Executive Summary: Safeguarding Adult Thematic Review of Self-Neglect

1. This Thematic Safeguarding Adults Review was commissioned by the Luton Safeguarding Adult Board was commissioned to consider the circumstances and learning for agencies resulting from the death of adults Adult I and Adult J.

2. The focus of the thematic review was to consider the circumstances and learning for agencies resulting from the deaths of Adult I and Adult J, both of whom had significant issues with self-neglect.

3. Adult I was a 56 year old man of Black African ethnicity originally from Rwanda. He came to the UK in 1975 aged 10 years. He had lived in his local authority housing flat since 1994. In the early hours of a morning in April 2022, the Fire and Rescue Service was notified of a serious fire in the flat where Adult I resided. Bedfordshire police were already in attendance at the address. Adult I was found dead on scaffolding outside of the building. The fire had been started deliberately. Adult I suffered from diabetes and was known to agencies with significant safeguarding concerns with regards to self-neglect and hoarding. He was diagnosed with paranoid schizophrenia in 2012 and with a depressive disorder in 2008.

4. Adult J was a 75 year old White British man born in Hemel Hempstead and who had moved to Luton in the 1980s. He lived on his own in a semi-detached privately rented house. He had a number of health issues. The Ambulance Service was called to SS's home in May 2022; at that point, the general hygiene of Mr Savage's home was extremely poor. He had COPD, was incontinent of urine, had swollen ankles and was on oxygen daily when he required it. The neighbours reported to the Ambulance crew that SS had not been out of his home in months. Adult J was subsequently taken to hospital but died the next day.

5. The review aimed to evaluate the interventions provided, understand the lived experiences of these individuals and identify areas for improvement in safeguarding practices. Key areas of focus included the effectiveness of multiagency working, the timeliness of interventions, the understanding of the individuals' mental capacity, and the adequacy of guidance and resources available to practitioners dealing with severe self-neglect and hoarding.

The agencies involved in the review are listed at Appendix A, the key findings of the review were:

1. **Self-Neglect and Hoarding as Safeguarding Matters**:
    - Self-neglect and hoarding were not appropriately identified as safeguarding issues, leading to a lack of coordinated intervention.
    - Both men lived in extreme and squalid conditions, posing physical risks to themselves and potentially others.

- Practitioners expressed frustration over the failure of agencies to respond to these cases as significant safeguarding concerns.

2. **Ineffective Long-Term Intervention and Silo Working**:
   - Interventions were not effective in the long term, with agencies often acting in isolation.
   - There were delays and stop-start interventions that were not well-coordinated.
   - The local safeguarding system did not ensure timely and decisive action to safeguard the individuals.

3. **Lack of Effective Multiagency Working**:
   - There was a lack of effective multiagency working, resulting in no clear plan to safeguard the men.
   - MDT meetings about Adult J did not involve Adult Social Care (ASC).
   - The challenges presented by the men made it difficult for professionals to work with them, but this should have been overcome with better multiagency collaboration.

4. **Inconsistency in Case Handling**:
   - There was inconsistency in how the two cases were handled.
   - Even when self-neglect was recognized, it was not fully understood or explored as a safeguarding matter by all agencies.
   - There was a lack of professional curiosity and detailed personal history exploration in Adult I's case.

5. **Concerns About Mental Health and Cognitive Capacity**:
   - There was a lack of access to appropriate mental health support and cognitive capacity assessments.
   - Both men were self-neglecting, and their mental capacity was not always assumed or tested appropriately.
   - The relationship between mental capacity and cognitive impairment was relevant to their chronic self-neglect and living conditions.

6. **Impact of COVID-19 Lockdown**:
   - Changes to practice and visiting during the COVID-19 lockdown limited the degree of intervention.
   - Face-to-face interventions were stalled, leading to further deterioration in their circumstances.
   - There was more reliance on self-reporting and telephone assessments, which were not always followed up effectively.

7. Inconsistent Application of Mental Capacity Assessments:
   - Mental capacity assessments were not consistently applied, and there was a lack of access to appropriate mental health support. This was crucial for understanding the individuals' ability to make safe decisions and accept help.

These issues highlight the need for better identification and response to self-neglect, improved multiagency collaboration, timely and coordinated interventions, and thorough assessments of individuals' mental health and cognitive capacity.

Overall, the agencies' responses to self-neglect cases were characterised by a lack of recognition of the severity of the issues, isolated and delayed interventions, inadequate multiagency collaboration, and insufficient professional curiosity and assessment. These shortcomings highlight the need for improved identification, coordination, and timely intervention in self-neglect cases.

The review identified several examples of good practice in the handling of the self-neglect cases of Adult I and Adult J:

1. **Consistent Involvement by CCS Respiratory Team**:
   - The Cambridgeshire Community Services (CCS) respiratory team was consistently involved with Mr. SS, providing regular visits and support despite the challenging conditions. They held multidisciplinary team meetings and worked with various agencies to address his needs.
2. **Supportive Relationships**:
   - In Mr. SS's case, there was good practice in forming supportive relationships with him. The respiratory nurses maintained regular contact and tried to understand his needs and preferences, even when he was reluctant to accept help.
3. **Fire Safety Interventions**:
   - The Fire Service provided important interventions, such as conducting Home Fire Safety Visits, fitting smoke alarms, and offering advice to mitigate fire risks in both cases.
4. **Efforts to Engage and Support**:
   - Despite the challenges, there were efforts to engage and support both individuals. For instance, Mr. SS's daughter was involved in helping to clean his house, and there were attempts to move him to more suitable accommodation.
5. **Mental Capacity Assessments**:
   - In Mr. SS's case, there were multiple assessments of his mental capacity by the CCS respiratory nurses, which demonstrated an awareness of the need to consider his cognitive functioning and decision-making ability.
6. **Persistence During COVID-19**:
   - The CCS respiratory team continued to visit Mr. SS during the COVID-19 lockdown, providing doorstep assessments and support to reduce risks, despite the limitations imposed by the pandemic.

These examples of good practice highlight the dedication and efforts of certain professionals and agencies to provide support and address the needs of the individuals, even in the face of significant challenges.

The review made several recommendations:

1. Sharing Learning and Workshops:

- Share the learning summary locally and place it on the LSAB website.

- Hold multiagency workshops using these cases as case studies for learning.

2. **Develop New Safeguarding Procedures on Self-Neglect:**
    - Develop clear criteria for self-neglect, including safeguarding thresholds and intervention levels.
    - Create flowcharts for assessment, planning, and decision-making processes.
    - Use consistent language to safeguard individuals who self-neglect.
    - Conduct full multidisciplinary assessments involving family and social context.
    - Regularly audit cases to evaluate the quality of assessments and family involvement.
    - Establish specific timeframes for responses and multiagency intervention.
    - Provide advice on escalating concerns beyond a single agency.
    - Ensure quarterly oversight of high-risk self-neglect cases through a multiagency process.
    - Convene multiagency risk management meetings for high-risk cases.

3. **Policy and Training for Engaging Uncooperative Adults:**
    - Develop guidelines for working with individuals who are difficult to engage, considering mental capacity and cultural needs.
    - Appoint advocates for individuals considered under the s42 duty.
    - Conduct workshop training for practitioners on thresholds for single or multiagency involvement, promoting best interests of high-risk vulnerable adults, and early and regular mental capacity assessments.

These recommendations aim to improve the response to chronic self-neglect, ensure effective multiagency collaboration, and provide better support for practitioners dealing with complex cases.

Conclusion

Local agencies need to work together to address these recommendations and suggested actions. It is clear that there has already been some policy and procedural development locally in relation to cases of self-neglect involving hoarding. Above all, there is a need for speedier and more proactive responses in such cases of extreme self-neglect working whenever possible with the individual but also with their extended families

Beverley McConnell
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Appendix A: Agencies involved in the Review

- Bedfordshire Ambulance
- Bedfordshire Constabulary - Police
- Bedfordshire Fire Service
- Bedfordshire Hospitals Trust
- Beds Ambulance Service / East of England Ambulance Service
- BLMK CCG
- Cambridgeshire Community Services
- East London Foundation Trust
- GPs
- LBC Adult Safeguarding
- LBC Early Intervention Prevention
- Luton Adult Social Care
- Luton Borough Housing Dept
- Luton MASH
- Probation Service