7 minute briefing

Mary

Mary

This Safeguarding Adults Review concerns Mary, a woman in her 80s who was found deceased at her home in Croydon in February 2024. It was clear she had been deceased for some time. Mary was found in an unsecured property with very little furniture; kitchen cupboards were bare and there were very few possessions.

Mary had been known to health and social care services including GP, District (community) Nursing Service, pharmacy, mental health support. She had also been in contact with a Social Worker, Occupational Therapist, Age UK, Mind and other commissioned services.

Mary had a known condition of hypothyroidism for which she was prescribed long-term medication. However, Mary denied any symptoms and consistently declined medication. She had a one hour per week shopping call but in August 2022 Mary asked for this to be cancelled and at this time social care completed an assessment and indicated some form of self neglect that she may be struggling but she declined support. Age UK assisted in buying some furniture.

Police were called by an informant who was walking past Mary's property and noted that the front door was ajar and they entered the house and found Mary on the sofa. London Ambulance estimated she had been deceased for over a year. The last indicators of life were in August 2022 by way of her Oyster card and bank account usage.

The last contacts with Mary were in 2022 when services closed her case for support and when there was last activity on her bank account and Oyster card.

Themes in the case of Mary

Findings

Findings are conclusions and insights drawn from the analysis of data and evidence gathered during the review with the aim of the Safeguarding Adults Review being to enable “lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again”.

Finding 1: Routine Review
This finding is about how to create or use an existing system to support the review of high risk or high need cases that would otherwise become dormant, closed or lost. This is especially relevant where risks relate to self-neglect, a common feature of which is that individuals do not seek support or actively avoid it.

Finding 2: Closure Checklist
Inspired by the views and ideas of practitioners, this finding is about using, making and standardising checklists of considerations and actions to take before closing a case. This may include checking who else remains involved in the case and scoping for any unmet needs (such as untreated mental health).

Finding 3: Thresholds for multi-agency approaches to self-neglect
This finding builds on a foundation of sound practice in which agencies are able to identify and refer cases of self-neglect. To enhance practice in this area feedback on the quality and content of professional referrals of self-neglect cases will support safeguarding enquiry decision-making. There are different options for providing feedback on referral quality, from case by case feedback to strategic, lead-led service to service liaison.

Finding 4: Exploring the underlying causes of self-neglect
This finding considers common factors in self-neglect and approaches to supporting a culture of curiosity and exploration of underlying factors. In relation to mental capacity, this may be scoping professional groups who as a matter of routine do not assess capacity and may need support. In relation to guidance, this is about raising the profile of a more systematic analysis of the factors present in a case - with an emphasis on unmet needs.

Recommendations

1. **Routine Review [Opportunities for Engagement]:** Review the terms of reference for the GP Huddle, annual health checks or a similar process and consider whether additional capacity could be created to review closed or dormant cases.
2. **Closure Checklist [Opportunities for Engagement]**: Organisations should work together to standardise their checklists of considerations for closing cases, especially where continuing risks of self-neglect or unmet needs are foreseeable.
3. **Thresholds for multi-agency approaches to self-neglect [Multi-agency and escalation processes]:** How can a system of feedback on referrals be developed so that referrers are able to undertake their own quality assurance and ensure that they are providing information and level of detail needed by Adult Social Care?
4. **Exploring the underlying causes of self-neglect [Factors influencing self-neglect]**

- A scoping of Training Needs Analysis should identify where agencies or professional groups are not trained or able to carry out assessments under the MCA 2005 and may therefore need additional support or assistance.
- The CSAB should consider how to raise awareness of the self-neglect guidance and develop practice tools to support the systematic analysis of underlying reasons for an individual’s self-neglecting behaviours.

Good Practice

While services were working with Mary there is evidence that professionals worked hard to maintain their engagement with her, responding to her interests, needs and priorities. There is evidence that practitioners were persistent, communicative and creative in their attempts. However, over time services withdrew or closed her case, due to loss of contact and disengagement or Mary declining input. This withdrawal from contact was gradual, taking place over a period of time.