Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
Abuse must stop

Learning from reviews to improve practice: Themes - Self-neglect, alcohol misuse, challenges to engagement.

In 2017 the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) received a Safeguarding Adult Review referral relating to 'David' who lived in Stoke-on-Trent and died aged 50 with self-neglect contributing to his death. He had lived with his mother, but after her death he moved from the home address as it wasn't in his name and now fell into the 'under-occupancy' ruling. The loss of his mother had a significant emotional impact upon David and he became very lonely.

David appears to have been unable or unwilling to care for himself. He had a lengthy history of excessive alcohol use. Several agencies were involved in supporting him at home; his personal hygiene was extremely poor and his home was unclean most of the time.

There were issues of mobility reported however when David was seen in Police custody by the mental health team there was no record (or recollection by staff) that he was unable to move freely. He had several mental health assessments which didn't result in the offer of ongoing treatment. Agencies were involved in trying to support him to reduce and eventually stop his alcohol use however he declined offers of inpatient detox.

Adult Social Care (Stoke on Trent) maintained appointeeship for David in an attempt to reduce his access to alcohol, they also arranged for him to receive care at home. This was initially two calls per day, but this changed to one longer call to support him more effectively with his personal care.

West Midlands Ambulance Service was repeatedly called by David, sometimes daily, and regular, inappropriate and unnecessary calls made to Staffordshire Police. It is believed that this was mainly because of boredom and loneliness. David's presentation caused unpopularity in his community as he was often soiled and unclean.

At the inquest the Coroner recorded that death was because of bronchopneumonia, chronic obstructive pulmonary disease, skin ulceration and chronic alcoholism. Whilst there were no concerns about the provision of care offered and sometimes agreed to by David, the SSASPB decided to conduct a multi-agency learning review to better understand the links between substance misuse, mental ill-health and self-neglect as many professionals were left wondering what they could have done to improve David's willingness to engage with them.

The review highlighted areas of good practice and those where improvements could be made.

Lessons learned:

Areas of good practice:

- GP was excellent at sharing their concerns with other agencies including ASC and WMAS
- Housing allowed David to remain in the home he shared with his mother over and above any usual timescale as the house met under-occupancy scheme.
- David's situation was referred to the Vulnerability Hubs for information sharing
- Excellent support provided over the phone at 2am by the Mental Health Access Team.

Areas for improvement:

- There was an over reliance on alcohol misuse to explain presentation
- There is a service gap for multi-occupancy housing provision for U55s - loneliness
- Need for creativity for people with extremely poor self-hygiene to make sure that they can access support e.g. church, self-help groups, voluntary services.
- Full documentation on case files is essential, allows others to really understand why decisions were made and trends in well-being.