
# SAFEGUARDING ADULT REVIEW: KIERAN

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January 2021

# Acknowledgement

Members of the Swindon Safeguarding Partnership (SSP) and the independent reviewer express their sincere regret at the death of Kieran. Sincere condolences are offered to his relatives and friends.

The reviewer, working with SSP members, hope and intend that this review will enable lessons to be learned, and will contribute to service development and improvement.

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# 1. Introduction

1.1. 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.

1.2. 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.

1.3. Swindon Borough Council (SBC) Money Management Team (MMT) had administered Kieran's financial affairs under Appointeeship, initially from 2002 when the arrangement was set up with the cooperation and at the request of Kieran's Uncle. Kieran's personal allowance was collected by a private carer[2]. The private carer had been providing support since before August 2012[3] when Kieran was discharged from the Care Programme Approach (CPA).

1.4. 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. 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.

1.5. 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 MMT was not involved in this decision. AWP has concluded[4] that this is one instance that demonstrates the need for improved implementation of the Care Programme Approach (CPA) that emerges from this case, 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.

1.6. It is important to acknowledge here that the Care Act 2014 was implemented on 1st April 2015. No-one appears to have referred Kieran for a care and support assessment

[1] Kieran's given name has been used with permission from his family.
[2] The records pertaining to the beginning of the involvement of the carer are no longer available. Kieran's relatives believe that the carer was provided by SBC, for which Kieran was charged, and, therefore, was a formal arrangement. By the time records are available, the arrangement was clearly seen by the agencies involved as a private arrangement.
[3] Relatives believe the arrangement was in place by 2005
[4] Noted in the AWP Serious Incident investigation and report.

between that implementation date and when AWP resumed its involvement with Kieran in November 2016. A duty to assess[5] would have arisen if Kieran appeared to have care and support needs. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury[6].

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

1.8. 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[7]. 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.

1.9. Kieran was living independently. This review is an opportunity to consider how services worked with him and with each other to prevent and to protect him from abuse and neglect, including self-neglect, and to support his wish to live independently.

[5] Section 9 Care Act 2014.
[6] Care and Support (Eligibility Criteria) Regulations 2014.
[7] The identity of the private carer has been withheld.

## 2. Safeguarding Adult Review

2.1. Swindon Safeguarding Partnership (SSP) has a statutory duty[8] to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. A Safeguarding Adults Board (SAB), here SSP, has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect[9].

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[10]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. The referral for consideration of the case for a SAR was sent by AWP on 12th July 2019. The referral noted that Kieran had been receiving support regarding his mental health and personal care. Concerns around self-neglect and hoarding were noted. Under summary of events it was recorded that Kieran had established psychiatric diagnoses of Obsessive Compulsive Disorder, Schizophrenia and Autistic Spectrum Disorder (the latter not formally diagnosed) and there had also been physical health concerns in the weeks leading to his death which resulted in a short hospital admission in early January 2019.

2.5. SSP's Practice Review Group discussed the case on 10th September 2019. It is recorded that it was agreed that the case did not meet the criteria for a SAR as it appeared that Kieran's death was not the result of abuse and/or neglect (which includes self-neglect). However, the group also concluded that there was potentially learning to be gained and disseminated from the case regarding the services that had been provided.

2.6. In her review of this recommendation, on 1st October 2019, SSP's Independent Chair suggested that the time lapse between Kieran's death (January 2019) and SAR referral (July) indicated the need for more robust arrangements to gather and consider information in a more timely way about cases where SAR criteria may be met. **Recommendation One:** SSP should complete its review of SAR referral procedures and disseminate the revised approach and requirements across all partner agencies.

2.7. The Independent Chair endorsed the conclusion of the review group but added that there were reasonable grounds to explore further how AWP and ASC worked together to promote Kieran's wellbeing and safety, specifically the interface of assessment and

[8] Sections 44(1)-(3), Care Act 2014
[9] Section 44(4).
[10] Section 44(5), Care Act 2014

services provided under the Care Act 2014 and CPA, not least because of the safeguarding referrals that had been submitted whilst Kieran was alive and the evidence of financial exploitation/abuse and self-neglect. She considered that the review should be carried out as an inter-agency case learning review.

2.8. It would be more accurate to record that the decision was that the SAR referral did not meet the mandatory criteria in Section 44(1) (2) (3) Care Act 2014 but that the SSP concluded that it was appropriate to conduct a discretionary review as permitted in Section 44(4). The statutory guidance that accompanies the Care Act 2014 gives responsibility to the SAB to determine the type of review that is then conducted to provide effective learning and recommendations for improvement action[11].
**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.

2.9. Following further discussions, involving Kieran's relatives and one of SSP's statutory partners, the decision was modified in order to commission an Independent Reviewer. This independent overview report writer was approached to undertake a SAR, partly because of some apparent similarities between this case and another in Swindon[12] that he had reviewed and which was nearing completion. The Covid-19 pandemic meant that work on this review recommenced in later July 2020.

2.10. The following agencies which had commissioned or provided services to Kieran contributed to the review alongside the independent overview report writer.

- Independent overview report writers:
  - Michael Preston-Shoot
- SSP Strategic Manger: Safeguarding
- Wiltshire Police Service (WPS)
- Swindon Borough Council (SBC) – Adult Social Care and Adult Safeguarding
- Swindon Borough Council - Money Management Team
- Clinical Commissioning Group (CCG)
- Great Western Hospitals NHS Trust (GWH NHSFT)
- Care First
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South West Ambulance Service NHS Trust (SWAS)
- GP Surgery
- Dorset and Wiltshire Fire and Rescue Service

The Practice Review Group received administrative support from the SSP Business Support Officer.

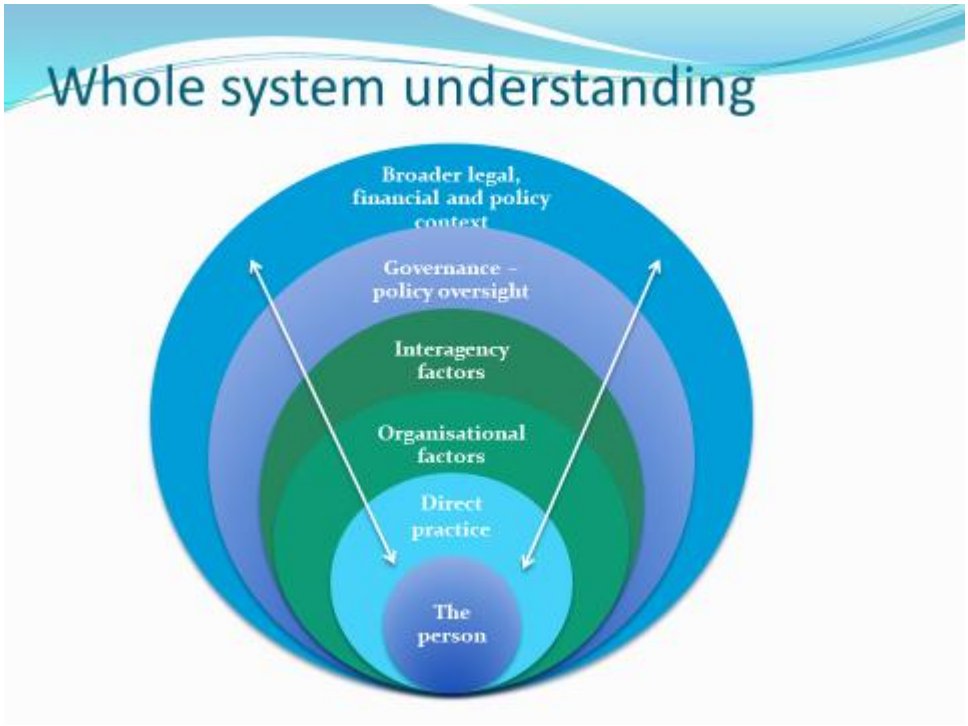
[11] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (Section 14.164).
[12] Preston-Shoot, M. (2020) *Safeguarding Adult Review: Terry*. Swindon Safeguarding Partnership.

# 3. Review Process

## 3.1. Focus

3.1.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs[13], including those on adults who self-neglect[14]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.1.2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.




3.1.3. Specific lines of enquiry, or terms of reference, were identified as follows:

*3.1.3.1. Engagement with KH and other significant adults:*

- Were Kieran's wishes clearly documented in assessments, support plans and reviews and were these appropriately balanced alongside wider considerations such as levels of risk and vulnerabilities?

[13] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[14] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

- Were assessments and reviews timely and was Kieran's care and support plan SMART and up to date. How well did the professionals know Kieran and his history?
- Did Kieran's care and support plans provide strategies to improve outcomes in relation to self-neglect, hoarding, financial management, as well as his medical and health needs?
- Were professionals inquisitive about Kieran's family circumstances and significant adults and did they make appropriate efforts to engage with them to share information?
- Could family relations and other significant adults have been enabled to have a more active role in caring and supporting Kieran?
- Did Kieran experience consistency with professionals?
- Was there evidence of professionals assessing Kieran's capacity?

*3.1.3.2. Multi-agency Working:*

- How effectively and timely were professionals sharing information about Kieran with others both internally within agencies and externally to other agencies?
- What evidence is there of joint working between agencies to promote Kieran's wellbeing and safety (for example, holistic assessments, plans and reviews which considered Kieran's medical conditions and health needs alongside his environment)?
- Did professionals have a shared understanding of the delegated responsibilities between the different agencies?
- Were there missed opportunities to identify and assess safeguarding issues, for example self-neglect, hoarding and Kieran's vulnerability?
- Was Kieran considered by all professionals involved to have mental capacity – was Kieran's mental capacity assessment shared and referred to in formal records and considered within his care and support package?
- Was escalation used appropriately by professionals to raise and address concerns?

*3.1.3.3. Policy & Procedure*

- Were professionals confident in identifying self-neglect/hoarding and do agencies provide a consistent and effective response in recognising it as a safeguarding concern – was there a reference to multi-agency policy on Hoarding?
- Care Programme Approach, how other agencies understand CPA arrangements, and how AWP communicates these arrangements to other agencies involved.
- Did agencies demonstrate appropriate professional curiosity in relation to family circumstances?
- Were there any organisational or resource factors which may have impacted on practice in this case?
- Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgements in this case?

## 3.2. Methodology

3.2.1. The timeframe for the review covers the period from 1st August 2016 to the date of Kieran's death in January 2019. However, information from outside this timeframe has been included when significant for understanding learning from this case.

3.2.2. Agencies were requested to provide a chronology and reflective review of their involvement with Kieran within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review.

3.2.3. The individual chronologies were combined and analysed by the Independent Reviewer and discussed with the Practice Review Group.

3.2.4. Two learning events with practitioners involved in, and with managers with knowledge of Kieran's case were held virtually, due to the Covid-19 pandemic. These events explored key episodes and events within the timeframe being reviewed based on issues and concerns emerging from the combined chronology and reflective agency accounts.

3.2.5. Thus, a hybrid methodology has been used, designed to provide for a proportionate, fully inclusive and focused review.

## 3.3. Family involvement

3.3.1. Kieran's relatives have contributed significantly to this review. The timeframe for this review was pushed back to August 2016 at their request and the key lines of enquiry/terms of reference were discussed and agreed with them. They have contributed information about Kieran's history and about the condition in which they found the house after his death. They have itemised very clearly their concerns and questions regarding how services worked with Kieran. They have read and commented on this report.

3.3.2. Their expressed wish throughout this review has been that services and agencies learn from what took place so that similar situations can be avoided in future. They hope that new and/or revised procedures will be implemented that will improve and enhance service provision and practitioner involvement with adults at risk.

3.3.3. In parallel with this review, family members have used complaint procedures with AWP and with SBC ASC. The Independent Reviewer has seen both detail of the complaints that Kieran's relatives submitted and the responses from the agencies concerned. Reference is made in the analysis that follows to the process and outcomes of these procedures.

3.3.4. The analysis that follows also includes observations from Kieran's relatives about specific episodes and also about the condition in which they found his accommodation after he had died. Their feedback about how they perceived the response of agencies to their questions and complaints has also been included.

## 3.4. Parallel processes

3.4.1. GWH NHSFT conducted an internal root cause analysis investigation regarding missing records from Kieran's one hospital admission during the time frame under review. This is referred to in the analysis that follows.

3.4.2. AWP conducted a root cause analysis following Kieran's death, the outcome of which has been shared with his relatives. Findings and conclusions from this investigation have been included in the analysis that follows.

3.4.3. SBC ASC has formally responded to a stage 2 complaint made by Kieran's relatives.

3.4.4. Details of the above have been shared with the Independent Reviewer.

## 4. Evidence-Base for Good Practice

4.1. Reference was made earlier to research and findings from SARs that enable a model of good practice to be constructed. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The components of each domain most relevant to Kieran's case are summarised here.

4.2. It is recommended that direct practice with the adult is characterised by the following:

4.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes;
4.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills;
4.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage;
4.2.4. It is helpful to build up a picture of the person's history;
4.2.5. Recognition and work to address issues of loss and trauma in a person's life experience;
4.2.6. Recognition and work to address repetitive patterns;
4.2.7. Contact should be maintained rather than the case closed so that trust can be built up;
4.2.8. Comprehensive risk assessments are advised, especially in situations of service refusal;
4.2.9. Where possible involvement of family and friends in assessments and care planning, with clear expectations of and support provided for those in a caring role;
4.2.10. Thorough mental capacity assessments, which include consideration of executive capacity;
4.2.11. Careful preparation at the point of transition, for example hospital discharge;
4.2.12. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
4.2.13. Thorough health, mental health and care and support assessments, plans and regular reviews.

4.3. It is recommended that the work of the team around the adult should comprise:

4.3.1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker, which may be termed working together;
4.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
4.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
4.3.4. Multi-agency meetings that pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options;
4.3.5. Use of policies and procedures for working with adults who self-neglect;
4.3.6. Use of the duty to enquire (Section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;
4.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;
4.3.8. Clear and thorough recording of assessments, reviews and decision-making.

4.4. It is recommended that the organisations around the team provide:

4.4.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;
4.4.2. Support for staff working with people who are hard to engage, resistant and sometimes hostile;
4.4.3. Specialist legal and safeguarding advice;
4.4.4. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
4.4.5. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.5. SABs are recommended to consider:

4.5.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect;
4.5.2. Workshops on practice and the management of practice with adults who self-neglect.

4.6. This model enables scrutiny of the chronology in this case and exploration of what facilitated good practice and what acted as barriers to good practice in this case through a subsequent thematic analysis.

## 5. Chronology and Initial Commentary

5.1. Some information about Kieran that predates the timeframe for the review was included in the introduction to this report. Accordingly, the chronology here begins on 1st August 2016. Where the commentary draws on specific components of the aforementioned evidence-base, italics are used for emphasis.

5.2. In August 2016 a GP referred Kieran to AWP (specifically PCLS). An appointment letter was issued for assessment. Following a sequence of missed appointments, the referral did not proceed and Kieran was discharged from PCLS in September.

5.3. **Commentary:** Kieran's relatives have told the Independent Reviewer that he did not open letters. In their view he did not have decisional capacity regarding decisions about involvement with services with respect to his mental health. The evidence-base advises that there should be *thorough assessments* following referrals, with a full *exploration of what may appear to be service refusal*. The apparent absence of any exploration of why Kieran was not responding is an omission.

5.4. In late November 2016 MMT met with Kieran's private carer to discuss their involvement with Kieran. This does not appear to have resulted in a formalised arrangement with clear expectations about the use being made by the private carer of Kieran's weekly allowance[15]. Kieran was referred again to AWP by MMT in November 2016 and an assessment at Kieran's home followed in December. An assessment recorded risk of self-neglect and non-engagement. Kieran's first Care Coordinator was a Community Psychiatric Nurse. There appear to have been six visits between January and September 2017. Kieran's mental state was assessed as stable and risk low. His private carer was taking some responsibility for supporting Kieran as recorded by the Care Coordinator following home visits when he was present. There were, however, concerns about Kieran's home environment (hoarding) and his ability to care for himself and his home. It has been stated that he did not recognise his need for support[16].

5.5. **Commentary:** As MMT reflected in its contribution to the combined case chronology, best practice would have been demonstrated in clear expectations and monitoring of the support being offered by the *private carer*. There is no evidence of a formal *mental capacity assessment* at this time despite the recorded concerns about self-neglect and Kieran's lack of recognition of his need for support. Kieran's relatives have told the Independent Reviewer that, in their view, he was not capable of understanding the importance of changing his clothes, of washing and of keeping a clean home. This is another way of saying that he did not have decisional or executive capacity. Given the concerns already being noted about his home circumstances, this was a missed opportunity to assess Kieran's mental capacity. Finally, it already appears likely that Kieran had eligible *care and support needs that should have been formally assessed* at this point (Section 9 Care Act 2014). This represents another potential omission.

5.6. Further concern about Kieran's *mental capacity* regarding decisions about self-care might have been triggered by the observation in November 2017 that he was unable to consider a situation in which the private carer was not in a position to support him[17]. In December a CPA review was

[15] MMT submission to the combine case chronology.
[16] The information in this Section comes from the AWP Serious Incident investigation and report.
[17] This is recorded in the AWP Serious Incident investigation and report. AWP records for November 2017 note that the private carer had not visited for a while, the kitchen in particular being "in quite a state." Kieran said that the carer had been unwell and unable to visit.

held, attended by his first Care Coordinator, his new Care Coordinator who was a Social Worker, a Psychiatrist and Kieran's private carer. There had been some liaison with MMT regarding ownership of the property and the need for repairs to faults. Kieran's mental health was recorded as stable. There were concerns about his physical health, nutrition, personal care and household hygiene. A *care and support assessment* was completed, which resulted in a care package of two hours per week. A health check by the GP was advised.

5.7. **Commentary:** In line with *Making Safeguarding Personal*, Kieran's *view* was recorded. He did not agree with expressed concerns about his personal care and condition in the home. He thought that he was managing[18]. He was happy with his private carer but the carer appears to have said that he was unable to continue to offer support in the way that he once had. This appears to be a missed opportunity to explore further the nature of this *care arrangement* and the support Kieran required. The disconnection between what Kieran was saying and what practitioners were observing represents another apparent missed opportunity to *assess his mental capacity*. It is not immediately apparent how the limited care package was meant to address the needs that had been identified regarding his personal care, including nutrition, and management of his home environment.

5.8. The first adult safeguarding concern was referred by AWP on 19th December 2017. The referral referenced self-neglect (lack of personal care) and significant hoarding, Kieran's limited awareness of risk and his apparent lack of insight into his needs and the skills necessary to care for himself and his home. It observes that repairs had been identified as required to his shower and boiler, and that his GP had been requested to complete a physical health check. It also records that Kieran was declining to accept a care package.

5.9. **Commentary:** The *adult safeguarding referral* was good practice. However, it was screened out, which is highly questionable. It appears from the information available at the time that Kieran had care and support needs, was experiencing abuse and neglect, which includes self-neglect, and was unable to protect himself as a result of his care and support needs. As such, the criteria in Section 42(1) Care Act 2014 are met and a safeguarding adult enquiry should, arguably, have followed. Information on the SAR referral about the decision not to proceed to an enquiry includes references to support already being provided, advice to obtain a fire safety check, and a statement that no purpose would be served by holding a meeting. Multi-agency meetings should always be considered in order to facilitate information-sharing, discuss evident risks and agree a risk management plan, and identify roles and responsibilities, including which agency will lead the collaboration and provide the key worker. Entries from the agencies involved on the combined case chronology reflect that the self-neglect and hoarding guidance had been introduced in October 2017, with a recommendation that further work was required to refresh and embed the guidance. A further reflection is offered, namely that the decision-making rationale regarding Section 42(1) *has not been clearly recorded.* Information was not exchanged with MMT and there was no apparent consideration of risks of abuse and neglect, including financial abuse/exploitation. No *mental capacity assessment* has been recorded in relation to Kieran's decision to decline a care package. **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.

5.10. Also in December 2017 MMT conducted a land registry search to establish ownership of the property in which Kieran was living. MMT's contribution to the combined chronology observes

[18] Drawn from the AWP Serious Incident investigation report.

that this search should have been conducted earlier. **Commentary:** This is one of many occasions in which Kieran's relatives might have been contacted. *Involving the family*, where relatives are being asked for information, is not an infringement of information-sharing legislation[19] and a person's right to private life[20].

5.11. A Practice Nurse completed the advised check of Kieran's physical health on 11th January 2018. Nothing abnormal was detected; although his liver function was abnormal, this was within acceptable limits. He is noted as being just within the obese category. **Commentary:** This is the first check on Kieran's physical health since August 2016 when detailed exploration of the case chronology begins. Given the concerns about Kieran's self-care, including diet, more routine observation might have been beneficial.

5.12. On 17th January the Care Coordinator requested a fire safety check and a joint visit was conducted with Dorset and Wiltshire Fire and Rescue Service on 29th January. The combined chronology records that the visit was within the prescribed timeframe for responses to referrals. On the clutter rating index, hoarding had not yet reached level 6, which would have triggered another adult safeguarding referral. Significantly high risks were recorded regarding electrical equipment and the cooker. Fire detectors were fitted, which reduced the risk to medium. **Commentary:** This is an example of good *inter-agency cooperation*. However, no contact was made with Kieran's relative who owned the property, again missing an opportunity for *family involvement*. Although the level of hoarding had not yet reached the level where Dorset and Wiltshire Fire and Rescue Service would have referred an adult safeguarding concern, this visit acts as a reminder to all services both to see the situation holistically and also to refer adult safeguarding concerns even when another agency is actively involved.

5.13. From January 2018 the combined case chronology consistently records what appear to have been monthly repeat prescriptions, the last such entry being in November 2018. The chronology also records that in January AWP requested the GP surgery to arrange a review of Kieran's compliance with medication and administration of a cholesterol test on account of concern about his diet and ability to self-care. Kieran did not attend the appointment for the test and there is no evidence that these requests were followed up. The evidence-base is clear that good practice includes *thorough health care assessments, plans and reviews*. **Recommendation Five:** SSP to request from the CCG clarification of best practice in relation to the monitoring of repeat prescriptions when patients have both mental health and physical health needs.

5.14. In February 2018 MMT paid for a replacement boiler. In the same month AWP sought advice from a Learning Disability Team regarding Kieran and self-neglect. This was followed up in March since no response had been received. It appears that a Care Coordinator finally met with members of that team in May. It appears to have been concluded that Kieran did not meet the threshold for involvement from that team. An entry on the SAR referral records the possibility that Kieran might have been on the autistic spectrum but a GP referral, with Kieran's consent, would be necessary to establish this through an assessment.

5.15. **Commentary:** More timely *inter-agency collaboration* would have been appropriate. An assumption also appears evident, namely that Kieran had decisional capacity with respect to any referral. The referral to explore whether Kieran was on the autistic spectrum does not appear to have been pursued, which was a missed opportunity. No *mental capacity assessment* appears to have been conducted with respect to the decision about assessment by the Learning Disability

[19] Data Protection Act 2018.
[20] Human Rights Act 1998.

and Autistic Spectrum Disorder Team or, for that matter, any other decision. **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[21]. This recommendation could be taken forward by SSP's practice review group.

5.16. The care and support package following the assessment is listed as having been agreed in February at 2 hours per week. The first agency commissioned to provide the care and support package did not commence as planned in March. A second agency was commissioned and their first visit was done jointly with a Care Coordinator. Prior to the care package commencing, a financial assessment was completed to determine what contribution Kieran would have to make. There was liaison with MMT at this point.

5.17. **Commentary:** The initial plan was for the care agency to visit for 30 minutes fortnightly, gradually building up to 2 hours weekly, with the aim of addressing Kieran's self-neglect and hoarding. In May, following a review, the frequency of visits was recommended to be increased to 30 minutes weekly. Kieran declined but the weekly visits commenced, only for Kieran to cancel every other week. The Care Coordinator was informed of this pattern but no action has been reported as a consequence. Moreover, the Care Agency has reported that their staff were only allowed by Kieran into the kitchen. This reluctance to engage may have been explored but it is not apparent from the documentation submitted to the review. Equally, there is no evidence to suggest that it was seen as a risk requiring review by the practitioners involved.

5.18. **Commentary:** Whilst it is clear from research on self-neglect that it is important to establish a *relationship of continuity and trust*, and whilst there is evidence that those involved recognised that relationships between Kieran and the care staff would be key, it is difficult to see how the frequency and length of visits was designed to do this and to address Kieran's self-neglect and hoarding. It is also unclear whether the decision to increase the frequency of visits was taken in his best interests, which assumes that Kieran was assessed as not having the capacity to decide on the nature of the care and support package to meet his needs. It is also unclear what contingency plan was envisaged, if any, to address the risks arising from his self-neglect and hoarding, and from his difficulty in meeting his needs associated with activities of daily living.

5.19. On 28th May Kieran fell whilst visiting Reading but did not sustain any significant injury. In the same month it is reported[22] that Kieran was not reacting well to attempts to declutter his home. **Commentary:** This observation does not appear to have prompted a *multi-agency meeting* to review of the approach to the case.

5.20. Also in May metre readings were sent to MMT. The following month DWP confirmed that Kieran was paid an enhanced level of Personal Independence Payment. There were large sums of money in the house, which Kieran did not want to be handed over to MMT. The Care Coordinator discussed financial concerns with MMT, including arrangements for paying for the TV licence. **Commentary:** A lack of understanding regarding the management of Kieran's financial affairs appears evident, namely who was responsible for paying for bills[23]. In addition, since MMT held Appointeeship, it had been confirmed that Kieran did not have capacity to manage his own financial affairs. That *mental capacity assessment* does not appear to have been

[21] This repeats a recommendation within the SAR completed for SSP of the case of Terry.
[22] AWP Serious Incident investigation and report.
[23] AWP Serious Incident investigation and report.

reviewed when Kieran declined to hand over the large amount of money in the home; no best interest decision was taken at this point.

5.21. In July there was another change of Care Coordinator. **Commentary:** The evidence-base emphasises the importance of *continuity* in order to establish a relationship of trust.

5.22. Also in July Kieran was the victim of financial abuse. Money was stolen from his home by two women described as sex workers whom Kieran appears to have encountered when out. WPS investigated but concluded that the evidential threshold was not met, so no prosecution resulted. WPS informed the Care Coordinator, spoke to Kieran's neighbours and referred an adult safeguarding concern to SBC ASC. Kieran continued to resist any change to financial arrangements.

5.23. **Commentary:** No *mental capacity assessment* was conducted as a result of the financial abuse that Kieran had experienced and his ongoing refusal to change how he managed money at home. The *safeguarding referral* by WPS was good practice. Once again, however, the referral did not lead to an enquiry under Section 42(2) Care Act. Rather, action was deemed appropriate under care management from AWP but, as the SBC ASC entry on the combined chronology observes, what follow-up by the Care Coordinator was being advised by the Enquiry Manager was not specified. The SBC ASC entry is appropriately critically reflective. No feedback was given to WPS as the referring service. There is no evidence that the Council met its Section 42 duty. Section 42(2) should have been triggered or, at the very least, information gathered prior to any final decision. Thus, this was a highly questionable decision given the criteria for adult safeguarding enquiries outlined in Section 42(1) and the recurring concerns about self-neglect and risk of exploitation, which were rated amber in the adult safeguarding files. Indeed it is recorded in the files that the referral was "inappropriate". **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[24]. This recommendation could be taken forward by SSP's practice review group.

5.24. In August it is recorded that Care Agency staff were working well with Kieran. He was still resisting changes to management of his financial affairs. There were some joint visits involving the Care Coordinator and Carers employed by the Care Agency. The Care Agency and Care Coordinator *reviewed* the care and support package and determined to leave the arrangement as 30 minutes weekly. This review appears to have included a new *risk assessment*. Risk to self was assessed as medium. Kieran had no insight into his mental health and poor self-care. Risk from others was also assessed as medium, not least because of his recent experience of financial abuse. The risk of *non-engagement* was assessed as high, given Kieran's history of not attending appointments, his dislike of regular visits and his reluctance or refusal to engage. Indeed, that same month Kieran did not attend for his pneumonia vaccination. The plan appears to have been to continue to build rapport and to keep the kitchen clean.

5.25. **Commentary:** It remains difficult to see how the plan would mitigate the risks that had been clearly identified. That includes the ongoing fire risk as a result of hoarding and the condition of the home in which Kieran was living. His non-attendance for a pneumonia vaccination does not appear to have been followed-up, raising concerns similar to those above relating to monitoring of repeat prescriptions[25].

[24] This repeats a recommendation in the SSP (2020) Safeguarding Adult Review: Terry.
[25] Section 5.13 and recommendation five.

5.26. In November attempts by the Care Coordinator to make contact with Kieran's private carer had proved unsuccessful so no joint plan, which had been intended as a result of the August risk assessment and care plan review, had proved possible. It appeared that the private carer was disinterested in working with the services involved to improve Kieran's wellbeing. A CPA *review* was completed. Kieran was still resisting health care checks and attempts to protect the money he kept at home and to improve the cleanliness of his living environment and his personal care. Apparently there were concerns about Kieran's physical health.

5.27. **Commentary:** Once again, given the concerns and the apparent lack of progress in mitigating the identified risk, the opportunity to convene a *multi-agency meeting* was missed.

5.28. In December 2018 MMT made contact with the private carer. He did not know who owned the property in which Kieran had been living. He disclosed that he had been involved for approximately twelve years. **Commentary:** An MMT entry in the combined chronology accepts that this conversation was a missed opportunity to review and formalise the arrangements with the private carer. Moreover, had a *multi-agency meeting* been held, MMT would have known that the Care Coordinator had been unsuccessful in making contact with the private carer and that there were concerns about what support the private carer was offering. In place of *collaboration and communication*, agencies were working in silos.

5.29. On 18th December Care Agency staff found Kieran complaining of feeling unwell. Kieran was seen at the GP surgery for abdominal pain and nausea. His haemoglobin was higher than normal. The following day bloods were taken at the GP Surgery, the results of which were normal apart from slightly raised cholesterol. Poor diet was considered. On 24th December Kieran cancelled the scheduled visit by Care Agency staff. Staff could not get him to answer his door on 1st January.

5.30. On 2nd January 2019 Care Agency staff made contact with Kieran by telephone. As Kieran did not sound well, the GP was contacted but would not make a home visit[26]. Kieran would not visit the GP Surgery but agreed to paramedics being called. The Care Coordinator was informed. SWAS conveyed Kieran to GWH NHSFT where he was initially diagnosed with appendicitis and admitted for surgery. Screening for sepsis and acute kidney injury was completed[27] but nothing abnormal was detected. A social history was taken and next of kin recorded. Available Hospital records noted that Kieran was oriented in time and place so no further action was taken to establish his ability to consent to treatment. Hospital notes have not recorded any safeguarding concerns.

5.31. **Commentary:** SWAS sent an adult at risk referral to SBC ASC on 8th January. This identified self-neglect and a need for increased care and support. There is a disconnection between the information contained in the SWAW referral and the handover of care when the Ambulance Crew transferred Kieran into the care of the Hospital. The clerking assessment on his arrival makes no mention of his unkempt and unwashed presentation. Moreover, once again, rather than gather further information and/or progress to an adult safeguarding enquiry under Section 42(2), the referred concern was forwarded to AWP. This is the third missed opportunity to formally address referred adult safeguarding concerns.

5.32. Investigations and tests by GWH NHSFT detected nothing abnormal so he was discharged once worsening advice had been given. The Care Agency was notified on the day of Kieran's

[26] Care Agency information supplied as part of consideration of the SAR referral.
[27] In line with NICE protocols.

*discharge*, 5th January. **Commentary:** Notification of discharge is good practice since it enabled the care and support package to recommence without delay.

5.33. Care Agency staff were unable to gain access to see Kieran on 8th, 15th and 22nd January. On the first of these unsuccessful, the Care Coordinator was also present. The Care Coordinator was informed of the unsuccessful calls on 15th and 22nd January. Kieran also missed an appointment at the GP surgery on 8th January. However, Kieran was seen together by the Care Coordinator and a Social Worker on 14th January. He agreed to an increase in the care and support plan. A *mental capacity assessment* was completed.

5.34. **Commentary:** Kieran apparently looked unwell during this visit but no action in response to this appears to have been taken. The mental capacity assessment appears to have focused on his welfare and safety at home. The outcome has not been recorded in the documentation available to the Independent Reviewer and it is unclear what the risk mitigation plan was. Apparently a mental capacity assessment regarding money management was planned.

5.35. The Care Coordinator was unsuccessful when making a home visit on 22nd January, having also been unsuccessful in making contact with the private carer who may have seen Kieran on 17th January. On 23rd January, as a result of failed attempts to see Kieran, WPS forced entry and found him deceased.

# 6. Analysis

6.1. The analysis in this Section is informed by contributions from those practitioners and managers who attended the learning events. It is also informed by contributions from Kieran's relatives. It is based around those components of the evidence-base that are most relevant to this case.

## 6.2. Direct Practice with Kieran

6.2.1. *Family Involvement*. None of the services and practitioners involved made contact with Kieran's relatives until after he had died. Even then there were delays in AWP making contact with family members as their contact details had not been recorded in the designated place on the system used. It appears that Kieran may not have wanted contact to have been made with his relatives[28]. 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[29]. As a result his support network was not well understood; neither was his history and his lived experience of his family. Practitioners working with Kieran told the Independent Reviewer that he never talked about his family; rather, his private carer appeared to be an important person for him. The balance to be struck between an individual's self-determination and autonomy, on the one side, and duty of care to safeguard on the other, is further discussed below.

6.2.2. Not all agencies appear to have had details of Kieran's next of kin and other family members[30]. Kieran's relatives have stated that they did not know about certain episodes, such as a chip pan fire on a gas hob in the kitchen that led to a four ring electric cooker being installed. They also told the Independent Reviewer that Kieran did not always let them into the house and was generally inclined not to reach out for help. The one exception had been an Uncle, with whom he had enjoyed a close relationship until he passed away in January 2015. His death impacted on Kieran. The Uncle had acted as a "father figure" and Kieran would follow instructions that he gave. It is unfortunate that the Uncle's death occurred at a time when statutory services were not working with Kieran. Loss, especially bereavement, is closely connected with self-neglect. The significance for Kieran of the death of a "significant other" was not recognised in terms of how events subsequently unfolded.

6.2.3. Highlighting lack of engagement with family members, the Independent Reviewer was told that contact had been made with the Council after the Uncle's death, clarifying next of kin details and ownership of the house in which Kieron was living. Relatives wondered why they were not contacted when Kieran was admitted to hospital in January 2019. It is clear that Kieran did not always welcome family members when they visited. Responding to Kieran's reluctance to engage and preference to rely on his private carer, they depended on the involvement of practitioners. It has been accepted that there was a lack of professional curiosity about Kieran's extended family network. When practitioners at the same time are also concerned about whether it would be justified, lawful and proportionate to qualify

[28] AWP Serious Incident investigation and report.

[29] Data Protection Act 2018.

[30] The Care Agency did not have contact details for family members. Care Coordinators do not appear to have had contact details other than for Kieran's Uncle who died before AWP resumed its involvement. When the Uncle's telephone number was eventually found by a Care Coordinator and dialled, that enabled contact with Kieran's relatives to be established.

Kieran's "right to private and family life[31]" and to seek information from, and share information with family members, a breakdown in communication results.

6.2.4. *Carers*. 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 private 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. Recommendation eight seeks to address this learning point.

6.2.5. At one of the learning events MMT clarified that a tighter process has been introduced regarding agreements with third parties who collect cash as part of an Appointeeship arrangement. MMT no longer accepts an ongoing situation without seeking to ensure that an individual's needs are being met. At another of the learning events practitioners reported that it had been very difficult to make contact with the private carer and he did not respond to notes left for him at Kieran's home. A practitioner had visited the setting where the private carer was reported as working but to no avail.

6.2.6. Family members have questioned what the private carer was authorise to do with the money he collected weekly on Kieran's behalf and whether anyone audited or checked what responsibilities he was taking on. They have asked what was known about Kieran paying the private carer an additional sum to do his laundry. They have clarified that Kieran found it difficult to cope after his Mother's death. He was placed in residential care for some time but strongly disliked it and absconded. The aim thereafter was for Kieran to live independently but in a fit-for-purpose home and with support. They believe the arrangement with the private carer originated at this time through mental health services. The carer was supposed to be providing help with shopping and cleaning. It is important to *understand a person's history*. None of this detail appears in any information provided by the services involved with this review.

6.2.7. The SBC ASC formal response to the family's stage two complaint accepts that further investigations should have been undertaken in order to understand what services the private carer was providing. Efforts were made by Care Coordinators to contact the private carer, including leaving letters with MMT and at Kieran's home but he did not respond. When the private carer did make contact prior to Christmas 2018, leaving a telephone number, there was no response again when the Care Coordinator attempted to make contact[32]. There was no review by AWP and/or MMT that established whether or not the private carer was willing and able to continue to offer support. These considerations should have been included in the CPA plan which, as AWP has acknowledged, was insufficiently robust.

[31] Article 8, European Convention on Human Rights.

[32] The Independent Reviewer understands that a Care Coordinator visited a location where the private carer was said to be employed but he was not there.

6.2.8. Other SARs[33] have emphasised the importance of professional curiosity and multi-agency coordination with respect to obtaining assurance that informal and unregistered carers are offering support. It is also important to recognise their needs by way of carer assessments.

6.2.9. **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[34].

6.2.10. **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.

6.2.11. *Making Safeguarding Personal*. At the learning events practitioners stated that they tried hard to work alongside Kieran and took their lead from him. There is evidence that his wishes were known and respected. They timed visits towards the end of the day as Kieran was known to sleep in of a morning. Those practitioners who worked with Kieran felt that they had built a rapport with him, which enabled them to gain access and also subsequently the care agency staff. They recognised that he needed a very 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. They felt that this approach achieved some success, enabling changes to be made, however small.

6.2.12. However, at the learning events it was also recognised that a balance had 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. Those working with him reflected that 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. They commented on the significant concern that Kieran had been heating his home from the gas cooker and that the electric hob was active when he was found deceased.

6.2.13. Since Kieran's death family members have asked the agencies involved to explain how they saw their duty of care. AWP in its review[35] found good practice in person-centred care planning that prioritised his choices regarding the care and support package. To avoid the immediate risk of dis-engagement, there was an emphasis on developing rapport to overcome his wariness, with a priority on his immediate health and safety. However, the AWP review also found that there was no *care plan* to address the adult safeguarding concerns highlighted by WPS in July 2018, the focus being solely on what Kieran would agree to do with his money. *Risk management and contingency plans* were not up-to-date and were not revised after key episodes, such as his Hospital admission in January 2019. The

[33] For example, Salford Community Safety Partnership and Salford Safeguarding Adults Board (no date) *Learning Review – Mary*.

[34] This recommendation and the following one repeat what has been recommended in another SSP SAR (2020), namely the case of Terry.

[35] AWP Serious Incident investigation and report.

roles of different services and practitioners, in addition to a neighbour and the private carer, were not clarified, including for emergency response.

6.2.14. The SBC ASC response to the family's stage 2 complaint observes that Kieran did not want to change the chair he used, despite the fact that its condition had significantly deteriorated. He did not wish his relatives to be contacted when he was admitted to Hospital. He did not agree to a key safe being installed. These are all examples where his wishes were known and respected. What is much less clear is what consideration, if any, was given to the need to balance his wishes against mitigating risks of abuse and neglect, including self-neglect. What is also unclear is whether Kieran had the required mental capacity for each of these decisions.

6.2.15. It is possible to conclude that the fear of loss of contact with Kieran and the risk of his non-engagement resulted in services treading warily and leaving needs unmet and risks unaddressed. Making Safeguarding Personal must include professional curiosity and authoritative questioning alongside establishing a person's wishes and feelings, with careful consideration of the balance to be struck between self-determination and duty of care. Guidance is available[36] that is designed to ensure a rounded understanding and implementation of Making Safeguarding Personal. **Recommendation Ten:** SSP seeks assurance that Making Safeguarding Personal is accurately understood and that understanding embedded in practice across partner agencies.

6.2.16. *Mental Capacity Assessment*. The view clearly expressed by Kieran's relatives is that he did not have mental capacity with respect to managing his money and bills, or making decisions about his health and wellbeing. He did not, they believe, understand the importance of a good nutritional intake. They believe that his mental capacity should have been kept under constant review.

6.2.17. Practitioners who attended the learning events acknowledged that achieving best practice with respect to mental capacity assessments remains a challenge. Sometimes it is difficult to reach a definitive yes/no conclusion, in which case it would be helpful to have a forum in which complex cases could be discussed. Practitioners reflected that there were missed opportunities to develop a greater understanding of his executive functioning and whether he could use or weigh what they were saying to him. One example given, that might have shed light on his mental capacity, was that he could not envisage or think through what would happen if his private carer was no longer able to visit. A further assessment of his mental capacity with respect to his living arrangements and care needs had been planned but he died before this work could be completed.

6.2.18. AWP in its review of this case acknowledges that 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, AWP's Serious Incident investigation and report concludes that earlier assessment would not have compromised this principle. Earlier assessment 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. As a result of the root cause analysis, AWP includes a review of capacity assessment and decision-making, including

[36] Cooper, A. (2019) *'Myths and Realities' about Making Safeguarding Personal*. LGA/ADASS.

plans and recording, in its recommendations for the Trust. The Independent Reviewer understands that the AWP improvement plan, which is in place, has actioned this recommendation. **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.

6.2.19. As the chronology and commentary in this report have already noted, there were missed opportunities to assess Kieran's capacity from the point when concerns were first evident about his personal care and safety. There was, for example, no mental capacity assessment in December 2017 when a care and support assessment was completed and concerns were highlighted about his understanding of his situation and his ability to self-care. The assessment of his capacity to manage his financial affairs should have followed the occasion when he was financially abused and there was concern about the amount of money Kieran was keeping in the house.

6.2.20. NICE guidance also advises that consideration of mental capacity should include assessment of executive capacity. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[37], with a subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their wellbeing. It focuses on the person's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity). Recommendation six above is designed to ensure that this aspect of mental capacity assessment is addressed.

6.2.21. From before the timeframe under review here 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 monitored also by AWP. Family members have pinpointed non-payment of TV licence, home insurance and other bills, resulting in the involvement of bailiffs and court proceedings. They have questioned who was responsible for welfare checks regarding his financial wellbeing and for ensuring that bills were paid.

6.2.22. The SBC ASC response to the family's stage 2 complaint acknowledges several shortcomings regarding how SBC MMT, in conjunction with AWP, managed Kieran's finances. Ownership of the property was not clarified, there is no record of contact with the owner regarding the condition of the property, and Kieran should not have been regarded as responsible for paying for the replacement boiler as he was essentially the tenant. Repair and renovation work should have been agreed with the owner of the property. Thus MMT should not have approved the change of boiler as Kieran did not own the property.

6.2.23. When SBC changed its corporate banking arrangements, some direct debits were not transferred, including those pertaining to Kieran's case. This resulted in home and contents insurance not being renewed and debts accruing with respect to TV licence and water rates. This was not identified by staff in MMT and was not raised by any Care Coordinator, perhaps because Kieran's post was not checked. Family members have told the Independent Reviewer that Kieran did not open his post. Kieran's escalating electricity costs were identified and raised as a concern by AWP, due to him using the electric cooker to heat his

[37] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

home, but the concern was not satisfactorily addressed. Kieran would not use some of the radiators in the house because of his record collection being stacked against them. This, once more, raises the issue of his mental capacity. The shower being inoperative[38] was identified in a CPA review in December 2018 and an estimate for repair was to be requested. This does not appear to have been done prior to Kieran's death. This report recognises that oversight of appointed sub-contractors is also essential and made clear who has responsibility for this.

6.2.24. This report has already itemised the changes that MMT has made to its procedures and the analysis by AWP that concluded that Mental Health practitioners did not know that MMT did not incorporate support regarding financial matters[39]. AWP had discharged Kieran in 2012 without a multi-agency discussion that should have included oversight and management of his financial affairs. Owing to misunderstandings between MMT and AWP regarding the functions of the former, the outcome was a lack of oversight of Kieran's financial needs and arrangements, even after his experience of financial abuse in July 2018 and despite liaison between the two services. The AWP Serious Incident investigation and report also acknowledges the need for improved CPA practice to ensure that the responsibilities of Care Coordinators include oversight of the person's financial affairs. The conclusion from this SAR analysis would suggest, additionally, that Care Coordinators must be clearer on next steps when a person does not have capacity to manage their financial affairs but is resisting suggestions about what is in their best interests with respect to money that they are holding.

6.2.25. Recommendation nine above seeks to ensure that SSP receives assurance regarding the outcome of these MMT practice and procedural changes. The Independent Reviewer understands that MMT involvement is now flagged on ASC records and that multi-disciplinary team meetings are now being convened where there are concerns. **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 partners, that there are clear plans and annual reviews of service users' financial affairs where these are being administered by MMT.

6.2.26. *Assessment, care planning and reviews*. Kieran's relatives have described the condition in which they found the home after he had died. They have described finding "heart breaking" debris and filth, including a blocked toilet, squalor and faeces, water infiltrating a bedroom wall, black spores on the windows, an inoperative shower, leaking taps and unclean work surfaces. His bed was black and filthy. There were bare wires. The arm chair he used had springs coming through. The kitchen sink was leaking. Rubbish was piled up and rooms were not easily accessible. They have described the house as "uninhabitable." Given that context, they have asked what the care plan was and what the outcomes were of care reviews.

6.2.27. The AWP Serious Incident investigation and report pinpoints delays in assessing Kieran's mental capacity regarding his personal care and safety that resulted in less than timely interventions. There was a significant delay in assessing Kieran's care and support needs[40], explained as due to the first Care Coordinator not having a social work/social care

[38] The shower was cut-off by contractors when fitting the boiler
[39] Sections 1.5, 5.20 and 6.2.4.
[40] Section 9 Care Act 2014.

background, and an initial focus on his mental health when AWP reopened his case. He was assessed as having eligible needs but there was a delay in commencement of the care package, initially because of Kieran's reluctance to engage with the plan and subsequently because of difficulties in commissioning a Care Agency. Given what is known of Kieran's eligible needs, it is difficult to conceive of how the care and support package was designed to address them, in particular his self-neglect and hoarding, even allowing for the importance of building up a relationship of trust.

6.2.28. Although there were reviews of the care and support package, as itemised in the earlier chronology, these did not result in any fundamental shift in approach. This is perhaps surprising given the level of self-neglect that must have been apparent at the time and the repetitive pattern of Kieran cancelling or not responding to scheduled visits.

6.2.29. Practitioners attending the learning events, mirroring the findings of the AWP Serious Incident Investigation, reported that during the early phase of the time period under review, there had been a lack of familiarity with Care Act 2014 care and support assessments. This had been rectified with the co-location of Social Workers with AWP, such that Recovery Workers are now more familiar with Section 9 care Act 2014 assessments. Nonetheless, they also observed that Kieran had limited functional skills, especially regarding his ability to maintain an adequate diet. They recognised that this was not sufficiently picked up, for example when Kieran had contact with medical and healthcare staff.

6.2.30. When an adult is experiencing or likely to experience abuse and/or neglect, assessment and management of risk are fundamental to best practice. The risk of fire was addressed by the involvement of Dorset and Wiltshire Fire and Rescue Service. However, it is difficult to see how the risks arising from self-neglect and hoarding, and from financial abuse or exploitation, were mitigated by care and support planning. 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. Nonetheless AWP concluded that crisis and contingency planning was not robust. Planning was insufficiently detailed and was not circulated to all agencies involved. Moreover, the approach taken actually, including the omission to consider next steps when he declined to engage and/or resisted suggestions in his best interests, left Kieran in a situation of what appears to have been considerable self-neglect.

6.2.31. The response to the family's stage 2 complaint by SBC ASC observes that Kieran would only permit limited cleaning and that staff did not identified the extent to which the home had fallen into disrepair. 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. Practitioners at the learning events also reflected that Kieran would only allow carer staff to tidy the kitchen area. He had a profound attachment to his home and had apparently been told by his mother never to give it up.

6.2.32. Practitioners at the learning events reflected on the interplay between, and the balance to be struck between Making Safeguarding Personal and the impact of an individual when intervention to respond to risk is enforced rather than negotiated. Practitioners felt that further clarity would be helpful regarding how to navigate this ethical dilemma, namely when intervening to prevent the likelihood of serious risk has to be balanced against an

individual's stated wishes. **Recommendation Fourteen:** SSP should review the guidance provided across partner agencies regarding risk assessment and risk management[41].

6.2.33. When family members were faced with the task of clearing Kieran's home after his death, they found unused medication. They have questioned whether medical/health reviews were done and who was supposed to oversee that Kieran kept such appointments.

6.2.34. Other SARs[42] have highlighted the importance of clear processes when adults at risk of abuse and neglect, including self-neglect, do not keep scheduled appointments. That said, practitioners at the learning events were clear that Kieran's mental health was stable and that he was compliant with respect to taking medication. Some formal reviews of his medication had also occurred.

6.2.35. Of concern to practitioners attending the learning events was the lack of clarity regarding whether Kieran was on the autistic spectrum. The Independent Reviewer was told that the waiting list for an autism diagnostic assessment was around one year. Practitioners felt that they had insufficient screening skills in this area and that more autism awareness training was needed. Other SARs[43] have also identified gaps in practitioners' awareness of autism and in specialist provision for assessment and support for people on the spectrum.

6.2.36. For a person with Kieran's comorbidities, in other words co-existing mental health and physical health concerns, an individualised plan is best practice, supported by record systems that flag up missed appointments with respect to "vulnerable" adults at risk. **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 the local autism strategy, with particular reference to the commissioning of training, and assessment and service provision.

### 6.3. Team around the Person

6.3.1. *Inter-agency collaboration*. The earlier combined chronology itemises occasions when there were joint visits and liaison between different practitioners and services involved. For example, around May 2018 the then Care Coordinator liaised with other agencies. There were other occasions when, arguably, communication and collaboration between different services could have been enhanced. For example, GWH NHSFT did not refer Kieran to AWP's Mental Health Liaison Team when he had been admitted in January 2019, possibly because mental health was not the primary reasons for his admission. Nor is it clear whether the Hospital referred Kieran for a review of his care and support package prior to his discharge. Another example, as the review has already observed, was the lack of clear links between MMT, other Council services and health/mental health providers at the time. This could be extended to include DWP also. A third example is that AWP was not aware of Kieran's Hospital admission.

6.3.2. Practitioners who attended the learning events were clear that closer communication between services was needed as a matter of routine, including ensuring that all services involved were present at case reviews. They were clear that complex and challenging cases

[41] This repeats a recommendation in SSP's SAR (2020) on the case of Terry.
[42] For example, Lambeth Safeguarding Adults Board (2019) *Mr E*.
[43] For example, Milton Keynes Safeguarding Adults Board (2019) *Adult B*.

required a uniform and agreed response, where services work closely together and where all views are valued and listened to. In this case that had not been apparent. Holding planning meetings as standard practice was suggested, together with the circulation of case summaries to highlight the key concerns that needed to be addressed.

6.3.3. As the AWP Serious Incident investigation and report highlights, intra-organisational communication and collaboration may also need attention in an integrated service model. Thus, at the time of this case, when a Care Coordinator's background is psychiatric healthcare, collaboration with staff with social work and social care knowledge and expertise will be essential to ensure that the needs of the whole person are identified and responded to. This has been recognised by AWP in the recommendations contained in its root cause analysis with respect to Social Work involvement in each of its teams. The Independent Reviewer understands that work is underway to ensure that practitioners from a health care background are familiar with responsibilities under the Care Act 2014 and that Social Workers integrated in mental health teams have the requisite knowledge to offer a holistic service.

6.3.4. *Information-Sharing*. There were examples of good practice regarding the sharing of information, for example by WPS in their investigation of Kieran's experience of financial exploitation/abuse, and between AWP and the Care Agency. However, not all the agencies involved knew how to contact Kieran's next of kin. SWAS did not have these details and so could not inform Kieran's relatives that he had been transported to Hospital. As the chronology recorded, there was also a mismatch between information held by SWAS and that recorded by GWH NHSFT when Kieran arrived at the Emergency Department regarding self-neglect and his care and support needs. There were also delays in information-sharing. It appears that the GP Surgery only received the Hospital discharge summary on 8th April 2019. The chronology contains an entry that suggests that this is not an uncommon situation. **Recommendation Seventeen:** SSP seeks assurance regarding the timeliness of Hospital discharge summaries.

6.3.5. *Multi-Agency meetings*. As has already been observed, 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. The Independent Reviewer understands that a meeting was planned between a Mental Health Services Service Manager, MMT and the Care Coordinator to review concerns and legal options, such as Deputyship, to increase the support available to Kieran. Sadly, Kieran died before this meeting could take place.

6.3.6. Those attending the learning events were clear that multi-agency meetings had been the exception rather than the norm. They recognised their usefulness, for example in agreeing lead agency and key worker. They recognised the value of the Risk Enablement Panel as a forum where complex and challenging cases could be discussed but that forum was not used in Kieran's case. Doubts were also expressed as to whether the Risk Enablement Panels terms of reference were sufficient broad to include complex cases involving both people with and without mental capacity. They suggested that all agencies should be able to convene multi-agency meetings and that the responsibility should not rest with Adult Safeguarding alone. Finally, the Independent Reviewer was told that AWP has instigated multi-agency meetings to consider cases involving high risk but not all practitioners across primary as well as secondary healthcare would necessarily attend.

6.3.7. The impression conveyed was that organisational and multi-agency culture had yet to embed and normalise the use of multi-agency meetings and case conferences. Similarly,

some uncertainty was conveyed 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. **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.

6.3.8. *Safeguarding literacy*. Concerns about the response to the three adult safeguarding referrals were explored in the earlier chronology and commentary. In relation to Kieran's Hospital admission, there seems to be some contradictory information. It has been suggested in the combined chronology that Kieran had not eaten since before Christmas but Hospital tests found no evidence of deranged bloods or that he had been without hydration and nutrition for that length of time. Hospital discharge notes also indicate that he had been drinking and eating whilst in the Hospital. Combined with how he presented on arrival at the Emergency Department might have indicated the need for further safeguarding follow-through.

6.3.9. The response to the family from SBC ASC regarding their stage two complaints contains an acknowledgement that a Section 42(2) adult safeguarding enquiry should have been opened in response to the first referral that was received. That acknowledgement supports the critique of the adult safeguarding responses to this case contained earlier in this SAR.

6.3.10. Practitioners at the learning events reflected that they could have challenged the outcomes of referred adult safeguarding concerns and that the decision not to progress to a Section 42(2) enquiry had influenced how they had approached the case subsequently. They also noted that a meeting had been planned to consider whether there were legal powers available to assist with taking the case forward, including application for Deputyship, but Kieran died before this meeting could take place.

6.3.11. *Recording*. Reference has just been made to the disparity in recording by SWAS and GWH NHSFT regarding Kieran's presentation on 2nd January 2019. The combined chronology indicates that SBC ASC had no record of the SWAS referred adult safeguarding concern. GWH NHSFT has not been able to locate records once Kieran was transferred onto the wards from the Emergency Department. The Hospital is, therefore, unable to confirm whether or not Kieran was referred for (re)assessment of care and support needs prior to discharge. As a consequence also, there is a lack of detailed information regarding mental capacity assessment, consideration of any mental health needs, and steps taken to assess and respond to his support needs.

6.3.12. GWH NHSFT has investigated the issue of the missing records. A record exists that documents that the records were sent from the hospital ward to the Health Records Department. However, at the time there was no system, it appears, for logging incoming paper records to evidence receipt. Such a system is now in place. The report of the investigation has also recommended that the hospital ward has a facility to record electronically the movement of paper records and that the Hospital Trust moves to a paperless system of recording.

6.3.13. The AWP Serious Incident investigation and report observes that interventions designed to address Kieran's needs had not been recorded in a care plan. Such an omission is particularly regrettable when there are case handovers between staff, as in this case with four Care Coordinators having been involved since AWP reopened Kieran's case.

6.3.14. AWP has found no specific reference in electronic records to a kitchen fire but there are frequent references to fire hazards in the recorded notes. Similarly, nothing has been found in the electronic records regarding rubbish and drug paraphernalia outside the house, including in a garage. This was, however, mentioned to the Independent Reviewer by Kieran's relatives.

6.3.15. The SBC ASC response to the stage 2 complaint submitted by Kieran's relatives includes several acknowledgements regarding the shortfalls in recording practice. There appears to be no record of why Kieran's cooker, when replaced, was electric rather than gas, or of private arrangements regarding the carer's involvement with respect to Kieran's laundry. There is no record of any water leak, nor of any damage to locks other than WPS needing to force entry on the day that Kieran was found deceased. There are no references in AWP's electronic records to Kieran's home having been cuckooed although relatives believe that, on at least one occasion, WPS involvement had been necessary to remove people who had taken over his home[44].

6.3.16. Practitioners at the learning events observed that it had been difficult to understand from the records who his relatives were.

6.3.17. Recording is an essential component of best practice. **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.

## 6.4. Organisations around the Team

6.4.1. *Supervision and staff support*. At the learning events practitioners noted that supervision is very individual. Thus, even when supervision is of good quality, another forum is needed whereby all the practitioners can come together to agree the approach to cases involving significant risks. This observation connects to another point made at the learning events, namely how managers oversee such cases. That said, the AWP serious Incident report observes that its staff reported feeling well supported by managers and colleagues. It notes, however, that there had not been a formal debriefing regarding this case. Nonetheless, the Independent Reviewer understands that debriefing has been provided by a Psychologist and that this is now a standard offer when serious incidents occur.

6.4.2. It is good practice to ensure that there are opportunities for staff to debrief and reflect after a service user's death. For those involved the outcome of this case was distressing. At the learning events practitioners described how harrowing it had been to find Kieran deceased. It is good practice to make space for staff to grieve. There is an organisational responsibility here. Practitioners told the Independent Reviewer that support from managers had been good, with psychological support offered. What had been difficult, however, was the impact on those involved of the length of time between Kieran's death and, first, the Serious Incident Investigation and then the SAR process. **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.

[44] AWP's electronic records date back to 2011/12. There are earlier paper records that may contain further details.

6.4.3. *Policies and procedures*. None of the documentation submitted for this review indicates use of self-neglect procedures. The Independent Reviewer is aware that SSP is reviewing self-neglect policy and procedures. The AWP Serious Incident investigation and report acknowledges that a "no response" policy was followed on 22nd January, although a more robust crisis plan would have perhaps prompted an earlier response to difficulties in making contact with Kieran. That report suggests that a welfare check before that on 23rd January by WPS would have been appropriate.

6.4.4. One key feature of safer practice is a culture where organisations around the team encourage escalation of concerns in order to ensure that risks are addressed and shared plans formulated. The AWP Serious Incident report recognises this when recommending that all its teams have a clear plan for escalation when a person's engagement raises concerns and other providers are involved. The Independent Reviewer is also aware that SSP is reviewing escalation procedures.

6.4.5. *Access to specialist advice*. AWP has already addressed in changes to team structures how social work knowledge and expertise is made available to Care Coordinators whose knowledge and expertise is health-based. Reference has also been made to the Risk Enablement Panel and the advice its members could offer regarding complex and challenging cases where the balance between autonomy and a duty of care and protection may be difficult to strike. The accessibility of mental health and mental capacity specialists is worth revisiting. Finally, practitioners at the learning events expressed some uncertainty as to how they could respond to complex cases drawing on available legal powers. It was noted that SBC employees can, with Service Manager agreement, access legal advice. The Independent Reviewer understands that the same facility is not available within AWP.

6.4.6. *Training*. Practitioners at the learning events emphasised that cases of self-neglect were challenging and further training would be helpful.

## 7. Revisiting the Terms of Reference

7.1. SBC ASC has apologised for the initial lack of response to concerns raised by Kieran's relatives and for the manner of response to their questions, which resulted in a stage 2 complaint. A full apology has been given. SBC has offered to write off debts that accrued against Kieran's account as a result of the failure to identify the lapse in direct debits and some monies will also be repaid to his estate. Management oversight of MMT is being strengthened. AWP through its Serious Incident report has also acknowledged practice shortcomings in this case.

7.2. Other SARs[45] have also highlighted that family relatives can become understandably frustrated and annoyed by delayed responses to their complaints and the tone within them. The Independent Reviewer believes that the formal response from SBC and the investigation by AWP are candid and reflective, accepting responsibility for shortcomings in practice and in the responses to legitimate questions asked by Kieran's relatives.

7.3. Some of the findings in this SAR parallel what other SSP commissioned reviews have reported. An earlier SAR published by SSP[46] found that there was no coherent assessment of mental capacity and the factors influencing an individual's decision-making in that case. Safeguarding referrals were closed because the lens through which the case was seen was one of lifestyle choice and carer stress. That SAR also found that there had been pressure on adult safeguarding systems. Another SAR[47] found repetitive concerns regarding private carers and raised concerns about the response to self-neglect and safeguarding concerns, lack of professional curiosity and family involvement.

7.4. These concerns and findings, the lessons to be learned, are not unique to Swindon. There are clear parallels with what has emerged from the first national analysis of SARs[48]. The review group and the Independent Reviewer believe that there is valuable learning for SSP and its partner agencies from SARs that have been conducted locally, regionally and nationally. These SARs can be used to shine a light on policies, systems and practices locally. They can be used to inform an analysis of the degree to which findings in this particular SAR are unique to the case or emblematic of more deep-rooted systemic issues, which present obstacles to achieving best practice. **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[49].

7.5. This SAR has identified lessons to be learned in respect of each of the terms of reference. The approach to Making Safeguarding Personal, the lack of engagement with Kieran's relatives and with his private carer, and the absence of robust assessments, plans and reviews meant that Kieran's wellbeing, a key requirement in the Care Act 2014, was not enhanced. Acknowledging that there is a difficult balance to be struck between Kieran's self-determination and autonomy, and prevention and protection from abuse and neglect, including self-neglect, a more robust approach to adult safeguarding should have included detailed investigations or enquiries, multi-agency meetings, risk management plans and contingency planning, coupled with explicit

[45] For example, Preston-Shoot, M. (2018) *Safeguarding Adult Review – Howard*. Isle of Wight SAB.
[46] Swindon SAB (2017) *Report of Learning Together Safeguarding Adults Review: HS (Honor)*.
[47] SSP (2020) *Safeguarding Adult Review – Terry*.
[48] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *First National SAR Analysis April 2017 – March 2019. Findings for Sector-Led Improvement*. London: LGA/ADASS.
[49] The same recommendation appears to SSP's SAR (2020) on the case of Terry.

consideration of legal options if it proved difficult to mitigate significant risks. Supervision and management oversight should have ensured that policies and procedures were followed, including strict adherence to CPA guidance[50]. There are clear systemic lessons to be learned.

7.6. Nonetheless, it is important to acknowledge that work has already begun to embed learning from this case. Training has been offered across teams on Appointeeship and Deputyship following a collation of cases involving MMT and AWP. Learning from this case has been used to review concerns in similar cases, and further work is planned on caseloads and well underway on the interface between SBC ASC, MMT and AWP. In particular, work is underway on strengthening the strategic and operational relationship between SBC and AWP. It includes the development of a memorandum of understanding, agreement on performance reporting, regular meetings of service managers and service leads, the creation of new roles and the strengthening of the social work presence in the integrated mental health service.

7.7. Practitioners at the learning events observed that there are now interface meetings involving AWP and Adult Safeguarding in SBC for the purpose of case discussion, escalation of concerns and challenge. They indicated that there is greater familiarity with escalation protocols and robust liaison now with MMT, including the updating of care plans.

7.8. **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.

[50] AWP Serious Incident investigation and report.

# 8. 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 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 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 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.

## Glossary

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| ADASS | Association of Directors of Adult Social Services |
| ASC | Adult Social Care |
| AWP | Avon and Wiltshire Mental Health Partnership NHS Trust |
| CPA | Care Programme Approach |
| DWP | Department of Work and Pensions |
| GP | General Practitioner |
| GWH NHSFT | Great Western Hospital NHS Foundation Trust |
| LGA | Local Government Association |
| MMT | Money Management Team |
| PCLS | Primary Care Liaison Service |
| SAB | Safeguarding Adults Board |
| SAR | Safeguarding Adult Review |
| SBC | Swindon Borough Council |
| SSP | Swindon Safeguarding Partnership |
| SWAS | South West Ambulance Service |