

1. Who was Mrs H?

Lived with her husband for almost 60 years until he was admitted to a care home. Mrs H had multiple physical and mental health difficulties, including paranoia and had attempted suicide several times.

Mrs H had an extensive history of contact with mental health services including hospital admissions.

2. Background

Mrs H had been admitted to a mental health service, discharged to a care home, but returned home since she was considered to have the mental capacity to decide where she should live.

Mrs H was provided with care at home to support her and to ensure that she took medication.

3. What happened?

Mrs H said that she had experienced a seizure since she could not access her medication and a decision was made to allow her unregulated access to it.

Mrs H's care package was reduced, and Mrs H refused to allow carers in. Mrs. H was found collapsed on the floor and died in hospital.

8. Learning: record best interests' decisions

Not all best interests' decisions have to be recorded, but when you are making significant ones about where someone should live or what support they should receive then it is good practice to record how these decisions were arrived at.

[You can read the full Safeguarding Adult Review here](#)



4. Learning: organic brain/ frontal lobe syndrome can impact on mental capacity

Certain brain conditions can affect mental capacity, including the ability to turn decisions into actions.

Mrs H appears to have been able to talk persuasively but was unable keep herself safe. Mental Capacity Assessments need to consider executive functioning.

7. Learning: involve families

Mrs. H at times said that she did not want her family to be involved or notified about her. Even in these situations you can still listen to the concerns raised by family members, even if you do not have consent to share information with them.

Always verify different accounts of events.

6. Learning: Take timely action

Mrs. H refused to let her carers into her home. Always agree a plan for how to respond to refusals of care with the care provider and other professionals.

This should include what to do when care is refused; who should be notified and what situations would require a more assertive response?

5. Learning: Respond to self-harm

Mrs. H had a history of suicide attempts and took overdoses of medication. Always conduct mental health risk assessments and create Suicide Safety Plans with people where there is a risk of self-harm or suicide.

The Royal College of Psychiatrists provides guidance on what [Suicide Safety Plans](#) should contain.

Mrs H

Learning Briefing

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