Case Study

‘Anne’

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.

Anne began to miss her healthcare appointments. Her health deteriorated due to poor self-care and she was admitted to hospital. 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 and said she didn’t need any help. The social worker agreed to contact a ‘deep clean’ agency and closed the referral. There was no direct assessment and no home visit.

What was hidden?	
From Social Care? *Social Care did not see that Anne’s flat was filled with clutter. She had stopped taking the dogs out. The flat was strewn with puppy training pads, urine and faeces.* *Anne had stopped having friends around and refused her son’s offer of dog walkers – she was too embarrassed. Anne dreaded the prospect of returning home but didn’t disclose this – she felt she didn’t deserve any help.*	***From Health?*** *Health did not see the whole picture. They treated Anne’s individual health needs but did not step back to see the whole picture of Anne’s increasing difficulties.* *Neither Community Health nor her GP had records of the self-neglect concerns.* *Health did not know Anne may miss contacts because she blocked unknown phone numbers, being harassed by debt collectors. They didn’t know she may miss appointments because of memory problems.*
From Housing? *Housing was not aware of any concerns.* *They didn’t know her flat was becoming unsuitable due to her mobility.* *They didn’t know Anne had stopped using her toilet. She was worried she would be blamed for a recurring blocked drain problem.*	***From Anne’s Family?*** *Anne’s family thought Social Care had arranged a package of care.* *Her son didn’t know she had declined help. He didn’t know about the referral for a deep clean. Anne didn’t tell him, knowing he would want to pay for it.*

Anne didn’t have the deep clean. Her health and home conditions continued to deteriorate. The next month, the ambulance service took her to hospital following a further fall. They referred Anne to Social Care due to the conditions at home. The Community Social Work team spoke with family and advised them to speak with the Hospital Social Work team.

Anne discharged herself before any contact was made. Community Nurses provided Anne with follow-up care, visiting her at home. Within a month, the ambulance service was called again following a further fall. They made a Safeguarding Adult notification giving detailed description of her dire circumstances. When the Community Social Work team phoned Anne, she said she did not need any support and the referral was closed.

<table>
<tr><th colspan="2">What was hidden?</th></tr>
<tr><td rowspan="2">From Social Care?

Social Care were not aware of Anne's self-discharge from hospital – follow up was lost.

Social Care did not visit Anne at home following the Safeguarding referral, so did not see the dire conditions she lived in. They did not hear from other professionals involved or really explore the family's concerns.

They did not see the pattern of escalating concerns from previous referrals.

Anne's underlying despair remained hidden as there was no relationship established that could help her express this.</td><td>From Health?

Levels of Anne's self-neglect were 'hidden in plain sight' – many different professionals visiting Anne at home, saw her home conditions but did not truly recognise the state of self-neglect.</td></tr>
<tr><td>From Anne's Family?

Family didn't know what help Anne was being offered or what help she had turned down.

They didn't know how to help her or who should be coordinating her care as referrals were passed between services.</td></tr>
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As Anne deteriorated further, a Community Nurse made a Safeguarding notification, but it went to a wrong email address. Another nurse contacted Social Care to discuss concerns. Sadly, before this assessment was carried out, Anne's son found her unconscious. Her legs were ulcerated 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.

What could have made a difference? Key messages:

- Open up those hidden areas. **Share information, work in partnership**.
- Respect the person's wishes but look beyond the superficial response. Be prepared to be tenacious with compassion.
- Use your professional skills to evaluate the whole context, not just the episode in front of you. Use a structured risk assessment.
- Involve families. Consider calling a Family Group Conference. Family may have a wealth of information and be a great source of assets.
- Use the West Midlands Self Neglect Guidance and Safeguarding Pathway.

Message from Anne's Family:

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.

How many reports are written like this one 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. At some point in history, there needs to be one final review, the one that really gets the point across, where afterwards these mistakes stop happening. Someone's death under these circumstances will be the last death. This is my contribution to the review. Anything that will at least try to make THIS be the one that sticks.

What can you do to make this happen?

Read the whole report at https://www.sandwellsab.org.uk/safeguarding-policy-and-procedures/safeguarding-adult-reviews/