Norfolk Safeguarding Adults Board Safeguarding Adults Review: Case Adult S – Executive Summary

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Summary - Safeguarding Adults Review concerning the death of Adult S at his home in Norwich

Adult S was found deceased at his home by his neighbour in March 2022. Concerns had been raised that Adult S had been exploited by people he formed acquaintances with. Multiple agencies had made referrals for Adult S in the two years leading to his death.

1. Background to the review

Adult S was a 72-year-old white male, who lived alone in a two-bedroom flat provided by Norwich City Council. Adult S had no known family network, but he shared a strong bond with his neighbour, who over 15 years, extended friendship, support and assistance. Adult S was described by professionals as an 'interesting, quirky character' who could sometimes be 'challenging', when questioned during assessments. He tended to share varying accounts of his personal history with different individuals. Throughout his life, Adult S often expressed feelings of loneliness and had younger adult friends and acquaintances who used his flat as a place to meet. This led to concerns that he was being exploited.

Several agencies collaborated to address Adult S's needs. He frequently voiced his struggles with mental health, personal care, medication management, and housing to professionals. He developed a strong rapport with his GPs, who often saw him without prior notice, sometimes multiple times a week.

Adult S frequently expressed concerns about drug-related activities near his flat, which made him anxious and fearful. He repeatedly requested relocation to more secure, sheltered accommodation, where he believed he would 'feel safer'. He was considered a low priority for a move due to his current accommodation being classified as adequate for his current needs. Multiple referrals were made for Adult S due to suicidal ideation, overdoses, and concerns regarding his vulnerability to exploitation.

Adult S's mental health deteriorated in early 2022 and he was admitted to the hospital following another suicide attempt. Sadly, after being discharged, Adult S was discovered deceased in his home by his neighbour on 7 March 2022.

2. The Key Lines of Enquiry

The Safeguarding Adult Board (SAB) identified 5 key lines of enquiry for this review:

- To explore the role of good practice by agencies, for example evidence of good multiagency working.
- Were the multi-agency responses to the initial safeguarding concerns from September 2021 effective?
- How confident are staff from different agencies in identifying and understanding the dynamics of adult exploitation in particular County Lines, and knowing how to respond?
- Was there an effective multi-agency response to mental health concerns raised about Adult S's safety?
- Did housing providers respond effectively to Adult S's safeguarding concerns?

This review looked at the period **1 September 2021** to Adult S's death on **7 March 2022.**

3. The multi-agency review panel for this review

The SAR Panel (SARP) met seven times for this review. The panel was made up of representatives from Norfolk County Council (NCC) Adult Social Care, Voluntary Norfolk, Norfolk MIND, Norfolk Constabulary, East of England Ambulance Service, the Integrated Care Board (representing the GP), Norfolk and Norwich University Hospital (NNUH), Norfolk and Suffolk NHS Foundation Trust (NSFT) and Norwich City Council (NRCC) Housing.

The independent reviewer met twice with Adult S's neighbour, which provided a valuable insight into Adults S's background, friendships, and home situation before his passing.

4. A summary of findings from the five key lines of enquiry in this review

4.1 To explore the role of good practice by agencies, for example evidence of good multi-agency working

There were many instances of effective collaboration among multiple agencies and within individual agencies, both in terms of good practice and information sharing. Practitioners displayed diligence, care and understanding of the risks to Adult S, trying their hardest to improve his situation. Adult S was consistently described by partners as a "willing recipient" of support by many agencies. This consistent interaction led to a deep understanding of his wishes and feelings, albeit with occasional inconsistencies from Adult S.

Over the six months leading up to his unfortunate passing in March 2022, Adult S consulted with five different GPs. The surgery staff displayed remarkable patience and empathy toward his complex needs. Housing was identified as one of the root causes of Adult S's mental health issues, prompting professionals to work diligently toward a resolution.

NSFT Crisis Resolution and Home Treatment (CRHT) team recognised Adult S's need for respite support. The team arranged for him to stay at Holly Tree House on two separate occasions in November 2021 and January 2022, Adult S felt happy and supported there.

In February 2022, a Health Improvement Practitioner (HIP) took the initiative by convening a multi-agency practitioner meeting. This meeting had been overdue for some time, and although not all key partners were in attendance, it marked the first joint planning session with shared objectives.

Conclusions and learning points from this key line of enquiry
It is evident that many professionals worked diligently and in partnership to support Adult S and there are many examples of good multi-agency practice. This view was corroborated by Adult S's neighbour during conversations with the reviewer. There were some missed opportunities, in particular the need for an earlier multi-disciplinary meeting.

4.2 Were the multi-agency responses to the initial safeguarding concerns from September 2021 effective?

There is no doubt that Adult S felt unsafe at home, actively sought help from many sources, and his vulnerabilities left him at risk. Professionals used various terms to describe Adult S, including 'inconsistent' and 'evasive' when providing information. Adult S's neighbour shared how he tended to provide different accounts to different individuals. These characteristics and inconsistencies collectively present challenges for professionals.

The case was assigned to a Social Care Assistant Practitioner (AP) in November 2021. In hindsight, it was noted that, given the complexities of this case, which may not have been fully understood at the time, it might have been more appropriate to allocate it to a more experienced Social Worker.

The GP made a referral to Adult Social Care due to concerns about potential exploitation, following disclosures from Adult S. In the following month Adult S threatened to 'kill himself' and subsequently took an overdose of medication at home. He was admitted to NNUH. Voluntary Norfolk also made a referral to Social Care following disclosures from Adult S. On the same day, the NSFT crisis team alerted NRCC Housing to potential ‘cuckooing’ and safeguarding risks.

The AP conducted a Care Act assessment at Adult S's home. The assessment identified the main areas of need i.e., a package of care, assistive technology, and assistance with home cleaning. It was noted during the review that the appropriate Care Act assessment online forms had not been completed but replaced by detailed case notes.

A professionals meeting was instigated by the HIP in February 2022. The meeting, whilst productive, unfortunately lacked attendance from key agencies, in particular the Police, NRCC Housing, Voluntary Norfolk and Norfolk MIND. Consequently, vital information, especially related to the risks of exploitation and supporting background evidence, was not shared.

In February 2022, Adult S was admitted to hospital. On discharge, concerns were raised about the condition of his property which was described as 'untidy but not unlivable’, also that he may take further overdoses.

Conclusions and learning points from this key line of enquiry
With the benefit of hindsight, it might have been more appropriate to allocate the case to a more experienced Social Worker. The online Care Act assessment had not been completed but replaced by detailed case notes. Also, professionals could have used the Professional Disagreement policy, if they felt that progress with assessments was slow.

The Care Act assessment in December 2021 did not recognise or include risks of possible exploitation of Adult S, despite three previous referrals for this reason. Another concern was the lack of a Multi-Disciplinary Team (MDT) or Professionals meetings, prior to February 2022, with no single agency assuming a 'lead professional' role. This meant that important information was not shared and there was no evidence of an outcome focused plan.

4.3 How confident are staff from different agencies in identifying and understanding the dynamics of adult exploitation in particular County Lines, and knowing how to respond?

Adult S's social connections were intricate and complex. Individuals would stay at his flat, and some of them were characterised by neighbours and professionals as potentially exploiting his vulnerability and loneliness. The reviewer concluded that the threats to Adult S were predominantly non-physical in nature, with acquaintances attempting to exploit and take advantage of his vulnerability and loneliness, often for their financial gain.

Gerard Doherty (2020)[1] described - *'**Exploitative familiarity'** …. Available evidence suggests that exploitative familiarity has a significant impact on the lives of some disabled people, not only in terms of the breadth of offences committed using this form of insidious exploitation but also because of the potential grave consequences.*

Often, isolated disabled people are victimised in their homes by locals who may use the effects of victims' impairments to manipulate and betray purported friendships. Exploitation can continue unchecked, particularly where there is lack of institutional involvement.

* It is acknowledged by the reviewer that Adult S was not registered as disabled. However, his physical condition led to severely restricted mobility and increased his vulnerability.

Conclusions and learning points from this key line of enquiry
The lack of key partners at the professionals meeting on 21 February 2022 meant that the full extent of the risks of exploitation or cuckooing were not considered. Most practitioners working with Adult S were aware of aspects of his exploitation and coercion by acquaintances, but it was not fully acknowledged in Care Act assessment and did not lead to a safeguarding enquiry.

There was a lack of professional curiosity regarding financial exploitation of Adult S which subsequently didn't identify him as a victim of **exploitative friendships**, or 'cuckooing'.

4.4 Was there an effective multi-agency response to mental health concerns raised about his safety?

The were various sources of support for Adult S with his mental health from different agencies, it painted a complex picture. It was noted that during the review period, mental health intervention assessments didn't identify any acute mental illness in Adult S.

Adult S's mental capacity - There was a lack of evidence to indicate that Adult S's mental capacity was formally assessed, even though recordings indicated that he 'lacked capacity'. For instance, during his admission to NNUH in February 2022, it was documented that he 'lacked capacity,' but no formal assessment was conducted. No mental capacity assessment was completed despite concerns regarding his cognitive functioning.

There is evidence indicating that Adult S might have **lacked executive functioning**, which pertains to the contrast between a person's ability to express a decision (decisional capacity) and their capability to carry out that choice.

This could be attributed to factors such as drug or alcohol usage, mental health issues, learning disabilities, or neurological conditions. For instance, his inability to address decisions about who he let into his flat could be illustrative of this challenge.

Conclusions and learning points from this key line of enquiry
Opportunities to conduct a mental capacity assessment were not taken and assumptions were made about Adult S's capacity. This demonstrated a lack of professional curiosity.

No account of the effect of his social isolation or drug abuse on his mental capacity, there was a lack of professional curiosity and therefore no opportunity to make best interests decisions on his behalf.

[1] Prejudice, friendship and the abuse of disabled people: an exploration into the concept of exploitative familiarity ('mate crime') https://doi.org/10.1080/09687599.2019.1688646

4.5 Did Housing providers respond effectively to Adult S's safeguarding concerns?

Norwich City Council (NRCC) held very limited records for Adult S, and there was no documented evidence of anti-social behavior at Adult S's location. Additionally, there was insufficient evidence of 'cuckooing' from the Police, despite their investigations. Social Care had also recorded that there was no evidence of 'cuckooing'.

NRCC records indicate that Adult S was allocated the lowest banding level because he was deemed at the time, to be 'adequately housed'. Norwich is an area of extremely high demand for social housing with 4,350 applicants (as of October 2023) waiting to be re-housed. Norwich City Council only had limited properties available to meet this demand.

Conclusions and Learning points from this key line of enquiry
Norwich City Council Housing were not invited to the Professionals meeting in February 2022, despite being identified as one of the partners who 'could effect change', this was an important missed opportunity. An internal NRCC safeguarding concern had been raised but the planned face-to-face contact was not made by the Tenancy Management Team.

5. Recommendations to effect change following this review

- To ensure a person's statutory rights are not missed, NCC Adult Social Care must not substitute Care Act assessments for detailed case notes. Care Act assessments must be completed in a timely manner, on the appropriate forms. Where there are delays in progressing with Care Act assessments, NCC should provide assurance that they have a robust process for prioritising and monitoring any escalating risk. Social Care managers will ensure there is a robust performance management approach, therefore having overview and sign off of Care Act assessments. These should be checked in subsequent management overviews of the case.

  NCC to complete a 'dip sample' and assurance made to the NSAB within 9 months of the publication of this report.

- Practitioners are reminded that in complex cases they are encouraged, at an early stage, to convene multi-disciplinary meetings. This process is underpinned by the NSAB Complex Case guidance (link below). Every opportunity should be given to use these multi-disciplinary team meetings and the appointment of a lead professional, particularly in cases involving risk factors around exploitation. NSAB will promote the use of the Complex Case guidance following this review:
  Complex Case guidance (norfolksafeguardingadultsboard.info)

- NSAB in coordination with the Community Safety Partnership is to lead a viability study to assess the value of the Norfolk Vulnerable Adult Risk Assessment Conference (VARAC), as outlined in Project Adder, including the sustainability of this as a countywide model.

- NSAB to oversee a task & finish group for the development of material which sets out the issues of social isolation, loneliness and drug dependency in relation to mental capacity. Consideration should be given to a set of training standards, endorsed by NSAB, which can be used by agencies to check the content of the training given, to ensure these issues are included.

- There needs to be a greater understanding and attention given to the effects of ‘’exploitative friendships’’ and coercion by acquaintances alongside the allegations of cuckooing. To have clarity of a person’s social network, loneliness and associated risks, drawing on the work done in other areas. NSAB will ensure, through its quality assurance frameworks, that this is evidenced in training materials and partner briefings shared through NSAB communication networks. (This recommendation will link directly to recommendation 11.1 in Norfolk SAR P, published in February 2024).

- NSAB will raise awareness of managing professional difficulties (link below) policy across partnership where practitioners feel a case not progressing. This will be evidenced in training materials and partner briefings shared through NSAB communication networks. Professional-Difficulties-V2FINALDEC-2020.pdf norfolksafeguardingadultsboard.info)

- There needs to be greater oversight, to ensure and effective timely response, from Norwich City Council and other Norfolk Housing Alliance housing management teams to cases where an internal safeguarding concern has been raised. The council also needs to raise awareness amongst professionals of the eligibility for housing and how banding decisions are made and reviewed to enable all professionals to work together to manage expectations and needs of the person. Norwich City Council will report on progress to NSAB within 9 months of the publication of the report.

- NCC to provide assurance to the NSAB 9 months after publication of the report, that when complex cases are identified that the most appropriate worker is allocated, and the case is managed and monitored through supervision.

  NCC to complete a ‘dip sample’ and assurance made to the NSAB within 9 months of the publication of this report.

6. Acknowledgements

The independent reviewer would like to ‘thank’ the review panel members and the Norfolk Safeguarding Adults Board manager and business team for their support and guidance during this review.

Also, the time and insight given by Adult S’s neighbour, who had a very close bond with Adult S and wanted to ensure that the lessons learnt from his death can help others in similar situations. The independent reviewer was grateful for his input.