Safeguarding Adults Review: Case Adult P

Executive Summary

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Summary – Safeguarding Adults Review concerning the death of Adult P at his home in Norwich.

In August 2021, Adult P passed away at his residence in Norwich. Professionals had expressed concerns about the potential exploitation of Adult P. Subsequently, after experiencing a fall at home, Adult P activated his Careline365 alarm to request assistance. Unfortunately, when an ambulance arrived the next morning, Adult P was discovered to have passed away. This review specifically examined the factors contributing to the delay in responding to the alarm and the circumstances surrounding his death.

1. Background to the review

This is a summary of the review into the complex case of Adult P, the care he received, and the support provided.

Adult P was a white male, aged 37 when he died on 9 August 2021. 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 they were 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 a 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 held at the end of October 2022.

2. The key lines of enquiry

Four key themes were identified by the initial review panel in October 2022:

- 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 raised about his safety?

The review covered the period **1 August 2019 to 9 August 2021**. Other key events outside of this time were considered if they were deemed relevant.

3. The multi-agency review panel for this review

The SAR panel (SARP) met five times for this review. The panel was made up of representatives from Norfolk County Council (NCC) adult social care, Norfolk Constabulary, East of England Ambulance Service, the Integrated Care Board (representing the GP), Norfolk & Norwich University Hospital, Norfolk & Suffolk NHS Foundation Trust, Careline365 representatives, Clarion Housing and Broadland Housing.

The review used the Signs of Safety methodology when looking at each of the four key themes.

4. The four key lines of enquiry

4.1 Were the responses to the initial safeguarding concerns (in September 2020, when the safeguarding enquiry commenced) effective?

Concerns were raised during 2020 by professionals for Adult P's safety following two alleged assaults. Adult P said he had 'a drug debt' and was 'being threatened'. Police conducted extensive investigations, which resulted in no further action.

Adult P was admitted to hospital in September 2020, following a suicide attempt with intent. A safeguarding referral was made by hospital staff on the day of admission. Whilst Adult P was in hospital the occupational therapist raised concerns that Adult P was at high risk of falls within his flat and completed a mobility assessment.

Arrangements were made between the hospital discharge team, NSFT care coordinator, social worker, and housing provider for respite accommodation. His flat was secured by the housing provider, while he was in respite accommodation.

Potential 'cuckooing' was investigated by police, but Adult P decided to withdraw support from the investigation, which was subsequently closed.

A section 42 enquiry, jointly led by police and social care, commenced on 29 September 2020. No safeguarding enquiry and risk assessment was recorded at the time by adult social care but was completed retrospectively. The safeguarding episode remained open at the time of death.

Learning from this key line of enquiry

- To raise awareness of the signs and symptoms of 'cuckooing', resulting in a county wide approach, across the partnership

- To ensure that section 42 enquiries are not left 'open' and are completed within timescales

4.2 Was the response by Careline365 to the alarm call timely, appropriate and within service level agreements?

Norfolk County Council Assistive Technology team used five approved providers of community alarms across the county. Norfolk County Council did not have a countywide service level agreement (SLA) for response times to community alarms at the time of the review.

A Careline365 community alarm and associated equipment was installed in Adult P's residence in July 2021. At the time of installation, the process when providing new alarms was that the installer asked the client to complete a new customer self-declaration form. Adult P completed this; it gave basic health information about him and did not highlight any previous safeguarding or high-risk safety issues.
This meant that only basic information was passed to the ambulance service meaning that the call was subsequently classed as lower priority.

Adult P suffered a fall on 8 August 2021 and activated his fall detector. In line with protocol, calls were made to his first and second contacts, neither of who were able to attend Adult P's address and check on his welfare. Subsequently, a call was made to the ambulance service requesting a welfare check. They responded that the current wait time 'was 8 hours.' Due to high demand, the ambulance subsequently attended 13 hours later and found Adult P deceased. Ambulance service confirmed that the alarm call was graded as 'Category 4' (see below) due to the background information received about Adult P.

Category 4 *- coded calls are for patients whose condition is not urgent but does require a face-to-face assessment. The Category 4 regional level target aims to respond to nine out of ten patients within 180 minutes. Patients who have fallen and just require assistance or minor injuries would be coded into this category.*

The police then attended, after being contacted by the ambulance service, and found Adult P deceased.

Learning from this key line of enquiry

- A Norfolk County Council service level agreement or protocol is needed to include response levels and industry standard accreditation across all community alarm providers in Norfolk
- Multi-agency support for individuals, particularly those at high risk, to complete the self-assessment declaration at installation of the care alarm. This will ensure that the care alarm providers can identify higher risk clients and respond accordingly
- Assurance that Careline365 will review and amend its policy in consultation with TEC Quality with a view to continuing to attempt to make contact with an individual following a non-response call, until a resolution is achieved.

4.3 Were the risks to Adult P adequately assessed and responded to by the housing providers?

Adult P lived in a first floor flat provided by Clarion Housing since 2005, he subsequently moved to a bungalow provided by Broadland Housing in December 2020. Clarion worked proactively with partner agencies to try and find more suitable accommodation for Adult P when his ongoing mobility issues increased during 2020.

Housing teams were responsive to Adult P's needs and understood the risks others posed to him. There was evidence to show they worked positively and in partnership with him and other agencies such as social care and the mental health team, when safeguarding issues escalated.

When Adult P reported physical abuse in September 2020, the property was secured, to prevent further thefts, and alternative accommodation options were explored. Adult P moved into a bungalow provided by Broadland Housing in December 2020. It was unclear in recording how much, if any, background information about Adult P's risks and safeguarding history was handed over from Clarion to Broadland Housing. This was identified as an area for learning.

Learning from this key line of enquiry

- There needs to be a better handover of background and safety information, particularly for high-risk clients when they move between Norfolk's housing providers.

4.4 Was there a multi-agency response to Adult P's mental health concerns raised about his safety?

Adult P suffered abuse from an early age and subsequently led a complex life requiring a lot of support. Adult P's physical health, housing and mental health needs were continually met and reviewed by practitioners. Practitioners worked effectively in partnership and tried everything they could to improve outcomes for Adult P, but this was often made difficult by his reluctance to engage with them or attend appointments.

Covid had an adverse effect on Adult P's mental health, and he found the social isolation difficult; his mental health suffered, and his drug and alcohol intake increased. There were occasions when Adult P declined domiciliary care and his home conditions deteriorated. Adult P said this was because he 'couldn't afford it'. This was recognised by the social worker who arranged a fee waiver.

A referral was made by the nursing team in hospital to the occupational therapy team for adaptations to Adult P's home. Broadland Housing's policy meant that no adaptations could take place until Adult P had lived there for 12 months.
This policy was subsequently revised, and the 12-month period removed.

Learning from this key line of enquiry

- The partnership needs to develop more effective ways of engaging clients who are reluctant to engage, or frequently miss appointments.

5. Recommendations/actions to effect change following this review

5.1. NSAB to 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 Business Group and linked to ongoing work on exploitation and county lines. The document will include signs and symptoms and how to raise concerns. This briefing should be used as widely as possible, including via the Locality Safeguarding Adults Partnership.

5.2. 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.

5.3. Assurance that Careline365 will review and amend its policy in consultation with TEC Quality, with a view to continuing to attempt to make contact with an individual following a non-response call until a resolution is achieved.

5.4. 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. Success to be measured through either introduction of an updated policy or confirmation through dip-sample audit that current process, if followed, is fit for purpose.

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

5.6. 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 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 dip sample audit of enquiries over a 12-month period to check if all had been actioned or closed appropriately within nine months of publication of the SAR report.

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

6. Acknowledgements

The independent reviewer would like to thank the Norfolk Safeguarding Adults Board manager and the NSAB team, practitioners and review group members for their support and guidance during the completion of this review.

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