SAFEGUARDING ADULTS REVIEW

Adult K – February 2024

ONE PAGE SUMMARY

Background: this discretionary Safeguarding Adults Review (SAR) was initiated following a referral from the Church of England following a review into the death of Adult K. Adult K took his own life on the day he was due to appear in court in regard to historic child abuse allegations made against him. The question was asked in the report of whether Adult K's death should've been referred for a SAR at the time it happened.

Findings: On the basis of the information shared for purposes of this SAR, it does not appear that there are significant concerns about how organisations worked together to safeguard Adult K and there are no systemic issues that can be identified from the information provided. There is ample evidence that the agencies interacting with Adult K were working in line with expected practice of the time. There are many examples of good practice in regard to timely referrals between agencies. The regular engagement and thorough work done by the GP Practice is of particular note.

Some agencies were unable to provide a complete account of their work due to recording issues and the accessibility of historic information. However, when the information provided from all agencies is reviewed as a whole, there are no indicators that the content that was unavailable is of significance to this review.

One Reflective Thought for Workers: Risk Management - does this information/observation/interaction indicate the person is at an increased risk of harm? If so, how am I mitigating the risk? Who else am I sharing this information with to help mitigate the risk?

One Key Lesson for Organisations: scanning and uploading documents to electronic recording systems is only helpful if the documents are legible afterwards so a check should be done to ensure this is the case before destroying the original document.

BACKGROUND

This report concerns the death of Adult K, a former priest, who moved to Oxfordshire in 2010. Adult K has been charged with six counts of sexual abuse, which were said to have taken place in the mid-1980s and took his own life the day before his court appearance. He was found dead in the bath at his home in Otter Court with self-inflicted wounds. A coroner concluded he had intended to take his own life.

A number of disclosures were made to the Church from 2012 onwards and followed up with complaints about the response to these. Between 2012 and 2014 he said he disclosed his abuse by Adult K to senior Church leaders.

In 2017, he made Clergy Discipline Measure complaints against Adult K for the alleged abuse and also the members of the clergy listed above for failing to respond to his disclosures appropriately or in accordance with the House of Bishops' safeguarding policy.

The church of England's Independent Report can be accessed online.

The Independent Report makes a recommendation that the Oxfordshire Safeguarding Adults Board (OSAB) conducts a Safeguarding Adults Review into the death of Adult K.

The referral was considered and while it was agreed that the circumstances of Adult K's death did not meet the criteria for a mandatory SAR, the OSAB would conduct a discretionary SAR to review the questions arising from the Church of England's report.

Adult K was noted in records as a white, British male. There are no indications from records around religion, sexuality or any other protected characteristic.

METHODOLOGY

This Safeguarding Adults Review (SAR) was conducted under the discretionary SAR framework.

The referral came from the Church of England on the basis of a review they had completed. The Author of that review felt the information potentially indicated a level of self-neglect by Adult K, a level of neglect by organisations and/or concerns about how agencies worked together. After scoping information from agencies, the SAR Subgroup did not feel the criteria were met for a mandatory review but wished to address the concern of the Church of England report so undertook this discretionary SAR.

Agencies were asked to review their records from the period Adult K moved to Oxfordshire (early 2010) to the point of his death. Agencies were asked to provide a detailed chronology for the period from the commencement of the Care Act 2014 (1st April 2015) with a summary chronology of involvement prior to this. Agencies were provided with the Review Form developed by the OSAB and directed to analyse their involvement with Adult K.

This SAR report does not aim to replicate or reproduce any analysis or learning points highlighted in the Church of England's own report. It aims to identify any new learning by reviewing the multi-agency support offered to Adult K while he was in Oxfordshire.

Due to the passage of time, several agencies were unable to speak to their staff who had direct contact with Adult K to clarify points within the written records. Other agencies pointed out that they had gone through significant changes to their internal recording systems (moving from paper-based to electronic or from one electronic system to another) and so noted that they were relying on scanned images of handwritten documents which were hard to decipher upon review.

Also, since this time, processes have changed across all agencies. For example, in the Police, information sharing to other agencies is now clearly recorded in a pro-forma template within reports.

SUMMARY OF INVOLVEMENTS

Church of England

The Church of England commissioned an independent review, conducted by a former Director of Children and Director of Adult services with over 30 years of experience. The subsequent published report provides all relevant information and interaction between Adult K and the Church of England. The conclusions in respect of Adult K can be found at page 57 and read:

"Adult K appeared to have received no support from the Church of England when the police investigation began in 2015, but was offered support once the complaint was made against him by the survivor in 2016, which he appeared to accept on a couple of occasions. The Independent Reviewer was impressed by the concern shown and the recognition of the seriousness of the situation by the Senior Caseworker, National Safeguarding Team, at the failure of Adult K to appear at court on the 6 June 2017. The Senior Caseworker subsequently contacted the Diocesan Safeguarding Advisor in Oxford who reported the concerns to the police.

Whilst there were checks to find out where he lived and whether he had permission to officiate, the Independent Reviewer has not seen any evidence to suggest he was offered or received support. There clearly would have been a matter of timing regarding any support as the police did not interview Adult K until September 2015. Once Adult K returned to hospital in Oxford, the Head of Pastoral Care at the hospital was made aware he had been admitted to Sandford Ward and arrangements were made for one of the hospital Clergy to visit him. This happened on a number of occasions up until Christmas 2016.

The Head of Pastoral Care also reported that a retired Archdeacon had contacted the hospital enquiring as to whether Adult K was an inpatient or not. The Head of Pastoral Care stated he was unable to confirm due to patient confidentiality. There is written evidence that the retired Archdeacon arranged to support Adult K, and he did make telephone contact with him on a number of occasions and also spoke with him. He contacted Adult K by phone on 1 January 2017 and 7 January 2017, but had no reply. On 8 January 2017 he did to speak with him, whilst he was still in hospital; Adult K said "he was improving." The retired Archdeacon attempted to contact Adult K one more time, but he heard nothing back from him. He did comment "I always said to Adult K let me know if you want me to come and see you."

The Bishop of Oxford also made checks in relation to Adult K when he became Bishop in July 2016. He received assurance that Adult K did not have permission to officiate, he was not attending church, and he was also being offered pastoral support via the retired Archdeacon, but had indicated he did not want any support.

SUMMARY OF INVOLVEMENTS

Thames Valley Police (TVP)

TVP's first interaction with Adult K appears to be in autumn 2015, when West Yorkshire Police were trying to further their investigation into the historic sexual abuse mentioned above. TVP were tasked with finding out if Adult K lived at the address West Yorkshire Police had for him and if so, what type of accommodation it was. After establishing this, there were no further interactions until late summer 2016.

During Summer 2016, a call was made to the Police by staff at a car dealership worried about Adult K's erratic behaviour in their showroom. Police attended and Adult K surrendered his keys and was returned home. The next day the same thing happened with a different dealership. Police attended Adult K's home address and called for medical and mental health care. The Doctor and Ambulance staff attending are noted in Police records as "could not make a decision about capacity, so they left the address." A week later Adult K was reported missing. He was receiving a mental health assessment at his home address but disappeared during the assessment. He was found within two hours and taken to Hospital.

Two months later, Adult K was reported as missing again, when a mental health team had attended his house in an attempt to execute a Section 135 warrant. Again, he was located within two hours.

Seven months after this, TVP were asked to serve a postal requisition (effectively a summons) from West Yorkshire Police in regard to the historic sex offences. This was served and there are no notes of Adult K exhibiting any undue distress at the summons.

A month later, West Yorkshire Police requested TVP check Adult K's home address as he had failed to appear for his court date in the summons. He was found dead in his home.

SUMMARY OF INVOLVEMENTS

Primary Care – GP Practice

The first point of contact with the GP practice was in January 2010 and the last contact was June 2017. During that time, the GP practice were continuously involved in his care and Adult K was a regular visitor to the practice. Regardless of the purpose of the visit, it appears from the GP record that Adult K was always asked about his mental health. There are multiple visits where the focus of the discussion was solely about his mental health and the medication to manage his bipolar affective disorder. As well as the regular conversations about his mental health, there is evidence throughout the GP record of referrals made to mental health services when there were escalating concerns about Adult K's mental health and there appears to have been a well reciprocated line of communication back to the GP practice from mental health services. These appear to have been followed up with Adult K in subsequent visits to the GP practice. There were also a number of referrals for further medical tests on specific health issues, one of which resulted in a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

Otter's Court

Otter's Court was not a Care Home, but owner-occupied retirement apartments, with some support offered on an individual (purchased) basis. As such it is not subject to the same regulatory framework and requirements as a Care Home. Otter's Court did have a warden, who is noted as contacting services when they felt there was a need, such as the GP practice and Community Mental Health services. The warden spoke to Adult K whenever they happened to cross paths as they would with any other resident and, other than those occasions they called external services, Adult K was not considered a demanding resident or one that they were regularly concerned about. There is a note that the warden received a suicide note from Adult K the day before his death. This was discussed with him directly, and Adult K claimed to have changed his mind since writing the note. The note was not shared with any other service at the time. The warden has since left the organisation so it has not been possible to find out anything further and the original note appears to have been destroyed.

SUMMARY OF INVOLVEMENTS

Oxford Health NHS Foundation Trust

Adult K was referred into Community Mental Health team in late Summer of 2011 by his GP, who indicated a history of Bipolar Affective Disorder. This referral indicated his first presentation with a mental disorder to services was in 2009 when he was admitted to a Lincolnshire Hospital.

During his time under the care of Oxford Health Mental Health Services he was cared for in the community and admitted to acute mental health wards both informally and formally under the Mental Health Act (once under S2, twice under S3 and once under S5). Concerns regarding his physical and cognitive wellbeing were also followed up with timely referrals to appropriate services. Adult K was followed up by both Community Therapy Service to aid his rehabilitation back in the community and facilitate further assessment. He has had regular outpatient care and at times would make unplanned visits to the outpatient clinic and the team managed to fit him into the clinics to address his concerns. The inpatient and community mental health team liaised well to ensure smooth discharge and tried to have a Personal Assistant funded to help with his Activities of Daily Living (ADLs) however funding was only agreed for medication support.

The community team were responsive to the needs of Adult K, liaised with multiple agencies to ensure continuity of care and followed up when he was placed out of county and were diligent in speaking directly with the ward and actively sought a bed back in Oxford to repatriate him back to a familiar care team. The team were responsive to calls from a friend when they raised concerns regarding Adult K's deterioration in mental state and contacts were made with Adult K as a result. At times Adult K was irritated by the follow up and did not always have insight into his changing mental state.

The team did visit Adult K at home the day before Adult K took his life and he appeared outwardly calm with no indication that he planned to end his life. Adult K was described as in good humour and the team agreed with Adult K they would visit again later in the week. Oxford Health were aware of the court case although they were not made aware of the suicide note the warden had received that same day. On reflection, while the suicide note would've been useful to know about, it is felt based on the interactions with Adult K that this did not impact the outcome of the visit.

SUMMARY OF INVOLVEMENTS

Oxford University Hospitals NHS Foundation Trust

Adult K was only seen twice by the acute trust. The first time was as a result of a referral from his GP for shortness of breath. The second time also related to shortness of breath whilst under a Section 3 of the Mental Health Act. Both interactions followed all expectations on practice and Adult K's wishes were respected in regard to the first interaction where he chose to self-discharge before receiving the full recommended treatment. OUH requested his GP follow up on this.

Oxfordshire County Council – Adult Social Care and the Approved Mental Health Professional (AMHP) service

Adult K first became known to Oxfordshire mental health services in 2016 following reports of him being seen driving dangerously locally as well as being found sleeping naked in the communal areas of his accommodation.

It is recorded that Adult K's reason for moving to Oxfordshire was to improve his mental health following a deterioration in his previous county.

On one occasion he was assessed and detained due to him stabbing himself in what Adult K claimed to be a serious attempt to take his own life. When asked about the reasons for this, he shared that this was due to experience of fatigue and a lack of enjoyment or pleasure in anything.

The AMHP and the Section 12 Doctors deliberated on whether detention was appropriate, and mutually determined that detention was appropriate. There is evidence in the file that he his needs were assessed and appropriately managed.

Adult K didn't always recognise the relapse indicators in his mental health and this could lead to him going on spending sprees and purchasing high value items such as a new car (referenced in the TVP report). Adult K is also believed to have almost been scammed online to the sum of £5k, which was prevented as his Coordinator recognised it was a scam.

Adult K's mental capacity appears to have been considered regularly during interactions with Adult K.

REFLECTIONS

After a review of the information received, the following reflections are offered:

1. The returns from agencies indicate that all agencies acted in line with their expected practice as it was at the time. There is no indication from records that agencies did not act upon concerns they may have had about Adult K and there are numerous examples of referrals between agencies when there were concerns.

2. Police Officers who attended to present Adult K with the summons to court had no concerns about his mental health or noted any distress beyond that expected of any other person receiving a summons. Officers had previously shared concerns with mental health services when they had concerns. There is no record that this summons or court date was shared with any other agency, although Oxford Health were made aware through other means. Similarly, there is no record the suicide note from the day before Adult K's death, known only to the warden, was shared with any other organisation.

3. Professionals who interacted with him in the days running up to his death did not note any concerns about his behaviour or mental health and Mental Health professionals who interacted with him the day before his death had no concerns about him. While it would've been best practice to ensure the court date and suicide note were shared, on reflection it is not felt that this additional information would've influenced the outcome of the visit the day before his death.

4. There have been some minor issues for agencies in retrieving information from old records, hampered by changes to recording systems and to poor quality scans of handwritten documents. The Author does not feel that the missing information changes the conclusion of this report but it does offer two learning points for future work, if not already acted upon:

    1. Agencies should ensure that scanned documents are legible once scanned and uploaded onto electronic records, and

    2. Agencies should ensure that when moving from one electronic recording system to another, a clearly mapped out plan indicates where information stored on the old system can be found on the new system.

CONCLUSION

- On the basis of the information shared for purposes of this SAR, it does not appear that there are significant concerns about how organisations worked together to safeguard Adult K. There is ample evidence that the statutory organisations interacting with Adult K were working in line with expected practice of the time. There are many examples of good practice in regard to timely referrals between agencies. The regular engagement and thorough work done by the GP Practice is of particular note.

- Some agencies were unable to provide a complete account of their work due to recording issues and the accessibility of historic information. However, when the information provided from all agencies is reviewed as a whole, there are no indicators that the content that was unavailable is of significance to this review.

- The proactive sharing of factors that might escalate risk of harm to the person, so in this case the court date and the suicide note, could improve multi-agency working in future cases. However, it is felt this would not have influenced the outcome in Adult K's case as the court case was known to agencies from other sources and the suicide note was received by a private company outside the regulatory framework other organisations adhere to.

RECOMMENDATIONS & ACTIONS

The OSAB should consider how to build on and improve the relationship and communication channels between non-Board organisations, such as the Diocese and housing providers, and the Board to help promote the safeguarding of adults interacting with these organisations. It would also help in the event of future cases that might meet the criteria for a Safeguarding Adults Review or other review processes.

1. Board to request of the Engagement Subgroup that communication channels with non-Board members is considered under the planned engagement work, if not already part of the workplan.

Board members should satisfy themselves that they have a system in place for checking the quality of documents uploaded onto internal recording systems. This is to ensure that in the event of future review activity, either internal or external, all records are clear and accessible.

2. Board to request the PIQA Subgroup add quality of recording to its workplan, either as a standalone audit work or incorporated into the safeguarding self-assessment.