Swindon Safeguarding Partnership
Executive Summary
Safeguarding Adult Review – Kieran

Introduction

Kieran[1] was found deceased at his home on 23rd January 2019. Police Officers forced entry following concern that Kieran had not been seen for several days. He was aged 65, was White British and had been living alone since the death of his mother in 2002. The Coroner gave the cause of death as an upper gastro-intestinal bleed caused by duodenal ulcers, which would have been difficult to spot and scan. This condition had not been picked up during Kieran's hospital admission shortly before he died. This admission, between 2nd and 5th January, had followed Kieran complaining of stomach pains.

Kieran's early history includes a record of mild learning disability in 1972 and a first contact with psychiatric services in 1975 following his father's death. His IQ was given as 63 and obsessive symptoms and ritualistic activity were recorded. His mother's death in 2002 prompted renewed contact with psychiatric services following an overdose. Appointeeship with respect to his financial affairs appears to have begun at this time. His weekly allowance was collected by a carer. His family believe that this had begun as a formal arrangement around 2005, facilitated by Swindon Borough Council (SBC). Records from that time are not available and it became widely accepted by agencies involved that it was a private arrangement.

A diagnosis of schizophrenia has been noted but there is little other recorded detail from this time of what support was provided for Kieran. A care plan from 2010 references weekly domestic support, including shopping. There were plumbing and heating issues in 2011 that required attention. AWP records contain entries in November 2011 of exchanges of telephone messages with Kieran's relatives. It appears that they had little contact with him. This may have been because he apparently disliked visitors.

AWP had no involvement with Kieran between 2012 and 2016. This appears to have been the result of a service restructure and because there had been no active mental health interventions. SBC Money Management Team (MMT) was not involved in this decision. AWP has concluded[2] that this is one instance that demonstrates the need for improved implementation of the Care Programme Approach (CPA), and for improved understanding between MMT and mental health services. In 2013 MMT expressed concern about Kieran's discharge from the CPA, with advice given to re-refer via his General Practitioner (GP). This advice does not appear to have been followed and represents a missed opportunity.

The Care Act 2014 was implemented on 1st April 2015. No-one appears to have referred Kieran for a care and support assessment between that implementation date and when AWP resumed its involvement with Kieran in November 2016. Care and support needs arise from or are related to physical or mental impairment or illness.

The house in which Kieran lived was owned by his extended family and he was not charged rent. In the final few years of his life there were increasing concerns about self-neglect and hoarding. His case had been reopened by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) by the

[1] Kieran's given name has been used with permission from his family.
[2] Noted in the AWP Serious Incident investigation and report.

beginning of 2017 and a care and support package had additionally been arranged from April 2018 to address Kieran's self-neglect and hoarding.

There were concerns that Kieran was at risk of exploitation. There were also concerns about the adequacy of support being provided by the private carer. His relatives have described Kieran as a shy man, reticent of strangers. Practitioners working with Kieran echo this description. Kieran could be reluctant to allow access into his home and expressed dislike of too many visits and visitors, practitioners and relatives alike.

Findings – Working with Kieran

Some elements of a Making Safeguarding Personal approach are discernible. There is evidence that his wishes were known and respected. Practitioners recognised that he needed a tailored approach and could be difficult to engage. They adopted a cautious approach, not wanting to pressurise him unduly, seeing that the work would be long-term. This approach achieved some success, enabling changes to be made, however small.

However, a balance has to be struck between his autonomy or self-determination and the duty to safeguard him from known or likely significant risks. It is questionable whether that balance was appropriately considered in Kieran's case. Too much reliance may have been placed on the presumption of capacity, with an emphasis on building rapport and a relationship with Kieran, at the expense of a more holistic assessment of his needs and the risks inherent in his situation.

As a result there was no *care plan* to address adult safeguarding concerns, including vulnerability to exploitation and significant self-neglect. Risk assessments, and risk management and contingency plans, were not up-to-date and were not revised after key episodes. The roles of different services and practitioners, in addition to a neighbour and the private carer, were not clarified, including for emergency response.

Kieran's relatives do not believe that he had decisional capacity with respect to his health and welfare. There were missed opportunities to develop a greater understanding of his executive functioning and whether he could use or weigh what practitioners were saying to him about the risks inherent in his self-neglect.

The second of the five statutory principles in the Mental Capacity Act 2005 appears to have been highly influential in how this case was managed. That principle states that "a person is not deemed unable to make a decision unless all practicable steps to help them to do so have been unsuccessful." Also influential appear to have been uncertainty and ambiguity in his presentation. However, earlier and robust assessment would not have compromised this principle and would also have identified, in line with the first statutory principle and the starting point of capacity, whether it was necessary to balance his decision-making with his right to safety and protection.

Much earlier a decision had already been taken that Kieran did not have capacity to manage his financial affairs. Kieran's relatives have expressed considerable concern regarding how his financial affairs were managed by MMT and SBC's practice here has now changed. There was also delay in assessing Kieran's care and support needs and in commencing a care package, initially because of Kieran's reluctance to engage with the plan and subsequently because of difficulties in commissioning a Care Agency. The care and support package did not adequately address his needs, in particular his self-neglect and hoarding, even allowing for the importance of building up a relationship of trust. Reviews did not result in any fundamental shift of approach.

Influential may have been Kieran's experience of the involvement of services as intrusive. It is also possible that the conditions in which Kieran was living became in some way "normalised", to which practitioners became accustomed or desensitised with the result that they did not see the risks clearly enough. Kieran would only permit limited cleaning and entry to some parts of his home. Not all the rooms were inspected and there was no escalation of concern and no multi-agency meeting when Kieran was reluctant to engage. This links back to questions about understanding of Making Safeguarding Personal and application of the Mental Capacity Act.

There was an over-reliance on the support supposedly being provided by the private carer. Services did not work together in their efforts to make contact with him to express concerns about how Kieran's weekly allowance was being used and about what support Kieran would accept from him. Whilst it appears to have been Kieran's preference to be supported by his private carer, reportedly having a profound attachment to him, practitioners did not convene a meeting when efforts to engage the carer in the care plan failed. As a result, there was no oversight of this arrangement and this part of Kieran's potential support network was not clarified.

None of the services and practitioners involved made contact with Kieran's relatives until after he had died. Not all agencies appear to have had details of Kieran's next of kin and other family members. It appears that Kieran may not have wanted contact to have been made with his relatives. However, without Kieran's consent, making contact with his relatives would have been appropriate to collect information and justified because of concerns about how to safeguard him as an adult at risk. As a result his support network was not well understood; neither was his history and his lived experience of his family.

Findings – The Team around Kieran

There were joint visits and liaison between different practitioners and services involved. There were other occasions when communication and collaboration between different services could have been enhanced. Complex and challenging cases require a uniform and agreed response, where services work closely together and where all views are valued and listened to. Holding planning meetings should be standard practice, together with the circulation of case summaries to highlight the key concerns that need to be addressed.

There were examples of good practice regarding the sharing of information. There were also delays in information-sharing. A marked feature of this case is that at no time did all the services and practitioners come together to discuss how best to meet Kieran's needs and mitigate the risks in his case. One had been planned but Kieran died before it could take place. Multi-agency meetings should be the norm in such cases. Some uncertainty was found with respect to when the Section 42 Care Act 2014 adult safeguarding concern pathway might be used and when a multi-disciplinary team meeting pathway might be considered. Referred adult safeguarding concerns did not result in an adult safeguarding enquiry, despite the criteria[3] being met. There were shortfalls in recording, for example details of Kieran's next of kin, responses to fire hazards and repair work undertaken in his home.

Findings – Organisations around the Team

Supervision and management oversight of complex and challenging cases are central components of best practice. Although practitioners were able to access support, there was insufficient supervisory

[3] Section 42(1), Care Act 2014.

and management oversight of care and support planning, responses to concerns and to risks, and safeguarding decision-making.

None of the documentation submitted for this review indicates use of available self-neglect procedures. A review is underway of a policy on escalation of concerns.

Recommendations

Recommendation One: SSP should complete its review of SAR referral procedures and disseminate the revised approach and requirements across all partner agencies.

Recommendation Two: SSP with its partner agencies should review their shared understanding of the relevant legislation regarding referral and commissioning of SARs to ensure this accurately reflects the absolute and discretionary duties within Section 44, Care Act 2014.

Recommendation Three: SSP should consider what further work is required to refresh and embed in practice its guidance on self-neglect and hoarding.

Recommendation Four: SSP should seek assurance that decision-making regarding progression from Section 42(1) to Section 42(2) enquiries is sound and fully documented.

Recommendation Five: SSP to request from the CCG clarification of guidance given to GP practices regarding best practice in relation to the monitoring of repeat prescriptions when patients have both mental health and physical health needs.

Recommendation Six: SSP should review the outcomes of a multi-disciplinary audit of mental capacity assessments in cases involving self-neglect, alongside the learning from this review, and consider what further work is required from the Board and its partner agencies.

Recommendation Seven: SSP reviews recent audits on Section 42 referrals, decision-making and enquiries, alongside the findings of this SAR and considers what further actions are required.

Recommendation Eight: SSP should seek reassurance that there is adequate professional oversight of the role of informal carers in cases where concerns have been expressed about neglect and abuse. Carer assessments must be considered and where appropriate offered, with also a focus on assessing the degree to which family members can be engaged as a "circle of support." SSP should seek reassurance from partner agencies that there is documentation that prompts staff to consider the role of informal carers and the need to assess.

Recommendation Nine: SSP should seek reassurance regarding how MMT assesses and reviews, working in partnership with other services within the local authority and with other agencies, the suitability of family members and unrelated informal carers when it has legal responsibility for the administration of a person's financial and property affairs.

Recommendation Ten: SSP seeks assurance that Making Safeguarding Personal is accurately understood and that understanding embedded in practice across partner agencies.

Recommendation Eleven: SSP should seek assurance from AWP regarding ongoing monitoring of mental capacity assessment practice as a result of recommendations from its Serious Incident investigation of this case.

Recommendation Twelve: SSP seeks assurance that there are service level agreements and clear arrangements in place regarding best interest discussions between MMT and other service providers to ensure prevention of, and protection from financial abuse and exploitation.

Recommendation Thirteen: SSP should seek assurance from AWP, and indeed from other SSP partners, that there are clear plans and annual reviews of service users' financial affairs where these are being administered by MMT.

Recommendation Fourteen: SSP should review the guidance provided across partner agencies regarding risk assessment and risk management.

Recommendation Fifteen: SSP should review the guidance given by the CCG to GPs and other health care providers regarding outreach to "vulnerable" patients when scheduled appointments and/or health check reviews are missed.

Recommendation Sixteen: SSP should review with SBC and CCG the local autism strategy, with particular reference to the commissioning of training, and assessment and service provision.

Recommendation Seventeen: SSP seeks assurance regarding the timeliness of Hospital discharge summaries.

Recommendation Eighteen: SSP should review the guidance provided across partner agencies regarding use of multi-agency meetings in cases where there are significant concerns about the likelihood of significant risk of abuse and neglect, including self-neglect.

Recommendation Nineteen: SSP should seek assurance from partner agencies that the standard of recording is kept under regular review, including through staff supervision and case file audits.

Recommendation Twenty: SSP considers how to involve practitioners and managers who worked with Kieran to discuss the findings and recommendations from this SAR.

Recommendation Twenty One: SSP to seek assurance as to how partner agencies support staff when service users are found deceased.

Recommendation Twenty Two: SSP engages with its partner agencies in a continuing conversation about how the learning from SARs is being used to improve policies, procedures, service development, training and practice. The SSP's own strategic business plan should also be informed by an analysis of learning from this and other SARs.

Recommendation Twenty Three: SSP produces and monitors a partnership-wide action plan to implement the recommendations arising from learning from this SAR and that relating to the case of Terry, with a learning event after one year to review what has been achieved and what remains to be accomplished by way of policy and practice change.

Recommendation Twenty Four: SSP initiates a whole system conversation about how services individually and collectively respond to cases of self-neglect, with particular reference to the evidence-base for best practice and where the enablers and where the obstacles are to achieving that standard.