Learning Brief

Safeguarding Adults Review: 'Anne'

The Review

The Care Act 2014 requires Safeguarding Adults Boards to arrange a Safeguarding Adults Review if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. This review relates to self-neglect.

Background

Anne was a woman in her fifties when she died. She lived by herself in a ground floor council flat with her much loved two dogs. Anne had several medical problems which increasingly affected her mobility and ability to care for herself. She also had a history of anxiety and depression with low self-esteem. This meant she found it difficult to ask for or accept help. Anne had regular contact with Health services. She was also supported by her son and one of her sisters.

In December 2019, a pattern emerged of Anne missing her healthcare appointments. Her health deteriorated due to poor self-care and she was admitted to hospital in March 2020. Her family raised concerns about her self-neglect. This admission happened at the beginning of the Coronavirus pandemic when Health and Social Care were under extreme pressures. The Hospital Discharge team and Social Work team felt Anne's difficulties could be resolved in the community. Anne agreed to be discharged home. She said she didn't need any help. The social worker agreed to contact a 'deep clean' agency and closed the referral. This was not known by her family.

There was no direct assessment and no home visit. Social Care did not see the poor conditions of her home – nor did they uncover that Anne was dreading going back home but did not feel she deserved to be helped.

There was no coordinated care plan between agencies. Concerns about Anne's self-neglect were not flagged within her health records. There was no care plan to prompt vigilance to signs of further self-neglect, nor a contingency if further concerns arose. Housing could have offered additional resources or more suitable accommodation, but they were not aware of any of the concerns.

Anne's home environment and her physical condition continued to deteriorate during April 2020 and she had a further hospital admission. The ambulance service referred to Social Care, detailing concerns about her self-neglect. The Community Social Work team responded and advised the family to speak with the Hospital Social Work team. However, Anne took her own discharge before any contact was made. Hospital did not inform Adult Social Care of her self-discharge.

Community Nurses visited Anne at home. However, within a month, the ambulance service was called again due to a further fall. The crew made a Safeguarding Adult notification, describing in detail her dire condition. This notification was viewed by the Safeguarding Adults team who passed it to the Community Social Work team. They spoke to Anne by phone. Anne said she did not need any support and the referral was closed. There was no assessment, limited information gathering and no home visit.

Community Health services continued to try and support Anne with care for her pressure damage. When Anne's condition deteriorated further, a Community Nurse referred her again to Social Care.

Sadly, before Social Care could carry out an assessment, Anne's son found her unconscious. Her legs were ulcerated, one down to the bone. She had open infected sores to her groin and there were maggots underneath her. Anne's home was covered in faeces with mouldy food and fleas. Anne did not recover consciousness and died on the day she was admitted to hospital.

The Coroner determined that Anne had died of natural causes with the Coronavirus. The review concluded that Anne's death was not preventable but the circumstances in which she died, were.

Key Messages to Front Line Practitioners

1. You are only seeing a small part of the whole picture. **Share information, work in partnership.**
2. Making Safeguarding Personal does not mean walking away where a person is at risk but declines care. Look for the reasons behind behaviours. Be prepared to look past a superficial response. Be tenacious but with compassion and respect.
3. Involve families. Respect the knowledge they will have. Work creatively to involve them.
4. Use your professional skills to evaluate the whole context, not just the episode in front of you. Use a structured risk assessment.
5. Use the West Midlands Self Neglect Guidance and Safeguarding Adults Pathway.

Key Messages for Management and Strategic Development

1. So many reviews raise the same points of learning: multi-agency working, sharing information, effective risk assessment and risk management. This needs your leadership to make changes happen in practice.
2. Working with self-neglect is challenging for staff, balancing rights to decline care with reasonable steps to engage the person in change. Progress may be slow and rely on building relationships over time. Support staff with time and resources to be creative and flexible.
3. Use learning to review and update self-neglect guidance. Equip staff to use it through supervision and training.

Messages from the Family

Anne's family agreed to provide an impact statement. The full statement can be viewed here:

https://www.sandwellsab.org.uk/safeguarding-policy-and-procedures/safeguarding-adult-reviews/

The last few weeks of Anne's life were miserable and disgusting. She absolutely should not have been living in the state she was in when she passed away. We want to highlight the importance of involving family.

We also question how many reports have been written where the exact same themes are present? The information was there, broadly, across all the agencies, but so many opportunities were missed to share and collate the information.

There needs to be one final review where this sticks and these mistakes stop happening. This is my contribution to the review. Anything that will at least try to make THIS be the one that sticks.