FAMILY RESPONSES TO SAFEGUARDING ADULTS REVIEW: SEAN

We commend Brent Safeguarding Adults Board for commissioning this report to investigate the circumstances leading to Sean's death, and share the Board's hope and expectation that lessons will be learned which will help to prevent other vulnerable adults from sharing the fate which befell Sean.

THE PROCESS

This report has taken far too long. Guidelines recommend that SARs should take around 6 months but it was 16 months before we had sight of this one.

Based on the timetable we'd been given, and following our interview with the author in July 2018, we fully expected the completed report by the end of that year. Instead we heard nothing about progress, or lack of it, from September 2018 till February 2019 when we took the initiative to make contact.

This added unnecessary stress and rather unhelpfully seemed to mirror the lack of communication which featured so prominently in agency dealings with Sean.

Further deadlines were set and exceeded and when we did finally receive a copy of the report we were initially offered just under a week to read and digest it. In contrast, agencies involved had had several weeks to feed back their comments and to ensure that their viewpoints were heard and had been incorporated. Indeed that partly accounted for the delay we were told. This gave us the impression of disproportionate weight being given to agency feedback and raised, for us, questions about findings being watered down as a result.

Given the scope and remit of this SAR it could, and should, have been completed much sooner and we could, and should, have been kept informed of progress throughout the process.

Sadly, important documents and records could not be found, and we are left with a sketchy picture and many unanswered questions. But when we did get rare glimpses of Sean's own words and state of mind, the poignancy for us was acute.

THE REPORT FINDINGS

Ian Winter's report reads like a sorry catalogue of omission: missed opportunities, lost documents, poor record keeping and dire communication between agencies and individuals involved. Crucially no one took or had the time to get to know Sean as an individual with a history and changing needs, and no one took responsibility for ensuring a coordinated approach firmly centred on his wellbeing as enshrined in the Care Act 2014.

The report shows some examples of good practice but these were not followed through to any effect, or at the appropriate time, and we simply cannot endorse the author's praise for "the evident commitment and integrity of all those who tried to work with Sean" (p.50).

At the Coroner's Inquest we challenged the decision by Brent Adult Social Care management on 1st June 2016 to withdraw Sean's care package. Based on information available to us at that time, we felt that decision was premature, made assumptions about Sean's mental capacity that had not been reviewed or tested, and ran counter to the ethos of the Care Act. The Coroner disagreed saying he felt Social Services had fully discharged their duty towards a client who had refused services. We now learn that a "No Response" protocol did exist in Brent (as it should have by legislation) but was not complied with.

This reinforces our opinion that the decision to leave Sean without further intervention, and without consulting or even informing other agencies involved, was a profound error with grave – indeed fatal - consequences.

Here is an elderly man admitted to hospital in a state of chronic malnutrition. His flat is found to be uninhabitable with "debris and infestation…at a high level". He has expressed suicidal thoughts and has, on record, a history of mental ill health with symptoms of depression, isolation and psychotic episodes compounded by longstanding alcohol abuse. He is physically frail with emphysema and is increasingly unable to negotiate the stairs to his top floor flat. He has expressed violent and paranoid thoughts about his neighbours and feels a constant sense of unease in his surroundings. Back in 2013 his GP had recommended that he be rehoused on physical health grounds alone. He lacks motivation to go out and has lost informal or formal support and social networks as a result of all these factors.

He is, in short, a classic example of self-neglect, patently vulnerable – if left without support - to the precise same factors, circumstances and behaviour which necessitated his hospital admission in the first place. But he returns to the same inappropriate housing, albeit blitz cleaned, while services are reduced and then effectively withdrawn within a few short months.

In November 2016 the Consultant Psychiatrist at CNWL recorded that Sean "palpably brightened at the prospect of being moved to alternative accommodation…***and would not consider suicide if he was better supported or ideally rehoused***".

Referring to the four months preceding his hospital admission in November, Sean said he'd been lying in bed waiting to die having just enough water and cans of food to stay alive, ***and rather hoping that someone would find him.*** This was put on record in December 2016.

In early January he says ***he's pleased to have heard from his brothers***, and that he values having the enablers in daily ***as he likes to know someone is looking after him and someone cares for him***.

He also says ***he can't contact anyone because he needs a new sim card for his mobile phone,*** so is keen to have a lifeline to the outside world - even if no one bothered to act on this and make sure he had one.

In March a carer describes him as being ***presentable, organised and a very pleasant man,*** albeit not talkative with her.

This is not the picture of a man wilfully rejecting services and unwilling to cooperate when help was offered. There was clear potential to work with Sean, if anyone had exercised some joined up thinking and a modicum of "professional curiosity".

To pluck a few of the more glaring examples from the report:

Staggering though it is that a hospital safeguarding alert should disappear into the ether and never reach any intended recipient, why didn't anyone (especially the Community Mental Health Team) nevertheless pick up on the psychiatric consultant's warning that the mental health of elderly people can deteriorate back home after hospital discharge?

Given that his home had long been identified as unsuitable for his changed needs, why was rehousing not taken as an immediate and serious issue which was compounding Sean's physical and mental health problems?

Why was the Housing Association issuing Court proceedings instead of considering its social welfare role?

Why did no one have the sensitivity to consult Sean about the blitz cleaning of his home with the inevitable interference with his possessions, and consider the impact this would have on him?

Why did no one make sure he had a working mobile phone?

Why on earth did no one at any point in all this think to contact us relatives whilst, as it happens, some of us were writing to Sean or trying to ring him to find out how he was and offer support if needed?

Why was there not an ongoing review of his mental capacity?

And, most importantly, why did no one appear to give Sean any hope that there could be a future for him?

The reasons are clear: **the failure to recognise and respond to Sean as an extremely vulnerable adult at risk of a downward spiral without support; the failure of communication and cooperation between agencies to implement an agreed package of care and support with systems in place to ensure regular monitoring and review; and the massive failure of empathy, imagination and professional curiosity.**

Sean was unique but his situation is not, and it is our sincere hope that all involved will do better in their future dealings with the many vulnerable individuals who need their professional help.

Sean's family representatives