Safeguarding Adult Review:

'Kerr'

Presented to Oldham Safeguarding Adults Board on

4th November 2024

Independent Author: Michelle Grant

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1.0 Introduction

1.1 Kerr was a white British man who was 47 years old when he died at Royal Oldham Hospital (ROH) Intensive Care Unit (ICU) on the 3rd September 2023 following admission with sepsis.

1.2 He had a learning disability (LD), epilepsy and chronic renal failure resulting in anaemia for which he required regular erythropoietin[1] (EPO) injections. Kerr had lived in a rented property with his father with whom it was reported by his support workers he had a close relationship with until 2016 when it was felt by his father that he moved to alternative accommodation because he was struggling to manage his son's behaviours and the negative impact that his relationship with a 'girlfriend' was having. Kerr's 'girlfriend' who will be referred to as Adult 'A' lived with Kerr at different times throughout the timeframe of this review, she is known to have her own home in Manchester.

1.3 From 2016 Kerr received three days of support commissioned by Adult Social Care (ASC) from KeyRing[2] who provided low to medium support to manage his tenancy. KeyRing built up a rapport with Kerr over time and were the agency that appeared to know him best.

1.4 Kerr's finances were managed by a Court of Protection appointed Deputy[3] based at the Local Authority (LA) because following assessment it was evidenced that Kerr lacked the mental capacity to manage his own finances, including his tenancy. Throughout the period of the review his support workers had regular contact with his Deputy due to concerns about him being financially abused by others.

1.5 Kerr appeared to be a sociable person who enjoyed the company of other people, he had 'friends' who he visited in Manchester and Bury, also meeting someone online who he wanted to 'marry' despite not knowing them for very long. Kerr was also supported to access a gym where he could use the shower facilities because he was unable to access the bathroom in his home which was on the first floor. He was also fond of visiting the local library to use a computer and to sit in a comfortable chair by a large window where he could watch people go by.

1.6 From 2016 onwards Kerr was known to many different commissioned agencies up to the time of his death. He received care and support from several health services, his GP, the renal team, haematology, urology, podiatry, the community LD nurse from Pennine Care NHS Foundation Trust (PCFT) and the District Nursing (DN) service provided by Northern Care Alliance NHS Foundation Trust (NCA). He was required to attend numerous outpatient departments and clinics, and to be at home at times for home visits that were prearranged.

1.7 The combined agency chronology demonstrates that even with support, Kerr was a regular non-attender at hospital outpatient departments and community clinics. He would sometimes appear to prioritise meeting 'friends' rather than attending his health appointments despite support to attend these by staff accompanying him or ordering taxis to get him to and from appointments. He would also either not answer the door to practitioners/support staff, or not be at home at the agreed time on frequent occasions.

1.8 Despite this, KeyRing support workers made determined efforts to remind Kerr of upcoming appointments by ringing him or reminding him when they had face to face contact

[1] This medication is used to treat anaemia (low red blood cell count) in people with long-term serious kidney disease (chronic renal failure)

[2] KeyRing are an organisation that supports vulnerable people across the North West with independence and community connection

[3] A Deputy is a person the Court of Protection appoints to make decisions for someone once you have lost capacity to make them yourself. A deputy usually makes decisions about finances and property

with him, they also left written reminders on a notice board near his front door inside his property and sorted out any issues with his medication such as out of date medication, EPO injection availability as well as supporting him to order food shopping.

1.9 Kerr was identified as an adult at risk of abuse and exploitation by practitioners, who went on to make several safeguarding referrals about their concerns for his safety. He appeared to be coerced into giving his bank card to people so that money could be withdrawn from his bank account. He befriended a homeless man and let him into his home and subsequently had belongings stolen. A neighbour raised concerns that at times Kerr appeared to be allowing numerous people into his home and support and DN staff reported that on some home visits other voices could be heard inside his home and he would then not open his door.

1.10 The property Kerr was living in was unsuitable for his needs having a bedroom and bathroom only accessible up a steep flight of stairs. It required regular attention from the landlord to address faulty electric sockets, a leaking sink and bath causing damage to the ceiling below. Kerr was placed on the rehousing register, but no suitable alternative property was found prior to his death despite support staff helping him to bid on properties as they became available. Supporting living accommodation had been suggested to Kerr on one occasion but he was adamant that he would not accept this.

1.11 In between his care in the community Kerr was admitted to hospital on 3 occasions during the timeframe of the review. His care in the community, and each of these hospital inpatient episodes will be reflected upon as part of this Safeguarding Adult Review (SAR).

2.0 Safeguarding Adult Review Methodology and Panel Membership

2.1 Oldham Safeguarding Adult Board (OSAB) has a statutory duty under the Care Act 2014[4] to arrange a SAR where:

- An adult with care and support needs has died and the Safeguarding Adults Board (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 SAB, its members or others worked together to safeguard the adult.

2.2 The OSAB has discretion to commission reviews in circumstances where there is learning to be extracted from how agencies worked together but where it is inconclusive as to whether the individual's death was the result of abuse or neglect. Abuse and neglect include both financial abuse and self-neglect.

2.3 SAR panel members must cooperate in and contribute to the review with a view to identifying the lessons to be learned and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together and independently, 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 the Service Manager from the Learning Disability and Autism (LD&A) team at Oldham Council on the 1st of February 2024. There was a delay in referring for consultation for a SAR due to the death of Kerr being

[4] Care Act 2014 sections 44 (1), (2) and (3) https://www.legistlation.gov.uk [Accessed June 2024]

previously considered for a LeDeR[5] review. Kerr was known to the learning disability and autism service from 2016 when Kerr's father left the property, Kerr's partner Adult 'A' then began to spend time living with him in his home, on these occasions he would give her access to his money or request money from his Deputy to support her. On one occasion Kerr asked his Deputy for money to contribute to the cost of Adult 'A' paying for a funeral.

2.5 As well as his known health conditions, Kerr also sustained an injury to his knee when younger playing football. Kerr didn't tell anyone about the injury which subsequently became infected, this led to lasting damage resulting in Kerr having to wear a knee brace on occasions. Records also reflect in later life Kerr used crutches at times to aid his mobility.

2.6 A Care Act assessment[6] was completed with Kerr in February 2016. The outcome of the assessment was that Kerr would require support to develop his independence and manage his property, given that he had previously had support in place from his father. The care agency commissioned remained involved with Kerr from 2016 until the time of his death. The referrer noted that Kerr had a long history of self-neglect and was reported to be reluctant to engage with some professionals.

2.7 The referral was discussed at the OSAB's Safeguarding Review, Audit and Quality Assurance Subgroup on the 5th March 2024 where it was agreed that the criteria for a review were met. The focus of the review was to be on key learning areas and lines of enquiry was well as identifying where there is more learning needed in relation to themes that OSAB have had previous learning around.

2.8 The Independent Author for this SAR is Michelle Grant who is an Independent SAR author. Michelle has a health background working in acute hospitals for 20 years and latterly for 10 years in a Clinical Commissioning Group (CCG) and an Integrated Care Board (ICB) as the Designated Nurse for Adult Safeguarding and Mental Capacity Act (MCA) Lead. She has undertaken SAR author training and has since authored several Safeguarding Adult Reviews across the Country.

2.9 The Independent Author has no links to the OSAB or any of its partner agencies.

2.10 The following agencies which had commissioned or provided services to Kerr contributed to the review as panel members alongside the Independent Author.

Role	Organisation
Independent Author	
Business Manager	Oldham Safeguarding Adults Board Business Unit
Safeguarding and Mental Capacity Lead, Adult Social Care	Oldham Council
Principal Homeless Strategy Officer, Housing Options Team	Oldham Council

[5] LeDeR – Learning from Lives and Deaths Reviews of people with a learning disability or autism https://www.england.nhs.uk>learning>from>lives>and>deaths [Accessed June 2024]

[6] Section 9 of the Care Act 2014 informs that local authorities must carry out an assessment of needs for care and support, the nature of the assessment will vary depending on the person and their circumstances https://www.scie.org.uk>assessment-and-eligibility [Accessed June 2024]

Detective Constable, Investigation and Safeguarding Review Team	Greater Manchester Police
Named Nurse Safeguarding Adults	Northern Care Alliance NHS Foundation Trust
Named Professional Safeguarding Adults	Pennine Care NHS Foundation Trust
Named Professional Safeguarding Adults	Manchester University NHS Foundation Trust
Designated Professional Safeguarding Adults, Oldham Place Team	NHS Greater Manchester Integrated Care Board
Manager	KeyRing Living Support Networks Oldham
Manager	Support to Lead Homecare Support Services Oldham
Business Coordinator	Oldham Safeguarding Adults Board Business Unit
Higher Level Business Support Officer (minute taker)	Oldham Council

2.11 Following a review of the multi-agency combined chronology, the SAR decision document, and the SAR screening meeting minutes by the Independent Author it was agreed that the draft terms of reference for the review would be sent to the panel members to remotely agree and sign off. The Independent Author also posed questions to the partner agencies following a review of the combined chronology dated from December 2021 - September 2022 which assisted in the drafting of the report. The first panel meeting was held on the 11th July 2024 where family engagement, possible themes for a Practitioner Learning Event (PLE) and the initial draft report were discussed.

2.12 The panel met on the 11th July to discuss the information shared by agencies, identify any learning points and to agree the progress of the review. On 4th September 2024 a PLE was held which was attended by individuals from agencies who had worked directly with Kerr. The contribution by the practitioners at this event was invaluable in the panel members understanding what worked well in practice and what were the barriers to effective multiagency working, risk assessments and mental capacity assessments which if overcome would improve multiagency working to support people like Kerr across Oldham.

2.13 Additional communication with professionals who were either unable to attend the PLE or had minimal involvement in the team around Kerr helped to clarify practice and shape the learning. The panel met again on the 3rd October to discuss the information shared by Kerr's brother with the independent author and the findings from the PLE and conversations with staff unable to attend on the day. The changes to the draft report were discussed and the panel agreed that the changes required to achieve the final report could be achieved by remote sign off, which was achieved on 21st October 2024.

3.0 Equality and Diversity

3.1 Throughout this review process, the panel has considered the issues of equality. In particular, the 9 protected characteristics under the Equality Act 2010[7]. Disability applied to Kerr, he was on the GP surgery learning disability health check register and attended for annual health checks. He was also supported by the LD nurse from PCFT and had an LD healthcare passport[8]. Kerr was additionally allocated a social worker from the LD&A team within ASC. The panel also considered reasonable adjustments[9] under the equality act including barriers to accessing services; whether appropriate methods of communicating with Kerr were utilised when necessary; and if his limited mobility was considered by practitioners and appropriate support provided.

4.0 Terms of Reference

4.1 The Terms of Reference were agreed by the panel as set out in **Appendix 1** and are aligned with the 6 principles of adult safeguarding: empowerment, prevention, proportionality, protection, partnership, and accountability.

5.0 Family Engagement

5.1 Kerr's mother is known to have died a short time after the death of Kerr, his relationship with her during the timeframe of the review was remote, there was little contact between the two. The independent author spoke with Kerr's brother on 14th August to enable the review to have a better understanding of Kerr as a person.

5.2 Kerr's brother shared that Kerr was unable to attend mainstream education due to the level of his learning disabilities, he instead attended a local school which supported children with learning disabilities. When he left school Kerr was not able to undertake any paid employment but did work for a short time as a volunteer in a charity shop but did not enjoy this and so left. Kerr got a great deal of enjoyment out of playing football and watching football. His favourite teams were Liverpool and Rangers, and he was a frequent attender with his father at both Anfield and Ibrox on match days.

5.3 There was not much contact between the two brothers in the years leading up to Kerr's death. The relationship was strained with Adult 'A' causing numerous disagreements within their family. Kerr was reluctant to take advice from his family about the influence she was having on him which led to prolonged periods of estrangement.

5.4 Kerr's brother shared with the independent author that he was aware that Kerr had told his support workers that he didn't want any information about him sharing with his family, which was honoured by the staff, and which his brother understood, appreciating that this must have put them in a difficult position at times. Kerr's brother's most recent contact being with the KeyRing support staff when Kerr was admitted to the ICU at ROH in September 2023.

5.5 The independent author and panel members on behalf of the OSAB would like to thank Kerr's brother for his contribution to the review.

6.0 Parallel Processes

6.1 The decision to commission a LeDeR review has been declined in favour of a SAR with a broader remit to look at multi-agency working. There will be a Coroner's Inquest into the death of Kerr, the date has yet to be confirmed.

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[7] The Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/contents [Accessed June 2024]

[8] Helps staff to understand the persons needs and how they like to be treated

[9] The Equality Act 2010 requires organisations to have to make changes so disabled people aren't disadvantaged in accessing services, this is called 'the duty to make reasonable adjustments'.

7.0 Abridged Combined Agency Chronology from February 2022 - September 2023

7.1 In February 2022, a referral was made by Kerr's GP to the DN Service for lower leg dressings due to lymphoedema[10] causing bilateral swelling which was weeping but not thought to be infected at this time.

7.2 The following month, the GP received notification that despite a referral to haematology and discussion at their MDT which indicated Kerr needed further investigations into his anaemia, he was being discharged back to the care of his GP because he had not attended his OPD appointment on 3 consecutive occasions.

7.3 The same month, his GP referred Kerr to the Occupational Therapist (OT) due to his level of self-neglect and being unable to use his upstairs bathroom to manage his hygiene needs. He was described as 'very unkempt' stating 'he was not showering'. Kerr was spoken to by the service and at this contact stated he *"was able to manage"*. He was advised to keep bidding on properties with a ground floor bathroom.

7.4 By April, the DNs had recorded that Kerr was recurrently arriving late for his appointments meaning he couldn't always receive the expected care. This became a repeating pattern, or he would not attend at all.

7.5 In June, Kerr attended the Programmed Investigation Unit (PIU) at Rochdale Infirmary hospital (RI) for treatment for renal anaemia, he attended a further appointment the following month to complete this treatment.

7.6 The following month, Kerr attended the ROH Emergency Department (ED) with renal colic, he was referred appropriately to the outpatient renal colic pathway and had a CT scan which showed no further treatment would be required. Kerr was discharged back to the care of his GP. He was also referred to the podiatrist but did not attend his appointment so was again referred back to the care of his GP.

7.7 In the same month, ASC had arranged for Kerr to move to a 3-week short term stay to allow his property to be deep cleaned. Due to the care provider then declining to accommodate Kerr this was not actioned, and no further placement was sought.

7.8 In September, there was the first documented record of someone shouting in the background at Kerr's home when the support worker called him. He was asked who this was and stated, *"it was just a friend"*.

7.9 The same month, Kerr attended the Oldham Kidney Centre and was supported at this appointment by the community LD nurse. It was noted that Kerr appeared to have lost weight and was using crutches to walk stating his legs were "*very sore*". He was noted to be very thirsty and not able to give his correct date of birth. A best interest decision meeting with the renal consultant, LD nurse and an Independent Mental Capacity Advocate[11] (IMCA) was held to discuss renal dialysis which Kerr would need to attend hospital for, no conclusion in respect of Kerr's mental capacity to make this decision was documented at this time. Kerr stated at this meeting that he would be reluctant to have this treatment. The LD nurse e-mailed Kerr's social worker to request a referral for an IMCA. Non-engagement with haematology was picked up at a later GP appointment, the LD nurse agreed to support Kerr to these

[10] Lymphoedema is a log-term chronic condition that causes swelling in the body's tissues

[11] The Mental Capacity Act 2005 introduced the role of IMCA, these are a legal safeguard for people who lack the capacity to make specific important decisions about where they live and serious medical treatment options

appointments in future so the GP rereferred Kerr back to haematology 6 months after the initial non-engagement.

7.10 In mid-September, Greater Manchester Police (GMP) received a concern for welfare for Kerr, a member of the public had found him at 11pm on a street in Manchester reporting that he *'could not make his way back to Oldham'*. Officers attended, Kerr reported he had been with a '*friend*' who had abandoned him, Police drove him home; a care plan was submitted, and an onward referral was made to the Adult Referral Contact Centre (ARCC). ASC received this referral which was sent to a duty worker and Kerr's allocated social worker.

7.11 One week later, an MDT was held between Kerr's support worker, his social worker, and the LD nurse. The discussion was documented as being related to getting flea treatment for Kerr's cat and his home. The following day Kerr informed his support worker that he was going to Bury to meet his *"new girlfriend'*. When his support worker advised him to be careful going to somewhere he wasn't familiar with, he stated that he had been there before to meet her, he explained that "*she couldn't come to Oldham as she worked, and I am meeting her after work*". His support worker advised him not to travel back late, he replied that *'he wouldn't'*.

7.12 At the end of September, following the conclusion of Kerr's annual health check, Kerr was questioned on why he was travelling to South Manchester, he stated he was *"visiting his stepmother"*" but declined to give an address, he was also asked about his visits to Bury. The GP shared their concerns with the LD nurse and asked that this be shared at the next MDT meeting, there were concerns that this was a risky area of Manchester and Kerr had been assaulted there before. At the end of September Kerr also failed to attend his renal dietician appointment.

7.13 In early October, Kerr was supported by the community LD nurse to attend a haematology outpatient appointment but left before being seen because he got agitated by the length of wait. KeyRing were informed, and a further hospital appointment was made. KeyRing's contract meant that they were unable to support Kerr at all his health appointments as well as manage his shopping, medication, and bills. The community LD nurse from PCFT requested an MDT to discuss the concerns relating to ensuring Kerr attended his appointments. On the same day NCA staff indicated that they needed a best interest meeting to discuss the treatment of Kerr's poor renal function. A plan of care from Kerr's GP was requested by the DNs following two missed EPO injection appointments.

7.14 By mid-October, DNs completed a safeguarding referral due to their concerns that Kerr had missed another hospital appointment, and someone could be heard in the background of the telephone conversation with him and who refused to speak to practitioners when asked to do so.

7.15 An MDT was held and agreed that weekly meetings were required. Kerr's social worker agreed to chase up Kerr's housing application, contact environmental health about Kerr's poor living conditions and request an increase in support hours. A nursing home placement had funding agreed to allow Kerr's property to be fumigated but the manager was reluctant to accept Kerr as a resident. The renal consultant was to write a letter of support in relation to rehousing. His Deputy noted that Kerr was asking for large amounts of money to fund a trip to Blackpool, the MDT had concerns about who might be accessing Kerr's money, it was agreed to explain to Kerr the reason this request was being declined. Environmental Health had planned a visit in October but didn't attend despite e-mail contact from his support worker earlier in the day.

7.16 In early November, Kerr did not attend (DNA) a further DN appointment and again when contacted practitioners could hear someone else speaking in the background. This was

discussed with the community LD nurse; it was decided that a further safeguarding referral should be made.

7.17 In November, Kerr was seen by a member of the renal team, an IMCA and his support worker to discuss renal dialysis. During this conversation Kerr became both verbally and physically aggressive, he was allowed time to compose himself and calm down. When a simple explanation of the treatment required was explained to Kerr he made no eye contact, support was given to him to assist him in deciding about whether he would accept renal dialysis. A follow up meeting was planned for the beginning of December.

7.18 Later the same month, the LD&A duty team received a concern from the Rough Sleeping Initiative (RSI) officer that Kerr was allowing another user who was involved with a number of agencies including probation and who was known to the Police, to stay in his home and had been seen swapping telephone numbers with this person, a further safeguarding referral was made. At the end of this month the community LD nurse requested an MDT based on this new information. This concern was shared with KeyRing who had also requested that ASC undertake a capacity assessment on Kerr in relation to his understanding of financial abuse.

7.19 The best interest meeting to decide treatment by the renal team did not go ahead in early December as planned because the IMCA and Kerr's support worker were not able to attend. On the same day a neighbour reported to KeyRing staff that Kerr was still allowing a homeless man to stay in his home and now other people were visiting as well. Police could take no action because Kerr was allowing them into his home voluntarily. KeyRing staff contacted the letting agency to explain their concerns about Kerr's vulnerabilities and people staying at his home. KeyRing were advised that somebody would investigate what powers they had to address this and would respond back.

7.20 At the same time an e-mail from Kerr's social worker to MDT members was sent to confirm they would complete a mental capacity assessment in relation to Kerr's ability to manage his self-care and living conditions. The following day an MDT meeting was held with Kerr's KeyRing support worker, KeyRing Manager and Deputy. His Deputy was tasked with following up his housing application because it had been over a year since the application for re-housing was submitted and Kerr had still not been given a bidding number despite numerous emails sent to his housing officer for an update. The MDT also discussed contacting the Police Community Support Officers (PCSOs), they later advised Kerr that there were two men known locally to be going around the area committing burglary and that he should lock his doors. Actions agreed would be followed up at a further meeting the following week. The housing application went live on 16th December 2022. Following an OT review, Kerr's level of need and vulnerabilities resulted in his banding increasing from 3 to 2, it was suggested that this might increase further to band 1 following conversation with professionals involved.

7.21 The following week, there was a report of a burglary at Kerr's home address, the allegation being that somebody had entered his property and stolen his television. Kerr stated that when he goes out, he *'doesn't lock'* his property, there was no sign of forced entry at the address therefore GMP recorded the crime in line with National Crime Recording Standards (NCRS) and finalised as no further action.

7.22 The next day, Kerr did not have his mental capacity assessed by his social worker, he stated he was in Manchester at the time of the appointment. The MDT meeting went ahead without him a repeat of the actions from the meeting six days ago were discussed.

7.23 In mid-December, ASC received another safeguarding referral for Kerr from North West Ambulance Service NHS Trust (NWAS) documenting that Kerr's 'sister' Adult A had been feeling suicidal and attempted to self-harm with a knife. Kerr had tried to intervene and was

cut on the hand. Two days later a manager within ASC decided a safeguarding strategy meeting should be arranged to review Kerr's situation and agree a multi-agency safety plan and reassessment of Kerr's needs. The safeguarding concern was forwarded to Kerr's allocated social worker for action to be completed. In the 3rd week of December Kerr was seen face to face by a GP to discuss his ongoing haematology care, the community LD nurse was not in attendance at this appointment. Kerr was able to recall the appointment and explained he didn't like doctors examining him "*because doctors killed my father*" and this was why he became angry. He stated he would be happier with a nurse examining him.

7.24 At the beginning of January 2023 a KeyRing worker noted that Kerr's bedroom window was open again and spoke to him to ask if there was anybody staying there again. Kerr denied that there were people still staying at his home and that the window was open only *'to let fresh air into his bedroom'*. Kerr reported that his "*friend's mother had died and she needed money to pay for a funeral*" and he would like money to be able to buy a suit to wear. Kerr was advised by his KeyRing worker that money would not be provided for another person's funeral.

7.25 In mid-January, a mental capacity assessment was documented regarding Kerr's ability to decide whether he could consent to renal dialysis. Photographs were used of what the equipment looked like from an earlier meeting and an explanation of what would be involved was communicated. The consultant concluded that Kerr did not have the mental capacity to make this decision for himself and that a best interest decision was required. This was communicated to the IMCA and 4 days later Kerr was discussed at a renal high-risk meeting.

7.26 A further safeguarding referral was made by NCA staff following the disclosure by Kerr that there were *'people taking money off him and asking him to do unsafe acts that could cause him harm'*. His physical presentation at this appointment was noted to be poor, Kerr was unclean and wearing dirty clothes. Information about these concerns were shared with the community LD nurse and his KeyRing worker noting that the social worker needed to review the safeguarding referral and decide what action to take.

7.27 The following day, Kerr reported that his new television had been stolen, that he had let a homeless man stay with him again and that it might be this person that had stolen his television. As a result, the Police could take no further action, the crime was again recorded as burglary and finalised as no further action.

7.28 On 16th February, Kerr attended the ED at ROH after staff had tried to contact him due to abnormal blood test results from blood taken the previous day. Repeat bloods were done which showed that Kerr had an infection in his lower left leg, and that IV antibiotics were required. Following further medical review Kerr was moved to the medical assessment unit and commenced on IV antibiotics, the medical staff did question Kerr's ability to retain and weigh up the information about his care and treatment but did not complete a formal capacity assessment at this time. Kerr became distressed and did not want to remain in hospital, he tried to leave but was persuaded to return by KeyRing staff who also spoke to the ASC Emergency Duty Team (EDT) to advise them that Kerr was not wanting to stay in hospital. His KeyRing worker stayed with him until late in the evening to support his engagement with treatment. An attempt was made to contact the community LD nurse during this admission, but they were unavailable. The following day Kerr was reviewed, and it was felt he could be discharged on oral antibiotics, a medical discharge letter was sent to his GP indicating cellulitis and an infected skin ulcer. ASC were also made aware of his hospital discharge.

7.29 In March, Kerr made a first comment about wanting a passport. A further MDT meeting was held, Kerr's living conditions were discussed, which were being hindered by Kerr's attachment to the property he had shared with his father and his affection for his cat. The

social worker was waiting on an update from the housing officer, and it was agreed to meet two-weekly to ensure everyone was up to date with plans. The surgery MDT was updated as a result of the multi-agency MDT.

7.30 Following a repair to the lock on his back door Kerr had a second new television stolen in March. There was no damage to the property and Kerr was advised that letting other people have his new spare key had probably resulted in a further theft from his home. In the same month Kerr was eventually seen by the DNs after several missed appointments. He appeared very unkempt with poor personal hygiene. Kerr asked for someone to sign his passport application which was declined after he reported that he wanted to '*marry*' someone. This disclosure was reported to Kerr's social worker.

7.31 In the same month, someone reported the condition of Kerr's cat to the RSPCA who requested a home visit with the support of KeyRing. It was agreed that following this visit the cat would be rehomed somewhere where Kerr could visit it, the cat had had a flea infestation for six months before successful action was able to be taken. The infestation had led to earlier home visits by practitioners not being undertaken because of this. Kerr was also seen again by the renal team but by a different consultant, the BI meeting was still outstanding. Later that month Kerr was seen by the DNs in clinic, he presented with a wound to his forehead reporting that "*a bad man beat me up"* There was evidence of bruising to his arms which he would not let staff photograph, Kerr had not reported the assault to the Police. A safeguarding adult referral was again made by the DNs to the social worker by e-mail. A further MDT meeting was held, recording that the LD nurse would complete an OT referral to assess home support again. At the end of the month Kerr reported that a woman had arrived at his home in a taxi, *'shouted verbal abuse through his letter box*' and defaced this.

7.32 In early April, Kerr's property was fumigated and he was supported to buy new clothes and shoes by his KeyRing worker. In mid-April Kerr was reviewed by his GP and noted to have bleeding from the back of his left leg as a result of him falling on a brick, DNs were contacted requesting a urgent visit for wound dressing later that day. This visit prompted a call to the community LD nurse, who was informed that the house had recently been fumigated and that his social worker had concluded that Kerr had the mental capacity to make decisions about his care needs.

7.33 OPAL Advocacy became involved in trying to support with his housing application following a referral from KeyRing, this support was short lived, Kerr disengaged with the service following an episode where he became agitated and verbally abusive after a telephone call to someone believed to be his 'girlfriend'. He blamed the worker for the outcome of the telephone call, began to swear, throwing his crutches at the staff member and made attempts to intimidate them in a public area of the day centre. The following day, NWAS and the Out of Hours (OOHs) GP saw Kerr who was experiencing pain in the kidney area, Kerr refused to attend hospital and as the pain was settling, safety netting advice was given.

7.34 Later in April, the social worker added a case summary onto Mosaic, the ASC recording system noting the support Kerr was in receipt of and that the community LD nurse was closing their support because health actions were complete, that ongoing support was required and by whom. Further notification was made by DNs in relation to Kerr stating he was getting married; the social worker was unaware of this despite the earlier report by the DNs and sought clarification. Kerr had brief contact with his mother at the end of this month, it was not welcomed by Kerr himself and is the only known contact with direct family during the timeframe of the review. Kerr also attended the ED at ROH following a call from the Police to NWAS reporting Kerr as experiencing chest pain and toothache. The crew felt he was vulnerable, and his living conditions were extremely poor, this was communicated to hospital staff who raised

a safeguarding referral and contacted the EDT. The EDT worker advised that Kerr was having his property deep cleaned and was seen by support workers three times a week.

7.35 By mid-May, the deep clean of Kerr's property was complete and he accepted weekly support with cleaning his home. He was again seen by the DNs in clinic and showed staff pictures of his *'future wife'*. In the same month NWAS and Police were called to Kerr's home following a report of an assault. Kerr's 'sister' Adult A was being *'verbally abused by people when they were walking home and Kerr was punched in the head by 3 males'*. On arrival at home Kerr took a knife out of the kitchen and was waving it around in a distressed state. He calmed down and stated that *'his mental health had been worsening for a few days and this incident had further upset him'*. Kerr was voluntarily transferred to the ROH ED. Following assessment Kerr reported no suicidal thoughts and left the hospital without further assessment. The Police were informed, NWAS were contacted, and telephone contact was made by the OOHs doctors service, safety netting advice was given following telephone contact with Kerr. Kerr's GP received a hospital ED summary, no further action was felt necessary by the practice at this time. The following day Police attended Kerr at Oldham leisure centre following a report that he had been *"assaulted near a tram stop by people wearing balaclavas".* He did not want to go to hospital and asked to be taken home. The crime was recorded in line with NCRS and a care plan was submitted. No onward referral for safeguarding consideration was made because Kerr was felt to have capacity and his consent was not given.

7.36 Later that month, a further safeguarding referral was made by DNs reporting that Kerr attended clinic *'covered in fleas which he appeared unaware of',* he had also shown staff messages of someone he said he *'was getting married to and who had asked him for money'*. The social worker acknowledged that the team were aware of Kerr's living conditions, but that Kerr was refusing further support. It was confirmed that the financial abuse would be looked into and that a Deputy was managing Kerr's finances so that these were protected.

7.37 In late May, KeyRing raised their concerns with the social worker that now the community LD nurse was no longer supporting Kerr, he was missing more appointments or arriving late, and his health appeared to be declining. It was agreed by the social worker that an MDT was required following the concerns raised. Four days later Kerr was seen by podiatry who noted that he had gross oedema in his legs and maggots in his wounds. He was *'distressed over the death of his father and refusing to go to hospital'*. The social worker advised that if he was refusing to go to hospital then clinical staff needed to assess his capacity to understand his medical condition and the risk of not accepting treatment.

7.38 In early June, the MDT meeting was held with DNs, community LD nurse, support worker and social worker all in attendance. There was a further concern raised about Kerr presenting to DNs with a head injury, and poor hygiene, the conclusion was that Kerr had sustained these injuries because of a fall causing bruising, the cut to his head was as a result of shaving. His lack of attendance at appointments was discussed, noting that although Kerr had lots of appointments to attend which was confusing for him, he had the physical ability to attend on his own if he was aware of them. Support staff reported that in attempting to manage his hygiene needs he was regularly encouraged to wash but couldn't be forced to. In late June Kerr was seen again in podiatry and found to be in a much-deteriorated state, maggots were again present in his leg wounds, his general health and wellbeing were poor. The podiatrist concluded that Kerr was too unwell to have his mental capacity assessed in relation to his understanding of his healthcare needs and that hospital admission was required. Kerr was angry that an ambulance had been called in his best interest, he was again transferred to the ROH ED for further assessment and treatment.

7.39 Kerr was admitted to the medical assessment unit at the ROH, an urgent Deprivation of Liberty[12] (DoL) authorisation was made by the Trust for up to seven days and to the supervisory body the Local Authority. Both his LD health passport[13] and a medical summary accompanied him to hospital. The following day an e-mail from the hospital was sent to check the social worker was aware that Kerr had been admitted to hospital and advise that a meeting prior to discharge to manage his self-neglect in the community would be required.

7.40 During this inpatient episode, KeyRing staff provided excellent support to Kerr in trying to get him to engage with his care and treatment plan, communicated with health professionals and his Deputy over money taken from his bank account. Ward staff noted a female 'visitor' was eager for Kerr to be discharged and he had asked staff to take him to the hospital ATM so that he could withdraw money but "*not to tell his support worker*". A further adult safeguarding referral was made via e-mail by the community LD nurse reporting concerns about financial abuse.

7.41 Kerr had agreed to an endoscopy during this inpatient episode however following a telephone call with someone believed to be his 'sister' Adult A, he withdrew his consent to the procedure. The community LD nurse advised staff that there had been previous concerns about 'family' preventing him from seeking treatment and attending hospital appointments. It was clear during this inpatient episode that Kerr was not taking advice such as managing his personal hygiene and keeping his legs elevated to reduce their swelling while on the ward.

7.42 During this inpatient episode, a further MDT took place between Kerr's social worker, KeyRing support staff, his Deputy, NCA staff and the community LD nurse. Brief notes were added to Mosaic which recorded that a further meeting would take place prior to discharge. The social worker advised that the safeguarding investigations need not delay hospital discharge and that they and KeyRing would visit Kerr jointly to undertake a capacity assessment on whether Kerr could consent to his care and support plan. A rereferral back to community DNs was made. A hospital bed was to be arranged and a commode to support care back at home. The social worker saw Kerr on the ward and felt that he understood what he needed to do to improve his personal hygiene but that he was not able to do this consistently. The ward was informed that it was their decision whether to discharge him and that the social worker couldn't keep Kerr in hospital if he wanted to go home.

7.43 Transfer of Care staff were made aware of the outcome of the capacity assessment completed by the social worker and agreed that Kerr had capacity therefore no DoLS could be applied and discharge could not be prevented. This decision was also supported by ward medical staff. Discharge to assess paperwork was completed which concluded that Kerr required 24-hour care due to his inability to self-care, long standing evidence of self-neglect from safeguarding referrals and possible financial abuse, a hospital bed and commode were required.

7.44 The discharge planning meeting did not go ahead; it was cancelled by the social worker who stated they would visit Kerr on a regular basis after discharge following discussion with their manager. The community LD nurse was advised of this outcome. 3 weeks after admission Kerr was discharged home not having attended to his hygiene needs at all during his in-patient episode, and he could not be persuaded to have the endoscopy after speaking to 'family' to rule out the possibility of internal bleeding causing his anaemia.

[12] Deprivation of Liberty https//:www.scie.org.uk/mca/dols/at-a-glance/#: [Accessed June 2024]

[13] LD Health Passport is designed to assist people understand the health needs of someone with a learning disability https://www.england.nhs.uk

7.45 The day after discharge the social worker went to visit Kerr but got no response when they knocked on the door and shouted through the letterbox. He did allow his KeyRing support worker in later that day and stated he "*hadn't heard knocking on his door*". The social worker did see Kerr at home the following day and introduced him to a new support worker from a different agency who would be providing an additional 1 hour of support each morning to help with medication and personal hygiene. 6 days later a hospital bed and commode were delivered to Kerr's home.

7.46 Kerr was referred to the Urgent Care Response Team (UCRT) on hospital discharge, they felt the hospital discharge had been poorly planned. No home visit was undertaken, equipment had not been delivered prior to discharge, the home was cluttered and infested with flies. The hospital had recorded that Kerr was medically fit for discharge, but the discharge to assess staff had been unable to complete a home visit prior to his discharge home. Kerr had been contacted by the URCT and had agreed to a visit, but staff were unable to get a response at his home. The Police were called for a welfare check, Kerr was spoken to via telephone he stated he was ok at home. The following day a further visit was arranged, again Kerr did not answer the door, but voices could be heard from inside. Concerns were shared with Kerr's social worker. The DNs also attempted a home visit the following day, they were also unable to gain entry, both the social worker and GP were made aware.

7.47 At the end of July, the DNs escalated their concerns about the ability of Kerr to manage his self-care needs with his property also covered in flies and another failed visit for leg dressings. Escalation was made to a senior nurse the result being that an appointment for Kerr to attend clinic for leg dressings was made for eight days' time. The GP, Kerr's social worker and support worker were informed of this plan. On the same day Kerr's care was discussed at the social workers supervision and a summary of concerns were recorded, agreeing that Kerr had mental capacity to decide on what care and support he would accept. Additional support from the second care provider was to start from the beginning of August. It was agreed that the social worker would visit Kerr on a weekly basis. It was also noted that Kerr appeared to engage better with female staff, this had not been noted previously by ASC.

7.48 From August until Kerr's sad death, KeyRing support staff worked well with Support to Lead support staff, the second care agency commissioned by ASC in trying to encourage Kerr to comply with his care package, after one week of non-engagement the social worker was contacted by Support to Lead to discuss their concerns about not being able to engage Kerr, they made a further two attempts at contacting Kerr's social worker that were not responded to. Kerr also DNA his DN clinic visit early in the month to have his legs redressed and again the following day despite saying he would attend after a telephone call with him. This further non-engagement with appointments for leg dressings and EPO injections was discussed at the DN Huddle and concerns shared with their lead nurse and Kerr's social worker. A best interest meeting was proposed to discuss his capacity in relation to his healthcare. Kerr attended clinic on the 7th where it was noted his legs appeared infected, and advice was sought about his EPO injection due to his blood pressure being high. Kerr was advised that if he felt unwell, he was to attend the ED.

7.49 Two days later, Kerr was admitted to Manchester University NHS Foundation Trust (MFT) via ambulance after having a seizure in the street. Following clinical review, he was transferred to a high dependency unit (HDU) with high blood pressure and renal failure. Once stabilised, he was moved to a ward and a DoL was applied for. Staff had assessed him as not being able to consent to his care and treatment and he needed one-to-one supervision. During this inpatient stay, Kerr's LD was managed appropriately with community LD nurse involvement and physiotherapist due to Kerr's high risk of falls. His mental capacity to consent to his care

and treatment was to be revisited as his physical health improved however there is no documentation to support that his mental capacity was reassessed following the initial assessment for the purposes of applying for the DoL. During his hospital admission it was noted that when he collapsed in the street his bank card had been stolen and used, his Deputy was notified, and a stop was placed on his account.

7.50 The coordination of Kerr's hospital discharge was poorly communicated; his support workers were not informed of his discharge until after it happened and were informed there was no change in his care needs. The community DNs were not aware he had been admitted to hospital, Kerr was re referred to them on discharge by ward staff but the referral cannot be found by the DNs.

7.51 On 21st August, NWAS and Police attended Kerr's home following a report of self-harm, this was noted to be a cut trying to open a tin rather than self-harm. Conditions inside the property were noted to be extremely poor, Kerr was very unkempt, there was faeces on the floor, and Kerr was struggling with his mobility. It was clear that Kerr was not able to care for himself and was not engaging with his support package. An Early Help request was sent to ASC by NWAS and an ARCC referral made by the Police.

7.52 On the same day, ASC applied management oversight because of the safeguarding concerns, action was recorded as being that an MDT/Team Around the Adult (TAA) meeting was required to complete a multi-agency risk assessment and management plan. A mental capacity assessment was also required into Kerr's capacity to engage with his support package.

7.53 The following day, an e-mail was sent by KeyRing staff outlining their concerns for Kerr's health and wellbeing to both social care and health professionals and the lack of TAA meetings. His health was visibly declining, and he was increasingly withdrawing from engaging with support.

7.54 On the 29th August, KeyRing staff again e-mailed the lead social worker requesting a review of Kerr's support needs. They arranged for a GP home visit due to their concerns however this was allocated for the following day. NWAS were then contacted, and Kerr was taken to the ROH due to his reduced level of consciousness. He was later transferred to the ICU with probable sepsis, a further safeguarding referral was submitted to ASC by hospital staff.

7.55 The following day, ASC management oversight recorded that a strategy meeting was to be held on the 6th September, Kerr died on ICU on the 3rd September.

8.0 Analysis against the Terms of Reference

8.1 Empowerment - people supported and encouraged to make their own decisions and informed consent.

8.1.1 Kerr had a known learning disability, he had a hospital passport drawn up by the community LD nurse and shared with professionals, Kerr was also given a copy, he was registered by his GP for annual health checks, in line with expected practice. During the timeframe of this review Kerr had to move GP surgery due to his existing practice closing, he was therefore less known to the practice he was registered with for the purposes of this review. He received the assistance of a community LD nurse to support him at hospital appointments and out in the community. To be able to communicate complex information with Kerr, staff needed to use visual aids to support his level of understanding and maximise his ability to demonstrate his ability to give informed consent.

8.1.2 ASC commissioned KeyRing to support Kerr with managing his tenancy from 2016 onwards following a care needs assessment. This care package provided Kerr with 3 hours of support 3 times a week.

Section 9 (4) of the Care Act specifies that the needs assessment must identify the following:

- The persons care and support needs
- The impact of the person's needs for care and support on all aspects of wellbeing
- The outcomes that the person wants to achieve

8.1.3 Section 27 of the Care Act requires local authorities to keep care and support plans under review, and to carry out an assessment where they are satisfied that the person's circumstances have changed. ASC did have an 'open' Care Act assessment on Kerr's records, this was kept as a 'live document' and added to as necessary. KeyRing staff regularly reported to the social worker that they were concerned about Kerr, and his ability to engage with the support they were trying to offer. It is not clear to the independent author and panel how these concerns were fed into the MDT meetings and whether Kerr's views about his care and treatment formed the basis of actions required as a result.

8.1.4 In October 2022, there is reference to an increase in funding for support and that a nursing home placement was in Kerr's best interest but that the one home approached resulted in the home manager concluding that they would not be able to meet Kerr's needs. It is believed that this was a decision reached to allow Kerr's home to be fumigated and to stabilise his health. It is not clear to the independent author and panel how the need for 24-hour care was reached, if it was documented as a best interest decision following a capacity assessment of Kerr's ability to decide in respect of his living arrangements, and if so, why this was not actioned further, or revisited when it was clear Kerr was unable to manage his own home, after his last discharge from hospital in July 2023.

8.1.5 Throughout the timeframe of the review KeyRing were in regular contact with Kerr's social worker to raise their concerns about their ability to meet Kerr's needs under their agreed contract. They regularly asked the social worker to undertake care reviews requesting these as their concerns for Kerr's health and wellbeing increased. There is little documented evidence to support that either Kerr's voice was heard, or these concerns were acknowledged, and acted upon outside of planned MDT meetings which were inconsistently being held.

8.1.6 It was not until Kerr was in hospital in July 2023 that a further needs assessment was undertaken and further support for Kerr was commissioned, again it is not evidenced that Kerr had agreed to this. Support to Lead were commissioned from the beginning of August to provide an additional one hour of support in the mornings five days a week to aid Kerr in taking medication and in meeting his hygiene needs. The additional support did not have a substantial effect on Kerr engaging with staff to support his care needs. An assessment of Kerr's capacity and a re-evaluation with Kerr taking an active role in discussions about whether 24-hour care would be more appropriate with consideration given to using an IMCA[14] would have evidenced good practice at this point.

8.1.7 In April 2022, Kerr was discharged from Haematology due to non-attendance of three appointments, this does not appear to have prompted any professional curiosity in relation to why someone with a known learning disability had not attended, there was no communication with either the LD nurse or the NCA safeguarding team. When the GP referred Kerr to the OT due to his high level of self-neglect and not managing his hygiene needs an OT did speak to

[14] IMCA's support people who are assessed to lack capacity to make a best interest decision and they do not have family or friends appropriate to consult with about the decision

Kerr who stated he *'could manage'*. There was no further professional curiosity applied into the discrepancy in the GP's view and Kerr's view. In the same month the DNs were concerned about Kerr arriving late for appointments and couldn't always receive the care he needed, again no further professional curiosity, escalation or consideration of reasonable adjustments was triggered to address this. **[Recommendation 4 &5]**

8.1.8 The NCA OT team received two referrals, one from KeyRing to assess Kerr for a rehousing assessment because he needed an accessible property and the other from the GP. Kerr stated he did not require support, so no further action was taken by the service. There was no professional curiosity applied in relation to the reason for the assessment and Kerr's refusal of the service. It is unclear whether KeyRing were informed that the OT would not be assessing Kerr following their referral. **[Recommendation 5]**

8.1.9 Kerr presented at hospital in April 2022 stating he had been assaulted by a 'female friend who had mental health issues'. He refused a DASH[15] assessment, as there was no relationship between the two it did not meet the criteria for MARAC[16]. Kerr was felt to have the mental capacity to make this decision although there was no formal documentation about how the reasoning for this conclusion was reached. A DASH assessment could have been completed based on answers provided by Kerr during his consultation with a health professional following his injury. There was potential for one of the MARAC criteria to apply 'Potential Escalation' if the female friend's mental health continued to deteriorate. There was no professional curiosity about how she was being supported and if they lived together. **[Recommendation 2 & 5]**

8.1.10 From the behaviours demonstrated by Kerr he was able to understand at a certain level what he needed to do to maintain his personal hygiene and habitable living conditions but his ability to take the necessary steps to achieve this were regularly absent despite the support of staff. Therefore his 'executive function' should have been considered in greater detail when a capacity assessment was documented by his social worker. The consideration of executive function applies to both health and social care staff who had a role in supporting Kerr. His capacity to make different decisions about his care and treatment should have been reflected in his records. When risks are increasing it is more important to record how the person's ability to make an unwise decision has been concluded to evidence good practice. This finding is a repetition of previous SAR findings published by OSAB[17]. **[Recommendation 2]**

8.1.11 Executive functioning has been described as 'the ability to think, act and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we have learnt in the past, and use this information to solve problems of everyday life'[18]. Terms such as executive capacity/executive functioning do not appear in the MCA itself, nor in the Code of Practice. Applying the MCA is therefore often not straightforward, practitioners are faced with making difficult decisions in situations where the person's actions may be disconnected from their understanding.

8.1.12 The courts have recognised these concepts and referred to 'executive functioning' and 'executive dysfunction' in relevant case law. Practitioners at the PLE felt that MCA training should include more practical case examples which could occur in their field of work to support

[15] DASH – Domestic Abuse, stalking, harassment and honour-based violence assessment checklist

[16] MARAC – Multi Agency Risk Assessment Conference to agree and record safety plans for victims of domestic abuse

[17] ibid

[18] https://www.communitycare.co.uk/2023/12/19/executive-functioning-and-the-mental-capacity-act-2005-points-for-practice/ [Accessed August 2024]

them in being better able to evidence that executive functioning had been explored as part of the assessment of a person's mental capacity to make a particular decision at a particular time. [**Recommendation 2**]

8.1.13 In September 2022, Kerr did not attend an appointment with the renal dietician following reports of a significant loss of weight. There was communication between the community LD nurse, DNs and Kerr's support workers. The DN accepted the comment from Kerr's social worker that Kerr had mental capacity and was choosing not to attend health appointments. There was a missed opportunity to identify that assessments were required on Kerr by different health professionals to establish whether Kerr understood his health conditions and what he needed to do to enable staff to support him managing these. **[Recommendation 1]**

8.1.14 In mid-July 2023, a mental capacity assessment was started by ASC in relation to whether Kerr could make decisions about his personal hygiene, but this was not completed and therefore no determination about Kerr's capacity to make this decision was recorded.

8.1.15 In August 2023, when Kerr's care was discussed at the DN Huddle meeting it was agreed that a best interest decision meeting would be required. There is no evidence to support that a mental capacity assessment was formally recorded prior to the need for a best interest decision meeting, or who was going to complete this. Neither took place prior to Kerr's death the following month. At the PLE, the DNs felt that they were not best placed to undertake capacity assessments on Kerr because he had an LD. There was no contact with the community LD team or SLT team to see if they could support the documentation of a capacity assessment on Kerr to establish whether he was making an unwise decision in not attending his leg dressing appointments and the risk that this posed to his health. The SLT team sits within NCA as does the DN service, the community LD team sits within PCFT the ability of both specialist teams to support the DN service should be reviewed by both agencies. **[Recommendation 1 & 5]**

8.1.16 Kerr was seen by clinicians on three occasions to assess his mental capacity to give informed consent for renal dialysis, two to assess capacity and a further meeting to decide a best interest decision. The best interest decision had to be deferred twice due to lack of IMCA availability. When the meeting did go ahead Kerr's views and risks associated with the treatment and length of time each dialysis appointment would take as well as risk of infection from the intravenous line were taken into consideration. The conclusion was that it was not in Kerr's best interest to have this treatment, without it his renal function would slowly decline further, he would start developing symptoms related to end stage kidney disease, but this could be managed through medications. The panel and the independent author agree from the information available that this was an appropriate decision and evidenced good practice by the renal consultant.

8.1.17 The review finds that there has been considerable progress by the OSAB members in educating staff on the requirement and use of the MCA recognising that there is still work for agencies to do to provide assurance that this good practice is embedded and sustained. This review highlights that there is still work to do in supporting staff in recognising who is responsible for documenting a person's mental capacity to make a particular decision at a particular time. Consideration of their executive function in respect of carrying out what they need to do to demonstrate they have capacity and revisiting the assessment as risk to their health and wellbeing increases. **[Recommendation 1 & 2]**

8.2 Prevention – It is better to take action before harm occurs.

8.2.1 The combined chronology demonstrates that from mid-October 2022 and from March 2023 the MDT agreed that meetings to discuss risks to Kerr and to share information were

required weekly and two weekly respectively. There is no evidence in the combined chronology to support that the meetings were being held at this level of frequency.

8.2.2 The purpose of MDTs and the role of the 'care-coordinator' was discussed at the PLE, some practitioners felt that this responsibility sat with either a social worker or a mental health worker. MDTs were viewed as primarily a health and social care responsibility. For example, when discharge planning from hospital. viewing the care-coordinator role as being the responsibility of either health or social care meant that the opportunity to identify who could engage Kerr best was a lost opportunity. He did have a closer trusting relationship and more frequent contact with one of his support workers. Practitioners reflected on the importance of having an identified 'deputy' from each agency who could step in if the 'lead' was unable to attend. The MDTs were subsequently cancelled for a variety of reasons including availability of the social worker who was viewed as the 'lead', sickness, annual leave, absence of another MDT member, or lack of availability of an IMCA.

8.2.3 Given that the MDT members had agreed the necessity and frequency of the meetings, there was a collective lack of responsibility by the MDT to either provide a deputy to stand in for them, or for a different MDT member to chair the meeting so that they could go ahead. There was positive feedback from practitioners about the OSAB Tiered Risk Assessment and Management (TRAM) protocol with staff reporting that this was a better framework for broader multi-agency working and that they had a better understanding of the protocol since the time they were supporting Kerr. Training for agencies on being part of an MDT or TAA meeting should continue to embed that **any** member can call an MDT or TAA and to strengthen practitioners' confidence in leading a meeting. This echoes with the recent findings from partner agencies relating to the functioning of the TRAM Protocol across Oldham. **[Recommendation 5]**

8.2.4 The recording of MDTs was generally found to be poorly completed or not documented at all on Mosaic, the minutes were held by ASC and not routinely circulated to MDT members. Actions following MDT meetings that did take place were either not completed or there was no evidence to indicate that they had been completed. Some MDT meetings didn't go ahead but were instead used as information exchanges between various staff via e-mails. The lack of clear documentation in relation to known risks, additional concerns and action plans resulted in 'drift' and does not evidence good practice. **[Recommendation 5 & 6]**

8.2.5 Trying to coordinate MDTs against busy workloads with little or no administrative support was something that the PLE attendees reflected upon. Some had experience of being present at MDTs and felt that having to chair, take notes and listen to everyone's views was difficult, and was seen as a barrier to evidencing good practice. The ability to hold MDTs over multimedia platforms however was seen as a positive, as was the ability for these meetings to be recorded to support minute taking. The continued development of artificial intelligence (AI) in supporting multi-agency working holds the potential to support effective record keeping but will not be possible without a cost implication to public bodies.

8.2.6 It was not clear whether MDT meetings were held under safeguarding procedures as strategy meetings given the twelve referrals that were made to ASC by other agencies over the timeframe of the review. Had capacity been assessed and concluded that Kerr had capacity for different decisions he was required to make then the TRAM Protocol could have been utilised using TAA meetings which might have strengthened the response to Kerr's risk-taking behaviours.

8.2.7 In early June, an MDT meeting was held following further concerns about Kerr not attending appointments. It was noted at this time that although Kerr had lots of appointments

to attend, he had the physical ability to get to them independently if he was aware of them. What was not acknowledged was that even with the previous support of the community LD nurse, and his current support workers who weren't commissioned to support him to attend but did when possible, he still was not attending. Even when reminded he would often not attend being unable to time manage effectively when taxis were ordered and on occasions not returning to Oldham after visiting friends in other places. No further action was identified to address this clear problem, and no escalation was made either internally or externally by members of this MDT. No capacity assessment in relation to his ability to understand the need for him to prioritise his health appointments was felt necessary. **[Recommendation 5]**

8.2.8 At the end of July 2023 the DN discussed Kerr's poor home conditions, lack of self-care and not attending appointments with a senior nurse when it was known he had maggots in his leg wounds. The action following this discussion with a senior nurse was weak, offering Kerr a further appointment in 8 days' time. There was clearly a risk of significant infection and stronger action should have been identified because of this escalation. **[Recommendation 5]**

8.2.9 Also at the end of July the social worker discussed at supervision the management of Kerr. At this meeting it was agreed that Kerr had the mental capacity to agree to what support he would accept despite the longstanding evidence that his executive function suggested he lacked the mental capacity. It was discussed that additional support would be provided by Support to Lead from the beginning of August with no apparent recognition that the discharge to assess paperwork at the hospital communicated to the social worker and evidenced in the hospital passport had concluded that 24-hour care was needed. It was also noted that Kerr may prefer female workers which could improve his engagement, this was identified by his GP eight months earlier, Kerr blamed 'doctors' for the death of his father in hospital, but stated he would accept female staff. Poor communication or lack of professional curiosity and holistic assessment may be the reason this was only picked up by ASC later. Supervision was not effective in recognising that Kerr's executive function should be revisited at a further assessment of his mental capacity to agree his care package. **[Recommendation 5]**

8.2.10 Following the discussion about Kerr at the DN huddle in early August 2023, there was no acknowledgement that a clinician needed to assess Kerr's mental capacity to understand the importance of him having his infected leg wounds redressed and attending for EPO injections as a matter of urgency. The lack of consideration of mental capacity in the context of self-neglect at the DN huddle was a missed opportunity to evidence good practice. **[Recommendation 1 & 5]**

8.2.11 On 22nd August KeyRing shared their concerns that Kerr's health was declining and his engagement with support staff was getting worse. None of the agencies this concern was shared with took the lead in convening an MDT or TAA meeting or took responsibility for being the lead professional. A KeyRing manager could have also taken the lead in arranging an MDT or TAA meeting themselves. This was reflected on by the KeyRing support staff who attended the PLE, they felt that since their work with Kerr they had received further training and would know who to speak to about taking the lead an MDT or TAA if necessary. **[Recommendation 5]**

8.3 Proportionality - The least intrusive response appropriate to the risk presented.

8.3.1 There were frequent concerns raised with ASC about Kerr's vulnerability to financial exploitation and potential cuckooing. There is no evidence of a mental capacity assessment by ASC being undertaken in relation to Kerr's understanding of financial abuse and whether he was able to manage his finances effectively following one that was completed prior to his Deputy being appointed. Large scale financial abuse was limited due to Kerr having this

Deputy to oversee his money. There were repeated references in the combined chronology to the Deputy placing a block on Kerr's bank account when other people appeared to be using his bank card to withdraw money, or Kerr reported that he had 'lost' his bank card. The Deputy's ability to limit financial losses could be viewed as the reason no further capacity assessment about financial abuse was recorded and held on ASC's records.

8.3.2 Kerr's inability to manage his home security by either not locking doors when he wasn't home or by having other people in his property resulted in a financial burden to him when he had to use his own money to replace two stolen televisions.

8.3.3 The safeguarding referrals and communication between ASC and practitioners reporting hearing the voices of others inside Kerr's home resulting in occasions when he would not come to the door to speak to practitioners does not appear to have been addressed in any meaningful way by the MDT. The safeguarding referral made by the RSI manager alerting ASC to the observation that Kerr was letting a homeless man into his home and had been seen exchanging telephone numbers with them does not evidence that Kerr could be the victim of cuckooing. Neither does the report of a neighbour sharing that they had observed Kerr allowing even more people into his property. **[Recommendation 3]**

8.3.4 In November 2022, the letting agency responsible for the management of Kerr's tenancy were made aware of the possibility that Kerr was the victim of cuckooing. There is no evidence to support what action they took because of this and whether the possibility of Kerr breaching his tenancy agreement was discussed directly with him by the agency. It is noted that KeyRing staff raised it with him, but unknown whether his social worker was informed of the letting agencies view on a potential breach of tenancy to contribute to ongoing risk assessments and management plan for Kerr. There was also no evidence to support that Kerr's housing band could be revisited to see if it could be raised further from band 2 up to band 1 to reduce the risk by moving to alternative accommodation. **[Recommendation 3]**

8.3.5 There were no safeguarding measures put in place because of the concerns about Kerr being vulnerable to cuckooing. The Police viewed this as Kerr willingly allowing people into his home, resulting in no wider exploration by the Police themselves or via the MDT about his ability to understand what cuckooing was. Grooming is described as a form of abuse that involves manipulating someone until they are isolated, dependent, and more vulnerable to exploitation.[19] Grooming can be seen as a risk to children, but it can also affect adults. Wanting meaningful friendships with people can result in vulnerable people being at risk of abuse, by either cuckooing or grooming, the benefit of friendship being outweighed by any negative aspects they may experience. Grooming is not referred to in current guidance on cuckooing and modern slavery available on the OSAB website. OSAB members may want to include this terminology in their documents. **[Recommendation 3]**

8.3.6 OSAB[20] has published 'cuckooing a 7-minute briefing' document and an Exploitation in the form of Cuckooing Guidance document in May 2023 because of learning from previous SARs. Both new resources were in place in the latter part of the timeframe for this review and would not have been well embedded in staff approaches to managing such concerns relating to Kerr. At the PLE, some staff shared that they were still not aware of these documents. **[Recommendation 3]**

[19] https://www.anncrafttrust.org>signs-of-grooming-in-adults-what-towatch-out-for (May 2019) [Accessed June 2024]

[20] OSAB.org.uk [Accessed June 2024]

8.3.7 Development of a ‘cuckooing tracker’ by GMP Oldham District was identified in an earlier SAR[21] published by OSAB in April 2023. The tracker documents all those who are suspected of being targeted for cuckooing. Since this previous SAR cuckooing is now managed via fortnightly multiagency meetings specifically for Protecting Vulnerable People (PVP), this meeting reviews open cuckooing intelligence and new intelligence to ensure this is tasked out to the appropriate teams. The OSAB should seek assurances that information from both individual agencies and MDT/TAA meetings relating to cuckooing are shared with GMP Oldham District to make best use of the PVP meetings, allowing local officers to make regular visits to homes or allow proactive investigation from a specialised police team. **[Recommendation 3]**

8.3.8 Concerns raised about Kerr wanting to marry someone he had met online and who he knew very little about resulted in no additional action under MDT meetings or safeguarding procedures being taken. There were conversations with him about this by practitioners and support staff. Staff declined to sign his passport application and he was advised that his health would probably prevent him from travelling abroad if he didn't engage better with the management of his leg wounds, but this was not under safeguarding procedures. It was good practice to attempt to utilise Kerr's desire to travel in attempting to try and engage him in attending his leg dressing appointments, despite this being ultimately unsuccessful.

8.3.9 The OSAB published its Self-Neglect Toolkit in February 2021 alongside a 7-minute briefing paper[22] on self-neglect which followed a Thematic Self-Neglect SAR in 2019/20 following the death of people for who self-neglect was a concern. Both documents demonstrate themes that were evident in the behaviours of Kerr. Page 10 of the toolkit demonstrates clearly steps to follow in the management of self-neglect. A needs assessment was completed, Kerr's inability or unwillingness to engage with this should have resulted in his mental capacity being assessed for the different decisions he was required to make, which should in turn have populated a risk assessment document and management plan. Not all of these actions were demonstrated by agencies supporting Kerr, further work is required to embed these principles. One of the practitioners at the PLE stated that they did not know what 'good' looked like in managing someone who self neglects. The agency this staff member represented may want to seek assurance that this is not a wider issue across this group of staff and that they are aware of the support tools available on the management of self-neglect on the OSAB website.

8.4 Protection - support and representation for those in greatest need.

8.4.1 The TRAM Protocol has been in place across Oldham since it was introduced in February 2022, the OSAB recognises that the introduction of the TRAM Protocol has represented a significant culture change in safeguarding practice across partner agencies. Previous SARs published by the OSAB have reflected that the embedding of this protocol will enhance the work of practitioners supporting adults with multiple and complex needs.

8.4.2 The independent author and the panel members reflected on the findings from a recent piece of work to gain an understanding from partners about staff feedback on the TRAM Protocol. The consultation reflected that training on the protocol is still being rolled out, cases are being discussed at supervision sessions but there was still work to do in having staff confident enough to take the lead on calling meetings. There was a perception that ASC or PCFT would lead the TAA meetings. Continued training on the TRAM Protocol is required to

[21] OSAB SAR 'Robert' published April 2023 [Accessed June 2024]

evidence that the findings from published SARs locally and nationally relating -to multi-agency working, escalation and risk assessment is embedded. **[Recommendation 5]**

8.4.3 OSAB also has several guidance documents on its website including the Self-Neglect Toolkit: The Short Guide to Working with People in Circumstances of Complex Self-Neglect, and Guidance Where the Individual or Family are Not Engaging with Services. Kerr displayed frequent non-engagement with services and self-neglect with the risk to his physical health increasing in 2023. At the MDT meetings the actions that could have been considered in both the above documents are not well evidenced and do not provide a level of assurance that the OSAB would want to see. **[Recommendation 5]**

8.4.4 It is not clear whether appropriate reasonable adjustments were taken by PCFT staff in relation to supporting Kerr to attend haematology outpatient appointments, he DNA a number of these and became agitated at others due to the length of wait in the outpatient department. The review acknowledges that sometimes events happen that mean clinic appointment times cannot always be met, however the OSAB should seek assurance that wherever required reasonable adjustments are made to comply with the Equality Act. **[Recommendation 4]**

8.4.5 It was was known to agencies working with Kerr that he had an LD, there are examples in the abridged chronology where practitioners could have considered whether Kerr required reasonable adjustments. Home visits were considered and attempted by the DNs but these were not always successful, only managing to see Kerr in his own home on one occasion or were not feasible due to the flea infestation in his home and Kerr's inconsistent ability to be at home at prearranged times when DNs were to visit. **[Recommendation 4]**

8.4.6 In December 2022 Kerr shared that he didn't like hospitals because doctors had *'killed his father*', but he would see a nurse. It is unclear whether his preference for female workers was conveyed to other professionals and utilised as far as services could allow for. The social worker's supervision with their manager in late July 2023 records that this was the first time they were aware of it. **[Recommendation 4]**

8.4.7 Kerr's GP did not evidence that reasonable adjustments were considered/made by the practice on the 31st August, the request for a home visit by the KeyRing worker was not responded to appropriately. A text message was sent to Kerr advising him that he would need to contact the surgery by telephone to arrange a home visit as the online contact form was not for urgent use. Kerr was highly unlikely to comply with this request when he was so unwell. **[Recommendation 4]**

8.5 Partnership - local solutions through services working with their communities.

8.5.1 Kerr's home was provided by a private letting agency based in Bury Council and therefore the agency itself was not overseen by Oldham Housing Options (OHO) which sits within Oldham Council. The property however was in Oldham and any concerns about its condition or Kerr's risk of homelessness would have been responded to by Oldham Council. The property was not located in a selective licensing area and therefore not subject to additional monitoring requirements. No follow up action was taken by OHO relating to the concerns raised about Kerr letting people into his home. OHO were also not notified of the threat of eviction.

8.5.2 There is evidence to support that Environmental Health were aware of the poor home conditions in which Kerr was living which an agency worker at Environmental Health was attempting to review post the Covid 19 restrictions, however this was delayed due to the flea infestation at the property. The Pest Control Team also attempted to support the treatment of

the flea infestation, but this was delayed further due to missed appointments, non-payment of fee and pre-visit instructions not being followed.

8.5.3 In July 2022 a short stay placement had been authorised to allow a deep clean of Kerr's property as it was recognised that the home conditions were poor. This plan fell through due to the care provider withdrawing their offer of accommodation, no other alternative option seems to have been explored until 10 months later when there was a record of a deep clean in May 2023 which also coincided with Kerr accepting support to keep his property in a habitable state.

8.5.4 KeyRing support workers were e-mailing the housing options e-mail address rather than the housing register team e-mail address who are responsible for processing applications. The lack of chasing applicants and support workers however was not uncommon due to the high volume of applications being dealt with at the time and was not affected by the wrong e-mail address being used.

8.5.5 Kerr was admitted to ROH on 16th February 2023 with an infection in one of his lower legs, IV antibiotics were given, and he was persuaded to stay overnight. During this admission staff did consider Kerr's ability to give informed consent to his treatment, but no formal capacity assessment was recorded. He was considered medically fit for discharge the following day and capable of understanding the need to complete a course of oral antibiotics. The hospital LD nurse service were contacted but there was nobody available to support this admission. A discharge summary was sent to his GP and the EDT within ASC had been made aware of both his admission and discharge. It is not clear whether the DNs were aware that Kerr had an infected leg wound and when they next saw him for dressing changes. There were three missed meetings before he was finally seen again.

8.5.6 In late June 2023, Kerr was again transferred to ROH where he was admitted to a medical ward, a DoL was applied for by NCA because Kerr was felt to lack the capacity to consent to his care and treatment and he needed supervision. The community LD nurse supported Kerr during this admission and an MDT meeting was held at which it was agreed that a further meeting was required prior to discharge.

8.5.7 During this admission hospital staff felt that following an improvement in Kerr's physical health the DoL no longer applied, and he was becoming medically fit for discharge in July. Discharge to assess paperwork concluded that Kerr required 24-hour care due to his inability to self-care, and long-standing self-neglect resulting in multiple safeguarding concerns. The social worker advised that discharge from hospital should not be delayed by safeguarding enquiries because these could be followed up in the community. The further MDT was cancelled by the social worker which left the hospital discharge team to co-ordinate the discharge. The hospital rereferred Kerr back to the DNs for leg wound dressings and a hospital bed and commode were identified as being required for Kerr's home to enable him to manage.

8.5.8 The Transfer of Care staff at the hospital were aware of the social workers view that Kerr had the capacity to make decisions about his support package. The NCA panel member was able to confirm that the hospital's view was that Kerr required 24-hour care, and that this was communicated to ASC prior to discharge. An assessment of his capacity to understand his care needs was also documented in his hospital passport, concluding that he lacked capacity. ASC felt that the hospital needed to complete a capacity assessment on Kerr's ability to understand his care needs before the option for 24-hour care could be considered under a 'best interest' decision. This was a significant missed opportunity to consider Kerr's long term care provision. The social worker's view was the Kerr had capacity and could not be 'forced to agree to 24-hour care.

8.5.9 Hospital equipment did not arrive in Kerr's home until the week after he was discharged. Better communication following the cancellation of the MDT by the social worker could have allowed the need for 24-hour care to have been revisited. Practitioners at the PLE agreed that this discharge was poor, and that Kerr's home was not suitable for him to return to, but that poor communication and discharge coordination resulted in him returning home. The ordering of equipment was reflected upon at the PLE, and it was agreed that clearer information in relation to equipment provision could have reduced the delay in this being available when the hospital staff were informed that they could discharge Kerr.

8.5.9 At the beginning of August, the second care provider Support to Lead were commissioned by ASC to work with KeyRing in encouraging Kerr with medication compliance and his hygiene needs. Both agencies worked well together in their attempt to support Kerr, but it was not enough to prevent Kerr being admitted to hospital for the final time at the end of the month. Whether Kerr's assessed needs would have been better managed in a 24-hour care setting the review is not able to conclude. His level of self-neglect even with encouragement from staff he had built up a relationship with was not effective, the level of restraint required to deliver care against assessed need would most probably not have been in Kerr's best interest.

8.6 Accountability - accountability and transparency in safeguarding practise.

8.6.1 There were twelve references to Adult Safeguarding referrals being made by partner agencies between September 2022 and July 2023 as detailed in the table below. ASC have provided the blue text summarising the actions they undertook.

Date	Agency Reporting	Concern
15.09.2022	GMP	Walking in the middle of the road unable to see. The referral was received by the LD/A team, but a safeguarding concern was not completed on Mosaic.
12.10.2022	NCA DN	Coercion and control by another person. DN sent the safeguarding concern via e-mail on the advice from the LD/A team, as there was already an MDT supporting Kerr, no new safeguarding concern was opened on Mosaic.
04.11.2022	NCA DN	Woman in property heard on calls and DNA appointments. DN sent the concern via e-mail on the advice of the LD/A team, as there was already an MDT supporting Kerr, no new safeguarding concern was opened on Mosaic
23.11.2022	RSI	Homeless man befriended. An email was received by the LD/A duty worker who agreed to complete the safeguarding concern, but there is no evidence of this referral being completed on Mosaic.
14.12.2022	NWAS	Risk to safety from suicidal friend. A safeguarding referral was recorded on Mosaic regarding a 'number of concerns' relating to Kerr's living conditions, people living in his house and his current health. No safeguarding enquiries were made as there was already an MDT supporting Kerr.
19.01.2023	NCA renal team	Self-neglect and non-engagement.

		A safeguarding referral was sent to Adult MASH, then on to the allocated worker in the LD/A team. There is no safeguarding concern raised and evidence of action taken on Mosaic.
24.03.2023	NCA DN	Physical assault and suggesting he was getting married. DN sent the concern via e-mail on the advice of the LD/A team, as there was already an MDT supporting Kerr, no new safeguarding concern was opened on Mosaic.
29.04.2023	NWAS	Self-neglect and severely ulcerated legs. Safeguarding referral received but no new safeguarding concern is evidenced on Mosaic.
19.05.2023	NCA DN	Self-neglect and financial abuse. DN sent the concern via e-mail on the advice of the LD/A team, as there was already an MDT supporting Kerr, no new safeguarding concern was opened on Mosaic.
30.06.2023	PCFT LD nurse	Self-neglect and home environment. Safeguarding referral received by LD&A team, safeguarding concern opened relating to Kerr's ability to make decisions about his physical health, maggots in leg wound. Safeguarding action was moved to a strategy meeting. There is no evidence of a strategy meeting having been completed on Mosaic.
04.07.2023	NCA	Coercion and control and financial abuse. Safeguarding referral was received; no evidence of any further action being taken is available on Mosaic.
21.08.2023	GMP	Unsuitable home environment, contaminated with faeces. Safeguarding concern referred to ARCC this is evidenced in Mosaic with action being to convene an MDT/TAA meeting and complete an MCA.

8.6.2 The Local Authority has a duty to establish whether there is a statutory duty to make safeguarding enquiries in accordance with section 42 of the Care Act 2014. If the duty applies, then safeguarding enquiries **must** take place[23].

8.6.3 The combined agency chronology raises questions relating to whether appropriate action was taken by ASC on all occasions in response to safeguarding referrals being made by practitioners. Based on the table above it is not possible to conclude appropriate action was being taken because the documentation available on IT system used by ASC Mosaic does not support this. An example being the referral made by the police to the ARCC in September 2022, which was sent to the MASH, who forwarded the concern to both Kerr's social worker and the LD&A duty team e-mail inbox. No safeguarding concern was raised on the system which would have been expected practice, and no indication of the reason for this omission is recorded. The next contact was recorded on the 23rd November, which also demonstrates that the referral made on the 4th November by the DN was again not recorded on Mosaic.

[23] OSAB Part Three: Procedures for Responding to and Reporting Allegations, Concerns or Suspicions of Adult Abuse page 7 (2)

8.6.4 The safeguarding referral made by NWAS in December 2022 was uploaded on to Mosaic, it was documented that following Kerr's wish not to report this crime to the police, that a strategy meeting under safeguarding procedures should take place. There is no evidence to reflect on Mosaic that a strategy meeting was held.

8.6.5 No safeguarding enquiry was opened, there was no consideration of using the TRAM protocol for someone assessed as having capacity to make his own decisions about his care needs but was identified as an adult at risk. Due to Kerr's lack of consent this referral was not progressed, his consent could have been overridden under safeguarding procedures and a strategy meeting held to understand which agencies were supporting Kerr and how, and to assess risk and formulate a safety plan. A mental capacity assessment should have been undertaken again to assess Kerr's capacity to understand his care and support needs and to evidence a trend.

8.6.6 In January 2023, there is no evidence to support that the referral made by NCA was uploaded onto Mosaic and therefore no evidence of action taken as a result. The same outcome is found following the referrals made by the DN in March 2023, NWAS in April 2023, and the DN in May 2023 as in the table above. The next referral uploaded onto Mosaic is as a result of the referral made by PCFT on the 30th June, this was uploaded on the 5th July 2023 but no action taken is evidenced.

8.6.7 There are four referrals that reflect that the safeguarding concerns were reviewed and closed due to there already being existing MDTs that were reviewing concerns about Kerr. This was a missed opportunity to acknowledge that MDTs were not happening frequently enough to demonstrate consideration of escalating risks with mitigation factors identified.

8.6.8 In July 2023, the safeguarding referral made by NCA was raised on Mosaic with managerial oversight documented as being to organise a strategy meeting. The safeguarding meeting was not held before Kerr died in September.

8.6.9 On the 21st August following several concerns raised by MFT, NWAS and GMP making referrals into the LD/A team, managerial oversight documented that an MDT/TAA meeting was required to complete a multi-agency risk assessment and management plan. A mental capacity assessment was also required into Kerr's capacity to engage with his support package and to make decisions about medical treatment. There is no evidence of this action being completed prior to the death of Kerr.

8.6.10 At the PLE, multiple practitioners felt that the response to their making adult safeguarding referrals was ineffective, it didn't lead to robust risk assessments and meaningful actions. There was little feedback in relation to strategy discussions or referrals being actioned under Section 42 enquiries. There was little to no feedback to the referrer in relation to the outcome of their referral.

8.6.11 The OSAB's Multi-Agency Safeguarding Adults Policy Part One[24] identifies at 1.4.6 that when the statutory duty to undertake a safeguarding enquiry is met '*although the Local Authority is the lead agency for making enquiries it may consider others to undertake them'.* Practitioners felt that the absence of the social worker and no case reallocation or management oversight resulted in no meaningful action being taken because of their referrals. **[Recommendation 6]**

[24] OSAB Multi Agency Safeguarding Adults Policy Part 1 adopted (June 2017)

8.6.12 Practitioners also felt that the OSAB's Operational Procedures for Safeguarding Adults at Risk Part 2[25] was also not followed. Page 14 point 2.4.2 identifies that *communication on the outcome of the adult safeguarding concern will be shared with the referrer.* They described no direct feedback from the Local Authority when they raised an adult safeguarding referral. **[Recommendation 6]**

9. Good Practice

9.1 Greater Manchester Police

9.1.1 Oldham District are developing a PVP intelligence collection plan which aims to identify threat, identify any intelligence gaps and appoint an intelligence officer who will drive the intelligence collection, which includes cuckooing.

9.1.2 In September 2024 there was a lunch and learn delivered by the Local Authority in respect of partnership intelligence gathering and the pathways to submitting the partnership intelligence form.

9.2 GP surgery

9.2.1 Reasonable adjustments around gender specific healthcare indicated following the questioning of Kerr into why he disliked hospitals.

9.3 KeyRing

9.3.1 There were regular e-mails to the community LD nurse advising them of the health appointments that Kerr had which the nurse then supported Kerr with.

9.3.2 In November 2022 following Kerr reportedly having a homeless man in his property KeyRing staff observed later that his bedroom window was open which was unusual for Kerr. When questioned he answered that the room smelt but that the *'homeless man was no longer staying with him'.*

9.3.3 Staff regularly updated their risk assessment on Kerr, shared this with Kerr's social worker, escalating their concerns about his care package not meeting his needs in their view.

9.3.4 In their engagement with Kerr, KeyRing support workers recognising his vulnerabilities repeatedly worked over and above what their agreed contract required of them to plug gaps that they felt would not be filled by other agencies.

9.5 Northern Care Alliance NHS Foundation Trust

9.5.1 Kerr was supported appropriately to assess whether he could understand renal dialysis and how this would be delivered. There was a further meeting planned as part of his capacity assessment to establish whether he had the capacity to give informed consent to this treatment.

9.6 Oldham Adult Social Care

9.6.1 Kerr's finance Deputy worked hard with KeyRing to meet Kerr's needs and to provide the support and protection from financial abuse that he required.

9.7 Oldham Housing Options

9.7.1 Not directly related to this review but recognised as good practice, housing was aware that the chasing system reliant on staff to action housing applications was causing

[25] OSAB Multi Agency Safeguarding Adults Procedures Part 2 (December 2020)

unnecessary delays. There is now an electronic system in place from April 2024 that will send auto-responses/reminders relating to housing applications to speed up the process.

9.8 Pennine Care NHS Foundation Trust

9.8.1 The community LD nurse communicated regularly with Kerr via text to update/remind him of appointments, they also e-mailed his support workers to share this information. The MDT members were also kept updated with any information that required sharing. The community LD nurse was also proactive in health promotion, supporting Kerr at hospital appointments.

9.9 Manchester University NHS Foundation Trust

9.9.1 Safety netting advice was given to return or present at North Manchester General Hospital if becoming more unwell or pain unmanageable.

10. Conclusion

10.1 Supporting Kerr to manage his assessed needs against his care and support plans were clearly challenging and frustrating at times for both practitioners and his support staff. It is far easier to work with a compliant person than one who isn't, especially when there is long standing evidence of self-neglect which over time increases the risks to the person's physical health.

10.2 There were MDT meetings to try to support Kerr and to keep agencies working with him updated with the latest plans and actions. These however were not co-ordinated well, documented well, and with clear actions to address all the risks present to Kerr at various times across the timeframe of the review. There was also poor evidence of the few actions that were identified being completed.

10.3 Periods of absence by staff due to sick leave or annual leave led to some MDT meetings being cancelled with no other MDT member taking a leadership role in going ahead with the meeting or providing someone to deputise for them who had been briefed on the current risk issues and agreed plans to mitigate. Practitioners felt that there is still a lack of understanding across agencies in relation to the care coordination role.

10.4 Practitioners expressed their view that lack of administrative support was often a barrier to picking up the responsibility for managing an MDT as well as high workloads. Whilst both are acknowledged, there are no easy solutions to these barriers. Staff did acknowledge that IT solutions such as Microsoft Teams meetings made it easier for MDTs to be held remotely and the meeting recording function supported the ability to reflect meeting discussions, this still required administrative support or a lessening of workloads to make the work of MDTs more effective and efficient.

10.5 The management of the safeguarding referrals made to ASC by numerous different partner agencies reflects that the OSAB's adult safeguarding policies and procedures were not followed in line with expected practice. This poses the question whether this was a one off example or whether wider reflection on compliance with policy and procedure needs to be considered following the findings from this review. It was noted by staff attending the PLE that there was no representation from ASC at this event. Attempts had been made to allocate someone to be available, but workload pressures on this occasion made it impossible to provide a representative.

10.6 Consideration of executive dysfunction under the MCA was not evidenced in MCA assessments of Kerr and there appeared to be a lack of willingness from some agencies to

commit to formally document their assessments of Kerr's capacity to understand his care needs. The independent author and panel members do not conclude that Kerr had or did not have the mental capacity to make decisions about his care and treatment at given times when this should have been assessed and documented. Rather the lack of documentation does not evidence best practice under the legal framework. Had Kerr's capacity been assessed concluding that he lacked the capacity to give informed consent this could potentially have reflected that the risks to Kerr's health were acknowledged, but that the level of restraint required to manage his hygiene needs or have his infected leg wounds redressed would not have been in his best interest.

10.7 The Second National SARs Review Analysis which provided detailed analysis of learning from 652 SARs between 2019 and 2023 highlighted the same themes found in this review and previous SARs published by OSAB. The most noted practice shortcomings were poor risk assessment/risk management (in 82% of cases), shortcomings in mental capacity assessments (58%), and lack of recognition of abuse/neglect (56%).

10.8 An absence of professional curiosity meant that circumstances were sometimes taken at face value rather than explored in detail. Other highlighted shortcomings included absence of legal literacy, superficial acceptance of individuals' apparent reluctance to engage, poor recognition of the impact of trauma and attention to people's living conditions.

10.9 An earlier SAR published by OSAB[26] also made recommendations in respect of the same learning themes identified in this SAR, namely professional curiosity, multi-agency working, escalation, and risk assessment. **[Recommendation 5]**

10.10 Key points for practitioners to note when it comes to consideration of executive capacity under the MCA that can be drawn from case law are to always consider whether practicable support can be provided to someone experiencing difficulties with their executive functioning to enable them to make the decision in question. In the case of Kerr the DNs could have sought the support of the community LD team, the SLT team or a clinical psychologist to assist them in assessing Kerr's capacity to understand the importance of having his leg wounds assessed and dressed, as well as having his EPO injections. The availability of these teams to support the DN service in such circumstances should be reviewed by the agencies that commission them.

10.11 Difficulty with executive functioning is not by itself evidence of a lack of capacity. Practitioners need to be aware that people with executive functioning difficulties may overestimate their skills and abilities and underestimate their need for care and support. All practitioners need to take into consideration whether the person understands there is a mismatch between what they say they will do and how they act when faced with real situations, looking for evidence of past behaviours and whether this demonstrates an inability to put into effect their stated intention, should be recorded.

10.12 Legal frameworks exist to support staff in working with adults at risk of abuse and/or neglect, whether it be the MCA 2005 or the Care Act 2014. Used and effectively documented these support decisions made by both the person themselves where possible, and practitioners in being able to evidence 'best practice'. Seeing them as such still requires a culture shift in practice.

10.13 One of the KeyRing support workers who worked with Kerr had known him previously when she worked as bar staff at a pub which Kerr and his father had regularly visited. When Kerr recognised her as one of his support workers, she became the worker that Kerr engaged

[26] OSAB SAR 'Derek' published March 2022 [Accessed June 2024]

best with because of her connection to knowing his father whose loss he felt keenly. The human connection to knowing someone well is highlighted in being able to work with people who are wary of services to support them and in trying to keep continuity of staff working with people like Kerr. The review doesn't wish to reflect that this didn't happen in general, but to highlight the difference being professionally curious makes when working with people to understand them holistically does make. Wherever possible practitioners did attempt to maintain continuity in the staff who engaged with Kerr.

10.14 The compassion shown to Kerr and his family by the KeyRing staff following his last admission to hospital is to be commended. It was a member of KeyRing staff that rang Kerr's family and informed them of his admission to hospital and how unwell he was. Kerr's brother rang the KeyRing staff the following day to let them know that the decision had been made by Kerr's mother to switch off the life support following a conversation with medical staff and that he passed away peacefully.

11. Recommendations

11.1 The recommendations below result from the identified learning themes taken from the review of Kerr's care. Action taken by agencies because of these recommendations will strengthen the support offered to, and evidence best practice by agencies when working with people with complex needs who self-neglect, the most common reason for SABs nationally to commission SARs.

Recommendation 1
OSAB continue to take steps to respond to learning from previous SARs and improve legal literacy around the Mental Capacity Act via extensive practitioner guidance, training and seeking assurance from partner agencies. It is recommended that the OSAB: o Continue to endorse and promote single-agency use of the National MCA Competency Framework. o Promote existing practitioner guidance further. o Continue to offer multi-agency MCA training. o Work with neighbouring SABs to embed learning concerning the MCA found in SARs. o Encourage practitioners to evidence if capacity of the person to understand the abuse/neglect has been considered in their safeguarding referrals.
Recommendation 2
That OSAB ensures its multi-agency training includes clear consideration of: o Executive function in relation to the assessed persons' capacity o Where risk of serious harm/death is a possible outcome that there is clear documentation evidencing the reasons why capacity has not been formally assessed In addition, that OSAB receives assurance that single agency mental capacity training also includes these important elements.
Recommendation 3
That OSAB receives assurance from partner agencies that the OSAB Cuckooing Guidance and 7-minute briefing guide on cuckooing continues to be embedded across Oldham and that any concern by agencies that someone they are working with is suspected of being vulnerable to cuckooing is shared with GMP Oldham District to allow efficient use of their fortnightly multi-agency Protecting Vulnerable People meetings in assessing risk and implementing safety plans.

Recommendation 4
○ That OSAB promotes that agencies evidence that reasonable adjustments are made for people who would require these so that they have equal access to services in line with the Equality Act 2010. ○ That the OSAB considers whether a briefing paper should be produced reminding all agencies of the need to consider reasonable adjustments particularly with LD who have multiple needs.
Recommendation 5
That partner agencies of the OSAB should consider what further action is required to provide assurance to the Board that the learning from SAR 'Derek' is embedded in respect of: ○ Multi-agency working and escalation. ○ Single agency escalation. ○ Professional curiosity. ○ Risk assessment.
Recommendation 6
That Adult Social Care consider whether an audit of safeguarding practice on Mosaic is required because of the findings in this review to determine if the findings are specific to the management of Kerr or an indication of the potential for wider system failure. If an audit is agreed, then the OSAB and their partners will be informed of the audit findings and any necessary action plan.

Appendix 1

Six Principles of Safeguarding	
Empowerment – people supported and encouraged to make their own decisions and informed consent	• How were Kerr's own views about his care and treatment reflect in his support/safety plans? • What evidence is there of practitioners applying professional curiosity to understand Kerr background and how this may have influenced his decision making? • Why was there a lack of clarity over whose responsibility it was to document mental capacity assessments on Kerr for different decisions he was required to make? • How well did staff consider and document Kerr's executive function when assessing his capacity in relation to his ability to meet his own care needs? • Is there evidence of learning around MCA assessments found in earlier SARs commissioned by OSAB being embedded in practice with Kerr?
Prevention – it is better to take action before harm occurs	• Why was it unclear who the lead professional was to co-ordinate meetings? • When one agency cancelled an MDT/TAA meeting why did no other agency take the lead to ensure the meeting could go ahead and action plans reviewed? • Why were the meeting minutes and agreed actions documented from MDTs poorly recorded? • Is there evidence of practitioners escalating concerns to their managers where appropriate and using inter agency escalation?
Proportionality – the least intrusive response appropriate to the risk presented	• Was appropriate action taken when concerns were raised about the possibility of Kerr being the subject of financial exploitation, getting married to someone he had never met and potential cuckooing? • Is there evidence of practitioners learning from previous SARs commissioned by OSAB which make recommendations about how to manage self-neglect being put into practice to manage the risk to Kerr?
Protection – support and representation for those in greatest need	• Did safeguarding referrals made by agencies result in evidence of OSAB safeguarding policies and procedures being applied appropriately? • Is there evidence of the guidance when the individual is not engaging with services being used? • Was there evidence of reasonable adjustments being made for someone with a learning disability?
Partnership – local solutions through services working with their communities	• Was there evidence of good partnership working to safeguard Kerr?

	• Is there any learning relating to the hospital discharges of Kerr in 2023 from an MDT/Care in the community perspective? • Was the commissioning of the additional care package in 2023 to meet Kerr's assessed needs appropriate?
Accountability – transparency in safeguarding practice	• How often were Kerr's Care Needs assessment revisited considering the number of safeguarding referrals being made by agencies and concerns escalated by care provider? • Are there adequate records of appropriate safeguarding actions being documented before cases were closed?