Norfolk Safeguarding Adults Board Safeguarding Adults Review: Case Adult S

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1. Background

1.1 Adult S was a 72-year-old white male, originally from Scotland, who lived alone in a two-bedroom flat provided by Norwich City Council. Adult S was a qualified car mechanic for most of his working life.

1.2 The available information about his immediate family was non-existent, he had no known family network. Adult S stated that he was divorced and mentioned having two sons with whom he had lost contact. Adult S spoke of a troubled upbringing, mentioning that he was separated from his mother during his childhood. He was described by professionals as an ’interesting, quirky character’ who could sometimes be ‘challenging’, when questioned during assessments.

1.3 Adult S tended to share varying accounts of his personal history with different individuals, which occasionally made it challenging to determine the accuracy of his statements. For instance, during a hospital stay, Adult S claimed to be a Muslim and expressed a desire to be addressed as 'Jimmy.' He also requested to meet with an Imam. Notably, there were no indications of these requests being mentioned to other professionals or documented elsewhere.

1.4 Throughout his life, Adult S often expressed feelings of loneliness, especially after losing his two dogs, which had been a source of companionship. He shared a strong bond with his neighbour, J, who over 15 years, extended friendship, and assistance, even going as far as accompanying Adult S to medical appointments, showing their mutual care and support for one another. Additionally, Adult S had younger adult friends and acquaintances who used his flat as a place to meet and occasionally stayed over. Adult S was said to welcome their company as he was lonely, whilst others worried and raised concerns that he was being taken advantage of.

1.5 Several agencies collaborated to address Adult S's mental and physical health needs. He experienced chronic pain and sleepless nights due to long standing medical conditions e.g., sciatica, which sometimes led to him wandering the streets near his home at night. He frequently voiced his struggles with mental health, personal care, medication management, and housing to professionals, not always consistently. Adult S sought help from various sources, with regular visits to his GP. He developed a strong rapport with one GP, who often saw him without prior notice, sometimes multiple times a week.

1.6 Adult S frequently expressed concerns about drug-related activities near his flat, which made him anxious and fearful. He often mentioned ‘not wanting to return home’ after appointments or hospital admissions. Professionals and volunteers working with Adult S raised concerns about individuals living at his address, the risk of potential exploitation, ‘cuckooing’, and reported threats against him. Adult S repeatedly requested relocation to more secure, sheltered accommodation, where he believed he would ‘feel safer’. Although registered with Norwich City Council's Home Options team, he was considered a low priority due to his current accommodation being classified as adequate for his current needs.

1.7 Between November 2021 and February 2022, three Multi-Agency Safeguarding Hub (MASH) referrals were made for Adult S due to suicidal ideation, overdoses, and concerns regarding his vulnerability to exploitation.

1.8 In mid-November 2021, Adult S was discharged from Holly Tree House (HTH), a short-stay recovery provision by Norfolk MIND, and his needs remained unmet. This was due to Adult Social Services being unable to identify any providers with the capacity to support a suitable package of care for him at this time.

1.9 Norfolk County Council's (NCC) SWIFTS team provided support for him while a care package was sought. The Norfolk Swift Response Service is for people who are over 18, living at home in Norfolk and require physical or practical support with daily living tasks. It is part of Norfolk First Response and of the Adult Social Services Early Help and Prevention offer. Is a free 24-hour service a person can call if they have an urgent, unplanned need at home but don't need the emergency services. In early January 2022, Adult S was informed that he did not meet the criteria for supported accommodation, as concerns arose regarding potential risks to other residents due to his drug use.

1.10 As Adult S's mental health deteriorated further, he expressed suicidal thoughts and faced increasing difficulties with his personal care. His GP recommended a residential placement or similar support. In February 2022, he was admitted to the hospital following another suicide attempt.

1.11 Tragically, Adult S was discovered deceased in his home by his neighbour on 7 March 2022. The cause of death was recorded as fatal opioid toxicity.

1.12 The reviewer asked Adult S's neighbour if there were any photos available of Adult S. Unfortunately, none were found, highlighting the profound loneliness that characterised Adult S's life.

2. The Key Lines of Enquiry in this review

a. The Safeguarding Adult Board (SAB)'s interest was fivefold:

i. To explore the role of good practice by agencies, for example evidence of good multiagency working.
ii. Were the multi-agency responses to the initial safeguarding concerns from September 2021 effective?
iii. 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?
iv. Was there an effective multi-agency response to mental health concerns raised about Adult S's safety?
v. Did housing providers respond effectively to Adult S's safeguarding concerns?

3. Period to be covered by the review

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

4. Membership of the review panel

a. Membership of the SAR Panel (SARP) was as follows:

Title/ Role	Representing
Team Manager, Norwich Locality	Adult Social Care, Norfolk County Council
Director of Operations	Better Together / Voluntary Norfolk
Sector Safeguarding Lead & Named Professional	East of England Ambulance Service
Named GP for Safeguarding Adults	GP surgery - Woodcock Road, Norwich
Lead Professional for Safeguarding Children and Vulnerable Adults	Norfolk and Norwich University Hospital
Associate Director for Patient Safety & Safeguarding	Norfolk and Suffolk Foundation Trust
Adult Safeguarding Lead	Norfolk and Waveney Integrated Care Board
Quality Matron (Norwich)	Norfolk Community Health and Care
Detective Inspector	Norfolk Constabulary
Independent Living Manager	Norwich City Council
Board Manager	Norfolk Safeguarding Adult Board
Operations Lead	Norfolk MIND

5. Parallel reviews and investigations

a. 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.

b. A coroner's inquest into Adult S has not yet taken place. The coroner will be kept updated regarding the publishing of this report.

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

6. The governance of this review

a. Adult S's case was referred to the Safeguarding Adults Review Group (SARG) in March 2022 by Norfolk and Suffolk NHS Foundation Trust (the mental health trust). In April 2022 SARG agreed the statutory criteria under Sec 44(1) of the Care Act were met. Regrettably, there was then a 12-month delay in opening this review, due to difficulties in finding and commissioning a suitable author. The first panel meeting was held in May 2023.

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

c. The Independent Reviewer met with Adult S's neighbour, J in October 2023. The meeting provided an insight into Adult S's background, friendships, and home situation before his passing.

7. Key events and dates

2021

Aug Adult S self-refers to Norfolk and Suffolk NHS Foundation Trust (NSFT) wellbeing service after no previous history with NSFT. The initial wellbeing assessment deemed he had mental capacity and highlighted an ongoing risk to self. Referred to the Crisis Resolution Home Treatment team (CRHT).

Voluntary Norfolk befriending service provide support via weekly phone calls.

Oct **26 –** Adult S tells GP he is 'feeling suicidal', GP makes a telephone referral to a Mental Health Practitioner (MHP), based at the GP surgery, booked for early November.

Norwich City Council (NRCC) provide adaptions to the bathroom in Adult S's flat.

Nov **8 –** MHP notes young people's voices in the background during a phone consultation. Adult S says they are 'friends staying over'. MHP records 'to be guided by the GP' to request a Social Care needs assessment.

11 – Adult S Reports 'other people' staying at the house to GP, feeling suicidal and he is 'scared to go home', GP refers to CRHT, who meet Adult S at his home.

NSFT (CRHT) accept the referral and make home visit. Self-care noted as a concern.

CRHT requests a 5-day placement at Holly Tree House (HTH), (Norfolk MIND short stay recovery house). No referral to Social Care despite concerns.

14 – Placement commences at HTH – Norfolk MIND. Risk assessment completed, identify need for Social Care needs assessment.

18 – Referral to Social Care from Norfolk MIND worker due to exploitation concerns identified whilst at HTH – needs assessment completed by phone.

19 – Discharged from HTH – Social Care unable to find a support package to meet Adult S's needs at this time. Deemed by NSFT well-being service not to be suitable for intervention at MDT meeting.

21 – Home visit by NSFT Assistant Practitioner – concerns re appearance, neglect. Unable to use mobility scooter as no ramp in doorway of flat. Concerns noted but no clear safety plan in place or referral to Social Care.

22 – Adult S contacts GP 'feeling anxious' and says he is 'walking the streets' at night, safeguarding concerns noted but no referral made.

Norwich City Council (NRCC) advised Adult S to contact Social Care for housing needs assessment, after Adult S called housing options team. Referred by NRCC to Voluntary Norfolk to assist with application.

CRHT visits Adult S and notes 2 males present at address, records their details.

24 – Case allocated to Social Care, Assistant Practitioner (AP).

27 – CRHT home visit, informed Adult S he was being discharged back to the care of the GP. Notes Adult S is 'over sedated' and appears 'stoned' – concerns not recorded as shared with other agencies.

29 – Adult S attends surgery and mentions he has a 'suicide kit' - GP2 makes telephone **referral to Social Care** re concerns of exploitation and bruising to leg. CRHT discharge letter, back to the care of GP, plan for ongoing support unclear.

30 – Letter to Adult S from Norwich City Council (NRCC) stating he is allocated as 'lowest level band 1' on housing options system as deemed 'adequately housed'.

Dec **2 –** Adult S tells MHP he is feeling suicidal now he is aware he is low banding on housing options.

3 – NRCC Occupational Therapist (OT) visits Adult S at home and concludes after assessment that due to his good mobility, that he drives and is planning on moving, adaptations to the front step for his mobility scooter would not be recommended.

6 – NSFT call Social Care for update as no evidence referral has been actioned.

GP sends letter to NRCC housing options to support move to sheltered accommodation, due to risk of exploitation, stating Adult S would 'benefit greatly' from a move.

9 – Adult S threatens to 'kill himself' after GP appointment – 999 call following overdose, admitted to Norfolk and Norwich University Hospital (NNUH).

- NNUH makes referral to Mental Health Liaison Service (MHLS).
- NRCC discuss case at internal safeguarding meeting and log case as 'a safeguarding concern' on their internal system.
- Voluntary Norfolk makes a **referral to Social Care**. They inform GP and update Better Together Norfolk – good practice.

13 – NNUH OT assesses Adult S as 'functionally dependent' but needing a Social Care Act assessment. OT referral closed.

14 – Call from AP to NNUH following their request for assessment.

15 – Adult S seen by MHLS worker and Psychiatrist in hospital, plan for discharge with input from CRHT. Adult S reports friend (P) living with him sleeping on the sofa.

20 – NSFT query with AP why assessment not started since referral on 18/11 as Adult S about to be discharged? - No record of escalation.

MHLS refer Adult S to the Community Mental Health team for ongoing support.

22 – Adult S sent home from hospital following discharge plan, which states 'can be referred to pain team if he wishes'. No evidence of referral to a pain team.

23 – Social Care AP visits Adult S at home and completes **Care Act assessment.** Adult S tells Voluntary Norfolk he will 'be alone over Christmas'.

29 – Adult S calls Social Care to **request a safeguarding enquiry** as he 'feels suicidal' and needs 'somewhere safe to go'. Also, self refers to CRHT for support for 'loneliness and sadness'. CRHT gives Adult S support phone numbers.

30 – MHP call Adult S after referral from GP, as he is threatening suicide and he wanted Diprenorphine (a veterinary drug fatal to humans).

2022

Jan

3 – NSFT support worker visits Adult S and helps complete housing option forms.

4 – Social Care case management discussion. Advises Adult S that he does not meet the criteria for sheltered accommodation and his drug use could 'put other residents at risk'. Assistant Practitioner (AP) informs Adult S after assessment he does not have any care needs and is low priority for a house move.

6 – Voluntary Norfolk visit Adult S and give a £50 food voucher.

7 – GP contacts NSFT CRHT who ring Police re 'cuckooing' concerns as Adult S says, 'class A drug dealers are using his flat'. CRHT recorded as unable to contact AP.

7 – Police raise **Adult Protection Investigation** (API) following call from Crisis Team regarding concerns that Adult S is at high risk of exploitation/'cuckooing'.

9 – Adult S attends HTH following referral from CRHT for further assessment, stays for 5 days.

11 – HTH contact AP to raise concerns for safety when Adult S returns home. AP states Adult S cannot be accommodated in residential home due to drug use and concerns re his daily visit from a drug dealer.

13 – Medical assessment completed jointly by NSFT and Adult S received by Housing Options Team, with the aim of getting banding increased. AP calls HTH but declines to speak to Adult S**,** despite him trying to contact them for 2 days.

14 – GP completes medication review and makes changes to prescription in consultation with Mental Health worker.

17 – Adult S reports to Voluntary Norfolk worker that he 'has still not heard' from AP.

18 – Letter of support for increased banding from GP received by NRCC Housing options team.

20 – Report of assault of friend of Adult S by a neighbour at Adult S's flat, Police attend. NFA – safety marker placed on property by Police to support Adult S.

22 – Following request by NSFT, Police complete housing risk assessment and forward to Housing options team.

25 – GP calls AP who says she has provided Adult S with list of community groups he could attend. GP supports referral by NSFT to NEAT (Norwich Escalation Avoidance Team) and a referral to Menscraft 1.

26 – Social Care record states – Adult S 'does not have sufficient care needs' for a placement in HwC (Housing with Care). Adult S advised to apply for sheltered housing.

CFICS (Community Fully Integrated Care & Support pathway) referral received from Community Psychiatric Nurse for support with mental health.

Referral made by Norwich Escalation Avoidance Team (NEAT) to the High Intensity User (HIU) team at Norfolk Community Health and Care Team (NCHC) and subsequently to Occupational Therapy for a mobility assessment.

NCHC Health Improvement Practitioner (HIP) allocated for Adult S.

27 – Referral by AP for support from Assistive Technology service accepted.

28 – Adult S contacts GP surgery 5 times, refuses to stop until seen by GP4.

Feb **2 –** Voluntary Norfolk contact AP for update as Adult S has not heard from them. Informed a referral to an OT has been made by AP.

4 – GP future dates Adult S's prescription for diazepam to prevent 'stock piling' of drugs.

6 – NCHC Health Improvement Practitioner (HIP) invites Police and other partners to a professionals meeting in a weeks' time.

9 – Police attend incident where Adult S is threatening to jump in front of bus. NSFT Crisis team informed; Adult S taken home.

10 – HIP contacts Shelter UK for advice on getting Adult S's housing band upgraded. Informs NSFT and AP.

11 – Professionals meeting, initiated by the HIP - NSFT, GP, Social Care – agreed a letter which is emailed to NRCC Housing to try and get banding increased. Police, Voluntary Norfolk, and Housing were unable, or not invited, to attend the meeting.

11 – 999 calls from MH worker as Adult S threatening to kill himself at home. CRHT meets Adult S face to face. No referral or record of Social Care being updated. Police complete **API** (medium risk).

[1] **MensCraft** is a Norfolk-based charity focusing exclusively on the health and wellbeing of men. They support men facing life's challenges or experiencing difficulties with their mental health.

14 – S produces a pocketknife threatening to self-harm, during home visit by CRHT worker. No referral to made to Social Care.

16 – February 2022 Adult S is admitted to NNUH following an intentional polypharmacy (multiple drug) overdose. Referral made to substance misuse team. Flat recorded by Ambulance Service as being 'very cluttered' and proving difficult to remove Adult S. Suicide notes found in Adult S's pocket.

18 – Health Improvement Practitioner (HIP) makes a telephone **safeguarding referral** following a disclosure from Adult S stating drug dealing and 'cuckooing' at his flat.

21 – Adult S tells hospital OT and Physiotherapist that he 'does not want to go home' and 'will do it properly (i.e. suicide) this time' if he is sent home. NNUH Community Mental Health Team visited Adult S flat and reported it as flat 'untidy but not unlivable'.

22 – NNUH discharge co-ordinator contacts CRHT to discuss discharge planning. Recommended contacting District Direct for a 'deep clean' of the flat before Adult S returns.

24 – HCHC support worker raises concern with GP and AP regarding unsafe discharge from hospital.

25 – Attends GP in distressed state, says his phone and car were stolen and his 'home ransacked' whilst in hospital. Adult S says the front door was left open by paramedics when they attended on 16th.

Senior Peer Social Worker from NSFT attempts to contact and visit Adult S but he is not answering calls. Police alerted and welfare check requested.

Police attend and find Adult S safe but 'spaced out'.

28 – Julian Hospital (Mental Health Unit in Norwich) reports to Police that Adult S has been robbed and his bank card stolen.

Police attend and complete **API** – information from Adult S regarding the theft is 'inconsistent'. Investigations commence regarding theft of Adult S car, suspect identified but Police were not able to pursue the matter further as Adult S had passed away before he could provide a statement of loss[2], which would have been necessary for criminal proceedings to be brought.

Mar

1 – Recorded by Social Care as at home and 'safe and well'. CMHT visits Adult S at home, also present are 2 males, no details taken.

Police visit again re allegations of stolen cards. Record further concerns for Adult S and upgrade **API** to high risk.

2 – Telephone call by Police to MASH to **request a safeguarding enquiry**. Information shared with Social Care

3 – NSFT support worker visits Adult S and neighbour J.

[2] Where a victim gives exact details of the property that has been stolen and the circumstances leading to the alleged incident.

Mar **4 –** Adult S attends GP surgery feeling breathless.

7 – Adult S is found deceased on the floor of his property by his neighbour J.

The Ambulance crew reported the property was cluttered with a Clutter Image Rating Scale of 8 (the ratings scale from 1-9).

See link to the Norfolk guidance for self-neglect and hoarding, which outlines the clutter rating scale below.

Hoarding Guide for Practitioners(norfolksafeguardingadultsboard.info)

8. The five key lines of enquiry

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

i. This case demonstrates many instances of effective collaboration among multiple agencies and within individual agencies, both in terms of good practice and information sharing. There is evidence of practitioners displaying diligence, care and understanding the risks to Adult S whilst trying their hardest to improve his situation.

ii. These positive practices are evident in the chronologies and records related to this case. Notably, the support provided by various agencies, including the General Practitioner (GP), Norfolk and Suffolk NHS Foundation Trust (NSFT), Crisis Home Resolution Team (CRHT), Norfolk Community Health and Care NHS Trust (NCHC) Health Improvement Team, Voluntary Norfolk, and Better Together, stand out. Information exchange between these agencies often resulted in effective collaboration. Adult S's neighbour described the professionals he observed working with Adult S as, in his opinion, 'everyone tried their hardest to help him'.

iii. Adult S was consistently described by partners as a "willing recipient" of support by many agencies, including NNUH and Norfolk Mind. Despite facing physical limitations and mental health challenges, Adult S rarely missed appointments and actively engaged in the support provided. This consistent interaction led to a deep understanding of Adult S's wishes and feelings, albeit with occasional inconsistencies from Adult S.

iv. These insights were meticulously recorded and frequently translated into referrals to mental health support teams and community groups such as Menscraft, which Adult S enthusiastically, regularly attended pre-COVID, aiming to offer both support and safer alternatives for Adult S's.

v. Adult S primarily sought assistance from his GP, regularly contacting the surgery (once five times in one day on 28 January 2022), without prior appointment. Over the six months leading up to his unfortunate passing in March 2022, Adult S consulted with five different GPs.
It is notable that despite the frequency of interactions (totaling sixty-five in the six months preceding his death), the surgery staff displayed remarkable patience and empathy toward Adult S's complex needs. Adult S's neighbour often accompanied him to appointments and described GP4 as being 'absolutely brilliant' in the support given to him.

vi. The GPs consistently adapted their approach to accommodate Adult S's requests, reflecting a holistic understanding of his requirements. They demonstrated a shared comprehension of his needs and referred to Mental Health Crisis teams when the need arose. GP4 wrote to the Community Mental Health Team to enquire about ongoing support for Adult S when he was discharged from the Crisis Team in December 2021.

vii. There is evidence of a continuous review of the extensive medication that Adult S required and on occasions these were 'safety netted' to avoid stock piling, whilst addressing his escalating pain levels. An example of this would be in January 2022 when the GP staff team contacted the Mental Health Team at Hellesdon Hospital to confirm the change and levels of medication.

viii. In early 2022, a noteworthy example of multi-agency collaboration occurred when the General Practitioner (GP), Norfolk and Suffolk NHS Foundation Trust (NSFT), Norfolk Community Health and Care NHS Trust (NCHC), the Police, and Voluntary Norfolk joined forces to provide evidence supporting an application for housing on behalf of Adult S.

ix. Housing was identified as one of the root causes of Adult S's mental health issues, prompting professionals to work diligently toward a resolution.

x. The NSFT CRHT team recognised Adult S's need for respite support. Consequently, the team arranged for Adult S to stay at HTH on two separate occasions in November 2021 and January 2022.
His neighbour described how Adult S 'absolutely loved' being at HTH and 'felt very happy and supported' there. On 18 November 2021, referrals were made to the local authority by a HTH mental health worker (shown in the chronology as a referral to the Multi-Agency Safeguarding Hub (MASH), which was in fact to the Social Care Community Engagement Team (SCCE).

xi. The referral by the Community Mental Health Team to NEAT and the subsequent referral to the NCHC Health Improvement Practitioner (HIP) on 26 January 2022, served as another example of good practice.

xii. During the one-month period of NCHC HIP involvement, two suicide-related incidents occurred. Firstly, Adult S expressed an imminent intention to walk in front of a car. The HIP provided immediate support to Adult S, keeping him engaged over the telephone, while a colleague alerted emergency services for assistance.

xiii. The HIP took the initiative by convening a multi-agency practitioner meeting on 11 February. 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.

xiv. Throughout the review, it is remarkable to note the level of support provided to Adult S by colleagues from Voluntary Norfolk, who worked tirelessly to support Adult S, and often went 'over and above' to try and improve outcomes for him.

xv. There are other examples of single agency good practice which have been highlighted throughout the other key lines of enquiry.

xvi. **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 neighbour during conversations with the reviewer.
- **Learning** - there were some missed opportunities, in particular the need for a multi-disciplinary meeting and plan, these are covered in more detail in subsequent sections.

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

i. There is no doubt that Adult S felt unsafe at home, actively sought help from many sources, and his vulnerabilities left him at risk. One area of concern, raised by some professionals in the analysis of this case is the perceived lack of consideration of 'contextual' safeguarding in this case.

ii. **Contextual Safeguarding**
Contextual safeguarding was a concept developed by Professor Carlene Firmin[3] in 2015, primarily focusing on children and young adults and the safeguarding risks they are exposed to in their environment and by the people around them.

(This is explored more fully, in the context of risks to Adult S, in the next Section 8.3).

iii. Professionals used various terms to describe Adult S, including 'garrulous,' 'quirky,' 'interesting,' 'challenging,' and at times 'inconsistent' and 'evasive' when providing information. He was also described by NSFT colleagues as ‘unrealistic in his expectations’ of professionals with a ‘perceived element of shame and denial with regard to his illicit drug taking’.

iv. Adult S's neighbour shared how he tended to provide different accounts to different individuals regarding the same story. In January 2021, the Police and NSFT reported that Adult S was 'evasive' when questioned about other individuals staying at his flat. These characteristics and inconsistencies collectively presented challenges for professionals when evaluating the levels of safeguarding risk and completing assessments.

v. A safeguarding referral opportunity emerged on 11 November 2021 when a GP, following an assessment of Adult S by a Mental Health Practitioner (MHP), referred the case to the CRHT. This initial contact did not lead to a referral despite identified risks for potential exploitation or 'cuckooing'.

vi. Subsequently, Adult S was accommodated at HTH a week later for respite care, and a Norfolk Mind practitioner made a safeguarding referral. This referral was prompted by concerns that Adult S might face difficulties living independently in the community after his discharge.

vii. The referral was passed to the Social Care team, a management discussion ensued, and a request was made to extend the respite stay at HTH, while home-based support could be sourced.

viii. On 19 November upon discharge from HTH, Adult S was added to the 'unmet needs' list by Social Care due to the incapacity to provide the necessary level of care in his locality. Consequently, a referral was made by Social Care to SWIFTS to provide support for Adult S, who was recorded as 'not coping.'

[3] Contextual safeguarding | NSPCC Learning

ix. On 21 November, an NSFT CRHT AP conducted a home visit, documenting concerns about Adult S's appearance and signs of self-neglect. Notably, he was unable to use his mobility scooter due to the absence of a ramp in the doorway of his flat, significantly limiting his mobility. Although the support provided by NSFT was positive throughout this case, concerns were not raised when risks were identified. This may have been because other partner agencies were perceived by the practitioner to be escalating concerns. This has been acknowledged by NSFT who have reinforced the role of regular clinical supervision where reflective case discussions are to be used.

x. The case was assigned to a Social Care AP. 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**.**

xi. On 24 November, 6 December, and 20 December, NSFT practitioners attempted to contact the Social Care AP regarding progress with a Care Act assessment and the possibility of sheltered housing, but it was recorded that they were unable to establish contact. The recording revealed a perception that progress in conducting the assessment was slow, and there was a notable absence of communication from the AP leading up to the assessment on 23 December. There is no evidence of any escalation procedures to address this issue, being used at this point.

xii. On 29 November, Adult S attended the GP surgery, and a referral for a needs assessment was initiated due to concerns about Adult S possessing a 'suicide kit,' leg bruising, and potential exploitation, following disclosures from Adult S. It was recorded that the referral was passed to the allocated AP, but there are no details of the outcome.

xiii. On 9 December, after a GP appointment, Adult S threatened to 'kill himself' and subsequently took an overdose of medication at home. He was admitted to NNUH. While in the hospital, Adult S was referred by nursing staff to the Mental Health Liaison Service (MHLS) and was assessed by a Psychiatrist and an Occupational Therapist, who determined that Adult S was 'functionally dependent.' MHLS referred Adult S to the Community Mental Health team for ongoing support.

xiv. Voluntary Norfolk made a referral for a needs assessment on 9 December and informed the GP of the referral. The call was passed to the Duty Team, who were recorded as ‘updating the allocated Social Worker’. Voluntary Norfolk also contacted Better Together Norfolk to inform them of the referral and the rationale, this was good multi-agency practice.

xv. On the same day, the NSFT crisis team alerted Norwich City Council Housing Team (NRCC) to potential ‘cuckooing’ and safeguarding risks. NRCC promptly discussed the case with their internal safeguarding champion and subsequently added Adult S to their internal safeguarding system. They then coordinated arrangements for a visit to Adult S by the Tenancy Management Team, this visit did not take place.

xvi. Adult S was discharged from hospital on 22 December. There is no evidence of any contact with the Social Care AP at this point. This would appear to be a missed opportunity to inform the upcoming Care Act assessment and share important information.

xvii. On 23 December 2021, an 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. There was no mention at this stage of risks of exploitation of Adult S, despite three referrals in the previous two months.

xviii. It was noted that the AP did not complete the appropriate Care Act assessment on the Social Care recording system LAS, in a timely way, following the assessment on 23 December. (This was not identified at the subsequent management overview on 4 January). Instead, a detailed case note was written, in place of the assessment.
The reviewer was informed that there are currently no NCC guidelines for timescales in completing Care Act assessments on LAS (Social Care recording system).

xix. Later that week an urgent referral from the GP led to a call from a Mental Health Practitioner to Adult S. During the call, Adult S was threatening suicide and expressed a desire for Diprenorphine (a veterinary drug fatal to humans).

xx. No referral was made to Social Care at this point. Adult S visited the GP surgery the next day, and a referral was promptly made to the Crisis Team. The Crisis Team subsequently conducted a home visit on 3 January.

xxi. Unusually, Adult S made a call to the Social Care team on 29 December, asking for ‘a safeguarding enquiry’. The Crisis Team was alerted by the Emergency Duty Team and the AP was informed. It is unclear what or who, if anyone, prompted Adult S to call the team and make such a request, or if any contact was made with Adult S by the AP.

xxii. On 4 January 2022, a management overview conducted by the Social Care Team Leader highlighted the following points: Adult *S's care needs were assessed as not meeting the criteria for placement in Housing with Care (HwC). Despite Adult S expressing worries about 'cuckooing’, there was no current evidence to support this concern*.

xxiii. Notably, concerns regarding possible exploitation or ‘cuckooing’ were raised by SWIFTs, the GP, NSFT practitioners, and Adult S himself. It's worth considering that the lack of multi-agency information sharing at this stage could potentially explain why exploitation and safeguarding risks were not shared and considered during the Care Act assessment.

The professionals meeting on 11 February 2022

xxiv. Until 11 February 2022, there was a notable absence of Multi-Disciplinary Team or Professionals meetings, with no single agency assuming a 'lead professional' role and organising a meeting. It is noted that GP notes of 27 January 2022 state – *Update community matron and contact NSFT to arrange a professionals meeting*. There is no evidence this happened.

xxv. On 26 January, NSFT referred Adult S via NEAT to the High Intensity User (HIU) team at NCHC. This referral had a positive outcome, leading to the assignment of a Health Improvement Practitioner (HIP) to Adult S. The HIP quickly recognised the need for a multi-agency professionals’ meeting to collaboratively plan and share information, which was commendable. The HIP also sought additional information from the housing organization, Shelter, to gain advice to strengthen Adult S's case for an increased housing banding.

xxvi. The professionals 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. It remains unclear whether the meeting resulted in a clear, outcome-focused plan shared among the partners. Unfortunately, there is little evidence to support this, making it a significant missed opportunity**.**

Discharge from Hospital in February 2022.

xxvii. In mid-February 2022, Adult S was admitted to the hospital for the second time. During this admission, the HIP raised a safeguarding concern because Adult S reported threats from local youths who wanted to use his property for drug-related activities. Adult S stated that when he refused, they ‘threatened him with a knife’.

xxviii. On 24 February Adult S was discharged from the hospital and returned to his home. The hospital discharge team had concerns that Adult S might have been providing inaccurate information about the condition and safety of his property to avoid going home. In response to these concerns, they requested the Community Mental Health Team to visit the property. The visit took place on 21 February, and the team's report described the property as 'untidy but not unlivable.' This assessment was corroborated by the Social Care AP.

Consequently, it was agreed that Adult S could return home and that he was medically fit for discharge. It was documented in the hospital discharge plan that the AP stated that the Befriending Service (it is not clear in the discharge plan recording who would provide this service) would attend Adult S's flat, twice a week and maintain two phone calls per day.

xxix. In addition, a recording from the AP, shared with the independent reviewer, detailed a telephone conversation between the AP and a Support Worker for Better Together who had been supporting Adult S since June 2021. The Support Worker advised that a referral was made to them to support Adult S into the community.

xxx. The Support Worker had been in weekly contact with Adult S, encouraging him to join groups in his area but he has been reluctant to do this. He has been 'on a few dog walks' with the Support Worker.

xxxi. This highlights a disparity between what befriending support would be provided for Adult S and what is documented in the hospital discharge plan and the recording by the AP, which is a concern.

xxxii. The HIP expressed clear concerns to NNUH about the discharge, as they believed it was potentially unsafe due to the high risk of Adult S taking another intentional overdose. These concerns were also communicated to NSFT and the GP. The NNUH Discharge Coordinator contacted the AP on 24 February to express concerns about the state of Adult S's flat and the need for a possible 'deep clean' from District Direct[4] before Adult S's return. This never materialised, it is unclear why.

xxxiii. **Conclusions and learning points from this key line of enquiry**

- Although the support provided by NSFT was positive throughout this case, concerns were not raised when risks were identified. There was a perception this was being done by other professionals.
- Given the complexities and the benefit of hindsight, it might have been more appropriate to allocate it to a more experienced Social Worker, rather than an AP.
- The recording revealed a perception from professionals in NSFT and MIND that progress in conducting the assessment was 'slow'. There is no evidence of any escalation procedures being used - Professional-Difficulties-V2FINALDEC-2020.pdf norfolksafeguardingadultsboard.info)

[4] Five Norfolk District Councils are working with NNUH to support patients through the District Direct service, which is designed to prevent unnecessary hospital stays and re-admissions.

- Norfolk City Council Housing referred the case to their Tenancy Management team following internal safeguarding concerns, but no face-to-face contact was made in the 3 months prior to Adult S's death.
- There was no completion of a Care Act assessment on LAS following the APs' visit on 23 December, or recognition of this in subsequent management overview. Detailed case notes were written but these should not have replaced a full assessment.
- The Care Act assessment in December 2021 did not recognise or include risks of possible exploitation of Adult S, despite previous concerns being raised for this reason.
- There was a no Multi-Disciplinary Team (MDT) or Professionals meetings, prior to February 2022, with no single agency assuming a 'lead professional' role. See NSAB guidance for complex cases - Practice guidance | Norfolk Safeguarding Adults Board
- Key partners were not invited to the Professionals meeting on 21 February e.g., Norwich City Housing, Norfolk MIND, Voluntary Norfolk. This meant that important information was not shared and there was no evidence of an outcome focused plan.
- There is a disparity between what befriending support was recorded as being provided in the hospital discharge plan and the Social Care AP recording. This will have led to an assumption by the hospital discharge team, and other professionals, that a higher level of befriending support would be provided, than was actually the case.

c. **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?**

i. During the 6-month review period leading up to Adult S's death, there were numerous instances in which he made disclosures regarding potential exploitation by others or concerns about 'cuckooing'. Adult S's social connections appeared to be 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.

ii. Adult S's neighbour described him as someone who could 'look after himself' and not be easily physically threatened. The neighbour described how they supported and 'looked after each other' in this regard. As a result, the reviewer concluded that the threats to Adult S were predominantly non-physical in nature, with acquaintances attempting to exploit and take advantage of Adult S's vulnerability and loneliness, often for their financial gain.

iii. An example of this was when a friend of Adult S, (P) unsuccessfully tried to claim carers allowance on his behalf without his knowledge while Adult S was in hospital. Adult S became angry when he discovered this, and the friendship deteriorated. Another example was an acquaintance (R) described by a neighbour as a well-known 'local thief and drug dealer' who offered stolen goods and drugs to Adult S. When Adult S was in hospital R allegedly broke into his flat, stole his car keys, then sold the car (minus the documents) to a neighbour. Police investigated this allegation, but it was subsequently closed when Adult S declined to give evidence or identify the offender (See 8.3.13 below).

iv. Adult S's sense of isolation intensified during the Covid-19 pandemic due to restricted social interaction. Consequently, Adult S actively pursued companionship and offered invitations to individuals whom most would typically avoid, granting them permission to stay in and utilise his flat. Some of these individuals were described by a neighbour as 'working girls.' Adult S developed a particular attachment to one of them. He even requested that they move into his flat, and he felt disheartened when the offer was declined.

The concept of 'cuckooing' in the case of Adult S

v. There are many academic papers and thematic reviews written on the subject of 'cuckooing', its characteristics, the difference between 'mate crime' and cuckooing and the exploitation of adults.

vi. Two examples relevant to this case are:

> **Gerard Doherty (2020)** describes - ***'Exploitative familiarity'***[5] …. *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.*

> **Stephen J. Macdonald, Catherine Donovan, John Clayton and Marc Husband (2021) - Disability & society - Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation**[6]
> *Mate crime is defined as when a person or group of people befriend a disabled* person with the sole purpose to exploit, humiliate or take control of their assets.*

[5] Prejudice, friendship and the abuse of disabled people: an exploration into the concept of exploitative familiarity ('mate crime'): Disability & Society: Vol 35, No 9 (tandfonline.com)

[6] Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation (tandfonline.com)

*As disability scholars have acknowledged, experiences of loneliness and isolation create a space where exploitation can emerge, … one of the key features of mate crime is that the disabled** ***person often does not acknowledge that they are being exploited by the perpetrators; they see the perpetrators as friends, or potential intimate partners, and welcome them into their homes.***

*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.

Agencies responses to the allegations of 'cuckooing' of Adult S

vii. It is worth outlining in some detail the responses from the different partner agencies to allegations of 'cuckooing' or exploitation.

Social Care

viii. Received referrals from GP on 29 November and MIND on 18 November 2021 regarding concerns of exploitation and 'cuckooing'. Also, a concern for safety 11 January 2022 from a MIND practitioner to raise concerns for safety, related to 'cuckooing'/exploitation when Adult S returns home. There is no evidence that these were added to the Care Act assessment, nor were considered for a Section 42 safeguarding enquiry.

ix. On the 18 February 2022 a safeguarding referral was received from the NNUH. It stated, 'Adult S has been threatened by youths selling drugs outside his flat and has also been threatened with a knife'. Adult S often said during conversations with professionals that he was 'feeling unsafe at home' and 'was reluctant to return home'.

x. Despite these concerns the Care Act assessment completed on 23 December 2021 didn't include acknowledgement of potential exploitation or 'cuckooing'. The AP mentioned in the recording on 23 December, she visited Adult S at his home and reported that '*she did not observe any evidence of ''cuckooing'' or drug dealing during her visit*. The care plan was to arrange a package of care, refer to assistive technology, and provide information on cleaning services.

xi. A management overview by a Social Care manager on the 4 January 2022 highlights the following: Adult *S does not have sufficient care needs for a placement in HwC; he is worried about ''cuckooing' but there is no evidence of this currently.*

The General Practitioner

xii. Many of the disclosures were made to one of the five GPs who had contact with Adult S. The relevant records are summarised below: -

Date	Disclosure/GP recording	Outcome
20/09/21	GP suggests changing locks to prevent 'unwanted people' entering flat.	**1st record of ''cuckooing''**
11/11/21	J is sofa-surfing with him, but it is turning into 'a bad mistake'. Advises that his friend P used to come around. Denies being cuckooed.	**Referred to CRHT**
29/11/21	Discussed concerns re 'cuckooing', possible exploitation regarding medication and considering physical harm also regarding bruising.	**Referral to S/Care**
07/01/22	Spoke at length to Adult S, during which he said the Class A drug dealers were ''cuckooing'' him and alleges they are making him sell drugs and use his flat.	**Referred to Crisis Team, Police and S/W updated**
07/01/22	Updated the AP on allegations of being cuckooed, advises she had asked about this on previous occasions and always denied. Agreed that this is a serious potential safeguarding concern, and she (the AP) will contact patient to explore further. AP said to the GP on 7 January, that she had seen 'no evidence' of 'cuckooing' at Adult S property when she visited him at home.	**Good practice Information sharing**
25/01/22	Adult S keeps telling her (AP) he cannot keep himself safe, but she feels he can - locks the front door, has a particular drug dealer he buys from and aware not to buy from others	**Logged on GP records**
27/01/22	Recorded - Patient concerned about being cuckooed. Police aware marker put on property.	**Logged on GP records**

Police responses to allegations of cuckooing, exploitation, and robbery

xiii. Police fully investigated two allegations of exploitation/'cuckooing' and robbery in January and February 2022.

CAD record 1 (07.01.22 – 14.02.22) – Call from Crisis team manager

xiv. States Adult S has been referred to them due to suicidal feeling …due to drug dealers trying to get him to sell drugs and trying to 'cuckoo' his flat. Also states that they have threatened to' stab him and bash him up'. Concerns were raised on behalf of Adult S regarding his address being taken over by others, potentially for the sale of Class A drugs. Adult S's concerns were taken seriously, and a visit was conducted to listen to and record his concerns. Subsequently, the appropriate investigation was initiated, leading to the recording of an Adult Protection Investigation (API) that was shared with Adult Social Care.

xv. Adult S provided a limited account and description of the situation and expressed a reluctance to further engage with the investigation. Nevertheless, an officer completed a risk assessment to assist with housing application.

CAD record 2 (28.02.22 – 27.03.22) – Allegations of a robbery at S address

xvi. Officers make further contact with Adult S and a 'theft of motor vehicle' investigation is created. From conversation recorded on enquiry log – neighbour states he is told by Adult S that he was robbed by a group of youths who took his wallet, phone, and car keys. When the officer returned to speak with Adult S, he was not sure how he lost his phone or bank cards and seemed 'very confused'. Neighbour calls back to Police to say that he doesn't believe he has told police everything and suspects Adult S has been victim of a 'robbery'.

xvii. Local investigations revealed the car's location, as it had been sold to an unwitting member of the public by a friend of Adult S, identified as R. The plan was to arrest R for questioning regarding the alleged theft, but this was not executed within the six-day period between finding the vehicle and Adult S's death. The delay was attributed to the officer handling the case being on a short leave. Since there was no clear account from Adult S about how the vehicle or keys were lost or stolen, it remained unclear whether R had permission to use the car.

xviii. To resolve this uncertainty, it would have been necessary for the property owner to make a statement clarifying that R did not have permission. Unfortunately, due to Adult S's passing, the officer could not obtain this statement, leading to the closure of the matter.

xix. Evidence shows that Norfolk Police consistently responded in a timely manner when receiving calls related to Adult S's situation. In instances where risks were identified, Adult Protection Investigations (APIs) were conducted and recorded, with the findings shared among partners, including Adult Social Care and Mental Health services. Police completed a welfare check on 28 February 2022, after a request from the Social Care AP.

xx. After identifying the risk of ''cuckooing',' a risk assessment was completed by Police and shared with Housing in February 2022, following established procedures. It's noteworthy that there were no allegations of anti-social behavior linked to Adult S's address.

xxi. There was mention in the Police recording of a possible referral for Adult S to VARAC (Vulnerable Adult Risk Assessment Conference). The referral did not take place as the processes were still under development. This would be in line with recommendations outlined in Project Adder – Link gov.uk/government/publications/project-adder/about-project-adder.

xxii. The text below outlines the process for Norfolk VARAC, which is still at the development stage, but might have supported Adult S, were it fully functioning.

Vulnerable Adult Risk Assessment Conference (VARAC)

xxiii. As part of Project ADDER, the Vulnerable Adult Risk Assessment Conference (VARAC) was planned to be established. The purpose of VARAC was to provide multi-agency interventions to adults associated with drugs across greater Norwich who are at the highest risk of experiencing significant harm, exploitation or being a victim of crime.

xxiv. Examples of individuals that are suitable for VARAC intervention include:

- A vulnerable adult who doesn't use drugs but is being exploited by those involved in drug dealing (such as having their home cuckooed, which is when drug dealers take over the property for the purpose for using it for preparing, selling and dealing drugs or other related items such as weapons).
- A vulnerable adult is a drug user who is experiencing significant harm as a victim of criminal activity, such as sexual exploitation or trafficking.
- A vulnerable adult that uses drugs and is being exploited through financial pressures being put upon them by their drug supplier forcing them into criminal activity.

xxv. As part of VARAC, partner agencies would meet frequently to discuss individual cases and to share information that allows for a comprehensive picture of the individual and their situation to be presented. From this, each agency will commit their support in a way that best suits the individual and their case.

Norfolk and Suffolk Foundation Trust (NSFT)

xxvi. On 14 November 2021, a CRHT worker visited Adult S's residence and noted the presence of two males. The worker recorded their details, which was considered good practice.

xxvii. A report of ‘cuckooing' was made to the NSFT support coordinator on 6 December 2021 by Adult S. However, it was noted that Adult S was 'evasive' when questioned about this matter, and his accounts often varied when speaking to different NSFT professionals.

xxviii. 7 January 2022 Adult S again contacted CRHT reporting ‘cuckooing’ concerns, crisis worker arranged to see him on that day with a further referral to HTH being made and subsequent admission on 9 January. It was noted that Adult S frequently referred to younger friends who were 'keeping an eye on him,' but he also expressed concerns about being 'threatened with a knife' and having his 'cards stolen.'

xxix. Adult S was said to be 'scared' of some of the friends who stayed at his flat and appeared relieved when one of them (P), moved on.
(It was subsequently established by the author that P was the friend who tried to claim carers allowance.)

Norwich City Council Housing (NRCC)

xxx. NRCC produced guidance for staff regarding ‘cuckooing’ in June 2023 entitled - ‘Cuckooing’ – Guidance to aid tenancy sustainment.
Cuckooing | Cuckooing | Norwich City Council

xxxi. It states its aim as:
As a landlord, our aim is to work with tenants to help them sustain their tenancy. If we suspect that a tenant may be or is likely to be a victim of ‘cuckooing’, tenancy management, antisocial behaviour and other teams in the housing and community safety directorate will work together to ensure that the tenant is given every opportunity to engage with support.

xxxii. On 9 January 2022, NRCC initiated an internal safeguarding alert following a call from the NSFT care coordinator, which was related to Adult S's hospital admission and allegations of ‘cuckooing’.' NRCC promptly forwarded these concerns to the Tenancy Management Team, who had plans to visit Adult S for a risk assessment. Unfortunately, the visit had not occurred by the time of Adult S's death. It was unclear why.

xxxiii. It's important to note that NRCC had no evidence on file of ''cuckooing'' or antisocial behavior at Adult S's address at the time of his passing. However, partners, such as GP, Police, NCHC, NSFT would argue that various communications were sent to NRCC during January and February 2022, alerting them to the risks of exploitation, to increase the housing banding.

Norfolk and Waveney MIND

xxxiv. A MIND practitioner phoned the Social Care AP on 11 January 2022 to express concerns for safety on return home due to Adult S's disclosures, not specifically about 'cuckooing'. The MIND worker was recorded as being 'reassured' after speaking to AP.

Voluntary Norfolk

xxxv. On 11 January 2022 Adult S told a support worker he 'felt safe at HTH'. He did not have to worry about people knocking on the door or trying to 'cuckoo' him. Adult S said, 'a crack addict' threatened him with a knife and wanted to sell drugs from his flat'. The support worker called the Social Care AP to relay the concerns.

Norfolk and Norwich University Hospital (NNUH)

xxxvi. On 18 February 2022, the Substance Misuse team completed a referral expressing concerns about Adult S's safety. Adult S disclosed that he had received threats from local youths who wanted to sell drugs from his property. When he refused, he was 'threatened with a knife'. Additionally, the physiotherapist completed a report in which Adult S indicated that he felt he had been the victim of financial abuse by a 'so-called friend' named P. Adult S alleged that P was 'taking his money'. (This related to the claim for attendance allowance).

Norfolk Community Health and Care (NCHC)

xxxvii. When NCHC became involved with Adult S, the cuckooing risk had already been assessed and escalated including Police assessment and a marker on the property. The HIP involved with Adult S, was confident and clearly understood the dynamics of adult exploitation.

The professionals meeting on 11 February 2022

xxxviii. The focus of the meeting was to increase Adult S's housing band, due to the risk of exploitation and cuckooing. There was a missed opportunity to formulate an action plan, which included NRCC Housing and Police, based on shared intelligence from the agencies, as outlined above.

xxxix. Conclusions and learning points from this key line of enquiry

- The publication - ***The variable and evolving nature of 'cuckooing' as a form of criminal exploitation in street level drug markets - Jack Spicer & Leah Moyle & Ross Coomber (2019)***[7] – outlined a study of five disabled people who were described as having been 'cuckooed'.
- This is especially pertinent to the situation of Adult S, as it delved into their experiences and the perspectives of professionals involved in the context of cuckooing. The study's participants were largely isolated within their respective local communities, with most lacking contact with their families or lacking a circle of friends. It states – '*Social isolation was a significant factor experienced by all of the disabled participants in this study.* ***What appeared to make victims/survivors structurally vulnerable was their social positioning: they become vulnerable because they are living alone and lonely, typically in poverty, with very few adult services to sustain them, and with a lack of social connectivity to family and/or friendship networks'.***
- Among its findings, the study identified:

  '*Localised intelligence about who lives alone and how connected they are to social support networks is deemed critical in the identification of potential targets for cuckooing. Within the practitioner's narrative, forms of exploitation are often allowed to continue because of assumptions made about those individuals who are stigmatised, not just because of their disability, but because they are also constructed as 'druggies', 'alcoholics', 'criminals' or 'anti-social'. In addition, the construction of vulnerability can significantly mask the warning signs****….service providers and members of the community wrongly interpret warning signs of cuckooing as a sign that the person has 'fallen in with the wrong crowd' rather than identifying what is happening as exploitation.***

  Learning Points

  - A fully functioning VARAC process may have been able to identify further support for Adult S. It is not clear from this review if the VARAC process will become fully functional in the near future but recommends this is considered.
  - The lack of key partners at the Professionals meeting on 11 February 2022 meant that the full extent of the risks of exploitation were not considered.

[7] The variable and evolving nature of 'cuckooing' as a form of criminal exploitation in street level drug markets (bath.ac.uk)

- Most practitioners working with Adult S were aware of aspects of his exploitation and coercion by acquaintances, but it was not fully acknowledged in the 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'.

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

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

ii. A summary below will help understand the various strands and types of support partners provided and at what time.

General Practitioner (GP)

iii. Recording shows that the GPs were aware of and responded effectively to Adult S mental health concerns. Support was provided both in the surgery through the Mental Health Practitioner on at least 3 occasions and by referring to specialist services i.e., the NSFT crisis team on four occasions, when concerns escalated.

iv. On 21 January 2022 it was noted that GP 4 had written to CMHT to enquire about on-going support since discharge from the Crisis Team. Adult S was recorded as 'lurching from crisis to crises. Recording states - Following an urgent referral by GP on 19 January 2022, Adult S was then referred to an Adult Community Mental Health Team.

Norfolk Mind

v. Adult S received support through referrals from the CRHT team and attended HTH, a short-stay recovery facility operated by Norfolk Mind, on two occasions. Adult S first stay occurred in November 2021, during which he spoke about feelings of loneliness and discussed past traumas. This raised concerns about his health and the potential need for support upon his discharge and return home, leading to contact with Social Services in November 2021. This was passed on to the allocated AP as part of the forthcoming assessment.

vi. Adult S's second stay at HTH took place in February 2022, during which he expressed more explicit thoughts about self-harm and suicidal ideation. These concerns were also notified to the Social Care AP.

Mental Health Liaison Service (MHLS) – based at NNUH.

vii. Between December 2021 and March 2022, Adult S was admitted to NNUH on two occasions. The first admission occurred on 9 December 2021, and the second on 16 February 2022. On both occasions, he received assessments by the Mental Health Liaison Team (MHLT) and actively engaged in the process. During his first admission, there were three assessments conducted by the MHLT. These assessments resulted in a request for NNUH to refer Adult S to Social Care for assessment, along with a request for follow-up by his GP.

viii. Following his second admission in February 2022, due to an overdose, the NNUH internal respect form (plan of action on admission) states Adult S 'lacks capacity' as altered level of conscious level 4/15, using the Glasgow Coma Scale[8].

ix. There was no evidence to support a mental capacity assessment being required as no time specific decisions needed to be made. Subsequently, Adult S was discharged home on 24 February, with plans for follow-up by the Community Mental Health Team (CMHT) and Flexible Assertive Community Treatment (FACT) with support calls.

Norfolk Community Health and Care Team (NCHC)

x. Following a referral from the NEAT in January 2022 for admission avoidance, the referral was accepted, and an ongoing referral was made to the High Intensity User (HIU) team. The HIU team's focus group includes individuals who are lonely and isolated, homeless, dealing with mental health issues, and facing medico-social challenges.

xi. On 24 February 2022, Adult S was discharged from the HIU service. Initially, there was a plan for a 4-6 week supported living placement upon discharge from NNUH. However, later the same day, this plan was changed to a home discharge from NNUH. During this period, the HIP instigated a professionals meeting and re-engaged Adult S with voluntary services such as Menshed to reduce isolation and escalated the housing banding to address his housing needs.

Norfolk and Suffolk NHS Foundation Trust (NSFT)

xii. The role of NSFT in relation to Adult S was to initially provide psychological intervention to support his anxiety. Adult S self-referred to the Wellbeing Service (WBS) in August 2021. Over the course of this period, three telephone contacts were made until his discharge from the WBS on 1 December 2021. Prior to this, Adult S had no history with the NSFT.

[8] The Glasgow Coma Scale (GCS) is a clinical scale used to reliably measure a person's level of consciousness after a brain injury. The GCS assesses a person based on their ability to perform eye movements, speak, and move their body. These three behaviours make up the three elements of the scale: eye, verbal, and motor. A person's GCS score can range from 3 (completely unresponsive) to 15 (responsive).

xiii. The initial wellbeing assessment occurred on 16 September 2021, which highlighted an ongoing risk to self. Consequently, Adult S was referred to the CRHT and placed on a waiting list for allocation to a Lead Care Professional as soon as capacity allowed. In November 2021, Adult S was discharged back to his GP, with ongoing support offered by CRHT.

xiv. In January 2022, following an urgent referral by his GP, Adult S was further referred to an Adult Community Mental Health Team.

NSFT Community Mental Health Team

xv. Recording states – Adult S was active to a Community Mental Health Team (CMHT) from January 2022 until his death. At the time there was no Older Peoples Service within Norfolk. In October 2022, this provision was introduced to help improve assessments of those service users aged 70 to 74 years of age who have been referred for CMHT support. Adult S was not seen by the CMHT between January 2022 and his death in March 2022.

Voluntary Norfolk

xvi. Better Together (1-to-1 support to adults whose loneliness is the primary issue affecting their health & wellbeing) supported Adult S from 2019. Contact was lost during Covid lockdown from March 2020 when Adult S lost his phone and re-established later in 2020.

xvii. Adult S was supported from February 2021 to engage with Menscraft and Men's Sheds in Norwich. He also engaged with a walking group and was supported by a telephone befriender. He was closed to Better Together in June 2021, but re-established in December 2021 after a referral to the MASH.

xviii. There is clear evidence of effective information exchange and coordination with other agencies such as the CRHT team and the AP. The Crisis team were particularly effective in communicating with Voluntary Norfolk regarding Adult S's hospital discharges.

Adult S's mental capacity

xix. It is essential to emphasise that assessing an individual's mental capacity plays a pivotal role in how they are responded to by services. The legal framework is specifically crafted to safeguard individuals who lack mental capacity, as they are inherently more vulnerable.

xx. There is 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 and an altered level of conscious level of 4 out of 15.

xxi. It is also important to clarify when a capacity assessment is required. The Mental Capacity Act 2005 states - '*Capacity is about the ability to take a particular decision at the time it needs to be taken. It is decision-specific and time-specific'* (see below).

What can trigger a mental capacity assessment?
(Mental Capacity Act 2005)
A mental capacity assessment should be undertaken when the capacity of a patient to consent to treatment is in doubt. Lack of capacity cannot be demonstrated by referring to a person's age or appearance, condition, or any aspect of their behaviour. **Capacity is about the ability to take a particular decision at the time it needs to be taken. It is decision-specific and time-specific.**

xxii. 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 the condition of the garden or make wise decisions about who he let into his flat, could be illustrative of this challenge.

xxiii. **NICE guidance[9]** advises the assessment of **executive functioning**. It recommends that assessment should include real world observation of a person's functioning and decision-making ability, with a subsequent discussion to assess whether someone can use and weigh information and understand concern about risks to their wellbeing. It also states that assumptions **should not be made** about people's mental capacity to be in control of their own care and support, and account should be taken of their history and life story. **Account should also be taken of the negative effect of social isolation on wellbeing,**

xxiv. Conclusions and learning points from this key line of enquiry

- The Mental Capacity Act 2005 says that individuals who are deemed to have full mental capacity are entitled to make unwise decisions and what some may deem 'poor' choices. This may have been the case with Adult S.
- Those who lack mental capacity are managed using best interest considerations, which are taken by professionals to improve outcomes. This was an opportunity not afforded to Adult S.

[9] NICE (2018) Decision Making and Mental Capacity. London: National Institute for Health and Clinical Excellence

- The concept of “executive’ or ‘decisional capacity” is particularly relevant where the individual has addictive or compulsive behaviours, as with Adult S. There is no evidence to support this was fully assessed for Adult S, instead ‘yes’ or ‘no’ decisions in terms of capacity, were made. This demonstrated a lack of professional curiosity.

Learning Points.

- 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 Adult S mental capacity, there was a lack of professional curiosity and therefore no opportunity to make best interests decisions on his behalf.
- It could be argued that no time specific or decision specific decisions needed to be made, but there were still numerous opportunities based on ‘decisional’ capacity.

e. Did housing providers respond effectively to Adult S’s safeguarding concerns?

i. There was a sentiment among certain partners, such as NSFT and Voluntary Norfolk, that Housing, along with Social Care, were the two key partners capable of 'effecting positive change' for Adult S.

ii. It is evident to the reviewer that Adult S believed that most of his issues stemmed from his housing situation. He believed that relocating would make him feel happier and alleviate his problems. This belief is supported by Adult S's statements that he felt 'safer' and 'happier' during two separate respite stays at HTH.

iii. 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’.

iv. NRCC records indicate that Adult S was allocated the lowest banding level because he was deemed at the time, to be 'adequately housed.' There was no evidence to the contrary and unless evidence could be provided to support an increased banding, due to welfare issues, the chances of securing alternative accommodation would be low.

v. It is worth noting that Norwich is an area of extremely high demand for social housing with 4,350 applicants (as of October 2023) waiting to be re-housed. Many of these are homeless, facing homelessness or living in conditions of severe housing need. Norwich City Council only had limited properties available to meet this demand. As such, it is important to note that that the Council had a policy which set out who qualifies for social housing in the city and how they prioritised those applicants in the greatest need.

vi. Adult S requested to join NRCC Home Options in November 2021 as he was struggling with mobility in his current accommodation.
On 6 December 2021, a letter was received from GP2 requesting a review of Adult S's housing banding. The letter outlined how the GP felt that Adult S *'would benefit greatly from a change of residence to help with his worsening mental health and suicidal ideation…'.* It is unclear if a response was received by the GP.

vii. The AP was asked in December 2021 to support Adult S in completing a minimum Housing Needs Report to assess his housing needs. Since Adult S had no email access, a referral was made for him by an NCC Support worker to Voluntary Norfolk, which was good practice. The AP's care needs assessment stated that Adult S could 'mobilise safely in his home'.

viii. The banding decision was challenged in early February 2022 by the HIP, who sought advice from Shelter UK. Many partners, including NSFT, GP, NCHC, Norfolk Mind, and the Police, submitted written evidence to NRCC Housing Options to have Adult S's banding increased from the lowest level. Importantly, during the same month the HIP instigated a professionals meeting, but Housing was not invited.

Communication between housing and other practitioners

ix. NSFT recording states that two practitioners 'experienced continued barriers and repeated hurdles with Housing*'* during efforts to increase Adult S banding from 'low' to 'bronze' level and help move to supported accommodation. It was also recorded by NCHC colleagues that the housing provider response was a 'challenge to navigate'. No specific examples were given but it is a concern that partners experienced this.

x. After an intentional overdose by Adult S and his admission to the hospital on 9 December 2021, the NSFT care coordinator contacted NRCC and informed them that Adult S was 'scared to return home.' This communication led to the raising of an internal safeguarding concern with the NRCC safeguarding champion, and safeguarding records were updated accordingly.

xi. Plans were made for the Tenancy Team to visit Adult S at home. On 9 December 2021 an arrangement was made with NSFT and tenancy management to visit Adult S at home on 14 December. However, this visit did not take place as Adult S was in hospital following an overdose. The Tenancy Management team did visit the property on 14 December to check that it was safe, there was no reply when they knocked at the door and the property was locked.

xii. On 26 January 2022 the Social Care record indicates that Adult S 'does not have sufficient care needs' for a placement in HwC (Housing with Care). Adult S advised to apply for sheltered housing. This was disappointing for Adult S, whose mental health further deteriorated and his suicidal ideations increased.

Housing issues on discharge from hospital in February 2022

xiii. The East of England Ambulance Service (EEAST) documented on 16 February 2022, that they encountered difficulty in removing Adult S due to 'the level of clutter in the property.' EEAST assigned a clutter rating of 8 (out of 9) when responding following Adult S's passing on 7 March 2022. This high rating indicates that the property was severely cluttered. This did not result in a referral for hoarding, which was a concern.

xiv. However, there is a contradiction from the AP on 24 February, who stated to the NNUH discharge coordinator that the property was 'not unlivable' and had a clutter rating of '2'.

xv. It is notable that the Community Mental Health Liaison team had also visited Adult S flat before discharge and concurred with the APs assessment of the property.

xvi. The neighbour of Adult S, when speaking to the reviewer, described the property as 'messy,' but he emphasised that it was not 'severely cluttered'.

xvii. He explained that the Ambulance Service encountered difficulties in moving Adult S due to a poorly positioned table that obstructed access.

Adaptations to S property

xviii. Records show that certain adaptations were made to Adult S's property during the review period. In early November 2021, bathroom adaptations were finished. Then, on 3 December 2021, the NRCC Occupational Therapist conducted a home visit and determined, after an assessment, that "due to his good mobility, his ability to drive, and his plans to move, adaptations to the front step for his mobility scooter would not be recommended."

xix. Conclusions and learning points from this key line of enquiry

- This review raised concerns about whether the Housing provider, Occupational Therapists, and the AP fully grasped the extent of Adult S's increasing mobility challenges, including the need for adaptations to the front step to facilitate the use of his mobility scooter.
- Adult S coped with conditions such as sciatica and claw toes, which caused him constant pain. However, in discussions with the neighbor, it became evident that Adult S hadn't used his scooter for ‘at least 10 years’ and was employing it as a 'lever' to force a relocation. Therefore, it is deemed to be another example of Adult S giving different stories to different practitioners.

Learning points

- NRCC Housing were not invited to the Professionals meeting on 21 February, despite being identified as one of the partners who ‘could effect change’, this was an important missed opportunity.
- Where an agency considers the level of clutter to be high i.e. 7 or over on the clutter image rating scale, a referral should be made.
- There was a visit to Adult S by the NRCC Tenancy Management team on 14 December, but he was not home. There is no evidence of any further visits prior to Adult S’s passing on 7 March, despite internal safeguarding concerns.
- There was a lack of communication from NRCC Housing to partners in response to their requests for banding increase in the six months prior to Adult S passing.

9. Summary of the main learning points from this review

a. Although the support provided by most professionals was positive throughout this case, safeguarding referrals were not submitted when concerns were identified. There was sometimes the perception this was being done by other professionals.

b. Given the complexities of the case, it might have been more appropriate to allocate it to a more experienced Social Worker, rather than an AP.

c. The recording revealed a perception from some professionals that progress in conducting the Care Act assessment was ‘slow’. There is no evidence of any escalation procedures being used.

d. There was no completion of a Care Act assessment following the APs’ visit or recognition of this in subsequent management overview. Detailed case notes were written but these should not have replaced a full assessment.
The assessment in December 2021 did not acknowledge the risks of possible exploitation.

e. Most practitioners working with Adult S were aware of aspects of his exploitation and coercion by acquaintances, but it was not fully explored or acknowledged in Care Act assessments and did not lead to a safeguarding enquiry.

f. There was a lack of professional curiosity regarding financial exploitation of Adult S which subsequently didn't identify him as a victim.

g. There was a no Multi-Disciplinary Team (MDT) or Professionals meetings, prior to February 2022, with no single agency assuming a 'lead professional' role. This would have helped prioritise appointments and support and ensure Adult S received the right intervention at the right time. When the meeting did take place, key partners were not invited. This meant that important information was not shared and there was no evidence of an outcome focused plan.

h. There is a disparity between what support was recorded as being provided in the hospital discharge plan in February 2022 and the Social Care AP recording. This will have led to an assumption by the hospital discharge team, and other professionals, that a higher level of befriending support would be provided, than was actually the case, which is a concern.

i. A fully functioning VARAC process may have been able to further support Adult S. There is an opportunity to review if the VARAC process will become fully functional in the near future.

j. Opportunities to conduct a Mental Capacity assessment were not taken and assumptions were made about Adult S's capacity. No account of the effect of his social isolation or drug abuse on Adult S mental capacity, there was a lack of professional curiosity and therefore no opportunity to make best interests decisions on his behalf.

k. There was a delay in visiting Adult S by the NRCC Tenancy Management team after the internal safeguarding referral on 9 December, despite internal safeguarding concerns.

l. There was a lack of communication from NRCC Housing to partners in response to their requests for a banding increase in the six months prior to Adult S passing.

10. Recommendations to effect change

a. 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 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.

b. 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 this review - Practice guidance | Norfolk Safeguarding Adults Board

c. The NSAB in co-ordination with the Community Safety Partnership 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.

d. 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.

e. 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. The 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).**

f. The 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, partners briefing shared through NSAB communication networks.
Professional-Difficulties-V2FINALDEC-2020.pdf (norfolksafeguardingadultsboard.info)

g. There needs to be greater oversight, to ensure an 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.

h. 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.

Appendix One – Abbreviations

A+E – Accident and Emergency Department
AP – Assistant Practitioner
API – Adult Protection Investigation
CFICS – Community Fully Integrated Care & Support pathway
CMHT – Community Mental Health Team
CRHT – Crisis Resolution and Home Treatment (CRHT)
EEAST – East of England Ambulance Service Trust
FACT – Flexible Assertive Community Treatment
HIP – Health Improvement Practitioner
HIU - High Intensity User
HTH – Holly Tree House
HWC – Housing with Care
JPUH – James Paget University Hospital
LA – Local Authority
MASH – Multi-Agency Safeguarding Hub
MHP – Mental Health Practitioner
MHLS – Mental Health Liaison Service
NCHC – Norfolk Community Health and Care NHS Trust
NHS – National Health Service
NEAT – Norwich Escalation Avoidance Team
NHSE – National Health Service England
NNUH – Norfolk and Norwich University Hospital
NRCC – Norwich City Council
NSAB – Norfolk Safeguarding Adults Board
NSFT – Norfolk and Suffolk NHS Foundation Trust
QA – Quality Assurance
SAB – Safeguarding Adult Board
SAR – Safeguarding Adult Review
SARG – Safeguarding Adult Review Group
SW – Social Worker
VARAC – Norfolk Vulnerable Adult Risk Assessment Conference
WBS – Wellbeing Service

Appendix Two– 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]