Ken – the Executive Summary of a Safeguarding Adults Review (SAR).

Cornwall and the Isles of Scillly Safeguarding Adults' Board commissioned this review during 2019. Ken had a severe learning disability, diabetes and was morbidly obese when he died in 2016. He was 60. He had lived in a cluttered bedroom in a home he shared with a sibling who had support needs arising from mental health challenges. It was Ken's hospitalisation which resulted from a fall and a delay in securing assistance that occasioned a safeguarding alert. Three years before Ken's death it was known by services that his "situation could easily become a crisis." Ken was known to adult social care, primary care, occupational therapy and the community learning disability team.

The review covers the period 2013-2016. The report was agreed by the Safeguarding Adults' Board in January 2021.

The review relied primarily on documentation. It considered: the principal events and service interventions; Ken's support and care planning; the adequacy of multi-agency/ professional interventions; the use of the Mental Capacity Act 2005; and the lessons identified.

The Learning Identified:

Although Ken's social worker invested in building a trusting relationship with Ken and his sibling, the social worker's retirement was a significant event. His joint visits to introduce new professionals were insufficiently persuasive in enabling a trusted professional to monitor the detection of new risks concerning Ken's health and his hazardous living circumstances.

Ken's confined and unstructured days narrowed over time. His sibling refused adaptations to the home, services and assessments. Although Ken's sibling did not register a Lasting Power of Attorney, their views prevailed without challenge. It is speculated that Ken did not have the mental capacity to refuse personal care and healthcare support and it appears possible that he was deprived of his liberty, albeit in his sibling's home.

If it was determined that Ken was refusing services, as opposed to his sibling, the options for intervention would begin with an assessment of his mental capacity. If this concluded that he lacked mental capacity to refuse personal care and the provision of community services such as day care, then the local authority could have applied to the Court of Protection.

An assertion that Ken "…*would self-neglect his personal care needs due to his lack of insight"* was not supported by a mental capacity assessment. It is not just the absence of any research attributing self-neglect to adults with learning disabilities, it is the fact that Ken had life-long, conspicuous and considerable support needs. Self-neglect hinges on a wide range of behaviour which includes neglecting to care for personal hygiene, health or surroundings, for example. If Ken's support needs were not addressed, then the most likely outcome would be death.

The Recommendations:

(a) Host a multi-agency learning event for the organisations which were involved in supporting Ken to consider the implications of this review for future practice.

(b) Since assumptions about the caregiving of Ken's sibling were taken at face value and took no account of the family history, practitioners should be encouraged to search out historical information across agencies.

(c) It is incumbent on professionals to understand each family's context, to determine who is the focus of professional intervention and what assessments, services and resources are most appropriate.

(d) Services provided by health and social care professionals may develop formulations such as "This person is self-neglecting and hoarding…" Such formulations should be open to challenge and the credibility of the evidence examined, most particularly when the person concerned has a severe learning disability.