Case Review 1: Multi-Agency Review in Relation to Mary

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Background to Mary

- Mary was in her mid eighties when she died. She had experienced chronic health issues in her older age and was in contact with a number of medical services. She had been with the same GP for some time and appears to have had a good relationship with the practice.
- Mary's husband had died some years previously. She had three children, one of whom had died in adulthood. Her daughter lived in Scotland and her son lived nearby. Mary's son spent some time staying at Mary's home and, although not registered as her carer, he appears to have provided frequent support to her.
- The relationship between Mary and her son may have been under strain because of her increasing reliance upon his care.
- There is some evidence that Mary was neglectful of her own health needs. Mary experienced increasing episodes of confusion which may have intensified her self-neglect. Mary was said to be independent and a strong character.

What Happened?

- In December 2016 Mary's neighbour called an emergency ambulance to attend to Mary. The neighbour had become concerned about Mary's health.
- When paramedics arrived they found Mary to be in poor physical health. The conditions in which Mary was found were also poor and there were indications of a poor level of care.
- Mary was transported to hospital by ambulance and admitted, her condition deteriorated and, following a move to a central Manchester hospital, Mary sadly died.
- Mary's son was arrested following her death on suspicion of wilful neglect (no charges were brought following an extended investigation)
- At inquest the Coroner ruled that Mary had died of natural causes

What were the key questions raised by the review?

- The review focused on the following key issues:
- Non-engagement/refusal of services
- Assessing mental capacity and working with fluctuating capacity
- Working with carers who do not engage with services or recognise themselves as a carer
- Partnership working and sharing information to appropriately manage risk

Themes covered by the Review are:

- Domestic Abuse in all its forms
- Self-neglect

What was the key learning from the review?

- Medical services responded to Mary's needs and she received an appropriate standard of care, however, Mary sometimes refused services and was neglectful of her own needs.
- Mary sought help in crisis situations however when the crisis had passed she did not engage with Social Care services. The challenge of sustaining engagement with Mary was apparent in the case.
- The balance between self-determination of care and self-neglect is difficult for professionals to work with. Key principles around listening to the person and sustaining engagement are crucial, applying the principles of Making Safeguarding Personal.
- Ongoing risk assessment is important to ensure that professionals can respond in a timely way if risks increase.
- Carer's may not recognise themselves as carer's, professionals should focus on assessment of the carer's needs and risks associated with caring for a person with ongoing complex needs

What changes has the review identified?

- Forums for multi-agency conversations and joint working enable professionals to discuss people such as Mary, where they sit below the threshold for, or are reluctant to engage in services.
- All professionals should apply professional curiosity in relation to possible financial or other forms of abuse.
- Continuing focus is needed in relation to working with people who self-neglect. This case has contributed to further development of the local self-neglect strategy.

Useful Resources

- NHS England Adult Safeguarding Pocket Guide www.England.nhs.uk/wp-co
- Care Act Guide www.scie.org.uk/care-act
- Carers information and support www.carers.org.uk , www.skillsforcare.org.uk, www.elder.org/dementia-care/caregiver-tips
- Financial abuse - my money/mylife www.co-operativebank.co.uk/aboutus

Practice improvement points:

WHAT ELSE WE KNOW ABOUT:

- **SELF-NEGLECT**
- **MENTAL CAPACITY**

Self Neglect

- Care Act 2014 – Self Neglect a Safeguarding issue
- Complex issue
- SSAB Multi-agency policy and procedure
  - Needs a person centred approach
  - Proportionate to the level of
- Practice audit survey
- Current SAR
- Nationally – links between Mental Capacity and Self-neglect

Mental Capacity Act 2005

- Framework and principles for making decisions where there are concerns about a person's mental capacity or where they lack mental capacity
- Nationally CQC has identified problems with application of MCA (2014 Report to Select Committee)
- NICE published guidance on MCA and decision making (October 2018)
- Application of MCA – biggest area of learning from SARs (Michael Preston-Shoot)
- SSAB Review and Training Programme for 2019