



One Minute Case Learning Summary

'Mrs E' and 'Mr F' Safeguarding Adults Reviews

What is a Safeguarding Adults Review?

Safeguarding 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 reviews help us learn from good practice and also learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm. These reviews of two older people share similar themes of neglect by family members, and have similar learning and recommendations for change.

Mrs E - case summary

Mrs E was a frail older woman in her eighties with a diagnosis of dementia and complex physical and mental health needs. She lacked mental capacity in relation to decisions about her care and support needs. Her main carers were her son and her husband.

Several incidents occurred in 2016 and 2017 to raise concerns about her care and support needs and her poor living conditions. In May 2019, a safeguarding concern was raised about neglect and acts of omission and Mrs E was admitted to hospital, where it was noted she was dirty and had matted hair. She was discharged with a four times a day package of care. The family requested that this be cancelled saying they had concerns about the carers and about the cost of the care. This was done following a Best Interests decision.

Mrs E did not receive visits from any service after December 2019. The onset of the pandemic meant that many face-to-face services ceased after March 2020 and Mrs E did not get her prescribed injections. Welfare checks were made by telephone but family reported no concerns. The pandemic meant there were delays to the planned home adaptations and these were not completed before she died, a year after the need for improved washing and toilet facilities was identified.

Mrs E died at home in June 2020. When the ambulance service responded, Mrs E's husband reported that she had been unwell and in a comatose state for three days prior to calling for help from services. Mrs E was found in a poor state and covered in dried faeces. Her death was found to be partly due to an infected pressure sore.

Mr F - case summary

Mr F was an older man in his eighties who had a number of mental and physical health conditions, including dementia, depression, kidney and respiratory disease.

Mr F lived with his stepson, who was his main carer. Mr F was referred to Adult Social Care by his GP in September 2018, and following a hospital admission in November 2018 he was discharged with a package of care. He lacked insight into his needs and refused many aspects of care offered by practitioners. He reduced his care package and eventually cancelled it, putting him at significant risk of harm. Although he



was considered to have mental capacity to make this decision, he was influenced by his stepson, and his mental capacity was doubted at times by professionals.

There were a number of concerns identified about the care provided by Mr F's stepson, including poor medication management, keys being removed from the key safe which caused practitioners difficulty in gaining access, and a lack of awareness of Mr F's poor health. Professionals also noted the stepson's misuse of substances.

In September 2019 Mr F was found in a poor condition by a visiting professional who called an ambulance. No action had been taken by his stepson. Mr F died in hospital 3 days later.

Key Findings/Lessons

Mrs E

- There was good practice identified in that a Mental Capacity Act assessment was carried out, with attempted engagement with Mrs E.
- Although the Best Interests decision to cancel the care package was made appropriately, but there was no review or monitoring following this, despite the high risk of neglect.
- There was little evidence of multi-agency communication and information sharing.
- The care package was cancelled by the family in part due to financial concerns, which increased the risk of harm to Mrs E. Some safeguards could have been put in place to ensure the family was not misusing Mrs E's money.
- Mrs E could have been offered an advocate to help make her views known. She was entitled to advocacy under the Care Act and Mental Capacity Act.
- Mrs E had advanced dementia, a life limiting condition which requires highly skilled care at the end of life. Contact could have been made with the palliative care service.

Mr F

- There was good practice identified in the determination and persistence of frontline staff in continuing their contact with Mr F, despite Mr F's resistance to care and treatment, the lack of engagement of his carers, and practical difficulties of access to the property and resources in the home. In particular the Mental Health and Dementia nurses were able to build a good relationship with Mr F and support him emotionally.
- There was doubt about Mr F's mental capacity to make informed decisions about his care and finances. However, his mental capacity was never formally assessed which meant there was no clarity about the legal framework for interventions.
- The coercion by his stepson and how it influenced Mr F's decisions was not recognised and could potentially have been a criminal offence.
- It was suspected that Mr F's care package may have been cancelled for financial reasons. This could have been explored further and options considered to enable care to continue.
- The concerns about Mr F may have met the threshold for a safeguarding enquiry under the Care Act which may have led to different care and support outcomes for Mr F. If they did not meet the threshold, professionals could have used the Multi Agency Risk Management framework to work



together to address the risks to Mr F more robustly and in a coordinated way. However they were not aware of this framework at the time.

- There could have been better information sharing between professionals, for example sharing of information with domiciliary care agencies. Police input could have been sought on the issues of coercion and substance misuse.
- Mr F could have been supported by an independent advocate to understand the options available to him and express his views without being influenced by his carer.

Key Points For Learning & Reflection

- Are you confident in spotting signs of neglect, financial abuse, and coercion? Consider reviewing the 4LSAB Safeguarding Concerns Guidance and whether you may have development needs in any of these areas of safeguarding.
- Spend some time reflecting on how 'professionally curious' you are in your work with adults, families and carers. This means thinking 'outside the box', thinking objectively and keeping an open mind about what we see, hear and the evidence as it is presented to us.
- Do you have an understanding of the MARM framework and when to use it? Consider watching the MARM podcast or reviewing the MARM tools on the PSAB website.
- Do you have a good understanding of the Mental Capacity Act and how to apply it to your practice? Consider if you need further information, guidance or training in this area.
- Have you experienced any situations in your practice where you needed to have difficult conversations with family carers? How did you approach these issues? You may wish to discuss these with your manager or colleagues.

Further information and useful resources

Safeguarding Concerns Guidance: <https://www.portsmouthsab.uk/procedures/>

Multi Agency Risk Management (MARM) Framework:

Policy and supporting tools <https://www.portsmouthsab.uk/procedures/>

Podcast about MARM <https://www.youtube.com/watch?v=0-Ptlfqfm5M>

Carers and safeguarding: a briefing for people who work with carers:

<https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers>

Mental Capacity Assessment and Determination of Best Interests: <http://www.portsmouthsab.uk/wp-content/uploads/2021/10/PCC-ASC-Mental-Capacity-Assessment-Determination-of-Best-Interests-v2.docx>

Mental Capacity Act 2005 Code of Practice: <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

Portsmouth Carers Centre: <https://www.portsmouth.gov.uk/services/health-and-care/carers/portsmouth-carers-centre/>

Portsmouth Advocacy Service: <https://www.solentmind.org.uk/support-for-you/our-services/portsmouth-advocacy-service/>

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