KENT & MEDWAY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

MARY SMITH

Executive Summary

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EXECUTIVE SUMMARY

1. INTRODUCTION

This Safeguarding Adults Review (SAR) examines the circumstances surrounding the death on 3 April 2014 of Mary Smith, a woman aged 43 years, of town A, Kent.

2. THE REVIEW PROCESS

The review began with the first meeting of the SAR Review Panel on 22 September 2014. Organisations that attended had indicated that they had potentially relevant involvement with Mary prior to her death.

As a result, the following organisations were requested to provide Individual Management Reviews (IMRs):

- Kent Police
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- Kent County Council Adult Social Services (KASS)
- NHS England (Kent & Medway Area Team)
- Dartford and Gravesham NHS Trust (DGT)
- Kings College Hospital NHS Foundation Trust (KCH)

IMRs include the following:

- a chronology of interaction with Mary;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

As well as those organisations providing an IMR, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) were requested to provide a free text report covering their involvement with Mary during the period covered by the Review.

3. TERMS OF REFERENCE

The terms of reference were agreed by the Review Panel before the start of the SAR.

<u>Introduction</u>

Following the death of Mary, the Kent & Medway Safeguarding Adults Board (KMSAB) has commissioned a Safeguarding Adults Review (SAR).

Methodology

All agencies are asked to check if they had contact and/or involvement with Mary in the period from 1 January 2009 to 3 April 2014 (date of Mary's death). If so, they are further asked to secure those records and notify the Independent Chairman of the SAR Panel.

The SAR will be based on IMRs and reports submitted by agencies which had involvement with Mary that was relevant to the circumstances of death during the period of the Review.

Whether an agency is required to submit an IMR or a report will be dependent on the extent and relevance of its involvement with Mary.

Independent Management Reports (IMRs)

Each IMR will be prepared by an appropriately skilled person who did not have any direct involvement with Mary, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology and an analysis of the involvement that the agency submitting it had with Mary. IMRs must be submitted using the version of the template that is current at the time of completion. The KMSAB Business Unit will supply the current template.

The chronology will include each occasion that the agency had contact with Mary between the relevant dates, in circumstances that led to or should have led to safeguarding concerns.

The analysis of agency involvement should include:

- the key and priority practice episodes (these will be drawn from the agency chronology);
- the agency's involvement, commenting on the work undertaken and the adherence to intra and inter agency policy and procedures, or accepted best clinical/professional practice, in use at the time;
- the agency's and inter-agency assessment of Mary's needs, including emotional needs; and any risk identified, including signs or disclosures of neglect or Abuse;
- the direct work undertaken with Mary and, if relevant, her family members;
- inter-agency information sharing and co-operation to meet Mary's identified needs;
- the decisions, actions taken and timescales, noting any gaps, errors and successes and why these occurred;

- the views of the practitioners involved and any management or supervisory oversight of the work, seeking to understand the work undertaken by what was known at the time, not through hindsight, but noting any gaps; and
- the context in which the agency undertook its work, and any factors intrinsic to the agency or external to the case which may have impacted on the work.

The analysis should highlight good and poor practice by both individuals and the agency. It should include issues such as the resourcing, workload, supervision, support, and the training and experience of the professionals involved.

Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

The IMR should note the key lessons, including concerns and good practice, which have been learned as a result of the agency review, and any recommendations to be taken as a result within the agency or by other bodies. It should include whether the agency has accepted such internal recommendations as formal actions.

NHS IMRs will be overseen by the Designated Nurse from the CCG in which Mary lived before her death.

Completed IMRs will be considered at a meeting of the SAR Panel and an Overview Report will be drafted by the Independent Chairman. The draft Overview Report will be considered at a further meeting of the SAR Panel and a final, agreed version will be submitted to the Chair of KMSAB.

<u>Safeguarding Adults Review Panel</u>

The Panel will be commissioned by the KMSAB Chair.

KMSAB will appoint a panel of senior and experienced practitioners with experience in safeguarding to draw together the learning from the IMRS and to comment on the work undertaken. The SAR Panel members should be independent of the line-management for this case.

An Independent Chair of the SAR has been appointed and he will also draft the Overview Report.

The Panel will be made up of an Independent Chairman and representatives from:

- NHS Dartford, Gravesham, Medway & Swale CCG
- Kent Police
- KMPT
- KCC

- KMSAB Board Manager
- KMSAB Admin Support (non-participating role)
- Medway Council

None of the Panel Members have had direct involvement in the management of Mary's case.

The Panel is able to co-opt specialist advice as needed.

Involvement of Family Members

Close relatives will be advised of the SAR at an early stage by the Panel Chairman. They will be told of its purpose, how it will be conducted and how they may be involved; including by direct conversation with the Independent Chairman.

The SAR Panel Independent Chairman will contact family members during the period when IMRs are being conducted in order to allow them the opportunity to express any views they may have about agency involvement during the period under review.

The SAR Panel Independent Chairman will contact family members on completion of the draft Overview Report to tell them about the conclusions, lessons learned and recommendations.

Safeguarding Adults Review Governance

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

The SAR will be signed off by KMSAB.

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

HM Coroner for the area in which Mary died will be informed of the review by the Chair of KMSAB.

4. KEY ISSUES ARISING FROM THE REVIEW

Mary died as a result of taking an overdose of drugs. At the inquest into her death, HM Coroner for North West Kent gave a verdict of Drug Related Death.

Mary lived alone in a flat in town A for several years before her death. During that time she had an ongoing dispute with a neighbour who lived in the upstairs flat and police had attended calls from or involving her on over 200 occasions.

Mary reported multiple physical symptoms to her GP over several years and she was prescribed large quantities of medication at frequent intervals. Numerous tests and investigations were carried out at hospitals but there was never a diagnosis of a medical condition that could account for her symptoms. She was a wheelchair user for some years and her mobility was limited. As well as taking prescription medication, Mary was known to be a heavy drinker.

Although she was not diagnosed with any mental health condition, it is likely that this contributed to her vulnerability. Although there are examples of good work by agencies, they found her hard to reach and missed opportunities to work with partner agencies to support her.

The SAR has examined in detail the involvement that agencies had with the Mary and has reached conclusions and recommendations, and identified lessons learned, which may improving safeguarding and outcomes for vulnerable adults in Kent & Medway and elsewhere.

5. CONCLUSIONS, LESSONS LEARNED AND RECOMMENDATIONS FROM THE REVIEW

Conclusions

Kent Police had the most contact with Mary during the period covered by the review (1 January 2009 to 3 April 2014). Despite most of their attendances being initiated by her, they found her hard to reach. She frequently refused to cooperate with their efforts to deal with crimes that she reported. However, there was insufficient recognition that she was a vulnerable person or that she may have had mental health issues, despite the fact that there were clear indications of both.

Individual officers did make referrals to mental health services and other agencies but it was not until the last few months of her life that the approach was coordinated. During that period the focus seemed to be on criminalising Mary's behaviour in order to deal with her situation. The one multi-agency meeting that Kent Police convened to discuss Mary was ineffective for the reasons set out in this report.

Kent & Medway Partnership Trust (KMPT) also found Mary hard to reach. If people have a mental health disorder, the nature of that disorder may make them reluctant or even unable to interact with others, particularly organisations. This is something that KMPT professionals understand and deal with on a regular basis, so they are more likely to appreciate the need to be more flexible and creative when attempting to engage with people. Despite this, potential avenues for contact, such as through Mary's GP, were not explored and there were missed opportunities to engage with her and undertake an assessment of her mental health.

Kent Adult Services Older Persons and Physical Disability (OPPD) division had some positive interventions with Mary and appear to have gained her trust on occasions. However there were two referrals which had adult safeguarding concerns. It's not recorded as to why it was decided not to follow them up using the multi-agency Safeguarding Adults Policies Protocols and Guidance as a framework. A further concern is that at present there is no policy or guidance for dealing with non-contact following referrals. This is the subject of a recommendation.

The actions of Mary's GP practice raise significant concerns. The combination and quantity of medication that she was prescribed and the frequency at which it was prescribed do not appear to correlate with any medical diagnosis. The combination of medication, together with the knowledge that she was a heavy drinker, was such that it presented an obvious risk of harm to her health.

There does not appear to have been any recognition of the safeguarding concerns that GPs were made aware of, none of which were referred to agencies that could have dealt with them more effectively.

In summary, there was good work done with Mary but opportunities were missed to carry out coordinated multi-agency work to support Mary and establish the causes of her problems.

On 10 September 2014, Kent & Medway Safeguarding Adults Board (KMSAB) approved the Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect, which were revised on 1 April 2015 to take account of the provisions of the Care Act 2014. While there is no statutory definition of self-neglect, Mary displayed a number of the indicators that would have resulted in the policy being invoked had it been in place in the months and years preceding her death.

The policy and procedures will address the gaps in multi-agency working that have been identified in this review providing that all agencies know of its existence, understand it and implement it. If they do, there is a real likelihood that people like Mary will receive appropriate support. All agencies subject to this review are represented on KMSAB and it is incumbent on them to ensure that staff at all levels have a knowledge and understanding of it.

Lessons Learned

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

1 Agencies must adopt a flexible and creative approach to engaging with vulnerable adults using all possible means, including contact with family and other agencies.

2 There is a need for agencies to ensure that the policies, protocols and guidance produced by Kent & Medway Safeguarding Adults Board are consistently put into practice.

3 Agencies need to be constantly reviewing whether the service users would benefit from services provided by other agencies. If they believe that to be the case, they must make appropriate referrals.

4 Agencies must continually be aware that self-reporting by service users may need to be corroborated before it is acted upon.

Recommendations

The Review Panel makes the following recommendations:

	Recommendation	**Agency**
1.	Kent Police must ensure that their officers understand the power of arrest for breaching a restraining order.	Kent Police
2.	Agencies that are the subject of this SAR must ensure that their processes for engaging with partner agencies at practitioner level are robust enough to ensure that meaningful outcomes can be achieved.	All Agencies
3.	When experiencing difficulties engaging with people with disabilities, Kent Police should consider contacting other agencies with relevant knowledge and experience.	Kent Police
4.	Kent Police must ensure that when they initiate multi-agency meetings, representatives attending have authority to commit the resources necessary to achieve the aims of the meeting. Furthermore, they must ensure that the aims of the meeting are made clear when invitations are sent so that other agencies send representatives with an appropriate level of authority.	Kent Police

5.	Kent Police must ensure that its officers and staff deal sensitively with vulnerable people, engaging with other agencies when appropriate, and do not seek to criminalise their behaviour as a primary means of resolving a situation.	Kent Police
6.	KMPT must have a process that ensures requests for information are followed up if no reply is received.	KMPT
7.	Where KMPT receive information that may indicate that serious criminal offences are being committed, it must be referred to Kent Police.	KMPT
8.	KMPT must ensure that they have a process in place to ensure that work done by student social workers is effectively supervised.	KMPT
9.	KMPT should examine the contradictory decisions made following Mary's final referral to establish whether there is a need to make their internal communication process more effective.	KMPT
10.	When reviewing and amending their DNA policy, KMPT should emphasise the need to consider consulting other agencies who the person might be more willing to engage with.	KMPT
11.	KCC should produce and implement a policy containing directions and guidance about the methods of contact and number of attempts that are before a case is closed.	KCC
12.	KCC must ensure that all staff who may receive referrals understand what action they must take to ensure that the appropriate response is provided.	KCC
13.	KCC must ensure that urgent work is covered when staff are absent and there are systems to support this.	KCC

14.	GPs must review their approach to safeguarding adults and children, which must include the requirement to refer safeguarding concerns to other agencies as appropriate.	NHS England
15.	NHS England must ensure that there is a review of the medication prescribed to all other patients at Practice A who are subject to polypharmacy.	NHS England
16.	NHS England must consider what action is appropriate in the light of the serious concerns about Practice A that are described in this review.	NHS England
17.	The Chair of KMSAB should seek to establish the outcome of any NHS England investigation of this case in order to satisfy the Board that patients at Practice A are not at risk of harm resulting from the issues identified during this review.	Chair of KMSAB
18.	Dartford & Gravesham NHS Trust must ensure that a mental capacity assessment is undertaken in appropriate cases and that this, together with the results of the assessment, are clearly recorded.	Dartford & Gravesham NHS Trust
19.	All agencies represented on KMSAB must ensure that staff at all levels are aware of the Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect, and that they understand and implement it.	All KMSAB Agencies