Luton Safeguarding
LSAB
Adult Board
Working in partnership
to protect adults at risk

Safeguarding Adult Review
Abdullah

Commissioned by Luton Safeguarding Adult Board

Sept 2020

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1. Introduction

1.1 Luton Safeguarding Adults Board commissioned a Safeguarding Adult Review (SAR) concerning Abdullah a 47-year-old man who died in May 2018. He was found at home in his flat. He lived in a housing scheme which offered some on-site support. A SAR is convened when an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect whether or not it knew about or suspected the abuse or neglect before the adult died. The Terms of Reference are included as Appendix 1.

1.2 The circumstances of the death of Abdullah were referred to the Board for consideration of a possible SAR by East London Foundation Trust (ELFT) a mental health NHS Trust. He used the Trust's services as well as those of a number of other agencies. He had a history of alcohol misuse, self-neglect, physical ill-health, and housing issues. Abdullah was a Somalian national, and after his arrival in Luton, his life in the town was dominated by the issues listed above. He was vulnerable in a number of ways. He was known to Bedfordshire Police as both a victim but on occasion as, an offender too. In the latter respect he was also known to a Community Rehabilitation Company – formerly part of the Probation Service. On proposing a SAR ELFT identified concerns both about their own practice but also the way agencies worked together to safeguard Abdullah.

1.3 The purpose of this SAR is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The SAR should suggest how practice could be improved. A Review is about learning, not blaming, and aims to improve future practice through recommendations to the Board. This SAR covers in significant detail a period from 15th September 2015 until his death in early May 2018. A multi-agency panel of the Board set up to oversee the SAR identified those agencies that had or may have had information about Abdullah during this period. Agencies were also invited to include any other information they considered relevant outside the time period identified and also draw it to the attention of the Panel.

1.4 The multi-agency panel commissioned an independent author to complete the report – Alan Coe. I am an independent social care consultant and have authored Safeguarding Adult Review reports over the past nine years. I qualified as a social worker and at various points in my career have been an Assistant Director of Social Services, inspected social care services in both England and Scotland and has been an independent chair of both a Safeguarding Adults' and a Safeguarding Children's Board

2. Methodology

2.1 The process of gaining an understanding of how and why Abdullah died and the circumstances surrounding that, was threefold. Firstly, each agency reviewed their own records, produced a chronology and offered a critique of what they did including whether or not it followed procedures and represented good practice. Each chronology produced was undertaken by a senior representative from the relevant agency who had not been directly involved in Abdullah's care or was responsible for the immediate oversight of it. Where there were concerns about practice the individual agencies took immediate action to address them and produced an action plan to support any necessary changes.

2.2 Secondly, the chronologies were made available to the author who reviewed them, produced an integrated chronology of significant events and identified issues about how the combined partnership of services operated to assist Abdullah and where that partnership could have done more to assist him.

2.3 Finally, there was a presentation event involving all agencies. The author of this report also attended and participated. This helped clarify and understand the reports produced by each agency. The group also had access to a combined chronology of key events to better understand the interrelationship of actions of each individual agency with those of other agencies.

3. Background and personal Information

3.1 Abdullah was 47 years old. He was born in Somalia. At various points he told those people working with him that he witnessed the killing of his parents and siblings in 1999. He then went to Uganda with his wife and two daughters. Abdullah came to England and sought asylum in about 2001 leaving his family behind. Since living in the UK there is information that demonstrates he was dealing with substantial personal difficulties. In April 2009 he received a 12-month Community Service order for an offence of criminal damage. This was supervised by the Staffordshire and West Midlands Probation Service.

3.2 After his death a social worker from one of the Council's adult social care teams was allocated the responsibility of undertaking a safeguarding enquiry. As part of that enquiry the social worker obtained the name of a sister who lived in London. None of the agencies involved with Abdullah referred to him having a family network. In the conversation between the social worker and his sister there is no reference to the family's previous traumatic history in Somalia. She did say that he hadn't always drunk alcohol and was a practicing Muslim. He was described as a very charming man who lived with his wife and four children in the East Midlands. Following a series of domestic incidents his wife obtained an injunction which prevented him from seeing his children. When he breached that he was imprisoned. His sister believed that the breakdown of his marriage led to his subsequent alcohol misuse.

3.3 I have been unable to discuss Abdullah with his sister as unfortunately the Board partners have been unable to find contact details of her. She is unaware of SAR.

3.4 According to the sister despite the official finding of death by natural causes she considered that his excessive alcohol intake contributed to his health. She also believed that his mental health issues had not been treated. She reported that in 2016, after 10 years of estrangement from his family, he made contact with her. At that point she brought him to live with her in London. He stayed for three months but returned to Luton as he understood that this was the only way he could obtain an alcohol rehabilitation service.

3.5 Abdullah had been known to various agencies in Luton from 2010. There were housing issues including him being evicted for anti-social and drunken behaviour. He was a longstanding user of mental health services and was supervised under the Care Programme Approach (CPA)[1]. His physical health was not good for the most part due to the misuse of alcohol. There was a hospital admission in 2012 to support alcohol withdrawal. It was successful but he subsequently lapsed. At the time of his admission he had tried to throw himself under a train. There was also a further attempt at detoxification within the time frame of this Review.

3.6 Whilst pre-dating the timescale included in the Terms of Reference, there is a relevant letter from a consultant psychiatrist to a doctor in an NHS walk-in centre in Luton dated March 2011. In it the consultant says that Abdullah reported drinking two bottles of vodka daily and had been doing so for about 10 years. His psychiatric problems included Post-Traumatic Stress Disorder. (PTSD)

3.7 At various points Abdullah engaged with local drug and alcohol services and was the subject of a safeguarding assessment in 2013. He was known to the Police both as a victim of crime and as a perpetrator. Furthermore, he was known to various housing providers with Luton Council housing services commissioning them to provide him with accommodation and support. In 2013 the Council considered he was not suitable for support with housing due to his long-term addiction and would be unable to sustain a tenancy.

3.8 Abdullah was known to the Council's Safeguarding Services as he was the subject of more than one safeguarding enquiry. Over the period under consideration he was regularly admitted to Luton & Dunstable Hospital for treatment of physical illnesses that were associated with the impact of his alcohol and drug misuse.

4. Summary of Abdullah's care and support from September 2015

4.1 The information in this section comes from the various agency chronologies submitted. It does not attempt to provide a comprehensive list of every incident and contact but draws out those of particular significance.

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[1] – CPA is a standard national approach within community mental health services

4.2 ELFT was the consistent agency present throughout the timescale of September 2015 until Abdullah's death in May 2018. As mentioned in the previous paragraph his problems seemed to be rooted in his traumatic past in Somalia together with and possibly linked to his misuse of alcohol. He was subject to CPA. CPA, introduced in 1990, provides a framework for effective mental health care for people with severe mental health problems. Its four main elements are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a key worker (care co-ordinator) to keep in close touch with the service user, and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

4.3 His inclusion under CPA is significant as this meant he had an allocated care coordinator and was under the supervision of a Consultant Psychiatrist. A formal review of his care would be expected to take place on a regular basis and at an agreed frequency.

4.4 From September 2015 until the end of that year Abdullah's links with services mainly related to his physical and mental health but touched on wider issues of his behaviour.

4.5 On the 15th September 2015 he was brought by ambulance with a Police escort to Luton and Dunstable University Hospital (LDUH) under Section 136 of the Mental Health Act[2]. There was no reference to this in the Police chronology.

4.6 He transferred almost immediately to a specialist psychiatric unit in Luton run by ELFT. According to LDUH notes he was diagnosed with Bipolar Effective Disorder. Follow up through ELFT says that Abdullah claimed that prior to his admission he was trying to kill himself. The consultant in charge of his care in hospital recommended a detoxification programme and he was discharged a week later. He was referred to alcohol services by his care coordinator in early November but his ELFT notes from early December say that this referral failed but with no explanation as to why.

4.7 On the 15th October 2015 Abdullah had kept a routine appointment with his care coordinator and mentioned a recent arrest, that his accommodation was in poor condition and that he was not sleeping well. His care coordinator visited his home on the 19th and reported to his housing provider about concerns about the property. There is no corresponding reference in the housing agency chronology.

[2] Section 136 0f the Mental Health Act 1983 (amended 2007) gives the Police the power to remove a person from a public place when they appear to be suffering from a mental disorder and remove them to a place of safety.

4.8 On 10th November 2015 Abdullah was also seen at LDUH as a result of an injury to his hand. The notes indicate that alcohol contributed to his injury and a letter was sent to the GP describing him as ‘non-compliant.’ On the same day he was removed from his GP surgery’s list. His care coordinator offered to assist with finding an alternative GP although the necessary forms were not completed until the following January. I have seen no information from corresponding GP records to explain or justify his removal.

4.9 From the 15th to the 30th December 2015 Abdullah was admitted to a psychiatric admission ward. According to the notes he had stopped receiving a regular Depot[3] injection three months previously although the ELFT commentary on the chronology comments that there should have been a reference to this in his care plan and in a risk assessment but that they could not be found. During his stay in hospital Abdullah expressed a wish to move to supported accommodation as he did not feel safe in his flat. It was also noted that he was unkempt in appearance and had suffered severe weight loss. During his stay in hospital it was also reported that Abdullah had been drinking every day since 1999 – the year his family members were killed in Somalia.

4.10 One day after Abdullah was discharged from hospital, he was brought into LDUH by ambulance due to a possible seizure. Whilst there he initially refused all interventions and treatment. However, with encouragement an examination was completed, and no concerns noted. It was noted that he had been intoxicated whilst in the department. Having left LDUH he returned to A and E four hours later but left before triage. It was not reported that the GP was advised.

4.11 In terms of his physical care during 2015 on the 27th October Abdullah’s care coordinator made an appointment with LDUH for him and LDUH note that he attended three out of four out-patient appointments during November and December and this is repeated for his appointments in January and February 2016.

4.12 In the early months of 2016 Abdullah’s care coordinator arranged for support from the drug and alcohol service. At an initial three-way meeting on 12th February Abdullah said he was attacked with a baseball bat by three men who came out of a car. The care coordinator reported that he examined him and there was a swelling on his leg. This was reported to the Council as an adult safeguarding issue by Luton Alcohol Services but not until 15th April. The social care referral records the date of the three-way meeting with Abdullah as ‘Friday 12th March.’ The 12th March was in fact a Saturday.

4.13 Abdullah registered with his GP in Luton in February and remained with the same practice for the remainder of his life.

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[3] A depot injection is an injection that delivers a medication into the body over a sustained period of time.

4.14 In early March Abdullah was admitted for four days to LDUH with a reflux and swelling to the vocal cords. During his admission he was given detox medication to assist with withdrawal symptoms.

4.15 In April 2016 LDUH noted Abdullah was intoxicated during an out-patient's appointment and on the 16th April was seen when brought in by the Police with an injury to his finger. It was recorded that he was verbally abusive to staff and discharged back into Police custody. There is no corresponding Police reference.

4.16 On the 18th April the adult safeguarding alert from the alcohol services mentioned above (para 4.12) was raised with the Luton Council adult safeguarding services. The concern was screened and following that recorded as 'Information & advice'. However, the screening work included the identification that Abdullah had a newly allocated Care Coordinator at ELFT. A request was made on the 26th April that ELFT undertake a Care Act Assessment and facilitate a multi-agency risk assessment with Abdullah. There was no corresponding reference in the ELFT chronology to say that they undertook this.

4.17 During April and May there is evidence of Abdullah attending hospital out-patient appointments at LDUH. There was also a CPA review on the 16th May but no record of who attended or what the outcome was.

4.18 In early June 2016 Abdullah was allocated a new care Coordinator by ELFT. At this time there are also references in their chronology to the death of Abdullah's daughter and assistance being given with arrangements for him to attend the funeral. There is no evidence that this information was shared with Abdullah's GP.

4.19 On 7th July staff from Noah a homeless housing charity brought him to the Crisis Resolution and Home Treatment Team (CRHT) within ELFT as he was talking of having suicidal intentions. A crisis assessment was completed along with a risk assessment and a further risk assessment undertaken on a follow-up home visit. For a while his CPA was cancelled as this was overseen by another part of the mental health services run by ELFT. He was discharged from the CRHT on the 20th July after he stated he did not want their help anymore. Shortly after that Abdullah was reinstated on CPA as there was a review held on the 22nd September. At that review Abdullah confirmed he had sleeping difficulties, paranoid fears, and suicidal thoughts. He mentioned a friend who visited him, provided food and took away any knives or sharps that might put him at risk of self-harm.

4.20 Between the 14.07.16 and 15.07.16. Abdullah was admitted to LDUH and subsequently discharged. The notes at the time say he was brought into A and E whilst under police custody complaining of vomiting blood for 6 days. He was due to attend an endoscopy appointment which he said he had missed. A provisional diagnosis of acute pancreatitis was given, and he was admitted for further review. Detox medications were prescribed to aid withdrawal symptoms. He was referred to and seen by Alcohol Support Worker from James Kingham Project whilst an inpatient. I have not seen any corresponding references to this hospital admission in other chronologies submitted.

4.21 On 05.08.16 Abdullah was made the subject of 12-month Community Order for an offence of Religiously Aggravated Intentional Harassment or Alarm or Distress. Following an unannounced visit to see Abdullah on the 9th August his care coordinator contacted BENCH the community rehabilitation company (CRC) responsible for supervision of his court order to enquire whether a probation officer had yet been allocated to him.

4.22 On the 6th September the probation officer from BENCH completed a Risk Assessment and Initial Sentence Plan. The Plan identified actions for Abdullah 'to consider the impact of his alcohol use on his offending behaviour and also for him to engage with health professionals treating his mental health complaints (PTSD); to engage in offending behaviour work with his Officer and to budget his money better.'

4.23 Between the 08.09.16 and 12.09.16 Abdullah was admitted to hospital following a GP referral for investigations of rectal bleeding. Tests did not confirm this. While in hospital he was noted to be aggressive towards staff and was referred to the alcohol liaison service. He was tagged at this time and BENCH were contacted to inform them that he was with them although there is no corresponding BENCH entry.

4.24 During October 2016 Abdullah was in contact both with the mental health services and BENCH for routine appointments. Also, he was assessed in LDUH after he had reported he had been hit on the head with a brick. Although not referred to in the LDUH chronology this may have been linked to the theft of a wallet which he did report to the mental health services and his BENCH worker. On the 31st October on a visit to ELFT he was reported to be shouting and aggressive to staff. During that visit he referred to being beaten up and robbed three or four days previously and to feeling suicidal. The ELFT chronology author notes there was no escalation of these issues to more senior staff nor was there evidence that there were discussions with his probation officer. It was reported that there was also no consideration of adult safeguarding issues.

4.25 From the 7th to 16th November 2016 there was significant activity linked to Abdullah fleeing violence at his property. The Police were aware of this and learnt that Luton Council were rehousing him following a temporary stay in a local hotel which seemed to be arranged to keep him safe. Abdullah visited local mental health services to inform them that he needed to move because of violence and that also there were plans for him to go to a rehabilitation facility. Efforts to rehouse him were supported with the direct help of his probation officer and by the 16th he had been temporarily rehoused.

4.26 On the 11th November Abdullah attended an out-patient appointment at LDUH for his respiratory condition. He was reported to be intoxicated and security staff had to be called.

4.27 On 22.11.16 Abdullah informed a Luton Council housing officer that he had been offered an in-patient alcohol rehabilitation facility and handed the key back to his accommodation the following day. The facility was in Essex and BENCH decided to transfer Abdullah's supervision to their Harlow office. On the 19th December his care coordinator spoke with the Luton Drugs service who confirmed that Abdullah

was undergoing a three-month rehabilitation course. There was no evidence that his care coordinator was in touch with him while he was away.

4.28 On 27.02.17 BENCH received an email saying that Abdullah had discharged himself from the rehabilitation facility. On that day he was temporarily accommodated back in Luton. On 15.03.17 ELFT discovered from a phone call to the alcohol rehabilitation facility that Abdullah had left and at that point his care coordinator was unaware of his whereabouts. ELFT continued to experience difficulties locating him and he was eventually seen face to face when he was interviewed by a staff member on the 7th April in Police cells as he had been arrested for breaching his probation order. This charge was eventually dropped as the Community Rehabilitation Company at Harlow had not realised that he had moved back to Luton when he discharged himself from the rehabilitation facility and Abdullah had not informed them.

4.29 Between 03.05.17 and 11.05.17 Abdullah was admitted to LDUH with symptoms of vomiting blood. He was given advice about misuse of alcohol and referred to Luton drugs and alcohol services. On the day of his discharge he visited the mental health services and an out-patient appointment was arranged to see a psychiatrist as he hadn't been seen by one for a long time.

4.30 On 17.05.17 Abdullah saw his probation officer and said he had barely eaten in 20 days and was feeling dizzy. By the 27.05.17 he was readmitted to LDUH where the hospital identified self-neglect and made a safeguarding referral. He was discharged on 01.06.17. On 05.06.17 Abdullah was referred as a safeguarding concern by LDUH although there is no reference to this in the LDUH chronology. According to Luton Council safeguarding team the outcome of the alert was that he was to be: '*offered a social care assessment in order to ascertain what support he requires. I have also advised A to seek support from his GP practice*.' There are no entries on the GP surgery records to suggest that he did seek that help.

4.31 Between the 7.06.17 and 21.06.17 Abdullah attended three meetings with his probation officer. Although he mentioned he was experiencing vomiting blood there is no evidence that the officer was aware of Abdullah's recent hospital admission. On 27.06.17 he visited the ELFT mental health services and was described as being under the influence of alcohol. He maintained that he had recently put a rope around his neck and wanted to die. There is no evidence this information was shared outside of mental health services.

4.32 On 28.06.16 Abdullah visited his probation officer and mentioned his visit to mental health services the previous day.

4.33 On 03.07.17 Abdullah was seen by appointment by an ELFT doctor and his care coordinator. At that meeting he admitted to drinking two cans of beer a day but the doctor noted they knew he drank a lot more than that. Abdullah made no reference to feeling suicidal.

4.34 During the rest of July Abdullah was discharged by the new alcohol service provider in Luton - Resolutions - as he had not followed up on offers of help. He completed his probation order. He had four contacts with Luton and Dunstable Hospital. On the first occasion he went to A and E complaining of feeling dizzy. He

was given advice. On the second he was admitted following complaining that he was vomiting blood. He was given alcohol advice and referred to the alcohol services. He discharged himself against advice, On the third occasion he was admitted via A and E and was discharged the following day, He was again given alcohol advice and follow up was requested through his GP which is confirmed by the GP surgery. Finally, late in the month he was brought to the hospital by ambulance, but he did not remain for a medical review.

4.35 A similar pattern of hospital contact continued into the early days of August 2017. On 02.08.17, five days after his last contact with the hospital, he was again brought in by ambulance with similar symptoms to previous contacts. He acknowledged he had been drinking. On 03.08.17 he failed to attend a routine Dietician appointment, so the GP surgery tried to follow this up by phone and, when this was not successful, sent a standard letter. Again, there was no response.

4.36 On the 07.08.17. Abdullah again visited LDUH with a similar diagnosis. His vomiting was settled, and a note sent to his GP recommending detox rehabilitation.

4.37 On 26.07.17 Abdullah's Probation supervision ended. The author of the Bench chronology noted: 'No termination assessment completed ….No liaison with other agencies to advise that Probation "support" was coming to an end.' On the 31st July the GP reviewed Abdullah's situation who was described as stable but still drinking. The plan was for him to contact his mental health worker and restart Lansoprazole. The drug decreases the amount of acid produced in the stomach and is used to treat and prevent stomach and damage to the oesophagus from stomach acid, and other conditions involving excessive stomach acid.

4.38 On the 10th of August the Adult Safeguarding Team at Luton Council received a referral from the East of England Ambulance Trust. There was no detail about the nature of the referral. The record indicates a strategy discussion with staff at ELFT who were to follow up the initial concerns. It is further recorded in the case notes of the ASC Safeguarding Team that a request to ELFT for a social care assessment to be undertaken with Abdullah had previously been made and would be requested again.

4.39 On the following day according to Luton Housing's records he was accepted as eligible for permanent housing. Two weeks later he was issued with a tenancy breach letter as he had failed to keep his property tidy. This appears to relate to the temporary accommodation he was in.

4.40 On the 18th, 23rd and 25th of August Abdullah attended LDUH complaining of vomiting. On the first two occasions he left of his own volition before investigations were completed or treatment accepted. On the third visit he was discharged home with medication.

4.41 A new care coordinator was appointed to Abdullah on the 24th August.

4.42 On the 30th August he was arrested for a public order offence while under the influence of alcohol and was seen in the cells by a community nurse from ELFT. There was no corresponding Police entry.

4.43 On the 4th September he was seen at LDUH complaining of shoulder pain having been hit by a car. There was no fracture.

4.44 On the 13th September 2017 the Police, due to significant concerns for Abdullah's welfare undertook a home visit and forced entry as they he believed he was being financially exploited in his own home by another man. He was offered and accepted hostel accommodation. Presumably, associated with this there is a reference in the LDUH chronology on the 15th September of Abdullah being taken to hospital as he was diabetic and had not had insulin for a few days.

4.45 On the 18th September 2017, as a result of his vulnerability to exploitation, a safeguarding alert was raised citing 'severe neglect.' The adult social care record noted in view of previous concerns about Abdullah's self-neglect that clarification was required on his engagement with services and what action and or safeguarding measures has been implemented to address the concerns raised. This was screened by the Council Safeguarding Team and the outcome was that a full safeguarding enquiry should be undertaken. This was shared with ELFT, for their immediate attention and action. The Council Adult Safeguarding Team requested a proportionate response to this concern requesting a report back on ELFT's risk assessment and protection/prevention plan. There is record on the system that ELFT completed the S.42 Enquiry and a report was completed by the - Community Mental Health Team (CMHT) manager and sent to the ELFT Service manager for a quality check on 13/11/17. The completed report was received back by the Safeguarding Team on 14/11/17. The report details that subsequent to the Safeguarding Alert being received Abdullah had been rehoused at Rutland Court.

4.46 On the 9th October 2017 Abdullah was seen by his care coordinator. There was no mention in the record of the recent safeguarding concern.

4.47 On the 12th October Abdullah self-refers to Resolutions drug and alcohol service and attended his first appointment 8 days later. On the self-referral he said: "I would like to have one last opportunity to stop drinking alcohol as it is seriously harming my physical health." He stated on the 30th that his goal was total abstinence.

4.48 On the 23rd October there was a further change by ELFT of care coordinator for Abdullah. In late October both Adult Social Care and Resolutions independently comment that they were experiencing difficulties contacting Abdullah and also his care coordinator. On the 13th November there was a three-way meeting between Abdullah, his new care coordinator – a social worker - and the preceding one. Abdullah was intoxicated and said he spent £300 of his weekly benefits on a gambling habit and the rest on cigarettes and vodka. He acknowledged that ELFT could do little to help him unless he engaged with Resolutions. On the 20th October the GP was requested to provide a report on Abdullah for Resolutions and this was received on the 27th.

4.49 On the 16th November 2017 Abdullah attended his Resolutions appointment where he identified problems of not sleeping, being depressed and struggling with intrusive memories of his family being killed.

4.50 Between the 21st to 23rd November he was admitted to LDUH via A and E. He was diagnosed with alcohol-related Gastritis. He took his own discharge against medical advice, but he was considered to have the capacity to make a risky decision. On the 28th November he came to LDUH with the same issue as the week previously. He was discharged the same day having been given advice and medication. Also during November the GP shared blood test results with Luton Wellbeing Service and Resolutions

4.51 On the 5th December 2017 he was seen by his care coordinator. At that stage Abdullah was insistent that all his support should come via the CMHT and this view is confirmed in the Resolutions chronology. The following day, according to the ELFT chronology Abdullah was in Luton and assessed by a social worker following an incident in the street. 'Abdullah was stressed, anxious and tearful. He stated that he could not remember the offence, but I (the social worker) was informed he had been shown clear CCTV footage showing that he was in the Mall and shouting at people and being racially abusive.' There is no further information so it can be presumed that no charges ensued.

4.52 On the 20th December Abdullah was admitted to hospital overnight for observation but discharged the following day.
In early January 2018 there were contradictory views on Abdullah's progress. On the 5th January 2018 a Housing Officer reported to Adult Social Care that Abdullah was drinking less but on the 11th Abdullah admitted to Resolutions that he was drinking 35 units per day. On the 18th the ELFT Consultant Psychiatrist wrote to his GP saying that his behaviour had improved markedly since moving into supported accommodation, but he was also described as dishevelled and smelling of alcohol.

4.53 Between the 4th and 11th January Abdullah was readmitted to LDUH from A and E with symptoms of vomiting blood. Resolutions were aware he was in hospital and supplied information to the hospital about their engagement with him. When medically stable he was discharged with the expectation of follow up from his GP and Resolutions. It was noted that Abdullah had been admitted to hospital 19 times in the past 12 months.

4.54 On the 25th of January Penrose, the housing association supporting Abdullah noted positively a 'vast difference' in his behaviour. At this time there were no visits or admissions to LDUH. Abdullah was also attending agreed Extended Brief Interventions (EBI) with Resolutions. On the 28th January Abdullah was seen at the respiratory clinic at Luton and Dunstable hospital following a referral by the GP.

4.55 In February Abdullah missed two appointments with Resolutions. However, by mid-March there was a reference to him wanting to try residential rehabilitation again. The response from Passmore's, the agency who had accepted him 12 months previously, was that he would need to do some more work before they would contemplate taking on somebody who had previously discharged himself a week before the completion of his treatment. During March 2018 Resolutions continued to work with him and secured an appointment with Passmore's.

4.56 On the 12th February there was an incident at Abdullah's supported housing involving another man who had a knife. A Housing Officer from Penrose expressed some concern about the relationship between the two men as the officer could not get to speak with Abdullah by himself.

4.57 On the 1st and 8th March 2018 Abdullah was visited to ensure he was managing during a spell of very cold weather. On the second visit his care coordinator described Abdullah's flat as 'dirty' and his appearance as 'unkempt.'

4.58 On the 25th of March Abdullah was brought into LDUH by ambulance complaining of vomiting. He was discharged the same day with a recommendation of follow-up by his GP. The following day Abdullah made unannounced visits to his care coordinator who wasn't in and to Resolutions.

4.59 On the 4th April Abdullah was seen in LDUH having sustained an alcohol-related fall but was discharged the same day.

4.60 On the 19th April Abdullah was visibly distressed and shouting at staff at his housing project. When he had calmed down staff said that his agitation related in an unspecified way to the man with whom there had been the previous incident with a knife in February. The GP records show that Abdullah was taken by ambulance to LDUH on the 19th April but there is no further information from LDUH that explains why he went to hospital and what the outcome was. However, on the 21st April he was seen at LDUH with alcohol-related gastritis and discharged with medication and advice the same day. According to GP records he was advised by the hospital to stop drinking.

4.61 On the 30th April Abdullah made a complaint about the same man who had been involved in the incident with a knife on the 12th February which resulted in a safeguarding referral on the 1st May. Also, on the 30th of April there was a visit to Abdullah from a nurse from ELFT. The report says Abdullah looked scruffy. His room was very untidy and full of smoke. A staff member at the housing facility said that residents are not allowed to smoke in their rooms, but Abdullah ignored all warnings and was at risk of eviction. Abdullah informed the ELFT nurse that he has been physically unwell and has been to A&E 5 times in the last 2 weeks. There is no corroboration of this in LDUH records.

4.62 On the 3rd May a Resolutions worker contacted adult social care explaining that Abdullah wanted to move as he had concerns about his present accommodation

4.63 The safeguarding referral on the 1st May was followed up by two nurses from ELFT on the 4th of May who visited but Abdullah was not at home. At this time his new care coordinator was informed by the safeguarding team that Abdullah wanted to move because of the unwanted attention he was receiving from another resident.

4.64 On the 8th of May the Housing provider contacted Luton Council – Housing Department to say that his current accommodation was not suitable for him and that when staff had last seen him a week previously, he was covered in excrement and wearing no shoes.

4.65 On the 9th of May Abdullah was found dead at his home by housing support staff. It was recorded that he died of natural causes with pneumonia and bronchitis being contributory factors.

5. Analysis

5.1 There are a number of issues that emerge from a reading of the chronological events and from discussions with professionals working in Luton. These include:

- interpretation and application of Luton's adult safeguarding procedures including the policy for working with hard to engage people.
- Communication and coordination between agencies and multi-agency working; and
- Leadership;
- Recording of events; and
- Effective use of the provisions of the Mental Capacity Act

These issues are discussed in the ensuing paragraphs under subheadings.

5.2 Interpretation and application of Luton's adult safeguarding procedures

5.2.1 The guidance for all health and social care agencies working in Luton[4] identifies three definitions of abuse that at various times applied to Abdullah. They were Self-Neglect, Physical Abuse and Financial Abuse.

5.2.2 There is evidence that Abdullah, at various stages, met the threshold for a safeguarding concern but it appears that such a notification of a concern did not always result in ELFT undertaking an assessment. Even when they did, it is not clear they were always brought to a conclusion as to whether that concern met the threshold for further action and if so, what that action was. Listed below are examples of shortcomings in practice which, if normal practice, would have an impact on the ability of the LSAB partnership to safeguard people effectively.

5.2.3 By his own admission and from frequent occurrences outlined in the previous section it was abundantly clear that Abdullah drank excessively to the point where it had a significant adverse effect on his physical health and at times he could not look after himself. Potentially this met the threshold for a self-neglect safeguarding concern but was not always identified as such.

5.2.4 Abdullah also appeared to meet the threshold for how best to work with people who are hard to reach.[5] Contained within the Hard to Reach Guidance are definitions of the sorts of situations and personal characteristic that might trigger a multi-agency conference. I consider that Abdullah and his situation fell within the guidance but that a full multi-agency conference – also recommended in the Guidance- was never

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[4] Multi-Agency Safeguarding Adults Practice Guidance – Luton Safeguarding Adults Board 2015
[5] Working with Hard to Engage Adults – Luton Safeguarding Adults Board 2015

initiated. This would have been particularly useful when at one stage there were at least seven services and/or agencies regularly involved with him.

5.2.5 There are references in the preceding paragraphs to Abdullah being attacked (March, October and November 2016) but this does not appear to have led to him being seen as being in need of safeguarding. This was a missed opportunity.

5.2.6 The outcomes of some safeguarding concerns were not clear or evidenced as complete. For example, in April 2016 there was no evidence that the safeguarding concern was fully investigated, and conclusions reached. Also, I have seen no evidence that Abdullah's probation officer was advised of the safeguarding alert in May 2017 or that the GP was aware of the concerns raised. There was also no evidence that a social care assessment that was supposed to be undertaken as a result of the alert was ever undertaken. A third example relates to a serious safeguarding concern in September about self- neglect and exploitation by a third party. In that instance the ELFT commentary in their chronology says: 'No evidence of home visit documented to assess the condition of the property in light of the Section 42 enquiry. No initial Safeguarding visit, risk assessment and Safeguarding plan completed.' However, the ASC Safeguarding Records indicate that such a visit was undertaken by ELFT.

5.2.7 In December 2015 Abdullah was in hospital for two weeks and told staff that he did not feel safe in his flat but there is no evidence that this was considered to be a safeguarding issue.

5.2.8 In October 2016 and June 2017 Abdullah indicated to ELFT staff that he was feeling suicidal but there is no evidence that they considered applying safeguarding procedures. It may be that this was not an appropriate course of action but there is no record of how they addressed the obvious safety issues.

5.2.9 It was of concern that somebody who was seen by housing agency staff as being without shoes and covered in human excrement was not referred as an urgent safeguarding matter in view of the obvious self-neglect issues. It was of equal concern a safeguarding referral under self-neglect was not considered by his Probation Officer when Abdullah informed the officer that he had not eaten in about 20 days.

5.2.10 The chronology reveals that in early 2018 LDUH recognised that Abdullah had been admitted to hospital 19 times in 12 months. Although there was evidence of LDUH procedures to identify how to respond to frequent uses of A and E it was not clear from the chronology whether and if a safeguarding referral was considered.

5.3 Communication and coordination between agencies and multi-agency working.

5.3.1 At any point during the period under consideration a whole range of agencies were regularly in contact with Abdullah. This would include ELFT, Luton and Dunstable Hospital, his GP, Luton Council as commissioners of housing and various housing agencies, the drugs and alcohol service and Luton Council Adult Social Care including the safeguarding team. Between August 2016 and July 2017, the number of actively

involved agencies was probably at its highest as Abdullah was made subject of a Court Order and supervised by Bench.

5.3.2 For somebody with such complex and intractable problems, coordination of effort and effective communication was essential. In reality the effectiveness of it was questionable. In general, LDUH seemed not to know of the numbers of agencies endeavoring to support him or if they did, they only normally referred to the GP and the drug and alcohol services which were outposted at the hospital. The theme of alcohol misuse underlying Abdullah's frequent hospital attendances and admissions would be of use to his ELFT care coordinator in particular. However, I saw very few references in the ELFT chronology to suggest that they were aware of the frequency or the nature of his admissions. I was unsure that the hospital that LDUH even knew he was subject to CPA or if they did, they did not communicate with the mental health trust about his admissions.

5.3.3 The BENCH chronology notes the Sentence Plan should also be formulated with other relevant agencies but there was no evidence that it was. Although in an early meeting with his probation officer there is reference to discussions about mental health and alcohol services there is no evidence this led to a direct contact with those agencies at that time. In a similar manner I saw information about formal safeguarding concerns that seemed not to engage all agencies in the gathering of information to assess the degree of risk.

5.3.4 In October 2017 both adult social care and Resolutions commented on the difficulty of contacting Abdullah's care coordinator.

5.3.5 The issue of a shared approach is also picked up in the BENCH chronology when it says of a particular entry where Abdullah mentions his contact with mental health services: 'No follow up with other professionals following disclosure of issues at Mental Health Service. "*No consideration of home visit, no risk assessment review etc. Whilst we see him regularly, we are contributing little towards positive progress or actively managing risk of harm to himself through challenging his lifestyle, in particular continued alcohol use*."

5.3.6 What was conspicuous by its absence was coordination of effort. It raises the question of who or what agency should have ensured effective communication? It was surprising for example that his GP was not advised by the care coordinator that Abdullah's daughter had died. Abdullah was subject to Care Coordination under the Care Programme Approach for over seven years within mental health. However, there was little evidence for the period in question that his care was coordinated. I would have expected ELFT to have taken the lead in ensuring this.

5.3.7 Local ELFT guidance[6] provides as part of its principles: '*Ensuring effective partnership with relatives, carers, advocates, and statutory and third sector agencies and that CPA should be based on integration of health and social services.*' In these

[6] Trust-wide Care Programme Approach (CPA) Policy East London NHS Foundation Trust April 2017

respects, practice seemed not to conform to these principles consistently. Representatives of the agencies with which Abdullah was regularly involved, ought to have contributed to reviews of his care but they did not. Those reviews should have taken place regularly at agreed intervals but in the period covering this review they did not.

5.3.8 Responsibility for coordination of care and communication is not the sole responsibility of one agency. Within the chronology there are examples of other agencies who, although undertaking their responsibility for meeting Abdullah's needs missed opportunities to seek information from or share information with others. I identified in 5.2.6 that a safeguarding concern passed by adult social care to ELFT was not followed up. I have seen evidence and been given assurances that there are new systems in place to ensure concerns passed to other to follow up are completed.

5.3.9 Finally, it was disappointing to note that while Abdullah was in residential rehabilitation during late 2016 and early 2017 his CPA coordinator did not maintain contact and the response from BENCH was to transfer supervision more locally. Potentially this was an excellent opportunity to work with the drugs and alcohol service to plan for his return and try to build on what the service had achieved.

5.4 Leadership

5.4.1 Associated with communication and coordination is leadership. There was no evidence that any person or agency assumed leadership for ensuring effective care for Abdullah. Had there been multi-agency meetings convened under the multi-agency policy aimed at people who are hard to engage, there would have been an opportunity to identify a shared plan of support, the allocation of responsibilities for that plan, monitoring of outcomes and agreement who was to oversee that plan. This was a missed opportunity.

5.5 Recording of events.

5.5.1 Recording is at the cornerstone of good evidence-based practice. If it is not there, opportunities are missed to gather together the full picture of events concerning an individual. Within this report there are eight references to there not being a corresponding record of an event that involved two or more agencies. That is of considerable concern.

5.5.2 The examples contained in the chronological summary of key events include safeguarding concerns coming to a premature halt or lacking a feedback loop to confirm that assigned and agreed tasks had been completed.

5.5.3 Chronologies sent to me by the GP service and police services initially substantially under – represented their involvement. There were examples of the police bringing Abdullah to hospital but no record in their own information presented to me that they have done so. Subsequently I received additional information that demonstrated the Abdullah's issues were discussed appropriately within the GP

practice between the GP who saw him and other members of the team, and relevant onwards referrals made.

5.5.4 It is of particular concern that there is no direct corroborative evidence from his family and that the Council has been unable to find contact details of the sister that a social worker spoke with shortly after his death. This loss of opportunity for a family contribution to this Review is a significant failing.

5.6 *Effective use of the Mental Capacity Act*

5.6.1 There was little evidence to confirm that Abdullah had the capacity to make informed decisions about neglecting himself to the extent that he did. His GP considered that there was no reason to doubt his decision-making capacity.

5.6.2 Although the Mental Capacity Act says that: ‘’A person must be assumed to have capacity unless it is established that he lacks capacity”[7], there are reasons to expect formal consideration of at what point that might not have applied to Abdullah. Decisions about an assessed lack of mental capacity have to be both time and situation specific. One example of this is when: “the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to their community.”[8]

5.6.3 There were occasions where that more formal consideration might have been applied. For example, it was common for Abdullah to discharge himself from hospital, or the points when his personal care and hygiene significantly lacking, for example as reported on the 8th May 2017. This begs the question whether he had the capacity to make that judgment. These opportunities to at least consideration of mental capacity was in part missed due to the absence of formal multi agency meetings as outlined in safeguarding guidance.

5.6.4 In summary I would have expected evidence of more formal documentation of Abdullah’s mental capacity.

6. Conclusions

6.1 Abdullah’s situation is not uncommon in certain ways. A recent national report[9] that looked at 11 alcohol related SARs identified certain consistent characteristics. They were:

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[7] Section 1 (20) mental capacity Act 2005

[8] Gibbons, S (2006) Primary Assessment of Older People with Self-Care Challenges. Journal of Nurse Practitioners 323-328

[9] Learning from Tragedies – an analysis of alcohol-l related Safeguarding Adult Reviews published in 2017 – July 2019 Alcohol Change UK

- Non-engagement with services;
- Self-neglect;
- Exploitation of a vulnerable person;
- Chronic health problems;
- Non-engagement with services;
- Mental health Condition;
- Domestic and child abuse;
- Lack of family involvement; and
- Traumatic events triggering alcohol intake

These characteristics mirror almost exactly Abdullah's experience.

6.2 Abdullah had experienced considerable and extreme personal trauma in his life. For over seven years he had been known to mental health services and for the time this Review covers had also been known to a range of other agencies and services. Substantial efforts were made by dedicated professionals to engage him in addressing his problems and in particular his alcohol dependence. These were ultimately unsuccessful. The review identifies shortcoming in individual and multiagency practice. However, even had there been better communication, coordination, leadership and more effective safeguarding, the outcome for a man who consistently challenged professionals and refused services may not have been any different.

6.3 Abdullah's encounters with a range of agencies identify practice that at times fell below expectations and did not conform to my understanding of local procedures. As such it raises questions about how well people with complex problems requiring multi agency intervention are served? Does the Safeguarding Adults Board know whether the shortcomings identified here are typical of wider practice?

6.4 Other than stark facts of Abdullah's life experiences what is particularly lacking is a sense of what he was like. In most safeguarding reviews there are contributions from friends, family and neighbours who can say something about the person – such as his interests, likes and dislikes. He appeared to have nobody who was close to him. No professional assessments or reviews that I have read say anything of the person which should be part of a person-centered approach.

6.5 Abdullah appeared both socially and culturally isolated. There was no reference I saw to cultural or religious connections. Those acquaintances that are mentioned were uniformly mentioned as unhelpful and exploitative influences. This is important insofar as assessments and plans should be personalized and holistic. Professionals seemed to be trying to work with somebody with limited personal investment or commitment in his own future. How that was or might have been addressed is difficult to know but encouragement to develop a social life away from people who appeared similarly engaged in risky lifestyles might have helped find motivations in his life other than alcohol dependency and memories of unimaginable trauma.

6.6 I learnt from both the Police and LDUH that although quite frequent users of their respective services Abdullah would not have stood out insofar that they could cite example of people who used their services significantly more. However, had

opportunities been taken, particularly in terms of a multi-agency review of his situation the characteristics summarized in the recent research referred to in 6.1 would have been all too apparent.

6.7 I have been reassured that many of the issues raised in this report have already been understood and agencies separately and together have acted upon some of the issues raised in this report. I was told of a multi-agency City Centre initiative that helps to identify mental health problems at an earlier stage at an earlier stage and greater use of multiagency meetings particularly initiated by housing services. There is also a more robust audit of initial safeguarding concerns to ensure that any promised actions by any agency are completed.

7. Recommendations

7.1 Luton Safeguarding Adults Board should:

7.1.1 Seek assurances from all Board partners that their staff know and apply the multi-agency policy on self-neglect.
7.1.2 Assure itself that the single agency learning identified in this review has been embedded in day-today practice.
7.1.3 Require that the Quality Assurance and Performance Sub-group of the Board undertake a multi-agency audit of self-neglect cases to determine the quality and nature of support offered to people who are neglecting themselves and report back.
7.1.4 Request that the Quality Assurance and Performance Sub-group of the Board in all multi agency audits evaluate and comment on the quality of recording and in particular whether communications between agencies are equally recorded in agency documentation.
7.1.5 Promote the findings of this review and in particular promote greater consideration of multi-agency discussions where it appears an individual is endangering themselves by refusing professional advice.
7.1.6 Ensure multi-agency training in relation to self-neglect references this report and its findings.

Alan Coe
Independent Consultant

Appendix 1 Terms of Reference

Safeguarding Adult Review - ABDULLAH

TERMS OF REFERENCE AND SCOPE OF THE REVIEW

1. Decision-making criteria, subject of this Review, and what prompted a referral

1.1 On ***13th September 2018,*** *Luton's Safeguarding Adults* Review Subgroup *met and made the* recommendation, with the approval of the Independent Chair of the Safeguarding Adults Board (SAB) and, reference to the criteria as set out in Care Act 2014, that the threshold was met to commission a *Safeguarding Adults* Review in respect of:

1.2 Mr ABDULLAH's case was referred by East London Foundation Trust. He used the Trust's services as well as a number of others. He very sadly died, aged 48, after a history of alcohol use, self-neglect, physical health, and housing issues. Mr ABDULLAH was a Somalian national, and after his arrival in Luton, his whole life in the town was dominated by the issues listed above. He was vulnerable in a number of ways, but also known to Bedfordshire Police as both a victim but on occasion, an offender too. In the latter respect he was also known to the Probation Service. The referring agency identified concerns both about their own practice but also the way agencies worked together to safeguard Mr ABDULLAH.

2. The purpose of the Review

2.1 The purpose of a Safeguarding Adults Review is to identify themes, learning, improvements that are needed and to consolidate good practice.

The following **principles** should be applied by the SAB and its partner organisations to all Reviews:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and protect adults at risk, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- **Professionals** should be involved fully in Reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. However, all involved with SARs must be aware that the findings may be used in other proceedings and may therefore be shared more widely, for example as a result of court proceedings;
- **Families and friends**, should be invited to contribute as part of preparing the Final Review Report. This will be the responsibility of the Independent Report Author. Family and friends should understand at an early stage how they may be involved and their expectations should be managed appropriately and

sensitively. This is important to ensure that the focus remains on the adult at the centre of the SCR process. Throughout the Review process there should be a clear focus on the individual's journey, their experience and that of family and friends.

- Final Overview reports of SCRs are considered for **publication**, either in full or in part. The Board will give careful consideration when making a decision about publication to the need to balance the benefits of publishing all or some of the review with the need to protect the rights, including the privacy rights, of individuals. The signatories and the Independent Chair recognise that in some cases, the Boards may decide that this balance may weigh in favour of withholding from publication some or all of the contents of a review. The impact of SCRs and other reviews on improving services and on reducing the incidence of deaths or serious harm will be commented on in the SPB annual report.
- Improvement must be sustained through regular monitoring and follow up so that the findings from these Reviews make a real impact on improving services.

2.2 SARs and other case reviews should be **conducted** in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

2.3 The methodology agreed for this Safeguarding Adult Review is that of a practitioner's learning event, followed by a management learning discussion; these will be informed by chronologies for a from all relevant agencies. Agencies involved with ABDULLAH will be asked to complete chronologies for collation. For this review, no IMRs will be requested and there should be no need for practitioner interviews. The aim is to draw the learning together through the events, identify themes, and identify organisational learning.

3. Issues for consideration by agencies and outline of the steps to a final report

3.1 The review will consider:

- What happened (Chronology)

- Why it happened (Practitioner's learning event/ Management learning discussion)

- What action is now needed (Panel)

- What progress has been made (Management learning discussion/Panel)

3.2 The time period under consideration for this Review is 15th September 2015 to 10th May 2018**;** the rationale for this is that in 2015, East London Foundation Trust

took over providing mental health services in Luton, so can account for their actions with Mr ABDULLAH. The end date is the date that Mr ABDULLAH was found dead in his flat. There is however an expectation that records pre-dating ELFT taking on the Luton contract are available and can, where relevant, be summarised as context.

3.3 Steps in the Review Process

A chronology to be prepared on request by agencies. The LSCB / SAB Business Unit will provide the template/instructions and organise the integration of all agencies' chronologies

- Agencies are asked to consider and include with their response:
  – a written summary outlining the reasons their agency acted as it did;
  – comment where relevant about the levels of demand and any staffing issues that may have impacted on an organisation's ability to respond to ABDULLAH;
  – consider whether any organisational changes – such as change of provider or restructure - were in any way significant in offering continuity of care;
  – comment on any staff changes in terms of continuity of care to ABDULLAH and ensuring that any handover of responsibility was undertaken effectively; and
  – comment on effectiveness of communication with other agencies involved in support to ABDULLAH
- The Review process will involve a Practitioners' learning event, a Management learning discussion and a written report

4. Agencies involved in this Review

East London Foundation Trust

Resolutions

National Probation Service (Bedfordshire)

Luton and Dunstable University Hospital

Luton Clinical Commissioning Group

Luton Council

- Housing Needs
- Housing Operations
- Adult Social Care and Safeguarding
- Public Health – as commissioners

Bedfordshire Police

Noah

Mears Housing

All these organisations and will be asked to provide a chronology of their involvement.

5. Overview

5.1 This Safeguarding Adults Review will be overseen by a panel of senior local managers. Their responsibilities are to:

- Respond in a timely way to requests for information
- Be curious and open about their agency's work with Mr ABDULLAH
- Support all team managers and practitioners who might be involved in this process to reassure them and explain what a SAR is
- Brief the Chief Officers of their organisation at appropriate points in the process so that no one can subsequently feel they were unsighted on the Review or emerging issues

5.2 Panel members

Overview Report writer – Alan Coe (an experienced social care and safeguarding professional with no connections to Luton or any of the agencies in the review)

Chair of Panel – Fran Pearson (Independent Chair of Luton Safeguarding Adults Board)

Panel members from Luton agencies

Organisation	Job title
Luton Borough Council Housing	Head of Housing needs
Luton Borough Council Adult social Care	Head of Service/Principle Social Worker
Luton Adults Safeguarding Board	Independent Chair
ELFT	Luton community service manager
ELFT	Named professional for Adult Safeguarding
CCG	Head of adult safeguarding and designated nurse
Resolutions	Service Manager
Bedfordshire Police	Adult Safeguarding
Luton Borough Council	Service manager Strategic Safeguarding
Luton Adults Safeguarding board	Business manager
Noah Enterprise	Safeguarding Lead /Head of welfare Services
Luton & Dunstable Hospital	Safeguarding Lead

5.3 Agencies who have submitted chronologies

Organisation

Luton Borough Adult Social Care
LBC Housing Solutions
Luton & Dunstable Hospital
Bench
Noah enterprise
Penrose Synergy
Resolutions
GP/CCG
Bedfordshire Police
ELFT

5.4 **Agencies who have submitted Actions plan**

Resolutions
ELFT
Adult Social care
LBC Housing
Bedfordshire Police