Cumbria Safeguarding Adults Board

Thematic Safeguarding Adult Review

Self-Neglect

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Cumbria Safeguarding Adults Board

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Introduction

Cumbria Safeguarding Adults Board's self-neglect thematic Safeguarding Adult Review (SAR) considers six individuals who died in circumstances of self-neglect. Previous SARs had already led to improvement actions but given these further deaths, the Board wished to identify remaining systemic barriers to good practice and what further actions could improve safeguarding.

The thematic review sought chronologies of agencies' involvement with the six individuals as well as reflective and evaluative reports from agencies. In addition an online event, attended by 120 people representing over 20 agencies from across Cumbria, explored strengths and challenges in current self-neglect practice. The independent reviewer worked with a panel of senior agency representatives to analyse and extract the learning that could inform improvement priorities.

Findings

1. Meeting needs

The six individuals had complex, multiple needs relating to physical and mental health as well as to daily living and personal care. Many had faced challenges in their lives and had personal histories in which trauma and loss were notable features.

While there was some good practice by specialist services that could focus on one aspect of need, such as alcohol dependency, there were multiple barriers to broader and complex needs being recognised and met. Services did generally respond appropriately to acute physical health needs, but acute episodes were often followed by withdrawal, either by the individual or of the service. This meant that agencies rarely gained a full needs picture and root causes were not addressed. Practitioners sometimes did not see beyond the function of their own agency, missing opportunities to recognise the fuller picture and seek help from other agencies. Most individuals found making contact and keeping appointments with services difficult and signposting generally did not work; more direct practical support to attend was needed. Agencies struggled to overcome individuals' reluctance to engage and did not therefore gain clear understanding of the extent of their needs.

Yet even when needs were evident, they were sometimes not met. Practitioners took at face value individuals' reassurance that support was not needed. In some cases no Care Act assessment took place and no carer's assessment was offered. In one case where eligible needs were identified it was assumed they were being met by the individual's friend, despite contrary evidence. In another, where the individual's reluctance to accept support meant that their needs were not being met, no review or escalation took place. Another individual presented a very clear need and request for practical support to clear accumulated waste, yet no agency took responsibility for assisting him with arrangements that he was himself unable to make due to his level of distress.

A focus on presenting need at the cost of more deep-seated features results in a lack of holistic understanding. While the immediate context may call for presenting need to be met, more persistent approaches are also needed: greater levels of professional curiosity, better understanding of the individual's lived experience and assertive outreach in the provision of support. At the same time, self-neglect can present needs that are no single agency's responsibility, requiring discussion and shared decision-making to ensure that they are recognised and met.

2. Managing risk

The risks from self-neglect were sometimes recognised, proactively assessed and managed. In all cases, however, there were shortcomings.

- **Risks were not identified:** particularly those arising from the individual's mental state and self-neglect. For example, in one case a mental health triage recorded minimal risk and made no risk management plan, despite multiple risk factors being evident.
- **Known risks were not managed:** in three of the cases fire hazards were identified but not all necessary action was taken. Hazards remained but no escalation took place. In another case, cuckooing and exploitation/financial abuse were not explored as safeguarding issues.
- **No shared risk assessment took place:** where multiple agencies were involved, risk assessments were not shared and no shared risk management plan was made, resulting in individual agencies having a limited understanding of the risks the individual faced.

Formal safeguarding processes were inconsistent, with self-neglect sometimes not recognised as a safeguarding issue and weaknesses at decision-making points within the safeguarding pathway.

- **Referrals were not made:** There are multiple pathways for raising concerns and the criteria for referring self-neglect into safeguarding appear insufficiently understood. Referrals were not made where they would have been justified and for some it seems the CSAB threshold tool discouraged safeguarding referrals. In one case, attention was limited to physical injuries and medical condition, overlooking self-neglect. In another, an agency did not refer because they assumed others would. Elsewhere, practitioners simply did not recognise the need for referral and/or did not consult their agency's safeguarding specialists for advice.
- **Referrals were triaged out of safeguarding:** Even when referred into safeguarding, self-neglect may be diverted away from a S.42 pathway, sometimes with the CSAB threshold tool applied to inform this decision – a use for which it was not intended. Repeated safeguarding referrals may be considered in isolation, ignoring the cumulative evidence and without consultation with operational teams involved. The requirement to refer into safeguarding by phone is thought to risk case detail being lost in translation, resulting in decisions made on incomplete information.
- **Risk was assumed to be managed within case management:** Care and support involvement influenced decisions not to act under safeguarding, but managing self-neglect through a case management pathway resulted in insufficient engagement with risk elements in the individual's situation. Adult Social Care suggest a risk management process is needed that sits between safeguarding and case management and operates in parallel to them.

Overall, agencies have not worried enough about the risks arising from an individuals' self-neglect. Assumptions of lifestyle choice, assumptions of capacity, respect for privacy and lack of professional curiosity can all mitigate against gaining a true risk picture.

3. Making safeguarding personal

The principle of respect for individuals' views and wishes was seen as central to the work of all agencies and individuals' perspectives were certainly sought. The task of identifying views and wishes was often complicated, however, by individuals' reluctance to engage, by intoxication and intimidation, or the presence of others. In one case, failure to adapt communication methods to suit needs and preferences resulted in views being expressed primarily through a family member.

At the other extreme, individuals' views were sometimes prioritised over all else, with their refusal of support accepted at face value, without further professional curiosity, resulting in case closure. In one case, an individual's ability to take action to achieve a stated goal was overestimated, failing to allow for how alcohol dependency and mental ill-health was impacting on their motivation and ability to act, and leaving him without support.

4. Protected characteristics

Any public body must comply with the Equality Act 2010, which protects people with protected characteristics from unlawful discrimination. There was evidence of some adjustment of practice in response to disability, for example home visits rather than surgery consultations, and of age, disability and gender informing Police contacts. But very few protected characteristics were explicitly identified and it is unclear to what extent agencies record this information or ensure their practice is compliant. There was no evidence of attention to race, religion and sexual orientation.

5. Mental capacity

Capacity assessment was often absent in circumstances that warranted assessment taking place. In most cases the individual's behaviour continuously placed them at serious risk, yet there was a widespread reliance on an assumption of capacity rather than explicit assessment under the Mental Capacity Act. In some cases, the individual's alcohol dependency was well-known and related cognitive impairment could have been affecting their decision-making. The impact of persistent, heavy alcohol consumption on executive brain function is increasingly recognised as a key consideration in mental capacity and the lack of attention to it here was a serious omission.

There was some uncertainty about which agency should take responsibility for capacity assessment. Where assessments were undertaken, they were sometimes poorly completed. A further omission, where an individual lacked capacity to understand their care and support needs, was the absence of any subsequent best interests decision about how to keep them safe through the provision of support.

6. Family networks

In two cases, agencies took initiative in contacting families, one conducting a search (albeit unsuccessful) for family members so that concerns could be shared and another requesting background information to assist in understanding an individual's presentation. In most cases, however, agencies' only contact with families was when families sought it and even there the weight placed on their involvement varied. One relative was a key informant and decision-maker, reducing the amount of direct discussion with the individual. Another provided information that was not pursued in triaging the individual's needs and appeared not to affect the outcome. In yet another, an agency's previous involvement with the individual's partner was not considered.

7. Interagency working

Agencies had good understandings of each other's role and function and there was some good practice in sharing information and joint work but differences of opinion, particularly about safeguarding thresholds, were common, with no recourse sought to the CSAB escalation policy.

There were also, however, multiple shortcomings in information-sharing. GP surgeries and the Fire and Rescue Service in particular felt out of the information loop. In one case, misinterpretation of

data protection rules resulted in information not being shared when it should have been. Lack of feedback on the outcome of safeguarding (and other) referrals was a common concern. In other instances, failure to share information - that an individual had mental health problems, or had not collected their medication, or had been discharged from hospital - impacted negatively upon outcomes.

Interagency coordination can be promoted by the use of interagency risk management meetings and in one case, safeguarding meetings did result in effective risk management for a period. In other cases, however, where health-led multidisciplinary meetings were held their membership was insufficiently broad to impact on the overall strategy. Very few system-wide meetings took place. Silo-working was common, with a disconnect between health and social care agencies and no shared plan. It was sometimes unclear who was responsible for what aspect of intervention, and which agency, if any, was in an overall coordinating role. With no multiagency discussion, piecemeal communication failed to achieve constructive progress. The pressures of workload, capacity and competing priorities also influenced agencies' ability to work together.

It is hard to avoid the conclusion that interagency working was neither consistent nor effective. Given these difficulties, there have been calls for a new pathway for concerns that do not fit safeguarding criteria in order to promote shared safety planning and risk management.

8. Organisational systemic factors

Service provision is directly impacted by organisational structures, culture, systems, resources, staffing, management, workflow, training and support. This thematic SAR therefore sought information on the organisational context in which practice took place in these six cases.

All agencies provide training and guidance on safeguarding, although some offer limited or no coverage of self-neglect and some did not go far enough in addressing specific skill development needs. Support structures include supervision, specialist advice, decision-making tools, management scrutiny, legal advice and dissemination of SAR learning. CSAB policies and tools are routinely available and some agencies have guidance on specific aspects of practice. Organisational structures too are sometimes adapted to facilitate vigilance about self-neglect, as in the introduction of a hospital incident category for self-neglect that triggers safeguarding team oversight. In similar vein, a new housing management reporting module provides a more thorough recording and reporting process.

Support systems in place, however, were not always used. Management scrutiny and supervision were sometimes missing. Decision-making tools and guidance sometimes did not inform practice decisions. Some services were in a state of change or were introducing new policies, structures or operational procedures; these affected one individual's ease of contact with their GP and another's mental health triage, as well as Police decision-making on a welfare visit request. Some teams had staffing pressures that limited capacity to undertake timely assessments and to allocate the time necessary to work effectively. One local authority saw achieving a better balance between resource and demand requirements and reducing reliance on an external workforce as an urgent priority.

9. SAB governance

In this review, the only mention of CSAB's governance role was in relation to the safeguarding threshold tool. While intended as a resource to assist decision-making about referral into

safeguarding, it seems it can act as a barrier to safeguarding action and in one case it became the source of confusion, professional disagreement and delay.

10. National context

The interventions featured in this review took place in the immediate aftermath of the Covid pandemic. All services had experienced extreme pressures that for some were still ongoing. Despite this, relatively little impact on practice with these six individuals was attributable to the pandemic.

11. Current practice

The temperature check event explored participants' perspective on what is working well now in self-neglect practice across Cumbria and what improvements are needed. While positive changes have taken place, multiple challenges remain. The most consistently mentioned related to mental capacity, assumptions of lifestyle choice, lack of clarity on legal rules, focus on immediate symptoms rather than underlying causes and premature case closure. Many of these are systemic, with their roots in organisational factors that inhibit direct work.

At the level of interagency working, there are ongoing challenges in bringing agencies together, particularly outside of safeguarding pathways, establishing responsibilities, ensuring leadership and case coordination and keeping communication channels open. Resource challenges are common too with workloads and time constraints continuing to impact on practice, gaps in implementing trauma-informed practice, fragility in the voluntary sector and a lack of preventive services.

The priorities for action identified by participants show that service improvement requires systemic change. Actions can be taken on an individual level, but improvement relies on organisational level changes within and between agencies, to create the context in which best practice can flourish.

12. Concluding points

Self-neglect presents in diverse ways. The six individuals in this thematic SAR experienced physical, mental and emotional ill-health, absence of hygiene and personal care, substance dependency, home conditions of squalor and decay, hoarding and withdrawal from social contacts. The life experiences that contributed to their self-neglect were equally diverse. This diversity poses challenges of recognition and understanding. Nonetheless there are key markers of practice that apply in every case: professional curiosity, perseverance and trust, consideration of mental capacity, holistic appraisal of need, understanding of trauma, robust evaluation of risk. The challenge for agencies is to ensure that practitioners are not only skilled in these approaches but also able to use them. This requires flexible, supportive organisational systems and strong interagency collaboration.

The learning from this thematic review surfaces familiar themes from CSAB's previous self-neglect SARs – a picture that is repeated at national level in the second national analysis of SARs (2024[1]), where self-neglect features in 60% of all SARs completed between 2019 and 2023. This bears witness to the challenges that are posed by self-neglect but when those challenges are juxtaposed with the acute and ongoing resource constraints experienced within health and social care, the

[1] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

result can be a perfect storm. Resources of all kinds are in short supply and these constraints clearly influence agencies' ability to implement best practice.

The terms of reference for this thematic SAR sought to determine the degree to which the six principles of safeguarding, as set out in the statutory guidance[2], are in evidence across the six cases. There are both strengths and shortcomings in how each is demonstrated.

- **Prevention:** Do we take preventive action before harm occurs? While there are examples of preventive risk management, interpretation of safeguarding thresholds can be a barrier to taking action to prevent harm; there is uncertainty about pathways for interagency risk management below the safeguarding threshold.
- **Protection:** Do we protect and support those at greatest risk? While some risks were managed well, there were also some serious omissions and errors that resulted in risk going unchecked.
- **Accountability:** Do we deliver accountable safeguarding? While systems and structures to support practitioners exist, these do not always inform decision-making in practice.
- **Partnership:** Do we deliver an effective multiagency response? While there are some examples of good interagency collaboration, silo-working remained in evidence, with inconsistent information-sharing and absence of shared decision-making.
- **Empowerment:** Are people supported and encouraged to make their own decisions? Do their views inform agencies' interventions? Although individuals' views and wishes were sought, high-risk wishes were sometimes taken at face value without further exploration or consideration of mental capacity. This left risk unmanaged and signals perhaps an over-simplified interpretation of what making safeguarding personal means.
- **Proportionality:** Are we able to provide the least intrusive response appropriate to the risk presented? Proportionality is about judging the intervention that will address the level of risk present. In these cases, absence of action is more evident than over-zealous action. Responses were often insufficient to safeguard the individual and were therefore not proportionate.

Cumbria SAB has already led improvement action in self-neglect but implementing change takes time, particularly in the context of financial constraint, resource shortage and workload pressures facing agencies across the partnership. Yet the human stories of our six individuals and the learning from the tragic outcomes they experienced cannot fail to support the motivation and commitment of CSAB and its partner agencies to take action to promote better outcomes in future work.

13. Recommendations

This thematic review recommends that CSAB exercises leadership on a range of improvement priorities designed to lead to specific actions with measurable impact.

- **Assessment:** Revised tools to prompt recognition and response to self-neglect need and risk; training and guidance on professional curiosity, trauma informed practice and reluctance to engage; audit of advocacy use and action to promote advocacy; assurance on compliance with the Equality Act 2010; assurance on the completion of assessments under the Care Act 2014.

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- **Mental capacity:** Audit of how capacity is addressed in self-neglect cases followed by measures to boost awareness and practice; review of resources and guidance.
- **Risk and safeguarding:** Review of the CSAB threshold tool and its use; mechanisms to trigger alerts to agencies' safeguarding leads to ensure advice is sought; electronic referral pathways for safeguarding referrals; audit of safeguarding triage in relation to self-neglect referrals.
- **Interagency working:** Map existing risk management pathways for cases that fall outside of safeguarding and consider a formal interagency risk management pathway (Multi-agency Adult Risk Management (MARM) or Vulnerable Adult Risk Management (VARM) process), ensuring clear differentiation of all pathways and transition points to ensure escalation where necessary; review availability of services, including Health and Wellbeing Coaching, for longer-term support for people on a self-neglect pathway and consider what commissioning is necessary to meet this need; commission interagency training on self-neglect to support stronger multiagency engagement and shared responsibility for intervention.
- **Guidance and training:** Review CSAB guidance on self-neglect and introduce 'bitesize' learning tools, accessible to all agencies, covering specific topics; review the self-neglect content within the safeguarding training used by agencies, and subsequent development of this content where required; audit of agencies' use of guidance, training and learning tools.
- **Organisational context:** Review of how agencies' operational procedures may create barriers to use of services by people who self-neglect and action to promote more flexible outreach; an interagency protocol to determine how practical tasks of support where individuals are unable to take action themselves can be provided; measures to ensure both emotional and practical support is given to family members who lose someone through self-neglect.
- **Agency assurances:** from Lancashire and South Cumbria NHS Foundation Trust on changes following their internal investigation and monitoring of triage decisions; from North Cumbria Integrated Care NHS Trust and from Cumberland Council on actions in response to Coroners' Prevention of Future Deaths processes; from all agencies on organisational changes identified during their own internal reviews and in their responses to this SAR.
- **Dissemination:** A learning event to disseminate the findings of the thematic review and CSAB's action plan for addressing its recommendations, with a further event 12 months later to evaluate progress, outcomes and further forward changes needed.