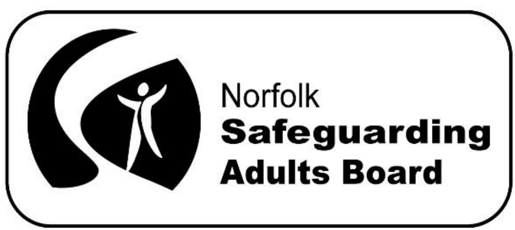

Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Case Adult P

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1. Background to the review

1.1 This report is a summary of the review into the complex case of Adult P. The care he received, and the support provided, was discussed in detail with the panel of experts and representatives from across the Norfolk partnership. This report therefore is the summary of findings and recommendations. It is written in accessible language to encourage readership and action.

1.2 The pertinent facts are:

- Adult P led a solitary life, with no social network and limited contact with his family.
- He suffered trauma as a child and a back injury as an adult, both of which contributed to complications in later life, including alcohol and substance misuse.
- Partner agencies worked hard to engage with Adult P and offer support with his mental and physical health and addictions, with limited success.
- Concerns were raised by carers and housing providers that people were abusing and taking advantage of him, leading to investigations by police.
- A move to more suitable and safer housing was arranged, along with an assistive technology alarm to support him.
- Unfortunately, Adult P would suffer a fall in his home, resulting in his death.
- The emergency response to assistive technology alarm, activated after the fall, is the main theme of this review.

1.3 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.

1.4 Adult P experienced a great deal of trauma as a child, he was abused sexually and physically. As a teenager he was admitted to a mental health hospital with depression and psychosis. 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.

1.5 On 20 September 2020 concerns were raised by a community mental health worker and again on 24 September by an occupational therapist, 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.

1.6 Adult P had a Care Act assessment in April 2020 and a reassessment of his needs in July 2021. It was not immediately possible to find a provider of rehabilitative support Adult P needed, resulting in a delay in receiving the daily care he required. Several agencies report Adult P's home was in a poor condition, cluttered and hoarded.

1.7 Assistive technology support was provided in summer 2021 by Norfolk County Council, including the provision of a care line alarm and Adult P was referred to specialist services for excessive alcohol use and class A drug use.

1.8 The night before Adult P died, Careline365 received a notification that his fall detector had been activated. A paramedic did not attend until 10.45 the next morning, when sadly, he was found dead at the property.

1.9 A Safeguarding Adults Review (SAR) referral was made to the Norfolk Safeguarding Adult Board (NSAB) on 13 August 2021 by Norfolk Constabulary, due to concerns about how agencies had worked together and the response to an alarm call.

1.10 Norfolk Safeguarding Adult Board has a statutory duty to arrange a Safeguarding Adult Review where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the board, its members or others worked together to safeguard the adult.

The SAR was commissioned under section 44 (1) of the Care Act 2014.

2. The purpose of the review

2.1 This Safeguarding Adult Review will determine what the relevant agencies and individuals involved in the case might have done differently in the case of Adult P. This is so that lessons can be learned from this case and those lessons applied to future cases to try and prevent similar circumstances arising again.

2.2 This SAR will:

- Encourage a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults
- Aim to identify opportunities to draw on what worked well and promote good practice; what could have gone better and learn from this.
- Make use of any relevant research and case evidence to inform the findings
- Seek the views of the clients on the support services provided to Adult P – this will take place after the initial learning review but before the publication of the final report

2.3 In relation to case Adult P, the specific purpose was to:

- Produce a simple and accessible chronology of pertinent events for Adult P
- Identify key episodes when critical actions were or were not taken.
- Explore the reasons why actions were taken or not taken at critical points
- Identify the learning that emerges in relation to how the agencies involved worked singly and jointly in the case

3. Period covered by the review

3.1 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.

4. Methodology for the review

4.1 The review group identified key practitioners directly involved with the case and explored four key themes (see below). These were agreed in the case discussion at the NSAB Safeguarding Adults Review Group in October 2021.

4.2 The review will not include a detailed narrative of each event and aspect of care and support; however, the panel will have had sight of this detail which informs the findings and recommendations.

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

4.4 The key questions were:

- What went well?
- What could have been better?
- What is the learning for future cases?

5. Key themes identified by the review panel

5.1 Four key themes were identified by the initial review panel in October 2021, these 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 raised about his safety?

6. Partnership review panel

6.1 An independent lead reviewer worked alongside a review panel, composed of senior managers. The membership of the panel was:

- NSAB manager (chair)
- SAR independent review writer
- Head of social care, adult mental health, Norfolk County Council (NCC)
- NSAB coordinator
- Assistant director for patient safety, Norfolk & Suffolk NHS Foundation Trust
- Detective inspector, Norfolk Constabulary
- Head of strategic partnerships, Careline365
- Deputy designated lead for adult safeguarding, Norfolk & Waveney Integtated Care Board
- Safeguarding adults practice consultant, NCC
- Alarm response supervisor, Careline365
- Safeguarding practitioner, East of England Ambulance Service
- Safeguarding lead, Change, Grow, Live
- Named professional for safeguarding adults & MCA lead, Norfolk & Norwich University Hospital (NNUH)
- Head of operations, Clarion Housing
- Assistant housing director, Broadland Housing
- Safeguarding named nurse, NNUH

7. Parallel reviews and investigations

7.1 Any parallel or similar reviews and investigations in Norfolk around the time of this review will be considered and will inform the learning. It is important to consider these to avoid duplication of learning points and to cross reference action plans and changes to practice.

7.2 A coroner's inquest into Adult P's death took place on 26th May 2022. The conclusion was a drug related death. The Coroner's Office noted that this review had been commissioned and will receive a copy of final report.

7.3 There were no ongoing police investigations at the time of this review.

8. Governance

8.1 The review panel will report directly to the monthly Safeguarding Adults Review Group via the board manager, which in turn reports to the Norfolk Safeguarding Adults Board.

8.2 Attempts were made by the independent reviewer, to contact Adult P's father by letter in October and November 2022, with no response. No attempt was made to contact adult P's ex-partner as no up to date address details were held.

9. Summary of key events and dates

9.1 Below is a summary of some of the key episodes, pertinent to this review. The review panel have had full sight of the full details of this case, which informed the findings. These events were collated from several sources, primarily the combined agency chronologies and single agency reports.

Date	Key Events
2019	(Adult P living in first floor flat provided by Clarion Housing, since 2005).
May	Adult P admitted to hospital for a detoxification from alcohol programme, referred for assessment by the mental health liaison (MHL) team.
Nov	Starts treatment with the community mental health team (CMHT). Adult P misses first appointment and does not respond to several attempts (two phone calls, one email and one letter) to contact him. Discharged back to the care of his GP in December 2019 (informed by letter).
Dec	Clarion Housing raise internal (within Clarion Housing, not to the local authority at this stage) safeguarding alert, following concerns raised by neighbours. Front door damaged and noted, by Clarion, that someone else was living at the flat.
2020	
Feb	Registers with GP at East Norwich Medical Partnership. Recorded as in 'poor health' and has 'lost 4 stone in past 6 months.' Further referral to CMHT. Attends hospital with head injury following an assault, money, phone and medication stolen. Following a police investigation, no evidence of the offence identified, crime was filed with no further action taken. Adult P did not engage with investigating officers.
April	Admitted to hospital after collapsing and sustaining a head injury. Social care recommends move to a ground floor flat as Adult P struggling with mobility issues. Tells hospital social worker he has '£400 drug debt and is being threatened and scared to go home'. This was logged in the social care case notes, no safeguarding referral was made.

Date	Key Events
2020	
May	Admitted to hospital following overdose, cited his son as a strong protective factor. Placed on flexible assertive community treatment (FACT[1]) by Norfolk and Suffolk NHS Foundation Trust (NSFT) care coordinator for a period of additional support.
July	Recorded as having ‘a mate’ living at the address by social worker during assessment, passed to welfare rights team for clarification regarding housing benefits being claimed by both parties.
Sept	Chronic back pain (Since 2012) worsening since fall in April and recorded as impacting on daily life. Referral to Norfolk and Suffolk Foundation Trust (NSFT) care coordinator. Admitted to Norfolk and Norwich University Hospital (NNUH) critical care following suicide attempt. Further safeguarding concerns SW in MH Team – S42 enquiry starts – recorded as ‘harassment, threats by friends and neighbours. Abuser reported to have stolen £12k of benefits back payment. Recorded as ‘scared to go to police, fear of repercussions from abuser(s)’. Clarion Housing appoint specialist support worker for Adult P; internal safeguarding case opened. Police undertake an investigation which is eventually closed as no further action as Adult P withdrew support for the investigation.
Oct	Clarion Housing secure Adult P’s property while he is in hospital. S42 enquiries start, led by police and SW. Detailed interview with police officer and social worker with Adult P where he discloses abuse and threats. Recorded by social worker and police inform Adult P they will follow witness protection protocol. Adult P discharged from NNUH to Heath Farm Care respite support for two months. Changes his name by deed poll. Reports being assaulted by another person – NFA by police. Broadland District Council housing options engaged to discuss more suitable accommodation.

[1] Flexible assertive community treatment (FACT) is a Dutch model of community-based mental health care that provides flexible, multidisciplinary support to people with severe mental illness.

Date	Key Events
2020	
Nov **Nov**	Adult P reported deteriorating mental state which manifested as increasing voices reporting that his prescribed medication was no longer effective. Respite provider worries about Adult P taking class A drugs whilst on leave. Collects some of his belongings from flat. Encouraged to engage with Change Grow Live (CGL), a specialist substance misuse service. Professionals meeting to further discuss safety planning when Adult P leaves respite care.
Dec	Allegation of assault by fellow resident - police NFA. Leaves Heath Farm and moves to bungalow owned by Broadland Housing. Recorded that Broadland are unaware of any previous safeguarding concerns.
2021	
Jan	Adult P encouraged to register with a new GP (Drayton Medical Practice). No concerns noted by his new NSFT care coordinator; they developed a care plan together.
Feb	Adult P's care transferred to the northwest adult community team. Adult P generally mentally stable with evidence of positive forward planning and continued to receive support from his Together worker from Norwich MIND[2].
March	Mental health deteriorates and says to be spending all his money on alcohol and heroin.
April	Adult P refuses to engage with CGL as he thinks the service is 'not very good'. Occupational therapy (OT) assessment concludes that adaptions should only be made once Adult P has been in his property for a year.

[2] Work to reduce the stigma associated with mental health, support people in their recovery and champion better services for all.

Date	Key Events
2021	
May	Physical health continuing to be monitored by GP. Domiciliary care arranged for one hour per day, seven days a week, provided by Breakforth. Referral by social care asst. practitioner to Assistive Technology for a community alarm accepted and added to waiting list.
June	Domiciliary care starts one hour a day. Adult P occasionally asks them not to attend, resulting in deterioration of the living conditions. Referral from social services to CGL. Grandfather passes away and Adult P has thoughts of self-harming, ambulance attends. Crew report the living conditions as very untidy and dirty – they contact social worker and Breakforth. Assistive Technology assessment completed, community alarm to be provided by Careline365 (previously known as Lifeline 24). Adult P also agrees to the provision of a fall detector device.
July	Community alarm installed after some initial technical issues. Options discussed with mental health worker and agreed with Adult P. Suggested that Adult P tests his falls detector each week – no response from Adult P. Breakforth continue to support Adult P and suggest he engages with CGL. Adult P says, 'doesn't want to do this, as they are no good'. Adult P states he can no longer afford to contribute towards the £70 per week cost of Breakforth service. Social care agrees fee waiver to enable to Breakforth to provide the much-needed service. CGL start assessment process and get medical records from GP. Work commences between CGL and Adult P.
August	Adult P's son visits and stays the night. Adult P seeks support to help with the garden, which is very untidy. Says he is in 'a lot of pain'. Referral for support with garden accepted by Broadland tenancy team.

Date	Key Events
	Scheduled appointment with NSFT cancelled by Adult P as he would be attending a CGL meeting instead, further appointment to be arranged. No acute risks identified at this point. 6 Aug - Mechanical fall tripping over cable, no injury, got himself off floor after one hour, stated ambulance not required. 8 Aug - Ambulance called / care alarm activated 21:27. Careline365 emergency call handler called three times with no answer. 9 Aug – Adult P found by ambulance crew unresponsive on kitchen floor.

10. Key Themes

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

Commentary

10.1 Concerns were raised, particularly during 2020, by community mental health workers, occupational therapists, social workers and an ex-partner regarding Adult P's safety. These followed two assaults, one in February 2020 and again in September 2020, where Adult P had personal belongings and money stolen. In February Adult P said he had 'a drug debt' and was 'being threatened' and 'was afraid to go home'. Both resulted in no further action by the police, following extensive investigations.

10.2 Adult P was admitted to an acute hospital, initially within a critical care unit on 21 September 2020 following a suicide attempt with intent.

A safeguarding referral was made by hospital staff on the day of admission due to concerns of his home environment, self-neglect, deteriorating mental health, drug, and alcohol abuse; also, due to concerns he was at risk of financial exploitation. Adult P disclosed to a CMHT practitioner that he was being threatened 'by a cousin' of someone who was previously recorded as staying at his house. Adult P said that £12,000 of back payments of his benefit money had been stolen and he had suffered physical abuse, often by use of weapons.

10.3 It was recorded that the electricity to Adult P's flat had been cut off as he could not pay the bill. This was restored quickly and did not contribute to the later fall.

10.4 Whilst Adult P was still an inpatient at the hospital the occupational therapist raised concerns that Adult P was at high risk of falls within his flat and completed a mobility and a stair assessment whilst he was an inpatient.

10.5 Potential 'cuckooing[3]' was investigated by police as part of their investigation in September 2020. Extensive efforts were made by the investigating officer to engage with Adult P, to obtain an evidential account from him, but after several attempts at making this arrangement, Adult P decided to withdraw support from the investigation, which was subsequently closed by police.

10.6 Adult P said again in September 2020 to an occupational therapist, he was 'very frightened to return home' and 'his life was at risk'. Arrangements were made between the hospital discharge team, NSFT care coordinator, social worker, and housing provider for respite accommodation. This multi-agency working ensured a positive outcome, and his flat was secured while he was in respite accommodation.

10.7 A section 42 enquiry, jointly led by police and social care commenced on 29 September 2020. Police started their investigation into the allegations made by Adult P and their witness protection protocol was followed. Adult P's flat was secured by the housing provider, while he was found a short-term bed in respite care. 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.

10.8 **What went well?**

- Good communication between hospital staff and the NSFT care coordinator, sharing safeguarding concerns, in particular the physical abuse and housing, safety concerns.
- Some responses to Adult P's shared safeguarding concerns were effective e.g., a police investigation, use of respite accommodation ensuring Adult P was safe, and securing his property whilst in hospital.
- Occupational therapy referral by hospital team for adaptations to Adult P's home on his return.

10.9 **What could have been better?**

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

- Information gathering undertaken by social care for the safeguarding enquiry, but not recorded on a safeguarding enquiry and risk assessment, albeit this was completed retrospectively. Case still logged as 'open' at

[3] the practice of taking over the home of a vulnerable person in order to establish a base for illegal drug dealing, typically as part of a county lines operation.

time of death. The risk assessment was completed and closed retrospectively after Adult P's death.

10.10 **Learning**

- Raise awareness of the signs and symptoms of 'cuckooing', resulting in a county wide approach, across the partnership.
- Ensure that section 42 enquiries are completed within timescales.

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

Commentary

10.11 Norfolk County Council Assistive Technology team currently use five approved providers of community alarms across the county. Provider industry-wide standards are managed by the TEC Services Association (TSA) who are the industry and advisory body for technology enabled care (TEC) in the UK - (See more details in **Appendix one**). The Norwich Careline365 call centre is currently the only provider in Norfolk who are TSA accredited.

10.12 Norfolk County Council currently does not have a countywide service level agreement (SLA) for response times to community alarms or provider industry standards. Each provider organisation has their own internal service level agreements and 999 response protocol.

10.13 A referral was made by the mental health social worker in May 2021 and an assessment by the Assistive Technology team in June. After some initial technical issues, N-Able (the NCC approved contractor), completed the installation of the Careline365 community alarm and associated equipment on 13 July 2021.

10.14 The process when providing new alarms is that the installer (in this case N-Able), asks the client to complete a new customer, self-declaration form; Adult P completed this. This gave basic health information about him and did not highlight any previous safeguarding or high-risk safety issues. Therefore, Careline365 records only had basic details of the following: high blood pressure, mental health issues, damaged vertebrae, and chronic back pain. This basic information was passed to the ambulance service which meant the call was classed as lower priority.

10.15 There was no external key safe system, (accessed by the Norfolk Swift service) at Adult P's property and no record of this being considered when he moved house. This meant that no one without a key would be able to access the property without forcing entry.

10.16 Between 13 July 2021 and the date of death, Adult P activated the Careline365 alarm eight times, subsequently informing the operator it was

activated by mistake, on each of these calls. Twice he fell and deliberately activated the alarm and support was arranged by an operator.

10.17 On one occasion Adult P managed to get himself off the floor whilst Careline365 were waiting on the call. The second time the ambulance service attended.

10.18 P suffered a fall on 8 August 2021 and activated his fall detector, this was responded to within seven seconds by Careline365. Adult P's first point of contact was registered on the Careline365 system as a next-door neighbour, Mr N. The second point of contact was his ex-partner, Miss A, who provided a mobile phone number.

10.19 Below is a schedule of the calls made to Careline365 on the evening of 8 August 2021, and the following morning (9th August 2021).

Time	Event	Response
21.11	Fall detector activated at Adult P's home.	Careline365 Operator (CO) attempts to make contact via alarm unit, no response then calls Adult P on landline. No response.
21.13	Call ended* - no response.	
21.18 **21.19** **21.22**	CO calls to Adult P's landline and mobile.	No response.
21.23 **21.24**	CO calls neighbour Mr N (listed as first contact).	No response from Mr N.
21.24	CO calls Miss A (listed as second contact).	Miss A cannot attend as she has children but will try calling Adult P.
21.26	CO calls ambulance service to request welfare check.	Informed the waiting time was currently eight hours – noted and call ended by Careline365. (Call remained open).
22.41	CO follow up call to Adult P	No response.
23.32	Miss A calls CO to see if they have had contact from Adult P.	CO replies negative.
10.41	Next morning – Adult P found deceased by paramedic team. Police notify Careline365 operator of the death.	

*Call ended – means that the operator put the phone down, but the case/call remained 'open'.

10.20 Calls were made to the 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 giving details of the alarm activation, attempts to contact Adult P and his known health conditions i.e., a damaged vertebra, chronic back pain, high blood pressure and history of mental health issues.

Details of the call from Careline below:

Ambulance emergency, is the patient breathing? Unknown

Tell me exactly what's happened? I'm calling form an emergency alarm centre and I've had an activation from a 36-year-old client who is a no response, and I can't get anyone to check on him, so we need an ambulance for a welfare check please.

What is the full address of the emergency please? Operator provide full address listed on the system.

Is the patient on his own? Yes

Do you have a contact number for him? Landline number given.

Confirm the number back to me? Number confirmed.

Can you confirm how old the patient is? 36

Does he appear to be awake? Unknown

Did you ever hear him talk or cry? No

Do you know what he is doing? Standing, sitting or lying down? Unknown

Is he moving at all? Unknown

Where exactly is he? Unknown

Do you know if the patient has tested positive for COVID in the last 14 days? Unknown

Can I take his full name? Full name given.

And his date of birth? Date of birth given

Is there any access information we need to be aware of? No

Is there any medical we need to be aware of? Yes, he has a damaged vertebra, chronic back pain, high blood pressure and history of mental health issues.

What are Careline going to do if a user cannot be contacted?

Our first follow up attempt will be to the alarm user to find out if help has arrived with them. If the client does not answer this call or informs us that help has not arrived yet, this call will be placed back into the system for another hour. After the hour has passed, we will make another call to the service user and to their contacts to find out if the help has arrived on site. If there is still no outcome achieved after this call, we will continue every hour thereafter to call the service user, then the contacts listed, then the emergency services for an update. This is in line with current TSA guidance which has been formulated in conjunction with ambulance, police and fire services.

They responded that the current wait time 'was 8 hours'. Following the ambulance request, Careline365 contacted Adult P at 22.41, without success.

10.21 The industry standards provided by TEC Quality – (Website - TEC Quality - QSF certification) state that -

As a minimum, TEC Quality certified organisations must:

Have procedures in place to ensure a service user's welfare when they cannot be contacted following:

- an emergency alarm.
- non-emergency alert/trigger.
- Outbound welfare/wellbeing call.

Continue to monitor a Service User's welfare where a call has been passed to a responder e.g., Next of Kin (NOK), or the Emergency Services until that responder arrives. Services can choose how they do this if the outcome is achieved e.g., key safe codes.

10.22 The ambulance subsequently attended 13 hours later and found Adult P deceased. Ambulance service (EEAST) colleagues confirmed that a clinical need from a silent care alarm coded as a 'Category 4' call in line with national protocol*. Due to the volume of calls which EEAST was experiencing at the time, calls which were assessed to have a higher clinical need were attended to first.

10.23 EEAST's response was in line with the Trust's Demand Management Plan. Business continuity was a separate plan and has different triggers. Actions such as "No Send" would have been in place advising low acuity callers to seek alternative medical attention via 111 or making own way to hospital and suspension of welfare calls to release capacity.

*The **NHS England Ambulance Response National Protocol 2017** was implemented at EEAST on the 18th October 2017.

The EEAST response call categories are outlined below:

- **Category 1** coded calls are for life threatening conditions, and we aim to respond in an average time of 7 minutes and to nine out of ten patients within 15 minutes. Types of calls that fall into this category are predominantly patients in confirmed, or suspected, cardiac arrest, severe allergic reactions, choking or severe (arterial) uncontrolled bleeding.
- **Category 2** coded calls are for patients whose condition is potentially serious and require rapid assessment, urgent on scene intervention or urgent transport to hospital. We aim to respond to nine out of ten patients with the appropriate emergency resource within 40 minutes and with an

average time of 18 minutes. Patients who are unconscious, experiencing chest pain or stroke symptoms would fall into this category.

- **Category 3** coded calls are for patients who have potentially urgent conditions that are not life threatening but do require treatment or transport. We aim to respond to nine out of ten patients with the appropriate resource within 120 minutes. Patients who have fallen and sustained injuries or minor road traffic accidents typically fall into this category.
- **Category 4** coded calls are for patients whose condition is not urgent but does require a face-to-face assessment. The C4 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.
- **Category 5** coded calls are for patients whose condition is not urgent but require an assessment, via telephone, by a Clinician in the first instance. We aim to conduct the call back within 180 minutes. This are the lowest acuity calls, normally when no specific life threatening, or serious symptoms have been identified during the initial triage or patients are just described as generally unwell.

NHS England Ambulance Response Programme guidance [4]

10.24 The police then attended, after being contacted by the Ambulance Service, and activated Adult P's Careline365 alarm and notified the call centre of his passing.

10.25 To give context, it is worth noting the scale of calls for one month received by Careline365 in Norfolk:

- Careline365 have approximately 6,000 alarm users across Norfolk
- In January 2023, Careline 365 received 6,600 calls from these alarms.
- Approximately 700 of the above calls were no responses, these calls included approximately 50% accidental activations.

10.26 Therefore, approximately 11% of the 6,000 alarm calls received resulted in no response from the user in Norfolk in January 2023.

10.27 **What went well?**

- Quick Installation of equipment following assessment by Assistive Technology team in May 2021

[4] NHS England » Ambulance Response Programme

- Recognition of the need for the equipment by the social worker and NSFT care coordinator

10.28 **What could have been better?**

- Greater understanding of Adult P's history and safety risks could have resulted in a more appropriate i.e., higher than category 4, response when the fall detector activated, ambulance service stating they were not able to attend for at least 8 hours. (It is worth noting that waiting times for non-emergency call were exceeding 11 hours at this time).

- Installation of a key safe system, (accessed by the Norfolk Swift service), may have resulted in alternative options, and therefore easier and quicker access to Adult P's property when the first and second responders could not attend.

- Careline365 monitored Adult P's welfare with two follow up calls which is a process they had had approved and signed off by TEC Quality (National Standards). However, it would be better for Careline365 to review the number of follow up contact calls after a referral to the ambulance service given current extended levels of ambulance wait times.

- A Norfolk-wide service level agreement that ensures all alarm providers in Norfolk meet industry wide (TSA) standards.

10.29 **Learning**

- A Norfolk County Council service level agreement or protocol to include for response levels and industry standard accreditation across <u>all</u> community alarm providers in Norfolk.
- Multi-agency support for individuals, particularly those at high risk, to complete the self-assessment declaration at installation of care alarms. 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.

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

Commentary

10.30 Adult P lived in a first floor flat provided by Clarion Housing since 2005. He moved to a bungalow provided by Broadland Housing in December 2020, following two months in respite care.

10.31 Clarion worked proactively with partner agencies to try and find more suitable accommodation for Adult P when his ongoing mobility issues increased during 2020. It was recognised that living in a first-floor flat was increasingly difficult for Adult P, and alternative options were sought. Clarion made an internal safeguarding referral, (to intensify the level of support, and understanding of risks to Adult P) in December 2019 following concerns raised by a neighbour. Damage was noted by the housing officer to the front door of the flat, which was quickly repaired, and another person was seen to be living with Adult P. There is no record of a referral to social care or investigation into potential cuckooing at this point.

10.32 A Clarion Housing specialist support worker was allocated to Adult P's case in September 2020, following alleged assaults on Adult P. The support worker continued to liaise effectively with other partner agencies, such as the mental health support worker, to ensure Adult P's safety. Of note, was the joint working to ensure Adult P could access respite care from October to December 2020.

10.33 Housing teams were generally responsive to Adult P's needs and understood the risks others posed to him. There is a lot of 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. There is evidence of a worker from Norfolk MIND being used as an advocate for Adult P, particularly during October 2020.

10.34 When Adult P reported physical abuse in September 2020, the property was secured, to prevent further thefts, and alternative accommodation options were explored. When 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 has been identified as an area for learning.

10.35 Housing providers currently do not have any responsibility to provide client background information to community alarm receiving centre when alarms are installed in their properties.

10.36 **What went well?**

- Good communications between housing officers and other professionals, especially when Adult P's mobility issues increased.
- Safeguarding concerns identified quickly, and positive action taken e.g., allocation of specialist support worker by Clarion Housing
- Effective multi-agency working to secure respite accommodation in October 2020
- Use of Norfolk MIND worker acting as advocate for Adult P

10.37 **What could have been better?**

- Better communication and risk assessment when Adult P moved between housing providers particularly considering the previous levels of risk.

10.38 **Learning**

- Better handover of background and safety information, particularly for high-risk clients when they move between Norfolk's housing providers.

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

Commentary

10.39 Adult P suffered abuse from a very early age and subsequently led a complex life requiring a lot of support. He was said to feel nervous around men (following the abuse by his stepfather) and more often built positive, supportive relationships with female multi-agency practitioners.
Adult P had a four-year-old son from a previous partner, who he would describe as a 'protective factor' and still played an important role in his life.

10.40 There is a lot of evidence to show that Adult P's physical health, housing and mental health needs were continually met and reviewed by practitioners. Multi-disciplinary teams communicated well and worked effectively to improve outcomes, but this was often made difficult by Adult P's reluctance to engage. There is also evidence to show numerous non-attendances with community mental health teams, all of which was frustrating for practitioners.

10.41 Adult P often declined to receive support for both alcohol and substance misuse even though he was assessed to be of high risk of accidental harm in the context of alcohol and heroin abuse, consistently acknowledged on his care plans.

10.42 An example would be the support of Change Grow Live (CGL) who were recommended by various partners, but Adult P's reluctance meant they only managed to engage in the last two months of his life. CGL have acknowledged in their internal review that the initial, open access letter to Adult P (which he didn't respond to) was not the most effective method of engagement. They have since made changes to their internal systems.

10.43 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. During this period face to face visits (where allowed) increased and he found these reassuring.

10.44 Practitioners, in particular the mental health social worker, social care assistant practitioner, the NSFT care coordinator and the Norfolk Integrated Housing and Community Support service worker, worked effectively in partnership and tried everything they could to improve outcomes for Adult P. They sourced food and cooking equipment when he moved home and ensured he was able to move to secure respite accommodation when Adult P was unable to go back to his home on discharge from hospital and felt unsafe.

10.45 Multi-agency working always included housing officers from Clarion and Broadland Housing and the responses to Adult P's reduced mobility, physical threats and social isolation were responded to quickly and effectively.

10.46 Evidence shows that discharge planning from hospital, with the social care practitioner, considered Adult P's wishes and feelings and safeguarding concerns were recorded and acted upon, and his safety was a priority. It was identified by the social worker that Adult P would benefit from one hour per day domiciliary support in his home. They also provided support with Adult P's benefits and applying for a bus pass.

10.47 The domiciliary care was provided by Breakforth and worked well, most of the time. They provided help keeping Adult P's home tidy, shopping, and meal preparations. There were occasions when Adult P declined their service 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, as they identified that Adult P's level of self-neglect would significantly increase without this.

10.48 A referral was made by the nursing team in hospital to the occupational therapy team for assessment to support Adult P. The assessment took place at Adult P's home in April 2021, but it was noted that Broadland Housing policy meant that no adaptations could take place until Adult P had lived there for 12 months. This policy has subsequently been revised by Broadland Housing and the 12-month period removed.

10.49 **What went well?**

- Excellent multi agency planning and partnership working. Multi-disciplinary teams identified Adult P's needs and planned accordingly.
- Consistent support during the Covid pandemic, to alleviate Adult P's social isolation and mental health needs.
- Early recognition of Adult P's increasing self-neglect by mental health social worker who provided a care fee waiver to enable support from Breakforth to continue.

10.50 **What could have been better?**

- Change Grow Live missed an opportunity to engage Adult P in treatment at the earliest opportunity. This learning has resulted in a change of process for professional referrals, as outlined above.

- Identifying why Adult P failed to engage or withdrew support with agencies and developing appropriate strategies to manage this.

10.51 **Learning**

- More effective ways of engaging clients who are reluctant to engage or frequently miss appointments. NHS England has guidance for Reducing Did Not Attend, in Outpatient services5

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

Learning Points from this review

10.52 Raise awareness of the signs and symptoms of cuckooing across the partnership and develop a countywide approach to dealing with this when concerns are raised. Partners to escalate where signs of potential cuckooing are evident.

10.53 A Norfolk County Council service level agreement or protocol to include for response levels and industry standard accreditation across all community alarm providers in Norfolk.

10.54 Multi-agency support for individuals particularly those at high risk, to complete the self-assessment declaration at installation of care alarms. This will ensure that the care alarm providers can identify high risk clients and respond accordingly.

10.55 Assurance that Careline365 will continue to monitor a service user's welfare, in accordance with TEC Quality standards, following referral to emergency service, until that responder arrives.

10.56 Better handover of background and safety information, particularly for high-risk clients when they move between Norfolk's housing providers.

10.57 Assurances from the local authority and police that section 42 enquiries and associated risk assessments are being completed in the appropriate timescale.

10.58 More effective ways of engaging clients who are reluctant to engage or frequently miss appointments. – (see below*)

*Norfolk and Waveney Integrated Care Boards (NWICB) safeguarding GP has devised a template policy to support general practices in recognising their safeguarding responsibilities with respect to "was not brought". The importance of attending practice and secondary care appointments should be discussed with the child / young person/ adult patient/ parent/ carer/ legal guardian. Failure to attend appointments should be discussed as early as possible. This template policy could be reviewed and adapted to meet the practice needs.

11. Recommendations/actions to effect change

Each of the following six recommendations has been mapped against the NSAB Thematic Learning Framework (TLF)

11.1 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 Partnerships (LSAPs).
[TLF category: Professional Curiosity]

11.2 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.
[TLF category: Ownership & Accountability: Management Grip]

11.3 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.
[TLF category: Ownership & Accountability: Management Grip]

11.4 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.
[TLF category: Ownership & Accountability: Management Grip]

11.5 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[6]
[TLF category: Ownership & Accountability: Management Grip]

11.6 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 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.
[TLF category: Ownership & Accountability: Management Grip]

END.

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

Appendix One

Norfolk Community Alarm Providers and National Quality Assurance Framework

The community alarm industry Quality Assurance standard - tsa-voice.org.uk/

Industry standards are provided by TEC Quality - tecquality.org.uk/tec-monitoring

<u>TEC Quality and TSA</u>

(TEC Quality audit and certify organisations against the Quality Standards Framework (QSF). QSF is the intellectual property of the TEC Services Association CIC (TSA). TEC Quality is a wholly owned subsidiary of the TSA).

Community Alarm Providers Information All prices shown exclude VAT and may be subject to change	Careline365 - Based in Norwich - National coverage - formerly known as Lifeline 24 01603 964306	Careline Community Service - Based in Kings Lynn - Covers Norfolk 01553 616200	Contact Care Lifeline - Based in Long Stratton - Covers Norfolk 0800 917 4680	Great Yarmouth Borough Council Community Alarm Service - Based in Great Yarmouth - Covers East Norfolk 01493 846654	n-able - Based in Norwich - Covers Norfolk, Suffolk, Cambs 0300 373 0199
Tunstall Lifeline Vi - Analog unit *NOT DIGITAL ready - Works through landline - Mains socket required within 2 metres - Up to 48 hours battery back up	**£12.49 per month** when paid monthly - First six weeks free when referred by AT Installation - Free by post and self set-up - Free installation when referred by AT	**£13.65 per month** when paid monthly Installation - £33 within the borough - £39 outside the borough - Free installation when referred by AT	**£16 per month** when paid monthly Installation £40 installation fee		
Chiptech Eva - Digital unit - Works through mobile network - Mains socket required - Up to 70 hours battery back up	**£15.75 per month** when paid monthly - First six weeks free when referred by AT Installation - Free by post and self set-up - Free installation when referred by AT	**£19.50 per month** when paid monthly Installation - £33 within the borough - £39 outside the borough - Free installation when referred by AT			**£15.99** when paid monthly - first six weeks free Installation - Free installation
Tynetec Reach IP - Digital Unit - Works through mobile network - Mains socket required - Up to 168 hours battery back up *on standby	**£15.75 per month** when paid monthly - First six weeks free when referred by AT Installation - Free by post and self set-up - Free installation when referred by AT			**£14.07 per month** when paid monthly Installation - £38.78 within the borough - £44.02 outside the borough	

Community alarms can give you peace of mind 24-hours-a-day, seven-days-a-week. They are ideal for anybody who feels vulnerable or is at risk in their home e.g., from falls.

A community alarm is a communications device that contains a loudspeaker and microphone. It is connected to a Monitoring Centre either though your landline or the mobile phone network. Community alarms have a battery backup but need to be plugged into the mains to work in your own home. Community alarms come with an alarm button, normally this is worn as a pendant round your neck or on your wrist. At the touch of this button, you will be able to speak to an operator. They will assess what support is needed, such as contacting your next of-kin, or the emergency services. This will work in your home or garden. Norfolk County Council do not provide community alarms, and these are a paid for service.

Additional equipment can be linked to a community alarm to activate an alert automatically, e.g., a falls sensor. The Norfolk County Council Assistive Technology Service carry out individual assessments to identify suitable equipment, to support adults in Norfolk to remain living safely in their own home. Equipment identified is provided for free on a long- term loan basis. Norfolk County Council works in partnership with a panel of community alarm providers, shown overleaf.

These providers have agreed to monitor any additional equipment provided at no additional cost to their customers. This means that your monitoring fee will not

increase if you have equipment provided by Norfolk County Council linked to your community alarm. Community alarm providers normally charge for installation. However, some community alarms can be installed for free at the same time as assessed for equipment, which is also installed for free.

The Assistive Technology service uses N-Able, part of the Norse group, for installations.

Appendix Two – initialisms/abbreviations

A+E – Accident and Emergency Department
CMHT – Community Mental Health Team
CQC – Care Quality Commission
EEAST - East of England Ambulance Service Trust
JPUH – James Paget University Hospital
LD+A – Learning Disability and Autism
LA – Local authority
NHS – National Health Service
NIHCSS – Norfolk Integrated Housing and Community Support Service
NHSE – National Health Service England
NNUH – Norfolk and Norwich University Hospital
NSAB – Norfolk Safeguarding Adults Board
NSFT – Norfolk and Suffolk Foundation Trust
QA – Quality assurance
SAB – Safeguarding adult board
SAR – Safeguarding Adult Review
SARG – Safeguarding Adult Review Group

Appendix Three – NSAB Assurance Framework

NSAB have ensured that this report follows the guidance as published in the SCIE Safeguarding Adult Review quality markers, link here:

Safeguarding Adult Reviews Quality Markers | SCIE