

**East Sussex Safeguarding Adult Review**

**Finley**

2023

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# **Introduction**

* 1. Finley was a White British man in his 30s. He was found deceased in November 2021 by his social worker following a notification from his mother that she could not contact her son. Finley had care and support needs. He had a diagnosis of schizophrenia and had been in hospital under section 3 of the Mental Health Act 1983 (2007 updated) until 7 weeks before his death. The cause of death was drug toxicity. However, Finley’s drug use was not fully understood by professionals or his family.
  2. The reviewer would like to offer condolences to Finley’s family and thank his mother for her contribution to this review which enabled the panel to view Finley beyond his diagnoses and presenting issues.
  3. The safeguarding adult review (SAR) referral was received on 7th June 2022 from Adult Social Care (ASC) East Sussex County Council (ESCC) and presented to the SAR Subgroup on 20th June 2022. The SAR Subgroup reached a decision in September 2022 that the SAR Criteria had been met and was endorsed by the East Sussex Safeguarding Adults Board (ESSAB) Independent Chair on 5th October. It is important to note that the purpose of a SAR is about learning to ensure that agencies work together to commit to preventing future deaths in similar circumstances.
  4. The reviewer commissioned to chair the review and complete the overview report is independent of any organisation within East Sussex.
  5. The methodology used involved having a practitioner event informed by each agency providing a summary of involvement. In addition, ASC submitted an Independent Management Review which had been completed prior to the commencement of the SAR, requested by the Director of Adult Social Care; Sussex Partnership Foundation NHS Trust (SPFT) shared their patient safety review.
  6. It is important that the review is informed by the experiences and perspectives of both practitioners and managers. The process enables practitioners and managers to have a constructive experience of taking part in the review that helps cultivate an open learning culture**.** To achieve this, a practitioner event was held on 8th March 2023 with representation from the relevant agencies.

1.7 It has been possible to identify good practice as well as highlighting the challenges faced by services when trying to support individuals with complex support needs. This is mirrored by Finley’s mother’s efforts to support her only son.

1.8 It is hoped that this review forms a legacy for Finley to help the ESSAB and its partner agencies to strengthen the way they work with individuals with complex needs.

# **Terms of Reference**

* 1. S44 of the Care Act 2014 requires that the East Sussex Safeguarding Adults Board must arrange for there to be a review of cases involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2.2 The focus of this review is on Finley’s final year of life, from January 2021 until his death in November 2021.

2.3 The following key lines of enquiry were agreed by the review panel:

* The impact of substance misuse on Finley’s capacity to keep himself safe.
* Professionals’ understanding of Lasting Power of Attorney, appointeeship, in the context of assessment of Finley’s capacity to make his own decisions regarding his care.
* To what extent Finley’s mother, as an informal carer, was included in his care planning.
* To what extent did the discharge planning include an assessment of Finley’s home arrangements, such as amenities needing to be turned on?
* How did agencies assess the suitability of Finley’s accommodation to enable him to live independently?
* What was the impact of Finley not receiving an autism assessment?
* How did professionals hear, and respond, to Finley? Was his voice heard?
* How were potential indicators of cuckooing assessed? How were potential indicators of financial abuse and exploitation responded to?
* To what extent did professionals recognise and respond to Finley’s potential self-neglect?
* What impact did the Covid-19 pandemic have on multi-agency working?

2.4 The agencies involved:

* Adult Social Care and Health (ASCH)
* Sussex NHS Integrated Care Board (ICB) (on Panel only)
* Primary Care: GP Practice
* Sussex Police
* Sussex Partnership Foundation NHS Trust (SPFT)
* Lewes District & Eastbourne Borough Council
* East Sussex Safer Communities Team -Strategic Commissioning Manager – Substance Misuse

# **Finley’s Background**

3.1 Finley was a white British man in his early 30s when he died. Finley’s mother described him as having a brilliant sense of humour and loving cartoons. Finley was a loner, only having a couple of friends as a child. His mother said he tended to push people away. When he was well, he was kind and considerate to others.

3.2 Finley’s mother described Finley as being hard work when he was a child. As a baby he screamed a lot and was difficult to get to sleep. From a very young age Finley had behavioural problems which were evident within the schools he attended. He moved schools when he was at risk of exclusion, but the behavioural issues continued, leading to school exclusions.

3.3 Finley’s mother informed this review that, during his teenage years, Finley’s behaviour became difficult to manage. This led his mother to contact Children’s Social Care for help. This resulted in him going to live with his birth father, with whom he had little contact during his childhood. By the age of 16 years, neither parent could manage him which led to Finley’s mother finding a bedsit for him and visiting him daily.

3.4 When Finley was 16, he was detained under S2 of the Mental Health Act. He was suffering from psychosis which appeared to be drug induced with Finley having used illicit substances. It was at this time that he was diagnosed with schizophrenia. He spent about two years in an adolescent unit.

3.5 Finley’s mother described how she found the transition from the child to adult services difficult as there were changes in how professionals worked with Finley. She stated that Finley needed more support than what was offered by adult services.

*‘He stayed 15 years old. He never grew up’ (*Finley’s mother*)*

3.6 At 19, Finley was placed in supported housing funded by Adult Social Care (ASC). This lasted for several years. However, his mother explained that he did not like it there and he did not receive the support that was set out by the home. Finley did not want his mother to make a fuss as he was worried about where he would be moved. Finley was given notice by the home as they could not offer the support he needed. This led to Finley moving to private housing.

3.7 Over a period of several years, Finley had a number of inpatient admissions, usually detained under the Mental Health Act (MHA), due to poor compliance to prescribed medication. Finley’s mother described how he spent his time on the computer, with his social life being solely online. He became isolated and not caring for himself, e.g., he would not wash his clothes.

3.8 Finley would not always accept the support offered by the services. In 2016, Finley was detained under s2 of the MHA and was subsequently a voluntary patient. When he was discharged from hospital, he received ASC funded outreach services and had an allocated social worker (SW) and a Community Support worker (CSW)from the ASC Mental Health Team. Home Works[[1]](#footnote-1) also became involved to assist with accommodation matters, including supporting to try to make homeless applications with the council.

3.9 At this time, Finley’s mother reported that Finley would not engage with social care reviews, and she was not included in them. Finley said he did not need anything.

*‘He fell through the system’ (Finley’s mother)*

3.10 Subsequently, Finley’s mother secured a private tenancy for him. He had declined Community Mental Health Team support but did continue to accept the ASC outreach services.

3.11 Finley’s mother explained that Finley had two carers who helped him with his medication, whilst his mother ordered his shopping. She visited him at weekends, as she did not live locally. In 2017, Finley’s tenancy was at risk due to antisocial behaviour, smoking cannabis, and noise. At this point Home Works became involved again to try to prevent Finely losing the tenancy.

3.12 In November 2017, Finley had a review with a Psychiatrist, and it was agreed to review him in a further 6 months. Then, in January 2018, following eviction from his flat, his mother decided to move him to be nearer to her. However, 12 weeks later Finley travelled back to East Sussex, getting lost in London on the way and losing his bank card. He found a place to live in Eastbourne and his mother paid as she had taken charge of his finances in 2012, through appointeeship for his benefits and a Lasting Power of Attorney agreed by Finley.

3.13 Towards the end of 2018, Finley was admitted to hospital on different occasions. Initially, in October 2018, he was detained under s2 of the MHA. Then, in November 2018, Finley was detained under s3. Whilst in hospital he was evicted from his home. He was discharged in the first week of 2019. The plan was for him to stay with a friend, but he soon reported that he could not stay there and was sleeping in a tent. His mother’s view was that he had been discharged to the street, with professionals taking Finley’s word that he had somewhere to go despite her telling them that he had been evicted. His allocated SW had not been involved in the discharge planning meeting and was not aware of the discharge. Finley’s mother said that he was homeless for three weeks and that she paid for him to stay at a bed and breakfast for 6 days.

3.14 Following this Eastbourne Borough council supported Finley to find temporary accommodation. Home Works were involved in supporting Finley, although his mother said that he declined this as she was already helping him with his finances. There were efforts to find Finley a supported living placement but without success. Finley continued to have frequent moves until, in October 2019, the council provided him with a flat.

3.15 By 2020, the allocated SW had withdrawn as Finley had support from a Community Psychiatric Nurse (CPN) and remained open to the ASC duty team. At this time, he was reported by his mother to be doing well and happy in his new flat. He was reported to have stopped his depot injection but stated he would take oral medication . As the Covid pandemic lockdown commenced, ASC made welfare calls to Finley and his mother, and he seemed to be doing reasonably well.

# **Key episodes through Finley’s final year of life**

Finley was the sole tenant of a 1-bedroom ground floor maisonette from 30th September 2019 until his death in November 2021.

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| **Key period 1. Potential indicators of cuckooing[[2]](#footnote-2) [[3]](#footnote-3)** |
| **January 2021**: Neighbours complaining about the condition of the front garden and rubbish bins. His mother is supporting Finley with his mental health and sorting out the garden.  **April 2021**: Mother informs the housing team that Finley may be subject to cuckooing as items are missing from his flat. A safeguarding referral is made by the housing team and reviewed by ASC. At this point, the information was shared with the ASC MH team for action as appropriate rather than for commencing a safeguarding enquiry.  **May 2021**: Cuckooing being looked at. A police welfare check is undertaken which confirms no evidence of cuckooing or drug use. The Tenancy Resolution Caseworker (TRC) visits home: reasonably tidy, with no evidence of squalor; no visible damage requiring repair, or of anyone staying. Neighbours expressed concerns that Finley was potentially being taken advantage of by visitors to the property. Mother emails ASC Mental Health team, Assessment and Treatment Service (ATS), GP to report that Finley is not coping, not taking his medication and is unwell. She reports a lack of funds in his account. She reports concerns about an individual she felt was taking advantage of Finley financially. The GP contacts the ATS, they try to contact Finley without success. |
| **Key period 2: Continued reports of drug use and children and young people visiting.** |
| **June 2021**: ASC contacted ATS as they were unable to make contact with Finley. Tenancy resolution caseworker received a call from neighbour who reported that previous night there had been:   * Two carloads of young people (around 8-9) showed up and entered the property. * They were noisy throughout the evening up until they left at around 21:30 - 22:00. * Strong smell of cannabis emanating from the property as the windows were open.   Adult Mental Health team finding it difficult to contact Finley. Joint visit managed between tenancy resolution caseworker and ASC Mental Health & Substance Misuse Team. Property not in state of absolute disrepair or squalor but messier than the previous tenancy resolution caseworker visit. Finley served with a formal warning letter re complaints. He claimed that the group of people at his property over the weekend were invited by one particular individual that he knows, although he did not specify who - these were the people that were smoking cannabis and their presence at his property was a one off. He said he did not expect them to return. Advice given about calling police if there were unwanted visitors. He declined ASC support.  Reports from neighbours suggested there were continuing visitors. This included one report of'lots of young people and children' visiting with allegations of antisocial behaviour (ASB), noise nuisance and cannabis smells emanating from the property. |
| **Key Period 3: Concerns regarding Finley’s welfare** |
| **July 2021**: Neighbours stated there had been no further incidents of ASB, but they were concerned about Finley’s welfare as he seemed to have lost weight. Mother raising concerns about lack of ASC Mental Health & Substance Misuse Team support.  **August 2021**: Neighbours raised concerns about regular groups of people coming and going and suggested that there could be drug dealing and misuse. Concerns also raised regarding Finley’s general welfare. Police Officers attempted a welfare check, but Finley declined to let them in as he said the door key was in the washing machine. The officers returned the next day and observed Finley to be unkempt. There was no evidence of cuckooing, identified by the police, at this point. There were signs of drug use, but Finley denied using drugs. He said that he had friends’ round, but they did not stay the night.  TRC visited Finley who stated that the visitors were not unwanted.  Mother contacts ASC MH Team requesting that follow up was completed on her son as she was really concerned about mental wellbeing and his risk of self-neglect. During this call she was frustrated and agitated voicing that she feels that staff do not listen to her concerns. Mother lives away from area, therefore most of her contact with Finley was via phone.  The ATS attempted to do a home visit to undertake a Mental Health Act Assessment due to concerns about Finley’s presentation. He refused on several occasions to let the team into his home. This led to the ATS conducting a joint visit with the police with a warrant to gain access and complete the assessment. This resulted in Finley being detained in hospital under s3 of the MHA. The assessment included:   * Risk of self-neglect high * Risk to others appears low however is using substances was irritable today. * Risk from others medium due to his general vulnerability. * Risk of further deterioration is high.   On admission he had a diagnosis of psychosis. He was considered to lack capacity and insight. The clinical view was a relapse of psychosis, potentially drug induced and anxiety.  During this admission Finley was allocated a Lead Practitioner to provide more consistent follow up in the community. During admission, it was noted that Finley was deemed to lack insight into his mental health and lacked capacity to make decisions regarding his health. |
| **Key Period 4: Finley is discharged home from hospital.** |
| **September 2021**: At the start of September neighbours and Finley’s mother report that the flat has been broken into. This is recorded as a suspected burglary. It is found that there has been drug use in the flat. Locks are changed to secure the premises whilst Finley is in hospital. Mother emails all agencies about her views against him being discharged from hospital without a care package, food, or money. A discharge planning meeting is held, with mother attending. She informs professionals that all amenities had been stopped and so she would need time to arrange reconnection prior to his discharge.  The ASC Duty SW attended the s117 discharge planning meeting. It was agreed that a social care assessment would be undertaken. This was undertaken and Finley reported he did not have any social care needs and could manage all activities of daily living.  There was liaison between the duty SW and the tenancy resolution case worker. This confirmed that Finley had been given an anti-social disorder contract in June, that he signed. It was confirmed that the council are understanding of Finley’s condition and would not evict due to drawing on walls, not maintaining flat or because he does not like to have furniture.  **October 2021:** As mother was away and not contactable, she was not part of Finley’s final discharge planning meeting, although had been involved prior to this. During this meeting staff asked Finley if his amenities were reconnected and if he had food, to which he answered "yes". The SW asked the tenancy resolution caseworker who could not confirm that the utilities had been turned on. Finley tells the tenancy resolution caseworker that utilities are on, and he has stocked up on food, as he had been on periods of leave prior to discharge.  At this point, as he is considered to have full capacity to make the decision, Finley is discharged from hospital. Two days after discharge the SW called duty at ATS voicing concerns that Finley’s social circumstances were deteriorating and that she had involved the tenancy resolution caseworker as Finley has no utilities, SW also reported that there was evidence that Finley had been using substances.  Mother informs TRC that she is still helping Finley to pay his bills out of his universal credit but had deferred budgeting for food etc to him.  During October, the ASC Mental Health & Substance Misuse Team appoint an allocated Social Worker to Finley who attempted a home visit and tried to phone but there was no answer. Joint visit planned by tenancy resolution caseworker with SW and CPN but did not take place. No answer when tenancy resolution caseworker visited the home.  On an occasion in October police had cause to detain Finley for a drug search, during the search he was handcuffed and compliant. Nothing was found and no crimes recorded.  Finley was long overdue his depot injection for schizophrenia due to him not attending the clinic. It was completed by the Community Mental Health Team (CMHT) on a home visit, with a plan to do home visits going forward.  **November 2021**: 02 November 2021 there was a joint visit by the TRC and CPN. Finley seen and he denied seeing any of the previous visitors.    On 23 November 2021 there was a joint visit between the SW and CPN. The social worker started the social care needs assessment; Finley expressed he wanted to live at his current address. He provided limited answers around what care and support he needed. Discussion was held around Finley’s mothers’ concerns about money and need to undertake capacity assessment regarding finances. Finley commented he is aware he needs to stop asking his mum for money. He said he had been ‘up and down’ with people coming into his home but said things had now settled.  On the 28 November 2021 Finley’s mother raised concerns for his welfare after not able to contact him. A welfare check was carried out by his social worker on the 29th of November who finds Finley deceased in his home.  The post-mortem concluded that the level of cocaine found in Finley’s blood was that of a typical recreational drug user. The cause of death was drug toxicity. |

# **Analysis of Practice**

The analysis is set out using the key lines of enquiry from the terms of reference.

**5.1 The impact of substance misuse on Finley’s capacity to keep himself safe.**

5.1.1 Finley had misused illicit drugs for a period of time. He had received a police caution for drugs possession 2017. In April 2021, the police received some intelligence regarding Finley’s involvement with drugs. As the source of the intelligence was considered to be untested, the information was kept on file.

5.1.2 In the police summary of information and at the practitioner event there was information provided that, in 2021, Finley was stopped and searched under S.23 of the Misuse of Drugs Act 1971, by police, when he was visiting another adult who was considered to be vulnerable to cuckooing. At this point Finley was not found in possession of drugs. It was reported there was a use of force form completed regarding the use of handcuffs as Finley had persisted in keeping his hands in his pockets during the search, despite being asked by the officers to keep his hands out of his pockets. There were other times when drug paraphernalia was found in his home, Finley would inform practitioners that it was not his.

5.1.3 It would have been of benefit for a multi-agency assessment of Finley’s drug use, to ensure effective information sharing and to evaluate the risks to Finley, and the children reported, by neighbours, to be visiting him.

5.1.4 When Finley was in hospital in August 2021, there was recognition that he had a chronic substance misuse issue and that substance misuse services had been unable to engage him in their programmes. However, this was seen as a separate issue to his mental health and the ward was not set up to be able to support him with this. No referrals to drugs services were made, only signposting for Finley to access support himself. There was a missed opportunity to undertake an assessment of his substance misuse when he was in hospital under S3 of the Mental Health Act 1983 (updated 2007).

5.1.5 At the practitioner event it was reported that there was a gap in the service provided to the acute inpatient mental health wards in terms of addressing drug use issues. It was reported that there had previously been workers visiting the ward to undertake interventions with individuals, but this was no longer in place. The SPFT policy for acute inpatient mental health sets out the requirement for patients admitted who experience both mental health and substance misuse problems needs to have comprehensive assessments, screening, and shared treatment plans in relation to substance misuse and mental health needs.[[4]](#footnote-4)

5.1.6 On admission to hospital, it was known that Finley used drugs. The SPFT patient safety review noted that he refused to engage with substance misuse services and that the extent of his drug use was not always known. However, this was a missed opportunity to ensure that drug use was clearly documented on his treatment plan, as this could have informed the discharge planning for him, in light of the concerns regarding others using his flat.

5.1.7 During Finley’s final year of life, there were key indicators that substance misuse was a high risk to his safety:

* His neighbours reported, repeatedly, that the property was being used for drug use.
* The Police were aware of previous drug use by Finley.
* His mother raised concerns that there had been a suspected theft within the property, and also that Finley was getting into debt, spending excessively on unknown items.
* When he was assessed under the Mental Health Act prior to admission to hospital, he was recorded as using substances.

5.1.8 Despite this, there were no drug services involved in seeking to help Finley. His mother, as appointee for his finance benefits, did not seem to be aware of the extent of his drug use. There could have been consideration about sharing the information with her. Depending on the risks posed to the individual or others, consideration can be made in safeguarding situations as to whether it is in the public interest to share information.[[5]](#footnote-5) Professionals need to ensure that they consider factors such as mental capacity when making a decision to share information in such circumstances.

* 1. **Professionals’ understanding of Lasting Power of Attorney, appointeeship, in the context of assessment of Finley’s capacity to make his own decisions regarding his care.**

5.2.1 It was well known by agencies that Finley’s mother held the LPA for him. His mother indicated that she held the LPA for both property/finance[[6]](#footnote-6)and health[[7]](#footnote-7). However, at the practitioner event the impression from the mental health clinicians was that the LPA was only for property/finance. The LPA status had been confirmed by Finley’s mother at the first s117 discharge planning meeting, yet the implications of this did not seem to be fully understood across the professional network.

5.2.2 Whilst Finley was in hospital in August- October 2021, his mother was in contact with the ward, and was included in some meetings. If the ward staff were unaware of the health LPA that may have limited the way in which they included Finley’s mother in the decisions for his care. During Finley’s admission he was considered not to have the insight into his mental health issues or the capacity to make decisions regarding his care. That would have meant that the health LPA needed to be applied, with his mother fully included in decisions. However, when Finley was discharged, he was assessed as having the capacity to make that decision. This meant that the involvement of the LPA for health and welfare may not have been an active consideration at that point as he was deemed to have capacity to make decisions around his care.

5.2.3 Meanwhile, there was also the financial LPA and appointeeship in place. As his mother held appointeeship for his benefits, it was required that she be included in making arrangements for Finley’s discharge, in terms of making sure the utilities were switched on and that he had food in. If there had been no property/finance LPA, the Local Authority may have explored appointeeship if Finley lacked the capacity to manage his affairs himself.

* 1. **To what extent Finley’s mother, as an informal carer, was included in his care planning.**

5.3.1 Finley’s mother reported that she was not invited to all of the ward meetings whilst Finley was under section in the months prior to his death. However, the ward team reported that they had been in regular contact with her, and she had been invited to the meetings. ASC Mental Health & Substance Misuse Team were also in contact with her on a regular basis. However, before the final discharge meeting, she had made it clear that she was taking a holiday and needed a break. Therefore, it would have been of benefit to include that in the discharge planning to ensure that Finley had his carer available at the point of discharge. Had he needed physical care, it would not have been possible to discharge him without his informal carer being available, or an alternative care package being in place. As part of the s117 discharge planning, there could have been greater recognition of the role his mother played in his care. Instead, professionals took the view that Finley said he was fine and that his grandmother was around to support him. As he had been going on leave to sort his flat out, he seemed to be able to be independent.

5.3.2 Professionals were very aware of Finley’s mother being there for him as she initiated regular contact with all services working with her son. Without her involvement, Finley would not have coped alone as he struggled to manage tasks such as shopping and budgeting independently.

5.3.3 ASC recorded Finley’s mother as his informal carer. Carer assessments were undertaken with her, the last being in May 2021. Each assessment led to a carer’s personal budget as well as the offer of advice and guidance around her wellbeing. Although this was done, there was something missing in the understanding of how Finley’s mother was coping and what she needed to enable her to continue as a carer. She was frequently contacting ASC to get help for her son. There were ASC plans to take on the appointeeship, but this was not achieved prior to Finley’s death. The ASC response to Finley’s mother’s concerns tended to focus on his lack of engagement rather than exploration of the dynamics of the mother/carer and son relationship.

5.3.4 When Finley was in hospital, staff engaged with his mother and involved her in the preliminary discharge planning. Finley’s mother was concerned that her son could not manage living alone. Meanwhile, ward staff, who had known Finley for a long time, perceived that Finley could be independent as had survived for years living in that way. It is not clear to what extent the ward staff understood the level of support Finley’s mother was providing for him. Additionally, his mother seemed to be unaware of the involvement of police in relation to Finley being searched for drugs.

5.3.5 Although there was significant evidence of services including Finley’s mother in his care decisions, Finley’s mother was not consistently able to see what support was in place. She expressed a view that Finley was set up to fail once the accommodation had been allocated to him. She was of the view that Finley had been left with no social worker, no CPN, and no care package. She said it was her belief that he was cuckooed and ended up selling his goods.[[8]](#footnote-8) His mother spoke to him daily. Prior to his death, Finley had been asking his mother for money for a debt, which she paid. 10 days before his death, his mother said that Finley had appeared to be very unwell. He had no coat, needed a new duvet, but did not have a care package.

5.3.6 Finley’s mother reported to the reviewer that she feels that the services were not joined up in supporting her son. This review has found that there was substantial working together by services, which continued when Finley was back in the community. This demonstrates how difficult it is for informal carers when they witness their loved one neglecting themselves. There can be a limit to the impact the carer and services can have on the outcomes for the individual, without their cooperation. In these situations, where there are reports of self-neglect, the Sussex Safeguarding Procedures should be used to support professionals in their decision making and how they work with family and social networks.

* 1. **To what extent did the discharge planning include an assessment of Finley’s home arrangements, such as amenities needing to be turned on?**

5.4.1 At the practitioner event, it was made clear that ward staff were aware that Finley’s grandmother had visited him to bring him his new door key. Finley informed staff that the amenities had been switched on. Although it was known that his mother was away, no one questioned what arrangements would not be in place in her absence, e.g., food shopping.

5.4.2 As Finley had been detained under s3 of the Mental Health Act, he was entitled to S117 aftercare provision. It was recorded that he declined a care package. As he had capacity, it was accepted that could make that decision, at this point. Had he accepted, he may have been offered a personal assistant to help with cleaning and shopping, subject to the outcome of a social care assessment. As there may have been a delay in sourcing this support, due to its availability, analternative social care support might have been offered.

5.4.3 Finley declined the S117 aftercare. He did agree for his mother to receive the s117 paperwork. The 2018 paperwork was sent to his mother, rather than the 2021 updated paperwork. Finley’s mother requested the updated paperwork including the care plan, list of medication, names, and contact numbers for the CPN and social worker. Given that Finley’s mother was doing his shopping and supporting him with his financial arrangements, it was reasonable for her to be informed about the provision. However, the paperwork was not finalised and sent to her prior to Finley’s death. This was a missed opportunity for the agencies to work with his mother to promote the options for support to Finley.

5.4.4 At the practitioner event, the housing team reported that they should have been involved in the S117 meeting due to the state of the property, any repairs needed or considering how to alleviate the pressure on the family in relation to the amenities. ASC had liaised with housing at the discharge planning stage. The ASC Mental Health & Substance Misuse Team Practice Manager at the event agreed to invite housing in future to S117 meetings where individuals are in social housing.

* 1. **How did agencies assess the suitability of Finley’s accommodation to enable him to live independently?** 
     1. It was recognised, by the tenancy resolution officer, that Finley needed supported living at the time of his discharge from hospital. However, he had a poor experience of such accommodation previously and so declined. The accommodation he had was in a quiet locality, not known for antisocial behaviour or drug dealing. Neighbours looked out for Finley. They raised concerns if there was antisocial behaviour, but also alerted housing when they thought that Finley did not look well.
     2. As already shown, during Finley’s final year of life, there were key indicators that substance misuse was a high risk to his safety. Finley never accepted any intervention for substance misuse recovery or treatment. His denial of addiction may have been too strong for him to accept help despite the professionals’ best attempts at an intervention. There was clear evidence from agencies he was not able to live well independently, i.e., tenancy issues, previous evictions, description of the living conditions inside the flat /state of the property, Finley's physical state and obvious signs of self-neglect. When considered holistically, this evidence is indicative of Finley living in unsuitable accommodation.
     3. When Finley was in hospital, there were staff who knew him well. They perceived him as someone who could live independently. Once he was clinically ready for discharge, there was a discharge plan in place. His mother argued that it was not appropriate for him to be discharged. It was suspected that there had been a burglary. There was single agency work to support Finley to address issues with his accommodation. However, this was not considered sufficiently from a multi-agency perspective. Housing were not fully aware of the discharge. This suggests that there was not sufficient multi-agency questioning as to whether the accommodation was acceptable for Finley’s needs.
     4. Given the concerns raised by the local community prior to his admission, as well as the suspected burglary and the concerns Finley’s mother consistently raised, there should have been a review of Finley’s safety within independent accommodation. The focus was on his views and desire to return home. He was considered to have the capacity to make the decision for his housing. However, not enough attention was made of the safety of the accommodation for Finley, in terms of the potential use of the accommodation by unknown individuals. When he was in hospital this was a key time to undertake a risk assessment for Finley and it offered a potential, reachable moment to engage him in a drugs programme.
  2. **What was the impact of Finley not receiving an autism assessment?**

5.6.1 Finley’s mother was convinced that he was autistic. However, she realises that a diagnosis may not have changed the outcome for her son.

5.6.2 The assessment was missed when Finley was a child. His mother repeatedly asked for an assessment. It had been considered in 2017 when the SW asked the GP to consider a referral for an autism assessment. However, hospital admissions led to this not being the right time to action the request. It was considered when he was an adult but was not actioned prior to his death. He was receiving services and an assessment could have helped in the planning for Finley’s care, financial benefits and support for education or work, and for him to understand why he might feel different to other people.[[9]](#footnote-9) Nevertheless, it was not appropriate for him to have the assessment whilst an inpatient and, once back in the community, would have needed to be actively engaged in any arrangements for an assessment.

5.6.3 An assessment may have helped Finley understand himself much more. It could have confirmed, or refuted, his mother’s view of his being autistic.

* 1. **How did professionals hear, and respond, to Finley? Was his voice heard?**

5.7.1 At the practitioner event there was good evidence of how professionals listened to Finley. When he was discharged from hospital in the weeks prior to his death, Finley agreed to having the long-acting depot injection. However, he did not attend the clinic to have this and so professionals adapted their service to enable Finley to have it at home.

5.7.2 Whilst in hospital, staff listened to Finley and responded to him to enable him to regain his independence. He was given s17, unescorted leave, during which he was reported to have visited his home to get it ready for when he was discharged. He was reported to be unhappy on the ward and was indicating that he wanted to be discharged.

5.7.3 There was evidence that Finley wanted to become more independent and not rely on his mother for his finances. Professionals listened to him but did not, immediately, respond with a practical way forward for Finley, i.e., Local Authority appointeeship or assistance to manage his budget. The appointeeship was planned but not enacted by the time of Finley’s death.

5.7.4 Some professionals made considerable efforts to engage with Finley and adapted their response to reach him. There was a consistent sense that professionals regarded Finley as having the capacity to make his decisions, and so they accepted his views about not wanting a social care assessment or other assistance. Professionals gave Finley guidance on how to seek help, e.g., to call the police if there were problems with unwanted visitors.

5.7.5 Finley’s vulnerabilities due to his self-neglect, mental health issues, substance misuse and risk of exploitation, should have alerted professionals to the need for further investigation when there are concerns that an individual is repeatedly making unwise decisions that put them at significant risk of harm or exploitation.[[10]](#footnote-10)

5.7.6 When there were signs of crisis, professionals responded in a timely way and worked together to ensure Finley’s safety. In-between mental health crises, professionals were restricted in what they could achieve with the legal frameworks, without the clear evidence of harm.

* 1. **How were potential indicators of cuckooing assessed? How were potential indicators of financial abuse and exploitation responded to?** 
     1. Finley’s mother raised concerns about cuckooing, along with neighbours reporting antisocial behaviour from visitors to the flat. Housing appropriately made a safeguarding referral in relation to possible cuckooing, and it was reported to the police who undertook welfare checks.
     2. There were two safeguarding referrals to ASC by housing, in April and May 2021. On these occasions the information shared was assessed as not requiring a s42 safeguarding enquiry, but for further information to be shared for action as appropriate. In May 2021, housing referred to the tenancy resolution team as they deal with cuckooing issues. The tenancy resolution officer followed up on the suspicion of cuckooing, speaking to Finley, his mother, and neighbours. In May 2021, there was a police welfare check which found no evidence of cuckooing or drug use. Yet, in August 2021, there was evidence of drug use, although Finley denied using drugs himself.
     3. The outcome of checks being made in relation to potential cuckooing seemed to be that professionals accepted that there was no cuckooing. ASC Mental Health & Substance Misuse Team practitioners reported that the tenancy resolution officer was of the view that Finley was not being cuckooed and that it was just a case of *‘local lads.* This was accepted by ASC Mental Health & Substance Misuse Team and no further follow up was made. This missed the opportunity to question why children were visiting Finley and what risk he posed to them.
     4. The police had Finley’s address flagged as a potential for cuckooing but did not have sufficient information to initiate police legal powers to enter the property. Finley said he invited people in and there were no signs of cuckooing when the police visited. This meant the police had only a single strand of intelligence suggesting that the property might be used for drug use.
     5. Had there been a clear suspicion of cuckooing then the police would have arranged a multi-professional meeting. This could have enabled structured information sharing between agencies to identify whether Finley or the children were at risk of exploitation and to undertake a joint risk assessment.
     6. At the practitioner event it was clear that the local area where Finley lived was not viewed as an area for risks in the same way as other parts of East Sussex, such as some seafront housing. Yet, it was suspected that there was a break in whilst he was in hospital.
     7. In his previous housing Finley lived in there were concerns that he was vulnerable to cuckooing. There was a police investigation that focused on Finley’s Class A drug use and his links to County lines and risk to children. The reports from his neighbours, in 2021, were of children arriving in taxis, of Finley being possibly taken advantage of and reports of substance misuse. These align with the signs of County Lines[[11]](#footnote-11) of:
* An increase in visitors and cars to a house or flat
* New faces appearing at the house or flat
* Change in resident's mood and/or demeanour
* Substance misuse and/or drug paraphernalia
* Young people seen in different cars/taxis driven by unknown adults
* An increase in anti-social behaviour in the community

5.8.8 There was alleged financial abuse, by an individual known to Finley. However, there does not appear to have been any understanding of this due to Finley refusing to respond when asked about it. Nevertheless, it was known that Finley was not managing his finances and was open about the fact that he was spending too much money on things and asking his mother for more money. This knowledge could have provoked greater curiosity from practitioners as to what Finley was spending his money on. The professional response was to acknowledge Finley’s views that he was not being exploited.

* 1. **To what extent did professionals recognise and respond to Finley’s potential self-neglect?**

5.9.1 When Finley was detained under the Mental Health Act and admitted to hospital, he was assessed as being at high risk of self-neglect. Yet there was limited multi-agency action taken to consider the impact of the risk on Finley once he was discharged, due to him declining support at the point of a social care assessment.

5.9.2 There was no multi-agency meeting held to focus on the self-neglect, in line with the Sussex self-neglect procedures. There seems to have been an assumption that the self-neglect was due to Finley’s mental health crisis, and so short term.

5.9.3 Prior to discharge from hospital he was granted unescorted s17 leave,[[12]](#footnote-12) during which he was reported to visit his flat. It would have been of benefit for the professionals working with him in the community to have been informed about the s17 leave. This was an opportunity to work with Finley to establish an agreement with him for how services could work with him when he returned home, to prevent long term neglect. However, when he was offered a social care assessment he declined. His refusal was accepted as he had the mental capacity to make that decision. Yet, this does not appear to have been considered in the context of the high risk of self-neglect. It was reported that the Occupational Therapist concluded that a home assessment was not required. This conclusion was based on the perception that ASC did not view that Finley had care and support needs, rather than Finley’s refusal to have social care assessment.

5.9.4 Had there been a multi-agency meeting held under the Sussex Safeguarding Procedures[[13]](#footnote-13) covering self-neglect, this could have ensured that all services were aware of the risks of self-neglect and a plan agreed with Finley and his mother as to how to proceed at the point of discharge.

* 1. **What impact did the Covid-19 pandemic have on multi-agency working?**

5.10.1 Finley was on the ASC Mental Health & Substance Misuse Team welfare list to be contacted regularly during the pandemic. However, Finley did not respond to phone calls or doorstep visits. The TRC did undertake home visits. When the Mental health team found it difficult to access the home, there was a joint visit undertaken with the Tenancy Resolution Caseworker.

5.10.2 A review of the impact of the first year of the Covid-19 pandemic on the East Sussex population was undertaken by Public Health.[[14]](#footnote-14) The report identified how the early stages of the pandemic exposed the significant societal inequalities across East Sussex, e.g., health, financial, access to housing.[[15]](#footnote-15) There were an estimated 190000-210,000 people across East Sussex who were considered to be clinically vulnerable.[[16]](#footnote-16) Finley was in this cohort, having been considered to be vulnerable by ASC. This would have created significant challenges for agencies to work together to support individuals safely, prior to the availability of vaccines.

5.10.3 It is difficult to gauge the impact of the pandemic on Finley. He lived a self-imposed isolated life which has been confirmed by his mother and practitioners who worked with him. Therefore, much of his life probably did not change during the lockdown. However, that is not to say that Finley would not have been affected. For those days when he wanted to get out into the community or do shopping, he would have been restricted. His mother was a long distance away. Due to Finley’s vulnerabilities, his mother could have been able to visit him to provide assistance including shopping for essential items.[[17]](#footnote-17) However, this would have been extremely difficult for her due to the travelling involved. In May and June 2020, Healthwatch East Sussex undertook a survey to identify the impact of the first pandemic lockdown on people’s health and wellbeing. This identified that the most common impact of the lockdown for adults was the lack of freedom, with concerns about loneliness, anxiety and access to health and care services.[[18]](#footnote-18) The impact for agencies to provide reassurance to individuals who needed them would have been a significant challenge at this stage in the pandemic.

# **6. Good Practice**

6.1 Finley’s mother identified some professionals who were effective in developing relationships with her son. She was particularly complementary about the tenancy resolution officer who consistently tried to work with Finley, as well as the CAMHS worker who continued to work with Finley into adulthood, until he was 21.

6.2 There were considerable efforts by the tenancy officer and tenancy resolution officer to work to keep Finley within accommodation. There were also timely responses to the concerns of neighbours.

6.3 Despite the Covid-19 pandemic restrictions, agencies maintained their efforts to undertake home visits to Finley.

6.4 When Finley was discharged from hospital, he declined a care package. However, there were joint visits by tenancy resolution officer, CPN or SW. This enabled a link to be maintained between Finley and agencies.

# **Conclusion and Learning for the Wider System**

The learning from Finley’s experience within this safeguarding adult review can be used to alert ESSAB and its partner agencies to wider learning across the system. This will be illustrated using the framework developed by Michael Preston-Shoot.[[19]](#footnote-19) This framework sets out the learning across four different aspects:

* Direct work with Individuals
* Team around the person (interagency working)
* Organisational aspects
* Governance

**Direct Work with the Individual and Carers**

**7.1 Engaging with Families**

7.1.1 Finley’s mother was his carer despite not living locally. She was offered regular care assessments by ASC to enable her to access support in her own right.[[20]](#footnote-20) She held appointeeship for Finley’s benefits, Lasting Power of Attorney for finance and property, and for health and welfare. She was in constant contact with agencies when she was concerned about Finley’s self-care. She recognised that agencies did liaise with her, but she did not always agree with the professional responses and did not witness the level of joint working that went on.

7.1.2 At the practitioner event, health professionals spoke of how it can be difficult to work with an adult, such as Finley, who has mental capacity and to fully include family members. There can be a tendency for the individual to agree for positive information to be shared with their family, but not the negatives. For example, responding well to treatment will be shared, but not the information about non-attendance at appointments or substance misuse. This leads to families being left out of decisions but feeling the responsibility to help their loved ones.

7.1.3 Where there is a health LPA in place, this should indicate what the individual has agreed to with their attorney. An individual is able to appoint a Lasting Power of Attorney (LPA) if they do so whilst they have the mental capacity to do so. The benefits of an LPA are so that the individual can state what they want to happen if they do not have the mental capacity to speak for themselves. There are LPAs for property/finance or health and welfare.

7.1.4 The health and welfare LPA can only be used when the individual (donor) does not have the capacity to make their own decisions. The attorney can then make decisions in regard to daily routine, for example washing, dressing, and eating, medical care and where the donor lives.[[21]](#footnote-21)

7.1.5 The property and finance LPA is for supporting an individual (donor) to make decisions about issues such as money, tax, bills, and benefits. The attorney can start making decisions while the donor still has mental capacity if that has been stated in the LPA and the donor has given permission.[[22]](#footnote-22)

7.1.6 When someone has fluctuating capacity, as in Finley’s case, it would be reasonable to seek their agreement to include their attorney at every point, so that they understand any changes to the individual’s health and treatment. Identification of missed appointments or substance misuse would, potentially, indicate a loss of capacity. Where the individual declines to consent to the attorney always being involved, this could initiate more exploration of the individual’s wishes, and the dynamics of the relationship.

**Recommendation 1: SPFT /ASCH to assure themselves as to the effectiveness of the tools in place to support their staff to understand Lasting Power of Attorney arrangements for property & finance and health & welfare, when they are activated and how their requirements are incorporated into a person's care, treatment, and support. This learning should be shared across partner agencies to raise awareness of Lasting Power of Attorney arrangements.**

**Interagency Working**

**7.2 Responding to indicators of cuckooing**

7.2.1 In Finley’s case, no specific evidence was found to support the suspicion that he might be at risk from cuckooing. Nevertheless, there were indicators of county lines and previous concerns in relation to cuckooing of an individual known to Finley. Although agencies shared some information, a safeguarding enquiry was not initiated and assumptions were made about the groups of young people visiting Finley, despite the concerns raised by the local community.

7.2.2 Families and neighbours can provide anecdotal information about suspected cuckooing. Indeed, communities are encouraged to raise concerns about indicators of County Lines.[[23]](#footnote-23) However, they might not inform the police directly, instead raising their concerns with the local workers they know well. This can create a risk due to the potential dilution of the exact nature of concerns not reaching the attention of the police. For example, the witnessing of groups of children and young people visiting premises at night being interpreted as adults visiting, or just being local young people.[[24]](#footnote-24)

7.2.3 The police powers are limited, unless there is clear evidence of the individual being at risk of harm. Even where welfare checks are undertaken, this might result in no clear evidence of an individual being the victim of cuckooing.’[[25]](#footnote-25) Sussex Police aims to hold a strategy meeting within 48 hours for ‘red’ cases, which are those assessed as high and / or immediate risk of harm.

7.2.4 Sussex Police has been undertaking a county-wide review of responses to adult exploitation including cuckooing. This includes meeting with police officers with the lead for cuckooing in East Sussex and shadowing two Multi-Agency Risk Meetings (MARM). The MARM is used to refer adults with multiple compound needs who risk falling between the gaps of existing services. By the very nature of the MARM meeting, people referred will have experienced at least four of the following risk areas: homelessness, offending behaviour, domestic abuse, substance use and mental health. The current outcomes of these reviews include developing a cuckooing action plan with related policy for Sussex Police (including engagement with partners) and there is already a MARM review planned by East Sussex County Council. This will ensure that all referrals are considered through the lens of exploitation given the high risks and high vulnerabilities linked to the people being referred into MARM.

7.2.5 According to the National Crime Agency’s National Strategic Assessment of Serious and Organised Crime (2021) COVID 19 lockdowns likely contributed to a continued rise in cases of county lines offending with potential victims more visible. At least 14.5% of referrals were flagged as county lines in 2020 compared to around 11% in 2019. [[26]](#footnote-26). This emphasises the need for agencies to work with the local communities to understand unusual activity in the area, involving children, young people, and adults vulnerable to exploitation.

**Recommendation 2: Sussex Police should consider how information and intelligence, including previous history and at other locations can inform the response to someone who is suspected of being a cuckooing victim (vulnerable to exploitation) but where they are denying they are being cuckooed. It may be beneficial that these situations are considered in the context of County Lines as well as Anti-Social behaviour.**

**Organisational Features**

**7.3 Dual diagnosis**

7.3.1 Finley was known to be a long-term drug user yet declined any support. When he was detained in hospital, there were missed opportunities to attempt to find ways to work with him. Over most of his life Finley had struggled to manage his daily routine in order to give him a fulfilling life.

7.3.2 Since Finley had been a child, his mother had been asking for an autism assessment. A referral for an assessment was considered prior to discharge the final time Finley was in hospital. With this in mind, it is important that agencies do consider autism when there is a situation in which an individual is struggling to manage in their environment. Individuals detained under the Mental Health Act are extremely vulnerable due to their inability to keep themselves safe. Admission to psychiatric units is undertaken to provide the appropriate assessment and treatment, as well as keeping the individual safe.

7.3.3 At the practitioner event, it was expressed that in the region of 75% patients have dual diagnosis on the acute mental health ward. The view expressed at the event was that staff are not equipped to deal with substance misuse. Staff signpost to services but that requires the individuals to be motivated to engage. In Finley’s case, he refused to engage with substance misuse service (CGL).

7.3.4 At the practitioner event, it was reported that there are no longer the links for drug advice and ward visits by drug workers, whereas, in the past there were weekly surgeries on the ward. However, there are new dual diagnosis workers within the Sussex Partnership NHS Foundation Trust and there remains a requirement to assess both mental health and substance misuse for any individual admitted who is known to have problems with both as set out in the Adult Acute Inpatient Mental Health Service Operational Policy.[[27]](#footnote-27) This defines the management of dual diagnosis within the acute inpatient setting. This means that on admission, patients who experience both mental health and substance misuse problems needs to have comprehensive assessments, screening, and shared treatment plans in relation to substance misuse and mental health needs.[[28]](#footnote-28)

7.3.5 The National Analysis of SARs (2020) found that attention to mental capacity was “*one of the most frequently noted deficiencies in direct practice in the SARs”.* This included failures to assess, or where mental capacity was not considered in cases where individuals were making chaotic choices or where they were involved in coercive or exploitative relationships.[[29]](#footnote-29) This could be considered when an individual is using drugs but is not willing to engage with services to help them to stop.

7.3.6 In December 2021, the Government launched its ten-year drug Strategy “from Harm to Hope”. In June 2022, national guidance was published outlining how a local partnership approach is needed to address the harm caused by the supply, demand, and misuse of drugs.[[30]](#footnote-30)   In East Sussex, there is a Harm to Hope Board which governs this work and  facilitates senior level buy-in from key partners to strategically combat substance misuse related harm and create a safer, healthier community.   The aim of this board is to bring together all key partners to provide strong leadership to support the work of all frontline practitioners involved in this work.

**Recommendation 3: Substance misuse service commissioners, the commissioned substance misuse service provider, and the Sussex Partnership NHS Foundation Trust to review, agree and implement arrangements for integrated assessment and support planning to support hospital discharges for people with both mental health problems and problematic use of substances. The outcomes for this group of people should inform the work of the Harm to Hope Board.**

**Governance**

**7.4 Multi-agency response to self-neglect**

7.4.1 Finley was known to neglect himself particularly during periods when he was unable to manage his medication and reached a mental health crisis. Multi-agency action was effective when there were concerns Finley was in crisis. There was evidence of joint working to ensure that Mental Health Act Assessments were completed. These led to Finley being detained under the Mental Health Act. However, once he was ready to be discharged, services were limited in the ways in which they could reach Finley and support him, as he would only engage to a certain extent. He was considered to have the mental capacity to make decisions about his care and support needs. This meant that he was able to keep his drug use out of the sight of professionals.

7.4.2 The Social Care Institute for Excellence (2018) defines self-neglect as:

* Lack of self-care to an extent that it threatens personal health and safety.
* Neglecting to care for one’s personal hygiene, health, or surroundings.
* Inability to avoid harm as a result of self-neglect.
* Failure to seek help or access services to meet health and social care needs.
* Inability or unwillingness to manage one’s personal affairs.[[31]](#footnote-31)

7.4.3 Therefore, the multi-agency response to someone who is known to have mental health crises, misuses substances, and is refusing help to support themselves, should be to follow the self-neglect procedures within the Sussex Safeguarding Procedures. It is important that professionals understand that the Mental Capacity Act does not stop them from acting to protect someone from self-neglect.

*‘the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided.’[[32]](#footnote-32)* (Alcohol Change, 2019)

7.4.4 The Sussex Safeguarding Procedures take account of learning from Safeguarding Adults Reviews (SARs) involving cases of self-neglect and set out a framework for collaborate partnership working when supporting adults who are experiencing self-neglect.However, practitioners need to feel confident to work with individuals and to follow the procedures. It is not the sole responsibility of ASC to lead on the response to self-neglect. The identifying agency can consider whether to convene a multi-agency meeting.[[33]](#footnote-33)

7.4.5 The relevance of multi-agency meetings is to aid information sharing to provide clarity as to the safeguarding concern and need for a s42 enquiry, or for a multi-agency response under the self-neglect procedures. This can also support the identification of the most appropriate lead agency, which will not necessarily be ASC. Relationship-based practice is vital for professionals to be able to engage with an individual who is self-neglecting.[[34]](#footnote-34) This should provide a key opportunity to consider mental capacity and risk in the context of self-neglect.

**Recommendation 4: The East Sussex Safeguarding Adult Board are asked to seek assurance from commissioners, providers, and partner agencies on arrangements for supporting staff to have the necessary knowledge, experience, and skills to recognise and act upon self-neglect with a specific focus on substance misuse.**

1. Home Works is a service that requires referrals by professionals. The service offers support to those who are vulnerable and have support needs due to age, disadvantage, disability, substance misuse or ill health, and ate experiencing housing related issues such as temporary accommodation, need support to move to more appropriate housing to meet their needs, need to support to maintain their independence. <https://www.bht.org.uk/services/homelessness/east-sussex-floating-support/#Residents_aged_16-59> - East Sussex Floating Support Service (formerly known as Home Works) [↑](#footnote-ref-1)
2. The UK Government defines county lines as: *County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.* [↑](#footnote-ref-2)
3. Gangs are known to target adults vulnerable due to prior experience of neglect, abuse, substance misuse, mental health issues, social isolation. The gangs can take over their homes which is known as ‘cuckooing’. Home Office (2018) *Criminal Exploitation of Children and Vulnerable Adults: County Lines Guidance*  [↑](#footnote-ref-3)
4. Sussex Partnership NHS Foundation Trust (2022) *Adult Acute Inpatient Mental Health Service Operational Policy.* Section 8. [↑](#footnote-ref-4)
5. Sussex SABs (2022) *Information Sharing Guide and Protocol. Version 2*. [↑](#footnote-ref-5)
6. For Property and Financial LPAs, the attorney can make day to day decisions about money, tax, bills, and benefits. The attorney can start making decisions while the donor still has mental capacity if the LPA states this, and the donor gives permission. <https://www.gov.uk/lasting-power-attorney-duties/property-financial-affairs> [↑](#footnote-ref-6)
7. The health and welfare attorney can only make decisions when the donor does not have mental capacity to make them. In these circumstances the attorney can make decisions about daily personal routines, medical care and where the donor lives. <https://www.gov.uk/lasting-power-attorney-duties/health-welfare> [↑](#footnote-ref-7)
8. Cuckooing was never confirmed by professionals, although was suspected. When checked Finley would deny to professionals. [↑](#footnote-ref-8)
9. <https://www.nhs.uk/conditions/autism/getting-diagnosed/how-to-get-diagnosed/> : accessed 20 March 2023. [↑](#footnote-ref-9)
10. HM Govt (2007) Mental Capacity Act Code of Practice. TSO. <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> [↑](#footnote-ref-10)
11. <https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines> [↑](#footnote-ref-11)
12. A detained patient is only allowed to leave the hospital when approved by their responsible clinician. The responsible clinician may set any conditions or restrictions on that leave they consider necessary in the interest of the patient or the protection of other persons. This can include that the person is escorted. <https://www.legislation.gov.uk/ukpga/1983/20/section/17> [↑](#footnote-ref-12)
13. <https://www.sussexsafeguardingadults.org/> [↑](#footnote-ref-13)
14. [2020 A year of Covid-19 in East Sussex (adph.org.uk)](https://www.adph.org.uk/wp-content/uploads/2022/05/2020-A-year-of-Covid-10-in-East-Sussex.pdf) [↑](#footnote-ref-14)
15. [2020 A year of Covid-19 in East Sussex (adph.org.uk)](https://www.adph.org.uk/wp-content/uploads/2022/05/2020-A-year-of-Covid-10-in-East-Sussex.pdf) [↑](#footnote-ref-15)
16. [2020 A year of Covid-19 in East Sussex (adph.org.uk)](https://www.adph.org.uk/wp-content/uploads/2022/05/2020-A-year-of-Covid-10-in-East-Sussex.pdf) [↑](#footnote-ref-16)
17. <https://www.gov.uk/guidance/making-a-support-bubble-with-another-household> [↑](#footnote-ref-17)
18. Healthwatch East Sussex (2020) *Covid-19: Health and Wellbeing in East Sussex during May and June 2020.* [↑](#footnote-ref-18)
19. Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement.* LGA*.*  [↑](#footnote-ref-19)
20. <https://www.eastsussex.gov.uk/social-care/carers/support/carers-assessment> [↑](#footnote-ref-20)
21. <https://www.gov.uk/lasting-power-attorney-duties/health-welfare>: accessed 21 March 2023. [↑](#footnote-ref-21)
22. <https://www.gov.uk/lasting-power-attorney-duties/property-financial-affairs> : accessed 21 March 2023. [↑](#footnote-ref-22)
23. Gangs are known to target adults vulnerable due to prior experience of neglect, abuse, substance misuse, mental health issues, social isolation. The gangs can take over their homes which is known as ‘cuckooing’. Home Office (2018) *Criminal Exploitation of Children and Vulnerable Adults: County Lines Guidance*  [↑](#footnote-ref-23)
24. <https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines> [↑](#footnote-ref-24)
25. Brighton SAB. SAR: James. [↑](#footnote-ref-25)
26. National Crime Agency *2021 National Strategic Assessment of Serious and Organised Crime*. [https://www.nationalcrimeagency.gov.uk/who-we-are/publications/533-national-strategic-assessment-of-serious-and-organised-crime-2021/file    p22-23](https://www.nationalcrimeagency.gov.uk/who-we-are/publications/533-national-strategic-assessment-of-serious-and-organised-crime-2021/file%20%20%20%20p22-23) para 60. [↑](#footnote-ref-26)
27. Sussex Partnership NHS Foundation Trust (2022) *Adult Acute Inpatient Mental Health Service Operational Policy.* Section 8. [↑](#footnote-ref-27)
28. Sussex Partnership NHS Foundation Trust (2022) *Adult Acute Inpatient Mental Health Service Operational Policy.* Section 8. [↑](#footnote-ref-28)
29. Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA. [↑](#footnote-ref-29)
30. <https://www.gov.uk/government/collections/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives> [↑](#footnote-ref-30)
31. <https://www.scie.org.uk/self-neglect/at-a-glance> : accessed 21 March 2023. [↑](#footnote-ref-31)
32. Alcohol Change UK (2019) *Learning from tragedies An analysis of alcohol-related Safeguarding Adult Reviews published in 2017*  [↑](#footnote-ref-32)
33. <https://www.sussexsafeguardingadults.org/> [↑](#footnote-ref-33)
34. Braye,S. Orr, D. Preston-Shoot, M. (2015) *Self-neglect policy and practice: key research messages.* SCIE*.*  [↑](#footnote-ref-34)