**Portsmouth Safeguarding Adults Board**

**One Minute Case Learning Summary**

**'Ms A'**

**Key Findings/Lessons**

* Numerous agencies were involved – all with their own concerns. Information was not shared effectively. Safeguarding advice could have been sought from MASH earlier or a concern raised.
* All professionals should be aware of living conditions - for example properties where you would feel uncomfortable accepting a drink or sitting down. The best approach would be to have an honest conversation with the person, especially if the conditions are having an impact on their health.
* When numerous agencies are involved consider the use of a MARM as a way of understanding/documenting risks and developing a multi-agency plan to manage them. MARM is helpful for cases of self neglect where the person has capacity but may be making unwise decisions, which could impact on their physical and emotional wellbeing.

**Case Summary**

Ms A was a woman in her mid-fifties with multiple health conditions, including diabetes and a heart condition. Six months before her death she developed a grade 4 pressure ulcer during hospital admissions at two different hospitals for heart surgery and a hip replacement.

She had a history of self neglect and disengagement with services, including in relation to managing her diabetes. She was known to a number of different services, including physiotherapy, heart failure team, and occupational therapy. Following her discharge from hospital, Ms A often did not take her medication and did not attend appointments to have her pressure ulcer dressed. Ms A's living conditions fluctuated but were often poor, with rubbish and noticeable smell. Professionals did not identify any cause to doubt Ms A's mental capacity to make decisions about her care.

Ms A lived with her 19 year old son who was her primary carer. Children's Services had previously been involved with Ms A when her son was younger due to concerns of neglect. During this time it was identified Ms A may need additional services to support her, but she declined to engage with help offered by Adult Social Care.

She was admitted to hospital in March 2020 due to back pain. On admission, hospital notes reported Ms A having suspected sepsis, and a large pressure sore to her back. Her home was in a poor condition with flies and cockroaches noted.

Ms A died in hospital, with causes of death listed as Covid-19 pneumonia, frailty, heart failure, ischaemic heart disease, and Type 2 diabetes.

**Key points for learning and reflection**

1. Review what action is required should a client with potentially life limiting health needs disengage or fail to attend appointments. Does your organisation have a policy on this?
2. 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.
3. Do you feel confident in having an 'honest conversation' when you are concerned about a client? Consider if there is any support or guidance you need to develop your practice in this area.
4. Ms A and her son would have benefitted from a whole family approach to their support. Have you seen the Family Approach toolkit containing resources for professionals?

**Key Findings/Lessons (continued)**

* Professionals could have asked more questions to ensure that Ms A's son was actually able to provide appropriate care and support. It is important to consider different ways to access support for carers - such as phone assessments or sitting services.
* The fire risks associated with Ms A's living conditions/hoarding were not identified. Professionals could have referred to the fire service for a Safe and Well visit. Ms A was the tenant of a large social landlord. They were unaware of the concerns about Ms A and her property and could have provided support. If possible, it is helpful to identify who the landlord is and ensure they are aware and involved - especially if it is a Housing Association/Council property.

*This case was reviewed by the PSAB's Safeguarding Adults Review subgroup due to concerns about the way organisations worked together to keep Ms A safe. Although the case did not meet statutory criteria for a mandatory Safeguarding Adults Review, PSAB is committed to reviewing cases to identify and share learning to improve safeguarding 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*](mailto:PSAB@portsmouthcc.gov.uk)

**Further information and useful resources**

**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-PtIfqfm5M>

**Hoarding Guidance**

<http://www.portsmouthsab.uk/wp-content/uploads/2019/05/4LSAB-Multi-agency-hoarding-Guidance-FINAL-updated-April-2019.pdf>

**Fire and Rescue Service**

Information on Safe and Well visits including referral form <https://www.hantsfire.gov.uk/keeping-safe/loveyourhome/safeandwell/>

**Portsmouth Carers Centre**

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

**Family Approach Protocol and Toolkit**

<https://www.hampshirescp.org.uk/toolkits/adopting-a-family-approach-joint-toolkit/adopting-a-family-approach-joint-toolkit-landing-page/>