Essex Safeguarding Adults Board

‘SIMON’

OVERVIEW REPORT

SAFEGUARDING ADULTS REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF SIMON, A 55 -YEAR-OLD MALE WHO DIED IN FEBRUARY 2021

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March 2022

[Final Version – July 2022]

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1. INTRODUCTION AND METHODOLOGY

Background

In July 2021, the Essex Safeguarding Adults Board considered the case of Simon who had been found deceased in his home. Simon was known to a number of services and was being supported at the time of his death. The safeguarding board recognised the potential to improve the way agencies worked together and commissioned this Safeguarding Adults Review (SAR)[1].

The review aimed to use the experiences of Simon to identify learning and to continually improve the way that agencies support the wellbeing of adults at risk. A wide number of agencies from the safeguarding partnership took part and four key findings were identified. These are outlined in this report as follows:

a) Person Centred Safeguarding
b) Multi Agency Safeguarding Referrals
c) Police Welfare Check and Missing Person Policies
d) Managing the Risk of Disengagement

Methodology

An independent lead reviewer was appointed to undertake the review, working alongside a panel of local professionals. Terms of reference were provided, identifying the key date parameters as June 2020 to February 2021. Chronologies and single organisation reviews were provided by each agency, analysing events and considering how changes to practice may deliver future improvement.

Whilst Simon did not have any living relatives or close friends who were able to take part in the review, a number of professionals who worked directly with Simon were able to.

Practitioners and senior representatives from each agency met for a further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for consideration by the safeguarding board. This overview report summarising the analysis and findings of the review panel was then prepared, having passed the safeguarding board's quality assurance process.

About This Report

This report outlines the recommendations in a concise format. It is written with the intention of publication and as such does not contain information which may identify those involved. The document aims to be as succinct and practical as possible and therefore does not contain a detailed chronology of events, or the 'working out' process for the review findings. The detailed analysis of events and the evidence underpinning this report are held in additional documents retained by the Essex Safeguarding Adults Board.

[1] Explanation and purpose of a safeguarding review - https://www.essexsab.org.uk/media/2493/safeguarding-adult-review-procedure.pdf

2. CASE SUMMARY AND KEY EVENTS

Simon – An Overview

In 2019, Simon moved to the Tendring area of Essex following the breakdown of his long term relationship. He had no family or friends in the area and after a period of rough sleeping reported to the local authority with housing needs. Tendring District Council immediately recognised his vulnerability and supported him with the provision of accommodation and further services to enable his independent living.

Simon had a medical history of suffering from poor physical health, in addition to depression and alcoholism. During 2020 his health continued to deteriorate and he received increasing support from a number of agencies and organisations. His access to medical services was however complicated by the COVID-19 pandemic, as he had developed a fear of infection from attending health settings. Simon was able to maintain contact with the professionals supporting him and whilst it was common for him to take a day to return any contact, he could be relied upon to reply.

In December 2020, Simon moved to a new home provided by the Salvation Army Housing Association (SAHA), having asked for new accommodation which was better able to meet his changing physical needs. Shortly afterwards the agencies working with Simon lost contact with him and significant effort was made to locate him. This was unsuccessful until the 6th February 2021, when he was found deceased in his new home, having died from natural causes related to his long term medical history.

Key Events

1) In October 2019, the Peabody Group were commissioned to support Simon through the Essex Outreach service. This was a short term service that aimed to help Simon in meeting his independent living needs and to access key services. He developed a good relationship with his support worker and maintained frequent contact both in person and by telephone. During the same month Simon registered with his new GP practice, although this registration process did not include a consultation with a doctor.

2) Between April and June 2020, Simon's support worker became increasingly concerned about his deteriorating health and wellbeing. Simon was encouraged to seek support from his GP, however he declined to do so explaining that he was too frightened as it may require him to attend hospital and become exposed to COVID-19.

3) By July 2020, Simon's health had deteriorated to the point where he had mobility difficulties and was unable to complete basic living tasks. Simon believed that he had suffered a number of 'mini' strokes and he was again encouraged to contact his GP. He continued to decline to do so, expressing his fear of having to attend hospital alone. His support worker contacted the GP surgery to inform them of his condition and to request support in applying to the local authority for a change of accommodation. By this time it was clear that Simon had significant care needs and was not able to keep himself safe. Whilst this met the threshold for a safeguarding referral[2] to Adult Social Care, at this stage it was not considered.

4) On the 17th August 2020, the support worker met with his manager to discuss Simon's case as the short term provision was due to end. It was agreed that due to his needs their services should continue and that this should be supported with an adult safeguarding referral. This was submitted outlining self-neglect and Simon's deteriorating ability to care for himself. The referral was received and reviewed by Essex Adult Social Care, which involved a telephone meeting with

[2] https://www.essex.gov.uk/report-abuse-or-neglect

Simon. The assessment determined that this was a medical issue that would be more appropriately managed by Simon's GP practice, who were asked to make contact with him to support his health and medical needs. At this time Simon's fear of attending health care settings and his reluctance to engage with his GP should have been understood. The social care referral was closed without Simon being informed of the outcome, or what he should do if he required further support.

5) Between August and October 2020, the GP surgery made a number of appointments for Simon to attend the practice, however he cancelled these at short notice and on the 5th October the practice informed social care that they had not been able to see him.

6) On the 20th October 2020, Simon contacted his support worker to request his support in securing new housing to meet the needs of his deteriorating physical health. He also explained that he had recently stayed in hospital, however when his support worker discussed this with the GP practice, he was informed that they had no record of any hospital admission. At this time other agencies who had been supporting Simon had also become concerned about his health and reported these concerns to his support worker.

7) At the end of October 2020, Simon did attend an appointment with his GP, which led to a number of referrals in relation to his physical health and his care needs. This included contact with adult social care, housing services, and referrals to other health services to support his mobility needs and to examine whether Simon had suffered from any strokes. Whilst a referral was made for Simon to be provided an appointment at the stroke TIA clinic, there were no measures put into place to support him attending the appointments and to support his fear of attending the hospital.

8) On the 27th October 2020, Essex Police received a report from Simon's housing provider to express concerns that he was a vulnerable person who was being financially exploited by a person known to be involved in criminality and the illegal use of controlled drugs. The housing provider also reported these concerns to Tendring housing services, explaining that Simon was becoming very stressed about the situation. A police officer visited Simon, who explained that he had given the person money voluntarily and that a crime had not occurred. The police case was closed.

9) On the 30th October 2020, the Community Rehabilitation Team[3] commenced services with Simon to support his mobility issues. They successfully met him at his home and a support plan was put into place, which included asking the GP to submit a change of housing request to support his physical needs.

10) On the 3rd November 2020, Simon failed to attend his appointment at the TIA clinic and subsequently missed a second appointment that had been made for the 24th November. As a result the clinic discharged him and advised the GP to re-refer if there was a continued need.

11) On the 4th November 2020, Simon informed his Peabody support worker that he had been the victim of a robbery. He did not provide any additional detail and it was not further explored or reported to the police.

12) On the 9th November 2020, adult social care received the GP's request for a Care Act assessment to be carried out, to determine if Simon met the threshold for additional social care support. This request outlined his deteriorating abilities and the need for alternative housing. The referral was quickly assessed, which included speaking with Simon, and it was determined that he had care needs that should be supported. A review of Simon's housing was requested and a reablement provider was commissioned to carry out an assessment with Simon to consider the development of a support package.

[3] At the time the Community and Rehabilitation service was provided by the Anglian Community Enterprise (ACE), now provided by the East Suffolk and North Essex NHS Foundation Trust.

13) On the 11th November 2020, housing services conducted a housing assessment with Simon and noted a significant deterioration in his health. He had lost sight in one eye, had become thin and unsteady on his feet, and was unable to conduct tasks such as carrying his shopping. The process to commission new housing began immediately and Simon was supported through the process of securing a new tenancy agreement. Whilst concerns about Simon were recognised, the submission of a safeguarding referral was not considered.

14) On the 18th November 2020, a worker from the reablement provider visited Simon's home to conduct an assessment. Receiving no reply they telephoned him and were told that he was in hospital and therefore no longer required support. The worker left and the case was closed. Essex Social Care were not informed of this until the 21st December, at which time they closed the case without any further contact with Simon.

15) On the 18th November 2020, housing services also visited Simon at this home for a pre-arranged appointment and met the reablement worker in the building's foyer. The housing officer telephoned Simon who confirmed that he was at home and their appointment proceeded, during which Simon explained that he had lied about being in hospital as he was embarrassed to receive support. This was not reported to social care or any other agency.

16) On the 12th December 2020, Simon moved into his new accommodation which had been provided by Salvation Army Housing Association (SAHA). At this time it was identified that the heating system was not working properly and a repair was prioritised. Agencies continued to work with Simon, which included visits to his new home.

17) On Monday the 4th January 2021, Simon informed housing services that he was temporarily not staying at his new home as the heating was not working. He said that he had been staying with the person who had previously been suspected of financially exploiting him and that he had now started to drink heavily, consuming a bottle and a half of whisky each day. The risk of exploitation was recognised and it was recorded that Simon may be at risk of cuckooing[4]. He was advised to go home and his support worker was updated. During the following days a number of agencies tried unsuccessfully to contact Simon, however contact was restored on the 7th January 2021.

18) On the 11th January 2021, Simon had a telephone meeting with his support worker and informed him that his heating was still not working. This was reported to SAHA, who arranged for an urgent repair to be made within 24 hours. This was however never completed as they were unable to contact Simon to make the arrangements.

19) Between the 12th and the 20th January 2021, all of the agencies working with Simon lost contact with him. Daily efforts were made to regain contact by telephone and by personal visits to his home. During this time it was identified that his mobile phone appeared to have been disconnected from the network and that whilst it was common for him to take a day to return contact, this was the longest time that the agencies had not been able to speak with him. Concerns for Simon's safety increased and there was significant liaison between the housing agencies and his support worker to coordinate their efforts in locating him.

20) On the 21st January 2021, Tendring housing services contacted Essex Police through the 'Live Chat' system[5], to express their concern for Simon's safety and to request that a welfare check was made. It was explained that he was vulnerable, had suffered a number of strokes, and that he had other medical needs. When asked if they believed him to be in immediate danger, the housing officer responded that they didn't think so. As a result the operator determined that the threshold for a welfare check had not been reached as there was no immediate risk of harm and the request was

[4] Cuckooing - https://crimestoppers-uk.org/campaigns-media/news/2018/mar/let-s-stop-cuckooing

[5] A digital online service, allowing people to communicate in real time with a member of staff working in the contact centre.

declined. At the time of making this decision, the operator did not research police systems to identify what was known about Simon and therefore the previous concerns of exploitation were not considered.

21) Between the 22nd January and the 3rd February 2021, the agencies working with Simon continued daily attempts to locate him, maintaining the coordination between the housing agencies and his support worker. On the 4th February, housing services informed the community rehabilitation team of their concerns and identified that they had also lost contact with Simon.

22) On the 4th February 2021, SAHA reported the increasing concerns for Simon's safety to Essex Police and requested that a welfare check was completed. It was explained that he had not been seen for three weeks and that whilst a number of agencies had made extensive efforts to regain contact their options were now exhausted. His medical vulnerability and risks of exploitation were explained, and his disappearance was explained as being out of character. The police call taker determined that the threshold to conduct a welfare check had not been met, as there was no evidence of an immediate risk to life or the risk of immediate harm. It was however recognised that Simon was missing and a missing person report was created, which was sent to a front line policing team for action.

23) The missing report was subsequently reviewed by the duty Inspector, who determined that Simon should not be recorded as missing as the reporting agencies could not reasonably be expected to know where he should be at any given time. He also determined that this did not meet the threshold to conduct a welfare check, as there was no evidence that he was at immediate risk. He recommended that the agencies continue their enquiries to locate him and the missing report was closed with no further police action.

24) On the 4th February 2021, SAHA submitted a safeguarding referral to Essex Adult Social Care, outlining that they had lost contact with Simon and that his disappearance was out of character. The referral outlined his medical vulnerabilities and that he may be subject of financial abuse from a person known to him.

25) On the 6th February 2021, a social worker went to Simon's home in response to the safeguarding referral submitted by SAHA. Finding the door shut but unlocked, the social worker contacted the police and requested that they attended to support her in locating Simon. Whilst the information presented to the police did not differ from the previous attempts to seek their involvement, they did support this request. Upon entering his home they found Simon deceased inside, appearing to have been deceased for some considerable time. The coroner subsequently recorded Simon's death to be from natural causes relating to his long term health issues.

3. WIDER CONTEXT

COVID-19 Pandemic

The key events in Simon's case took place in the midst of the COVID-19 pandemic. It was important for the SAR to consider how this may have affected the ability of professionals to support Simon, in addition to considering the need for any change to working practices should similar circumstances arise in the future.

In considering how this may have impacted professionals, two key issues were identified:

a) Whilst face to face meetings with Simon were maintained, their frequency was reduced and a significant amount of contact was conducted by text messaging. This made it difficult for professionals to identify that some of the information provided to them was not true and that Simon was providing conflicting information to those working with him. This issue may have been

overcome by a greater level of multi-agency information sharing and planning, which is dealt with fully in this report and forms part of the SAR recommendations.

b) Due to the national 'lockdown' and the governments 'work from home' guidance, mobile and remote working practices had to be implemented rapidly. Whilst professionals quickly adapted to this new way of working, it reduced the opportunity to receive support and guidance from colleagues and supervisors, that had previously been provided through everyday contact in the workplace. Not only would this have reduced the quality of case supervision, but it understandably led to professionals feeling a sense of isolation and a general feeling of nervousness whilst delivering services during 'lockdown' periods. During the last two years working practices have changed considerably and the greater use of mobile and remote working practices has become normal practice. These new ways of working have had time to mature and all agencies are now in a stronger position to manage the impact of any future circumstances similar to those created by the pandemic. For this reason there is no need for this review to make any specific recommendations about the delivery of services during a pandemic.

ALAN - SAR

In 2022 the Essex Adult Safeguarding Board published the 'Alan' safeguarding review, involving a case from the Castle Point and Rochford area of Essex. That review found similar safeguarding themes to the ones contained in Simon's case, particularly:

- How agencies support vulnerable people who are hard to reach and difficult to engage with. The review highlighted good practice developed by the Castle Point and Rochford Clinical Commissioning Group, in relation to how vulnerable people are identified at GP practices and how multi-agency services are coordinated.
- A lack of understanding in the police welfare check policy, including its purpose and the threshold required for checks to be made.
- How agencies manage the risk of persons who disengage from services, or where contact with them is lost.

4. CRITICAL ANALYSIS AND LEARNING

Finding 1 – Person Centred Safeguarding

Learning:

Many vulnerable people with complex needs find it difficult to engage with services. In order to support them a person centred approach to safeguarding is required, finding ways to support their engagement and to coordinate the work of the different agencies involved.

How agencies support people who have difficulty in engaging with services is a feature of many safeguarding reviews and if effective services are to be provided, it is important to recognise that some vulnerable people will need a higher level of support including an enhanced level of multi-agency coordination. This was certainly the case for Simon and it was a key feature identified in this review. Simon had complex health needs but faced barriers in accessing health services due to his fear of COVID-19 and his perceived risk of infection from attending health care settings. He was also vulnerable to exploitation due to the lack of supportive family and friends in his life, which increased the likelihood of him engaging in behaviours that were detrimental to his health and wellbeing.

Whilst there were a number of agencies working with Simon, they in the main worked independently and this meant that a holistic understanding of him was never developed. The professionals working

with Simon clearly wanted to do their best to support him, but would admit that they never understood what was happening in his life. Simon's fear of attending health care settings was an obvious barrier to improving his wellbeing, yet this was never really understood or planned for. What may have made a difference to Simon would have been a greater level of information sharing and professional discussion. A multi-agency support plan may then have been developed, coordinating the activity of the agencies involved and considering how further organisations may have contributed to this work. Such an approach would be an excellent example of 'Making Safeguarding Personal'[6], an approach that focuses on delivering the personalised outcomes of people who have care and support needs. This may have helped to prevent Simon from becoming at high risk of harm, or at least helped to understand the increasing risk to him and allowed agencies to work together to reduce it. Not only would this have benefitted Simon, it would have also been more efficient for the agencies involved.

Developing such a safeguarding approach was a theme examined in the 'Alan' safeguarding review, which highlighted best practice to improve the way services are provided to vulnerable people. This involved the development of systems at a local level to identify vulnerable people registered at GP practices and to hold multi- agency discussions to ensure that people's needs are met in a joined up approach.

The relatively new Integrated Care System within England provides an excellent opportunity to build upon current good practice and improve the way that vulnerable people are identified and supported within a multi-agency approach, seeking to improve information sharing and improve multi-agency joint planning. Integrated Care Systems[7] (ICSs) are new local partnerships between organisations that meet health and care needs and since April 2021 they have been introduced in every area of England. They aim to coordinate the services provided by organisations across the public, private, and voluntary sectors, to improve the quality of services and provide people greater control over the services they receive. The ICS system is a key pillar of the Health and Care Act 2022, which received royal assent in April 2022, providing a legislative framework for the system.

The Suffolk and North East Essex Integrated Care System is fully established and in 2022 plans to develop an Integrated Care Partnership (ICP) providing governance and oversight for the new partnership, alongside the newly established Integrated Care Boards which replace the existing Clinical Commissioning Groups. The development of the ICP alongside specific locality alliances of partner agencies (North East Essex alliance) provides a great opportunity to build upon existing arrangements in order to further improve the way that vulnerable people are identified and the way that services are delivered in a multi-agency approach.

It is recommended that the new Suffolk and North East Essex Integrated Care System, builds upon its existing partnership to continually improve procedures for the identification of vulnerable people and for multi-agency planning to be delivered. This should include consideration of:

a) Methods to consistently identify and flag vulnerable patients registered at individual GP practices.

b) A process to encourage multi-agency discussion about specific cases, including key agencies and any other organisation that may be working with an individual.

[6] https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

[7] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

c) The continued development of wider local partnerships, including a diverse range of local organisations that may add value to multi-agency planning. This should include the voluntary sector and local community groups.

Recommendation 1:	*The Suffolk and North East Essex Integrated Care Partnership, should build upon existing structures to continually improve the way that services are delivered to vulnerable people. This should include methods to consistently identify those who are vulnerable and to improve the way that services are delivered to them through coordinated multi-agency working practices and embracing the 'Making Safeguarding Personal' principles.*

Finding 2: Multi-Agency Safeguarding Referrals

Learning:

A number of opportunities to submit safeguarding referrals and to report the increasing concerns about Simon were missed. This was due to the lack of understanding as to when a referral should be considered and, in some cases, not following existing policy and procedure.

A key piece of learning identified during the review was the opportunity to improve the way that professionals understand and use procedures for the submission of safeguarding referrals to adult social care.

Throughout the spring and summer of 2020, a number of agencies had increasing concerns for Simon as his health deteriorated and he became unable to care for himself. Whilst the threshold for a safeguarding referral was met on a number of occasions, it was not considered by the professionals working with him. Whilst a safeguarding referral was submitted in August 2020, this was only done following a review to decide if Simon's support package could be extended.

Between October 2020 and February 2021, concerns for Simon continued to increase, including his risk of financial exploitation and that he may have been the victim of crime on two occasions. Despite this it was not until the 4th February 2021, that a second safeguarding referral was submitted, which resulted in a quick response from Essex Adult Social Care. Had referrals been submitted earlier, then this would have provided a formal process for the sharing of multi-agency information and an understanding of Simon's care needs. This may have helped Simon to improve his wellbeing and to reduce his escalating risk.

In examining the reasons as to why a better use of the referral process was not made, the review identified a lack of understanding in when a referral should be considered and the processes that should be followed when the need is identified. Where agencies did have safeguarding policies, these were not always understood and followed by staff.

To develop a greater understanding of the safeguarding referral process, it is recommended that all of the agencies review their existing safeguarding policies and where necessary produce new guidance. This should also consider the third party reporting of crimes to the police, where offences are disclosed to professionals who are working with vulnerable people. Policy and procedure should be underpinned by a training and awareness programme to ensure that they are understood and consistently followed.

The Essex Safeguarding Adults Board has recently refreshed and made changes to the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines[8] which are published on the website. Whilst addressing this SAR recommendation, it would be useful for agencies to also review the updated SET guidance.

Recommendation 2:	*All agencies should review existing policy in the use of safeguarding referrals and the third party reporting of crimes to the police. This should be underpinned by a training and awareness programme to ensure that new policy is consistently understood and followed.*

Finding 3: Police Welfare Check and Missing Person Policies

Learning:

Whilst Essex Police have a Welfare Check policy, this was not understood by the professionals working with Simon, nor was it consistently followed by staff within the police contact centre. The decision to not deal with Simon as a missing person showed that similar confusion existed in the way that adults at risk are considered under the police missing person policy.

After contact had been lost with Simon, there were two requests made to the police to seek their support in locating him and to check that he was safe. Both requested the police to conduct a welfare check, however following an assessment both were determined to not meet the threshold for one to be conducted.

Essex Police have an established policy that a welfare check will only be appropriate when there is an immediate risk to life, or when a person is suffering from immediate and significant harm. This is a policy supported by guidance from the College of Policing[9] and the requests in relation to Simon were declined as the threshold had not been met.

With the benefit of hindsight it is clear that Simon was at risk of significant harm and that a welfare check should have been authorised had all of the available information been known and properly considered. In examining why a different decision was not reached the review identified the following key issues:

a) Uncertainty existed amongst the professionals requesting the welfare check as to its purpose, including when it would be appropriate to request one and the information that should be presented to make the case that the risk of immediate harm existed.

b) Staff within the police contact centre only conducted a cursory risk assessment of the information initially provided to them and did not fully explore the nature of Simon's vulnerability. There was a lack of questioning to fully understand the callers concerns and the police information systems were not researched to review what was already known about Simon.

c) The method of the police contact was through the 'Live Chat' service, an instant messaging forum. The absence of a professional conversation hindered the ability to ask questions and to fully investigate the concerns.

[8] https://www.essexsab.org.uk/professionals/guidance-policies-protocols/?utm_source=e-shot&utm_medium=email&utm_campaign=ChangestotheSETSafeguardingAdultsGuidelines

[9] https://www.app.college.police.uk/app-content/mental-health/awol-patients/safe-and-well-checks/

As a consequence of this safeguarding review, Essex Police have identified the need to make changes to the current policy and its application by staff. A number of improvement recommendations[10] have been identified, including the need to promote a better understanding of the policy amongst partnership agencies. It is therefore recommended that Essex Police revises the Welfare Check policy and develops new guidance for staff to ensure that it is applied consistently. This should be underpinned by a program of vulnerability training for staff in the contact centre and additional training for supervisors who may be required to review any escalation process should a request be declined.

At the time of considering the second welfare check request, the police contact centre identified that Simon's location was not known and that he should be recorded as a missing person, a decision that was in accordance with the Essex Police missing policy and national guidance. The subsequent decision by the duty Inspector to cancel this missing report was flawed and is something that Essex Police intends to address within its revised welfare check policy. Whilst this is a positive step, there would be great benefit in the Essex Safeguarding Adults Board formalising the way that missing reports are managed when professionals report vulnerable adults as missing.

The partnership has an existing multi-agency protocol in place, agreed with the police, which aims to provide the best possible service to adults who have gone missing from care homes, hospitals, and mental health establishments. There would be great value in revising this protocol to include people in Simon's circumstances. A revised protocol would complement the updated police welfare check policy and provide clarity for future cases. Any new protocol should include reference to the existing partnership escalation policy, so that professionals feel confident in challenging any decision that they believe to be incorrect.

Recommendation 3:	*Essex Police should revise the current Welfare Check policy and develop new guidance for staff to ensure that its application is more consistent. This should be underpinned by a program of vulnerability training and the revised policy should be promoted widely across the safeguarding partnership.*

Recommendation 4:	*The existing multi-agency missing protocol should be revised to include vulnerable adults who are reported as missing by professionals after contact has been lost and where concern for their safety exists.*

Finding 4: Managing the Risk of Disengagement

Learning:

After contact had been lost with Simon, the response of the professionals did not escalate in proportion to the increasing risk. This was either because the agencies involved did not have disengagement or loss of contact policies, or where they did exist, they were not understood and followed by staff.

Whilst working with the different support services, Simon had been able to maintain contact with the professionals that he knew and trusted. This was mainly through the use of his mobile phone and whilst it was common for him to miss calls, or not respond immediately to text messages, he would typically return contact within a day. Whilst contact was lost with Simon for a short time between the 5th to 7th January 2021, his phone remained turned on and contact was quickly restored.

[10] Recommendations listed at Appendix A.

This pattern of behaviour changed significantly on the 11th January 2021, after which time Simon did not return any contact and within a short space of time his mobile phone became disconnected from the network. Whilst there were determined efforts to re-establish contact, this in the main followed the same methods of attempting to contact him by telephone and repeated visits to his home. After the police declined the welfare check on the 21st January 2021, this was not challenged or escalated until the 4th February, when SAHA made a second request with the police and a subsequent safeguarding referral which quickly led to Simon being found deceased at home.

As concerns for Simon escalated, it may have been helpful for the response to have escalated accordingly. It would have been appropriate to consider: making an earlier safeguarding referral to adult social care; appealing the interpretation of the police welfare check; and if necessary to have used the partnership escalation process to challenge the police response. In examining the reason why this was not done, it was identified that a number of the agencies did not have any policy or procedure for the disengagement or loss of contact with the vulnerable people using their services. One of the agencies did have a missed visit policy, however this was not followed as it was no longer included during induction training and staff were not aware of its existence.

The underlying reason as to why the loss of contact with Simon was not managed more effectively, was the absence of policy and procedure that was known to and understood by staff. It is therefore recommended that each agency should produce new policy and guidance in relation to the disengagement or loss of contact with service users. Any new policy should include an emphasis on multi-agency working, including the benefits of professional meetings to share information and for the formal coordination of planning. This should also include reference to policies for the submission of safeguarding referrals and should provide guidance in the use of the police welfare check and missing person policies. It would also be beneficial to include guidance on the partnership's escalation process.

Recommendation 5:	*All agencies should develop new policy and procedure to manage the disengagement or loss of contact with service users. New policy should be underpinned by a training and awareness program, including an annual refreshment for existing staff.*

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Concluding Comments

This adult safeguarding review has identified key learning for both single agencies and for the development of partnership working. The Essex Safeguarding Adults Board should now consider the recommendations and consider how they intend to deliver improvements to safeguarding practice. In addition to addressing multi-agency recommendations it should hold individual agencies to account for delivering the single agency recommendations.

Summary of Recommendations

NB: please also refer to the document explaining the identified themes for the 6 x SARs published in November 2022.

Recommendation 1:	The Suffolk and North East Essex Integrated Care Partnership, should build upon existing structures to continually improve the way that services are delivered to vulnerable people. This should include methods to consistently identify those who are vulnerable and to improve the way

	that services are delivered to them through coordinated multi-agency working practices and embracing the 'Making Safeguarding Personal' principles. *(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)*
Recommendation 2:	All agencies should review existing policy in the use of safeguarding referrals and the third party reporting of crimes to the police. This should be underpinned by a training and awareness programme to ensure that new policy is consistently understood and followed. *(Links to Theme 3: The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB)*
Recommendation 3:	Essex Police should revise the current Welfare Check policy and develop new guidance for staff to ensure that its application is more consistent. This should be underpinned by a program of vulnerability training and the revised policy should be promoted widely across the safeguarding partnership. *(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)*
Recommendation 4:	The existing multi-agency missing protocol should be revised to include vulnerable adults who are reported as missing by professionals after contact has been lost and where concern for their safety exists. *(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)*
Recommendation 5:	All agencies should develop new policy and procedure to manage the disengagement or loss of contact with service users. New policy should be underpinned by a training and awareness program, including an annual refreshment for existing staff. *(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)*

6. Appendix A – Police Improvement Recommendations

- **1** - The Contact Management sign-off / closing process for concern for welfare calls should be reviewed. Where there is no referral to a Local Policing Area (LPA) Inspector and no police attendance Force Control Room (FCR) Supervisors should, as now, be required to provide rationale on the STORM[11] incident for non-referral / non- attendance, but consideration should be given to requiring this rationale to be endorsed and signed off by the FCR Inspector or Resolution Centre equivalent.*(Recommendation Owner – Head of Contact Management Command)*
- **2** - Force Policy D1100 Concern for Welfare should be revised to define what constitutes a Collapsed Behind Closed Doors case and the threshold for police attendance in such cases. Policy should detail key elements of the SLA between Essex Police, ECFRS and EEAS to clarify what the agreed deployment criteria is between these agencies. (Recommendations Owner – Head of Contact Management Command)

[11] Police command and control computerised system

- **3** – Force Policy D1100 Concern for Welfare and Force Procedure B 1606 Missing Persons should be reviewed to ensure they adequately cover the cross over between concern and missing. The Concern for Welfare policy should be reviewed to ensure it provides clear guidance to staff that where the missing person criteria is met, this is the route that police must follow. (*Recommendation Owners – Head of Contact Management Command and Force Missing Persons Lead)*
- **4** - The practice of managing Concern for Welfare reports relating to vulnerable persons via Live Chat should be reviewed. In view of the risks associated to concern calls, consideration should be given as to whether such reports would be better managed by telephone. Consider amending policy to direct Call Handlers, receiving Live Chats reports of concern for welfare, to seek to establish telephone contact with the informant. (Recommendation Owner – Head of Contact Management Command)
- **5 –** Essex Police should share the learning from this IMR[12] with partner agencies via the Safeguarding Adults Boards and continue to work with partners, through the SABs[13], to further develop the partnership approach to concern for welfare incidents.*(Recommendation Owner – Head of Crime and Public Protection Command)*
- **6** – FCR staff should receive some further guidance on the effective use of THRIVE[14] in order to assess risk and determine response. (Recommendations Owner – Head of Contact Management Command)
- **7** – Learning from this IMR should be shared and local line management feedback provided to those FCR staff involved, in particular in relation to: a) The requirement to complete internal database checks where there is no police attendance. b) The requirement to record full rationale where it is decided there will be no police attendance. *(Recommendation Owner – Head of Contact Management Command)*

[12] Individual management review
[13] Safeguarding adult boards
[14] THRIVE – Risk assessment model