Suffolk Safeguarding Adults Board

'J' Case Study – Self Neglect

J's Story.

J lived on his own in a supported living property. He chose to live an isolated life and had a long history of alcohol dependency. He was divorced, and his children lived abroad and had no contact with their father. J was also estranged from his siblings who lived nearby.

J's lifestyle choices raised concerns with professionals, particularly his living conditions, self-neglect and general welfare. He lived in sparse conditions which were described as soiled and dirty.

J was described by Health professionals as having a brain injury and cognitive impairment and was challenging to care for, particularly when he had been drinking. This resulted in many concerns being raised by various agencies, but J was often resistant to offers of help or support.

J was known to services since 1999 was receiving home visits twice a day to assist with his personal care needs, which J didn't always feel he needed.

He had numerous hospital admissions and was admitted to hospital in January 2016 following a fall. A vulnerable adult referral was made by the Ambulance Service due to concerns about J's condition.

J returned home but was admitted to hospital again a month later. He was deemed to have capacity to make his own decisions and felt that he didn't need any support or care.

On discharge from hospital, there was no evidence that the care agency was notified or a care package being in place. The care package he had on admission had been discontinued.

J was found deceased in his home in conditions described as squalid on the 18th April 2016. There were no suspicious circumstances or third-party involvement in his death.

What went well?

- The concerns raised were appropriate and timely.
- There were many agencies offering support all of whom wanted the best for J.
- Carers tried their best to support J, who could be difficult especially when under the influence of alcohol.

What were we worried about?

- There was no evidence of a multi-agency discussion to ascertain what support J would need on his discharge from hospital.
- The hospital discharge process did not ensure that an appropriate support package was in place for J when he left hospital.
- The 'simple discharge' process, which would have resulted in the existing care package being reinstated was not used.
- J often overstated what he could do for himself, which meant that he didn't always get the care and support he needed.
- J's fluctuating capacity due to alcohol use was not addressed and he was deemed to be able to make his own decisions.

What is the learning from this case?

- The relevant guidance needs to be clear where fluctuating capacity results in cumulative unwise decision making.
- Hospitals need to have an effective multi-agency discharge process which results in an appropriate care package in place, particularly where the patient is at high risk due to self-neglect.
- Hospitals should have robust systems to inform all relevant partners when a high-risk patient is being discharged.
- The above should be incorporated into the risk matrix in the Suffolk self-neglect and Hoarding policy.