

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Mr Z

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Executive summary

 Preamble

1.1 When someone with care and support needs dies as a result of neglect or abuse, or where this is suspected, and there is a concern that the local authority or its partners could have done more to protect them, the Safeguarding Adults Board can commission a review to identify learning.

1.2 It is not for a Safeguarding Adults Review to investigate how a death or serious incident happened. Neither is it the responsibility of the review to apportion blame.

1.3 The purpose of all Safeguarding Adults Reviews is to focus on learning. The final Safeguarding Adults Review report and those responsible for disseminating the learning from it should ensure that the recommendations can be translated into practice, not just for those involved but to a wider audience to support ‘prevention strategies’ and influence strategic plans.

1.4 This review primarily focused on the care and support Mr Z received during the 10 months prior to his death (July 2015 to April 2016) but does include relevant information from before that time, to give a better understanding.

 Summary

2.1 Mr Z was described by a long-term support worker as a quiet man who often seemed nervous and didn’t like to mix. Other staff where he lived had a different view, that he was more out-going, able to be involved in projects and group activities. Professional staff characterised him as lonely. However, in the past he had been married and had a son. He looked forward to the visits his son made to him.

2.2 Mr Z had a learning disability, a history of being depressed and could get frustrated at times. He also had epilepsy and a diagnosis of paranoid psychosis.

2.3 Mr Z received care and support including: personal care, cooking, cleaning, shopping, and also to monitor his health and wellbeing and medication. He also attended a day centre twice a week.

2.4 While there was little evidence of assessments of capacity, it was apparent that he was deemed to have capacity.

2.5 Mr Z had a number of physical health needs. His care plan notes an ‘eating disorder’ and he was often incontinent of urine and faeces. From time to time this was investigated, or plans were made to investigate it.

2.6 Mr Z was very anxious about visiting doctors and hospitals, some care staff even said he “hated” doing so, although he did attend his GP from time to time and was willing to have x-rays. Staff at the accommodation where he lived, and who supported him, knew they had to convince him of the need to visit a doctor or seek medical help.

2.7 Mr Z died in April 2016 at home. The post mortem report indicated that the cause of death was peritonitis, which was due to bowel ischemia, which related to faecal loading ischemia. The secondary cause was hypertension and hypertensive disease.

 Learning

3.1 There was no one safeguarding incident that led to Mr Z’s death. The Safeguarding Adults Review (SAR) report evidences a lack of curiosity and focussed intervention over a number of years to:

* understand Mr Z’s eating difficulties and put a treatment plan in place;
* understand Mr Z’s incontinence and put a treatment plan in place;
* assess Mr Z’s capacity to make decisions and to plan interventions accordingly; and
* recognise that what were seen as his choices should have been seen in the wider context of self-neglect.

3.2 While there is learning around person centred support and professional curiosity the key areas for learning from this report are around:

* constipation and healthy eating; and
* capacity.

3.3 Constipation can kill people. Constipation is more of an issue for people with a learning disability than the general population. Constipation can be treated.

 Recommendations

4.1 The report makes recommendations for partners on:

* health and social care needs being reviewed;
* record keeping and information sharing;
* assessments and reviews of capacity;
* training around the Mental Capacity Act 2005;
* advocacy for people with a learning disability in supported or residential care setting;
* advice and information around constipation;
* learning events on self-neglect; and
* ensuring effective communication with emergency services.