Cumbria Safeguarding Adults Board

Safeguarding Adults Review

‘Poppy’

Overview Report

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Introduction

"Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult […] Safeguarding Adults Boards are free to arrange for a Safeguarding Adults Review in any other situations involving an adult in its area with needs for care and support".(DHSC, 2023)

Safeguarding Adults Reviews, both mandatory and discretionary are statutory reviews, carried out under section 44 Care Act 2014 and Care and Support Guidance.

Background to the case

Cumbria Safeguarding Adults Board considered the case of Poppy, a 65-year-old white British woman who died in December 2022. Poppy had a history of poorly managed Diabetes resulting in frequent hospital admissions. She had been assessed as having mental capacity to make decisions about her physical health conditions and there were concerns about self-neglect in the context of failing to care for her health.

Poppy lived in Cumbria at the time of her death, had care and support needs, and there was concern about how agencies worked together to protect her from self-neglect and mitigate the risks to her physical health by not administering her insulin.

About the Reviewer

This Safeguarding Adults Review has been led by an Independent Author, Eliot Smith, who is an Independent Health and Social Care Consultant with a background in social work, mental and physical health, and safeguarding. Eliot Smith has worked for both Local Authority and NHS services and has no prior connection to the case, Safeguarding Adults Board, or partner agencies.

Organisational involvement

A multi-agency panel was established by Cumbria Safeguarding Adults Board to conduct the review and oversee the process. Membership included the Lead Reviewer and representatives from key agencies with involvement in the case:

- Cumbria Safeguarding Adults Board.
- Integrated Care Board, representing primary care.
- Mental Health NHS Trust.
- Acute Hospital and Community Health NHS Trust.
- Adult Social Care.
- Police.
- Ambulance Service.
- Care provider.

Family involvement

The Independent Reviewer had the opportunity to speak to Poppy's daughter about the report, about how services worked together, and about her views on the system in Cumbria. Poppy's daughter had the opportunity to provide feedback on the findings to the report and received a copy of the report prior to final publication.

Poppy's daughter selected the pseudonym 'Poppy' for the report.

Parallel processes

The purpose of a Safeguarding Adults Review (SAR) is "not to hold any organisation or individual to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council"(DHSC, 2023). Where other processes are being followed good practice in communication between the Safeguarding Adults Partnership Board and other bodies ensures that no one process unnecessarily inhibits or compromises the other.

Methodology and limitations

The review will draw on systems learning theory and will evaluate evidence from a range of sources including agency chronologies, organisational outline reports, Safeguarding Adults Reviews, research, evidence-based practice, and the views and opinions of practitioners and agencies involved in Poppy's case.

Scope of the Review

The Safeguarding Adults Review will consider the period from **March 2022 to December 2022**. which includes Contextual information outside of this timeframe may be sought in order to make sense of decisions made.

A note on practitioner involvement and practitioner learning events

In line with statutory guidance, professionals within local agencies must be given the opportunity to be "involved in the review and invited to contribute their perspectives without fear of being blamed for actions they took in good faith"(DHSC, 2023). Members of staff and practitioners in health and social care agencies are able to offer a valuable insight into how systems and processes operate to provide care, support, and protection to adults at risk.

Practitioner learning events are a way of bringing together the relevant professionals involved in the case, facilitated by the Independent SAR Reviewer. The aim of the learning events is to clarify events within the chronology, answer the questions set by the Terms of Reference, and help to ground early analysis in practice.

Specific terms of reference

The purpose of the review is to use the experience of Poppy's case to identify learning about the multi-agency system. The Safeguarding Adults Review has identified a number of themes which will act as the terms of reference, or research questions, for the Review.

This will help to provide some initial structure to the analysis and findings of the review.
The themes identified as terms of reference for this Safeguarding Adults Review are as follows:

1. **Partnership working, communication & information Sharing –** Partnership and multi-agency working is the foundation of effective practice. What can Poppy's experience of the system in Cumbria teach us about multi-agency working and information sharing?
2. **Physical and Mental Health –** What were professional's views of the impact of Poppy's mental wellbeing on her ability to manage her physical health condition? How effectively did professionals explore Poppy's mental health?
3. **Mental Capacity –** How do agencies address the issue of mental capacity, autonomy, and freedom of choice?
4. **Risk assessment –** How do agencies assess risk and what was the professional understanding of the risks facing Poppy. Did this / how did this differ from Poppy's own views?
5. **Self-Neglect –** How do agencies in Cumbria interpret the definition of self-neglect? What sort of behaviours are included or excluded? How did this interpretation of self-neglect impact on decision made in this case?

6. **Professional Curiosity & Challenge –** "Professional Curiosity is the capacity and skills of communication to explore and understand what is happening for a person, rather than making assumptions or accepting things at face value" (CSAB, CSPC, & SaferCumbria, 2022). How do agencies in Cumbria apply the principle of professional curiosity in safeguarding practice?

Summary of practice

Case representation

Figure 1 provides a representation of the key elements in the case of Poppy. This visual representation sets out the context in which Poppy lived (individual characteristics, experience, and personal factors) and the issues that led to contact with services – physical and mental health diagnoses, safeguarding concerns, and contact with law enforcement. These factors shaped the role that health and social care services would have in her life.

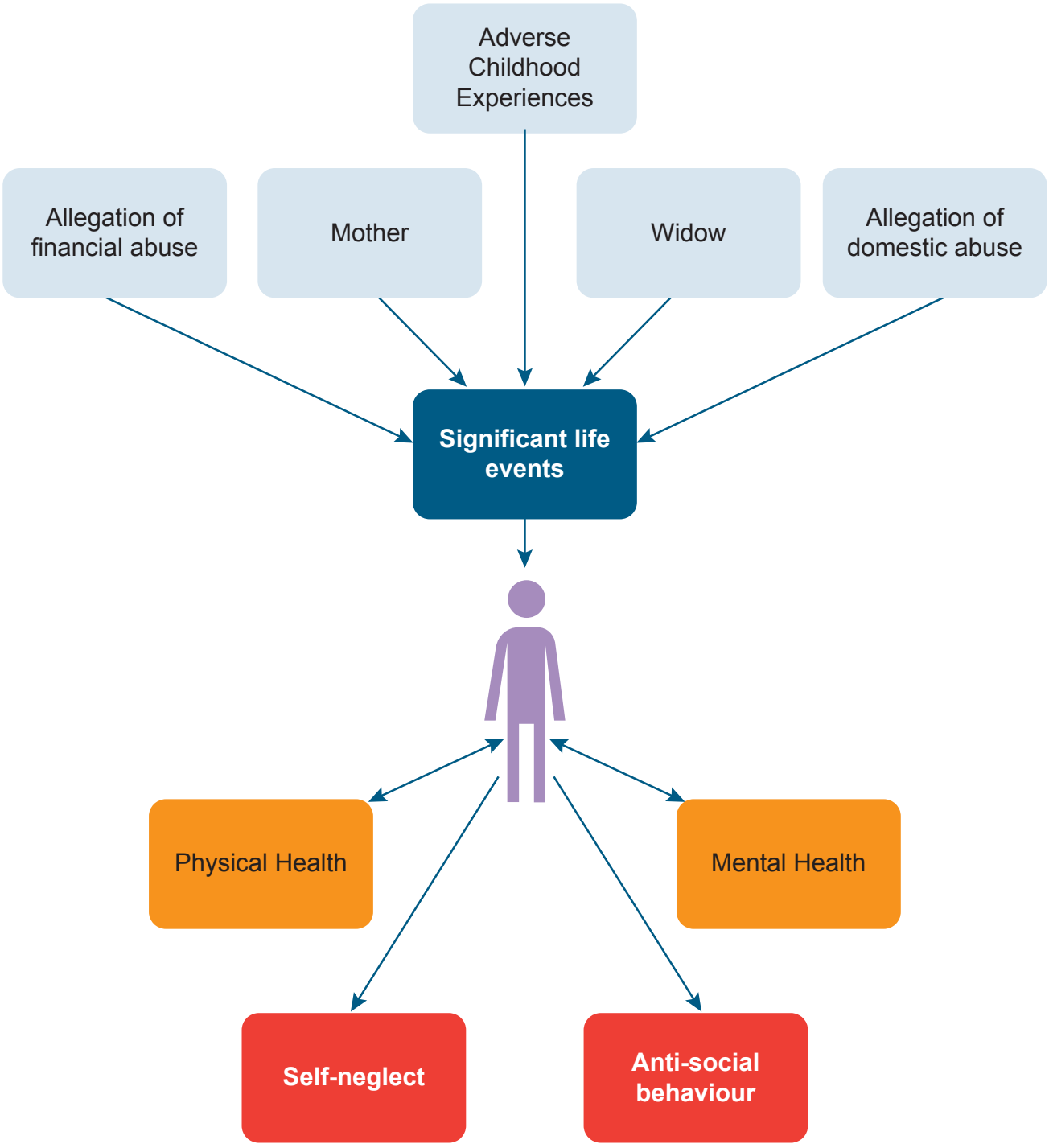

Figure 1: Key elements in the case of Poppy – a visual representation

Practice context

The case of Poppy is characterised by how services worked together and responded to Poppy's own views, decisions, and behaviours in relation to the management of her health and social care needs.

Evidence suggests that individuals' behaviours and emotional responses are based upon perceptions of events that are informed by patterns of cognition, core beliefs and assumptions (Fenn & Byrne, 2013), (Colvin & Williams, 2015). Multiple factors influence thoughts, beliefs, and assumptions about the world, including but certainly not limited to social and biological factors, past and current life events, including adverse childhood experiences and trauma, relationships, and others' behaviours. A cognitive model "hypothesises that people's emotions and behaviours are influenced by their perceptions of events" (Fenn & Byrne, 2013). Concerns about an individual's decisions or behaviours in relation to their health or social care needs must therefore be viewed in the context of their personal and social history, beliefs, assumptions, and thoughts about the world around them.

Individual context

Poppy was born in Scotland where her daughter still lives. Poppy moved to Cumbria when she was approximately 40 years old with her husband who in later life acted as her main carer. In the years leading up to her death, Poppy cared for a dog, and after the death of her husband in 2020 remained socially isolated with limited informal support in her local area. It has been recorded that Poppy had Adverse Childhood Experiences and trauma, and that in adulthood she had alleged domestic abuse, and was the victim of fraud. Poppy suffered from physical health conditions that included diabetes, fibromyalgia, and chronic fatigue syndrome. Her vision was poor, and she had cataracts. Poppy also had a diagnosis of depression and anxiety.

Organisational context

Contact with the health and social care system in Cumbria was as a result of health and social care needs. As a result of her health diagnoses, Poppy was supported by her GP, Community Health District Nurses, and Diabetes service. Health services were concerned about how Poppy managed her diabetes – both in lifestyle and dietary choices, and in how regularly she monitored her blood-glucose levels and insulin regime. Poppy's physical and mental health conditions also had an impact on her social care needs, and she received a package of care to address needs with nutrition, shopping, and social isolation through a care agency. In 2018 to 2019 Poppy also had contact with the police following concerns about her mental health and incidents involving neighbours including malicious communication and harassment. This cumulated in an admission to a psychiatric hospital for treatment of a non-organic psychotic disorder, related to paranoia and a fixation on her neighbours. No action was taken in relation to a range of behaviours towards her neighbours as they did not wish to pursue charges, which were also not deemed to be in the public interest.

Lessons learned and findings

The analysis and lessons learnt section considers what we can learn from Poppy's case and apply to the context of the wider system. This section takes each term of reference in turn and identifies the key lessons learned.

TOR 1: Partnership working: communication & information Sharing

Partnership and multi-agency working is the foundation of effective practice. What can Poppy's experience of the system in Cumbria teach us about multi-agency working and information sharing?

Background

Within health and social care, and in safeguarding systems, partnerships exist at a strategic and operational level. Strategic partnerships shape how systems work, promote collective action on shared initiatives, and often associated Partnership Boards are responsible for strategic plans and system working. Membership of strategic partnerships usually consists of representatives of statutory and non-statutory partners, and stakeholders who have an interest in the system.

Partnership working at an operational level describes how different organisations and individuals with a specific role or expertise work together towards shared aims – forming a partnership of agencies and informal carers around the person. The membership of operational, or case-based partnerships should be flexible, reflect the particular needs of the individual, and may vary over time. The challenge for case-based partnerships is to ensure that practitioners from across the system are communicating effectively so that decisions in one part of the system (for example in the health sector) support, and do not undermine, decisions in another part of the system (for example social care).

Lessons learned

Poppy was involved with a number of services in her local area by virtue of health conditions, social care needs, and behaviours towards her neighbours. Poppy received support from health professionals in primary care (universal health services) and secondary care, including district nurses and diabetes nurse specialists to support her with her physical health conditions. Poppy was known to adult social care and had a package of care to support her with social care needs and practical support. Poppy was also referred to specialist mental health services in relation to low mood and depression, and in relation to paranoid ideation and anti-social behaviour towards her neighbours where her mental health was thought to be a contributing factor. Following her disputes with neighbours Poppy also had contact with police.

The case of Poppy demonstrates the difference between communication and partnership. Agencies across the system were able to provide examples of communication with other agencies, for example, between Poppy's GP and district nurses, diabetic nurses, and mental health professionals, and Adult Social Care communication with the care provider. Communication was most effective between agencies in the same sector: within health and within social care. The communication between sectors included referrals to other agencies, sending safeguarding reports about self-neglect, or outcomes of assessments.

Evidence from professionals was that intra-sector communication was less effective, relying more on one-off communication and sharing of information, rather than the joint-working and shared decision-making that characterises partnership working. In many circumstances effective communication will be sufficient and true partnership working is not always necessary. Working in partnership is more likely to be needed in cases where:

- Individuals experience multiple vulnerabilities or conditions.
- There is complexity and single-agency decisions may have wider implications or unintended consequences.
- An individual's needs require multiple-agency input.

- There are significant risks that require multi-agency responses.
- There are safeguarding concerns across sectors.
- The needs of the case necessitate joint or coordinated decision-making.

In the case of Poppy, partnership working took place through ad hoc Multi-Disciplinary Team meetings (MDT) which were convened as and when necessary and provided a forum for discussion, shared decision-making, and coordination. Agencies routinely engage with MDTs and professionals value and prioritise their attendance at meetings. In some Safeguarding Adults Board areas MDT or similar processes have been formalised to procedures, much like safeguarding procedures, but for high-risk cases that do not meet the criteria for section 42 safeguarding enquiry.

Finding 1: Partnership working and the MDT

Context

Partnership working in the case of Poppy focused primarily on risks relating to health conditions, especially her poor self-management of diabetes, and low levels of concordance with treatment. Partnership working can take place through formal systems, such as strategy meetings for safeguarding cases, or regular weekly or monthly meetings, or can be less formal through ad hoc discussions of ad hoc Multi-Disciplinary Team (MDT) meetings.

Rationale

In the case of Poppy, partnership working took place through ad hoc Multi-Disciplinary Team meetings (MDT) which were convened as and when necessary and provided a forum for discussion, shared decision-making, and coordination. There are currently no formal procedures or standardisation of MDT meetings, although MDTs are widely used and universally felt to be beneficial. In Cumbria, current MDT practices are valued and the formalisation of MDTs to a risk procedure is unlikely to prove beneficial. However, there are still ways that MDTs could be made more inclusive and effective through guidance or training.

Recommendation

Cumbria Safeguarding Adult Board publish a “Guide to effective MDT working”.

TOR 2: Physical and Mental Health

What were professional’s views of the impact of Poppy’s mental wellbeing on her ability to manage her physical health condition? How effectively did professionals explore Poppy’s mental health?

Background

Poppy had experienced Adverse Childhood Experiences and trauma which impacted on her psychological vulnerability to low mood and mental state. She had been identified as appropriate for talking therapies and primary care mental health interventions but was reluctant to access formal treatment for depression and anxiety. During the chronology period, referrals for assessment of Poppy’s mental health were made within the acute hospital following medical admission for treatment of Diabetic Ketoacidosis as a result of her deliberately not taking her insulin. Poppy informed staff that she had stopped taking her insulin as a way of taking her life.

Poppy had a previous admission to a psychiatric inpatient unit in 2019 for treatment of a non-organic psychotic disorder, following experiences of auditory hallucinations and paranoia related to ‘long-standing paranoia and fixation with her neighbours.’ Further “bizarre” and “erratic” behaviours towards her neighbours were reported in 2022[1].

[1] Police, District Nurses, and family members reported bizarre and erratic behaviours. Concerns were shared with Adult Social Care.

These episodes also resulted in contact with the police, although no charges were brought – it was understood by her neighbours that she was not mentally well.

Learning

Despite concerns about Poppy's mental health, the main focus of services was on Poppy's Diabetes, including self-management and treatment, and associated risks while the deterioration in her mental health remained untreated. Poppy's daughter summarises her views as follows:

"I feel that if in November 2022 if all services had worked together so the police and district nurses along with mental health here they would of seen my mums behaviour and fully realised she was having a psychotic episode and needed that extra care like she had in 2019." (Daughter of Poppy)

In the case of Poppy, underlying vulnerabilities for the management of her diabetic condition were compounded by underlying mental health needs, failing eyesight, age, lifestyle and dietary factors, bereavement, and social isolation. Research suggests that mental health problems are more common among people living with type I diabetes than in the general population [5, 6] with poor outcomes for both conditions [7]. Individuals living with diabetes and mental health problems quality of life is worse, diabetes self-management is impaired, the incidence of complications is increased, and life expectancy is reduced [8]. The challenges faced by people with diabetes and experience of mental illness are complex and multifactorial, requiring an integrated approach and support and care from an effective multi-disciplinary team yet often diabetes and mental health conditions are managed and treated separately [9].

Integrated care can be achieved through a number of routes. The two main models of integrated care involve structural and virtual integration. Structural integration requires that different organisations either be merged or have some sort of formal partnership or joint-venture arrangement. Virtual integration requires only that the organisations work closely together (Grant, 2010). To respond to the needs of individuals with co-existing mental health needs and diabetes, a virtual integration could involve the statutory and voluntary sector, and service user representatives, with expertise in diabetes and mental health.

Table 1 sets out some examples of common approaches to virtual integrated care.

Approach	Examples
Improve awareness and expertise	Education and training Guidance and factsheets Knowledge-share Newsletters and communications
Regular interface	Diabetes & Mental Health Network Regular MDT meetings Specialist roles or team link roles Regular shared team meetings
Case-based integration	Reciprocal Screening tools Joint assessment or treatment clinic Case-based MDT Open communication for opinion or consultation

Table 1: Examples of approaches to virtual integration in health and social care

The benefits of integrated care have been well-demonstrated, and include improved outcomes for patients through high-quality care from well-trained local teams in relation to reductions in hospital admissions, delayed discharges, and reduced wait for social care assessment and interventions (Grant, 2010).

Finding 2: Mental Health and Diabetes

Context

Research suggests that mental health problems are more common among people living with type I diabetes than in the general population [5, 6] with poor outcomes for both conditions [7]. Individuals living with diabetes and mental health problems quality of life is worse, diabetes self-management is impaired, the incidence of complications is increased, and life expectancy is reduced [8].

Rationale

The challenges faced by people with diabetes and experience of mental illness are complex and multifactorial, requiring an integrated approach and support and care from an effective multi-disciplinary team yet often diabetes and mental health conditions are managed and treated separately [9]. This means can result in a silo approach to treatment of mental health and physical health, or a tendency to focus on the most pressing issue at any one time.

Recommendation

Health and social care services should identify opportunities for integrated care for individuals with co-existing mental health and diabetes conditions.

TOR 3: Mental capacity

How do agencies address the issue of mental capacity, autonomy, and freedom of choice?

Background

The Mental Capacity Act 2005 “provides the statutory framework for people who lack capacity to make decisions for themselves” (DCA, 2007). Mental capacity law is concerned with an individual’s ability to make a particular decision at a particular time. The Mental Capacity Act 2005 defines a lack of mental capacity as the inability to make a decision in relation to a matter because of an impairment, or disturbance in the functioning of, mind or brain. The principles to the Mental Capacity Act, designed to protect individual’s rights to make decisions, assume that individuals are able to make decisions unless established otherwise (principle 1), require individuals to be supported to make decisions before they can be considered to lack capacity (principle 2), and prevent a person from being treated as lacking capacity simply because they make an unwise decision.

In the case of Poppy, of greatest concern to professionals were decisions that impacted on Poppy’s diabetes; those involving medical treatment and insulin compliance, lifestyle, and diet. Where capacity was considered, it was related to Poppy’s ability to consent to treatment and follow diabetes self-management plans, including self-administration of insulin injections. Consent is a requirement for all treatment given by professionals. Consent relies on three conditions being met:

1. The individual has been given sufficient information to be able to give consent.
2. The individual has mental capacity to give consent.
3. Consent is given freely – without coercion or undue influence.

Lessons learned

Concordance is a term used to describe the degree to which an individual follows the treatment plan. Where medication compliance implies an individual 'obeys' the medication regime, medication concordance means that the person chooses to follow the regime. A number of factors have been identified that influence patient-concordance with diabetes treatment:

- Self-perception: Lots of people don't feel unwell.
- Mental health: depression, and negative symptoms of mental illness can lead to a lack of volition, or care about self-wellbeing.
- Mental capacity and impaired decision-making (including lack of executive capacity).
- Suicidal ideation: Individuals may mismanage diabetes to cause or hasten death[2].
- Motivation, stubbornness, and personality: "I will eat what I want to eat."
- Life events: such as bereavement and grief.
- Trust: Relationships with professionals, acceptance of professional views.
- Family relationships: Dependence on others for practical support and advice.
- Attention: increasing others' concern can result in increased response.
- Difference between understanding and believing risk and severity.
- Capability: Ther physical or intellectual ability to self-administer insulin.

In the case of Poppy, professionals who knew her were satisfied that any mental impairment she may have suffered did not prevent her from being able to make a decision for herself in relation to medical treatment, dietary choice, and self-management of her diabetes. The view taken was therefore that Poppy had fully understood the risks and consequences of non-concordance (non-compliance) with the treatment plan, but that she was within her right to make her own decisions. A previous Safeguarding Adults Review in Cumbria notes that there are many reasons that individuals make unwise choices or decisions, but that people rarely choose to neglect themselves, such that self-neglect is the consequence, not the decision (Halliwell, 2022).

It is therefore important that practitioners are able to consider what decisions are being made that lead to the consequence of self-neglect, in this case medical self-neglect of diabetes treatment.

Finding 3: Treatment-concordance and decision-making

Context

The principles to the Mental Capacity Act, designed to protect individual's rights to make decisions, even unwise decisions. Concordance is a term used to describe the degree to which an individual follows the treatment plan. A number of factors influence concordance with diabetes treatment, and choices that can result in medical self-neglect.

Rationale

A previous Safeguarding Adults Review in Cumbria notes that there are many reasons that individuals make unwise choices or decisions, but that people rarely choose to neglect themselves, such that self-neglect is the consequence, not the decision [7]. It is therefore important that practitioners are able to consider what decisions are being made that lead to the consequence of self-neglect, in this case medical self-neglect of diabetes treatment.

Questions for the Safeguarding Adults Board

How can the Safeguarding Adults Board support practitioners to explore individuals' decision-making and the factors behind unwise choices that result in a risk of self-neglect?

[2] There were particular concerns about Poppy's depression and suicidal ideation: Poppy was known to omit insulin to intentionally cause Diabetic Ketoacidosis (DKA) in attempts to end her life.

TOR 4: Risk assessment

How do agencies assess risk and what was the professional understanding of the risks facing Poppy. Did this/how did this differ from Poppy's own views?

Background

Risk and uncertainty are common concepts in health and social care. It is often impossible to predict with any certainty the outcome of any specific decisions or treatments. Uncertainty implies a situation where future events are not known. Uncertainty cannot be measured, it cannot be controlled for, and it cannot be managed. In order to minimise adverse outcomes, practitioners instead consider the probability, or likelihood, of those events based upon available information. The term risk describes "the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others" (Morgan, 2007). Unlike uncertainty, risks can be measured, can be managed, and to a certain extent, can be controlled.

Risk assessment involves gathering information and undertaking an analysis of risk factors including vulnerability and protective factors in an attempt to quantify the likelihood of a certain event taking place. Risk management is the formulation of a plan to avoid or reduce the impact of negative outcomes; it is the attempt to manage or reduce the likelihood of risk events that have not happened yet. For example, if an individual with type I diabetes omits their insulin medication, and consumes an unhealthy diet, the risk of Diabetic Ketoacidosis is high. Eating a healthier diet and following a medication regime, can significantly lower the risk. Assessing and managing risk in health and social care can be challenging and complicated. Practitioners may often need to assess multiple risks related to medical, psychological, and social factors, and these risks may often be interrelated and complex.

Lessons learned

In the case of Poppy, risks assessments were carried out by various agencies involved in her care, or in contact with her in different settings. The categories of risk analysed by agencies included risks to self, risks of self-neglect, risks of non-concordance with treatment, risks from others, and risks to others. Table 2 summaries the main risks identified in the case of Poppy.

Risk area	Risk	Service	Safeguarding category
To self	Not taking insulin	Physical health	Self-neglect
	Distress at home visits	Physical health	
	Disengagement	Various	
	Suicide	Mental health	
	Health & wellbeing	Social care	
	Cancel package of care	Social care	Self-neglect
From others	Fraud	Police	Financial abuse
	Financial abuse	Social care	Financial abuse
To others	Verbal abuse	Various	
	Petty theft (e.g., milk)	Police	
	Harassment	Police	

Table 2: Summary of main categories of risk assessment in the case of Poppy

In Poppy's case risk assessments were carried out by individual agencies, mostly in isolation and outside a multi-agency forum – risks of self-neglect, financial abuse, and harassment of neighbours were never joined-up. With the benefit of hindsight, it is possible to see how actions taken to address one risk may have unintended consequences to another. An example of this was an attempt to address the risk of distress to Poppy caused by daily home visits and administration of insulin, and the associated risk of verbal abuse towards staff. A plan was that in order for a home visit to take place, Poppy would need to contact the team to consent and confirm she was happy for a practitioner to visit. This plan reduced the risk of home visit-distress, and verbal abuse towards staff, however the unintended, although predictable, consequence was a reduction in contact with professionals, an increase in disengagement, and a worsening of non-concordance with insulin.

A multi-agency approach, while not always indicated, may have supported the assessment of the interconnectedness of risks in different areas, joined up different areas of risk, and improved the information available. In the analysis of probabilities and likelihoods more information and expertise results in greater accuracy, better risk analysis, and more effective risk management.

Finding 4: Interconnected risk

Context

The term risk describes "the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others" [8]. Unlike uncertainty, risks can be measured, can be managed, and to a certain extent, can be controlled. Risk management is the formulation of a plan to avoid or reduce the impact of negative outcomes; it is the attempt to manage or reduce the likelihood of risk events that have not happened yet. Assessing and managing risk in health and social care can be challenging and complicated.

Rationale

Practitioners may often need to assess multiple risks related to medical, psychological, and social factors. Risks may often be interrelated and complex – actions taken to address one risk may have unintended consequences in another. A multi-agency approach, while not always indicated, may have supported the assessment of the interconnectedness of risks in different areas, joined up different areas of risk, and improved the information available. In the analysis of probabilities and likelihoods more information and expertise results in greater accuracy, better risk analysis, and more effective risk management.

Recommendation

In the practice of risk management, practitioners should be encouraged to analyse the interconnectedness nature of risk. In cases of complexity and high-risk this should be done in a multi-agency forum, an MDT or safeguarding process.

TOR 5: Self-neglect

How do agencies in Cumbria interpret the definition of self-neglect? What sort of behaviours are included or excluded? How did this interpretation of self-neglect impact on decision made in this case?

Background

Care and Support Guidance defines self-neglect as encompassing "a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding" (DHSC, 2023). There has been a significant amount of research into self-neglect, adding to the statutory description of self-neglect three recognisable forms of self-neglect. Cumbria's self-neglect guidance (CSAB, 2021) summarises these as follows:

1. **Lack of self-care**, this may involve neglecting personal hygiene, nutrition and hydration or health. This type of neglect would involve a judgement to be made about what is an acceptable level of risk and what constitutes wellbeing.
2. **Lack of care of one's environment**, this may result in unpleasant or dirty home conditions and an increased level of risk in the domestic environment such as health and safety and fire risks associated with hoarding. This may again be subjective and require a judgement call to determine whether the conditions within an individual's home environment are acceptable.
3. **Refusal of services that could alleviate these issues**, this may include the refusal of care services, treatment, assessments, or intervention, which could potentially improve self-care or care of one's environment.

Research into self-neglect on the causes and risk factors for self-neglect often focuses on health-related or underlying medical causes connected to an individual's own capabilities, illnesses, and mental health. Commonly cited causes in research (SCIE, 2018), (Abumaria, 2020) and Cumbria's own self-neglect guidance (CSAB, 2021) include, but are not limited to:

- Dementia.
- Brain injury.
- Obsessive Compulsive Disorder.
- Physical illness, reduced energy levels, attention, or organisational skills and motivation.
- Reduced motivation as a side effect of medication.
- Addictions, including alcohol or drug dependency / misuse.
- Social isolation.
- Traumatic life-change, such as a loss of a carer or loved one.
- Age related changes in physical or mental health.
- Chronic mental health difficulty.
- Fear and anxiety.

The self-neglect guidance also includes useful sections on indicators of self-neglect, factors that may lead to individuals being overlooked, and guidance on determining the level of risk faced by the individual.

Lessons learned

Poppy's case would have fallen into the definitions of self-neglect in statutory and local guidance. Her refusal of services and treatment, and lack of self-care would have placed her at risk of self-neglect, and at high-risk of harm – "refusal of health / medical treatment that will have a significant impact on health/wellbeing (CSAB, 2021).

Guidance suggests that in such circumstances incidents must be reported to Designated Safeguarding Leads, and that safeguarding adults procedures should be initiated to manage risks. In the case of Poppy concerns were raised to safeguarding, and procedures were intended, however this happened relatively late in the case chronology, and Poppy sadly died before multi-agency safeguarding procedures could begin.

The effectiveness of approaches to self-neglect depends on a number of factors including the circumstances and causes of self-neglect, the tension between autonomy and duty of care, and the need for "a person-centred, relationship-based approach based upon developing trust, exploring the reasons for self-neglect and individual perspectives and preferences, offering support, and negotiating interventions" (Preston-Shoot, 2018). While there is no certainty that multi-agency safeguarding procedures would have been able to change the outcome in Poppy's case, safeguarding procedures may have helped to reduce the risk of harm resulting from self-neglect.

Finding 5: Using the CSAB Self-Neglect Guidance

Context

Poppy's case would have fallen into the definitions of self-neglect in statutory and local guidance. Her refusal of services and treatment, and lack of self-care would have placed her at risk of self-neglect, and at high-risk of harm – "refusal of health / medical treatment that will have a significant impact on health/wellbeing [9].

Rationale

Cumbria Safeguarding Adults Board has published guidance on self-neglect that provides information on definitions of self-neglect, indicators of self-neglect, factors that may lead to individuals being overlooked, and guidance on determining the level of risk faced by the individual and possible responses. In the case of Poppy, the safeguarding procedures proposed by the guidance were not triggered until relatively late on in the case. While there is no certainty that multi-agency safeguarding procedures would have been able to change the outcome in Poppy's case, safeguarding procedures may have helped to reduce the risk of harm resulting from self-neglect.

Recommendation

Cases of high-risk self-neglect should be referred to safeguarding under the self-neglect guidance at the earliest opportunity. The Safeguarding Adults Board may need to re-launch or raise the profile of the self-neglect guidance in relation to neglect of health conditions and refusal of treatment that may have a significant impact on health and wellbeing.

TOR 6: Professional curiosity and challenge

How do agencies in Cumbria apply the principle of professional curiosity in safeguarding practice?

> **Curiosity,** n. **1** a strong desire to know or learn something. **2** An unusual or interesting object (OED, 2006).
>
> **Professional curiosity**, n. "the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value" (CSAB et al., 2022)

Professional curiosity is a term which has been used often in Safeguarding Children Serious Case Reviews and Child Practice Reviews, and increasingly in Safeguarding Adults Reviews alongside related terms such as 'respectful uncertainty', and 'think the unthinkable'. It is often used to describe the situation where evidence or signs of abuse have been missed, where explanations have been accepted that later turn out to be false, or where a professional fails to follow up on what later turns out to be a crucial line of enquiry.

In most cases, identifying issues of professional curiosity requires a degree of hindsight. This, combined with the necessary focus on individual professional practice, introduces a risk of hindsight bias and outcome bias – judgements on professional practice based upon the outcome, rather than the professional's decision-making processes, or systems context.

Effective learning about professional curiosity should therefore be done sensitively and the outcome should be to encourage practitioners to nurture and develop critical thinking and intuitive assessment skills, rather than to judge or fault-find. Developing professional curiosity is a matter of nurturing a 'strong desire' among practitioners to **know or learn something** about what is happening in an individual's life and **taking action** when evidence of abuse, neglect, or self-neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice:

- **Accumulating risk:** Professionals can deal with risk and incidents in isolation rather than viewing the increase or repeating risk in cumulation.
- **Confirmation bias:** Professionals looking for evidence that supports their preconceived ideas/views.
- **Rule of optimism:** Rationalising new or escalating risks, even though there may be evidence to the contrary.
- **Disguised compliance:** Giving the appearance of engaging with professionals to reduce or deter involvement.
- **Knowing but not knowing:** Professionals sense that something is not right, but not knowing exactly what. Can be difficult to take action.
- **Uncertainty:** Unsubstantiated claims, retracted disclosures, contested accounts and inconclusive evidence. All common and temptations can be to discount concerns where there is no proof.
- **Managing tension:** Disagreement, defensiveness disruption and aggression can deter professionals from getting to the real issues.

From a joint learning session on professional curiosity (CSAB, CSPC, & SaferCumbria, 2023).

Lessons learned

It is perhaps this last barrier that was most apparent in the case of Poppy. Throughout the chronology, professionals record high levels of defensiveness, reluctance to engage, and avoidance. Poppy could be verbally abusive to staff, would demand visiting professionals leave her home, and would often go away on holiday without letting practitioners know where she was going, or arranging for insulin supplies while she was away. Agencies responded differently to the 'tension' in Poppy's case, including as described in previous sections, making safeguarding plans requiring Poppy to proactively contact the team in order to access a visit.

The lessons learned about professional curiosity amplify learning and recommendations in other terms of reference already discussed: effective Multi-Disciplinary Team (MDT) processes, the analysis of interconnected risk, and the importance of multi-agency safeguarding procedures for high-risk cases of self-neglect.

Finding 6: Overcoming barriers to professional curiosity

Context

Professional curiosity is “the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value” [2]. It is often used to describe the situation where evidence or signs of abuse have been missed, where explanations have been accepted that later turn out to be false, or where a professional fails to follow up on what later turns out to be a crucial line of enquiry.

Rationale

Developing professional curiosity is a matter of nurturing a ‘strong desire’ among practitioners to know or learn something about what is happening in an individual’s life and taking action when evidence of abuse, neglect, or self-neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.

Recommendation

Organisations in Cumbria should implement the cross-Board ‘Professional Curiosity: Guidance for Practitioners’ paying particular attention to actions organisations can take to support professional curiosity.

Summary of recommendations

No.	Finding	Rationale	Recommendation/Questions for the Safeguarding Adults Board
1.	Partnership working and the MDT	There are currently no formal procedures or standardisation of MDT meetings, although MDTs are widely used and universally felt to be beneficial. MDT practices are valued and the formalisation of MDTs to a risk procedure is unlikely to prove beneficial. However, there are still ways that MDTs could be made more inclusive and effective through guidance or training.	Cumbria Safeguarding Adult Board publish a “Guide to effective MDT working”.
2.	Mental health and Diabetes	The challenges faced by people with diabetes and experience of mental illness are complex and multifactorial, requiring an integrated approach and support and care from an effective multi-disciplinary team.	Health and social care services should identify opportunities for integrated care for individuals with co-existing mental health and diabetes conditions.
3.	Treatment concordance and unwise decisions	There are many reasons that individuals make unwise choices or decisions, but that people rarely choose to neglect themselves; self-neglect is often the consequence, not the decision [7]. It is important that practitioners are able to consider what decisions are being made that lead to the consequence of self-neglect.	How can the Safeguarding Adults Board support practitioners to explore individuals’ decision-making and the factors behind unwise choices that result in a risk of self-neglect?
4.	Interconnected risk	Practitioners may often need to assess multiple risks related to medical, psychological, and social factors. Risks may often be interrelated and complex – actions taken to address one risk may have unintended consequences in another. In the analysis of probabilities and likelihoods more information and expertise results in greater accuracy, better risk analysis, and more effective risk management.	In the practice of risk management, practitioners should be encouraged to analyse the interconnectedness nature of risk. In cases of complexity and high-risk this should be done in a multi-agency forum, an MDT or safeguarding process.

No.	Finding	Rationale	Recommendation/Questions for the Safeguarding Adults Board
5.	Using the CSAB Self-Neglect Guidance	Cumbria Safeguarding Adults Board has published guidance on self-neglect that provides information on definitions of self-neglect indicators of self-neglect, factors that may lead to individuals being overlooked, and guidance on determining the level of risk faced by the individual and possible responses. In the case of Poppy, the safeguarding procedures proposed by the guidance were not triggered until relatively late on in the case. While there is no certainty that multi-agency safeguarding procedures would have been able to change the outcome in Poppy's case, safeguarding procedures may have helped to reduce the risk of harm resulting from self-neglect.	Cases of high-risk self-neglect should be referred to safeguarding under the self-neglect guidance at the earliest opportunity. The Safeguarding Adults Board may need to re-launch or raise the profile of the self-neglect guidance in relation to neglect of health conditions and refusal of treatment that may have a significant impact on health and wellbeing.
6.	Overcoming barriers to professional curiosity	Developing professional curiosity is a matter of nurturing a 'strong desire' among practitioners to know or learn something about what is happening in an individual's life and taking action when evidence of abuse, neglect, or self-neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.	Organisations in Cumbria should implement the cross-Board 'Professional Curiosity: Guidance for Practitioners' paying particular attention to actions organisations can take to support professional curiosity.

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