Practitioner Learning Brief Safeguarding Adults Review (SAR): Susan

August - September 2021

During August, Susan's GP was advised (by her son's partner) of concerns about Susan's eating & drinking habits, personal hygiene and general wellbeing. A Social Prescriber attempted to contact Susan (as no consent to speak to Son's partner was noted in records) but despite several attempts of contact as there was no response from Susan was received so a voice message was left suggesting an appointment be made with the surgery.
The GP referred Susan to The Talking Therapies (IAPT) Service (for mental health concerns) in August, however they also discharged Susan due to their inability to contact her.
During September, Susan was seen in person by a Primary Care Advanced Nurse Practitioner in relation to a physical health concern (nothing was found to be abnormal), a GP also carried out a review regarding her depression (completed via telephone), where Susan reported that she was largely the same, triggered by her mother's ill health and agoraphobia. Susan also said she had been swapping her medications over, the GP referred her to a (new at the time) service called the Emotional Wellbeing Service (commissioned by the CCG) as well as a re-referral to Talking Therapies (IAPT).
The GP also gave crisis and suicide prevention advice, signing her off work for an additional month with a review planned after September.
Susan's son's partner reported again to GP that Susan was not eating or drinking and there was cat mess everywhere. Susan also did not attend her diabetic appointment.

October 2021 – March 2022

During October, the Ambulance service raised a safeguarding concern due to the state of Susan's home, her depression and wanting to die. Susan was admitted to hospital but declined any help when discharged. In December, the GP made a referral due to self-neglect, depression, and the risks created by Susan's health conditions, however, Susan declined any support. Concerns continued into 2022, with numerous attendances at the Emergency department. Whilst primary care attempted to offer social prescribing to Susan, a further safeguarding referral was made in March 2022 due to the home being cluttered, and Susan not taking her medication, eating or drinking. However, she continued to refuse any help.

Background

- **64-year-old female, with multiple chronic health condition, who lived with her son and his partner. Worked in a commercial,**
- **public facing role, when the Covid-19 pandemic commenced in March 2020. However, lost her job following a long period off sick. Her health had deteriorated**
- **over the last 12-18 months of her life She declined social care help and mental**
- **health intervention over the final two years of her life. Admitted to hospital in early October 2022 following a fall at home and**
- **died three days later while still in hospital.**

July - August 2022

Susan was admitted to hospital following an unwitnessed fall, where she remained for three weeks. By this time, her wider family had become increasingly concerned about her welfare, and her brother wrote to Adult Social Care to raise concerns. These concerns were shared with the hospital and a Section 42 enquiry was commenced at the beginning of August. In mid-August, Susan was discharged having declined any social care support or mental health intervention.

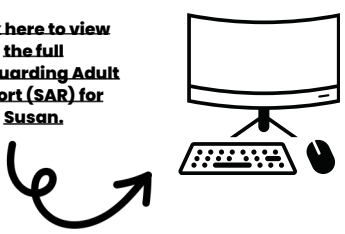
September - October 2022

There were continuing concerns about Susan in the community and efforts were made to engage her to support her health care, without success. Meanwhile, her family continued to raise concerns with agencies about her health and wellbeing. The Section 42 enquiry was allocated in September, with Adult Social Care trying to contact Susan without success. Before the enquiry was concluded, Susan died in hospital following a fall at home in October.

Good Practice:

It is noted that since Susan, the GP Practice has changed it practice in relation to self-neglect; they now have a lower threshold for considering self-neglect and what to do if this threshold is met.

Click here to view the full Safeguarding Adult Report (SAR) for Susan.



4 admissions to hospital

4 safeguarding concerns raised

1 S42 enquiry commenced

12 areas for improvement that were identified:

1. Review procedures for making safeguarding referrals (when self-neglect is witnessed), and how it can contribute to practitioner events (The Ambulance Trust).
2. Review how the Integrated Discharge Teams (and other discharge services) are managing the discharge of patients with safeguarding or self-neglect concerns (The Acute Hospital Trusts, Community Health Care and Adult Social Care).
3. Review how mental health advice can be provided for multi-disciplinary team meetings in hospital and GP practices for patients having repeat admissions related to self-neglect (EPUT and their commissioners).
4. (From SAR Anne) Review of the ESAB Self-Neglect Flow Chart and Self Neglect Guidance to incorporate fluctuating mental capacity, the consideration of physical health problems, and the need for Mental Capacity Act Assessments to be in place.
5. Seek assurance that partner organisations who employ staff responsible for deploying Mental Capacity Act assessments are satisfied those staff are competent to do so; particularly for cases with fluctuating mental capacity or where mental capacity may be affected by physical illness (ESAB).
6. Multi-agency discussions must be recorded to show what action will be taken, by whom, when there are escalating concerns about self-neglect.
7. (from SAR Colin) In SAR Colin (unpublished 2024) it was recommended that ESAB should ensure that a SET approach to developing a Multi-Agency Risk Management Framework is in place.
8. The agencies named in the SAR must provide assurance to the ESAB on how they ensure that their staff have access to safeguarding supervision and a clear escalation route for concerns that can be owned by senior leaders.
9. When a Section 42 enquiry is closed, if risks remain, there should be a plan for how to manage the risks across the multi-agency network (ASC).
10. (From SAR Anne) ESAB should commission a learning and development programme on a reviewed version of the self-neglect guidance across the multi-agency network to include case studies on identifying/assessing potential self-neglect.
11. Building upon a recommendation from SAR Anne to commission a multi-agency audit of self-neglect cases, Susan's case indicates that ESAB should commission a thematic review of self-neglect cases, featuring MCA and executive functioning, which have been referred to ESAB. Findings should form the basis of a joint work programme between the ESAB leads for ASC and the ICBs and should both incorporate training/toolkits for services and be promoted by commissioners of health and social care. ESAB should also plan for multi-agency audits of self-neglect cases to test the impact of work undertaken.
12. ESAB Chair should raise this SAR at the regional Chairs' network to consider whether the monitoring of the Discharge to Assess process needs to be raised with NHSE to ensure that safeguarding assurances are in place for pathway 0 (zero).

Essex Safeguarding Adults Board