# Swindon Safeguarding Partnership

# Safeguarding Adult Review – Kathy

## Mike Ward

## July 2026

# Contents

# Introduction

1. Kathy[1] was a 41 year old White British woman who died in November 2025 following an acute period of self-neglect. At that point she was not eating and had been in bed for 10 days. She was found covered in urine and faeces. She had a background history of an alcohol use disorder. Her cause of death was determined at postmortem to be (1) Bronchopneumonia (2) Alcoholic Liver Disease.

2. A referral for consideration as a SAR under Section 44 of the Care Act 2014 was submitted by Adult Safeguarding in Swindon Borough Council. The SAR referral identified alcohol abuse, self-neglect, institutional abuse and neglect or act of omission as key contributors to the situation that led to her death. However, the key reason for referral was concern around safeguarding practice in the days before her death.

3. The decision of the Swindon Safeguarding Partnership's (SSP) Review Group was that the referral met the SAR criteria. Because of concern about:
    - the identification of care and support needs;
    - the effectiveness of multi-agency working;
    - the response to suspected self-neglect;
    - systemic issues that may have contributed to Kathy's situation; and
    - the timeline of events leading up to her death raising questions about the effectiveness of the response from various agencies.

4. The scoping period for the review is the year from November 2024 until her death in November 2025.

## Purpose of the Safeguarding Adults Review

5. The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of a person and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:
    - To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
    - To review the effectiveness of procedures both multi-agency and those of individual agencies.
    - To inform and improve local inter-agency practice.
    - To improve practice by acting on learning (developing best practice).
    - To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

[1] Kathy is a pseudonym chosen by her stepfather.

6. There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything, prevented them from being able to properly help and protect Kathy from harm.

## Independent Review

7. Mike Ward was commissioned to write the overview report. He has been the author of over thirty SARs as well as Domestic Homicide Reviews, Drug and Alcohol Death Reviews and a member of a Mental Health Homicide Inquiry Team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers.

## Methodology

8. The Practice Review Group identified a short series of questions that act as the Key Lines of Enquiry for the Review. These are included in the Appendix. Key agencies were invited to submit brief information they considered relevant, including information from outside the time period.

9. The following agencies were involved in the process:
   - Adult MASH
   - Ambulance Service Trust
   - Hospital NHS Trust
   - GP Practice
   - 111 out of hours service
   - Department for Work and Pensions
   - Police

10. A Practitioner Reflection Day was held in April 2026, and a Managers' Reflection Day was held two days later; both workshops contributed a range of thoughts and views on Kathy and her care.

11. All this information was analysed by the author, and an initial draft of this report was produced and went to the Review Panel in June 2026. Further changes were made over the next two months, and a final draft was completed in July 2026.

## Family contact

12. An important element of any SAR process is contact with family. Kathy had a stepfather who was very involved in her care; he is the only family member known to have had significant contact with her. The author and an SSP representative met him at his home, and he provided a very detailed picture of Kathy's life which addressed many of the gaps in the initial information. The author is grateful for his contribution.

## Parallel processes

13. There were no Police inquiries that coincided with the SAR process. The Postmortem reported that she died of *1. Broncho Pneumonia* and *2. Alcoholic Liver Disease*. As a result, it was decided that a formal Coroner's inquest was not required.

# Background and personal Information

### Kathy's engagement with services prior to November 2025

14. The main focus of this report is a brief period in November 2025 when relevant services became aware that Kathy was in a very poor physical state and appeared to have quite significant care and support needs. Therefore, the central question is:
    - whether services responded appropriately to this crisis in her care?

15. However, a second question is whether prior steps could have been taken to prevent the crisis. The challenge was that she had relatively little contact with services before November 2025.

16. Primary Care record her as stating that her childhood was "not very good". Her father left the family when Kathy was very young. Her stepfather subsequently moved into the family home. She was described as having "plenty of friends" when younger. Her mother died in 2005 when Kathy was 21 and this seems to have been a significant trauma for her.

17. As an adult, she was interested in football, particularly the Lionesses and Newcastle United (her stepfather's team). She never worked and filled her time with crosswords and online puzzles. She also appears to have communicated with people all over the world via these puzzles.

18. Her stepfather described her as a *"lovely person"*. However, he also said that she had *"always been difficult"* and had ongoing problems with her mental health.

19. In her adult life she was in a longstanding intimate partnership with another woman. This appears to have been a turbulent relationship, and it ended in 2023. Following this, Kathy stayed in her flat and did not leave until her death.

20. During this period, she had ongoing support from her stepfather; he would stay over with her and was the person who discovered that she had died. He also provided her with essential and other support. He described having to buy all her shopping including alcohol. Kathy also had eight cats and a dog at the end of her life and their care added to her stepfather's challenges.

21. This care was a struggle because his own physical health limited his ability to intervene effectively. For example, he found it difficult to follow CPR[2] instructions over the phone due to a hearing impairment. He described how, during the final weeks, he tried to move Kathy's position in bed which was challenging because she was larger than him. It was clear that the physical aspects of this care took a toll on him. Moreover, at no point does he appear to have been offered access to support as a carer. However, this apparent gap needs to be seen in the context of the very limited contact between Kathy & her stepfather on the one hand and health & social care services on the other.

22. Kathy was the sole tenant of a Council property and had lived at the same address for seven years. She stated that she struggled with bills and, according to her stepfather, tended to *"bury her head in the sand about owing money"*. She had a number of contacts with Department for Work and Pensions; some of which were related to her non-engagement with aspects of the claims process. In February 25, she was reported to be in arrears with her rent, but her stepfather said that an uncle helped her to resolve this.[3]

23. According to her PIP[4] claim in 2023, she had a history of agoraphobia, anxiety and depression. The claim states that these started two years earlier and that Kathy was taking medication and had a Mental Health Nurse for support and had been offered counselling. Other symptoms Kathy declared were low mood, difficulty eating and panic attacks. In March 2024 - Kathy left a message on her Universal Credit journal stating that *"I missed my appointment as I am unable to attend the job centre at the moment due to severe anxiety and depression which has led to agoraphobia".*

24. Her stepfather reported that Kathy had an alcohol use disorder. She had a lifelong pattern of binge drinking and would drink heavily for a few days – a bottle and a half of spirits in a day was mentioned - but would then stop for a few days. Agency notes also suggest that Kathy had an alcohol use disorder but do not provide a clear picture of the this. The 111 out of hours service notes record that a friend had previously described Kathy as being *"alcoholic with an alcoholic partner"*. Ultimately, alcoholic liver disease was a secondary cause of her death.

[2] Cardiopulmonary resuscitation
[3] The author asked whether the uncle would be interviewed but was told he did not want involvement.
[4] Personal Independence Payment

25. However, in the last week of her life she appeared to have been in a period of sobriety. The Paramedics did not report seeing signs of intoxication, bottles or glasses in her room. Her stepfather confirmed that she was not drinking at that point. It is also important to note that the Paramedics saw no indications of alcohol withdrawals, which suggests she had had a non-dependent alcohol use disorder.

26. She also smoked cannabis for most of her adult life as well as being a regular cigarette smoker. Again, her stepfather said that she had stopped smoking cannabis one or two weeks before she died.

27. The Police have records prior to September 2017 in which Kathy was named as a witness, suspect or victim in various incidents. Some of these were domestic abuse related. One other incident was recorded in October 2022 – two males stood outside Kathy's house shouting, they were reported to be in possession of knives. Officers attended and arrested the males; no weapons were found. Kathy was intoxicated upon police arrival. Officers attempted to call her the following day to obtain a statement, but she did not engage or respond to follow-up contact. The case was closed with no further action.

28. Her contact with health services was also limited. She attended the Acute Hospital once, in 2017, as a result of punching a wall. She does not appear to have been involved with secondary care Mental Health Services. The Ambulance Service had previous contact with her only once: in January 2025 a third party called an Ambulance due to concern for Kathy's wellbeing. However, she reassured Paramedics that she was well and no further action was taken.

29. Her GP records contain 15 contacts between 2024 and the start of November 2025. These are either requests for Sertraline[5] (and possibly other drugs) or attempted and failed contacts by the Practice. It appears that there had been no GP contact for six months prior to the crisis that led to her death.

30. Housing Services also had had limited contact with Kathy. Notes for the period July to December 2024 identify a couple of home visits regarding property maintenance. Kathy was open with Housing staff about her agoraphobia and her struggles to leave the flat; however, staff did not identify her as presenting any cause for concern.

31. As can be seen, a key feature of Kathy's situation was the very limited interaction she had with services. Her stepfather was clear that she did not want contact with services and in most cases would not allow them into her flat.

[5] An antidepressant

## Her care in mid-November 2025

32. On 12 November 2025, Kathy was heard shouting in her flat. This is believed to be because she was trying to rouse her stepfather who was unable to hear her. A neighbour called the Police and because they could not reach anyone, they eventually forced the door open. They found Kathy and her stepfather inside and they reassured the Officers that all was well and it was simply a miscommunication and misunderstanding. No further action was taken by the Officers.

33. On 14th November the Ambulance Service received a call from Kathy's stepfather advising that her mental health was *"extreme, that patient is stating she doesn't need an ambulance but that she hasn't left the house in 2 years and 10 days ago her arms and legs became useless."* He also said that she was sat in urine and was confused. The call was passed to HealthHero for further assessment. The HealthHero notes from the incident conclude: *"Diagnosis: IMPRESSION – Sepsis confused, bed bound, incontinent and confused. PLAN - Cat 2, needs admission…Red flags and worsening advice given to stepfather. To contact back should anything change or worsen. No questions at the end of the consultation."*

34. HealthHero rang the Ambulance Service advising that Kathy would require face to face assessment. A little later the Ambulance Service received a call from Kathy herself advising that her stepfather had panicked and she didn't need an Ambulance. The response was stood down as this came from the patient herself.

35. The GP received a report of this from the Ambulance Service. This said that Kathy declined assessments and notes that she would seek assistance from mental health teams and her GP. No action was recorded from the Practice.

36. On the 17th November, the Ambulance Services received a call via a friend of Kathy stating that she had fallen over two weeks earlier and was now lying in bed in her own urine and that she was *"an alcoholic"*.

37. A crew was dispatched and Kathy's stepfather answered the door. He was not aware an Ambulance had been called. Kathy was in bed and conversed well with the Paramedics who had *"no concerns relating to her capacity"*. She was reported as stating that: *"she had seen her friend last night as had recently gone through a difficult break up, but she is fine now. Kathy refused any observations and stated she was well in herself. Crew asked if they could help Kathy in any way either with mental health or contacting GP".* The Paramedics noted that she had said: *'if she needs us, she will call us'*. She stated she had numbers to call in relation to her mental health and that she would contact her GP. Kathy was given worsening advice in relation to calling 999 if any emergency health concerns arose. She was left in the care of her stepfather who was staying with her. The paramedics sent a patient record to her GP.

38. On the same day (17th) the GP practice received a telephone call from 111. This reported that Kathy had been unable to move out of bed since a fall seven days earlier. She was lying in her own excrement and had refused paramedics because she felt there was no issue. She had agreed to speak to her GP and had a telephone consultation with a Surgery Paramedic (17th). She reported having slipped on cardboard and hurting her back by landing on a cat toy. She said that she had been trying to rest but was not being left alone. Nonetheless she said she was able to get up and mobilise. It was reported that she appeared orientated and denied any need for medical attention. She was aware that she could call back if needed.

39. Late on 19th November, a safeguarding concern was raised by 111 following a call from a friend of Kathy's. This was received by the Initial Contact Team at 11.37am the next day (20th). The concern focused on self-neglect and alcohol use. The GP surgery was immediately notified of the concerns around Kathy's health. The Initial Contact Team at Adult Social Care also called Kathy but was unable to reach her.

40. The referral was sent to the Multi-agency Safeguarding Hub (MASH) on the 20th. A dual pathway was determined embracing both a Care Act Assessment of her care and support needs (section 9) and safeguarding under section 42. However, the Care Act assessment was put through as "non urgent". No rationale was given for this.

41. The safeguarding enquiry was considered at the MASH huddle on 21st November. It was graded amber risk (red being the most urgent). The Local Authority notes state that: *"Given situation unclear why Care Act was put through as non-urgent. No rationale on the system given the concerns raised".* It is noted that the indications that she had not eaten for 10 days appeared to have been missed and that this could have changed the grading.

42. (It needs to be noted that with regard to her not eating, Kathy was described by the paramedics who saw her in the last week as "obese". This may not suggest a long term or immediately life-threatening pattern of difficulty with eating.)

43. The concern was passed, that day, to an Enquiry Manager who was off sick, but who was expected to be back the next day. However, the 21st November was a Friday, and no further action was taken until the Monday (24th).

44. On 23rd / 24th November, Ambulance Service Paramedics attended her address twice, once at 5pm and again just after midnight, due to her vomiting and experiencing abdominal pain.

45. Her stepfather reported that she had been bedbound for ten days, was not eating, and was primarily consuming whiskey with orange juice. It was stated she had not eaten for 10 days and was lying in faeces and urine. The property was in disrepair and there was a strong smell of ammonia. The bedroom had no working light and damp and mould were in evidence. Kathy was assessed by the Paramedics to have capacity to refuse treatment. Kathy refused

safeguarding but was advised that if she stayed in this environment she would likely die.

46. On the first of the two visits, the Paramedics stated that they encouraged her multiple times to engage and seek assessment, Kathy signed a refusal form stating she didn't want further help. She was given worsening advice and left in the care of her stepfather. On the second visit the Paramedics spoke with 111 out of hours service to help safety net Kathy. A practitioner advised what was on their records: "*that she was known to Mental Health services but with no recent contact logged. One month's supply of sertraline was dispensed on the 30th September, but she had had nothing since. Two days earlier there was mention of alcohol dependence following a concern for welfare but prior to this, entries to medical records were sparse and unremarkable."* A plan was made to refer Kathy to her GP in the morning for a home visit or phone call and the patient record shared with GP.

47. The Paramedics appear to have made significant efforts to engage with Kathy, including offering to help her shower and clean her living environment. They noted that she was reluctant to engage and appeared frustrated by the involvement of services.

48. Most significantly, the Paramedics all agreed that they had been surprised to discover that Kathy had subsequently died. They felt she was in a poor state but not one that was immediately life-threatening. Again, it was noted that her weight did not suggest that she was neglecting her nutrition.

49. On 24th November, the Enquiry Manager rang Kathy but received no answer. They then rang the GP practice to see if they had an update and half an hour later the practice informed them that Kathy had been found deceased by her stepfather. Attending Paramedics confirmed that rigor mortis had set in, and there were no suspicious circumstances surrounding her death.

# Analysis

50. Given the brevity of her contact with services, this review has a restricted focus. At its core are two key questions
    - Would it have been possible to identify Kathy's risk and vulnerability earlier in the period prior to her death?
    - Are there lessons from the management of the crisis in November 2025?

51. Two subsidiary questions are:
    - Have the lessons of SAR Robert been learned locally?
    - Was a Think Family approach in place, specifically in relation to the role of the stepfather?

## Earlier identification of her risk and vulnerability

52. The principles of Making Every Contact Count (MECC) and alcohol Identification and Brief Advice have been promoted for many years. It is important to identify problems at the earliest possible stage and use every available opportunity to highlight the possibility of making positive changes.

53. Even this approach is challenging with Kathy because she had such limited contact with services. However, in general terms Kathy is a reminder of the importance of robust alcohol screening processes to ensure that any alcohol-related risk is identified and highlighted. In accordance with NICE Public Health Guidance 24, best practice would ensure that the AUDIT alcohol screening tool[6] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service. Professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore this issue.

54. Moreover, the importance of Making Every Contact Count and the centrality of the *Prevention Principle* under the Care Act should be promoted to all public-facing practitioners.

55. That said, in Kathy's case, this message only really applies to Primary Care and DWP. Certainly, in Primary Care, use of the AUDIT tool should be standard practice. This might have identified any alcohol use disorder at an earlier stage and might have provided an opportunity to encourage her to, at least, review the need to change her drinking patterns.

56. Whether DWP had the same opportunity needs to be reviewed by the agency. However, all public-facing agencies should be considering how to integrate AUDIT into their work. Other screening tools such as Assist-Lite (drugs), PHQ-9 (depression) and GAD-7 (anxiety) could also be considered in this context.

## The management of the crisis in November 2025

### *The Ambulance Service and the Mental Capacity Act*

57. Only three agencies were involved in Kathy's care in the last ten days of her life: Adult Social Care, Primary Care and the Ambulance Service (111 out of hours service were also peripherally involved).

58. Ambulance Service personnel were the only people to see Kathy in that period. They saw her three times: including twice in the hours before her death. In each case real efforts were made to engage Kathy, provide physical care

[6] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)

and to persuade her to go to Hospital. When this failed, referrals were made to Primary Care and/or Adult Safeguarding.

59. The Paramedics recognised that Kathy was in a state of physical and mental decline but did not feel that she was at imminent risk of death. Their assessment was that she had mental capacity to take the decision to refuse care and given that there was no history of previous decisions placing her at risk, it is not possible to argue a different decision on the basis of lacking "executive capacity".

60. The real question is the adequacy of the mental capacity framework for this type of situation. The Paramedics spoke about the sense of "moral injury" caused by their professional view (that Kathy needed assessment or care in Hospital) clashing with Kathy's assertion that she did not need care. This feeling was exacerbated in the light of her subsequent death.

61. It is hard to build a case that professionals alone should have the right to override someone's right to "make unwise decisions". However, her main carer and two other friends who knew her well were clearly highly concerned about her situation. However, this does not have any weight in such mental capacity decisions.

62. The question for the Safeguarding Partnership is whether the combined weight of professional and carer judgement is something that should have more weight in a mental capacity assessment. If so, this should be escalated to the Department of Health and Social Care for consideration in any revision of the legislation or guidance.

### *Primary care*

63. Kathy's GP was notified of the concerns about her condition on at least four occasions in the 10-day period. As a result, the surgery paramedic rang her back on the 17th November. Kathy talked about her situation but declined any further help. Further concerns were escalated to the GP but although attempts were made to contact her by phone, these were unsuccessful and no-one from the practice saw her or even spoke to her after 17th November.

    In the original consideration of the SAR referral, the ICB acknowledged the challenges faced by non-emergency services, such as GPs, in responding to cases like Kathy's within short timeframes. GP's will aim to undertake a home visit the same day where there is a clinically indicated need.

64. The discussion highlighted the role of GP services, noting that they are not designed to provide urgent responses unless there is a clear and immediate risk. Information about Ambulance callouts or other concerns is often added to a patient's notes without triggering immediate follow-up unless it raises significant red flags. It was said that this systemic limitation may have contributed to delays in recognising the risk in Kathy's situation.

65. The surgery itself reflected on the contacts about Kathy. *Multiple contacts from other agencies and surgery inability to make contact could perhaps have led to the surgery completing a home welfare visit, or request for an urgent safeguarding MDT be held to discuss the situation?...There is a need for individuals, where concerns are being consistently raised and contact is difficult, to be raised with the surgery safeguarding team. This would provide an opportunity for a deeper look at records and discussion as to an appropriate way forward.*

66. The surgery asks whether there is *a need for a quicker multi-agency response for adults who are self-neglecting?* They also say: *Although capacity is being documented, a meeting to share concerns and discuss a safety plan would have been useful.*

67. It is impossible to know whether a home visit from a GP or Practice Nurse would have changed what happened to Kathy. Nonetheless, it does seem to be a potential gap in her care. However, meaningful change can only occur on this if there is a clear set of guidance and markers on when a visit would be required. The Safeguarding Partnership will need to request that the ICB ensures all GP practices have robust systems in place to effectively triage and prioritise urgent support needs, including home visit requests where required.

## *The response from Adult Social Care*

68. The response from Adult Social Care was initiated via a safeguarding concern from 111 late on 19th November and effectively began on Thursday 20th November (two working days before her death).

69. A number of questions have been raised about actions in that period:
    - Was the amber RAG rating of Kathy in the MASH huddle appropriate?
    - Was the allocation of the case to a worker who was off-sick at the time appropriate?
    - Should the initial Contact Team have taken further steps to ensure there was contact with Kathy?
    - Should the Urgent Response Team have taken steps to ensure there was contact with Kathy?

70. As with Primary Care, Adult Social Care have considered the implications of this scenario in some detail and taken steps to change systems.

71. Because of the missed information about her not eating for 10 days and the resultant lower RAG rating, huddle guidance has been updated to reflect that if significant harm/impact is indicated then action is taken that day; this overrides the rest of the RAG rating headings. An analysis box has been added to the RAG headings for information to be weighed sufficiently and for the Enquiry Manager to evidence their decision making. This has been shared with the team and reiterated in team meetings. Team training is also to be undertaken to reflect this.

72. The allocation of the case to an individual who was off sick has also been a point for review. Guidance has clarified that if an Enquiry Manager is off sick or out of office that the case should be allocated to another Enquiry Manager who is in work in order for swift action to be taken.

73. The Initial Contact Team (ICT) made one attempt to call Kathy on the day of the referral (20th Nov). They tried to call her again on 24th November; however, Kathy had already passed away at this point. They also did not call the GP surgery until 24th November. Given the nature of the concerns raised, ICT could have considered a referral to the Urgent Response Team (URT) for a home visit on 20th/21st Nov.

74. (NB all agencies do need to consider that calls to phones from unknown numbers are increasingly unlikely to be answered because of the increase in scam phone calls.)

75. Adult Social Care reflected on the role of URT vis a vis ICT. Their report suggests that there is a "power imbalance" between these two teams and a possible lack of clarity in their roles. This suggests that there is a need for Adult Social Care to review how, and through which means, urgent referrals are responded to.

## Think family

76. Kathy's stepfather reported that he was providing significant care to her. However, because of his age and physical abilities, he struggled to provide this care. He would clearly have benefited from support as a carer. However, no attempts were made to offer him support or an assessment under Section 10 of the Care Act.

77. The family of people with alcohol use disorders can also greatly benefit from support and can be a positive agent for change. Adfam, the national agency on alcohol, drugs and the family, offer extensive resources on this theme.

78. The importance of a "Think Family" approach has been highlighted in many previous SARs and the key role of carers is highlighted in the Care Act. However, again given that the seriousness of her care needs only emerged in the last ten days of her life it is unreasonable to expect such steps to have been taken. Nonetheless, this is a reminder of the ongoing need to think family.

## Have the lessons of SAR Robert been learned locally?

79. SAR Robert is a local SAR published in 2024. It can be accessed here:
    - Safeguarding Adult Review – Robert - full report - Swindon Safeguarding Partnership
    - Safeguarding Adult Review - Robert - Executive summary - Swindon Safeguarding Partnership
    - Safeguarding Adult Review - Robert - 7 minute briefing - Swindon Safeguarding Partnership
    - SSP Action plan proforma - Swindon Safeguarding Partnership

80. The review was asked to consider whether Kathy's care suggests that the lessons of SAR Robert have been learned locally. On the surface, there are apparent similarities between the cases: possible alcohol use disorder, self-neglect and carer's needs. SAR Robert also considers mental capacity. This highlights the prevalence of these themes in safeguarding and specifically the importance of professional training around both alcohol use disorders and the use of the Mental Capacity Act.

81. However, the lack of information about Kathy, including the role of alcohol in her life does mean that it is hard to draw any parallels. Even with the carer's role there are differences because SAR Robert emphasises the needs of female carers whereas Kathy had an older male carer. Nonetheless, both SARs do underline the need for carer support.

# Key Learning Points

82. The limited information available about Kathy means that only the most limited conclusions can be drawn about practice. However, it does emphasise five points.

83. Kathy's care highlights the importance of early intervention approaches such as Making Every Contact Count (MECC) and alcohol Identification and Brief Advice. Practitioners working with the public need to be Making Every Contact Count and routinely asking the AUDIT questions to identify alcohol use disorders. Other screening tools such as Assist-Lite (drugs), PHQ-9 (depression) and GAD-7 (anxiety) should also be considered in this context.

84. The Ambulance Service highlighted concerns about the application of the Mental Capacity Act and the sense of "moral injury" because their sense of what was needed collided with the framework of the Act. This raised the question of whether family and carer perceptions should have more weight in mental capacity decisions. The SSP should consider escalating this concern to the Department of Health and Social Care for consideration in any revision of the legislation or guidance.

85. A home visit from a GP or Practice Nurse was a potential gap in her care. The SSP will need to request that the ICB ensures all GP practices have robust systems in place to effectively triage and prioritise urgent support needs, including home visit requests where required.

86. Adult Social Care have taken steps to apply learning from the gaps in meeting Kathy's needs. However, it appears that there is a need to clarify how, and through which means, urgent referrals are responded to. In particular, the roles and relationship of the ICT and URT need to be clarified.

87. As in SAR Robert, Kathy is a reminder of the ongoing need for training on alcohol use disorders and mental capacity and the need for practitioners to *think family*.

# Good practice

88. The role of the Ambulance Service paramedics who attempted to care for Kathy was good practice. They both went above and beyond in their efforts to engage Kathy and were articulate about the problems they experienced in applying the Mental Capacity Act in this situation.

89. It is also positive that both Adult Social Care and the GP practice have reflected on the need for change in similar scenarios.

# Recommendations

**Recommendation A**

The Swindon Safeguarding Partnership in conjunction with Public Health and the ICB should

- ensure that all frontline services are aware of, and are able to use, robust alcohol screening tools such as the AUDIT tool to identify and record the level of alcohol related risk for clients;
- ensure that services are using other screening tools such as Assist-Lite where appropriate;
- ensure that services generally are using a Making Every Contact Count approach.

**Recommendation B**

- The Swindon Safeguarding Partnership should consider escalating concern about the lack of weight given to family and carer perceptions in mental capacity decisions to the Department of Health and Social Care for consideration in any revision of the legislation or guidance.

**Recommendation C**

- The Swindon Safeguarding Partnership should request that the ICB ensure all GP practices have robust systems in place to effectively triage and prioritise urgent support needs, including home visit requests where required.

**Recommendation D**

- Adult Social Care needs to ensure that learning from the gaps in meeting Kathy's needs are applied in practice and, in particular, clarify how, and through which means, urgent referrals are responded to. In particular, the roles and relationship of the ICT and URT need to be clarified.

**Recommendation E**

- The Swindon Safeguarding Partnership needs to ensure that recommendations from SAR Robert regarding the ongoing need to think family are being applied.

**Recommendation F**

- The Swindon Safeguarding Partnership needs to ensure that there is ongoing training on alcohol use disorders and the use of the Mental Capacity Act.

# Appendix 1 - Key Lines of Enquiry

This review attempts to identify the lessons learned from Kathy's case and being mindful of past SARs and to respond to those lessons to prevent safeguarding-related deaths. The panel ask the reviewer to consider cross cutting themes with other SARs currently underway with SSP also to ensure actions and learning, where appropriate, is thematic.

The critical question to be addressed by the review is:

What can agencies learn regarding the efficacy of treatment and support for people with mental health needs, alcohol dependency and self-neglect?

The Practice Review Group agreed on the following questions concerning Kathy to be addressed in this review:

1. What has been the impact on practice since the findings identified in SAR Robert including in relation to MDT working and information sharing?

2. How do we ensure as a system we consider a holistic view of a person needs, including their environment, a historical view and not just basing decisions on presenting need.

3. To what extent was Kathy's alcohol dependency and self-neglect linked to wider issues, such as trauma, financial difficulties, or challenges in accessing support and how was this understood and appropriate support provided?

4. Was Kathy's stepfather considered as a carer and offered support in his own right? If not, what are the barriers to this in practice and why as a system has this not changed since SAR Robert?

Findings from the Previous SARs

- "Robert" (2024) - How did agencies assess Robert's capacity, were the assessments shared, and how did this impact the care Robert received?
- Consideration of Findings from Homeless Fatality Review (HFR) Arlo and Paddy and any joint learning opportunities and similarities with systemic concerns.