

**EXECUTIVE SUMMARY
OF
A SERIOUS CASE REVIEW**

Mr. J

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**On behalf of the Kent and Medway Safeguarding
Vulnerable Adults Executive Board**

June 2013

1. INTRODUCTION

1.1 This report provides a summary of the process and outcomes of a Serious Case Review (SCR), initiated by the Kent and Medway Safeguarding Vulnerable Adults Executive Board (the Board). The SCR considers concerns that agencies had not worked together to best effect in a situation involving the exploitation and physical abuse of a vulnerable fifty-nine year old adult, referred to as Mr J.

1.2 Mr J died in 2009. This review has been completed over seven months, culminating in the endorsement of this report by the Board in June 2013. The reasons for that delay are discussed below.

1.3 The principal purpose of a SCR is to enable agencies to identify and learn lessons from their management of that case. There will be concerns about the extent to which issues arising from a case remain relevant after nearly four years. The review has sought to keep that in mind and to ensure that this remains a useful exercise which contributes to the promotion of strong safeguarding arrangements for vulnerable adults in Kent and Medway.

1.4 The key issues considered in the SCR are:

- Compliance with safeguarding procedures.
- The extent to which the wishes of Mr J and his family were taken into account.
- The quality of assessments and the actions taken to follow up those assessments
- The quality of information sharing and whether this had an impact on the care he received
- The understanding and use of the Mental Capacity Act (MCA) 2005
- Any correspondences with previous SCRs conducted by the Board.

2. THE FACTS

2.1 The period principally under review is from May 2008, when Mr J's vulnerabilities first began to be identified, until his death in May 2009.

2.2 From 2007 Mr J was living in supported temporary housing in Town A after a period of homelessness following the breakdown of his marriage. In May 2008 he saw his GP and reported that his memory had deteriorated dramatically during his time in Town A. He told the GP that he used to have an alcohol problem. The GP referred him to mental health services provided by the Mental Health Trust where it was found that he had Alzheimer's disease. Mr J was to be treated with medication and monitored.

2.3 It also emerged during 2008 that Mr J was experiencing difficulties with other residents at the supported housing and their associates. These people were variously said to be prostitutes and drug users. There were reports of thefts from Mr J which were investigated by police. Mr J would not agree to criminal charges being brought.

2.4 It was judged that Mr J was able to live more independently and could move on from the temporary accommodation he was in and, towards the end of 2008, he moved to Town B. In early 2009 police became aware of concerns that he was still being exploited by acquaintances he had met in Town A. Police were involved in criminal investigations when Mr J made allegations against these people but he subsequently withdrew the allegations or they could not be substantiated. He was seen twice in the Accident & Emergency Department at the Hospital with facial injuries, which he insisted had been caused accidentally.

2.5 In February a resettlement worker from Mr J's temporary accommodation in Town A, who had continued to support him, made a formal Adult Protection referral to KCC, because of the continuing concerns that he was being mistreated. A multi-agency meeting was held attended by representatives from KCC, the police, and housing services. There is no evidence of mental health services or the GP being invited.

2.6 The meeting concluded that there were strong indications that Mr J was using alcohol excessively and had done for many years, that he could not maintain his nutritional requirements and that he was very vulnerable to exploitation and abuse. A Care Manager became Mr J's key worker. Mr J agreed to move, the following day, to a "place of safety" at a residential care home, Home X.

2.7 Mr J stayed at Home X for about two months. During that period he spent less and less time at Home X, developing a pattern of leaving the home early in the morning, sometimes before breakfast, but being secretive about what he was doing. It was believed that he was continuing to use alcohol and to see the women said to have previously been involved in assaulting him. He

was consistently adamant that he did not want anyone to contact his daughter.

2.8 By April Mr J was largely caring for himself in Home X. A meeting of the professionals involved concluded that he should return to his home. Care workers would visit twice daily to support his self-care, diet and medication routine and to minimise the risk of neglect.

2.9 Within days of returning to his home evidence began to emerge that he was not managing well. He spoke openly of being an alcoholic. Carers noted that he was troubled and distracted and, on one occasion, unable to stand. Five days after coming home carers found that he had suffered a deep laceration to his arm, which he insisted was a “bee sting”. He was taken by ambulance to hospital where he presented as “alert and orientated”, was treated and discharged.

2.10 At various times his Care Manager, the resettlement worker and police officers visited the home. There was increasing cause for concern for Mr J who was soiling his bed and unable to determine whether it was day or night. There was evidence of alcohol being consumed in the flat. He increasingly refused to allow the carers to assist him in any way.

2.11 Some two weeks after leaving residential care he was taken to hospital by ambulance. He was found to have multiple cuts, bruises and possible pressure sores of varying ages, and to be extremely dehydrated. He had multiple injuries to his brain. He deteriorated further and died in hospital four days later.

3. CONCLUSIONS AND KEY LEARNING POINTS

3.1 There were some indications that Mr J might be “reached” by services. He had worked with agencies to come back from being homeless in 2006/7 and sought help with his use of alcohol in 2008, even though he did not sustain contact with that service. He recognised the need to move into the protection of residential care, and was reluctant to return to the place where he had been exploited and abused. It is disappointing that agencies and professionals did not make a stronger connection with him, and if possible his family, which might have provided a base to work from.

3.2 There was a missed opportunity in October 2008 when a GP intended that KCC be asked to assess Mr J, but did not ensure that the request reached them. Subsequently there was a continuing failure, principally by KCC, to involve the GP or ensure that he had a local GP when leaving residential care.

3.3 For the agencies with continuing responsibilities – the Mental Health Trust and KCC – there was no process of care planning, assessment and review. Input from professionals lacked direction and purpose, and was not alert to the safeguarding dimension of the situation. Although the care manager was actively supporting Mr J, liaising with other agencies and looking to meet his care needs, a much stronger safeguarding investigation and co-ordination role was required. The Care Manager lacked experience in safeguarding work but her line managers and safeguarding lead officers should have been alert to these issues.

3.4 There was also a confused approach to the implementation of adult protection arrangements once it became clear that Mr J was probably being exploited and abused. Throughout the period under review there was a lack of compliance across agencies with basic safeguarding procedures relating to the notification, recording and follow up of safeguarding concerns.

3.5 The swift decision to arrange residential care for Mr J once agencies had met and shared information was a positive response to a critical situation. However it was not followed up in a planned way and the arrangements made for Mr J to return home did not give adequate weight to the probability that he would be subject to further abuse.

3.6 When Mr J left residential care his health and home circumstances deteriorated very rapidly, with multiple indications that this might be linked to repeated abuse. This did not lead to the implementation of any safeguarding arrangements or any co-ordinated multi-agency response. All the agencies involved during that time should have recognised the need for such a response much more quickly.

3.7 The Police missed opportunities to identify and respond to the safeguarding implications of information received from officers. Incidents were

treated in isolation and the overall context of safeguarding concerns arising from indicators of violence and abuse was not acknowledged in the police response.

3.8 There were specific failures in the Hospital's response to Mr J's admission in May 2009. Police were not notified and no safeguarding alert was raised, despite evidence and concerns that he might be suffering from inflicted injuries.

3.9 There was never an assessment of Mr J's mental capacity. His presentation could be deceptive, suggesting he was more independent than was the case if agencies had taken account of the issues of abuse and exploitation. However, both when he left residential care and subsequently, as evidence of abuse increasingly emerged, there should have been a formal assessment of his capacity. Some of the professionals involved have accepted that, at that time, their knowledge of capacity legislation and procedures was limited.

3.10 There is clear evidence that Mr J strongly and consistently resisted any suggestion that agencies should make contact with his family. There was no indication that agencies should or could disregard his wishes until his final admission to hospital. When he was admitted hospital staff identified and contacted his daughter within 24 hours.

3.11 No agency has identified any issues in this review which have arisen in previous SCRs locally. However there was a serious and unnecessary delay in conducting this review. This appears to have arisen from a lack of understanding of the relationship between Serious Case Reviews and the investigations which may be conducted by police and the Coroner's Office. These are parallel processes and there is no reason why this review could not have been carried out immediately after Mr J's death. This has been recognised by all agencies.

4. RECOMMENDATIONS

4.1 Recommendations to the Kent and Medway Safeguarding Vulnerable Adults Executive Board

4.1.1 The Board should ensure that the following requirements are met and regularly monitored:

1. all partner agencies can demonstrate a satisfactory understanding and compliance with safeguarding arrangements and procedures, including the documentation of decisions taken and the reasons for those decisions.
2. all partner agencies can demonstrate robust and reliable arrangements for the supervision of staff.
3. all agencies have arrangements to equip staff, as appropriate, with a good and up to date working knowledge of the legislation relevant to the safeguarding of vulnerable adults.
4. the processes which support vulnerable adults in making decisions are supported by a multi-agency approach which includes formal assessments of risk.
5. where there is concern that a vulnerable adult may be the subject of abuse, a lead professional is always clearly identified
6. there are satisfactory arrangements in all relevant agencies to train and equip staff to exercise their responsibilities towards individuals who may not have the capacity to make informed decisions and follow them through.
7. assessments of vulnerable adults consider and document whether or not mental health and / or mental capacity legislation is relevant.
8. the key messages from this SCR are reflected in the Board's training programme
9. there are efficient arrangements for making and implementing decisions about any requirement to conduct a Serious Case Review

APPENDIX A: Independent management of this Review

Mr Kevin Harrington, JP

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has worked on more than 35 such reviews. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.