SOMERSET SAFEGUARDING ADULTS BOARD

Somerset Safeguarding Adults Board: PRESS RELEASE Review recommends improvements following death of Somerset resident

A series of recommendations have been made by the Somerset Safeguarding Adults Board (SSAB) following the death of a Somerset resident from peripheral vascular disease and frontal lobe dementia.

The recommendations are shared in a report published today (XX XXX 2024) which documents Peter's (pseudonym) self-neglect, with a predisposition to alcohol and drug use, and fluctuating mental capacity coupled with executive dysfunction, which was recognised at periods prior to his death. This review is to ensure that the services Peter came into contact within the lead up to his death were providing the appropriate level of care and to identify whether they could have prevented Peter's decline in mental capacity and self-neglect, which contributed to his death.

Prior to his death, organisations were attempting to support him in relation to his history of neglecting his own health and well-being. Peter's case highlights the difficulties organisations face in supporting people with complex health and social care needs, who have a Court of Protection order in respect to their care, residence and finances, but still retain capacity in other areas of their life.

Highlighting weaknesses in the way Peter has been assessed and the information recorded and shared across the health and social care system, the report makes various recommendations, including:

- Produce guidance for primary care clinicians regarding situations warranting Court of Protection consideration, including clear pathways for seeking clinical & legal advice.
- The Somerset NHS Foundation Trust to carry out a review of their policy, process, and systems giving assurance as how active risk issues are communicated to and managed by discharge teams.
- The Local Authority to arrange a qualitative peer review of self-neglect referrals whereby health related and/or financial mental capacity issues are a significant factor.
- The Somerset NHS Foundation Trust to arrange workshops with the involved surgical and district nursing teams to discuss this SAR and application of the Mental Capacity Act.
- The Care Home to provide anonymised evidence to the SSAB of using the MARM and/or resolving professional differences guidance.

- The SSAB should consider reviewing the MARM guidance to; a) incorporate recent imperatives from capacity-based case law judgements in a practitioner friendly manner and b) strengthen the link between it and the SSAB “Resolving Professional Differences” guidance.

The learning from the review will be shared with the NHS Integrated Care Board (ICB), housing employees within district councils and housing associations, employees of Somerset County Council’s Adult Social Care Service and the Community Council.

Professor Michael Preston-Shoot, Independent Chair of the SSAB said:

“The Somerset Safeguarding Adults Board exists to protect vulnerable people, and to make sure lessons are learned so that necessary improvements can be made. I want to take this opportunity to offer Peter’s family my sincere condolences for their loss.

Peter’s story has highlighted the need to truly understand mental capacity linked with self-neglect and how we share the information across the health and social care system to support and safeguard those in Somerset. The focus of the report surrounds how agencies worked together in their approach to Peter and concerns about his mental capacity and neglect of his own wellbeing. Throughout this process, all organisations have offered their contributions openly and honestly to allow us to learn from Peter’s sad death. I will now work with SSAB partners to ensure that this learning becomes embedded within daily practice.”

The Safeguarding Somerset Adults Board is made up of all the organisations which have a role in preventing the neglect and abuse of adults, including: Somerset Council, Somerset NHS Integrated Care Board, Avon & Somerset Police, Somerset NHS Foundation Trust, National Probation Service, Registered Care Provider Association and Healthwatch Somerset, Our members (somersetsafeguardingadults.org.uk)

For more information about the SSAB and a copy of the report visit www.ssab.safeguardingsomerset.org.uk

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Notes to editors