



One Minute Case Learning Summary

Pamela Ratsey: Safeguarding Adults Review

Case Summary

Pamela was an older person living in Hampshire, who had been living with acute mental illness and dementia. Hampshire County Council placed her at a Residential Care Home in Portsmouth in May 2017.

Pamela was known to a number of services, including the Older Persons Mental Health (OPMH) Team, Community Nursing, her GP, and Adult Social Care.

Pamela developed pressure ulcers while living at the Residential Care Home, and concerns about poor care and neglect of Pamela at the Residential Care Home were raised by family and other agencies from July 2017 to February 2018. Portsmouth City Council Adult Social Care undertook a safeguarding enquiry in November 2017. Pamela was transferred to a Nursing home by her family at the end of January 2018. On arrival, the Home Manager observed that she was dehydrated, mouth dry and sore, ears 'revolting', dry matted skin in her hair, eyes gunky and crusted over, A further safeguarding concern was raised to Portsmouth City Council. Pamela died at the Nursing home in March 2018.

The Coroner found that Pamela "died of osteomyelitis (caused by a grade 4 sacral pressure sore) and pneumonia. The pressure sore had deteriorated to such a critical level due to a lack of regular repositioning at her previous care home". The Coroner concluded that Pamela died of "natural causes contributed to by neglect".

It was the family's wish that Pamela's full name be used in the review, instead of a pseudonym.

Key Findings/Lessons

- Pamela's family had consistently raised concerns in the 6-8 months prior to her death. Across multiple services there was minimal engagement with Pamela's family, and a tendency to concentrate on a negative perception of family communication instead of listening to their concerns, plus seeking their views for assessments and reviews. Pamela's family felt that despite holding Power of Attorney (health & welfare) plus visiting daily, the concerns they expressed were not taken seriously and that they were not kept up to date on Pamela's changing needs.
- There was a lack of clarity and consistency in the consideration of mental capacity and whether a mental capacity assessment was required.
- There was a lack of professional curiosity and risk management by the professionals and agencies who held a responsibility to support Pamela. Increasing concern that her complex needs were not being adequately met by the Residential Care Home did not trigger the robust escalation required.
- Pamela's complex care needs were neglected at the home, and internal concerns about managing these needs were not shared with the placing authority or on hospital discharge.
- Several services did not escalate concerns about Pamela's increasing needs, and in a wider sense, there was limited evidence that agencies proactively engaged in reducing the risk of neglect. Safeguarding enquiries lacked clarity and depth, were not personalised, and did not effectively reduce the risk of neglect. There was a delay of almost two months in completing a review in response to family concerns and Pamela's wish to move, followed by a further delay in arranging a move (ultimately arranged by the family).



- There was good practice from the OPMH team who were responsive to Pamela's needs and risks. They monitored her closely after discharge until her acute mental health needs were managed. The social worker was also attentive to Pamela's needs when securing a placement in a residential care home. The reviewer noted that in general, there was evidence of agencies endeavouring to address Pamela's needs and risks, alongside some positive communication.

Key Points For Learning & Reflection

- Are you confident in spotting signs of neglect, and knowing when and how to raise a safeguarding concern? Consider reviewing the 4LSAB Safeguarding Concerns Guidance, which includes a Protocol for Pressure Ulcers and Adult Safeguarding.
- Do you feel confident in having an 'open & honest conversation' when you are concerned about a client, and keeping channels of communication open? Consider if there is any support or guidance you need to develop your practice in this area.
- Do you feel confident in your understanding of the Mental Capacity Act and Mental Health Act and applying them to your practice? In circumstances of presumed capacity and high risk, do you identify in the risk assessment how the adult understands risk, and what risk management measures are in place? Consider if you need further information, guidance or and training in this area.
- Reflecting on your own experiences, do you feel you provide personalised support to service users and their families? Is the voice of the service user and their family embedded in your practice? Consider if creating ways of strengthening wider service user engagement and personalisation is something your area needs to develop.
- Are you aware of your organisation's policies and processes for escalation and whistle blowing? Did you know there is a 4LSAB Safeguarding Adults Escalation Protocol?

Further information and useful resources

Pamela Ratsey: Safeguarding Adults Review full report: <https://www.portsmouthsab.uk/scrs-2/>

Safeguarding Concerns Guidance and Multi Agency Protocol for Pressure Ulcers and Adult Safeguarding: <https://www.portsmouthsab.uk/procedures/>

One Minute Guide to the Escalation Protocol: <http://www.portsmouthsab.uk/wp-content/uploads/2019/04/One-minute-guide-Escalation-Protocol.pdf>

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>

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