

1**Background**

Adult M was 72 years old. She was a private person and had very little contact with services. Her son and grandchildren visited every other day and helped with shopping but there was no other social circle.

Recent professional contact was with her GP and District Nurses to help care for wounds on her legs. She had some historic contact with the Police for anti-social behaviour targeted at her property. She was viewed to have mental capacity to make decisions about her care and treatment.

2**Safeguarding concern**

In April 2020, family contacted emergency services. Having spoken to her through her letterbox for four days, M appeared unresponsive. The Fire and Ambulance Service crews were concerned about the significant clutter within the property. On admission, hospital staff noted that she was dehydrated, her clothes were soiled, and she had infected leg wounds. Adult M died in hospital a few days later.

The NSAB arranged a multi-agency review of Adult M's case to identify what worked well and what we might do differently in the future.

3**Strengths in Practice**

There were no omissions in practice that would have prevented M's admission to hospital and subsequent death.

Although M did not always attend her appointments or follow advice, staff were proactive in trying to encourage M to accept support and work with her to agree solutions.

The Police response to anti-social behaviour was proportionate and in line with best practice.

Agencies were proactive in referring safeguarding adults concerns when required.

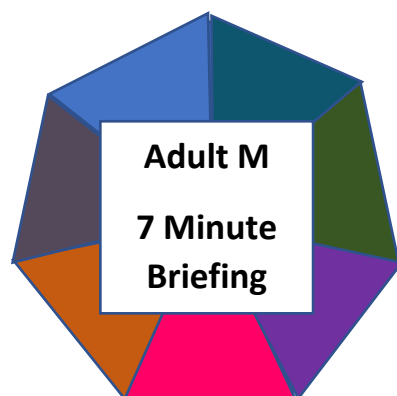
7**Implementing change**

Professionals can follow our [Self-Neglect Practice Guidance](#) when responding to self-neglect.

Residents and professionals can find out more about the [services and support for Carers in Newcastle](#).

TWFRS offer "Safe and Well Checks" – a home visit with the aim of identifying the associated hazards and risks within the home. Relevant fire safety, health and wellbeing advice will be provided. Email PandE@twfire.gov.uk if you feel someone would benefit from one of these.

We will update our communications materials to include specific messages about self-neglect. We will have an article in CityLife about self-neglect.

**6****Recommendations**

A standard process for communication between District Nurses and GP practices for all discharges and missed appointments is developed.

A publicity campaign to increase public awareness of self-neglect as a safeguarding issue is considered.

Carers Support Services in Newcastle are promoted, particularly towards those who may not see themselves as Carers.

4**What was challenging?**

Whilst generally there was good communication between agencies, the GP did not have a complete understanding of M's adherence to her treatment plan.

Only her family had insight into how M was coping at home.

Covid-19 and the message to stay at home, save lives, protect the NHS may have deterred M and her family seeking help and support.

Adult M's family did not view themselves as carers and were not accessing any services or support for this role.

5**Recommendation**

Promote access and referral information for the Tyne and Wear Fire and Rescue Service (TWFRS) Safe and Well Checks.