1 Background

The purpose of this briefing paper is to outline lessons learned arising from the death of a 50-year-old man who lived at home with his partner Caroline and their 9-year-old son Leo. Ian and his partner Caroline had been together for 20 years, and due to Covid 19 lockdown their son, Leo was being home schooled with appropriate engagement from mother and was not identified as a vulnerable child.

In 2020, Ian was admitted into hospital to have a wound treated that had become infected, he was in hospital for approximately 6 months and was also treated at the same time for his diabetes.

In response to the above it was determined a joint SAR and CSPR screening meeting would be beneficial to understand the events leading up to the identification of this case of neglect, as the area promotes a think family approach and would be beneficial to understand the events leading up to the identification of this case of neglect.

2 Incident -

On 26th January Stepping Hill NHS Foundation Trust Emergency Department (ED) contacted the Stockport Metropolitan Borough Council (SMBC) Out of Hours social work team as Ian had been taken to Hospital after his partner, Caroline, called for assistance. Caroline made a call to 111 service at approximately 11.25 pm stating Ian had been unwell for some time. It was relayed that Ian had been lying on the floor of the family lounge, unable to mobilise and presented confused. On arrival, NWAS report that Ian had several pressure ulcers, presented dehydrated, and report there was a distinct odour both at the property and from Ian. Safeguarding concerns were raised by North West Ambulance Service (NWAS) Paramedics and Hospital staff about the neglected state Ian was presented in.

3 Concerns

Both referrals triggered a home visit from Children's Social Care and a Section 47 investigation was initiated, with concern about the impact of the living conditions and dad's poor health state on the child. The Social workers found the home unclean, untidy, faeces on the front doorstep, unusable kitchen, clutter and boxes in the dining room, up to 12 dead mice and mouse traps appearing to be in place for some time. They identified Leo had been sleeping with his mother for some time in the upstairs bedroom, and there were a lot of sweet wrappers in the room.

The family had been described as keeping themselves to themselves, which did explain why neighbours did not appear aware of the circumstances within the home.

Ian, Leo's father, sadly passed away on January 30th, 2021. He died from his pressure ulcers and related sepsis.

4 Engagement with universal services

In April 2018, Ian marked a pattern of late presentation with health issues at his GP surgery. This presentation led to hospitalisation and toe amputation and a diagnosis of diabetes.

In June 2019, he presented with cellulitis and was sent for urgent scans but did not attend. When he re-presented to the GP a week later, he was sent immediately to hospital and was again admitted with an abscess needing treatment. He was discharged nine days later with suggested wound care from District Nurses, but records do not indicate that at this stage he had any specific support needs or significant health issues. A pattern was noted of Ian not attending health appointments. It was at this time that the GP surgery identified they were unable to make contact via his mobile. Letters were sent but he did not respond to any of these invitations across 2020.

Leo accessed health visiting and school nursing. The most recent contact was in relation to weight gain in November 2020 which was a positive contact with the school nurse. Leo had raised concerns about Covid-19 and attending school. The school nurse contacted mother who told her that she was going to contact the weight management service later that day. This engagement and referral were good practice.

5 Multi agency working -

In this instance the adults within this family were not engaging with services in relation to their main support needs such as health. Therefore, whilst there is learning this is not related to how agencies worked together to offer support.

6 Communication

Caroline had been "seen" by her GP via a telephone contact during Covid-19 restrictions in October in relation to her depression. She had been prescribed anti-depressants and expressed difficulty in staying on top of the house cleaning whilst caring for an ill partner and her son.

On the night Ian was taken to hospital, Paramedics did not see Leo at the house. This was explained as being due to Leo being upstairs when they attended to a critically ill patient. As a result, they described how paramedics had only entered the front room and not seen Leo or the rest of the house.

7 Learning Points

- Hidden harm has become more prevalent throughout the pandemic and can be less visible with fewer opportunities for trusted adults to be approached for disclosures. Considering this, education leads are now keen to explore alternative approaches, such as home visits for those children that haven't been seen with schools to explore what lessons may be learnt about triggers for escalated action such as, adult depressive presentations potentially associated to school attendance.
- Learning was identified in response to the NWAS and NHS Foundation Trust safeguarding referrals, as a home visit was undertaken. Children's Social Care identified that this should have happened within the context of a strategy meeting, leading to the further joint home visits.
- In the wider context, the pattern of non-engagement, that also includes Did not attend (DNA) or not responding to requests to make appointments for both general practice and secondary care could have alerted the practice to a pattern of self-neglect. It was identified that a home visit would be an ideal solution but unrealistic given the number of cases that would likely trigger from DNA.
- Was there a missed opportunity for the GP to explore the mothers caring responsibilities further and trigger a carers assessment. This enquiry could have created an opportunity to explore the household situation and trigger another agency contact.
- The panel discussed expectations for emergency services and whilst it was understood that the immediate concern was Ian's presentation, was there a missed opportunity in Think family approaches given the paramedics were the only professionals to access and understand the living circumstances of this family.

Safeguarding Children in Stockport

7 Minute Briefing

Safeguarding Adults in Stockport