Appendix 4: Case examples

Example 1

Two brothers with mild learning disabilities lived in their family home, where they had remained following the death of their parents some time previously. Large amounts of rubbish had accumulated both in the garden and inside the house, with cleanliness and self-neglect also an issue. They had been targeted by fraudsters, resulting in criminal investigation and conviction of those responsible, but the brothers had refused subsequent services from adult social care and their case had previously been closed.

The local authority received a concern that the brothers were at risk of self-neglect. It was not known if there was reasonable cause to suspect brothers were able to protect themselves from self-neglect or the risk of it, and so a s42 enquiry was not triggered.

The needs assessment commenced, and as this progressed, it became clear that with the right level of support to encourage the brothers to accept services, they were able and had mental capacity to take measures to protect themselves from the risk of self-neglect.

They developed a good relationship with their social worker, and as concerns about their health and wellbeing continued it was decided that the social worker would maintain contact, calling in every couple of weeks to see how they were, and offer any help needed, on their terms. After almost a year, through the gradual building of trust and understanding, the brothers asked to be considered for supported housing; with the social worker's help they improved the state of their house enough to sell it, and moved to a living environment in which practical support could be provided.

Example 2

Ms S is a 63 year old woman with mild learning disability. She has always lived with and was cared for by her parents until they both died over the last 5 years. She now lives alone in the former parental home. The house is in disrepair with no windows at the back of the house. The kitchen floor is always wet from the rain. The house is dirty. The house is cluttered with possessions such that it is difficult to walk through the house. Ms S is incontinent, her legs are ulcerated and weeping. Ms S has recently refused to let her sister into her house, but does still allow her GP to come into her house.

The GP has become so concerned he has decided to raise the matter in an MDG. This leads to another meeting involving more agencies that have some knowledge of Ms S. The GP feels Ms S's capacity to understand the risks may be in question. The Local Authority decided there is reasonable cause to suspect Ms S meets the criteria for s42 enquiry under the Care Act because there is reasonable cause to suspect that Ms S has needs for care and support, is at risk of self-neglect, and there is reasonable cause to suspect Ms S is unable to protect herself from self-neglect or the risk of it.

The enquiries agreed were for the GP, as the person who knows Ms S best, to work with Ms S to understand what her views and wishes are about her care and support needs and to encourage her to accept input and assessment from the Local Authority, and for the Local Authority to undertake a needs assessment. This leads to some care provision and short term nursing input to help her manage her incontinence and keep clean. This also leads to ongoing involvement with a voluntary sector organisation who are able to link Ms S with a volunteer who identifies some interests she has and links her in with

some community activities which she enjoys. Her quality of life, independence and mood dramatically improve over a 6-9 month period as a result of well coordinated actions to improve her situation which started via her GP working with her at her pace and with her consent building on a trusting relationship.

Example 3

Mr M, in his 70s, lives in an upper-floor council flat, and had hoarded over many years: his own possessions, items inherited from his family home, and materials he had collected from skips and building sites in case they came in useful. The material was piled from floor to ceiling in every room, and Mr M lived in a burrow tunnelled through the middle, with no lighting or heating, apart from a gas stove. Finally, after years of hiding in privacy, Mr M had realised that work being carried out on the building would lead to his living conditions being discovered. Mr M himself recounted how hard it had been for him to invite access to his home, how ashamed and scared he was, and how important his hoard was to him, having learnt as a child of the war never to waste anything.

Through working closely together, Mr M, his housing officer and experienced contractors have been able gradually to remove from his flat a very large volume of hoarded material and bring improvements to his home environment. It has taken time and patience, courage and faith, and a strong relationship based on trust. The housing officer has not judged Mr M, and has worked at his pace, positively affirming his progress. Both Mr M and his housing officer acknowledge his low self-esteem, and have connected with his doctor and mental health services. The officer has recognised the need to replace what Mr M is giving up, and has encouraged activities via engagement initially with the health improvement service that reflect his interests. Mr M has valued the officers honesty, kindness and sensitivity, his ability to listen, and the respect and reciprocity in their relationship.

Example 4

Ms T lives alone. She has been diagnosed as having a severe compulsive disorder which manifests itself in hoarding. Ms T experiences high levels of anxiety which impacts on her ability to attend to personal care and eat. There are unopened bags of cooked food that Ms T says she has forgotten to eat. Ms T says she is aware of the risk to her health and environment and has noticed vermin droppings in the kitchen. There is ample evidence of infestation to anyone visiting. She says she does not clean her home as it causes her anxiety to move things and throw things away.

Ms T gathers all her letters but doesn't open them. Ms T only goes out to familiar places where there are familiar faces.

Her landlord, a social housing organisation received a concern about her property from neighbours. They visited and identified she was at risk of harm through self-neglect. A referral was made to environmental health and also to adult social care. Adult social care checked with GP and mental health services, and found that Ms T had recently seen a psychiatrist. The psychiatrist was contacted and has a clear view that Ms T has full mental capacity to understand these risks, how her mental disorder affects these risks, and to make decisions about her care and support needs.

It turned out there was is no reason to suspect that Ms T is unable to protect herself from self-neglect, but due to the impact of the property on the others the environmental health and housing officers did have to advise Ms T that he would have to issue proceedings if she did not act to address the vermin issue. Once the issue was put to Ms T in a firm, but understanding way, together with an offer of help to find a reputable company to do the work, Ms T made the necessary arrangements and got her home free of vermin and a reduction in the clutter likely to encourage future infestations.

It was also identified that adult social care had a duty to offer a needs assessment. Ms T agreed to a needs assessment under the influence of the environmental health officer with whom she had struck up a trusting relationship. Ms T expressed a wish to try to continue to manage her needs herself, as she feels this is the best way for her to cope with her mental health in the longer term. The Local Authority provided information and advice on support services and how to access these. Outcomes were fedback to the psychiatrist who will continue to monitor Mr T’s mental health and the housing officer will make occasional contact to see that the property remains adequately clean and free from undue clutter and risk of infestation.