MM Case Summary

1. Background

1.1 The Essex Safeguarding Adults Board have completed a Multi-Agency Serious Incident Review (MASIR) into the death of MM. the aim of the review is to ascertain the facts, analyse them and identify any lessons that need to be learned. The function of the reviews was not to reinvestigate the incidents nor to apportion blame.

1.2 The review had the following terms of reference:

1. To explore and understand the circumstances that led to the death of MM
2. To investigate the involvement of local agencies who were involved with MM from January 2011 to her death on 6th May 2012
3. Consider the concerns of family, friends and neighbours during this period
4. To consider the application of the SET safeguarding adult procedures during the period from January 2011 to 6th May 2012.
5. To explore the application of the Mental Capacity Act 2005 in relation to the case

2. Case Summary

2.1 MM was a 89 year old lady living in her own home with a good network of support from her local church. She was estranged from her daughter. MM also had an adult son with Cerebral Palsy and Mental Health issues living independently.

2.2 MM had a strong dislike of anyone associated with Social Services since she believed they were responsible for 'removing' her son from her home when he moved to live independently in 2004. Documentation would also suggest that the estrangement from her daughter also stemmed from this time. As a result of concerns about her husband's care in hospital prior to his death in 2006 MM was also resistant to hospital admission. MM was often described as difficult or cantankerous by those who had involvement with her.

2.3 In January 2009 MM received meals-on-wheels after she contacted Social Services saying she had not eaten for 5 weeks. At this time MM said she spent much time in bed upon her doctor's advice because of a slipped disc. She declined any personal care despite admitting difficulty washing and dressing claiming friends were giving her a flannel to wash face and hands (she was using an upstairs bedroom). A general reluctance to share information was recorded. An Emergency Call pendant was also provided at this time.

2.4 MM visited by GP in July 2010 with possible gastrointestinal bleeding but is difficult to assess and refuses to go to hospital. Further visit in October and again on 29th November resulting in a hospital admission for a gastrointestinal

bleed. While in hospital also discovered that MM has a L3 wedge fracture (fractured spine) but refuses stronger analgesia as well as elderly assessment before being discharged home on 9th December. Social services arrange for a care agency to provide care for MM. GP also visits regularly during this period and MM is also supported by friends from church.

2.5 MM does however continue to be resistant to care and care agency report continued concerns including medication management, heating and laundry through early 2011. MM also refusing further physiotherapy and is provided with additional equipment by social services including a commode and profiling bed.

2.6 During February 2011 in addition to visits by care agency is also visited by social care and GP primarily around her discomfort with mattress on new bed also visits. MM is also concerned about cost of her care package but refuses to meet with the Councils Financial Assessment and Benefits Advice Team (FABA) to assess her financial arrangements.

2.7 Financial concerns continue through March and April 2011 including reduction to one carer for lunch and teatime visits. Care agency also reporting to social services that MM is refusing full personal care, only allowing the washing machine to be used once a week, mouldy food/out of date food and only allowing water to be heated on the stove. Friends are also reporting that MM is becoming increasingly difficult.

2.8 As a result of continuing difficulties trying to provide care to MM the Care agency gave 28 days' notice on their contract in June 2011. Care transferred to a new care provider from 14 July. By 21st October 2011 the second agency were also raising concerns with social care and particularly that three carers were refusing to attend as she had reduced them to tears. By this date MM was refusing to allow access to the carers but accepting support from friends and neighbours. A phone call on 24th October 2011 between the GP and social services states that it is felt that MM does not have capacity to make decisions at this time there is however no evidence of any assessment.

2.9 During November GPs visited on 3 occasions and noted that MM was refusing to take medication or any form of health or social care. MM does however ask her neighbour to call social care to request bed rails as has been falling out of bed

2.10 Following a referral by the GP to the intermediate care team as a result of concerns about her deteriorating condition an initial assessment was carried out by the Community Matron on 13 December 2011. On this visit MM would not allow a full physical examination. Bed rails were however ordered as she had recently fallen out of bed.

2.11 At this time MM was paying a private carer (wife of friend/ neighbour) to provide care three times a day and was not willing to consider any other care. The house was cold, but the community matron reported that MM was not willing to use her heating due to the cost. The Community Matron made a referral to

social care in relation to this issue and also referred MM to a physiotherapist as she had been bed bound since March 2011.

2.12 One day later (14 December 2011) the Community Matron also submitted a SET SAF 1 (safeguarding concern form) raising concerns about the poor living conditions and to explore what provisions could be made as a result.

2.13 In response to the SETSAF1 a social worker phoned MM. She said she was fine but in a bit of pain and heating was on a timer. MM did however claim it was a bad line and put phone down before putting phone down on a further three occasions.

2.14 On 2 February 2012 the community matron contacted social services to request a joint visit to assess MM's mental capacity as she was continually lying in a wet bed which had caused her to develop a rash on her back which appeared to be fungal. There was also concern that MM's skin was breaking down which would result in further deterioration. MM was still only accepting the care of her private carer.

2.15 On 10 February 2012 the Community matron carried out an MCA2 assessment to assess MM's capacity due to her developing pressure sores and her skin deterioration. MM was advised that she was at risk of further skin breakdown but was adamant that her mattress should not be changed back to a higher specification. At this time MM was found to have capacity to make this decision and so her mattress was not changed.

2.16 On 13 February 2012 information was reported from the carer that MM's pressure sore had healed. From 13-02-12 to the end of February the Community Matron continued to monitor MM arranging to visit as required, attended a meeting with MM's friend who had some concerns and reporting problems of frequency with MM's GP. MM still continued to only accept care from her private carer.

2.17 On 3 April 2012 the GP contacted the Community Matron and asked her to visit MM to complete a preferred place of care document as she had expressed her wish to die at home when the GP last visited. During the visit MM refused to complete the preferred place of care document. MM was lying in a wet bed and her carer reported having difficulty moving her, however speaking to both the carer and MM's friend both thought at this time that MM had capacity to make decisions regarding her care.

2.18 On 12 April 2012 MM's Carer contacted the Integrated Care Team to say that MM had a couple of pressure ulcers and required a visit from the nurses. Community nurses visited on 14th and 15th April. On 16th April they reported that the pressure ulcer was now a grade 3 but MM would not accept any increase to her care package or upgrade to her pressure relieving equipment. The pressure ulcer was reported to the GP who had seen MM and described her as being in a squalid state but she had refused nursing home care. At the time the GP visited MM was in a wet bed and faeces were smeared over the bed. MM did agree to a catheter being inserted which the GP requested be carried out.

2.19 On the following day (17th April 2012) MM was referred to the tissue viability team and referred to a dietician. MM was seen on 18th April for catheter insertion and despite being laid in a wet bed refused to have any care, she would not accept any increase of equipment even though the pressure ulcer on her right hip was now a grade 4. Consideration of referral for care from admission avoidance was considered but this was decided not to be appropriate. A mental health assessment referral was made

2.20 MM carer had accepted responsibility for emptying catheter bag and was met with to train and advise how this should be done. Following a discussioIt was also discussed with the carer that after she made her last visit of the day at 14.30pm MM was alone until 07.30 the following day, this was reported to the GP and safeguarding team who had been advising about the actions that were being taken also advised to carefully document all steps. MM was asked if she would accept care from a Marie Curie Nurse overnight but she refused this.

2.21 Between the 22nd and 26th April the Community Nursing team were visiting MM to offer care but MM was reluctant to accept and on several occasions refused to allow the nurses into the house, she screamed constantly when care was provided and expressed her wish to be left alone.

2.22 MM's GP visited her on 26 April 2012 with mental Health team and it was decided that MM did lack capacity; however no documentation was completed at this stage. Because documentation was not completed nursing staff felt that they were unable to take any decisions in relation to this capacity decision as it was not reported to them officially and so over the following weekend they attempted to carry on providing care with an increase care package.

2.23 Safeguarding meeting held on 27th April 2012. MM was visited three times by the nursing team and while she accepted tea and sandwiches she was not prepared to accept any degree of care. The carer was present during one of the visits but MM still would not allow a full assessment of her condition to be made. The nurse did however see that there were 5 pressure ulcers present but MM screamed and objected to any wound care being provided.

2.24 After this weekend MM still refused the majority of care offered and was not receiving adequate care to meet her needs. On 2nd May the Community nursing team visited MM and carried out a further MCA2 which found she lacked capacity. All documentation was completed and a best interest meeting was held and the decision taken to admit MM to Hospital. An ambulance was called and MM was transferred into the hospital's care, the nursing team stayed with her until this was possible and only left when the GP offered to stay with MM.

2.25 On admission to hospital staff recorded MM in a foetal position covered from neck to toe in faeces and urine. MM's hair was also noted as matted. Noted as having ground in faeces, reported as soaked but still staining the skin.

2.26 MM continued to deteriorate and died on 6th May.

3. Recommendations

3.1 There is currently no clear multi-agency process in Essex for managing self-neglect cases. Although such cases would benefit from following a process akin the SET safeguarding process self-neglect does not fall within this remit and therefore a similar process needs to be put in place. It is suggested that it would be beneficial to adopt the process currently used in Thurrock to allow a consistent approach to be taken across the greater Essex area.

3.2 Currently adult safeguarding practitioner meetings are held in each locality across the county and provide a good opportunity for practitioners' from all agencies to attend and discuss complex cases as well as to identify good practice. It is recommended that all agencies encourage their practitioners to attend these meetings and for information about these forums to be circulated widely.

3.3 Understanding of the role of the Mental Capacity Act by agencies, particularly GPs has been a theme throughout this review. Specifically with this case there has been confusion between the applicability of Mental Capacity Act and the Mental Health Act. It is therefore recommended that health commissioners continue to work with GP's to embed the Mental Capacity Act into day to day practice.

3.4 Accurate recording particularly with regard to names and relationships has been a particular issue with this case and it is there recommended that all agencies should ensure they have systems in place to quality assure case recording on adult safeguarding case files.

3.5 In light of learning from this and other MASIR reviews it is recommended that ESAB review the MASIR guidance and revise in light of experience.