Sandwell Safeguarding Adult Board

Safeguarding Adults Review
'Anne'
11th May 2021

Anne

- Anne was 56 years old when she died. Anne had trained as a nurse. She had a very caring side but didn't like asking for care for herself- she had low self-esteem.
- She had been married and had a son. Anne described her marriage as abusive – physical and emotional. This caused her long-term anxiety and difficulty in showing emotion.
- Anne was struggling to come to terms with the death of her father and coping with her mum's recent diagnosis of cancer.
- She lived by herself in a ground floor council house with her two dogs. The dogs were very important to her but had never been house trained. As her mobility reduced, the flat became less easy for her. The dog faeces in her house became worse, she became more isolated and did not want dog walkers or friends to come to the house

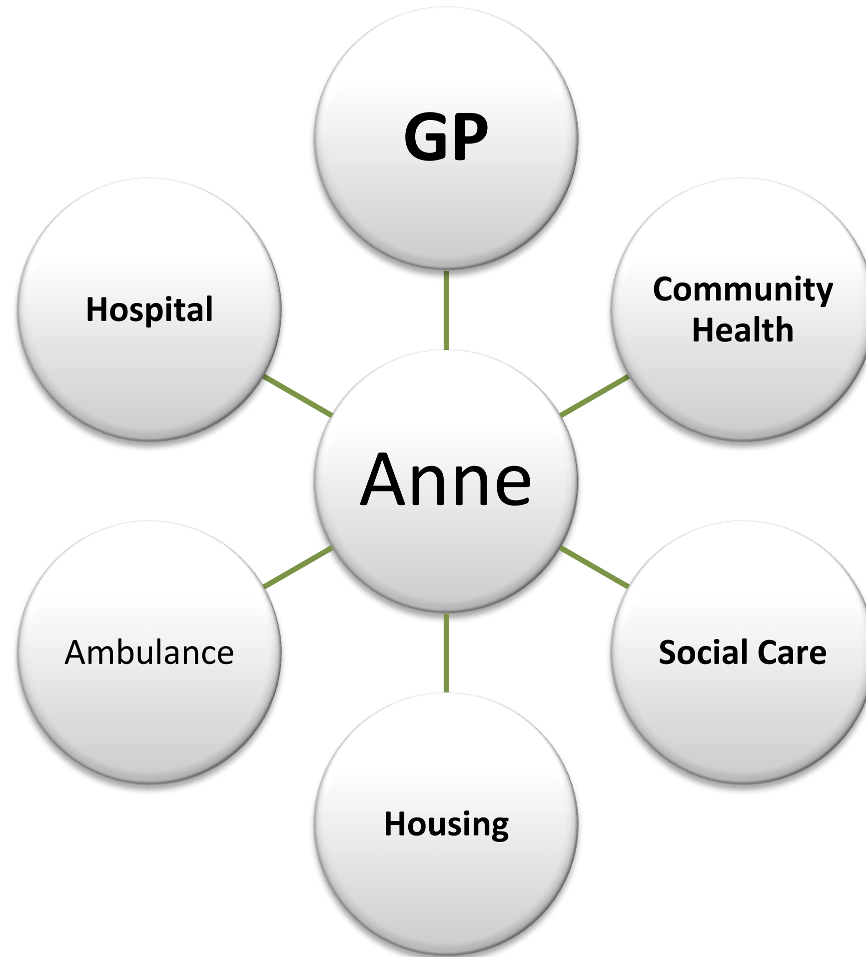
Anne

- Anne had several medical problems which affected her mobility and ability to care for herself. She also had a history of anxiety and depression and multiple falls.

- Historically, Anne had had sepsis. She believed this was caused by untreated UTI and blamed her previous GP for this. Consequently, Anne avoided going to her GP

- Anne was supported by her son and one of her sister’s as well as by agencies.

Key Agencies Involved in the Review



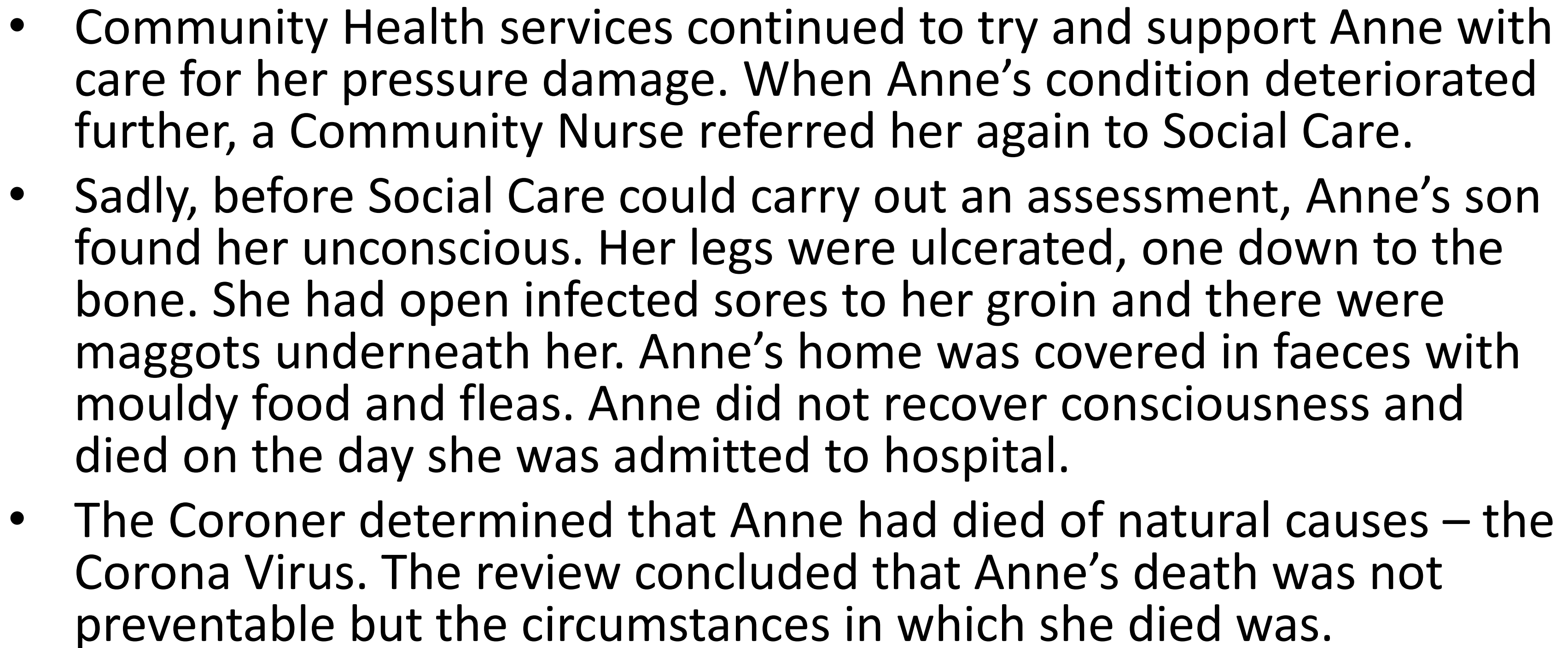
Timeline

- Anne received a high level of support from Health services.
- 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 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 continency if further concerns arose. Housing could have offered additional resources or more suitable accommodation, but they were not aware of any of the concerns.

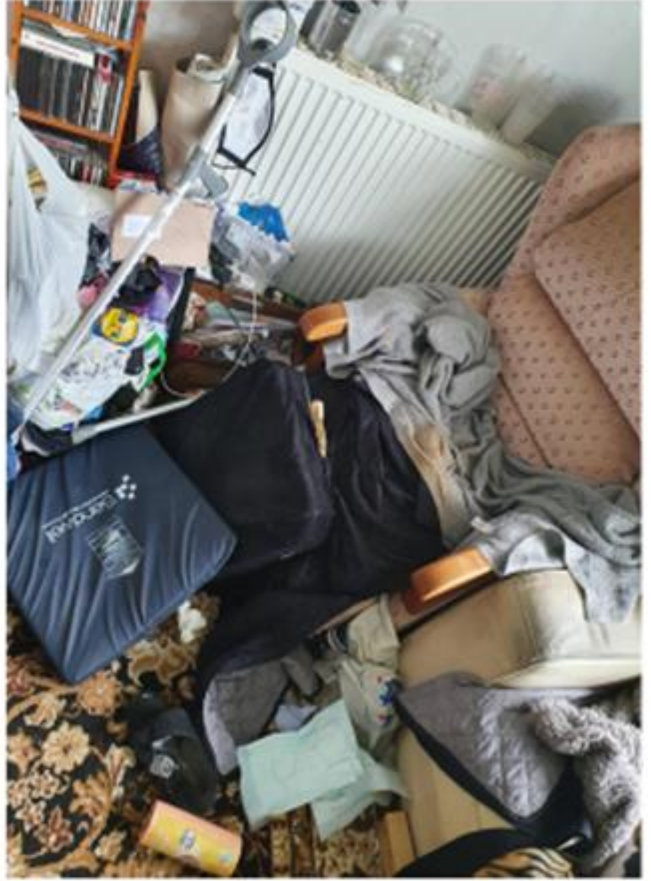
Timeline

- 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 Adult 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.

Timeline



- 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 – the Corona Virus. The review concluded that Anne’s death was not preventable but the circumstances in which she died was.



Anne: Learning points

- Some good practice by individual practitioners, showing compassion and tenacity in delivering care.
- However, overall lack of stepping back to see the whole picture and identify Anne's circumstances as self-neglect.
- Lack of awareness by some practitioners of the West Midlands self-neglect guidance – others were aware but did not apply it.
- Absence of establishing consistent relationship and truly 'seeing' Anne and looking beyond her superficial response.
- Hidden information and perspectives between agencies; between agencies and family
- Lack of multi-agency interaction at all stages
- Untapped resources – no contact made with Housing
- Some involvement of family but did not tap into their understanding. Missed opportunity to involve them in a coordinated response
- Lack of robust risk assessment and multi-agency coordinated care – no full assessments or home visits carried out by Adult Social Care
- Episodic approach to concerns – lack of assessing history and bringing together views of other agencies and family
- There was no coordinated plan between agencies

Conclusion

The review has examined the sad circumstances surrounding Anne's death and how agencies responded to self-neglect.

It is pointed that Anne's sister questioned the whole premise of describing Anne as self-neglectful. Her view was that Anne would not have neglected herself, had she had the help she needed.

The Sandwell Safeguarding Adult Board does have multi-agency guidance for working with self-neglect. The evidence from this review is that agencies were either unaware of the guidance or did not follow the guidance.

Anne's final months were during the first wave of the Corona Virus pandemic. Undoubtably, this put agencies under significant pressure and may well have impacted on the care that practitioners were able to provide. However, the lessons are not new. This Safeguarding Adult Review, like many others, has reinforced the need for multi-agency working, comprehensive risk assessment and safeguarding plans developed with the person and their family. This is even more important in times of significant pressures.

Anne's son commented that it was no-one's fault that Anne died but her wellbeing and dignity in her final months could have been and should have been vastly different. The author of this review agrees.

Recommendations

1. Quality Assurance on awareness and use of West Midlands guidance, followed by improvement programme
2. Use learning in the development of VARM

3. Use learning from this and other SN SAR's to revise West Midlands Guidance
   - risk tools
   - Family Group Conference inter-face with VARM
   - consultation panels

A statement from Anne’s son

The last few weeks of my mum’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.

Questions?