BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult Z

Executive Summary October 2019

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Background

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)
- Metastatic lung cancer (diagnosed July 2018);

Z had a heart bypass operation in 2011 and was a tobacco cigarette smoker which impacted on his breathing difficulties.

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

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 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.

Timeline

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

Communication between agencies was less than optimal throughout Z's care. Information was either not passed between agencies, not considered appropriate or

not acted upon by the receiving agency. Importantly, Z's hearing impairment was not taken into consideration when communicating with Z.

Social Care Assessment

Having received two assessments Z declined the offers of care packages. However, Z did ask for assistance, but on his terms; further discussion and professional curiosity was required to understand Z's reluctance to accept support, and perhaps co-design an intervention tolerable to Z.

Risk Assessment

No risk assessments were conducted by any agency. The following discernible risks were noted:

1. Z inability to access liquids and food during an extremely challenging period of hot weather;
2. Allowing taxi drivers access to his bank card to collect food for Z: One report states that: 'The risk of financial exploitation should have been considered, and the GP could have considered directly referring to social services', other agencies were also aware of this risk;
3. Z's known propensity to gamble, which was discussed in November/December with his daughter to enable protection; report states ' … a discussion could have been had around considering lasting power of attorney for health and welfare and/or for finances';
4. The fire risk noted on the 2/7/2018 reported to safeguarding. No referral to the Fire Service is recorded. Report states '… 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'.

Unmet Need

Throughout Z's period of health deterioration the level and urgency of need was not identified by the majority of agencies in contact with Z. Agencies also stated they did not understand the thresholds for Safeguarding referrals, and when they did refer, the system did not accept the referral. Only one agency had the resolve and tenacity to attempt to escalate the risks for Z.

Professional Curiosity and Mental Capacity

There was an absence of professional curiosity throughout Z's care. Likewise, at no point was a Mental Capacity assessment considered necessary.

Lack of Escalation

Several agencies were aware of the deterioration in Z's health and the risk therefore exposed, but only one agency attempted to escalate those concerns. The Housing agency was the only agency to evidently understand the perilous situation in which Z was living.

RECOMMENDATIONS

1. 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)
2. Individual agencies should consider and evaluate why risk assessments are not being utilised in practice
3. Agencies should ensure that communication practice with clients who have known sensory impairments require reassessment
4. Given the noted misunderstanding relating to 'appropriate safeguarding referrals', and appropriate 'thresholds' the Buckinghamshire Safeguarding Adults Board should consider reviewing the guidance followed by a county wide communication strategy with partners to clarify misunderstandings
5. Professional curiosity should be promoted in ongoing CPD for all staff and professional complacency challenged
6. A protocol should be designed to assist staff to 'risk manage' in situations where clients are reluctant (or refuse) services and risks remain
7. The Buckinghamshire Safeguarding architecture should consider the development of a specialist 'Self-Neglect Team. Business case to be developed.