/05/2016		Tom was found deceased in Address One by Lynsey.

5. ANALYSIS OF KEY EVENTS

5.1 Method

- 5.1.1 The Safeguarding Adult Review panel adopted the Hybrid System. This involved looking at key events to gain an understanding as to how decisions were made and to explore areas where agencies can improve practice.

5.1.2 The Safeguarding Adult Review panel analysed the notable events (Table 1) and from this sequence they identified which events were considered as the key events. Each agency was then supplied with a template⁷ and asked to analyse each key event and identify the following:

- Event date & time;
- Event i.e. what actually happened?
- Policy/Protocol/Practice Standard/Compliance i.e. what should have happened (including by whom);
- Relevant supplementary information;
- Missing information & gaps, omissions & breaches;
- Notable good practice;
- Contextual information & contributing factors to the above.

5.1.3 A learning event was then held and the practitioners who worked with Tom were invited. A structured and facilitated discussion took place around each of the key events. This was an opportunity for the groups of practitioners to think collectively and to enquire into the key events in a safe environment. The following areas were considered:

- What worked well in this case and why?
- What did you/your agency do that you/your agency should have/not have done? Why?
- What could have been done better?
- What needs to change?

5.1.4 This section of the report now looks in detail at each of the key events, bringing together the information provided by agencies and the information gleaned from the learning event.

5.2 Key Event One

Receipt of Safeguarding Alert 2 December 2015

What Happened?

5.2.1 On this date a safeguarding alert was received by Rochdale Adult Care Services. This alert had been forwarded by KP1 who received it in person from Lynsey. The alert referred to a previous assessment for Tom in 2014 (see

⁷ See Appendix D

table one). The alert contained the first and second name of Lynsey. There were concerns about Tom falling under the influence of alcohol; that on a 'couple' of occasions he had been the victim of a mugging; that he and his associates had been trying to light a fire in a local park while intoxicated.

- 5.2.2 The referral also included information that Tom was allowing people to stay in address one who were referred to as his 'carers'. Another associate (a known sex worker) had taken Tom's fob which allowed her access through the security system of the address. Lynsey said that Tom had his bank card stolen and that items, including records, had also been stolen from Address One.
- 5.2.3 KP1 followed up the safeguarding alert with a telephone call to Rochdale Adult Care on 07.12.2015 and provided further relevant background information. Consequently, the case notes at Rochdale Adult Care are comprehensive and contain useful background information about Tom including; how to meet with him; his housing position; his alcohol dependency; his finances and what Tom wanted.

What should have happened? (Policy/Protocol/Practice)

- 5.2.4 Action was taken in line with Safeguarding and Anti-Social Behaviour Policy, Protocol and Procedure.

Missing Information & gaps, omissions and breaches

- 5.2.5 On reviewing this event, Rochdale Adult Care identified a gap in the case notes. They made reference to neither a Mental Capacity Assessment nor a Care Act assessment⁸.
- 5.2.6 The reasons for questioning if a person has capacity to make a decision at a particular time may be that⁹:
- The person's behaviour or circumstances raise doubt as to whether they have the capacity to make a decision;
 - Concerns about a person's capacity have been raised by someone else; for example, a family member or a healthcare worker;
 - The person has previously been diagnosed with a condition causing impairment to the performance of their mind or brain, and it has already been shown that they lack capacity to make other decisions.

⁸ The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Local authorities must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care.

⁹ <http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-assessing-capacity>

- 5.2.7 If it is thought that an individual lacks capacity then that should be demonstrated. It should be shown that it is more likely than not – i.e. a balance of probability – that the person lacks the capacity to make a specific decision when they need to. An assessment when a person lacks capacity to make decisions should never be based simply on the person’s age, appearance, assumptions about their condition (including physical disabilities, learning difficulties and temporary conditions (e.g. drunkenness or unconsciousness), or any aspect of their behaviour. Guidance stresses the importance of documenting any decisions made in assessing capacity, and any reasons for the clinical judgment reached. The starting assumption should always be that the person has capacity.
- 5.2.8 While the case notes did not reflect this, it was clear from speaking to professionals that they had carefully considered Tom’s capacity to make decisions. He clearly misused alcohol and when heavily intoxicated made unwise personal choices. However, when not heavily intoxicated, he was capable of specific decisions, for example completing forms and documentation. Professionals therefore reached a decision that Tom met the first principle in the Mental Capacity Act i.e. a presumption of capacity. While this did fluctuate when intoxicated, overall he had no problems understanding the impact of his unwise decisions.
- 5.2.9 It was also clear this was kept under review and considered as a possible option. For example, at the second strategy meeting (see section 5.18) reference was made to ‘Appointee/Deputyship was discussed as a possible support option pending Tom’s engagement’. While a record should have been made as to a Mental Health Act Assessment, the panel did not feel this reduced the quality of the care and support Tom received nor did it contribute to his death.
- 5.2.10 In relation to the Care Act Assessment, professionals at the learning event recognised that a formal assessment had not taken place. The reason for this was that they considered it would have been difficult to do this with Tom; he was of sound mind, he was physically capable of looking after himself when sober. While Tom may not have been eligible for assistance, an assessment should have been completed and recorded. The panel felt that the completion of this assessment might have identified evidence of needs that could have assisted the safeguarding strategy decisions.
- 5.2.11 For example, little if anything was known about Tom’s background and family. Tom was a very private man and, for reasons that will never be known, he did not talk about his family or volunteer this information. A Care Act Assessment might have been an opportunity to probe this issue further. While it is a matter of conjecture as to whether Tom would have disclosed this information, had he done so then there might have been an opportunity to engage and involve Tom’s family in developing a plan to protect him.

5.2.12 During the learning event some key professionals appeared to know that Tom had family in Liverpool and believed that he did not have a relationship with them. While it is true that Tom had not seen his family in Liverpool for some years, there was no evidence of a rift between them and Tom. Had this been known then an option that could have been considered was to approach them and try and engage them in developing solutions.

Notable Good Practice

5.2.13 When KP1 provided the alert the initial information, it included reference to the fact that a fire safety check had been carried out at Address One jointly by Petrus, RBH, Greater Manchester Fire Service and Stepping Stones. As well as checking the premises in relation to fire hazards, means of escape etc. it seems this opportunity was used by support agencies to visit Tom's property and while there make a wider assessment as to his welfare and the state of the property.

5.3 Key Event Two

RBH Meeting with Tom 10 December 2015

What Happened?

5.3.1 Tom attended a pre-arranged interview at the local authority housing office with KP5, KP2 from Stepping Stones, KP3 from Petrus and a friend of Tom's. The interview was arranged to discuss allegations of anti-social behaviour at Address One and was viewed as a final warning. Previous warnings had failed to resolve the issue and legal action now needed to be considered.

5.3.2 Tom acknowledged there were issues with visitors to his flat and named several of them (Male A was not one of those named). Tom said he did not want these people at his property and said he had called the police on some occasions after one of them refused to move.

5.3.3 Tom was told that RBH could serve banning letters on the individuals to try and keep them away and Tom asked that this be done. He said he did not have the fobs which allowed him access to the block of flats where Address One is located. He was told these would be cancelled to prevent others using them. However, Tom did have the keys to Address One which were on a string around his neck.

5.3.4 Following the meeting KP5 sent an e-mail to Greater Manchester Police requesting passing attention was paid to Address One and for a crime prevention officer to pay a visit to Tom. A request was also made for the fobs that gave access to the flats complex and that related to Address One be cancelled.

- 5.3.5 Banning letters were produced for the four named individuals. As they were of no fixed abode, copies were sent to concierge staff at the flat complex, housing officers and Greater Manchester Police so that they could be served when the four were next seen. A copy of each letter was also provided to Tom so that, should they come to his property, he could ask them to leave and show them the letter.

What should have happened? (Policy/Protocol/Practice)

- 5.3.6 Actions were in line with the local authority policy and procedure on anti-social behaviour and tenancy matters.

Missing Information & gaps, omissions and breaches

- 5.3.7 The only gap that was identified was that the banning letters were not served personally upon the individuals they were addressed to. However, given these individuals were of no fixed abode, the fact copies were sent to other parties that might have contact with them (i.e. concierge, police etc.) was felt to be reasonable.

Notable Good Practice

- 5.3.8 All the actions agreed at this meeting were completed the same day. There was joint working between a number of agencies. Providing copies of the banning letters to Tom, so that he could give them to the banned individuals, allowed Tom to blame RBH and therefore negate any criticism of him by these persons. This would have helped act as a protective measure towards Tom by removing or reducing any criticism towards him by these untoward persons.

5.4 Key Event Three

Tom is taken to hospital 2 January 2016

What happened?

- 5.4.1 Tom was brought to accident and emergency at Royal Oldham Hospital. He had been found wandering in Rochdale Town Centre earlier that afternoon by the police. An ambulance had been called by the police as he had been noted to have been incontinent, and had dried blood on his forehead. Tom refused to wait in the Town Centre went home where the ambulance crew found him. The crew gained entry to his flat and recorded that in their opinion he was vulnerable as he had strangers staying in his flat.
- 5.4.2 Tom was seen by a triage nurse and reviewed by a doctor at 17.29. The doctor noted Tom had a background history of excessive alcohol consumption. Tom said he had fallen the day before whilst he had been drunk, he thought he had lost consciousness and he reported that he had felt confused at times

since then. He had abrasions to his forehead. A scan did not reveal any abnormalities and Tom was detained for a period of overnight observation.

- 5.4.3 Whilst on the observation ward a telephone call was received from Lynsey. Tom had given her name as his next of kin. She told the staff there was an on-going safeguarding investigation into allegations that Tom was suffering "financial abuse and exploitation by his friends". She went on to say that both the police and Rochdale Adult Care were aware of and dealing with this.
- 5.4.4 During his stay Tom was given relevant medication as per the Trust's Alcohol Pathway. Following review the next morning it was felt that Tom was medically stable and could be discharged from hospital. Prior to discharge the staff nurse discussed with Tom the concerns that Lynsey raised in her telephone call. Tom said the couple staying in his flat had left and he had a friend who would stay with him for the next 24 hrs.
- 5.4.5 The staff nurse completed an adult safeguarding /information sharing form which was forwarded to the Trust's Safeguarding team and Rochdale Adult Care. The staff nurse also telephoned the duty social worker who stated that Rochdale Adult Care were happy for Tom to be discharged.

What should have happened? (Policy/Protocol/Practice)

- 5.4.6 Staff appeared to demonstrate knowledge of adult safeguarding as per the Care Act 2014, the Hospital Trust Adults and Risk Policy and by sharing that information with Rochdale Adult Care. No gaps in policy were identified.

Missing Information & gaps, omissions and breaches

- 5.4.7 Neither the Trust nor the panel identified any.

Notable good practice

- 5.4.8 The sharing of information with Rochdale Adult Care was felt to be good practice

5.5 Key Event Four

First multi-agency strategy meeting 5 January 2016

What happened?

- 5.5.1 This was the first of two strategy meetings. The following agencies attended; Rochdale Adult Care, Petrus, RBH, Stepping Stones and Greater Manchester Police. Apologies were received from Pathways.
- 5.5.2 The meeting heard that Tom was due to make a court appearance about his property and was likely to be given 2-4 weeks' notice. RBH stated they had taken all steps to support him around rent arrears and anti-social behaviour

prior to this step being taken. An income officer had been trying to engage Tom around rent arrears without success. Rochdale Adult Care expressed concerns that eviction was being progressed whilst there were on-going safeguarding concerns which may be influencing the situation.

5.5.3 Stepping Stones had attempted to engage Tom by applying for discretionary payment¹⁰ and for a property at Redfearn House¹¹ without success. This would be explored further. Pathways said they would attempt to engage Tom with support around alcohol intake following limited previous engagement. Tom was not engaging with support through their service and had not attended for several weeks.

5.5.4 The police stated they had had a recent involvement with Tom. This included a non-emergency call made to them in which the caller referred to monies being stolen from the bank. When the police called that number, a person answered and denied knowledge of the earlier call. The first name that person gave matches a man who was known to visit Address One (the name given was not Male A).

5.5.5 The meeting felt that Tom had an understanding around his situation. He said that he will live on the streets if he loses Address One. The question the meeting considered was whether Tom believed this was a real possibility.

5.5.6 During the meeting information was shared and risks identified. These included;

- Imminent threat of homelessness;
- Alcohol Abuse and associated self-neglect;
- Vulnerability and risk of financial abuse/exploitation through unwanted persons staying at property;
- Risk to others identified as threats made during welfare visit to those that had been staying at Tom's property.

5.5.7 Agencies present at the meeting agreed to take the following actions;

1. A welfare check to be completed that afternoon – KP5 to conduct this visit, remind of court meeting and discuss proposed meeting alongside Rochdale Adult Care. If she is unable to see Tom, KP5 has agreed to inform PC1 who will request a welfare visit from police.

¹⁰ A discretionary housing payment could help you if your housing benefit doesn't cover the rent. ... A DHP is an extra payment to help people who claim housing benefit and are struggling to pay the rent. ... You can also apply for a DHP if you receive universal credit payments. Shelter: <https://england.shelter.org.uk> › Housing benefit

¹¹ Redfearn House is a Supported Accommodation Service for single people aged 18-65, who have complex support needs and who are homeless or at risk of homelessness. The project is staffed 24 hours a day, 7 days a week.

2. KP6/KP5 to liaise with KP11 ahead of attending court tomorrow to make judge aware of safeguarding meeting / actions.
3. Safeguarding lead professional at RBH to be made aware of this case.
4. KP6, KP1 and RBH are to arrange a meeting with Tom at Riverside to discuss current concerns and support options. KP2 to support Tom to attend, option of application to Redfearn house is to be re-approached with Tom.
5. KP6 to liaise with Tom's GP regarding his health.
6. KP6 and SW1 advised that Multi-Agency Risk Management (MRM)¹² protocol to be considered if Tom continues not to engage with support.
7. PC1 to look at outcome of recent PPIU and update SW6.
8. All agencies to maintain good communication channels and update on case as necessary.

What should have happened? (Policy/Protocol/Practice)

- 5.5.8 Staff appeared to demonstrate knowledge of adult safeguarding procedures and the MRM. No gaps in policy were identified.

Missing Information & gaps, omissions and breaches

- 5.5.9 As set out in paragraphs 5.2.6 et al, the Safeguarding Adult Review panel noted there was no mention of a Care Act Assessment or an assessment of Tom's mental capacity although it is recorded he understood the situation. The Safeguarding Adult Review panel felt that it would be good practice in future meetings to make a specific note of whether these assessments had been carried out and if not, why not.
- 5.5.10 The review panel also felt it would have been helpful from an early stage to have considered the role of Lynsey. Tom described her as his next of kin. While Lynsey had not lived with Tom for several years (because of his misuse of alcohol), she still maintained contact with him. Lynsey also kept in contact with the manager of the Petrus hub; the latter would contact Lynsey if Tom did not visit for breakfast and check if he was OK.
- 5.5.11 Unfortunately most professionals did not know about Lynsey.

¹² Multi-Agency Risk Management protocol. This protocol provides professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. It aims to provide professionals from all Rochdale Borough Safeguarding Adults Board (RBSAB) partner agencies with a framework for the management of complex cases where, despite ongoing work, serious risks are still present.

Notable good practice

- 5.5.12 The panel considered copies of the minutes of this meeting and felt the notes were clear and concise. Discussions with the key professionals at the learning event also disclosed that there was a very good understanding of Tom, and the context within which he lived his life. While the notes are comprehensive, the panel felt the learning event helped give them a much greater understanding of Tom and his needs. While professionals felt Tom was kind and helpful towards others, they also spoke about his willingness to be helped by agencies as being 'variable'. Tom was proud and never wanted to be seen as a 'grass'.
- 5.5.13 This might have been because Tom was part of a group of drinkers that had formed in Rochdale. They were felt to have a culture of their own. While they often helped each other, they also took advantage of Tom. Everyone knew everyone else. While Tom may have felt that he was separate from this group, he had been drawn into them. This group would visit Petrus for their breakfast and a bath. However, they would also take over other people's flats.
- 5.5.14 While Tom had capacity and was a proud and intelligent man, key professionals felt he was also lonely and liked company. This may be why he associated with this group. Certainly professionals, such as his GP, recognised that such association was unwise and told Tom (see table one). Professionals at the learning event felt that this group sometimes assisted Tom's intoxication to keep him vulnerable.

5.6 Key Event Five

Joint visit to Tom by RBH and Police 5 January 2016

What happened?

- 5.6.1 Actions one and two from the first strategy meeting was to visit Tom and carry out a welfare check if necessary. This action was completed after the meeting when KP5 from RBH and PC1 from the police visited Address One. Tom was present and allowed them into his property. He had an injury to his head and said that he had fallen and had been taken to hospital .
- 5.6.2 As the conversation progressed Tom became more agitated and KP5 and PC1 withdrew. They knew that he acted this way when spoken to and this was often dependent upon his alcohol consumption: when Tom became agitated it was impossible to interact effectively with him.

What should have happened? (Policy/Protocol/Practice)

- 5.6.3 No gaps in policy were identified.

Missing Information & gaps, omissions and breaches

5.6.4 Nothing identified.

Notable good practice

5.6.5 None identified.

5.7 Key Event Six

Tom is taken to hospital 6 January 2016

What happened?

5.7.1 Tom was brought to Fairfield General Hospital by ambulance. He had been found on the floor of Rochdale Bus Station with a laceration to his eyebrow. He told the ambulance crew that he had been drinking, but had no other recollection of events or how he had sustained the injury to his eye. The doctor did not feel Tom needed to be admitted to hospital. The wound was cleaned and dressed and Tom was discharged home.

What should have happened? (Policy/Protocol/Practice)

5.7.2 The expected level of practice was provided.

Missing Information & gaps, omissions and breaches

5.7.3 None were identified.

Notable good practice

5.7.4 None identified.

5.8 Key Event Seven

Visit to Address One by PCSO 21 January 2016

What happened?

5.8.1 PCSO1 visited Address One. Tom had telephoned the police in relation to a man and woman who were in his flat and refusing to leave. Tom said they had come to his flat to use drugs, and that he didn't feel safe and so had to leave. On arrival the PCSO1 found there was no one at Address One.

5.8.2 PCSO1 made an intelligence submission and stated there were some concerns in relation to the amount of visitors that Tom was getting in his flat. The concierge had deactivated his fobs as Tom was giving them out to people constantly. The submission noted that Tom is an alcoholic who is vulnerable as drug users, other alcoholics and homeless people are using him and his property. It was also noted that RBH are in the process of trying to obtain banning letters to stop these people from entering the block of flats.

- 5.8.3 The information submission was PPI 'triaged'¹³. There was no crime recorded and the risk was recorded as 'standard'. The Public Protection Investigation Unit (PPIU) made a referral to the Integrated Alcohol Team (IAT) & Renaissance Alcohol Team. An action was sent to the Integrated Neighbourhood Policing Team (INAT) for passing attention to be paid.

What should have happened? (Policy/Protocol/Practice)

- 5.8.4 The Integrated Neighbourhood Policing Team should have raised a 'Neighbourhood Police Investigation' upon receipt of the action from the Public Protection Investigation Unit.

Missing Information & gaps, omissions and breaches

- 5.8.5 There was a gap in that respect of the lack of a Neighbourhood Police Investigation (see above). In addition, the Greater Manchester Police representative on the panel felt that it would be good practice in the future for Integrated Neighbourhood Policing Teams to complete risk assessments on vulnerable adults and a recommendation has been made (see section 9)

Notable good practice

- 5.8.6 When reviewing this key event, the Greater Manchester Police member felt that the deactivation of the fobs and the preparation of banning letters to try and deter untoward visitors to Tom's flat was an example of good practice.

5.9 Key Event Eight

Tom is taken to hospital 28 January 2016

What happened?

- 5.9.1 Tom came to the council offices at Riverside in Rochdale for a pre-arranged meeting. He was heavily intoxicated and had bruising around his cheek and head and with his eye purple and swollen shut. Tom said he had fallen in his flat that morning, he couldn't see and he had a pain in his head. An ambulance was called and he was taken to hospital.
- 5.9.2 Tom told a doctor at accident and emergency that he sustained the injury the previous day when he had been drinking and had a fall. A scan did not reveal any serious injury. The doctor noted that Rochdale Adult Care should be contacted to check if it was safe for Tom to be discharged, in light of the known "safeguarding meeting" which had been arranged for the same day.

¹³ In Greater Manchester Police information such this is passed to the Public Protection Investigation Unit for 'triaging' which is a process for determining issues such as risk assessment, what actions need to be taken and whether information should be shared with other agencies.

5.9.3 Tom was moved to an observation ward to await the results of his scan, and to allow time for staff to contact Rochdale Adult Care. However, he would not wait for staff to contact Rochdale Adult Care. The doctor noted that his capacity to consent to stay in hospital had been assessed and he had capacity to make this decision¹⁴. Tom was also assessed as being fully aware of the risks to his safety in respect of his choice to continue abusing alcohol. He was discharged home and declined the offer of transport.

What should have happened? (Policy/Protocol/Practice)

5.9.4 Staff demonstrated a good understanding of safeguarding adult's procedure and consent to treatment policy and procedure.

Missing Information & gaps, omissions and breaches

5.9.5 The expected level of practice was provided.

Notable good practice

5.9.6 None identified.

5.10 Key Event Nine

Contact between Petrus and RBH 9 and 10 February 2016

What happened?

5.10.1 On 9 February 2016 KP11, the Income Officer at RBH, contacted Petrus and informed them that an application was going to be made for immediate possession of Address One. KP11 said a number of attempts had been made to resolve this with without success because Tom had an accident and was intoxicated. Petrus informed KP11 that they would try and arrange another meeting between agencies and try to get Tom to re-engage with services.

5.10.2 The following day Petrus contacted KP11 to reassure them that attempts were being made to arrange a meeting with agencies. Petrus were conscious of the timescales in relation to the application for possession and wished RBH to understand that attempts were being made. KP11 said that one of the officers involved was on leave and that the matter could wait until they returned

What should have happened? (Policy/Protocol/Practice)

5.10.3 Staff demonstrated a good understanding of the need for inter-agency information sharing.

¹⁴ The panel discussed whether a full Mental Health Act capacity assessment should have been completed. They concluded that, when the doctor referred to Tom as having capacity, this was a reference to him having met the first principle in the Mental Capacity Act i.e. a presumption of capacity. It was therefore not necessary to proceed to the next stage of a formal assessment.

Missing Information & gaps, omissions and breaches

5.10.4 The expected level of practice was provided.

Notable good practice

- 5.10.5 This event demonstrated continued effective partnership working and contact between agencies and support workers in the interests of Tom. At the learning event professionals spoke about how forthright and 'hell bent' Tom was to remain in his property. Tom told one professional that he would not leave the property except in a 'cardboard box'. Professionals recognised this and, as is demonstrated by this event, tried to work together on issues such as repossession.
- 5.10.6 The dichotomy for professionals was that, while Tom wanted to stay in the flat, professionals found it difficult to put measures in place there to protect Tom from the risks he faced. At the learning event, while recognising how proud Tom was and how much he felt an attachment to the property, some professionals expressed a view that they had actually hoped Tom would be evicted as this might have forced him into protected housing where the risks he faced from others might have been easier to manage.

5.11 Key Event Ten

Tom attends Petrus Hub for meeting 19 February 2016

What happened?

- 5.11.1 Tom visited the Petrus Hub and spoke to KP3 regarding noise complaints, rent arrears and service charges. Tom was asked if he would consent to KP6 joining the discussion. He said he was, so KP6 was contacted and came straight to the office.
- 5.11.2 Tom was told what course of action RBH wanted to take and that it might be beneficial for him to look at alternatives such as supported or sheltered housing although RBH had said they were not going to offer sheltered housing as an option. Tom was very clear about not wanting to leave his flat as he had been there for a considerable amount of time.
- 5.11.3 Discussion took place on the option of maximising Tom's income so he could maintain a payment plan to deal with the arrears and service charges at the property. This included an employment and support allowance group so that Tom did not incur any further sanctions, an application for severe disability premium and an income & expenditure review so that an affordable payment plan could be offered to RBH. Appointments were made for Tom to return so these actions could be completed.

What should have happened? (Policy/Protocol/Practice)

5.11.4 Staff demonstrated a good understanding of Tom's needs and the availability of options to resolve his financial situation.

Missing Information & gaps, omissions and breaches

5.11.5 At the learning event professionals discussed the housing issues that Tom faced. One issue identified was that Tom lived in a two-bedroomed local authority flat. Therefore, because of the so called bedroom tax, his arears bill was greater than it could have been. The local authority operated an 'under occupancy offer' which means that people who find themselves in this position are offered a smaller property.

5.11.6 While Tom could not have been forced to take this offer and move, it is not clear if the offer was ever made to Tom. If one of the keys to providing Tom with greater protection was housing, then the panel felt it would have been good practice to have had a discussion with Tom about the 'occupancy offer' and document the results. Perhaps this could have been an action from the strategy meeting. The panel recognise that, even if this offer had been made, there was no degree of certainty that Tom would have accepted it given some of the comments he made about not wanting to leave Address One.

5.11.7 The panel debated why Tom seemed to have such a strong desire to remain at Address One when it was not ideal for his needs both in terms of cost and security from unwelcome visitors. The panel considered that it was possible Tom's attachment was emotional and was connected to the fact that he and Lynsey had once made it their home. The panel felt that, had that been known and explored with Tom and Lynsey, it might have created further opportunities to negotiate a move that was acceptable to Tom.

Notable good practice

5.11.8 The actions of the officers from Petrus and Rochdale Adult Care demonstrated persistence in engaging Tom and an understanding of the necessity of grasping the initiative when Tom was receptive to discussions. For example, KP3 immediately contacted KP6 who came straight to the Petrus Hub when Tom presented there.

5.12 Key Event Eleven

Welfare visit to Address One by Police and RBH 25 February 2016

What happened?

5.12.1 KP5 and KP2 from RBH together with PCSO1 paid a welfare visit to Tom at Address One as part of a weekly estate evening walkabout. They were allowed into his property. A named male friend of Tom (who was not Male A)

was present. Tom was told this was a welfare check and that support officers would be assisting him with financial management.

What should have happened? (Policy/Protocol/Practice)

- 5.12.2 This action was part of a partnership estate management process and was not part of any specific policy.

Missing Information & gaps, omissions and breaches

- 5.12.3 None identified.

Notable good practice

- 5.12.4 None identified by the agencies. However the Safeguarding Adult Review Panel felt the weekly estate evening walkabout was an example of good interagency working developed by practitioners.

5.13 Key Event Twelve

Submission of Intelligence by PCSO 4 March 2016

What happened?

- 5.13.1 PCSO1 submitted an intelligence report that a couple were residing with Tom who was a vulnerable alcoholic who becomes befriended by homeless people and alcoholics who take advantage of his flat and steal from him.
- 5.13.2 The information was 'triaged' by the PPIU. It was identified that there had been six previous PPI submissions due to alcohol issues. No crime was reported and the information had been passed to Rochdale Adult Care and a further action forwarded to the Integrated Neighbourhood Policing Team (INPT). No further action was required by the PPIU.

What should have happened? (Policy/Protocol/Practice)

- 5.13.3 This was an intelligence submission made in accordance with Greater Manchester Police policy.

Missing Information & gaps, omissions and breaches

- 5.13.4 A risk assessment was not submitted on this occasion. The panel felt that it would have been good practice to have identified and recorded the names and details of the couple and for a check to be carried out to see what information was recorded on them. If the PCSO did not have the name, then it would have been good practice to have made enquiries to ascertain who they were.

Notable good practice

5.13.5 None identified.

5.14 Key Event Thirteen

Tom attends Petrus 15 March 2016

What happened?

5.14.1 Tom visited Petrus having not attended appointments made during brief encounters with him. An employment and allowance questionnaire had been completed. Tom signed it and it was sent off. Tom was asked to complete the income and expenditure form to develop a payment plan for RBH. However, Tom felt he had been at Petrus long enough and had other things to do.

What should have happened? (Policy/Protocol/Practice)

5.14.2 This was not a policy/protocol or practice issues.

Missing Information & gaps, omissions and breaches

5.14.3 No gaps were identified. However, this demonstrates the difficulties that were experienced in trying to engage Tom in completing actions designed to assist him.

Notable good practice

5.14.4 This key event reinforces the efforts that were made by professionals to help Tom out of the situation he was in, facing arrears and eviction. It is an example of the sort of behaviour that professionals commented upon when they said that Tom's willingness to engage was variable.

5.15 Key Event Fourteen

Tom attends GP surgery 16 March 2016

What happened?

5.15.1 Tom visited his GP for a review appointment. His medication was reviewed and Tom was encouraged to reduce his alcohol intake. He was still under the Detox Team and had a key social worker. He said he still attended group sessions.

What should have happened? (Policy/Protocol/Practice)

5.15.2 Action taken in accordance with the Care Act 2014.

Missing Information & gaps, omissions and breaches

5.15.3 There was no evidence of communication between the GP and the Detox Team and the summary record did not provide the extra detail needed.

Notable good practice

- 5.15.4 There was evidence of engagement and regular screening appointments for Tom with his GP.

5.16 Key Event Fifteen

Tom attends Petrus Hub 21 March 2016

What happened?

- 5.16.1 Tom visited the Petrus Hub so that KP3 could carry out the income and expenditure review needed to arrange a payment plan with RBH. KP3 contacted ESA¹⁵ to check on the progress of the Health Questionnaire. They informed KP3 that further assistance was needed with a supporting letter which was completed and sent.

What should have happened? (Policy/Protocol/Practice)

- 5.16.2 This was not a policy/protocol or practice issues.

Missing Information & gaps, omissions and breaches

- 5.16.3 None identified.

Notable good practice

- 5.16.4 None Identified.

5.17 Key Event Sixteen

Tom attends Pathways 22 March 2016

What happened?

- 5.17.1 Tom attended an appointment to see KP8, his Recovery Coach, at Pathways Drug and Alcohol Treatment Service. He had missed several appointments. KP3 maintained a close relationship with Rochdale Adult Care and they mutually agreed to support Tom to attend appointments. On this visit, Tom said that on an average day he was drinking two litres of white cider and two cans of 9% lager. Over the last weekend his consumption had increased to between four and five litres daily.
- 5.17.2 On the previous day Tom reported two people had been staying at his flat. He refused to name them. His Personal Independent Payment was due to be placed in his bank account on midnight that night. Tom said he had no pin number for his account but was expecting it to arrive in his bank account this morning. He believed that the two individuals staying with him had opened his

¹⁵ ESA stands for employment and support allowance, the benefit which has replaced incapacity benefit.

post and obtained his pin number. He believes they then found his bank card and went to the cash machine and emptied his account.

- 5.17.3 Later that day Tom reported that he found his bank card behind the front door. He then went to his bank and found that his account was empty. He also found that his mobile phone had been stolen. He had tried to report the incident at the bank and to stop his card. However, the bank was busy and he became too agitated to wait. The bank had given Tom a number to phone to stop the card.
- 5.17.4 KP8 offered to ring the bank but Tom had none of his bank details with him. KP8 advised Tom to speak to the bank as a matter of urgency and report the matter to the police. Tom said two people who had been banned from his block of flats were now sleeping in the rubbish chute. He was advised to report this matter to the police as well.
- 5.17.5 The following day KP8 attended the strategy meeting (see event seventeen below) and reported this information. The police officer in attendance said they were unaware of the incident and would visit Tom and invite him to provide a statement.

What should have happened? (Policy/Protocol/Practice)

- 5.17.6 This information was correctly recorded on the Pathways Database (Poppie).

Missing Information & gaps, omissions and breaches

- 5.17.7 There were no omissions.

Notable good practice

- 5.17.8 When Tom started his episode of treatment in 2015 a risk assessment was undertaken by Pathways and this did not identify financial abuse. By January 2016, when risk was re-assessed, the danger of financial abuse was recorded as high. There was evidence of good communication between Pathways and other agencies involved in Tom's care.

5.18 Key Event Seventeen

Second multi-agency strategy meeting 23 March 2016

What happened?

- 5.18.1 The following agencies were represented; Rochdale Adult Care, Police, RBH, Petrus, Pathways. Apologies were given by Stepping Stones and RBH Enforcement. The safeguarding concerns around Tom were discussed and the actions taken to date were detailed by each agency. There was an agreement that Tom required support and had been given all relevant information on who to contact should further issues arise regarding unwanted persons

attending his property. The risks identified at the last meeting were reviewed and the current risks identified as; on-going alcohol abuse; threat of homelessness; self-neglect; unwanted persons at property; potential financial abuse.

5.18.2 Concerns remain around Tom's vulnerability to exploitation however Tom was known to actively encourage individuals to stay at his property. Safeguarding relating to this issue had therefore been closed. PCSOs visited regularly, RBH had issued banning orders, the concierge had the banned list and would also ask Tom if he was happy to accept visitors when they are present at the entrance. Tom has been advised to contact police if they are required and has been provided the non-emergency 101 number as well as the number for Rochdale Adult Care along with the emergency duty team telephone number.

5.18.3 Tom regularly attended Petrus with a view to supporting him to access correct benefit entitlement and reduce sanctions against him. It was reported Tom was now appearing to engage and it would be unlikely that the Judge would approve the eviction order. KP8 disclosed the information she had received yesterday concerning the theft from Tom's bank (see event sixteen above). Those present at the meeting were made aware that Tom was due to receive a significant payment¹⁶. Concern remained that he was at risk of financial abuse. Options were discussed relating to this risk however these would require Tom to engage. One option considered was that of making some sort of legal appointment/deputyship to protect Tom and his money. However this would have required an assessment that Tom did not have capacity.

5.18.4 The following actions were allocated to agencies;

1. PCSO1 to visit Tom to establish if he would like to report the crime relating to theft of monies. To consider safeguarding referral around financial abuse if Tom agrees;
2. Safeguarding relating to finances to be progressed by KP6 if Tom was agreeable to the referral;
3. Petrus to establish when Tom was likely to receive financial windfall and expected amount. Petrus to also continue supporting around accessing correct benefits;
4. RBH to update on position regarding court application and eviction process;
5. Good communication to be maintained by all agencies involved.

¹⁶ Reputedly this figure was very substantial.

What should have happened? (Policy/Protocol/Practice)

5.18.5 This meeting was conducted in accordance with the Safeguarding Adults policy and multi-agency protocols.

Missing Information & gaps, omissions and breaches

5.18.6 There were no omissions in respect of policy. As part of the safeguarding review Rochdale Adult Care identified key events and reviewed the way the strategy meetings were conducted. They concluded the strategy meetings could have been more structured given Tom's lifestyle and vulnerability. With hindsight, they believe that, at the first strategy meeting consideration could have been given to putting a framework of future meetings in place that could have improved co-ordination of actions. Such an approach could have;

- (a) Discussed how long the group felt it would take to get Tom to an improved situation and document an overarching strategy that would describe what the group felt could be achieved and how long it would take to get there;
- (b) Set out a series of meeting dates for, say, a 6-month period getting a commitment from each agency to attend;
- (c) Agree that agencies could recall the group to discuss significant events/deterioration in his wellbeing/discuss a change in tactics;
- (d) Essentially a sign up from agencies to act as a virtual team for an agreed period of time around Tom.

5.18.7 At the learning event key professionals also discussed the strategy meetings. The risks to Tom and the actions to address those risks are clearly recorded in the minutes. Following the first strategy meeting KP6 completed a risk assessment. This clearly documents the risks and provides a severity rating (in this case it was a rating of 15 indicating Tom was at severe risk of harm).

5.18.8 The learning event discussed whether, given Tom's reluctance to engage with agencies, his case fell within the Rochdale Multi Agency Risk Management (MRM). This protocol is intended to¹⁷;

'Provide professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. It aims to provide professionals from all Rochdale Borough Safeguarding Adults Board (RBSAB) partner agencies with a framework for the management of complex cases where, despite ongoing work, serious risks are still present. The Multi-agency Risk Management protocol (abbreviated to

¹⁷ Multi-Agency Risk Management protocol V10.0 February 2015: Rochdale Borough Safeguarding Adult Review and Practice Excellence Group.

MRM) is a multi-agency process to discuss, identify and document serious current risks for high risk cases, and formulate an action plan identifying appropriate agencies responsibility for actions. It also provides a mechanism for review and re-evaluation of the action plan. The MRM was developed for adults who are vulnerable and at risk of significant harm or death and have the mental capacity to make unwise choices. If the adult is assessed as having the capacity to understand the consequences of refusing services, then MRM should be considered'.

5.18.9 It was evident from the learning event that key professionals knew of the existence of MRM and were considering its use. Professionals felt that they were on the pathway towards escalating Tom's case to an MRM and this would have been the next step when all options and actions had been exhausted. The panel did not feel that, at this stage, escalating Tom's case to MRM would have provided professionals with any more options to address the risk Tom faced.

5.18.10 While Tom's case was not yet being considered through MRM, key professionals felt that it would be good practice in the future to use the risk assessment template within the MRM in safeguarding strategy meetings. While the minutes that were prepared clearly listed the risks and actions, the use of the MRM template to log and share them with other agencies would provide a common template with which to identify and rate risk. Key professionals also felt that it would be helpful in the future to embed the protection plan within the minutes of the strategy meetings so that it can be shared with other agencies hence giving all a clearer understanding of what is being done to protect the adult in question.

Notable good practice

5.18.11 Although the panel identified some areas for improvement in relation to the strategy meetings they felt the minutes and actions were comprehensive, the risks were correctly identified and the plan to protect Tom was robust. The panel has already commented on the need in the future to consider engaging families. With the exception of that action, the panel did not identify any other actions that they felt had been missed.

5.18.12 At the learning event, key professionals commented upon the sense of joint ownership that they felt when dealing with Tom. Members felt that they understood the individual parts they held and that they were trying to work within Tom's wishes. The panel concurred with this view and felt that there was evidence of shared understanding and a willingness to work together. One professional wondered whether Tom had an emotional attachment to the flat given that he had taken over the tenancy from Lynsey.

5.19 Key Event Eighteen

Tom is brought to hospital with a head injury-23 March 2016

What happened?

- 5.19.1 Tom came to the Urgent Care Centre at Rochdale Infirmary. He said he had fallen earlier that day. He couldn't recall when, neither could he remember any details with regards to the mechanism of the fall. He reported that he had been drinking that day, was known to "Pathways" Rochdale Alcohol team, and had a key worker. Tom told the doctor he had banged his head and his shoulder.
- 5.19.2 The doctor noted evidence of amnesia and Tom was sent for a CT scan. He was transferred to Royal Oldham Hospital. The scan did not reveal any serious injury or abnormality and Tom was deemed medically well enough to be discharged. During his overnight stay, Tom told the nurse in charge that he needed to use the ward telephone to contact his bank, as he said he had had some money stolen from his account. Tom was allowed to use the telephone and he was discharged home. He was offered transport and chose to make his own way home.

What should have happened? (Policy/Protocol/Practice)

- 5.19.3 Expected level of clinical practice was provided.

Missing Information & gaps, omissions and breaches

- 5.19.4 None identified.

Notable good practice

- 5.19.5 None Identified.

5.20 Key Event Nineteen

Information concerning visitors to Tom's flat 4 April 2016

What happened?

- 5.20.1 CCTV staff monitoring the complex where Tom's flat is located sent an e-mail to KP15 from RBH stating that a lot of young people are being given access to Tom's flat and highlighting that Tom may need help from support services.
- 5.20.2 KP15 then shared this information with KP5 and KP6. The e-mail was also shared with Petrus and Stepping Stones and a request made that they speak to Tom about the issue. KP5 said she would also arrange to visit Tom later in the week to discuss the issue.

What should have happened? (Policy/Protocol/Practice)

5.20.3 Expected level of clinical practice were followed in relation to Anti-social behaviour, and Safeguarding Adults Policy and an alert raised direct with KP6 who was the social worker handling Tom's case.

Missing Information & gaps, omissions and breaches

5.20.4 None identified.

Notable good practice

5.20.5 None Identified.

5.21 Key Event Twenty

Tom fails to attend Petrus Hub 13 April 2016

What happened?

5.21.1 Petrus staff were concerned that Tom had not visited the hub to access support required for the court hearing due on 10 May 2016. As he could not be found, KP3 had a walk around Rochdale Town Centre to see if they could locate Tom although this was done without success.

5.21.2 On 18 April 2016 KP12 spoke with KP6 about the forthcoming court case and that neither Rochdale Adult Care nor Petrus had been able to locate Tom to complete the relevant paperwork. It was therefore agreed that KP3, KP6 and KP13 would meet at the court as a multi-agency procedure.

What should have happened? (Policy/Protocol/Practice)

5.21.3 Expected level of practice was followed.

Missing Information & gaps, omissions and breaches

5.21.4 None identified.

Notable good practice

5.21.5 At the learning event staff commented that Tom could be very difficult to contact and keep in touch with. An example of this was the very patchy way he maintained contact with Pathways in relation to the treatment of his alcohol misuse. Tom did have access to a mobile telephone however he had been known to give this away to others which made contact difficult.

5.21.6 Tom could be unpredictable and his willingness to be helped was variable. Professionals commented upon the fact that, the closer the date came when

something was going to happen (i.e. eviction) the more Tom drank. The fact Tom might not be seen for a period of time and then re-appear may help explain why, when he was killed by Male A, his absence did not raise immediate concerns.

- 5.21.7 On this occasion the panel felt that the actions of KP3, in going to look for Tom in Rochdale Town Centre, reflected the care that professionals showed towards him.

5.22 Key Event Twenty One

Tom visits the Petrus Hub 26 April 2016

What happened?

- 5.22.1 Tom visited Petrus hub. He used their telephone to contact his private pension provider. Tom told also said he had had a considerable amount of money taken from his bank account and he believed his card had been taken whilst he was asleep. The bank provided Tom with a list of withdrawals and where the card was used. An appointment was made for Tom to return to the Hub the following day.
- 5.22.2 On 27.04.2016 Tom returned to the hub and telephoned the bank. He said he did not have time to contact ESA and therefore an appointment was made for Tom to return the following day (28.04.2016).

What should have happened? (Policy/Protocol/Practice)

- 5.22.3 Petrus Protecting Adults at Risk Policy states that staff should usually report an alleged incident to a manager as soon as possible and before the end of the working day. If there is a suspicion of crime this should be reported immediately.

Missing Information & gaps, omissions and breaches

- 5.22.4 The theft was not reported to a manager or the police as the staff member understood that Rochdale Adult Care and the police were aware of this allegation. The panel discussed the different approaches taken by banks in relation to the protection of customers that may be at risk of financial exploitation.
- 5.22.5 The panel's experience is that the approach banks take to these matters can vary. They felt this case demonstrated there may be a need for local engagement with banks to ensure they recognise the risk of financial exploitation of vulnerable adults and have measures in place for identifying those at risk and steps to protect them.

Notable good practice

5.22.5 None identified.

5.23 Key Event Twenty Two

Tom visited the Petrus Hub with Male A 28 April 2016

What happened?

5.23.1 Tom visited the Hub in the company of Male A. Tom cancelled an appointment with KP3 and it was rearranged for 02.05.2016. KP3 spoke to Tom alone and asked if he was well and happy being in the company of Male A and Tom assured KP3 he was.

What should have happened? (Policy/Protocol/Practice)

5.23.2 This was not a policy issue.

Missing Information & gaps, omissions and breaches

5.23.3 None identified.

Notable good practice

5.23.4 None Identified.

5.24 Key Event Twenty Three

Tom visited by Housing Officer and PCSO 28 April 2016

What happened?

5.24.1 KP2, KP5 and PCSO1 carried out a visit to Tom's address. The reason for the visit was to carry out a welfare check on him as he had previously been identified as vulnerable. Tom did not answer the knock on the door at first. When he did come to the door he was described as intoxicated although coherent and calm. Tom was heard to say "You're going to upset my friend".

5.24.2 KP2 and KP5 entered the flat and PCSO1 remained in the hallway with Tom for a few seconds to ask if he was happy with this visitor. Tom told the PCSO that he was as he was an "old friend and welcome". A male was in the living room with a can of lager. PCSO1 had never seen this male previously associating with Tom. When asked he gave his name as Male A.

5.24.3 PCSO1 said Tom was calm and happy to talk to her inside the flat and offered her a cup of coffee which she refused. KP5 says that Tom informed her he was fine and no one was harassing him anymore. Male A said to KP5 that he would make sure no one would be allowed in whilst he was there. KP5 said Tom appeared to be fine and normal. She said Tom gave her 'no concern for alarm' during the visit and did not appear threatened or scared by Male A.

- 5.24.4 The visit lasted a few minutes. Tom followed the officers out onto to landing leaving Male A in the lounge. While on the landing Tom talked about the security of the block of flats, and how he appreciated the visit and the officers checking on him.
- 5.24.5 PCSO1 says that, although calm, Tom became a bit emotional, slightly rambling and had watery eyes. PCSO1 said this was a common behaviour and conversation that Tom had with her when he was intoxicated. PCSO1 did not see any injuries on Tom's face or his hands. KP2 said Tom's behaviour did not seem any different from when she had seen him in the past. KP2 did not recall anything significant during Tom's conversation with them.

What should have happened? (Policy/Protocol/Practice)

- 5.24.4 This was part of a routine partnership weekly estate walkabout and was not a policy issue.

Missing Information & gaps, omissions and breaches

- 5.24.5 The review panel felt it was important to analyse this event in some detail given the presence of Male A in the flat. The panel heard that, following the discovery of Tom's body, Greater Manchester Police Professional Standards Branch conducted a review into the circumstances of the police contact with Tom. No disciplinary issues were identified from that review. The panel felt, because of that decision, it was reasonable to conclude the actions of PCSO1 appear to have met the standards of service expected by Greater Manchester Police.
- 5.24.6 While the panel accepted these findings, they did feel there was learning from this event. The panel discussed at length several 'what if scenarios?' in relation to what was known or might have been discovered about Male A if a check of local and national police information systems had been conducted.
- 5.24.7 The panel felt this event demonstrated the disparity that appears to exist in the way in which contact by professionals differs between vulnerable children and vulnerable adults. If Tom had been a child, there would have been a much greater expectation in relation to the information that followed from that visit and what was then recorded on both police and local authority systems. This would have included details of Male A and an assessment of the risks he might have posed to Tom if he had been a vulnerable child.
- 5.24.8 While the review panel make no criticism of the actions of PCSO1 or her two colleagues KP2 and KP5, they believe that conducting a check on police information of Male A might have opened other options for exploration. For example, had such a check identified Male A's history and the fact he was on bail, that might have led to consideration of a controlled disclosure of that information to Tom so that he knew the risks he faced from Male A.

5.24.9 Disclosure of a person's convictions and the risk they pose are well embedded in relation to domestic abuse through 'Sarah's Law'¹⁸. While there is no legislation that extends this 'right to know' to circumstances like this case, the panel felt that consideration of a disclosure to Tom about Male A would have been excellent practice.

Notable good practice

5.24.10 While the review panel identified some learning they also felt that the joint visits undertaken by police and housing officers demonstrated evidence of good inter-agency practice.

¹⁸ The Domestic Violence Disclosure Scheme was introduced in 2014, giving members of the public a 'right to ask' Police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to that individual. Under certain circumstances the police can disclose information to a victim without an application.

6. LESSONS IDENTIFIED

6.1 Lessons Identified

- 6.1 The panel identified the following lessons. Where a recommendation made by either an agency or the panel follows from a lesson the relevant recommendation number is cross referenced in bold at the bottom of each lesson.

Lesson one (Recommendations 1 and 2)

Narrative

Several agencies had contact with Tom and contributed to the strategy meetings that were held. While KP6 arranged these meetings, it is not clear which, if any agency or professional was responsible for managing Tom's case.

Lesson

Early identification of a lead professional and agency for an adult safeguarding case helps ensure structure and accountability is maintained in the process.

Lesson two (Recommendations 3 & 4)

Narrative

There were examples within the review of occasions when Tom was seen by professionals and his mental capacity was considered. There were references to Tom 'having capacity' however these lacked detail as to why this conclusion had been reached or whether it was a formal assessment or a decision that Tom met the first principle in the Mental Capacity Act i.e. a presumption of capacity.

Lesson

It is important that, when either a first principle decision or a full assessment of mental capacity is undertaken, that it is documented. The record should include the nature of the assessment (e.g. 'first principle' or full assessment) together with the evidence for reaching the decision as to capacity. This improves information sharing between agencies and helps ensure the nature and level of risk faced by a vulnerable adult is understood.

Lesson three (Recommendations 5)

Narrative

Tom was very attached to Address One and this was implicit in many of the things he said to professionals. The reasons for this might have been identified had professionals spoken to Lynsey and Tom's family in Liverpool. In turn that might have led to exploring housing solutions that were acceptable to Tom and might have led to the reduction of arrears and the opportunity to separate him from untoward visitors;

Lesson

Engaging and involving families and exploring family background is helpful when seeking to solve problems and protect vulnerable adults such as Tom.

Lesson four (Recommendation 6)

Narrative

There was a good relationship between Lynsey and Petrus and a regular exchange of information between them as to Tom's whereabouts. However, that relationship was not visible to other agencies and its existence was not shared at the strategy meeting. Other agencies were unaware of Lynsey and the value she may have had in helping to act as an intermediary in discussions with Tom.

Lesson

It is important to ensure that at strategy meetings, all relevant information is shared between agencies. This is important for the development of options that help address the risk a vulnerable adult might face.

Lesson five (Recommendation 8)

Narrative

The panel felt the current approach to safeguarding adults, particularly in the way that strategy meetings are conducted and risks recorded are not as structured as they should be. The panel felt the model set out in the MRM model provides more rigour.

Lesson

Adopting a common approach and templates for recording issues like minutes, actions and risks etc. provides more rigour and consistency. This improves information sharing between agencies and helps ensure the nature and level of risk faced by a vulnerable adult is understood and documented consistently.

Lesson six (Recommendation 7)

Narrative

There is no evidence agencies shared information with the bank (or banks)¹⁹, or that they were included within the strategy meeting plans to reduce the risks Tom faced.

Lesson

When financial abuse is known or suspected early contact with banks might help ensure that plans can be agreed and put into place that helps protect the victim from further abuse.

Lesson seven (Recommendation 9)

Narrative

Professionals referred on several occasions to Tom displaying the signs of being 'a drinker'. There were also references to Tom being part of a group of other 'drinkers'. In fact, Tom was someone who misused alcohol and was therefore vulnerable.

Lesson

It is important not to stigmatise or label individuals as 'drinkers'. Such an approach means that an analysis as to the reasons why that individual is misusing alcohol does not take place and opportunities to help them may be missed.

¹⁹ See footnote 9

7. CONCLUSIONS

- 7.1 The review panel believe that Tom's death was a tragedy and they extend their sympathies to Lynsey and Tom's family for their loss. It is clear Tom was a kind, compassionate and caring man. Sadly, despite having tried, he was unable to overcome his propensity to misuse alcohol. Many others also tried hard to help Tom in this battle.
- 7.2 Ultimately Tom could not remain abstinent from alcohol. This led to him living alone at Address One. Here he became drawn into a community: the common bond of which was the frequent misuse of alcohol. This led to Tom being vulnerable to physical harm when he became intoxicated. The panel saw many examples of this including a fall into a fire and collapses which led to hospitalisation.
- 7.3 The root cause of those incidents was intoxication and the panel do not believe there was anything that agencies could have done differently to have avoided those risks. Tom had capacity and was an intelligent man. He could not be deprived of his liberty to order to force him to abstain. There was an abundance of evidence that Tom had received advice and guidance for some years about the need to reduce or abstain from consuming alcohol.
- 7.4 There was evidence Tom engaged with his GP and with service providers such as Pathways. The panel also felt that other professionals recognised Tom's need for support with alcohol misuse and actively encouraged him to keep appointments there. Unfortunately, because of Tom's lifestyle, his pattern of engagement with services was intermittent.
- 7.5 Throughout his life, Tom seemed to put others before himself. Living alone at Address One, it became a gathering point for others who misused alcohol. The panel saw evidence that on many occasions Tom appeared to extend the hand of friendship to others. That included allowing people to live at the property and to borrow his money and possessions.
- 7.6 Sadly, some of those individuals misused Tom's friendship and stole money and possessions from him. Tom's good nature, combined with his misuse of alcohol, made him vulnerable to financial exploitation. This was recognised by Lynsey who reported her concerns which in turn led to a safeguarding referral.
- 7.7 The panel felt that, while there were some lessons arising from the safeguarding processes, overall there was evidence of excellent partnership working between the professionals in both the statutory and voluntary agencies involved with Tom. All of them seemed to recognise Tom's vulnerabilities and worked hard to put actions in place that would address the immediate risks he faced from other individuals who visited his address. For

example, removing fobs, monitoring CCTV and making joint welfare visits to Tom.

- 7.8 The panel also felt there was evidence of good partnership working, and sympathy, in the way that agencies worked together to deal with Tom's housing needs. There were two issues here: Tom's inability to resolve his arrears and the unsuitability of the property for his needs. Unfortunately, Tom could not be persuaded to leave the address. The panel felt that, had there been engagement with Lynsey and Tom's family, more might have been known about Tom's reasons for wanting to remain there and this could have led to an acceptable solution being developed.
- 7.9 Tom became the victim of crime when his bank card was stolen and used to withdraw money from his account. When this became known, through Pathways, the panel felt there was evidence of good interagency working. Tom was given immediate advice to speak to the bank²⁰ and the matter was reported to the police at the strategy team meeting. Unfortunately, Tom did not feel able to provide information that might have assisted the police in identifying those responsible: he said he did not want to be seen as a 'grass'.
- 7.10 The review panel felt this demonstrated the hold that some of the individuals who visited Tom had over him. Professionals appeared to recognise Tom's vulnerability to those sorts of risks. They were documented following the strategy team meetings and professionals appeared to take action in response to the risks. For example, the welfare visits that were made by the police and council officers and the information that was shared when Tom visited Petrus and said he was worried about unwanted persons at his property.
- 7.11 Overall the panel concluded that the actions of agencies and professionals were reasonable and in some areas, there was clear evidence of excellent interagency working and good practice. While Tom expressed concerns on some occasions, he would also give reassurances that the people involved had moved on or were in fact 'friends', about whom there should be no concern. The final visit to Tom at address one by professionals on 28.04.2016 was an example of how they accepted these reassurances and did not check or challenge Male A.
- 7.12 In reaching the judgment that the actions of professionals were reasonable, the panel do so against the contemporary policy and practice in respect of adult safeguarding. The panel believe the most important issue arising from this review is the need to align culture, policy and practice much more with that which exists in relation to protecting vulnerable children.

²⁰ When Lynsey reviewed this report she commented upon how helpful Tom's bank in Rochdale had been. She said the staff were very aware of Tom's vulnerability and took it upon themselves to be very patient and kind to him. They had persuaded him to always try and come into the bank to draw out money rather than from the cash machine and this was a protective factor on their part. The staff were said to be devastated by Tom's death as they interacted with him on a daily basis and really liked him and were concerned for him. Tom always spoke very highly of the bank staff.

- 7.13 If Tom had been a vulnerable child there would have been a much greater level of expectation in relation to the actions of professionals. For example, the gathering and recording of information, the structure of strategy meetings, the recording of risk, the scrutiny and challenge applied to new information and consideration of what that information meant to the identified risks.
- 7.14 The review panel recognise that changing culture and practice will not happen overnight and will not be a revolution. There are very real practical reasons why safeguarding vulnerable adults is not like safeguarding vulnerable children. Not least because it is much more difficult to ensure adults, like Tom, do not make unwise choices in their lives. However, the review panel believe this is a journey that needs to be embarked on now so that there will be an evolution in the way that vulnerable adults are safeguarded.

8. RECOMMENDATIONS

8.1 The Review panel recommends that Rochdale Borough Safeguarding Adult Board;

- i. Work with all agencies to identify how to improve the level of professional enquiry that is made in respect of concerns about vulnerable adults;
- ii. Ensure that, in cases where abuse is known or suspected, a named professional who can take responsibility for leading the actions to reduce the abuse is identified from within the partner agencies;
- iii. Ensure that when an adult safeguarding referral is made, a Care Act assessment is always considered as a means of gaining as much information as possible even if the subject may not obviously qualify for care;
- iv. Reinforce the need to ensure a formal capacity assessment is made to check if people's judgements on 'first principle' is accurate and they have capacity within the terms of the Mental Capacity. The outcome of that assessment, and the rationale for it, should always be recorded;
- v. Ensure that key family members are identified and consideration given to engaging them in the safeguarding process (e.g. inviting them to strategy meetings if appropriate);
- vi. Ensure information and contact details for key family members are, subject to their consent, shared with other agencies at strategy meetings unless there is a good reason for not doing so;
- vii. Engage with local banks²¹ and financial institutions to ensure they recognise the risk of financial exploitation of vulnerable adults and have measures in place for identifying those at risk and steps to protect them;
- viii. Gives consideration to developing templates for key processes and meetings;
- ix. Undertake work to ensure that professionals recognise and understand the problem of alcohol misuse and how they can work with and support people who misuse alcohol. In particular, more guidance is needed as to what the thresholds are when assessing the vulnerability of someone who misuses alcohol.

²¹ Following Lynsey's comments at footnote 19, it is important to stress that Tom's bank demonstrated good practice in the way they dealt with him and it is this sort of good practice that should be promulgated to other agencies, banks and financial institutions.

Appendix A

Definitions

The Care Act 2014

The Care Act 2014 introduces new responsibilities for local authorities and safeguarding adults' boards. It also has major implications for care, health and housing providers, people who use services, carers and advocates.

Section 44 Safeguarding adults' reviews

- (1) A Safeguarding Adult Board (hereinafter referred to as a 'board') must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
 - (a) There is reasonable cause for concern about how the board, members of it or other persons with relevant functions worked together to safeguard the adult, and
 - (b) Condition 1 or 2 is met.
- (2) Condition 1 is met if—
 - (a) The adult has died, and
 - (b) The board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
- (3) Condition 2 is met if—
 - (a) The adult is still alive, and
 - (b) The board knows or suspects that the adult has experienced serious abuse or neglect.
- (4) A board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
- (5) Each member of the board must co-operate in and contribute to the carrying out of a review under this section with a view to—
 - (a) Identifying the lessons to be learnt from the adult's case, and
 - (b) Applying those lessons to future cases.

Mental Capacity Act

What is Best Interests Decision Making?²²

The Mental Capacity Act (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. This is one of the principles of the MCA.

A lack of capacity must have been established as a result of assessing the person's capacity in accordance with the MCA and its Code of Practice. To find out more about assessing mental capacity visit our 'what is mental capacity?' pages.

The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day to day care (including both care staff, relatives or friends), or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation have to be made.

If the person has appointed someone (called an 'attorney') by making a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA – predecessors to LPAs) to make decisions on their behalf, then that attorney must make decisions in the person's best interests where they have the authority to do so and the person lacks capacity (this could include consent to care or treatment). If a person has a 'deputy' appointed by the Court of Protection then they must make decisions in the person's best interests where they have the authority to do so and the person lacks capacity.

Decisions about a person's property or their financial matters must be in the person's best interests but can only be made by an attorney appointed under an LPA or EPA, a court-appointed deputy, or the Court of Protection itself.

Certain decisions must never be made on behalf of a person who lacks capacity. These are called 'excluded decisions' and more can be found out about these on our 'what are excluded decisions?' pages.

If a person has a valid and applicable advance decision to refuse treatment, then that decision must be respected even if it may not appear to be in the person's best interests. The MCA Code of Practice has more information about this (Chapter 9).

If a person who lacks capacity needs to be kept in a care home or hospital because it is in their best interests then additional safeguards may apply. These are called the Deprivation of Liberty Safeguards (DoLS) and there is additional guidance about them in a separate Code of Practice (Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice – 2008).

²² Source: Mental Health Foundation www.bestinterests.org.uk

Best interests decisions do not apply when considering the involvement of someone who lacks capacity in research. This involves a different process and criteria. The MCA Code of Practice has more information on this (Chapter 11).

What is 'best interests'?

The law gives a checklist of key factors which decision makers must consider when working out what is in the best interests of a person who lacks capacity. This list is not exhaustive and you should refer to the Code of Practice for more details.

- It is important not to make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.
- The decision-maker must consider all the relevant circumstances relating to the decision in question.
- The decision-maker must consider whether the person is likely to regain capacity (for example, after receiving medical treatment). If so, can the decision or act wait until then?
- The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.
- If the decision concerns the provision or withdrawal of life-sustaining treatment the decision-maker must not be motivated by a desire to bring about the person's death.

The decision maker must in particular consider:

- the person's past and present wishes and feelings (in particular if they have been written down); and
- any beliefs and values (for example, religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors.

As far as possible the decision-maker must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

- anyone previously named by the person lacking capacity as someone to be consulted;
- carers, close relatives or close friends or anyone else interested in the person's welfare;
- any Attorney appointed under a Lasting Power of Attorney; and
- Any Deputy appointed by the Court of Protection to make decisions for the person.

If you are making the decision under the Mental Capacity Act you must take the above steps, amongst others and weigh up the above factors in order to determine what is in the person's best interests. For more information you should refer to the Code of Practice.

For decisions about serious medical treatment, certain changes of accommodation and care reviews where the person lacks capacity, and where there is no one who fits into any of the above categories to be consulted, the decision maker must consider whether they need to involve an Independent Mental Capacity Advocate (IMCA). Decision makers must also consider involving an IMCA in decisions involving adult protection issues, even if there is someone who fits into any of the above categories who could be consulted.

Appendix B

Panel Membership

Panel Members	Agency	Role
Rebecca Ashworth	RBH	Neighbourhood Housing Manager
Paul Cheeseman	Independent	Author & Support to Chair
Bilal Choudhury	RBSAB/RBSCB Boards Business Unit	Business Support Officer
Philip Foster	Petrus	Deputy Co-ordinator
Gina Helsby	Pennine Acute Hospitals NHS Trust	
David Hunter	Independent	Chair
Val Hussein	GMP Police	Detective Inspector
Karen McCormick	HMR CCG	Designated Nurse Safeguarding Vulnerable Adults
Tony Philbin	RBSAB/RBSCB Boards Business Unit	Safeguarding Boards Business Manager
Sian Schofield	Pennine Care NHS Foundation Trust	Head of Nursing and Strategic Lead for Safeguarding
Jane Timson	RBC Adult Care	Head of Safeguarding & Practice Assurance

Index to Key Professionals

Identifier	Role
KP1	Staff member Stepping Stones
KP2	Staff Member RBH
KP3	Key Worker Petrus
KP5	Enforcement Officer RBH
KP6	Social Worker1 RACS
KP8	Recovery Coach Pathways
PC1	GMP Police Officer

KP11	Income Officer RBH
PCSO1	First Police Community Support Officer
KP12	Petrus Officer
KP13	Social Worker2
KP15	RBH Officer
KP16	Staff Member Turning Point
PCSO2	Second Police Community Support Officer

Appendix C

Your name:		Job title/designation:		Date completed:	
Agency/Service:					
Event date & time		1.			
Event i.e. What actually happened?					
Policy/Protocol/Practice Standard/Compliance i.e. What should have happened (including by whom)					
Relevant supplementary information					
Missing information & gaps, omissions & breaches					
Notable good practice					
Contextual information & contributing factors to the above					

Appendix D

Action Plan

No.	Recommendations for Rochdale Borough Safeguarding Adult Board	Key Actions	Evidence	Key Outcomes	Lead Officer	Date