‘Tina’ LEARNING BRIEFING
MAY 2024

Isle of Wight Safeguarding Adults Board

OVERVIEW

In October 2022, a referral was made the to the Isle of Wight Safeguarding Adult Board for consideration under its statutory duty to undertake a Safeguarding Adult Review, in relation to the death of Tina in March 2021.

Following a full review of the information available from partner agencies, it was agreed that the case did not meet the criteria for a formal safeguarding review under the Care Act legislation. However, it was felt that there may be an opportunity for focused learning.

In February 2024, key agencies involved with the care and support needs of Tina, met to identify the events leading up to March 2021 when Tina sadly passed away.

SUMMARY OF THE CASE

Tina and her husband had lived together since they were teenagers and worked in the entertainment industry and would sing at venues at home and abroad.

Tina had a complex and long history of mental ill health, periods of alcohol use and self-neglect. Tina’s diagnosis was of Bi-polar affective disorder, she had been struggling for decades with her mental health and had been sectioned under the mental health act (MHA) many times as well as informal admissions to a mental health hospital. Tina’s mental health was further affected through the trauma of not being able to have children which resulted in an attempt to take her life in Aug 2003.

Records show a common theme of co-dependency between TINA and her husband, with both experiencing issues with alcohol use and multiple reports of domestic abuse, it is noted that domestic assaults were recorded as taking place against both parties.

TINA’s husband was her main carer and kept her medications in a locked drawer, however there had been concerns raised that at times that her husband had mis managed her medication leading to acute episodes of mental ill health.

On the 17th March 2021, during a period where her mental health had deteriorated, and additional support was being provided. Tina accessed the keys to the medicine drawer and was later found unresponsive, surrounded by empty medication packets. Despite the efforts of her husband and the ambulance crew, Tina was pronounced deceased.

KEY FINDINGS:

- Within health services, there are multiple ICT systems, that do not communicate, meaning staff have to access multiple systems to get a clear picture.
- Due to the IT constraints not all professionals working with Tina had access to the same information, particularly around the management of medication and the management of escalating poor mental health.
- Although Tina's husband had assumed the role of 'guardian' of her medication, was he adequately 'trained' to manage medication and aware of the risks of over/under medicating.
- There was a query as to whether the MARM framework was successfully applied and with engagement from professionals questioned.
- It was noted that MARM outcomes are variable depending on the skills of the chair and attendees.
- There was a discrepancy on the understanding of the medication 'safe', with partners interpreting this differently.
- The COV19 pandemic meant working practices had changed with a reduction in home visits, the importance of having 'eyes on' individual was highlighted, particularly in the home environment.

LEARNING IDENTIFIED / QUESTIONS FOR PRACTITIONERS:

→ Practitioners to review the 4LSAB MARM Chair Guidance document to refresh themselves on the expectation of undertaking this role.
→ ASC to implement and embed a High-Risk Pathway to capture and manage complex cases.
→ All agencies make a commitment to attend to MARM's when requested to improve outcomes.
→ IW SAB to consider implementing unexpected death protocol to improve initial learning and capture potential SARs at an earlier stage.
→ Practitioners to consider an assessment of an individual's capability and/or appropriateness to manage medication on behalf of someone, particularly when safeguarding concerns are present.
→ Practitioners to consider whether S42 closures should step down to a MARM in high-risk cases.
→ IW SAB to complete an audit of the effectiveness of MARM's and make recommendations for improvements.
→ Practitioners to consider appropriateness of the medication storage as part of a medication review.
→ Practitioners to consider whether individuals with complex lives (e.g. poor mental health, substance misuse and/or Domestic Abuse) should trigger a MARM.

LINKS FOR BEST PRACTICE AND FURTHER TRAINING

- Making decisions on the duty to carry out Safeguarding Adults enquiries | Local Government Association
- Making Safeguarding Personal toolkit | Local Government Association
- Revisiting Safeguarding Practice (Updated March 2022)
- Safeguarding adults | SCIE
- Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance (April 2023)
- Domestic Abuse Statutory Guidance (July 2022)
- Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England
- ADATINA Out of Area Safeguarding Adults Arrangements: Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements