7-minute briefing on

Safeguarding Adult Review – Adult P

1. Background and context

Adult P was a male, aged 37 when he died in August 2021 at his home in Norwich. He lived alone with little information known about his immediate family. Adult P experienced trauma as a child. He had limited mobility, used a mobility scooter, had a history of falls, mental ill health, drug, and alcohol use. Concerns were raised that people were exploiting him. Agencies worked hard to support Adult P, but his home was in a poor condition. The night before Adult P died, he activated his Careline365 fall detector. A paramedic attended 13 hours later, when sadly Adult P was found deceased. The following are the six recommendations from the review of his death.

2. Cuckooing and exploitation

There could have been a better understanding or consideration of cuckooing or exploitation of Adult P. For example, his disclosure that 'a mate' was living at the address, and the allegations of physical abuse and threats to his life. Norfolk Safeguarding Adults Board (NSAB) will oversee the development of a briefing document and an effective countywide response regarding cuckooing, with the aim to support appropriate identification and responses by professionals and agencies.

3. The installation and use of Assistive Technology in homes

Adult P had a Careline365 alarm installed in his home. There was no standard service level agreement across the five approved alarm providers in Norfolk. On installation, clients need to have support completing the self-assessment, outlining their health conditions, and safeguarding risks. This will ensure that if the alarm is activated, the correct level of grading can be allocated to the call, resulting in an effective, timely response.

4. Alarm providers response to an alert

NSAB will monitor that alarm providers review and amend their policies, with a view to continuing to attempt to contact the person following a non-response call until a resolution e.g. emergency services on site, is achieved.

5. Effective handover of information between housing providers

It was identified that when Adult P moved between housing providers, background and safeguarding information was not shared effectively. Norfolk housing providers and district councils will ensure a more effective handover of background and safety information, particularly for high-risk clients when they move between providers.

6. Non-attendance at appointments

Adult P did not attend many important medical appointments. Patterns like these need to be identified and acted upon, particularly for high-risk clients. A 'did not attend' policy is under development, led by the integrated care board; this should be further developed and implemented across the partnership.

7. Section 42 enquiries

It was identified that a Section 42 (safeguarding) enquiry was started but not completed prior to Adult P's death. This was not in line with current procedures. Therefore, the local authority and Norfolk Constabulary will review their systems, to ensure that there is a way to monitor investigations that take too long, or become stuck, and also that practitioners update partner agencies when their agency's involvement in a case comes to an end.