Safeguarding Adults Review

A multi-agency review into the events surrounding the death of James Anthony Sootheran

Anthony's Story

Anthony was his mother's only child. His personal characteristics such as ethnicity, sexuality and religious beliefs are not recorded in the reports shared as part of this review. He died in his home aged 59 and his carers were later convicted of his murder.

After his education at Bloxham School was completed, Anthony worked as an Auctioneer's Clerk performing a variety of roles in the company, including performing surveys for residential properties for the purposes of mortgage valuation. It was while working here that he met his future wife.

Anthony was an intelligent man with an almost-encyclopaedic knowledge of farming, cattle, and local farmland and would talk for hours if you brought up one of these topics. He also had an incredible memory for dates and facts and could recall the selling price of land and farm machinery from previous auctions going back years.

He was never shy and everyone who met him liked him. He was described by family as popular and always having a lot of friends.

Anthony was always busy and became more so after marriage. The couple moved house and the new property required extensive work so this added to the demands on their time on top of maintaining their jobs.

The couple had a daughter in 1988 and Anthony adored her, although by this point there were signs that he was struggling with his mental health. However, his daughter remained a topic that could get him talking for lengthy periods of time.

Before their daughter turned two, Anthony and his wife divorced. Anthony had some contact with his daughter as she grew up and in to adulthood but this became more sporadic as his daughter aged.

Anthony's Story

In 2004 Anthony's neighbour wrote to his GP to say Anthony had lost an enormous amount of weight, his appearance was unkempt and he was taking little care of his personal hygiene. The GP was asked to help as a matter of urgency and it appears they worked closely with a local Mental Health unit to engage with Anthony, resulting in him voluntarily attending for several weeks in late 2004, although he was noted as being quite resistant to coming into hospital. After leaving the Mental Health unit towards the end of 2004, the Doctor wrote to Anthony's GP to say that there had been some improvement in Anthony's condition although he was still noted as having poor personal hygiene and was resistant to medical examination or making any significant changes to his lifestyle.

Shortly after this, the Crisis Team visited the Sootherans. It was noted that Anthony continued to self-neglect and his mother had been struggling to cope. He talked about suicide as an option rather than going back into hospital. His mother reported at that time that she did not feel she could ask him to leave or leave him on his own and did not know how to manage his difficult behaviour. However, he had also just started on a new course of medication that had helped him sleep and his mother said things had been much better since then. She was left with the number of the Crisis Team and encouraged to call if she needed to.

During 2005 there were several further contacts with health services. These interactions contain reports of Anthony not eating or drinking for periods of time and his diet is noted as being extremely poor but still better than it was prior to his admission to the Mental Health unit in 2004.

In 2006 Anthony was diagnosed with severe depression and anxiety which led to an episode of in-patient treatment in October 2006 under the Mental Health Act. This was discharged at the end of January 2007. Anthony lived with his mother in a property while his farm was rented out to tenants. Following some problems with the tenants, a friend offered to help evict them and subsequently took up the tenancy along with her husband.

Anthony's Story

In 2008, Anthony and his mother moved back to the farm and an agreement was reportedly made where the friend, Lynda, agreed to provide paid care to Anthony's increasingly frail mother until his mother died in 2012.

Anthony deteriorated following the death of his mother and was rarely seen out. Friends and family raised concerns about his health and wellbeing and reported they were prevented from seeing him by Lynda.

Reports show Lynda stated she was not employed as Anthony's carer but ran errands for him, on occasion provided personal care and provided meals. The frequency and quality of this support were the subject of concerns raised.

Safeguarding concerns were raised and Anthony was assessed as having capacity to make decisions about his care and support. Further assessment of this was planned but did not take place as Lynda requested it be rescheduled. Anthony was very frail, unsteady on his feet and was described as living in 'squalid conditions'.

On 18th March 2014, Anthony was found dead by a visiting GP. There was no heating and he was inappropriately dressed. He was emaciated with a BMI of 15.6 and had a large pressure ulcer along with numerous abrasions. A post-mortem establish cause of death as Cachexia, Bronchopneumonia with possible sepsis related to the pressure ulcer.

Lynda was convicted of Anthony's murder in 2021.

DRAFT REPORT – NOT FOR CIRCULATION

The Care Act 2014 & the Safeguarding Adults Review (SAR)

The Care Act 2014 (which came into force on 1st April 2015) brought in the first legislative framework for safeguarding adults with care and support needs. Prior to this, while guidance existed (such as the *No Secrets* guidance from the Department of Health), there were no legal powers to conduct safeguarding enquiries outside of Police powers where a crime was known or suspected. The introduction of the Care Act 2014 sought to put adult safeguarding on the same basis as children's safeguarding and placed duties on organisations to work together to protect adults who were unable to protect themselves from abuse and neglect.

As well as this duty, the law established Safeguarding Adults Boards (SAB). SABs have a number of responsibilities, one of which is conducting Safeguarding Adults Reviews (SAR). SARs are a statutory review process for adults with care and support needs who have died or been seriously harmed through abuse or neglect The review aims to find out what agencies did well and what they could've done better as a partnership. It is not an investigation to assign blame or fault at any agency, it is instead looking at systemic issues of multi-agency working and how this could be improved.

The Oxfordshire Safeguarding Adults Board (OSAB) met in April 2022 to discuss the death of Anthony. As his death occurred prior to the enactment of the Care Act 2014, the OSAB agreed to conduct a Discretionary SAR to compliment the learning yielded by the other investigations processes which had taken place. It was agreed to hold a practitioner learning event facilitated by a safeguarding professional who was independent of the case and of the OSAB. The purpose of this method was to hold a group conversation about how things have (or have not) changed in how we work together since 2014. The event was designed to include the views of a broad range of people and agencies who were involved or who had expertise in areas of care and support relevant to the person who has died and the circumstances leading to their death. The predicted benefits of using this methodology are that it is group led, ensuring a full contribution of learning from staff involved in the case, and enables practitioners to explore the root cause of decision-making in practice.

The Practitioner Learning Event was led by an Independent Facilitator, Vikki Gray, Head of Safeguarding for NHS England South East Region.

DRAFT REPORT – NOT FOR CIRCULATION

1. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

1. Key Line of Enquiry: **Professional Curiosity & Person Centred Approach Discussion and findings**

Anthony was isolated and he was reported to be a 'recluse' who neglected his personal hygiene and dietary needs and described by his GP as living in 'total squalor'. He had a history of mental health concerns and had been detained in the past. There were concerns raised by family that he was being neglected by a non-family informal carer

Social workers and Police followed up through several visits to his home and the GP also visited, it was deemed Anthony had 'mental capacity' to make decisions around care and support (See slide 8). The lived experience of social workers was that Anthony was in a remote location where there were large dogs, the carer was assertive and also confrontational making it very challenging for social care to access.

It was a challenge for professionals, family and friends to gain access to see Anthony due to his carer, Lynda, advising it was not a suitable time to see him or that he had gone out. Lynda's ability to divert practitioners from seeing Anthony impacted on their ability to make informed assessments.

There were power and control concerns in regards to the behaviour of carer. However, this was pre Care Act[2] and pre-Domestic Abuse Act[3] so safeguarding did not have a statutory footing and the deeper understanding of coercive and controlling domestic abuse and grooming of adults for financial abuse was not in law or guidance.

A focus on self neglect can hinder consideration of wider vulnerability to being groomed and exploited. The exploration of risk due to Anthony's wealth was not apparent

Participants felt agencies often have to work in an episodic way, responding to crisis and escalations of concerns and then withdrawing due to high caseloads which do not lend themselves to keeping people 'open' for long term support, especially when they do not want to engage

It was felt that Interagency communication was less robust than it is now so at that time information was not shared or shared in a timely way between mental health, general practice, social care and police professionals to create a picture of what life was like for Anthony including exploration of his wishes and what was driving those and the actual and potential risks and mitigations.

Workloads and administrative support to coordinate information for complex cases. There was no Multi-agency Adults Risk Management (MARM) framework[4] at the time of these events that may have pieced information together and enabled multi-agency discussion about risk

2 https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

3 https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

4 https://www.osab.co.uk/resources-and-publications/multi-agency-risk-management-marm-framework/

For consideration by the OSAB

Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information and is an issue frequently cited in safeguarding adults reviews[5] as an area for improvement. Although visiting professionals were curious about what was happening, they felt intimidated by Anthony's carer even when attending in pairs or in joint visits. Anthony died in March 2014 before the Care Act was enacted meaning mechanisms for delivering statutory safeguarding adults responsibilities were not yet in place.

- The OSAB to review how professional curiosity is explored and encouraged in partner agencies and how concerns from family and friends are robustly explored. Is professional curiosity explicit within training and supervision to enable the right conditions to support this in practice?
- The OSAB to assure itself that all agencies are sighted on agreed welfare check processes, what is a welfare check, how and when to ask for it and who carries out, reporting back and decision making?
- The OSAB to consider how it monitors the effectiveness of current multi-agency escalation and resolution procedures
- Disguised compliance is a significant learning and development area in child safeguarding[6]. What guidance and training is available to agencies and professionals in Oxfordshire to identify and manage possible disguised compliance and/or aggressive and non-engaging informal carers when working with adults who rely on others for their care as Anthony did?

5 http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf
6 https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/disguised-compliance

Why is professional curiosity important?

DEFINITION:

"Professional curiosity is the capacity and communication skill to explore and understand what is happening to a person or within a family rather than making assumptions or accepting things at face value."

Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received.

Lack of professional curiosity is a repeated theme in Serious Incidents, Safeguarding Adult Reviews (SAR), Child Learning Practice Reviews (CLPR) and Domestic Homicide Reviews (DHR)

Looking:

- Is there anything about what I am seeing in my interaction with this child or adult which prompts questions or makes me feel uneasy or concerned?
- Am I observing behaviour which is indicative of abuse or neglect?
- Does what I am seeing support or contradict what I am being told?

Listening:

- Am I being told anything which requires further clarification?
- Am I concerned about what I am hearing family members saying to each other?
- Is someone in this family trying to tell me something but finding it difficult to express themselves? If so, how can I help them to do so?

Asking:

- Are there direct questions which I could ask in my direct contact with this family which will provide more information about the vulnerability of individual family members?

Checking out:

- Do I know what other professionals are involved with this family?
- Have other professionals observed what I have seen?
- Are professionals being told the same or different things, or do explanations from family members change over time or according to who you ask?
- Are other professionals concerned? If so, what action has been taken so far and is there anything else which should or could be done by me or anyone else?

2. Key Line of Enquiry: Thinking, feeling, acting. Discussion and findings

Key concerns were for Anthony's welfare, family reported they felt Lynda was neglecting Anthony but enquiries fell back to him being assessed as having capacity to make his own choices. Consideration of Anthony's executive capacity was not clearly documented so it is unknown if it was given consideration while assessing capacity.

Anthony's vulnerability to coercion and control did not appear to have been explored, work at that time was centred around concerns about his self neglect and mental health.

Anthony had been described as 'difficult' by some health professionals over the years and was seen to cause problems for his mother when she became increasingly frail. It can be frustrating and stressful for professionals on the front line to work with people who self neglect[7]

Legal literacy, or at least availability of legal advice, is a barrier in self neglect situations[8], questions remain about whether Anthony was deprived of his liberty under Article 5 of the Human Rights Act[9] in his home without legal authorisation. Legal advice on whether this should have proceeded to the Courts was not considered by any agency in written records.

Anthony was vulnerable due to his frailty and mental health issues, there were concerns about Lynda's influence although it was not apparent this considered through the lens of domestic abuse, coercion and control at the time. It is important to note that the offence, learning and practice around coercion and control was not well established until post 2015[10].

Lynda was controlling who Anthony saw and towards the end of his life it is unclear whether he had capacity to decide for himself and capacity assessments were hindered by this lack of access. It is not clear whether and how professionals did or didn't identify their role in protecting Anthony.

7 https://www.scie.org.uk/self-neglect/at-a-glance#:~:text=Working%20with%20people%20who%20self-neglect%20can%20be%20alarming,high%20and%20the%20options%20for%20intervention%20are%20limited.

8 http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

9 https://www.legislation.gov.uk/ukpga/1998/42/section

2. Key Line of Enquiry: Thinking, feeling, acting. Discussion and findings (contd)

Having a pen portrait of the person to understand the context of their life and being 'trauma informed' when presenting as self neglect would be beneficial. According to reports from mental health professionals, Anthony did not like change, he had fears about judgements of others and had not enjoyed eating for many years. It is not apparent that any specialist eating disorder service was considered which later became learning in the London SAR for YY[11].

There were no concerns about the care Lynda provided to Mrs Sootheran (mother) and were described as having a 'close relationship' it is possible that Lynda resented Anthony for the worry his behaviour caused his mother. There is a question of whether this history of providing 'good' care and her past professional caring role influenced professionals when considering her care of Anthony.

There was an absence of information about spirituality or sexuality in Anthony's care assessments. Understanding key elements of a persons identity can help build relationships and provide person-centred support. Professionals had varied responses to whether there were sources of advice and support in their agency to advise on ethnicity, culture and spirituality. Police and mental health services had an identified person they could contact for advice and information but not all partners were sure.

Recognising risks of gender bias where women are more likely to take on caring roles as in Lynda's case. Did Anthony being male and his carer being female affect the considerations around risk of harm being perpetrated?

Exploring with Anthony why he did not want to engage and advice; what were his concerns/fears around engagement? Who would have been the best person to engage with him to begin with? This approach is reliant on professional curiosity. Multi-agency meetings are key to identifying concerns, assessing risks and planning actions – professionals are not always sure who can call a multi-agency meeting

11 https://www.camden.gov.uk/safeguarding-adults#lide

For consideration by the OSAB

- From research in to child abuse, it is suggested that abuse by women is underreported and that gender stereotypes are harmful and silencing[12]. Carers UK report that women are more likely to take on caring roles. All OSAB partners to consider how, when making assessments of men or those who identify as men, workers are able to be curious about situations and not make assumptions about carers based on gender
- It is a significant concern to be considered to lack capacity when you do not which is why the presumption of capacity is enshrined in law. Arguably, it is equally concerning to be said to have capacity when you do not and be left to cause yourself or others harm when those decisions are not really yours. How do OSAB partners ensure as part of training, record keeping and supervision, issues around mental capacity are regularly discussed and reviewed, especially for individuals who self neglect?
- How do OSAB partners ensure professionals have access to legal advice to consider whether Inherent Jurisdiction is an option where an adult is vulnerable but may not be autonomous due coercion or illness for example
- Curious enquiry to establish a persons characteristics and biography is important to a person-centred approach, to understand their story, what has happened to them and what is of importance to them rather than to professionals and organisations, do all OSAB partners audit assessment templates to gain assurance this is happening?

12 https://napac.org.uk/women-who-abuse/

3. Key Line of Enquiry: How do we see and hear the adult behind the carer?

Lack of continuity in seeing the same worker was discussed although agree this is not always possible, for high risk/very complex individuals a designated key worker is essential and such cases should be monitored by managers to ensure optimum level of continuity and supervision for the key worker and themselves as supervisor

Recognising, assessing and managing behaviours in carers or other adults who are obstructing or manipulating professionals away from seeing the adult bas discussed in 'disguised compliance'.

Non face to face consultations are now a new normal, there is guidance from organisations such as RCGP[13], Safelives[14] on conducting non face to face consultation as these can be exploited by abusers to keep professionals away from intervening

Consent – ensuring all involved in obtaining or working under the consent of the individual are competent in applying the mental capacity and/or have access to practical advice and support in this area. Consent should be regularly revisited with the person and not a one off recording.

Time for professionals and families to speak and listen, how is information from families robustly analysed as part of risk assessment?

Escalation: how is the OSAB multi-agency escalation process[15] reviewed and monitored and used in training

Individual agencies escalations are easier in small teams than bigger but also workers can feel concerned about overburdening the system with escalations

13 https://elearning.rcgp.org.uk/mod/page/view.php?id=10812

14 https://safelives.org.uk/file/domestic-abuse-guidance-virtual-health-settings-c19pdf

15 https://www.osab.co.uk/wp-content/uploads/2020/02/Procedure-for-adults-who-don't-engage-or-don't-meet-criteria.pdf#:~:text=Where%20there%20is%20a%20difference%20of%20opinion%20as,at%20risk%20who%20are%20not%20engaging%20with%20services.

For consideration by the OSAB

- In child safeguarding, techniques by which parents/carers resist change to draw attention toward their needs and away from the childs, and draw the focus of work toward achieving their cooperation rather than ensuring that the child receives adequate care. There are parallels to draw here for adults who rely on others for care and, given the advancement in this area in children's safeguarding, there are opportunities for the OSAB to work with the Safeguarding Children's Partnership to create transferable learning opportunities.
- OSAB partners to consider prompts in electronic records for revisiting consent with adults about their care and support arrangements
- Is obtaining legal advice flagged in multi-agency escalation to prompt consideration of whether this is needed as part of the response?
- OSAB to ensure analysis and response to concerns raised by families and friends is explicit in training and guidance to multi-agency partners, this is another area where collaboration with Children's Safeguarding partnership to ensure this is in place may be more effective

OSAB Safeguarding Adult Reviews: Comparative Learning to review against Anthony's case

Adult V: This SAR yielded comparative learning with Anthony's case in relation to professional curiosity and missed opportunities to explore adult V's lifestyle choices

There were also similar findings in terms of professional overreliance and role of optimism in relation to how well things were going for Adult V.

Assumptions were made about mental capacity and there was no evidence of consideration of executive capacity

Concerns about the robustness of shared decision making and multi-agency working

The author did not have access to any IMRs from agencies for Adult V – the OSAB may wish to consider how it is scrutinising the nuances of both good and sub-optimal practice within each agency to deeply understand what is required to improve safeguarding adults in Oxfordshire

Adult J: In this SAR, family raised concerns that did not have sufficient influence the decisions about risk, care and support

Recommendations were made in relation to exploring a 'team around the family' model and also a 'Team around the adult' approach to self neglect

The role of the GP in supporting adults who self neglect could be improved with more emphasis on leading the multi-agency response if other organisations have little involvement

Specific Learning for the Board on Self Neglect

Since Anthony's death, the Board has produced a resource on self-neglect. The Author has reviewed the resource and discussed these at the practitioner meeting. These are the suggestions of the Author to improve the resource.

OSAB to consider how to disseminate the self-neglect tool more widely, how to make it more intuitive to click and access certain sections for busy professionals and to review its effectiveness

The resources available on OSAB website for self neglect could contain optional practical templates for professionals to use to structure and record such as risks, capacity assessments, legal options, adult and family views and wishes, goal setting.

The resources would benefit from a paragraph written by each agency in Oxfordshire to describe what they provide for people who self-neglect e.g what the Police can offer, the Fire service, GP , mental health and so on.

OSAB to consider developing a leaflet for professionals and version for the public on self neglect so that family members, neighbours and friends can understand more about self-neglect and know how to obtain support, advice and escalate in relation to any concerns.

Next Steps

1. For the OSAB Partnership to review all the areas for consideration from the Key Lines of Enquiries, the comparative recommendations for Adult V and Adult J alongside the online self neglect resources the Board offer and then consolidate any actions required as a result in to a single action plan.

2. After discussions with the family, they are keen that the OSAB works with organisations to raise the profile of how the general public can raise a concern and what they can do if they feel their concern has not been listened to, understood or acted upon appropriately.

3. This is the first time the Board has conducted a review using this methodology and produced a learning document in this format. Consideration should be given to whether this is a format for future reviews, alongside adopting the Review in Rapid Time methodology that has been developed by SCIE and is being supported by the Department for Health & Social Care.

Actions

1. OSAB to task the Engagement Subgroup with creating a form of words for publicly available websites on **how to raise a concern about a friend or family member they are worried about.**
2. OSAB Procedures Subgroup to review **Self-neglect** guidance in line with the learning from this review and how learning in regard to this is embedded within partner organisations.
3. OSAB to review guidance on **professional curiosity** in line with the learning from this review and how learning in regard to this is embedded within partner organisations.
4. Related to Action 3, OSAB to work with member organisations in regard to ensuring there is a **pen portrait** of clients to understand them and their lives prior to the organisation's involvement.