# Teeswide Safeguarding Adults Board

## Learning from Regional and National SAR Cases:

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| **Title of Review:** | **Anne SAR** |
| **Theme of Review:** | Self-Neglect, COVID-19, Lack of Multi-Agency approach |
| **Local Authority:** | Sandwell |
| **Date Published:** | May 2021 |
| **Link to Full Report:** | https://www.sandwellsab.org.uk/wp-content/uploads/2021/08/Anne-overview-report.pdf |

**Case Details:**

Anne was in her fifties and lived alone with her two dogs, she had three sisters and also had a close relationship with her son. Anne was a nurse who was very caring but did not extend this caring nature to herself and found it difficult to ask for help.
Anne had multiple health problems including diabetes, cardiac problems and poor mobility, she received a high level of care and treatment from Primary, Community and Acute Health services.
Anne had a history of anxiety and depression and was struggling with the loss of her father and recent diagnosis of cancer her mother had received, she attributed her longstanding anxiety to her previous abusive marriage.
Anne's physical health deteriorated rapidly over the last year of her life where she had more than forty-five falls and there were increasing concerns about self-neglect necessitating hospital admissions and referrals to Adult Social Care.
This was the early stages of the Coronavirus virus pandemic and the plan was to support Anne in the community, six weeks later she was found unconscious by her son at her home. Ambulance crews described the home as being in an alarming condition and Anne was in an extremely poor state, she died on the day of her hospital admission.
The Coroner found that Anne had died of natural causes. Anne's death was due to Bilateral Bronchopneumonia with Covid-19 and Heart Disease as secondary factors.

Key Findings

1. Working with self-neglect presents practitioners with significant challenges in meeting their duty of care. Practitioners need to respect the adult's rights to make decisions about their life. However, this needs to be balanced with taking all reasonable steps to engage the adult in care and support, as proportionate to the risks presented. **The review found that practitioners were either not aware of the SAB's Self-Neglect guidance or did not apply it.**
2. Research highlights the importance of establishing and using relationships to try and understand the root causes of self-neglecting behaviours and negotiating change. Professionals helped Anne to engage in anxiety management, however, there was **limited evidence of trying to understand the reasons underlying her self-neglect and there were missed opportunities to try and engage her in other psychological therapies at an earlier stage.**
3. Anne's son and sister had a very good understanding of the extent of her difficulties. The family were not truly heard, involved, or supported in trying to care for Anne. **Research has identified the value of Family Group Conferences in Safeguarding Adults.** This could have greatly improved the coordination of Anne's care and maximised use of the assets that her family could offer. **A Family Group Conference would have also helped draw out the different perspectives and developed a meaningful shared plan, combining the strengths and assets of Anne, her family, and professionals.**

4. There was a lack of stepping back and viewing the totality of Anne's circumstances through the lens of safeguarding. **There were missed opportunities by some, to make earlier referrals through Safeguarding Adults procedures.**
5. The responses to the Safeguarding Adults referrals did not meet the fundamentals of good risk Assessment, there was a need to dig deeper, to look behind Anne's assertions that she did not need any help. **Referrals were viewed episodically without due regard to the history that signalled a deteriorating picture and significant harm.** Telephone contact was also relied upon with no home visits, the constraints of Covid at that time were acknowledged however it was confirmed the restrictions still allowed for home visits and that a SW should have visited Anne at home with a CN.
6. The structure of ASC services worked against SWs building trusting relationships over time. **The chronology demonstrated a lack of consistent SWs with repeated transitions between different parts of Safeguarding Adult services, Community Social Work teams and Hospital Social Work teams.** This had an adverse impact on continuity and personalised care. No SW had face to face contact with Anne.
7. Throughout the review scope period, there was an absence of risk assessment to identify emerging concerns as well as to identify when a Safeguarding Adult referral was warranted. **The absence of a risk assessment meant there was no shared understanding of concerns between the agencies or clarity about the actions that should be taken.**
8. **There were missed opportunities to refer to Adult Safeguarding when Anne discharged herself from hospital**. However a Community Nurse did later submit a referral, unfortunately this was sent to the wrong email address and the concerns were not recorded in the Primary Care records as self-neglect. A referral was also sent for counselling by Anne's GP however this did not make any reference to self-neglect and stated 'no' to risks, therefore she was not offered a face-to-face assessment and as she did not answer the call a voicemail was left requesting that she self-refer.
9. **There was no multi-agency working with housing who could have offered additional resources or more suitable accommodation,** they were not made aware of the self-neglect or concerns regarding the hoarding and conditions of the property.
10. **Anne's final months were during the first wave of the Coronavirus pandemic when agencies were under significant pressures and trying to adapt to new ways of working** in unprecedented emergency conditions. This provoked uncertainty and anxiety for professionals. The review acknowledged that agencies were grappling with new systems and without the guidance that became available during the later stages of the pandemic. This undoubtably would impact on the services that agencies were able to provide. **However restrictions did not prevent multi-agency meetings occurring (albeit virtually) nor did it change the fundamentals of good risk assessment. Coordinated care becomes even more important in challenging times.**

| **Key Findings Relevant to the Teeswide Safeguarding Adults Board** |
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| 1. Is there effective guidance and tools in place to offer a Family Group Conference in Safeguarding Adults across Tees? |
| 2. Are practitioners across Tees aware of the TSAB Self-Neglect Guidance? Should this be further promoted? |