SAFEGUARDING ADULTS REVIEW: NORMAN

Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

January 2026

1. Introduction

Norman was an 82 year old man when he died in February 2022.

Norman had a long history of depression and anxiety, and had been known to mental health services since 2013. On the 5th of February 2022, Norman was found dead by paramedics on the first-floor landing of the address. The Police noted that both Norman and his wife, Jean, were extremely frail and thin to the point of emaciation.

The death was treated as unexplained rather than suspicious, as there was no evidence or suspicion of any unlawful contributing factors or any criminal element to Norman's death.

Following the death, Cambridgeshire Constabulary completed a referral to the Safeguarding Adults Board for consideration of a Safeguarding Adults Review. Partner agencies were requested to provide a summary of involvement, and the case was considered by the SAR subcommittee in 2022 where there was a unanimous decision that the case met the criteria for a mandatory Safeguarding Adult Review.

There have been considerable delays in the completion of this SAR, as the originally commissioned independent author had passed away unexpectedly mid-way writing their draft report. A second author was commissioned to take over but stopped responding to further communication from the Safeguarding Board's Business Unit. In order to progress the review, the Safeguarding Adults Board agreed to undertake a tabletop exercise facilitated by Cambridgeshire Constabulary.

Attempts were made to contact Norman's wife for her involvement with the review, but no response was received.

Safeguarding Adults Reviews should be proportionate to the complexity and nature of the particular case. In this case the review panel decided that a proportionate and strength-based review, using chronologies and a facilitated agency meeting to draw out the good practice and areas for learning would be used.

2. Scope of the review

This case review is focused on the period of time relevant to the involvement of the agencies, to seek any missed opportunities and learning. Norman had interactions with a number of agencies, at certain points, ranged from 2013 to just before his death in 2022. This period focusses on a period from Jan 2021 to his death in Feb 2022.

A number of agencies engaged in this case at various stages. These included:

- Adult Social Care
- Cambridgeshire Constabulary
- ICB
- GP Services
- CPFT
- Ambulance services
- IDVA.
- DWP
- Fire Service
- HUC

Each of these services were asked to comment on their involvement and history of the case. Ambulance service involvement relates to call for Norman being deceased.

3. Norman

Norman was an 82 year old man, who lived with his wife Jean in a Cambridgeshire village since they married.

Norman had a long history of depression and anxiety, and had been known to mental health services since 2013 where he was seen periodically. He contacted the GP often for anxieties around physical symptoms and how they might represent significant illness. Concerns persisted about Norman, and he was described as dishevelled, with a long beard. His compliance with medication, and with his care and treatment plan was variable. His food and fluid intake were consistently low.

In April 2019, Norman's wife contacted the NHS 111 service as Norman's mental health was deteriorating and he was having suicidal thoughts. She stated that Norman had not washed or bathed for 6 weeks and had been diagnosed with depression. The 111 service informed her that her call would be transferred to the Mental Health Crises Team for a call back within the hour and advised her to call 111 again if they did not receive a call back or his symptoms worsened.

Norman was referred to CPFT mental health services again by his GP, where he had a 6 week admission to the willow ward, an acute assessment ward for adults aged 65 and over suffering with mental health problems, for a severe episode of recurrent depressive disorder after a 2 month period of self-neglect and anxieties around physical health. Norman was treated and discharged in June 2019 with a change in medication and a plan for ongoing psychiatric care in the community to be coordinated by a Community Psychiatric Nurse (CPN). His CPN visited regularly to monitor his medication and mental state.

Throughout the remainder of 2019 and early 2020, Norman did not attend planned GP appointments and was next reviewed in March 2020. This consultation generated renewed concerns that his mental health was again beginning to deteriorate, with some signs of self-neglect, prompting contact to be made with the Older Persons Community Mental Health Team. Physical exam at that time revealed no new medical concerns and follow up blood tests were normal.

In March 2021, Norman had a GP consultation which centred on a renewed health anxiety that he might have cancer. Further contact was made with the Older Persons Community Mental Health Team to update them on his presentation and to request further review.

Norman raised identical concerns in May 2021, and a home visit was planned. This visit was undertaken by an Emergency Care Practitioner (ECP) and confirmed ongoing mental health concerns and poor medication compliance. This prompted contact again with the Older Persons Community Mental Health Team, repeat blood tests and a Social Care Adult Early Help referral to see if more social support might be available.

Norman spoke with the Adult Early Help team and told them he was suffering with cancer, although he had not been diagnosed. Norman said he did not feel he needed support with his daily routines instead stating he needed radiotherapy.

In June 2021, Adult Social Care received an anonymous referral stating that Norman's mental health and resultant behaviour was having a negative impact on his wife. At the time it was noted he was open to mental health and had declined any help from CCC adult early help team.

A psychiatrist periodically reviewed Norman, the most recent visit being in August 2021. On this occasion it was felt Norman was at moderate risk of self-neglect and formal care was suggested however Norman and his wife were not receptive to this.

In September 2021, Norman's CPN highlighted the lack of overall progress in Norman's mental state despite her ongoing input over a period of time. Norman continued to have ongoing health anxieties, poor self-care, and weight loss. Norman weighed 52 kilograms and complained of itchy skin. Norman's CPN indicated that a mental health admission had been requested but that the ward was full and suggested requesting his GP in arranging blood tests and vitamin screen as part of community monitoring.

In January 2022, Norman contacted the GP requesting a home visit. The GP made a call to Norman's CPN who advised that Norman had been deemed to have capacity, and had been discussed in the Mental Health team's Multidisciplinary Team meeting. An informal admission to the Willow Ward was offered but Norman had declined this but accepted a package of support.

A visit to Norman was made by an ECP. Norman was alone at home and was able to mobilise independently. He admitted to poor appetite but no pain on eating. A note was made of the appearance of weight loss. Venepuncture was unsuccessful, so a follow up visit was planned for later in January. At this visit, bloods were successfully taken. The ECP discussed the visit with CPN who felt that no further additional action was required, given their ongoing weekly review. Blood results showed a mild increase in inflammatory markers and mildly elevated calcium levels.

An ECP attempted to follow up Norman by phone, but Norman ended the call. Recognition was made that ongoing weight and BMI monitoring was needed, with the plan to discuss this with CPN. Jean called the GP practice on 3rd February 2022 to indicate that Norman wished to speak to a clinician and was requesting a home visit. A home visit was arranged for that afternoon, where Norman reported dizziness but was difficult to engage further and was reluctant to answer additional questions. Jean remarked on his poor oral intake and how this was related to his thoughts that he was dying from cancer. On examination he was found to have a low body weight of 35kg, a normal blood pressure, with no postural blood pressure drop, and a normal heart rate.

On Friday 4th February 2022, a staff member from the GP Practice called 101, to report concern for Norman and Jean after an (unnamed) friend of the couple had brought a letter into the surgery documenting concern about both Norman and Jean, their house environment which included a toilet seat that Norman had damaged; the lack of food in their house; their thin physical appearance as neither Norman nor Jean had been eating well; and their poor state of hygiene. It also raised concerns that shouting had been heard, and that Norman had been physically abusing Jean and may have recently pushed her down the stairs. The staff member also reported that the previous day, Norman had a home visit as he had been feeling unwell, and Norman was reported to be very frail and thin, had been feeling very faint, and weighed approximately 5 stones.

A police officer attended to carry out a welfare check and spoke to Jean who disclosed that Norman had earlier that day struck her with his left hand to her right elbow, causing a bruise; and has also "thumped her" several times recently. Jean stated that this was due to a decline in his mental health after he stopped taking his prescribed anxiety and depression medication, and that he was an otherwise doting husband who she was adamant that she did not want to be apart from. Jean also stated that Norman had an assigned nurse from Fulbourn Hospital who was putting together a care plan to help them as Norman had also stopped washing and caring for himself and had not been eating much. The police officer found Norman upstairs asleep in bed. Norman was under the covers, with his eyes closed, and was breathing steadily. It was decided to leave Norman at home as an alternative to arrest, based on proportionality, and for a neighbour to come and be present with Jean that night, as Jean did not want to leave Norman and go elsewhere. On leaving the address with this neighbour present, the police officer completed a crime report to document the assault, and completed and submitted a Medium-risk DASH risk assessment as well as a form 102 Adult Safeguarding form, both of

which were submitted to the Multi-Agency Safeguarding Hub. The 102 documented concerns for the state of the house and Norman and Jean having unmet support needs – limited mobility, physical frailty, Norman's declining mental health and self-neglect, evidence of hoarding, unsanitary conditions owing to lack of cleaning, reliance on neighbours for basic tasks such as food shopping and medication collection.

The following day, a neighbour arrived with some food shopping and found Norman laying at the top of the stairs and called 999. Jean had been unable to move him or provide any first aid. When the paramedics arrived, CPR was started but was withdrawn. A crew member explained to Jean that Norman had died, and Jean responded saying "That's what he has kept saying he wants" adding that he suffered from severe depression.

On attendance to conduct an initial investigation, Police noted that both Norman and Jean were extremely frail and thin to the point of emaciation. Jean told Police that Norman had not eaten or drunk properly for at least 6 months, taking only a few sweets and few sips of milk each day.

The house was in a state of squalor. The floor, walls and fixtures were all very dusty as though they had not been cleaned for a long time. The toilet seat was broken, and two of the three bedrooms were piled floor to ceiling with clothing, defunct appliances, books and general detritus, and were completely uninhabitable. The only habitable bedroom was also cluttered but there was a clear walkway from the door of the room round three sides of the bed. The headboard was fabric covered and was against the wall and had a large, noticeable grease stain on it as though the grease had accumulated from years of leaning against it. The kitchen and lounge were also extremely cluttered, with stacks of old magazines, papers, books, games, food and drink items and crockery piled high. There was food in the kitchen but many of the utensils were dust-covered and festooned with cobwebs, and every surface was greasy and dirty looking.

1. Analysis and Learning

A facilitated multi-agency meeting was held via MS Teams which included representatives from Adult Social Care, DASV Partnership, CPFT, ICB, GP, Police.

This group were asked to consider the details within the combined chronology and the following key themes, the aim of which was to extrapolate learning for those agencies who had been involved in the case, as well as those in the wider safeguarding adults' workforce. A TOR was supplied to the group in advance of this meeting.

1) When there are concerns about someone who has a mental health diagnosis and an allocated mental health worker, professionals in other organisations sometimes hand on the issue to the mental health worker without fully understanding how that service works, and whether the mental health worker has the necessary knowledge and skills to recognise deteriorating health and social care needs and in the absence of a feedback loop which would allow them to find out how the issue was followed up. Although the panel felt that most decisions to hand over are correct, how does the system support thinking about when it is appropriate to do this?

The group discussed this case and recognised that services and processes had evolved from 2021/2022, to now in 2024/2025. Therefore, the group were 'looking through a lens' to a former time and place which works differently now. It was however that during this case, there was intermittent multi agency involvement (working together) to produce a solution to support Norman. The interface could have been better in terms of communication with the other agencies and role keeping. NHS and Doctors noted that there is a hard divide between GP and primary care. There is now a process in place which was not there when this case

occurred, where multi agency discussions take place should cases like this come in. This process has come in after similar cases identified within this time period.

2) Does a mental health diagnosis create diagnostic overshadowing which might in turn affect the way that other agencies respond to risks and issues unconnected to a mental health diagnosis? How could a system pick up whether and when this happens and address any perceptions that mental health services should be picking up issues, when a multi-agency response is needed and appropriate?

The MARM process (Multiagency risk management) was introduced in 2019 and refreshed in 2022 with workshops and multi-agency training. This process potentially would have picked up the concerns raised by different agencies and place them under this banner. However as articulated by the group, the knowledge around MARMs is 'hit and miss' across organisations. Police commented that our Multiagency Safeguarding Hub (MASH) is aware and makes these recommendations when considering various safeguarding and vulnerability referrals it receives. It was noted that there were three missed appointments and opportunities on those missed appointments, to engage with Norman.

3) When an older person with lifelong mental health problems has a carer, professionals can conclude they are not isolated and as a result, less at risk. This can mean that a carer is not spoken to or fully assessed. What are the risks when this happens? and what would help create a culture where there can be more certainty that carers of older people are asked about their needs and heard?

It has been noted by most agencies that Jean (wife of Norman) was very dismissive and deflecting of the behaviours involving Norman. It was agreed that there was not sufficient scrutiny of her responses and delving deeper into the answers that she gave. Taking a 'one more step' approach involving her, could have yielded further information.

4) Older adults who self-neglect do not always understand the potential consequences of some of their behaviours – for example not eating. Is there a way the system can support professionals to feel confident to do Mental Capacity assessments in this particularly difficult area which understandably do not always feel confident about, that notice these risks and draw them out? What is the interplay between mental health and mental capacity and what challenges does this present to professionals?

The GP surgery commented on 'diagnostic overshadowing' and that no one had considered an eating disorder and that agencies should be thinking wider than just mental health. However, it was also noted that Norman's wife was not helping at times with different/conflicting information and making engagement difficult. The challenge clearly was that other advice/interventions and guidance could have been given to support Norman.

5) Is there a risk that, for older adults with mental health problems, new and emerging physical health problems escalate because they are too often attributed to their mental health, or the response seen as the job of a mental health professional to progress? Are physical health problems that need the fresh eyes of a relevant professional, or a multi-agency response, getting left too long with poor outcomes, or at worst, tragic consequences for this group of older adults?

The group agreed that this was a case where significant emphasis was put on Mental Health issues. No other considerations around malnourishment or living conditions considered as a contributing factor. Furthermore, it was agreed that there was not enough 'professional curiosity' from partner agencies. Visits to the home address were overshadowed at times by the partner and not enough intrusive questions were asked, to present a clearer and more cogent picture of the living conditions. Police upon attendance did not speak to Norman and

that could have identified further issues/concerns. However good discretion used in terms of the condition of Norman alongside taking positive action in relation to DA matters.

6) Are there areas of good practice that should be highlighted to develop learning points and recommendations

No significant good practice areas identified in this case.

2. Recommendations

The following multi-agency recommendations have been formulated based on the learning arising from this case. Consideration was made to previous case reviews where similar learning has arisen, and work is being undertaken to improve practice.

I. The partners of the Safeguarding Partnership Board should ensure that all staff and partner agencies are aware of the MARM process. This would encourage collaboration and a collegiate approach to safeguarding and working together to identify and minimise risk.

II. The Safeguarding Partnership Board and partners should support practitioners to increase their skills and confidence in encouraging staff to be more 'professionally curious.' Asking more questions and avoid being deflected off those challenging conversations, helps build a wider picture of risks to those involved and how to mitigate them going forward.

III. Similarly, the Safeguarding Partnership Board and partners should support practitioners to increase their skills and understanding that not all adult safeguarding matters are related to MH issues. Staff should be trained to identify other issues such as malnourishment and hoarding are significant factors in the deterioration of health.