Abbey's story

Abbey was a 69-year-old woman who lived independently in a 3-bedroom house she inherited from her parents. Professionals who worked with Abbey said her home was not cluttered, but it was described as 'unkempt, very dirty and in disrepair' by her family, who advised she often had the blinds shut and made no effort to decorate or make the house feel homely, and her basic utilities were inadequate. Not one to cook, it was felt she lived on convenience food such as ready meals, fruit, and snacks.

Abbey was a private person and liked to keep to herself, having just a couple of close friends she spoke to regularly and losing contact with her extended family. After a bout of flu in January 2020, Abbey's mental health deteriorated, and she would not or could not eat. She was admitted to hospital 3 times in January/February 2020 in a dehydrated state and the last time she was admitted, she required 3 litres of fluid intravenously to rehydrate. After this bout of flu, Abbey did not always take good care of her personal hygiene by neglecting to clean her teeth, wash her hair regularly, and do washing.

Mental health issues and suicide was prevalent in Abbey's family, with three close relatives dying by suicide, and two others who made multiple attempts to take their own lives. Abbey also tried to take her own life in her 20's following the breakdown of a romantic relationship.

Abbey's cousin was trying to support her with shopping and visiting and felt that she was 'passively trying to commit suicide' during the months leading to her death by not eating or taking her medication and would frequently put off professionals working with her by saying she would 'eat later'.

Medication was prescribed to Abbey by her GP for Type 2 Diabetes, depression, and protein shakes. She was referred to Home First as it was felt she would benefit from support in her nutrition and medications during lockdown. Abbey ended this support package after 17 days and was later found deceased in her home. Professionals involved in the review felt that her decision to not eat had a significant impact on her death due to exacerbating pre-existing conditions.

A Partnership Review was undertaken to look at where learning could be taken from the unfortunate events leading to Abbey's death. Abbey's cousin was actively part of this review and provided valuable insight and challenge throughout.

Summary of Learning

Themes the Review focused on

- Was there appropriate use and understanding of assessments for things like self-neglect, mental capacity and executive functioning, financial barriers to ongoing support, and eating disorders?

- How effective was information sharing and joined up working between professionals involved in Abbey's life?
- Was enough professional curiosity shown by those working with Abbey around her eating, and in ensuring her safety after support ceased?
- What impact, if any, did COVID have on the quality of services Abbey received?
- How well was Abbey's voice and wishes heard through her journey?

What went well?

- Abbey was a private person, and her wishes were listened too and respected
- Service provision was provided and in a timely way during unprecedented times (lockdown 1)
- Conversations were had with Abbey about food and nutrition by professionals who had noticed her negative response (gagging) when food was mentioned
- Consideration to capacity had been given when case handed over from hospital team to social care, and throughout her care by professionals
- Professionals were noticing food had been consumed in the home, and evidence of food
- Engagement from Abbey's cousin in supporting her and in communicating issues effectively with professionals
- Referrals for extra support made (e.g., Warm Homes and Red Cross)
- Abbey had been persuaded to keep Home First support for a little longer

What did not go so well?

- Difficult for professionals to notice significant changes during COVID restrictions but also in a short space of time working with Abbey
- Missed opportunities to challenge Abbey when she said she will eat later or notice her baggy clothing may be hiding weight loss. Different carers were visiting her meaning no consistency, but also a MAR chart was not formally recognised as required in the handover from EIT to Home First when care began
- Carers did not have access to medical mental health history records
- Monitoring of Abbey's weight and eating habits was not a key part of handover care planning
- Risks flagged by Abbey's cousin in a phone call and letter were not acted on. Letter was also not seen as quick as it could have due to COVID impact on staff accessing the office
- No evidence of a Next of Kin discussion with Abbey, which meant when support from Home First ceased, her cousin was not notified leaving Abbey with no support
- Support visits were shorter due to COVID from Home First and Lead Clinician

The fundamental learning from this case

- Importance of risk assessing which includes a view of self-neglect and capacity consideration
- Ownership of risk is crucial. If risk is being passed to another professional or organisation, the person passing it over should hold it until they are certain it has been accepted by the other organisation
- Further training on risk assessing and refresher of tools available within organisations involved
- Importance of working from the same IT systems, staff having access to the right information cross agency, but also a need to record in one place

- Professional curiosity is paramount to looking deeper at a person's life and asking questions that may help keep them safe (e.g., identifying who else may be able to support them like a next of kin, or are they eating when they say they are)
- Understanding of eating disorders needs to be a key consideration when risk assessing