BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult Z

Overview Report October 2019

Dr Paul Kingston, Independent Reviewer and Author

CONTENTS

CONDOLENCES

This Serious Case Review was initiated as a result of the death of Z on 27/07/2018 and the Buckinghamshire Safeguarding Adults Board wished to identify whether there was any learning regarding the way agencies worked together to support Z.

The Safeguarding Adults Board and the author of this review would like to express their sincere condolences to Z'S family and all those who knew him and have been affected by his death.

THE AUTHOR

Dr Paul Kingston is the Independent Chair for Children and Adults at Wigan Borough Council, Independent Chair for the Royal British Legion Safeguarding Forum and he chairs the Safeguarding Adults National Network for NHS England. He co-chairs the National Safeguarding Steering Group for NHS England and is a member of the NICE Guideline Group on 'Safeguarding in Care Homes'. He has published widely over 25 years on safeguarding issues, and is the author of over 20 Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews (SCR/SAR/DHR).

REASONING FOR CONDUCTING THIS SAR

During the initial local case review a number of missed opportunities in engaging with Z were noted. A number of teams were involved in Z's care and support and there seemed to be a host of different responses from all involved. There was also concern that agencies did not follow appropriate processes in managing the concerns reported. The initial chronology produced suggested that services were not working well enough together to engage with Z and provide support.

Additionally, Z may have required palliative care at the end of his life due to respiratory failure and there were concerns that he should have been made more comfortable at the end of his life. There were a number of calls/missed opportunities to ensure he was on the right "pathway" and to ensure he died in a dignified manner.

TERMS OF REFERENCE: (OCTOBER 2018 – MARCH 2019)

The purpose of a SAR is:

- to involve agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future;
- to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different practitioners with whom they work;
- to provide insights into underlying issues such as the impact of organisational culture on professional decision making;
- to identify if any processes or systems need to be changed or developed as a result of improved understanding about the needs of adults at risk;
- to strengthen the accountability of managers to take responsibility for the context and culture in which their staff are working and ensure that they have the support and resources they need.

Case Reference details: therein will be referred to as Z.

The following agencies completed a timeline and analysis of their involvement:

- Red Kite Housing (RK)
- Buckinghamshire County Council Contracts (BCC)

- Connection Support (Prevention Matters) (CS)
- General Practitioner (GP)
- Buckinghamshire Health Care NHS (BHT)
- Buckinghamshire Adult Social Care (ASC)
- South Central Ambulance Service (SCAS) (short report)
- British Red Cross (BRC)

Additionally a SAR panel discussion was held on the 13/2/2019. The information from this meeting has been integrated into the review.

PANEL MEMBERS

Name	Agency	Job Title
Julie Murray	Bucks CC CHASC	Safeguarding Adults, Deprivation of Liberty Safeguards and LASM.
Lee Scrafton	Bucks CC CHASC	Contracts Team Manager, Joint commissioning
Krista Brewer	CCG	Safeguarding Adult Lead
Katriona Kennedy	Bucks Healthcare NHS Trust	Head of Nursing for Elderly and community Care
Barbara Poole	Healthwatch	Panel Member of Healthwatch
Liz Bubbear	Connection Support	Operations and Development Manager
Kevin Eckley	Red Kite Housing	Sheltered Housing Manager
Deborah Fisher	Red Cross	Director Crisis Response & Independent Living

The Panel, with the support of the Independent Reviewer/s will:

- Assist with the arrangements for the Review, including briefing and supporting their staff to engage in any individual discussions for the Review if required and attend the Practitioners' Review Day
- Identify the roles and responsibilities of each agency involved and analyse the extent to which the agency has met its responsibilities, identifying good practice and any issues with policies, procedures and practice
- Identify the culture and context in which the staff of each agency work, and analyse the extent to which they support effective practice
- Identify and analyse how well the agencies have shared information and worked together
- Report as findings good practice which should be shared and learned from
- Report as findings issues in individual agencies' cultures, structures, policies , procedures and practice which should be shared and learned from
- Report as findings any measures which would improve the effectiveness of joint work

In the above context, the Panel will note the extent to which the work of the agencies was:

- Consistent with the principles of Making Safeguarding Personal
- Person centred
- Informed by needs and risks assessments
- Timely
- Adequate and appropriate
- Responsive to crises and risks

Additional Areas of Focus

The circumstances leading to this Review require specific attention also to be paid to the following:

1. Information sharing / communication: Was this carried out in a timely manner. To examine the extent that there was effective communication within agencies/teams and with outside agencies and the impact on this on the support that Adult Z received.

2. Mental Capacity / consent: To determine if Z's mental capacity was considered by agencies and if necessary whether appropriate mental capacity assessments/best interest assessments were carried out. If not whether his consent was sought before the care package was put in place and whilst it was in place?
3. Assessment: Were appropriate assessments, including risk assessment, carried out in this case?
4. What should have been the protocol with regard to support being offered to Z?
5. What happens when someone refuses care but it is considered to be in his best interest to have care?
6. Advocacy: Was Advocacy considered, or should it have been considered.

TIMEFRAME FOR THE SAR

The timeframe set for the Review is July 2017 to July 2018 with any significant incidents outside of these dates to be included, particularly those where Z refuses services.

REVIEW PRINCIPLES, HINDSIGHT AND POSITIVE REFLECTION

The primary purpose of this review is of learning lessons, SAR's are not investigations or concerned with disciplinary issues, these are for the police, the coroner and operational directors to address. This comment in the Pemberton Domestic Homicide Review is applicable in any form of review, investigation or enquiry that has a scope over several years;

> "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[1]

[1] **A domestic homicide review into the deaths of Julia and William Pemberton, Walker,M. McGlade, M Gamble, J. November 2008 http://www.thamesvalley.police.uk/aboutus/crprev-domabu/crprev-domabu-whatdomabu/crprev-domabu-whatdomabu-howtvp/crprev-domabu-whatdomabu-howtvp-pemberton.htm (accessed 18.02.2016)**

Similarly, it is helpful to reflect on the statements contained in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

> *"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."*[2]

These principles have been borne in mind in the conduct of this SAR and in the writing of this Overview Report.

ASSESSMENT AND RISK MANAGEMENT

A good quality assessment is one that:[3]

- Is focused on the person; who are they? What is their history? What do they care about? What really matters? Who do they love? Who loves them?
- Understands a person's history to inform an assessment of risk and uses that information to identify patterns of risk / behaviour that inform plans for working with a person to safeguard them from harm;
- Identifies and understands the person's religious, cultural, language and ethnic background;
- Explores and agrees a person's strengths;
- Identifies the person's needs and explains the reasons for those needs;
- Identifies unmet needs;
- Details the services / organisations providing services to the person and;

[2] **Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)**

[3] **https://www.nice.org.uk/guidance/qs182/chapter/Quality-statement-1-Care-and-support-needs-assessment**

- Describes the relationships that matter to the person, together with any concerns or issues that are important for practitioners' awareness.

These principles will be considered as they arise in the documentary evidence.

OVERVIEW

Adult Z was born in 1940. He died in High Wycombe, where he had lived for many years in July 2018. He lived in a ground floor Housing Association (RK) supported flat, to which he had moved in May 2017, having previously lived in a first floor flat in the same complex in which he had lived for six years. Before that he had lived in local authority housing in High Wycombe. He had four children, two of whom were daughters from his first marriage, but were in contact even though they did not live nearby, and despite at times fraught relationships. They both also contacted agencies to express concerns about their father's well-being. It is not known what contact he had with his two other children.

Little information is provided by agencies participating in this SAR about Z's earlier life, about his wishes and feelings other than to record his tendency to refuse services and care; no social history has been provided by any agency providing him with support and care. This is a matter that is referenced later in this report.

HEALTH

Z was 78 years old when he died. He had the following diagnosed conditions:

- Chronic Obstructive Pulmonary Disease (COPD) (diagnosed in 2008)[4]
- Metastatic lung cancer (diagnosed July 2018);

Z had a heart bypass operation in 2011;

Z was a tobacco cigarette smoker; impacting on his breathing difficulties;

Z was considered by agencies to be resistant to accepting support and to be 'unkempt'[5].

Z also experienced anxiety and had panic attacks; this was known to those agencies that had provided him with care and support over some time (his GP, RK, and CS). It

[4] **ASC Community Response and Reablement Team Chronology**
[5] **BHT IMR**

is not clear from information provided by agencies whether or not this was a diagnosed condition. However, from reading the chronology, it was clearly something that had a significant impact upon his daily life.

Z was also reported to have a gambling addiction by one of his daughters.

FAMILY

Z lived alone. It is not known from the information provided whether he was twice divorced or a widower.

He had children from two marriages. He was, it seems in greater contact with his two daughters from his first marriage, one living in the north of England, the other lived in Dorset. While both advised agencies that they had limited contact with their father, they both contacted agencies regularly to express concern and seek support for him. The other two children from Z's second marriage were apparently not in contact with him. There is no reference in information provided by agencies for this SAR about any friends. Where this report refers to, '*Z's daughters*', it refers to those from his first marriage.

TIMELINE OF SIGNIFICANT EVENTS DURING SAR PERIOD

Date	Event	*Learning theme*/Comment
08/11/2016	Z was discharged from hospital and reportedly had not received an assessment of needs; one of his daughters called the ASC Contact Centre to refer as she was worried about him. She was told she could not self-refer this way and should do so via the GP or contact the ASC Community Response and Reablement Team. Having contacted Reablement they advised her to go through the GP and CRR.	***Assessing and managing risk and Professional curiosity*** This seems an unhelpful response, although the reference in the chronology provided by ASC suggests that the daughter was accepting of this advice. However, given her concerns and Z's recent discharge, there should have been at least an informal risk assessment and action taken if necessary. There is

		no reference to any of this, nor any consideration of professional curiosity about Z's daily life. The risks were identified in a telephone discussion with Z's daughter on 11/11/2016, when she described his inability to self-care, his '*end stage COPD*'[6] and his gambling debts.
28/11/2017 – 01/12/2017	Z contacted his GP to request an inhaler prescription; this caused concern as he had been issued with one only six days previously. The GP pharmacist called Z and left a message on his answering service to this effect. Two days later, on 30/11/2017, Z called again and again requested an inhaler prescription. This time he was asked to see the GP Pharmacist, which he did the following day on 01/12/2017. Z was given smoking cessation advice and guidance on how to use his inhaler. The pharmacist noted Z's 'panic attacks'.	*Assessing and managing risk and Professional curiosity* There is no recorded consideration of Z's current state of COPD; is he able to cope without a new prescription? Why has he used the previous prescription so quickly? No consideration of his mental health, or capacity – was he confused and therefore using the inhaler inappropriately? The response of 'smoking cessation advice and guidance for correct inhaler use' seems to not recognise the level of risk presented. Six days later he was admitted to hospital with breathing difficulty.

[6] **ASC Chronology**

06/12/2017	Z was admitted to hospital with 'breathing problems'.	
13/12/2017	Z was discharged home from Stoke Mandeville.	
19/12/2017	Z's daughter contacted ASC, explaining her concern that [again] he was sent home with no assessment or services, that he needed help, that he was confused, that he could not cope at home and could not manage daily living activities.	Referral for ASC assessment within 10 days. Screening assessment completed by phone. No opportunity to see the circumstances in which Z was living.
27/12/2017	Z called the out of hours GP as he had experienced a panic attack.	Response included a request to the registered GP to visit Z at home.
02/01/2018	The GP visited Z at home. They advised on *'inhaler technique'*.	*Assessing and managing risk and Professional curiosity* Given the fact that Z had been in hospital only three weeks before and had experienced a panic attack six days before, it seems unfortunate that there was no apparent discussion about mental health, no questioning about his day to day ability to self-care and no risk assessment.
02/01/2018	The Community Response and Reablement Team (CR&R) worker visited Z and conducted a Care Act 2014 S9 assessment of need. The assessment stated: *Eligibility:*	*Assessing and managing risk and professional curiosity* *Application of the Mental Capacity Act (2005) requirements*

	• *Z's needs were assessed as meeting the national eligibility criteria under the Care Act 2014 section 9.* • *Z has COPD (condition 1).* • *This affects his ability to maintain a habitable environment and accessing the community (condition 2).* • *As a result of this his mental and emotional well-being is affected having to rely on others to have his needs met (condition 3).* *Outcomes:* • *Family support Z in competing an application for Attendance Allowance,* • *IF the application for Attendance Allowance is successful Ms L could support Z to manage the money to pay for a cleaner and taxis to access the community. Z agreed this would be a positive step for his daughter to manage the money to prevent it being spent in the slot machines.* • *Telecare and prevention Matters were declined by Z.*	No consideration of capacity or need for consideration of lasting power of attorney (health & welfare). No consideration of Z's daily lived experience, nor his wishes and feelings. Entire lack of consideration of the fact that Z refuses care regularly, so suggesting, *'if the application for Attendance Allowance is successful MsL could support Z to manage the money to pay for a cleaner and taxis to access the community'* is highly optimistic. No consideration of the need for legal frameworks (i.e. power of attorney) to enable his daughter to manage the potential Attendance Allowance. No reference to risk or of any discussion around impact of declining services on Z's welfare. Entire lack of understanding of addiction, '*Z agreed this would be a positive step for his daughter to manage the money to prevent it being spent in the slot machines'*.
May 2018	Throughout May the Pharmacist consults with the GP because Z requests multiple	No consideration of

	inhalers and is misusing.	confusion. Panic attacks are considered the cause of overuse. No risk assessment.
01/07/2018	Z called an ambulance. He described his anxiety that he had *'run out of medication'* [presumably inhalers]. He also described his difficulty in breathing. The ambulance service raised a concern via the safeguarding adults process due to Z expressing his worry about being alone, about not having family to support him. The ambulance service also highlighted its own concerns about the burns in his carpet and the fire risk.	*Assessing and managing risk* *Lack of understanding of safeguarding adults multi-agency policy and procedures* Unclear what the safeguarding adults concern is; rather there is identification of a range of risks that should have been referred as a social care matter. The fact that this was apparently 'rejected' by the safeguarding team meant that the referring agency (ambulance service) potentially had a sense that the risk was less evident than they had thought. Additionally, by mistakenly referring through 'safeguarding', there is a possibility that the evident risks identified for Z are not addressed (i.e. 'does not meet threshold = therefore no risk). No referral to the Fire

		Service for a risk assessment.
01/07/2018	Z was admitted to Stoke Mandeville Hospital.	
02/07/18	Diagnosed primary lung cancer- transferred to a specialist respiratory ward. BHT discharge to the Community for end of life care. No evidence the hospital was aware of the safeguarding Alert.	Lack of communication between the ambulance service and the hospital.
06/07/18	Occupational Therapy (OT) review. Z felt anxious about going home and being alone. Declined a full assessment by the OT but accepted referral to the Red Cross.	***Assessing and managing risk*** Acceptance of this refusal resulted in Z being at risk and unable to care for himself on discharge.
10/07/18	OT discussed care and support package Z declined. Plan made for OT to discuss again on the 11/07/18.	
11/07/18	OT review: OT advised three times a day care for discharge as a package of care. Z declined but did say '*he would not mind but doesn't want people fussing around him'*. Sign posting made in case he changes mind.	***Assessing and managing risk*** Response is not proportionate to risk.
12/07/18	OT recorded that Z consented for referral to Red Cross for shopping and domestic tasks and advised that Z was '*anxious about being at home alone for the first few hours until he settles in'*.	***Assessing and managing risk*** Note: not a package of care that equated to the OT's assessment.
12/07/2018	British Red Cross (BRC) Support at Home (SaH) service received a referral	***Unmet needs***

	regarding Z. Referral for low level support with shopping and domestic activities. Planned telephone and welfare call put in place for 16.7.18, as the service operates Monday-Friday.	Referral was for a far lower level of support than needed – only a telephone call three days after discharge planned. BRC could not address the anxiety Z expressed to the OT about the first few hours at home.
13/07/18	OT suggested that a pendant alarm for home would assist Z. He declined and said he had a mobile phone.	***Assessing and managing risk*** Did Z understand that the pendant alarm would assist much more effectively? Was this an informed decision?
13/07/18	Z was discharged home. It is noted that Z is non-compliant with medication and physically frail.	***Unmet needs and high risk*** No care provision on discharge.
16/07/18 – 19/07/18	Between and 16 and 17/07/18 four telephone calls were made by British Red Cross (BRC) to Z without establishing contact and a call made on 17.07.18 to the Next of Kin (daughter) with no reply, finally achieving the conversation with Z's daughter on 19/07/2018. BRC was informed by Z's daughter that her father was terminally ill and that he	***Unmet needs*** ***Assessing and managing risk*** BRC seems to have tried their best to get hold of Z and his daughter. However, he was left without support, despite an assessment in hospital that he needed care

	did not hear the telephone – both pieces of information that had not previously been shared with the BRC.	three times a day for six days. ***Inadequate discharge communication*** BRC had not been told that he had terminal cancer, nor that he was hard of hearing and probably would not hear the telephone. BRC therefore had been unable to make informed risk assessments.
20/07/2018	Support Worker from Red Kite Housing, NN expressed concern that he had recently come out of hospital and declined care, that he had no food and just sat in the chair showing signs of neglect. NN referred her concerns to ASC via the Contact Centre and was advised that for immediate care she would need to contact the GP.	***Assessing and managing risk*** The Contact Centre did not seem to want to assist the Sheltered Housing Officer and she was referred back to the GP. No apparent reference to risks.
23/07/2018	BRC support worker visited Z at home and conducted an assessment of his needs and devised a support plan.	This was the only time that BRC was able to visit prior to Z's death.
24/07/2018	Z was referred to the Connection Support Prevention Matters Service (CSPM)[7]	This service knew Z well, having supported him on and off since 02/09/2016.
25.07.2018	The CSPM service allocated Z a support worker.	

[7] **CSPM IMR states that 'Prevention Matters (funded by Buckinghamshire County Council) is a major initiative working with people aged 18+ who are approaching the threshold for Adult Social Care services who without intervention may require more intensive health and social care support in the near future. It aims to increase their independence and reduce the impact on social care services'.**

26/07/2018	CSPM Support worker spoke with Z on the telephone and was very concerned about his welfare. She escalated to her manager who suggested referring the ASC safeguarding. He was advised that Red Kite Housing Association had tried and '*it didn't meet safeguarding threshold*'.	***Lack of understanding of safeguarding adults multi-agency policy and procedures*** Unless the concerns identified were regarding self-neglect (the concerns are not specified in detail in this IMR) and that seems unlikely, then the service was wanting to refer because they identified risk not abuse or neglect. The IMR states, '*this was a potentially serious situation of neglect that was deteriorating'*; the service considered that he was being neglected by statutory agencies?
26/07/2018	Red Kite Support Worker, NN was advised by another tenant that they had heard Z calling for help. He had not had anything to eat or drink [this was the middle of the Summer 2018 heatwave][8]. Support Worker contacted GP, family and social care.	***Assessing and managing risk*** It is not clear how long Z had been without food or drink. Lack of risk assessment. NN provided Z with water and sought to reassure him. Her actions should be identified as very good practice; she took responsibility for his needs.

[8] https://www.bbc.co.uk/news/uk-45399134 **Summer 2018: joint hottest summer on record for the UK as a whole, and the hottest ever for England**

		The GP surgery had no apparent reference to the Level 3 guidance from NHS England issued on 23/07/2018[9] highlighting the significant risk of harm in the heatwave to, (amongst others, but this is cited here as relevant to Z) older people over 75 and those with a '*serious chronic condition, especially heart or breathing problems*'[10]*.* However, the support worker did what she could and tried to assist Z herself and then seeking support from social care, the GP and CSPM. The response she recorded from the GP is of significant concern: a) Receptionist advises the on call GP will call but they don't b) There was (reportedly) '*nothing they could do*'[11] *c)* The receptionist advised*, 'call the daughter or social services'.*

[9] https://www.england.nhs.uk/2018/07/heat-health-watch-alert-level-3-heatwave-action-3/

[10] https://www.nhs.uk/live-well/healthy-body/heatwave-how-to-cope-in-hot-weather/

[11] **Red Kite Chronology**

26/07/2018	CPW1 (worker from CPSM – Community Support Prevention Matters) visited Z. She was very concerned for his welfare and sought to share information with: • Z's GP • Z's daughters • Bucks County Council Safeguarding Team and the Response and Enablement Team When this was not successful and the working day ceased, she raised concerns with the local authority Emergency Duty Team social worker.	The EDT worker seems to have been helpful, but also explained it was not their responsibility, nor accountability and therefore not a matter they could help with. The CPSM felt this to be unhelpful, but had not, presumably been given information about the role of EDT, or where else to go for support.
27.07.2018	South Central Ambulance was called and when paramedic arrived, Z had a cardiac arrest and despite their efforts, he died at 13.05.	

SYNTHESIS OF THE TIME LINE ABOVE

Z had two admissions to BHT in 2017, the first admission (7/7/2017- 11/7/2017) attended to his COPD, and the second admission (7/12/2017-14/12/2017) also dealt with COPD. At this time the client was described as independent in activities of daily living. In July 2018 Z was admitted to BHT again with COPD however during this admission a diagnosis of primary lung cancer was made. Throughout the period July 2017 to November 2017 there appears little contact with agencies other than the pharmacist and GP who were trying to control the use of Z's inhaler.

In November 2017 Z's health started to deteriorate and the community engagement worker requested an urgent assessment. Z was telephone screened and also received a face to face assessment in December 2017 and had confirmed eligible care and support needs. Z declined support but agreed to allow his daughter to apply

for benefits, to control his finances. By March 2018 his daughter had not applied for financial support and advice was again offered.

July 2018 was a period of further decline in Z's health culminating in the Ambulance Service transporting Z to a place of safety – the A&E on the 1/7/2018. The Ambulance Service also made a report to Safeguarding which was screened as not triggering a safeguarding response. The safeguarding report was allegedly sent from safeguarding to the CRR for further Care Act Assessment, but there is no record if this was received.

Z remains in hospital from the 1/7/2018-13/7/2018.
It is at this point that the situation with Z's health starts to rapidly deteriorate. Z is noted to be calling out for help with his door propped open on the 20/7/2018 he reports he has not taken any food or liquids. Limited attempts at escalation are now made. This situation continues to deteriorate over the next seven days, and ultimately Z dies on the 27/7/2018.

FINDINGS AND EMERGENT LEARNING THEMES

Communication

Throughout, Z's care package information was either not passed between agencies[12][13][14][15] not considered appropriate[16][17] to the receiving agency, or not acted

[12] BHT IMR reports a plan to refer Z to palliative care after the diagnosis of cancer: there is no evidence this referral was made.
[13] BRC IMR reports receiving a referral from the hospital OT for low level support, this referral did not inform BRC that Z was terminally ill with Cancer.
[14] The ambulance safeguarding referral having not triggered a safeguarding response was sent to CRR for further care act assessment. No follow up from this referral is noted, and it is even clear if the email referral was made.
[15] THE RC after receiving a referral note that they *'received no communication from the referrer, written or verbal, to inform us that Adult Z was terminally ill nor that it would be difficult to reach him by phone as he could not hear the phone'*.
[16] RK IMR raised a safeguarding concern on the 20/7/2017 but was informed this did not reach the threshold for safeguarding.
[17] SCAS also made a safeguarding referral on the 1/7/2018 which was also screened as not triggering a safeguarding response.

upon by the receiving agency. This failure to optimise communication between agencies led to inevitable failures in planning appropriate care for Z. It is also evident that without a well-defined communication strategy it was not possible for one individual or one agency to care coordinate for Z. Hearing impairment was a particular difficulty for Z and identified on several occasions; this meant agencies could not support him effectively by phone; this was a particular problem for CS[18]. This information was consistently reported to agencies by family members, nonetheless, phone calls, instead of face to face visits were consistently utilised. Added to hearing difficulties Z certainly in the last few weeks of his life became increasingly immobile, which would have exacerbated his ability to reach the phone in time to receive the phone call. Z was never referred for help with this, even though several agencies were advised of the problem.

Social Care Assessment

There were two care assessments conducted – one by telephone and one face to face and on both occasions Z was considered eligible for social care support. However, the ASC IMR report Z refusing services or referrals. However, it is not clear from reports what mitigating action ASC considered given the risk noted from such refusals. Although Z refused services whilst in hospital he did advise the OT that he was anxious about returning home in July 2018 and wished someone could be there to help him. The OT did inform the BRC of this in her referral, even though the service could not assist with this problem. It seems that having made that referral (even though it was pointless in terms of this need), accountability and concern for his well-being ceased.

Similarly, BHT having acknowledged Z required support and care needs (assessed by the OT as requiring a care package three times a day), did not assess Z for a 'kitchen assessment', BHT IMR states:

> *' …this would have been best practice and would have provided insight into how Z would manage at home'*.

The fact that his declination of that care meant he had telephone calling and irregular support provision by the British Red Cross (which did what was required of them),

[18] **CSPM IMR**

was a significant difference in support provision. As Z's health deteriorated his health and support needs increased.

Risk and Assessment

There is an absence of consideration of risk other than by the RK Support Worker and the CS worker (and then not within any explicit multi-agency framework). This absence would have been compounded by the communication failures noted above. No agency seemed to undertake any explicit risk assessment that considered antecedents and indicators as well as incidents as they occurred.

The GP and GP pharmacists' continued a discussion about smoking cessation and correct use of inhalers, rather than seeking to understand what lay behind Z's constant request for prescriptions was unhelpful, as was the discussion about him 'stockpiling' of them.

The discernable risks that were observed and noted include:

1. Z inability to access liquids and food during an extremely challenging period of hot weather: CS IMR;
2. Allowing taxi drivers access to his bank card to collect food for Z: The GP IMR states that: '*The risk of financial exploitation should have been considered, and the GP could have considered directly referring to social services*', and other agencies (ASC) were also aware of this risk;
3. Z's know propensity to gamble which was discussed in November/December with his daughter to enable protection, and the GP IMR states *' … a discussion could have been had around considering lasting power of attorney for health and welfare and/or for finances'.* ASC IMR;
4. The fire risk noted on the 2/7/2018 reported to safeguarding. No referral to the Fire Service is recorded. The CC Line 75 notes: *'… no rationale for suggesting no further action by safeguarding and no attempts to make contact with Adult Z (no evidence that threshold tool was used)'.*
5. The hospital IMR notes that it was evident that Z required support with care needs whilst in hospital. However, having refused care and support after discharge, *'…there is no evidence that any risk assessment was made'. This would have been*

appropriate in order for Z to understand the impact refusals of care may have had and in order for health care professionals to mitigate risk'.

This risk situation has been accurately expressed with the following observations in the ASC IMR:

> *'When adult Z declined services in January 2018 there was no analysis of the risks this might trigger and any actions that might be taken.*
> *Safeguarding response in July 2018 did not appear to take account of known risk factors following SCAS report. There was no recognition that this was a man who had previously declined services and was now demanding ambulance transport to hospital as he was feeling unsafe at home.*
> *CRR did not respond to an emailed concern from safeguarding in July 2018. It is not clear whether the email was sent or whether the lack of action was an oversight. This was 3 weeks before adult Z died and was an opportunity to get Reablement involved much earlier than their referral on 20 July. However it may be that adult Z was in hospital for this period but there was no social care record to identify this.*

UNMET NEED

Z had numerous needs that were not met at any point of his contact with agencies during this period including:

LACK OF COMPREHENSION OF LOCAL MULTI-AGENCY SAFEGUARDING POLICY AND PROCEDURES / CARE ACT 2014 DUTIES

As previously reported above the GP IMR states that:

> '*The risk of financial exploitation should have been considered, and he GP could have considered directly referring to social services'*[19].

This is not a matter of 'could', but certainly of 'should' in the opinion of the author. Nonetheless, when a safeguarding referral was received by adult social care in July 2018 it was not considered to meet the threshold, however there is no evidence a threshold tool was even used. Therefore it is not clear on what basis the referral was declined. At the SAR panel ASC stated:

[19] **NHS CCG IMR**

> *'On reflection the referral coordinator that took this referral should have looked into the history on BCC ASC database'.*

and

> *' … Safeguarding – should have done a lot more information gathering and taken ownership. Information should have been shared with the correct people. No analysis was done and the decision for NFA was made in the absence of information. Safeguarding need to look deeper into their own shared records (all ASC Teams record on the same system)'.*

Furthermore ASC stated at the SAR panel meeting that *'notes were muddled'*, and that:

> *'The safeguarding team were not aware that Z was terminally ill although if they had looked further into ASC notes they would have seen that the community teams had contact with Z on the 1st, 25th and 26th July 2018'.*

Of serious concern is the statement that:

> *'Screening is done by non-qualified workers but any self-neglect should now be escalated to a qualified practitioner immediately and looked into'.*

This statement is positive and suggests self-neglect is accepted as a safeguarding issue, however in this case Z was never formally considered to be self-neglecting. Indeed at the SAR panel meeting the explanation offered for not reaching the threshold for safeguarding was that:

> *' … with the information received there was no evidence that Z was self-neglecting therefore was signposted onto the next service to assess'.*

Essentially there was sufficient information on the system to alert safeguarding that neglect, if not self-neglect, had been noted by numerous agencies and should have led to safeguarding action, or at least further enquiries.

Effective safeguarding was further compromised as the CS IMR and that of RK refer to a lack of understanding of the 'threshold' for safeguarding and are confused as to why their concerns regarding risk were not accepted as safeguarding referrals. This is an area of significant concern, surely for the Safeguarding Adults Board; two

agencies that are mandated to support adults at risk of abuse & neglect do not understand the Care Act nor the local policy and procedures. In particular, CS is commissioned to prevent harm; they surely must therefore know how to refer if that is not successful. CS asks in its IMR for guidance about this matter. This is the responsibility of the Safeguarding Adults Board: Paragraph 14.151 of the statutory guidance[20] states:

> '*The SAB must develop clear policies and processes that have been agreed with other interested parties, and that reflect the local service arrangements, roles and responsibilities. It will promote multi-agency training that ensures a common understanding of abuse and neglect, appropriate responses and agree how to work together. Policies will state what organisations and individuals are expected to do where they suspect abuse or neglect'.*

Several agencies referred to Z using taxi drivers to purchase his shopping and him giving them his debit card and pin number. While seen as not ideal, no practitioner other than Z's Sheltered Housing Officer considered this to be a matter that was of significant concern and warranted a safeguarding adults referral. None apparently thought about whether or not risks to Z were present for other adults at risk of abuse & neglect.

On 26/07/2018, Sheltered Housing Officer from RK was visiting another tenant who stated she had heard Z calling for help. The worker sought support from a range of agencies, including the GP and social care; she was especially concerned that it was a heatwave and stated he had not eaten nor had anything to drink. The response the worker recorded from the GP is of significant concern:

a) Receptionist advises the on call GP will call but they fail to do so;
b) There was (reportedly) '*nothing they could do;*'[21]
c) The receptionist advised*, 'call the daughter or social services'.*

This response potentially indicates not only a lack of understanding of safeguarding adults responsibilities, but also a lack of any commitment to partnership working.

[20] **https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1**
[21] **RK Chronology**

A further concern relates to thresholds, the CS IMR relates a recent conversation between one of their staff and adult safeguarding where they have been advised that:

> *' … they [Adult Safeguarding] are being much tougher on referrals and that health issues should be dealt with by the Health Services and that Adult Safeguarding will reject them'.*

This appears to suggest that thresholds for safeguarding can be manipulated to reduce demand. It is therefore not surprising that CS and RK are unsure of what might be considered an appropriate safeguarding issue, and as importantly, what the thresholds for such a referral might be. Notwithstanding the availability of a threshold document for the Buckinghamshire health and social care architecture, agencies appear unsure of how to interpret thresholds. This issue requires urgent attention.

NEGLECT/SELF NEGLECT

There are intimations that neglect was noted by practitioners, for example CS IMR states:

> *'It was clear to CPW1 and Manager1 in Prevention Matters that this was a potentially serious situation of **neglect** that was deteriorating. They understood that they needed to alert GP and/or social care as a matter of urgency. This had already been done by Red Kite, but nevertheless the CPW1 rang the ESWT to press for some urgent action.'*

The BHT IMR noted physical signs of neglect. They suggest that self-neglect was not contemplated:

> *'There are notations that Client Z was unkempt; example toe nails very long and skin dry with some damage. Professional curiosity was not engaged and no evidence of further exploration made or discussions made with Client Z relating to this. Coupled with the decline in care and support in the home or as a standalone concern there is no evidence that **self-neglect** was considered as a concern or explored at all'.*

The CC in cell 146 also reports:

> *'Telephone call from Red Kite Housing: N has called regarding Adult Z. She has been to visit him. He has recently come out of hospital and declined care, he has no food and is just sat in the chair showing signs of **neglect**. Advised*

> *that for immediate care she would need to contact the GP. As per note on previously the referral has now been sent to CRR.'*

This suggests a lack of professional curiosity, and an inability to triangulate information (see communication section above), which may have prompted a more immediate and appropriate response, particularly from safeguarding. Furthermore it appears the Self Neglect Tool Kit was not utilised in this case. During meetings of the SAR subgroup at least two agencies admitted not being aware of this document.

PROFESSIONAL CURIOSITY

The lack of professional interest, let alone curiosity in Z's experience is striking. There appears to have been an acceptance of Z's 'choices' (largely around refusal of care) and no apparent questioning of the reasons behind this, nor of the associated risk. The GP Pharmacist visited Z at home and spoke to him on the telephone on many occasions. However, the recording is all about effective inhaler technique and smoking cessation.

The lack of professional curiosity extends to a lack of concern about the way in which he was to manage once home, having been advised he had lung cancer and was on a palliative care pathway (allegedly) and no practitioner identifying the risks around his hearing impairment, and in terms of his use of taxis to buy his shopping. It seems from the information provided to the SAR that no agency had an interest / curiosity in who Z was, what his background was and why he might be making choices to refuse (some) care.

The only agency to mention professional curiosity absence is BHT

MENTAL CAPACITY AND POTENTIAL UNWISE DECISIONS

There is only superficial mention of Z's mental capacity. The ASC IMR states that over 18 months of contact with several professionals:

> *' … none of them raised any concerns or doubts over Z's ability to make decisions for himself – i.e. there was no reason to doubt capacity'.*

BHT is more cautious, noting (during hospital admission)

> *' … notations that would point to confusion and therefore we would expect to see capacity assessment(s) and reference to this in the notes'.*

This position was reinforced at the SAR panel discussion where the BHT representative stated Z had fluctuating capacity of wanting care. Further the consensus amongst the attendees was that Z was regularly confused but no one assessed why – the question was then asked *' … can we justify why no one did a mental capacity assessment?'.* The BHT representative went so far as to say:

> *' …. The biggest gap was the lack of assessment of his mental capacity and also questions how persuasive were they when trying to help Z'.*

Notwithstanding the absence of capacity assessments the BHT IMR attentively points out that:

> *'Furthermore if Client Z was appropriately assessed as making 'unwise decisions' there is still action to be made and it is not evident that this has been consistently done. Following the MCA Code of Practice section 2:11 where somebody makes repeated unwise decisions that would put that person at significant risk then there is a cause for concern and action must be taken.'*

The Mental capacity Act Code of Practice[22] makes the same statement that if somebody:

> *' … repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or - makes a particular unwise decision that is obviously irrational or out of character. These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information to help them understand the consequences of the decision they are making?'*

The Care Act Statutory Guidance (2018 updated) reinforces this position[23]:

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

[23] https://www.gov.uk/government/publications/care-act-statutory-guidance

> *'This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.'*

FOCUS ON THE PERSON (MSP):

It is of concern that Z died having had intervention in the last year of his life by a number of agencies, both statutory and voluntary, none of which seem to know (or have shared) much information about his life, background, wishes, choices, feelings and family structure.

Knowing and understanding a person's history, preferences, wishes & feelings are a fundamentally important element of assessment and safeguarding. Without this information, practitioners were working with someone who was depersonalised and patterns of risk and harm were not easily identifiable.

The assessment undertaken in January 2018[24] does not seem to enquire about Z's feelings or emotional responses to his situation, despite the knowledge about his panic attacks and anxiety.

REFUSING SERVICES

Throughout the documentation Z is described as 'refusing services', however as the BHT IMR notes, ambivalence appears a more appropriate description of Z's attitude to support. When offered a support package (visits three times a day) the day before hospital discharge his response was *' … would not mind but does not want people fussing around'*, this is then recoded as *'declining care'*. The author of the BHT IMR insightfully notes:

> *'There is no evidence of negotiating here or exploring further as to what Z concerns and fears are. Could we have reduced these visits to once or twice a day with a view to review? Could there have been further discussion here to*

[24] **ASC Chronology**

understand exactly Z's concerns relating to people 'fussing around'? Could we have given reassurance at all? It is not evident that BHT has made safeguarding personal consistently'.

There is no doubt that Z was reluctant to accept support, however as the BHT IMR points out, little effort was exerted to understand Z's reluctance and therefore customize a solution that may have been at least partially acceptable to Z.

LACK OF ESCALATION

There are few references to escalation in the documentation. However the staff member from RK did show substantial concern for Z and did attempt to persuade various agencies of the seriousness of the situation. During the SAR panel discussion RK reported that this same care worker:

' … was the only person to go the extra mile and feels terrible that despite all she did, nothing was done in time. She felt helpless as she told people he could not cope overnight on his own'.

The IMR from CS supports this view and states:

' The RK worker had put a great effort into trying to safeguard Z and involving statutory organisations. CS took a secondary role in supporting the efforts of RK in trying to speed up a response to Z's urgent needs'.

The IMR from CS actually reports that the staff member attempted to secure the attention of the emergency social work team (ESWT) on one occasion only to be informed that they had only two people covering the whole of Buckinghamshire that evening. Whilst not being reassured by the response from the ESWT this individual did not phone the out of hours manager for her agency: it then subsequently became clear that this individual did not know how to use the system of support/escalation.

The evidence suggests that the agency whose role was only to provide community housing (RK) was the only organisation that made the dominant effort to secure a safeguarding response for Z. Unfortunately the agencies with a statutory duty to safeguard individuals provided a lamentable response.

ACCEPTING THE SERIOUSNESS OF THE SITUATION

The seriousness of Z's predicament was not acknowledged by any of the agencies connected to Z, except the RK staff member noted above and Connection Support. This staff member should be commended for her resilience and concern, although as noted above this concern led to personal distress.

COMMENTS ON THE QUALITY OF IMRS

Agency	Comment
Red Kite Housing Association	Inadequate. No reflection nor analysis, despite important role of Sheltered Housing Officer who may well have (and needed to share) valuable insight into the strengths and areas of development of the safeguarding system, given her experience in supporting Z. Concerning lack of reflective practice.
Bucks Healthcare NHS Trust	Good standard of IMR, Helpfully lays out role and relevant structures of agency. The report is written well and is focused; clear analysis and areas of development identified and triangulated; no apparent wish to avoid acknowledgement of development areas.
British Red Cross	Adequate IMR – Clear, to the point. Could have been more reflective on own agency practice. However, positive consideration of areas of review the agency considers the safeguarding system in Bucks requires.
NHS CCG (GP)	Adequate IMR. Good summary of responses to Z's contacts. Good identification of issues regarding the Mental Capacity Act (2005) and use of Power(s) of Attorney. It is concerning that the author, the **safeguarding lead GP** [my emphasis] stated in conclusion: '*The risk of financial exploitation should have been considered, and the GP* ***could*** [my emphasis] *have considered directly referring to social services'*[25]. There is no consideration of the fact that Z was not the only person at risk that it was potentially a criminal matter and

[25] **CCG IMR**

	that action needed to be taken to support and safeguard him and others. Further, assumptions were made that he would refuse this, but he was not asked.
CSPM	Good IMR – helpful outline of agency role and summary of agency activity. Identification of good practice (CPW1 commitment to finding support for Z, despite only meeting once).
ASC	Adequate,

RECOMMENDATIONS

	Agency	Evidence
The health and social care architecture in Buckinghamshire should consider how more effective communication might take place with integrated intelligence systems in situations of safeguarding (ICS)	All	Audit and 'deep dives'
Individual agencies should consider and evaluate why risk assessments are not being utilised in practice.	All	Audit and 'deep dives'
Agencies should ensure that communication practice with clients who have known sensory impairments require	All	Audit and 'deep dive'

reassessment.		
Given the noted misunderstanding relating to 'appropriate safeguarding referrals', and appropriate 'thresholds' the Board should consider reviewing the guidance followed by a county wide communication strategy with partners to clarify mis-understandings	SAB	
Professional curiosity should be promoted in ongoing CPD for all staff and professional complacency challenged.	All	Audit and 'deep dives'
A protocol should be designed to assist staff to 'risk manage' in situations where clients are reluctant (or refuse) services and risks remain	SAB and all	
The Buckinghamshire Safeguarding architecture should consider the development of a specialist 'Self-Neglect Team'.	All	Business case to be developed