Cumbria Safeguarding Adults Board

Safeguarding Adults Review: Poppy

Learning Briefing

This learning briefing summarises the key learning and recommendations following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR commissioned by CSAB considered the case of Poppy, a 65-year-old white British woman who died in December 2022. Poppy had a history of poorly managed Diabetes resulting in frequent hospital admissions. She had been assessed as having mental capacity to make decisions about her physical health conditions and there were concerns about self-neglect in the context of failing to care for her health.

A SAR takes place where there is reasonable concern about how the Safeguarding Adults Board or members of it worked together to safeguard the adult, the adult has died, and the SAB knows or suspects the death resulted from abuse or neglect.

The SAR combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Poppy and her family. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Poppy

Poppy lived in Cumbria at the time of her death, she had care and support needs, and there was concern about how agencies worked together to protect her from self-neglect and mitigate the risks to her physical health by not administering her insulin.

Poppy was born in Scotland where her daughter still lives. Poppy moved to Cumbria when she was approximately 40 years old with her husband who, in later life acted as her main carer. In the years leading up to her death, Poppy cared for a dog, and after the death of her husband in 2020 remained socially isolated with limited informal support in her local area. It has been recorded that Poppy had Adverse Childhood Experiences and trauma, and that in adulthood she had alleged domestic abuse, and was the victim of fraud. Poppy suffered from physical health conditions that included diabetes, fibromyalgia, and chronic fatigue syndrome. Her vision was poor, and she had cataracts. Poppy also had a diagnosis of depression and anxiety.

The report made a number of recommendations which have been accepted by Cumbria Safeguarding Adults Board. You will find a summary of the recommendations and learning below. You can also read the full SAR Poppy report.

Finding 1: Partnership Working and the MDT

Context

Partnership working in the case of Poppy focused primarily on risks relating to health conditions, especially her poor self-management of diabetes, and low levels of concordance with treatment. Partnership working can take place through formal systems, such as strategy meetings for safeguarding cases, or regular weekly or monthly meetings, or can be less formal through ad hoc discussions of ad hoc Multi-Disciplinary Team (MDT) meetings.

Rationale

In the case of Poppy, partnership working took place through ad hoc Multi-Disciplinary Team meetings (MDT) which were convened as and when necessary and provided a forum for discussion, shared decision-making, and coordination. There are currently no formal procedures or standardisation of MDT meetings, although MDTs are widely used and universally felt to be beneficial. In Cumbria, current MDT practices are valued and the formalisation of MDTs to a risk procedure is unlikely to prove beneficial. However, there are still ways that MDTs could be made more inclusive and effective through guidance or training.

Recommendation

Cumbria Safeguarding Adult Board publish a “Guide to effective MDT working”.

Finding 2: Mental Health and Diabetes

Context

Research suggests that mental health problems are more common among people living with type I diabetes than in the general population with poor outcomes for both conditions. Individuals living with diabetes and mental health problems quality of life is worse, diabetes self-management is impaired, the incidence of complications is increased, and life expectancy is reduced.

Rationale

The challenges faced by people with diabetes and experience of mental illness are complex and multifactorial, requiring an integrated approach and support and care from an effective multi-disciplinary team yet often diabetes and mental health conditions are managed and treated separately. This means can result in a silo approach to treatment of mental health and physical health, or a tendency to focus on the most pressing issue at any one time.

Recommendation

Health and social care services should identify opportunities for integrated care for individuals with co-existing mental health and diabetes conditions.

Finding 3: Treatment-concordance and decision-making

Context

The principles to the Mental Capacity Act, designed to protect individual's rights to make decisions, even unwise decisions. Concordance is a term used to describe the degree to which an individual follows the treatment plan. A number of factors influence concordance with diabetes treatment, and choices that can result in medical self-neglect.

Rationale

A previous Safeguarding Adults Review in Cumbria notes that there are many reasons that individuals make unwise choices or decisions, but that people rarely choose to neglect themselves, such that self-neglect is the consequence, not the decision. It is therefore important that practitioners are able to consider what decisions are being made that lead to the consequence of self-neglect, in this case medical self-neglect of diabetes treatment.

Questions for the Safeguarding Adults Board

How can the Safeguarding Adults Board support practitioners to explore individuals' decision-making and the factors behind unwise choices that result in a risk of self-neglect?

Finding 4: Interconnected risk

Context

The term risk describes "the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others". Unlike uncertainty, risks can be measured, can be managed, and to a certain extent, can be controlled. Risk management is the formulation of a plan to avoid or reduce the impact of negative outcomes; it is the attempt to manage or reduce the likelihood of risk events that have not happened yet. Assessing and managing risk in health and social care can be challenging and complicated.

Rationale

Practitioners may often need to assess multiple risks related to medical, psychological, and social factors. Risks may often be interrelated and complex – actions taken to address one risk may have unintended consequences in another. A multi-agency approach, while not always indicated, may have supported the assessment of the interconnectedness of risks in different areas, joined up different areas of risk, and improved the information available. In the analysis of probabilities and likelihoods more information and expertise results in greater accuracy, better risk analysis, and more effective risk management.

Recommendation

In the practice of risk management, practitioners should be encouraged to analyse the interconnectedness nature of risk. In cases of complexity and high-risk this should be done in a multi-agency forum, an MDT or safeguarding process.

Finding 5: Using the CSAB Self-Neglect Guidance

Context

Poppy's case would have fallen into the definitions of self-neglect in statutory and local guidance. Her refusal of services and treatment, and lack of self-care would have placed her at risk of self-neglect, and at high-risk of harm – "refusal of health/medical treatment that will have a significant impact on health/wellbeing.

Rationale

Cumbria Safeguarding Adults Board has published guidance on self-neglect that provides information on definitions of self-neglect, indicators of self-neglect, factors that may lead to individuals being overlooked, and guidance on determining the level of risk faced by the individual and possible responses. In the case of Poppy, the safeguarding procedures proposed by the guidance were not triggered until relatively late on in the case. While there is no certainty that multi-agency safeguarding procedures would have been able to change the outcome in Poppy's case, safeguarding procedures may have helped to reduce the risk of harm resulting from self-neglect.

Recommendation

Cases of high-risk self-neglect should be referred to safeguarding under the self-neglect guidance at the earliest opportunity. The Safeguarding Adults Board may need to re-launch or raise the profile of the self-neglect guidance in relation to neglect of health conditions and refusal of treatment that may have a significant impact on health and wellbeing.

Finding 6: Overcoming barriers to professional curiosity

Context

Professional curiosity is "the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value". It is often used to describe the situation where evidence or signs of abuse have been missed, where explanations have been accepted that later turn out to be false, or where a professional fails to follow up on what later turns out to be a crucial line of enquiry.

Rationale

Developing professional curiosity is a matter of nurturing a 'strong desire' among practitioners to **know or learn something** about what is happening in an individual's life and **taking action** when evidence of abuse, neglect, or self-neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.

Recommendation

Organisations in Cumbria should implement the cross-Board 'Professional Curiosity: Guidance for Practitioners' paying particular attention to actions organisations can take to support professional curiosity.

CSAB will continue to work with partners to ensure learning and recommendations from the SAR are embedded. You can read the full SAR report **here**.

Further learning & resources for frontline practitioners

- **CSAB Self-neglect guidance**
- **Professional Curiosity resources**
- **MCA learning and resources**
- **CSAB Escalation guidance**

A SAR lunch & learn session to share the learning from SAR Poppy will be co-ordinated by the Learning & Development sub-group in due course.

Cumbria Safeguarding Adults Board will continue to work with partners to develop actions and improvements in response to the recommendations the report makes