Summary Report of the Safeguarding Adults Review into the death of Mr B who died in July 2015

Safeguarding Adult Review panel chaired by J. Cassidy

Review Commenced - September 2015
Review Concluded - February 2016

1. Introduction

1.1 This summary of the full Safeguarding Adults Review (SAR) report covers the main findings and key recommendations of the SAR, undertaken under the (incoming) Care Act 2014-Section 44 on behalf of the Richmond Safeguarding Adults Board (SAB), and relating to a gentleman, referred to as Mr B throughout.

1.2 The Safeguarding Adults Review is not intended to attribute blame but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Richmond in the future.

1.3 The review was underpinned by the local Richmond SAB SAR Protocol 2014 and this was already reflecting of the new requirements contained in The Care Act 2014 and its guidance.

2. The Background & Circumstances that Led to the Review

2.1 Mr B was a staunchly independent gentleman. He lived at home with his son in a property provided by the Richmond Housing Partnership. Being aged in his mid-90's, Mr B managed his own affairs and his day to day living without help from others, including his family carer. There was much evidence that Mr B preferred to keep control of his everyday life and did not ask for or agree to interventions and offers of support. Mr B was known to do his own shopping until June 2015. Mr B specifically refused any help with his personal care from his family carer.

2.2 Mr B. had been registered with the same GP practice since 1997. He had a number of serious health conditions for which he was receiving medication. Mr B was informed about all his diagnoses and available treatment options but he overall did not accept or present for treatment.

2.3 The living conditions and Mr B's health and welfare became a concern just prior to his death when a gas operative raised the alarm and ASC were informed. Upon Mr B's death, the full extent of his unkempt and unhygienic living conditions became apparent. The conditions of Mr B's and his home caused for sufficient concern for a Post Mortem to be undertaken and a Coroner's enquiry and investigation of the circumstances of Mr B's death by the Metropolitan Police.

2.4 Richmond SAB agreed that it was appropriate to undertake a SAR involving:

- London Borough of Richmond Upon Thames – Adult & Community Services (ASC)
- Richmond Housing Partnership (RHP)
- General Practitioner (GP)

3. Key Findings

3.1 All three agencies had applicable safeguarding adult's policies in place, ASC and RHP included protocols on relating to self-neglect.

3.2 Awareness and competence by staff of the use of policies was assured. Training relating to safeguarding adults is provided to ASC staff (Increased levels of role specific training taking account of seniority) and RHP provides training to all its operatives and caretakers. Good training is particularly evident with the commendable actions of the gas operative in this case and actions relating to onward reporting.

3.3 The gas operatives actions of offering to call an ambulance whilst with Mr B and making his concern known to Mr B and to his office who in turn progressed the information to ASC was commendable. His information raised sufficient concern and it should have resulted in an appropriate response for Mr B. The same gas operative also returned and reported back that Mr B's wound appeared improved and that all appeared to be well.

3.4 Resource issues and high volumes of work affected the response by ASC in that the risk management was not as effective and responsive as could have been the case. The seriousness of a possible 'head injury' was overlooked, information was taken at face value and Mr B was not seen in person. Both Mr B and his family carer refused offers of assessments and support over the telephone.

3.5 There was good telephone communication between Mr B and ASC staff. Mr B and the worker explored if a visit was necessary and offered an assessment with a view of possible support. The conversation content was confirmed by the family carer and assessments likewise refused. There was no indication that would have raised any further concerns at this stage and Mr B's wishes respected.

3.6 Information was exchanged between ASC and RHP. Information was not exchanged with Mr B's GP, who provided as much treatment and care to Mr B as he would accept. This included treatment for a number of serious medical conditions and the GP accepted Mr B's decisions relating to his refusal of treatment as Mr B had full mental capacity. ASC did not contact the GP regarding the possible 'head injury' (and had no contact details on file). Consequently the GP was unable to review or offer any requisite treatment. There was no need for the GP to contact other service as all concerns related to Mr B's health. ASC actions were appropriate but insufficient.

3.7 There was an issue of boundaries apparent with expectation and reliance on the part of ASC for RHP employees to check on Mr B following the referral. The responsibility should be that of ASC.

3.8 ASC and RHP and worked well together throughout.

4. Conclusion

4.1 Mr B was in control of his life and decision making and there was no indication at any time that he lacked mental capacity, rather he made particular choices that suited him. He decided to comply with some medical tests and treatments and refused to be persuaded to have others.

4.2 The GP was not informed by ASC of Mr B's 'head injury' and this was a missed opportunity to ensure Mr B's comfort if not treatment.

4.3 Mr B was an ordinary tenant until the gas operative raised concern. RHP rightly signposted the concerns to ASC, who in turn took action to ascertain Mr B's and his relatives view. They accepted the refusal of assessments and did not effectively respond to the concern of a 'head injury' and failed to pass this information onto Mr B's GP.

5. Recommendations

1	**Training**	RHP continue to roll out safeguarding awareness training to its immediate partner contractor.
2	**RHP Protocol**	Consideration be given to reviewing RHP's current referral protocol to ASC.
3	**Staff Guidance**	Guidance for staff to be produced that advises what steps to take when the GP is unknown.
4	**Service Development**	Consideration be given to the development of a MARAC or other multi-agency approach to assist in situations of a complex nature.
5	**Staff Guidance and Protocols**	Review of protocols for staff around the issue of how the service should respond to issues of self-neglect.
6	**Information Sharing**	Information Sharing Protocols are reviewed to ensure clarity about what can and what cannot be shared.
7	**Training**	Access Team staff, particularly Social Care Advisor roles, receive refresher/training in relation to risk assessments of referrals received. Social Care Advisor staff also receive further training/guidance in relation to information gathering to ensure that the full range of sources are considered.
8	**System Development or Protocol**	There is exploration/development within GP practices of a more robust trigger system or protocol for alerting the practice in relation to regular 'drop-in' patients who stop dropping in unexpectedly.
9	**Relative Engagement**	The SAB determine post-report liaison with the relative regarding the outcomes of the Review.
10	**Staff Guidance**	Refresher guidance is provided to ACS, particularly the Access Team, in relation to the support available from Health partners such as 111 services
11	**Training**	The CCG roll out updated training in relation to Mental Capacity Act Assessments for GP practices.