Nottinghamshire
Safeguarding
Adults Board
Stop abuse and neglect

Safeguarding Adults Review (SAR) – Executive Summary

Subject: N22

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Nottinghamshire Safeguarding Adults Board wishes to place on record its sincere thanks to the agencies who provided care and support for Adult N who worked closely with the Board and Independent Reviewer and Author. They provided valuable information which was used to help shape and inform this review, and the Safeguarding Adult Review would not have been possible to undertake without their co-operation, open reflection and information. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board managers and support staff have been invaluable throughout this process.

Introduction

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and explore examples of good practice where this is likely to identify lessons that can be applied to future cases. The purpose of the Review is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

Overview

This Safeguarding Adults Review has been commissioned by Nottinghamshire Safeguarding Adults Board in response to concerns around multi-agency working and missed opportunities to support and engage with Adult N.

Adult N reported being alcohol dependent since the age of 15 years old. He was homeless for much of his life. He struggled with managing his finances and, whenever he returned to the streets, he appeared more vulnerable than other rough sleepers and was assaulted on a number of occasions.

In April 2021, Adult N attended an appointment with his GP. He stated that he had recently returned to the area, and had suffered a relapse in relation to the use of alcohol but felt he was now in a stable position. He was referred to a drug and alcohol support and advice service (Support and Advice Service) and prescribed medication for his epilepsy. In May 2021, the Support and Advice Service received the referral, but was unable to contact Adult N.

Later in May 2021, Adult N became a resident at a Hostel run by a homelessness charity. In accordance with its operating procedures, Adult N was subject to a risk assessment completed by the Hostel's staff. He scored as a medium risk in relation to substance misuse, suicide and mental health. In the other areas he scored as low risk. A support action plan was also completed by the Hostel's staff which sought to address support for Adult N in relation to the issues of housing, health, employment and substance misuse.

On admission Adult N was requested to adhere to the Hostel's Acceptable Behaviour Contract, which detailed many conditions of his residence including not to bring alcohol or illegal substances onto the premises. Adult N read and signed this contract.

A few days after admission, Adult N returned to the Hostel where he was found concealing a bottle of cider – this was confiscated and he received a warning from staff. In late May he informed staff that he was struggling with alcohol issues and he was advised to arrange an appointment with the Support and Advice Service. He later informed his Hostel Key Worker that he had missed his appointment with the Support and Advice Service but wished to stop drinking alcohol. He reported that he was struggling with past trauma issues, but refused to elaborate on what these were. He agreed to work with the Support and Advice Service and was informed that should he require counselling he should inform the Hostel staff.

In early June 2021, alcohol was discovered in Adult N's room and he received a warning from Hostel staff. The Hostel operated a "three-warning" policy, which if not adhered to placed continued residency at risk. A few days later Adult N met with his Hostel Key Worker who set goals for the completion of a housing application form and arranging an appointment with his GP.

At an appointment in mid-June 2021 with the Support and Advice Service, he undertook a comprehensive assessment, and after completion he reported wanting to become alcohol free. A severity of alcohol dependency test was completed, which indicated that he had sever alcohol dependency and a plan was made to arrange a nurse-led alcohol assessment.

Later in June, Adult N arrived back at the Hostel after the 9pm curfew, which resulted in him being refused entry. He returned the following day.

Toward the end of June, the Support and Advice Service made telephone contact with Adult N, who reported having no reduction in his alcohol use. Despite numerous appointment

reminders sent to Adult N after this contact, Adult N did not attend a pre-planned nurse-led alcohol assessment.

In early July 2021, Adult N was found rough sleeping in a shop doorway by a Street Outreach worker. Adult N reported to the worker that he had not stayed at the Hostel the previous night as he had been helping a homeless person and had missed the 9pm curfew. He was provided with a card detailing how he could access support from Street Outreach if needed. Adult N returned to the Hostel where he participated in a focus group. However, during the session he reportedly became irate and was asked to leave it, and later owing to his behaviour he was asked to leave the Hostel. Shortly after leaving, he was arrested for assault, and enquiries identified that both he and the victim were under the influence of alcohol. He received a police caution after the victim declined to register a complaint. As a result of him being under the influence of alcohol at the time of the offence, the Police referred him to the Nottinghamshire Healthcare NHS Trust Liaison and Diversion Team, which operates in custody suites with the aim of identifying a person's vulnerabilities at the earliest point of the criminal justice system and, where appropriate, sharing relevant information with the justice agencies and referring people into relevant services. Adult N reported to the team that he had a mental health illness, that he was an alcoholic and that he was currently homeless. He was provided with information regarding how to contact mental health crisis and accessing housing support.

In mid-June 2021, following breaches of the conditions of the Hostel's policy, Adult N was asked to leave the Hostel for a period of time. He returned at the end of the period and no further issues were identified for a number of weeks.

In late July, during an appointment with his recovery coordinator at the Support and Advice Service, Adult N reported consuming approximately 60 units of alcohol on a daily basis. He had been advised to record his consumption in a diary but he did not provide this to the recovery coordinator. Adult N also expressed an interest in attending alcohol workshops. However at the end of July he failed to attend a further appointment with the recovery coordinator, and did not respond to attempts to contact him. In early August, the recovery coordinator contacted the Hostel. A member of staff reported that Adult N had reduced his alcohol intake but it was suspected that he had started using other substances known as Black Mamba or Spice. The recovery coordinator asked the Hostel to inform Adult N of an available face-to-face appointment the following day, but Adult N did not attend.

In mid-August, Adult N did attend a face-to-face appointment at the Support and Advice Service and an alcohol screening test was undertaken. He was under the influence of alcohol at the time, and reported that he had consumed approximately 30 units of alcohol prior to the appointment. He was again advised to try to reduce his intake and complete a consumption diary so that detoxification options could be explored. A few days later he attended a face-to-face appointment with the Support and Advice Service nurse to complete an alcohol assessment. He expressed a desire to explore an inpatient alcohol detoxification programme and was advised that he would need blood tests undertaken by his GP. The Support and Advice Service contacted his GP to request these.

In late August, the Police and Ambulance Service were called to attend a property owned and managed by the Hostel provider. It was reported that Adult N and another individual had overdosed after suspectedly taking unknown substances. Adult N was taken to hospital, where he was initially unresponsive. It was recorded by the hospital that he may have injected heroin and cocaine and consumed alcohol. Following the administering of a drug to reverse an overdose Adult N regained consciousness, and he was discharged once his treatment was complete. Due to the assessment of the seriousness of the incident, the Hostel did not permit Adult N access until the following day. On his return the following day, he was found by Hostel staff to be heavily under the influence of alcohol which breached his tenancy agreement, he was refused access, and he was asked to return the following day for reassessment. On the same day, the Support and Advice Service contacted the Hostel to inform Adult N of the date of his next face-to-face appointment, and the Hostel staff informed the Support and Advice Service of the recent events. When Adult N returned the following day, he was reassessed back into the Hostel and advised that his behaviour was unacceptable and would not be tolerated.

At the beginning of September Adult N did not attend his face-to-face appointment with his recovery coordinator, but did attend the following week. A risk review was undertaken and Adult N reported that his recent overdose was accidental after using another person's needle. He was advised to undertake a blood-born virus test. Adult N also stated that he was consuming varying levels of alcohol subject to the amount of money available, and was continuing to use other substances. On the same date, following several unsuccessful attempts to contact Adult N, the GP suspended his prescriptions.

In mid-September, owing to a culmination in his behaviours, Adult N was evicted from the Hostel. The following day he failed to attend a pre-arranged appointment with his recovery

coordinator who contacted the Hostel and was informed of Adult N's eviction due to failure to keep up with his rent payments. Adult N did then attend the Support and Advice Service premises later on the same day, and informed his recovery coordinator that he was now sleeping rough and consuming approximately 60 units of alcohol a day. A further meeting was arranged for the following week. The following day Adult N was found unconscious after taking Heroin. The Ambulance Crew in attendance provided oxygen and he regained consciousness. Medical observations identified no specific concerns and Adult N refused to attend hospital. A mental capacity assessment undertaken by the Ambulance Crew deemed that Adult N had the capacity to make the decision.

In late September, Adult N did not attend a pre-arranged appointment with his recovery coordinator, but then made an unscheduled visit the following day. He was advised to visit the local authority so he could complete an accommodation application. He did so the following day. He was then found by a Street Outreach worker the day after, with whom he discussed wanting to stay somewhere that could provide more support than the Hostel had. The worker advised him to contact the Support and Advice Service so that he could be referred to a local independent housing association, and also confirmed that they would provide him with a mobile phone to enable the Street Outreach team to contact him if he needed support.

At the end of September, Adult N reported to his recovery coordinator that he had witnessed an assault during the night and after intervening had also been assaulted. He also reported that he had reduced his daily intake of alcohol. The coordinator contacted a local housing project to explore potential accommodation options. The local authority also on the same date contacted Adult N's mother, who confirmed that she was unable to accommodate him, and the Hostel, who stated that Adult N could return if he paid his outstanding service fees. The housing officer contacted the Street Outreach Team to request assistance in locating Adult N, but as no contact was established his case was closed a few days later.

In early October, Adult N was again located by a Street Outreach worker sleeping rough, cold and wet. He was provided with a new sleeping bag and food, and the worker arranged to meet him the following day to provide him with a mobile phone and complete referral paperwork for a local housing provider, which duly took place. The worker also contacted the Support and Advice Service to let them know that Adult N would be unable to attend his next appointment as he had a housing application appointment.

Two days later, the Street Outreach worker attempted to contact Adult N by telephone to attend an appointment at the local housing provider so that he could be assessed for suitability, but was unable to do so. Adult N was located by the worker the following day and a taxi was arranged to transport him to the local housing provider. Following his attendance, it was agreed that following an assessment Adult N would be able to stay at the accommodation once he had received his benefits which could be used to pay for the cost of the residence. The Street Outreach worker provided Adult N with food and arranged to contact him the following week.

The day after, Adult N was found collapsed and unresponsive after consuming a substance, and suffered a cardiac arrest. Sadly he did not regain consciousness and he passed away in mid-October 2021.

Recommendations and Learning from the review are summarised below, but access to the full report can be requested by contacting Safeguarding1.Adults@nottscc.gov.uk

Recommendations

1. The Rough Sleeper Coordinator should promote the establishment of the pre-eviction protocol to all housing exempt accommodation providers to ensure they understand the process, embed it in practice and ensure that relevant agencies are notified of the residents planned eviction, instigating referrals to the Rough Sleeper Action Group and Vulnerable Persons Panel meetings.
2. Nottinghamshire Safeguarding Adults Board should work with housing exempt accommodation providers, to audit their risk assessment process with the aim of promoting multi-agency working, and information sharing, that result in the establishment of support plans that mitigate or manage the risks posed to the individual.
3. Framework Street Outreach should raise awareness within its organisation of the availability of the "Personal Budget" and how workers may access it, to support homeless individuals with accommodation needs.
4. Nottinghamshire Safeguarding Adults Board should update its "Safeguarding Adults at Risk" Referral Pathway to include Referral Pathways to advise practitioners how to respond to Homelessness and Rough Sleeping and work with Nottinghamshire Adult Social Care to ensure future guidance they produce reflects the same referral pathways.

5. Nottinghamshire Safeguarding Adults Board should seek assurance from its statutory partner agencies that their existing Mental Capacity Act training incorporates reference to the consideration of executive impairment and that Nottinghamshire Safeguarding Adults Board produced a 7-minute briefing on executive impairment and promoted to partners through its communication strategy.
6. Nottinghamshire Safeguarding Adults Board through the development of their prevention strategy should promote the value of holding multi-agency meetings to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to Adults “Rough Sleeping and experiencing Homelessness”.
7. Nottinghamshire Safeguarding Adults Board should commission a county wide review of the approach to the Vulnerable Persons panels and review the Vulnerable Persons Partnership Meeting Terms of Reference to establish appropriate strategic oversight, governance, and accountability arrangements.
8. Nottinghamshire Safeguarding Adult’s Board should endorse the co-produced recommendations in the Nottinghamshire Director of Public Health annual report for 2023 particularly recommendation 1, that organisations with responsibility for housing should collaborate to develop joined up, sustainable, long-term housing solutions which include appropriate support for people with experience of severe multiple disadvantage.
9. Drawing upon learning form this case Nottinghamshire Safeguarding Adults Board should promote its Professional Curiosity guidance with partner agencies and through its assurance activities ensure the requirement to apply professional curiosity is embedded in agency safeguarding adult training.
10. Nottinghamshire Safeguarding Adults Board should work in partnership with Nottinghamshire County Council Public Health to review supported exempt housing arrangements in Nottinghamshire, to identify risks and opportunities to influence changes to policy at a local and national level.