SCIE case study: escalation of risk around self-neglect and pressure care: ZZ

Introduction and background

ZZ was a 79 year old woman who died on 10 June 2014 in circumstances that give rise to concerns about the way that local professionals and agencies work together to safeguard adults at risk. The cause of ZZ's death was multiple organ failure and septicaemia.

ZZ was in receipt of a care package consisting of three periods of care each day commissioned by the area's Council Adult Social Care (ASC) from Plan Care (PC) home care agency. The care package included: personal care, support to prepare food and domestic tasks. ZZ's nephew also visited around three times per week, bringing shopping.

On the morning of 9 June 2014, ZZ's two carers from PC contacted her GP to report that ZZ was poorly – disorientated and weak, refusing to eat any food and barely drinking. London Ambulance Service (LAS) was called out, but ZZ refused to go to hospital and was deemed by LAS at this point to have capacity. The GP was called to ZZ's home, and on arrival found ZZ to be incoherent, emaciated, unkempt and with grade 4 pressure ulcers on her sacrum and elbow and elsewhere on her body. When the GP asked paramedics to move ZZ from the sofa, the large, stained dent suggested that she had been lying in the same position for a long time. The GP determined that at this point ZZ did not have capacity and urgent hospitalisation was in her best interests.

On 9 June 2014, ZZ was admitted to hospital. The discharge nurses noted she was in the foetal position, with severe muscle wastage (contracture) and extremely malnourished. They diagnosed 13 pressure ulcers at various sites across her body including hands, feet, chest, sacrum and legs. Nine of these were grade four and bones/ tissue were visible in places.

ZZ was described by a member of nursing staff as follows:

ZZ was emaciated. She was covered in her own faeces which was stuck to her skin. I would describe it like snakeskin it was stuck all over the lower part of her body, legs and feet it must have been there for months. Her body was badly contracted she looked like she had been in that same position for a very long time, she would not have walked for a long time as her legs were locked. We tried to move her arms and legs to expose the sores but her joints were locked as her elbow was moved it went straight into her abdomen as it was locked

A critical care consultant said "the lack of muscle and deterioration of her body was one of the worst cases he had seen in his career". Hospital X raised a safeguarding alert, and a safeguarding investigation was initiated. ZZ's nephew was present on the ward. A safeguarding alert was also raised by LAS and by the GP.

On 9 June 2014, ZZ was admitted to intensive care, and passed away on the afternoon of 10 June 2014. A post-mortem found that ZZ died of multiple organ failure due to septicaemia, caused by infected ulcers. On 11 June 2014, the case was referred to the police under the category of wilful neglect.

These concerns led on 14 August 2014 to a decision to undertake a Serious Case Review (SCR) in respect of ZZ. This decision was taken in line with the Safeguarding Adults Partnership Board (SAPB) SCR protocol. The rationale for undertaking this SCR is included in the SCR protocol which states that the area's "SAPB has responsibility for conducting a SCR when there are concerns about the way inter-agency working to safeguard an adult(s) at risk may have been a factor in the death of an adult(s) at risk …where abuse or neglect is known or suspected to be a factor in their death."

Analysis: There were examples of good practice in working with ZZ. The following stand out as examples of this which can helpfully inform practice:

- The swift response of LAS, the GP and Hospital in recognising that a safeguarding alert was required to be raised.
- The robust gathering of evidence by the Hospital.
- Housing Department responses (in respect of arrears and ZZ's reticence to allow necessary work to be carried out) which referred to background information about ZZ (who she was, what was difficult for her and why) in coming to compassionate decisions.
- The coordination and recording of multi-agency safeguarding meetings with clear action planning and accountability for actions and following up whether these had been carried out.
- Escalation of concerns within Hospital.
- Escalation of information following the safeguarding alert within ASC.
- Learning needs/ opportunities highlighted for PC in ASC procurement monitoring meetings were followed up, for example in the context of repeated issues in respect of financial abuse. This issue was the focus of a provider forum to support learning and development.
- Regular liaison between the Council commissioning and procurement team and CQC and PC.
- The practice in Hospital that offered counselling and debriefing to staff who had cared for ZZ.
- The commitment across all agencies to learning necessary lessons from the circumstances surrounding the death of ZZ and to putting in place and carrying out comprehensive action plans to respond to those lessons in practice.

Whilst this good practice in the support of ZZ was identified, the following were key aspects of practice in respect of which necessary learning is underlined by this review:

- The need for a greater degree of focus on the individual
- Practice in respect of assessment care planning and review
- Practice in working with risk
- Identification of risk of pressure ulcers
- Working with self-neglect
- Practice in the context of the Mental Capacity Act (MCA) and legal literacy
- Staff support / supervision