



Safeguarding Adults Review: Adult S

Briefing Paper for Practitioners

1. Background and context

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.

1.1 The five key lines of enquiry for the review

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

- 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?

2. The purpose of the review

The overall purpose of a Safeguarding Adult Review (SAR) 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 in the care and treatment of Adult S.

3. Recommendations and areas for learning and improvement

There were **seven recommendations** in the review of Adult S. The themes identified in these are summarised below:

3.1 The recording of Care Act Assessments and professional difficulties

With hindsight, it might have been more appropriate to allocate this complex 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 Difficulties policy, when 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.

The recommendation says - 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. This should be checked in subsequent management overviews of the case.

And a further recommendation says - NSAB will raise awareness of the managing professional difficulties (link below) policy across partnerships where practitioners feel a case is not progressing. - [Professional-Difficulties-V2FINALDEC-2020.pdf](#)
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3.2 The use of Multi-Disciplinary Team (MDT meetings and Lead Professionals)

A concern was the lack of a Multi-Disciplinary Team (MDT) or professional's 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. Practitioners are reminded that in complex cases, they are encouraged, at an early stage, to convene multi-disciplinary meetings, ensuring that all relevant professionals working on the case are invited e.g. Housing, who were not invited in this case.

The recommendation says - 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.

The NSAB will promote the use of the Complex Case guidance following the review.- [Complex Case guidance \(norfolksafeguardingadultsboard.info\)](#)

3.3 The development of the Vulnerable Adult Risk Assessment Conferences (VARAC)

There was mention in the review of making a referral for Adult S to VARAC, but the process had not been fully developed. The review identified an opportunity to progress a viability study into the future development of the VARAC process.

The recommendation says - 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.

3.4 Mental Capacity Assessment and Executive and Decisional Capacity

There was no evidence to indicate that Adult S's mental capacity was formally assessed, despite concerns that he 'lacked capacity'. There is evidence indicating that Adult S might have **lacked executive capacity**, 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.

The recommendation says - 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 the NSAB, which can be used by agencies to check the content of the training given, to ensure these issues are included.

3.5 Cuckooing and Exploitative Friendships

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. 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'.

The recommendation says - There needs to be 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).

3.6 The role of housing when safeguarding concerns are raised

Practitioners need to ensure that housing are invited to all multi-disciplinary meetings and that concerns around exploitation are shared. Professionals need to understand how the allocations of housing bands are allocated, the demand for social housing versus the supply and the management of the expectations of the person(s), when they request a move.

The recommendation says - There needs to be greater oversight from Norwich City Council and other Norfolk Housing Alliance housing management teams, of 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 the needs of the person.