Background

A Safeguarding Adult Review (SAR) is a multi-agency process that considers whether a death or serious harm experienced by an adult at risk of abuse or neglect, could have been prevented. The purpose is to promote learning and improvement action to prevent future deaths or serious harm occurring again. It was a unanimous decision of the Oldham Safeguarding Adults Board (OSAB) SAR Subgroup that the criteria for a SAR were met in relation to 'Kerr'. The SAR Overview Report is available online. Kerr had a learning disability (LD), epilepsy and chronic renal failure resulting in anaemia. The SAR found that Kerr had a long history of self-neglect; it was thought that he had been subject to financial abuse; and that there was learning about how partner agencies worked together to safeguard him. Kerr was 47 years old when he died in hospital following an admission with sepsis. Kerr enjoyed playing and watching football with his father, who he lived with. When Kerr's father died, he became increasingly weary of health professionals. Kerr enjoyed the company of others he valued as 'friends'. He would travel independently to meet up with 'friends' in other towns or visit his 'girlfriend'. On occasions, she would stay at his home.

What Happened?

Kerr sustained a knee injury when he was younger playing football. He did not tell anyone about the injury which subsequently became infected and led to lasting damage. In later life, Kerr used crutches at times. Kerr's property was not suitable to enable him to maintain his personal hygiene easily, the bathroom was up steep narrow stairs. A deep clean was planned to treat a flea infestation caused by his pet cat. He declined a move because of the memories of living there with his father. A Care Act Assessment determined that Kerr required support to develop his independence and manage his property. There were several safeguarding referrals made in relation to Kerr. A neighbour raised concerns that he was allowing numerous people into his home and District Nurses reported Kerr would not open his door to them and other voices could be heard inside. Kerr befriended a homeless man and let him into his home and subsequently had belongings stolen. Police could take no action because Kerr had willingly let them into his home. Kerr appeared to be coerced into giving his bank card to others to withdraw money and met someone online who he wanted to marry despite not knowing them for very long.

Learning from OSAB SARs: Kerr

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Cuckooing

The SAR found that concerns about financial exploitation and cuckooing did not appear to have been addressed in any meaningful way; there were no safeguarding measures put in place. Greater Manchester Police (GMP) Oldham have developed a cuckooing tracker, documenting those suspected of being targeted for cuckooing. Regular multi-agency, Protecting Vulnerable People meetings are now led by GMP Oldham to ensure cuckooing intelligence is passed to appropriate teams. Practitioners can share intelligence by calling 101, via the GMP website or by submitting the GMP Partner Intelligence Form.

Mental Capacity Act

Kerr was assessed as lacking the mental capacity to manage his personal finances, and had a court appointed Deputy to manage benefit payments and his bank account. There were no capacity assessments in relation to his ability to understand the risks of not engaging with support plans. The escalating risks to Kerr's increasing self-neglect did not prompt further capacity assessments. The SAR found that there has been considerable progress in educating staff on use of the Mental Capacity Act but there is still work to do to support staff to recognise who is responsible for documenting a person's mental capacity to make a particular decision at a particular time. Practitioners need to be aware that people with executive functioning difficulties may overestimate their abilities and underestimate their need for care and support. Practitioners need to consider and record whether the person understands there is a mismatch between what they say they will do and how they then act in real situations, looking for evidence of past behaviours and whether this demonstrates an inability to put into effect their stated intention. Find more information and guidance via the OSAB MCA Policy and the OSAB Executive Functioning Guidance.

Reasonable Adjustments

The Equality Act 2010 states that changes that should be considered to remove or reduce a disadvantage related to a person's needs such as finding a different way to do something or providing equipment. The SAR considered whether appropriate methods of communicating with Kerr were utilised when necessary; and if his limited mobility was considered and appropriate support provided. The SAR found that reasonable adjustments were not always considered on all occasions when Kerr might have benefitted from them particularly in relation to supporting him to attend appointments and when he became agitated at appointments due to the length of waiting times. A message was sent to Kerr advising him that he would need to call the GP practice to arrange a home visit but Kerr was highly unlikely to comply with this request when he was so unwell. More information can be found via an OSAB 7-Minute Briefing and guides related to people with a learning disability can be found via Gov.uk.

Multi-Agency Working

The SAR found that Multidisciplinary Team (MDT) or Team Around the Adult (TAA) meetings were not held as frequently as had been agreed for numerous reasons. Not all agencies who were working with Kerr were involved in these; they were not coordinated or documented well, with no clear actions to address all the risks present to Kerr. There was also poor evidence of the few actions that were identified being completed. There was confusion over roles with the general misunderstanding being that TAA meetings should be led by either Social Care or Mental Health staff. There was a collective lack of responsibility by the TAA to either provide a deputy to attend, or for a different TAA member to chair so that meetings could go ahead. The SAR questions whether appropriate action was taken in response to numerous safeguarding referrals as no safeguarding enquiry was opened and there was no consideration of using the Tiered Risk Assessment and Management (TRAM) Protocol for someone assessed as having capacity to make his own decisions about his care needs but identified as an adult at risk. Practitioners who supported Kerr had positive feedback about the TRAM Protocol reporting that they now had a better understanding and recognise that any member can call a TAA meeting.

Further Information

Practitioners can find guidance related to the findings of this SAR via links provided throughout this briefing. In addition, the following resources are also available: OSAB Practitioner Cuckooing Guidance and 7-Minute Briefing; OSAB Practitioner Financial Exploitation Toolkit and 7-Minute Briefing; OSAB Practical Guide to Assessing Capacity; OSAB TRAM Protocol Summary Guide and Flowchart; OSAB Lead Professional Guidance; OSAB Professional Curiosity Guidance; and OSAB Guidance Where the Individual is Not Engaging with Services. OSAB also offers multi-agency training related to the Mental Capacity Act, TRAM Protocol, and Self-Neglect.

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