Learnings from Safeguarding Adults Review "May"

01 Background

May had lived in a House of Multiple Occupancy (HMO) for many years. She spoke fondly about aspects of her furnished room in the house. She did not have to worry about bills as the rent was all inclusive, she had a bed and a warm fire.

May received a Notice to Quit from her HMO. Her housing needs were assessed as being eligible for a one bedroomed property. May was unhappy in her new sheltered housing flat and told her new social housing provider that she felt "forced" into the tenancy and the flat did not suit her lifestyle.

02 Safeguarding Concerns

A Safeguarding Adults Review (SAR) was commissioned by the Herefordshire Safeguarding Adults Board in response to the circumstances surrounding the death of 'May' in February 2019. At the time of her death May lived alone in a one bedroomed flat with no bed, little furniture or food. She did not use heating or cooking facilities and had no TV or phone. She slept on the living room floor.

May spent most of the day outside, in cafés and betting shops to keep warm and told various professionals that she often walked six to eight miles per day.

03 Case details

May's neighbours, and staff in shops and cafés where she used to frequent were concerned for her but May declined support and was reported to be angry that support from social care was offered just because she "chose to live differently".

04 case details cont..

Adult Social Care received 3 referrals in March 2018, 2 from Police and 1 from the Ambulance Service

May was taken to hospital having developed hypothermia during the night in her flat.

The acute trust documented that there was a high likelihood of readmission and injury if sent home. She was also having chest pains.

The social housing provider was not made aware of the concerns about May, the police or ambulance referrals or the visit from Adult Social Care Staff. They did not know that May had had hypothermia. May continued her lifestyle after she was discharged from hospital.

05 Themes

- **Mental Capacity – V-Capability**
- **Self-Neglect**
- **Think "Well-Being Principle"**

06 Overall Finding

It was not found that there was any connection between May's death and any failure of multi-agency response to her circumstances.

However the quality of May's life was affected by the way in which her needs and decisions were interpreted by a range of agencies and the lack of interagency discussion about her predicament.

07 What we have learned

A person may have capacity to make a decision but struggle with the capability to act upon it.

A whole systems approach to "wellbeing" can be preventative of crises as well as supporting good quality of life for people we work with.

There was a really strong element of community concern which should be actively encouraged.

May – Safeguarding Adult Review – Implementing Change

Mental Capacity Act: Capacity –v - Capability:

A person may have capacity to make a decision, but struggle with the capability to act upon the decision. Capacity to make a decision should not lead us to assume that a person can carry the decision out without support. Among adults who are vulnerable to self-neglect, a person may have capacity to make a decision, but struggle with the capability to act upon the decision. A key point in identifying self-neglect involves determining whether the individual can both make and implement decisions regarding personal needs, health, and safety.

Wellbeing Principle:

The concept of 'wellbeing' and how we need to actively promote this must be understood by all agencies working with adults in Herefordshire. A 'whole systems' approach is necessary, attention to wellbeing in our thinking and professional assessments can ultimately be preventative of crises as well as supporting a good quality of life for the people we work with.

Herefordshire Safeguarding Adults board