Safeguarding Adults Review: Case Adult P

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Briefing paper for practitioners

Author	Paul Nicholls – Independent Reviewer
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1. Background and context.

Adult P was a white male, aged 37 when he died on 9 August 2021 at his home in Norwich. He lived alone with little information known about his immediate family. There is a reference to a former partner and record of a son. Adult P experienced a great deal of trauma as a child, he was abused sexually and physically. He suffered a back injury in 2019 and as a result had limited mobility. He used a mobility scooter, had a history of falls, mental ill health, drug, and alcohol use. Concerns were raised that Adult P was allowing people to come into his home and threatening him.

A safeguarding adult enquiry was opened regarding financial abuse and exploitation.

Agencies worked hard to support Adult P and reported that his home was in poor condition: cluttered and hoarded. The night before Adult P died, Careline 365 received a notification that his fall detector had been activated. A paramedic did not attend until 10.45 the next morning when sadly Adult P was found dead at the property.

A Safeguarding Adults Review (SAR) referral was made to the Norfolk Safeguarding Adults Board (NSAB) on 13 August 2021 by Norfolk Constabulary, due to concerns about how agencies had worked together and the response to the alarm call.
The review was delayed in starting due to difficulties in securing an independent author, with the first panel meeting being held at the end of October 2022.

Four key themes were identified for this review they were:

- Were the responses to the initial safeguarding concerns (in September 2020) effective?
- Was the response by Careline365 to the alarm call timely, appropriate and within service level agreements?
- Were the risks to Adult P adequately assessed and responded to by the housing providers?
- Was there an effective multi-agency response to Adult P's mental health concerns around his safety?

2. The purpose of the review

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice issues
- how to improve local inter-agency practice

The SAR panel included relevant agencies involved the care and treatment of Adult P.

3. Recommendations and areas for learning and improvement

There were six recommendations in the review of Adult P. The themes identified in these are summarised below

Cuckooing and exploitation
There could have been a better understanding or consideration of cuckooing / adult exploitation following Adult P's disclosure that 'a mate' was living at the address, and the subsequent allegations of physical abuse and threats to his life.
It was acknowledged that the police investigation into the alleged cuckooing was hampered somewhat by Adult P's reluctance to continue with the investigation.

There is a recommendation that NSAB oversee the development of a briefing document and an effective countywide response, based on the learning from this review regarding cuckooing with the aim to support appropriate identification and responses by professionals and agencies. This work will be led by the Norfolk Safeguarding Adults Board's Business Group and linked to ongoing work on exploitation and county lines.

The implementation and use of assistive technology in homes
Adult P had a Careline365 alarm installed in his home. Careline365 were one of five alarm providers across Norfolk. There was no standard service level agreement across these providers. Also, when the alarms are installed, the user is asked to complete a self-assessment, outlining their health conditions and support needs. Practitioners need to support users in completing these forms, to ensure their needs are clearly identified and any background safeguarding risks are detailed.
This will ensure that if an alarm is activated, the correct level of grading can be allocated to the call, resulting in an effective, timely response.

The recommendation says: Assistive Technology team to lead on the development of a Norfolk County Council wide service level agreement, across all community alarm providers that Norfolk County Council work in partnership with by August 2023. This SLA will be shared with other Norfolk housing providers, where appropriate. Assistive Technology will also lead on the development of support for

individuals, to share their information about their needs and vulnerabilities with their care alarm provider.

Also, NSAB will ensure that Careline365 will review and amend its policy, with a view to continuing to attempt to make contact with an individual following a non-response call until a resolution is achieved.

Effective handover of information between housing providers

In this review it was identified that when Adult P moved between housing providers, background and safeguarding information was not shared effectively.

The recommendation says: housing providers and district councils to review the approach which ensures a more effective handover of background and safety information, particularly for high-risk clients when they move between providers.

Non-attendance at appointments

It was identified in this review that Adult P did not attend many medical appointments. We need to ensure that this is identified and acted upon, particularly for high-risk clients such as Adult P. The review group noted that a policy is under development, led by the integrated care board and this should be further developed and implemented across the partnership.

Norfolk and Waveney Integrated Care Boards (NWICB) lead on the further development and embedding of the 'was not brought' policy across health providers - NHS England guidance[1]

Section 42 enquiries

The review identified that a Section 42 enquiry was started ten months prior to Adult P's death but was not closed until after his passing. This was not in line with current procedures. Therefore, the recommendation was as follows:

The local authority and Norfolk Constabulary to review their systems for quality governance around the recording of Section 42 enquiries, to ensure that there is a mechanism in place to monitor investigations that take too long or become stuck, and also that practitioners update partner agencies when one agency's involvement in a case comes to an end. They should undertake a dip sample audit of enquiries over a 12-month period to check if all had been actioned or closed appropriately, using their own policy standards, with the audit completed within nine months of publication of the SAR report.

[1] NHS England » Reducing did not attends (DNAs) in outpatient services

4. NSAB Response

NSAB will ensure that this learning is followed up through its composite action plan and test how well agencies have applied the learning from SARs through the Safeguarding Adults Review group and board meetings.

END.