OFFICIAL SENSITIVE

KENT AND MEDWAY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Beryl Simpson

Executive Summary

Author: Paul Pearce

Commissioned by: Kent and Medway Safeguarding Adults Board

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CONTENTS

Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

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EXECUTIVE SUMMARY

1. The Review Process

1.1 This summary outlines the process undertaken by the Safeguarding Adults Review Panel in reviewing the case of Beryl Simpson, who lived in Kent. Beryl was a white British woman aged 82 years at the time of her death.

1.2 This Safeguarding Adults Review (SAR) was commissioned by Kent and Medway Safeguarding Adults Board (KMSAB), following a referral made by the Community Safety Manager of Town A Borough Council.

1.3 A SAR is not an inquiry into how someone died or suffered injury, or to find out who is responsible. Its purpose is to:

- look at any lessons we can learn from the case about the way all local professionals and agencies worked together;
- review the effectiveness of safeguarding adults policy and protocols;
- inform and improve local safeguarding practice for all agencies involved; and
- deliver an overview report and recommendations for future action.

1.4 The key outcome of a SAR is to improve the safeguarding of adults in future. For this to happen as widely and thoroughly as possible, professionals need to be able to understand fully what happened and what needs to change.

2. Contributing Organisations

2.1 Each of the following organisations completed an IMR:

- Kent Police
- Kent County Council Adult Social Care & Health
- GP Practice 1
- Kent & Medway NHS and Social Care Partnership Trust
- Town A Borough Council
- Maidstone and Tunbridge Wells NHS Trust

3. Review Panel Members

3.1 The members of the SAR Panel were:

- Claire Axon-Peters, West Kent Clinical Commissioning Group
- Susie Harper, Kent Police

- Annie Ho, Kent Council County
- Paul Pearce, SAR Independent Chairman and Author
- Community Safety Manager[1], Town A Borough Council
- Cecelia Wigley, Kent and Medway NHS & Social Care Partnership Trust

4. Independent Chairman and Author

4.1 The Independent Chairman and author of this report is a retired senior police officer. He has enhanced experience and knowledge of safeguarding issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to safeguarding. He has been the Independent Chairman and author of Safeguarding Adults, Domestic Homicide and Serious Case Reviews. He has a background in conducting reviews and investigations, including those involving disciplinary matters.

4.2 The Independent Chairman has not worked in Kent, nor does he have association with any of the agencies represented on the SAR Panel.

5. Terms of Reference

These Terms of Reference were agreed by the Review Panel in advance of this SAR being conducted.

5.1 Background

5.1.1 Beryl Simpson, aged 82 years, lived with her daughter Margaret, aged 62 years, in a house that Beryl owned in Town A, Kent. On 6 December 2016, following concerns raised by Kent County Council Adult Social Care & Health (ASCH) about Beryl's welfare, officers from Kent Police used their power under Section 17 of the Police and Criminal Evidence Act 1984 to enter the house.

5.1.2 They found Beryl in a very poor state of health; she was emaciated and malnourished. Margaret was also present in the house, which was in poor repair. There was no working toilet, it was cold and there was evidence of long-term extreme hoarding. After Beryl's condition was stabilised by paramedics, she was taken to Hospital 1. Despite intensive treatment she failed to thrive and died in hospital on 15 December 2016.

5.1.3 A referral requesting a Safeguarding Adults Review (SAR) was submitted by Town A's Community Safety Manager to Kent and Medway Safeguarding Adults Board (KMSAB) on 23 February 2017.

[1] To protect the anonymity of the family, this individual has not been named as it would enable the identification of the Town A

5.1.4 On 7 March 2017, a KMSAB SAR Core Group met and decided that the case met the criteria for a review.

5.1.5 A SAR request had also been submitted in relation to Margaret Simpson and this was considered by the SAR Core Panel. It was decided that although Margaret did not meet the requirements for a SAR, the history and ongoing concerns about her would need to be investigated, and recommendations made.

5.1.6 On 12 April 2017, a SAR Panel, chaired by an Independent Chairman, met to begin the SAR. It was agreed that the priority in relation to Margaret's welfare was that agencies should work together to address the current and ongoing safeguarding concerns. It was not the purpose of the SAR to direct or manage that work and therefore the period reviewed by the SAR would end on the date of Beryl's death. However, the fact that Beryl and Margaret lived together, and agencies had significant contact with Margaret during the review period, there were lessons that could be learned from how they dealt with her. The SAR will therefore consider agencies' involvement with Margaret insofar as it was relevant to the safeguarding of Beryl.

5.2 Safeguarding Adults Reviews

5.2.1 KMSAB has published a document entitled Procedure For Safeguarding Adults Reviews. This SAR will be carried out in accordance with the procedure set out in that document. It is revised regularly; the version current at the time of this SAR is dated April 2017. It should be read in conjunction with these terms of reference, which are specific to this SAR.

5.3 The Purposes of the SAR

5.3.1 The purposes of this SAR are to:

i. Establish what lessons are to be learned from the death of Beryl Simpson in terms of the way in which professionals and organisations work individually and together to safeguard victims.

ii. Identify what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses for all adults who need safeguarding support through intra and inter-agency working.

iv. Prevent harm to and improve service responses for all adults who need safeguarding support, through improved intra and inter-agency working.

5.4 SAR Methodology

5.4.1 The Chairman of the SAR Panel will write the SAR Overview Report, which will be presented to KMSAB. It will be based on information gathered from agencies identified as having had contact with Beryl and/or Margaret in circumstances relevant to Beryl's safeguarding.

5.4.2 Information will be gathered by means of an Independent Management Report (IMR) submitted by each agency identified as having relevant contact with Beryl and/or Margaret. KMSAB has agreed a template for IMRs and these must be used.

5.4.3 The IMR will be researched and written by a person working for the agency submitting it. This person must have the appropriate skills and seniority to be able to research, analyse and question the actions taken by individuals in their organisation. They must not:

- have had direct involvement with Beryl or Margaret; or
- be an immediate line manager of any member of staff whose actions are, or may be, subject to review within the IMR.

5.4.4 Each IMR will include a chronology and analysis of the service provided by the agency submitting it during the period covered by the SAR. The IMR will highlight both good and poor practice, and if appropriate will make recommendations for the individual agency and/or multi-agency working. The IMR will include context relating to issues such as resourcing/workload/supervision/support and training/experience of the professionals involved.

5.4.5 Each agency must include the circumstances of their first recorded contact with Beryl or Margaret in the chronology of their IMR, regardless of the date. The chronology must include all information about contact with Beryl or Margaret between 1 January 2012 and 15 December 2016 (the period covered by this SAR).

5.4.6 Each agency's IMR must contain a comprehensive summary of all information that is relevant to the safeguarding of Beryl and/or Margaret during the period covered by the SAR. If the information is not relevant to safeguarding, a brief précis of it will be sufficient.

5.4.7 Any issues relevant to equality, for example disability, sexual orientation, culture and/or faith should also be considered by the IMR writer. If none are relevant, a statement to the effect that these have been considered must be included.

5.4.8 The completed IMR must meet the submission date agreed by the SAR Panel. Each agency must ensure that sufficient time is available for the IMR to be signed off by a senior manager in the organisation, including return to the author for any amendments or addition required.

5.4.9 Completed IMRs will be considered at a meeting of the SAR Panel. If members of the panel have queries arising an IMR, these will be sent to the IMR writer to be answered.

5.4.10 Following the IMRs being agreed by the SAR Panel, the Chairman will write a Draft Overview Report. The Chairman is independent of the agencies subject to the SAR and will use that independence to scrutinise the analysis and conclusions in the IMRs, adding rigour to it if required. Where necessary, the Chairman will seek or research further information to supplement the IMRs, to enable better supported independent conclusions about the lessons to be learned from the case.

5.4.11 The Overview Report will contain:

- Independent summary and analysis of the contact and involvement that each agency with had with Beryl and/or Margaret.
- Independent summary and analysis of the way agencies worked together to safeguard Beryl and Margaret.
- Conclusions about the way in which agencies acted, singly or together, to safeguard Beryl and Margaret, and whether their policies and procedures should be changed to ensure better safeguarding in future.
- Recommendations for action that should be taken to improve the safeguarding of adults, either by a single agency or by agencies working together.
- Lessons learned from the way in which agencies interacted with Beryl and Margaret, and how these can be applied to safeguarding adults in future.
- An action plan setting out how agencies will implement the recommendations, including: what action is needed, who will be accountable for completing it and the timescale in it will be completed.

5.4.12 The Overview Report will be considered at a further meeting of the SAR Panel, following which agreed changes will be made to the draft. The agreed version will be submitted to the Chair of KMSAB for consideration by the Board.

5.5 Specific Issues to be Addressed

5.5.1 The following issues will be examined in this SAR and considered in the Overview Report:

- What was each agency's involvement with Beryl and/or Margaret? What work was undertaken with each or both? Did that work adhere to intra and inter-agency policy and procedures, or accepted best clinical/professional practice, in use at the time?
- What was the agency's and inter-agency assessment of Beryl's and/or Margaret's needs, including emotional needs; and any risk identified, including signs or disclosures of neglect or abuse?
- What contact, if any, was there with their Relatives?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- What decisions and actions were taken, noting any gaps, errors and successes, and why these occurred?
- What was the context in which the agency and its staff were working? Were there any factors intrinsic to the agency or external to the case which may have impacted on the work?
- Were practitioners sensitive to the needs of Beryl and Margaret and knowledgeable about potential indicators of safeguarding concerns? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- What are the views of the practitioners who were involved in working with Beryl and/or Margaret?
- Was there appropriate management and/or supervisory oversight of practitioners' work?
- Did the agency apply the *Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect* after its publication in September 2014?
- Was there inter-agency information sharing and co-operation to meet Beryl's and/or Margaret's identified needs? Did each agency comply with information sharing protocols?
- Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious, sexual orientation and gender identity of Beryl or Margaret (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- Are there lessons to be learned from this case relating to the way in which agencies worked to safeguard Beryl and/or Margaret? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were agency services to Beryl and/or Margaret?

5.6 Participation by Relatives

5.6.1 The SAR Panel will seek to identify the name and contact details of the family of Beryl and Margaret. Relatives will be advised of the SAR at an early stage by the Independent Chairman. They will be told of its purpose, how it will be conducted and how they may be involved. The Independent Chairman will meet with Relatives at this stage if they wish to.

5.6.2 The Independent Chairman will contact Relatives again during the period when IMRs are being conducted to allow them to express any views they may have about agency involvement with Beryl and/or Margaret.

5.6.3 The SAR Panel Chairman will contact Relatives again following the completion of the Draft Overview Report to discuss the report and its findings with them.

5.7. SAR Governance

5.7.1 The Independent Chairman of the SAR Panel will be responsible for telling the KMSAB Chair of any emerging findings that require attention before the SAR is completed.

5.7.2 The Draft Overview Report will be sent to the KMSAB Independent Chair for their view, prior to it being listed it as a confidential agenda at a KMSAB meeting.

5.7.3 If the KMSAB Chair is satisfied with the Overview Report, the SAR will be presented to the next KMSAB for sign off.

5.7.4 KMSAB will be responsible for the co-ordination of any media management in relation to this SAR in line with an agreed media strategy.

5.7.5. Decisions about publication will be made at the KMSAB at the final presentation of the Overview Report.

6. Summary Chronology

6.1 The safeguarding involvement that organisations had with Beryl during the review period can be described in three discrete periods:

From	To
03/04/2012	28/01/2013
03/03/2014	07/08/2015
15/11/2016	06/12/2016

6.2 The first of these periods began when Kent Police received an anonymous call, which caused police officers to make enquiries in the street where Beryl lived. As a result, they went to the house where they saw and spoke with her and Margaret. They were not allowed into the house.

6.3 Because of concerns about Beryl arising from their visit, the police officers submitted a vulnerable adult referral to Kent County Council Adult Social Care & Health (ASCH). Following this, a lot of activity took place involving Kent Police, ASCH, KMPT, and GPs. Beryl's son and brother were told about this and contributed to it.

6.4 The activity largely ceased following a case conference in August 2012, with ASCH closing the case in January 2013. Beryl was not seen after the initial visit by police officers and was spoken to once during this period.

6.5 The second period of involvement again began with a visit to Beryl's home by police officers. She was not seen or spoken to on this occasion but another vulnerable adult referral was submitted to ASCH. A Police Community Support Officer (PCSO) and a ASCH Social Worker (SW) made a joint visit to Beryl's home but they did not see or speak to either her or Margaret.

6.6 The SW spoke with Beryl's daughter-in-law and brother on 1 May 2014. They expressed serious concerns about her wellbeing. No further action was taken by organisations and ASCH closed the case in April 2015. Beryl was not seen or spoken to during this period.

6.7 The final period of involvement began on 15 November 2016. South East Coast Ambulance Service submitted a vulnerable adult referral about Beryl to ASCH after Margaret made a call to the NHS non-emergency number expressing concern about her mother's health. Following attempts by ASCH to contact Beryl, this eventually led to police officers entering the house with an ambulance crew on 6 December. She was taken to Hospital 1 where despite intensive treatment, she died on 15 December 2016.

7. Conclusions

7.1 The condition in which Beryl was found when her house was entered by police officers on 6 December 2016, indicated she had suffered prolonged neglect. She was admitted to hospital but despite receiving intensive and appropriate treatment, she died just over a week later.

7.2 The last record of Beryl being seen by an organisation was in April 2012, when she came out of her house briefly to speak to the police. The last recorded contact with her was about two months later, when she had a telephone

conversation with a KMPT social worker. Following that, all contact at the address was with her daughter Margaret.

7.3 When a person has suffered neglect, it need not have been at the hands of another person. Kent and Medway Safeguarding Adults Board (KMSAB) has recognised this and identified self-neglect as a specific safeguarding issue. In September 2014, the Board adopted the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect (SNPP), a comprehensive document describing self-neglect and what multi-agency action should be taken when it is identified. The early recognition by KMSAB that self-neglect is a safeguarding issue, prior to the implementation of the Care Act 2014 in April 2015, was good practice.

7.4 The SNPP were not in place during the first two periods when organisations were actively involved in Beryl's case. However, there were some shortcomings in the way organisations dealt with Beryl's case during those periods, which cannot be attributed to this. They were examples of poor practice and recommendations have been made accordingly.

7.5 During the final period of involvement, from the SECAmb vulnerable adult referral to Beryl's house being entered, there was no specific reference to self-neglect or implementing the protocols set out in the SNPP. KMSAB member organisations should satisfy the Board that relevant staff have received multi-agency training based on the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect.

7.6 The fundamental issue in this review is that organisations did not have any contact with her in the last four and a half years of her life. While it is accepted that it will always be challenging to support people who decline help, there seems to have been a lack of what has become known as 'professional curiousity' about Beryl's condition. There is little evidence that, when contact was made in the initial stages with Beryl and Margaret, and latterly with Margaret, any questions were asked about Beryl's health and wellbeing. It went further than Margaret being permitted to speak for Beryl; she was not asked about Beryl. There was no evidence that Beryl lacked the mental capacity to make decisions for herself; more effort should have been made to speak to her.

7.7 During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB must include content emphasising the need to consider separately the safeguarding of each person living in a household where self-neglect is believed to being taking place.

7.8 The SNPP emphasises the need to consider an assessment of a person's mental capacity (as defined in the Mental Capacity Act 2005). The lack of contact with Beryl in the years leading up to her death meant that the need for a mental capacity assessment was never considered, still less was there the opportunity to diagnose any physical or mental health condition. However, the sum of the involvement organisations had during the review period, together with the conditions found when police officers entered her house in December 2016, suggests that the mention in her husband's notes more than ten years previously that Beryl had Miss Havisham (Diogenes) syndrome might have been accurate. It is a condition specifically related to extreme self-neglect and worthy of mention in the SNPP, to flag its existence to professionals for their consideration. Advice should be sort from an expert to ensure that advice and guidance on the condition is accurate.

7.9 During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include reference to Miss Havisham (Diogenes) Syndrome, its symptoms and the action that professionals must take if they believe a person may be suffering from it.

7.10 In this case, Kent Police used the power under Section 17 of the Police and Criminal Evidence Act 1984 to enter Beryl's home. This is one of several powers available to intervene in cases where either life or limb is at risk imminently or it is believed that a person may present a serious threat to the safety of themselves or others. Such a power must be used only when the criteria set out in law are met, but in those cases where they are, not using the power may have grave consequences.

7.11 It is important that safeguarding professionals have a broad understanding of these powers and which agency or agencies are permitted to use them. Where the power is one that they are permitted to use, they must have a detailed understanding of it. In a multi-agency scenario, more than one power may apply and it is important that the decision and rationale for selecting which one is most appropriate is recorded. This should include consideration of the provisions of Sections 4B, 5 and 6 of the Mental Capacity Act 2005 if it is believed that a person lacks mental capacity.

7.12 During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include content setting out the powers that allow intervention when there is a serious risk of harm to a person or others, and which agencies can exercise those powers.

7.13 The professionals meetings are an appropriate way to share information held by agencies about people who self-neglect and to reach decisions about the best way forward. The meeting held in 2012 was not effective because intended outcomes were not set and actions not followed up. During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include guidance about holding professionals meetings in self-neglect cases.

7.14 The Review Panel feels that due to its complexities, this case still presented challenges to professionals in 2016, despite the Self-Neglect Policy and Procedures having been in place for over two years then. At the time of writing this report, the Self-Neglect Policy and Procedures are undergoing revision. The panel feels that KMSAB should consider using this case as the basis of a multi-agency exercise to test the effectiveness of the revised Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect in helping professionals to manage complex cases of self-neglect.

7.15 There are three references during the review period to professionals, each from a different discipline, mentioning or advocating what could be described as a 'softly softly' approach to trying to gain the trust of Beryl and/or Margaret. While this might work in many cases, there is evidence that on the two occasions when Beryl was seen or spoken to, it resulted from a more assertive approach being taken by the professional involved. The review panel does not recommend one approach as more effective than the other in general; each case must be decided on the circumstances present. It is important however, that the desired result is clearly understood – in this case gaining access to Beryl – and consideration is given to what has worked previously, and to all options if nothing has worked so far.

8. Lessons To Be Learned

The Review Panel has identified that the following lessons should be learned from this review:

8.1 When dealing with cases of self-neglect in a household, organisations must consider the safeguarding of each person living in it and make every effort to ensure that each is spoken to separately.

8.1.1 In most cases of extreme self-neglect, as suffered by Beryl, the victim lives alone. Where this is not so, others living with them would be likely to assist in providing and facilitating the care and treatment the victim needs to prevent

their condition deteriorating to the extent that it did in Beryl's case.

8.1.2 As this case demonstrates, there are exceptions and it is important that where there is evidence of self-neglect, assumptions should not be made and the safeguarding of each occupant should be considered separately and action taken that is appropriate to the needs of each.

8.2 It is necessary to establish the mental health capacity and/or the mental health condition of a person who is suffering from self-neglect.

8.2.1 This emphasises the importance of assessing the mental capacity and health of someone suffering from self-neglect. It will better enable professionals to make decisions about the balance between an individual's rights and organisations' duties and responsibilities.

8.2.2 Those who self-neglect may have difficulty in engaging with organisations that have safeguarding responsibilities, which makes assessment of mental capacity more difficult. However, it is necessary to explore all options in trying to establish why a person is suffering from self-neglect.

8.3 When new multi-agency policies, protocols and procedures are introduced, which cover specific safeguarding issues, consideration must be given to how training is delivered to staff from those agencies to which they are intended to apply.

8.3.1 There is a need to ensure that multi-agency training is delivered when multi-agency policies, protocols and procedures are introduced, in addition to agency-specific training. Where a policy applies to a specific area of safeguarding, such as self-neglect, the training needs to be focused on that area, rather being incorporated into wider safeguarding training.

8.4 Professionals must understand the powers that exist in law to intervene in cases where a person is behaving in a way which places them or someone else at serious risk.

8.4.1 Powers exist to allow intervention in the minority of cases where safeguarding concerns are such that life and limb is believed to be at risk but the subject declines help.

8.4.2 The decision to use these powers should not be taken lightly, but used appropriately they may save life or prevent injury. It is important that professionals involved in safeguarding understand what powers exist and which agencies can implement them where, when and how.

9. Recommendations

9.1 The Review Panel makes the following recommendations from this SAR:

	Recommendation	Organisation
1.	Kent Police must consider its current adult safeguarding procedures in the light of this case to ensure that the missed opportunity to follow up the initial good work following their contact with Beryl and Margaret in April 2012 would not happen now.	Kent Police
2.	When a decision is taken at the Central Referral Unit that action is required to be taken by an organisation, a CRU staff member who works for that organisation should make the necessary contact and request.	Kent Police ASCH NHS
3.	ASCH must consider its current adult safeguarding procedures in the light of this case, to ensure that the issues identified would not happen now.	ASCH
4.	ASCH should have criteria for closing cases, with actions to be completed before closure, including an appropriate degree of scrutiny of the decision.	ASCH
5.	KMSAB member organisations should satisfy the Board that relevant staff have received multi-agency training based on the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect.	KMSAB
6.	During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB must include content emphasising the need to consider separately, the safeguarding of each person living in a household where self-neglect is believed to being taking place.	KMSAB

7.	During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include reference to Miss Havisham (Diogenes) Syndrome, its symptoms and the action that professionals must take if they believe a person may be suffering from it.	KMSAB
8.	During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include content setting out the powers that allow intervention when there is a serious risk of harm to a person or others, and which agencies can exercise those powers.	KMSAB
9.	During the current revision of the Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect, KMSAB should include guidance about holding professionals meetings in self-neglect cases.	KMSAB
10.	The panel feels that KMSAB should consider using this case as the basis of a multi-agency exercise to test the effectiveness of the revised Kent and Medway Multi-Agency Policy and Procedures to Support People Who Self-Neglect in helping professionals to manage complex cases of self-neglect.	KMSAB