Case Learning Summary: 'Mary' Safeguarding Adults Review

What is a Safeguarding Adults Review?

Safeguarding Adults Boards have a responsibility to ensure that organisations that work with adults at risk can learn from their own practice and that of others. When adults with care and support needs die or are seriously harmed in certain circumstances, the Care Act requires us to undertake a review. The Care Act also gives us the power to review other cases where there may be learning. The reviews help us learn from good practice and learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm.

Who was Mary?

Mary was a 35-year-old White British woman. She had several long standing mental and physical health conditions, which caused emotional instability, low stress tolerance, chronic expression of suicidal thoughts and self-harming. When Mary was well she was a very caring person who liked to help others and wanted to be a volunteer. She enjoyed spending time with her sister and helping her with her children. Mary had never lived independently as an adult and in the period leading to her death she lived in a care home in Portsmouth, where she joined a walking group and a netball club, enjoyed going to the local market to purchase fruit for the service and herself and also made gem art and wrote poetry.

Mary's aftercare needs under the Mental Health Act were the responsibility of Southampton City Council (for social care) and Hampshire and Isle of Wight Integrated Care Board (for health), but she was accommodated in Portsmouth and received care from Portsmouth mental health services.

What happened to Mary?

Mary lived in a care home for adults with mental health needs for two years where she was initially happy and relatively stable. Towards the end of this time Mary's mental health deteriorated: she self-harmed a number of times and stopped taking her medication. Care home staff worked hard to support her but Mary was eventually evicted from the care home due to multiple incidents of verbal and physical aggression to staff members and conflict with another resident, which eventually led to police involvement. The five months leading up to her death were very unsettled: Mary experienced a number of overdoses which led to hospital stays and mental health inpatient admissions. During this period Mary was homeless - she was initially accommodated briefly in a hotel, but mainly sofa surfed at her partner's home. Her partner found her unresponsive following a suspected overdose, and Mary sadly died in hospital four days later.

Key Findings/Lessons

The review identified some good practice, including a high degree of engagement and regular risk assessments by NHS staff.

However, the review also identified that:

- it ought to have been apparent that the breakdown of the care home placement would have required a new assessment of Mary's needs. There were **significant delays in undertaking a new Care Act assessment and aftercare review**. The delays negatively affected Mary and the professionals seeking to respond to her needs.
- Mary did not have an allocated social worker: the social worker's role was only related to reviewing her assessment. **The social worker did not meet Mary face to face, which created barriers to communication** with other professionals and to understanding Mary's needs and wishes. **Use of the Multi-Agency Risk Management Framework (MARM) could have helped manage risk** and coordinate plans with Mary's involvement.
- There were **missed opportunities for proactive discharge planning** when Mary left inpatient care. Updated plans should have been agreed with Mary and shared with the various professionals.
- The responsibility for assessing Mary was allocated to a newly qualified social worker. **Ready access to support and a high level of supervision would have been essential** but this was not made available. The social worker was not supported to create a fully developed proposal to the Aftercare Forum (funding panel), and their response did not fully recognise the risks and urgency of making a decision, even if only for temporary support.
- Efforts were made by Portsmouth managers to escalate concerns over lack of action / delays, but the **escalation was not at the appropriate level of seniority.**
- **Frontline staff did not receive timely support after Mary's death.**

Since Mary's death, Southampton City Council has implemented a number of improvements, including new practice guidance and training, more frequent funding panel meetings, and new policies for allocation of work and supervision.

The review made two recommendations for the Portsmouth Safeguarding Adults Board:

- To adopt and promote aftercare practice guidance across the system.
- To ensure that concerns over lack of action or delays relating to individuals regarded as being at significant risk are escalated at a senior level.

Portsmouth City Council and Solent NHS Trust were recommended to review all similar current placements.

The review also asked the Southampton Safeguarding Adults Board to assure itself that improvements have been made in the Southampton system about the other issues identified.

Key Points for Learning & Reflection

- Are you confident in when and how to escalate issues with another agency? Are you familiar with your own agency's escalation processes and the 4LSAB Escalation Protocol (which is used specifically for safeguarding-related escalation)? If you supervise others, make sure you allow opportunities during supervision to discuss any concerns about cases which may need escalation.
- Are you and your team familiar with MARM and confident on how to use it to support multi agency working and risk management? Have you watched the MARM podcast and reviewed the MARM toolkit?

Further information and useful resources

4LSAB Escalation Protocol (https://www.portsmouthsab.uk/procedures/)

MARM Framework and toolkit (https://www.portsmouthsab.uk/procedures/)

S117 aftercare guidance:

- NHS Who Pays guidance (NHS England » Who Pays?)
- Ordinary residence guide (Ordinary residence guide: Determining local authority responsibilities under the Care Act and the Mental Health Act | Local Government Association)
- Worcestershire Judgment (R (on the application of Worcestershire County Council) (Appellant) v Secretary of State for Health and Social Care (Respondent) - Press Summary (supremecourt.uk))

Managers are encouraged to explore the learning points in team meetings and supervisions. If you require further information about the case, please contact PSAB@portsmouthcc.gov.uk.