Luton Safeguarding Adult Board

Report of Safeguarding Adult Thematic Review

Self-Neglect

Cases Adult I and Adult J.

Self-neglect is a safeguarding issue.

July 2023
Author – Amy Weir MA

Contents

Appendices

1. Introduction

This Safeguarding Adult Thematic Review (SAR) has been commissioned by the Luton Safeguarding Adult Board, following the holding of Rapid Review meetings, to consider the circumstances and learning for agencies resulting from the death of adults Adult J and Adult I. In both cases self-neglect was a concern. The home conditions in which both men were living were also a cause for concern.

Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). The Care Act 2014, sections 44(1), (2) and (3), requires that a Safeguarding Adults Review (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked better to protect the adult from harm. Under section 44(4) a SAR can be undertaken in other cases concerning adults with care and support needs.

The response to cases of self-neglect and concomitant poor living conditions and hoarding is a key challenge in services for adults. Self-neglect results in individuals being unable to care for their basic needs. For those involved, including family and friends, these cases are professionally and personally challenging as they are characterised by the individual suffering of harm whilst they pose considerable quandaries about how to resolve the issues. There are significant ethical and legal considerations, particularly where adults appear to have the mental capacity to refuse support. The focus of this Review is to consider the interventions in this case and to raise awareness of the lived experience of these two men.

“Self-neglect is associated with adverse outcomes and multiple comorbidities and can result in deterioration of physical and mental well-being; increased mortality; risk of fire, particularly related to hoarding; falls and trips; poor housing structures, lack of repairs, loss of accommodation, homelessness; infection or vermin; risk to others, including visiting professionals and emergency services; and increased use of health-care services, hospice care, hospitalisation, and emergency department visits.” IRISS 2022

2. Background to the Review

2.1 The Review considers two cases of self-neglect – Adult I and Adult J. These were chronic circumstances which resulted in poor outcomes for both men.

2.2 Adult I was at the time of his death 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. A Rapid review meeting was held on 30/06/2022.

2.3 Adult J was at the time of his death 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 J's home in May 2022; at that point, the general hygiene of Adult J'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 J had not been out of his home in months. Adult J was subsequently taken to hospital but died the next day. A Rapid review meeting was held on 21/07/2022.

3. Review's Scope and Focus

3.1 The review has been set up to focus on the following areas:

- Is there clear guidance within the safeguarding system about the thresholds for and methods of intervention in relation to severe self-neglect and hoarding? Were the criteria for a Section 42 considered? How did the local authority satisfy itself that an enquiry was not needed to help it to decide what action to take to support and protect the persons in question?
- Did practitioners demonstrate a good understanding of the lived experience and circumstances of these two individuals and if not, what were the barriers to this?
- Was the intervention provided timely or were there delays in responding, and if so, why?
- Did practitioners fully consider whether these two men had "capacity" to manage their daily lives and to keep themselves safe?
- Do practitioners know who they can turn to for expert advice and support (including through a trusted assessor approach) in these areas if an adult is at risk but uncooperative and inconsistent in their engagement with services?
- How well does commissioning function across the partnership to facilitate identification or creation of accommodation-based support that can meet complex needs and how responsive is this to periods of crisis?
- How does local availability of resources impact on care planning and safeguarding?

3.2 The overall timeframe set for the main focus of the thematic review is from December 2019 to May 2022. In particular the following are the key periods in each case.

Adult I - March 2020 – April 2022 – his death, aged 56 years.

Adult J - December 2019 – May 2022 – his death, aged 75 years.

There is also consideration of the earlier service involvement, where relevant, in both cases.

4. Review Methodology

4.1 A Systems Practice Model has been used as the methodology for this thematic SAR. It has focused on the actions and decisions of the individuals and agencies who were directly involved, to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken.

4.2 Reviews are designed to determine what agencies and individuals might have done differently that could have prevented harm.

4.3 The focus has been on the team, the service, the agency as a whole and the collective actions of agencies together as well as the responsibility of individuals to act professionally and to work effectively.

4.4 The review has been conducted with due regard to the principles of fairness, impartiality, thoroughness, accountability, transparency and above all with a focus on the experience of the client.

4.5 The SAR has built upon the learning from the key events chronologies and Individual Management Reports concerning the two men considered from those agencies which were involved and a practitioners' event to explore good practice, missed opportunities and learning.

4.6 The review has therefore included:

- A review of the records relating to Adults Adult I and Adult J
- Individual Management Reports and chronologies from each of the agencies who were involved with them.
- Two Practitioner meetings led by the Reviewer.
- Family engagement was planned to take place through and this has been achieved in relation to Adult J. No response to messages was received from family of Adult I.
- A brief report by the independent reviewer, focusing on learning rather than the events including:
    - A conclusion as to whether as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
    - Recommendations demonstrating responses to the Case and System Issues identified.

5. Agency Involvement

The following agencies were involved with these adults: Adult I and Adult J

- Bedfordshire Fire Service
- Luton Borough Housing Dept
- Luton Adult Social Care
- LBC Early Intervention Prevention
- LBC Adult Safeguarding

- Bedfordshire Constabulary - Police
- Cambridgeshire Community Services
- GPs
- BLMK CCG
- ELFT
- Beds Ambulance Service / East of England Ambulance Service
- Probation Service
- Luton & Dunstable Bedfordshire Trust Hospital
- Bedfordshire Ambulance
- Luton MASH

6. Family Involvement in the Review

6.1 As part of the review process, the author has tried to make contact with the family of Adult I. A letter explaining the process was sent to his brother. He was asked whether he would like to contribute to the review but no response has been received.

6.2 Adult J's family have provided the reviewer with more background information about him. The Reviewer spoke to Adult J's daughter in early June. She was very positive about the respiratory team which had supported her father and kept in touch with her. She was concerned that there had been many different social workers involved and felt that there could have been more impact on expediting her father's move to appropriate accommodation. It had distressed her that she was not present when her father died in hospital because her new address had not been updated on his records and other agencies were not consulted.

7. Profile of I and Agency Involvement

7.1 Adult I was a Black African man who had come to the UK from Rwanda in 1975 as a 10 year old child. He died in April 2022.

7.2 Adult I had been living in his 14th floor flat since 1994. He lived alone and seems to have had very little family contact and appears only to have had contact with his brother. He moved to Luton from London. He stated that he was a railway engineer and had been affected by the 7/2007 bombings.

7.2 Adult I had complex health needs. He was obese and diagnosed with type 2 diabetes in 2004; he was said to have a depressive disorder which was diagnosed in 2008 and he was diagnosed as having paranoid schizophrenia in 2012.

7.3 The Probation Service was previously involved with Adult I. He was made subject to Community Orders 2009 and 2011 for "sexual offences".

7.4 There was a MASH referral by Police in 2017 and 2018 as he had contacted the Police about racial abuse he had experienced. His flat was found to be littered and untidy. The Fire Service also visited and a safeguarding referral was made in relation to hoarding in the property, his well-being and his weight and diabetes.

7.5 A Housing Officer visited Adult I in 2019. The flat was described as cluttered and as posing a risk of fire. Although this situation was said to have improved in the short term. However, in January 2020 the Fire Service made a referral to ASC MASH relating to self-neglect, hoarding, mental health concerns and diabetes. He was said to be overloading electrical sockets and to be using candles which was a risk because he described himself as being drowsy possibly because of his diabetes. A Home Fire Safety Visit was also requested. Referrals were made to the well-being service and also back to local authority housing to assist with decluttering. He did not reply to further messages from the local authority housing in 2020 and there was a failed visit in May 2021.

7.6 During 2020 and 2021 he was in touch with his GP and he had routine flu and COVID vaccinations. In June 2021, a referral was made by the GP to the community diabetic team but he was said not to meet its criteria. The GP also referred him to the diabetic obesity service but he was said not to meet the criteria.

7.7 The Police had involvement with Adult I in 2021 and 2022 when he reported a hate incident but he did not follow it up with them. In October 2021, the Financial Ombudsman notified Police that Adult I was alleging that his building society was withholding funds, that he was "dreaming of vengeance" and that he was being radicalised.

7.8 In March 2022 he was described in a review by the Housing agency as reclusive but not confrontational.

7.9 In early April 2022, Adult I was arrested for malicious communications and two offences under the Public Order Act 1986. He was held in custody and then bailed pending further investigations. There were concerns about him remaining mute while in custody and he was assessed by the mental health Liaison and Diversion service while in custody which gave advice.

7.10 Three weeks later in April 2022, several deliberate fires occurred at his block of flats. He was suspected of being responsible and Police went to arrest him in the early hours of the morning. Unfortunately, he set a fire in his own flat and died after falling from the 14th floor balcony trying to escape via a scaffold erected for maintenance. This was a major incident and other residents in the flats were affected as well as the practitioners who attended the incident.

7.11 There were many risk factors apparent in Adult I's case. He was isolated and does not appear to have had friends or family to support him. His earlier history of contact with mental health services was known but indications of his deteriorating mental health did not appear to be recognised or triangulated by those working with him around the impact of being subject to racial abuse, fear of being subject to financial fraud and feeling radicalised.

7.12 Services responded to immediate concerns but there is little evidence of professional questioning or curiosity about why issues were arising. Referrals were made but there was a lack of multiagency working, consideration of the concerns and coordination of intervention in the case.

8. Profile of Adult J and agency involvement

8.1 Adult J was a white British male who was divorced and lived alone in a privately rented semi-detached house. He died in May 2022 aged 75 years following emergency admission to hospital as a result of suffering from severe infections - urosepsis, pneumonia and cellulitis.

8.2 Adult J had contact with one daughter which Cambridgeshire Community Services (CCS) promoted but he was estranged from other family members. He had a group of friends in Hemel Hempstead and wanted to move there though he had not been able to go there for some time because of his deteriorating health.

8.3 Adult J had complex health needs. He had COPD and used Oxygen daily. He was incontinent of urine. His mobility was limited. By mid-2019, he was unable to access upstairs and slept on a sofa downstairs. He could not use the bath and there were no adaptations to the home to meet his needs. He was using a bucket for a toilet and there was a foul smell in the house. He was breathless and he was weak on his legs. The house was very cluttered and there was no space to use a Zimmer frame.

8.4 In November 2019, he declined support from carers or cleaners and said he just wanted to move to a bungalow in Hemel Hempstead. He said he did not want to pay for services. Adult J wanted to maintain his independence and he struggled to cope without outside help. He was therefore not fully cooperative. He was reluctant to provide information which was needed to pursue the support he required e.g. the name of his landlord for a long time so that adaptations could be discussed.

8.5 Adult J was known to adult social care from 2019. His case was open and closed several times during the next two years 2019 to 2021. At the end of 2019, he was declining practical support and wanting to move. He had been given a commode. During a Home Fire Safety Visit, a fire risk was identified from having a gas fire and oxygen cylinders close by. The Fire Service provided advice to move them away from the fire; smoke alarms were also fitted and the service made a safeguarding referral. This could only mitigate the risk and not eliminate the hazards fully. During the COVID lockdown period in 2020, he did not want anyone to visit and the home conditions deteriorated. The then allocated social worker kept in touch by phone and she worked with him for seven months. Following a final home visit in January 2020 where the home remained unclean and cluttered, Adult J declined support, and the case was then closed with adult social care (ASC) though significant risk and problems remained. CCS Respiratory service continued to visit monthly, however, were not given access to the home. Assessment, advice and support were still provided by CCS on the doorstep – with the aim of reducing risk to the patient.

8.6 Adult J became very suspicious of the staff of his Housing agency. He made unfounded accusations against them about removing documents from his house. This raised concerns with his respiratory nurses about his mental health when consider with his hoarding behaviours.

8.7 By 2021, it was reported that the house was full of flies and that rats were present. There was no heating apart from one electric heater, this was seen as a risk due to the clutter. There was no running water. The respiratory nurse, who visited him regularly, was concerned about his limited mobility and the clutter and hoarding in the house. He was stated to “have mental capacity” in July 2021. The CCS respiratory team held many multidisciplinary team meetings because of the high level of concern but not until May 2022 was there a section 42 enquiry undertaken.

8.8 Latterly, as his circumstances deteriorated Adult J was engaging with professionals and being more cooperative. A “heavy duty clean” of the house was organised and his daughter came to help. He decided that he wanted to move to Norfolk to be closer to his daughter but despite CCS and the social worker referring him, this did not happen due to Adult J not meeting the criteria for Norfolk housing register.

8.9 There were several referrals to ASC MASH concerning Adult J’s vulnerability – January 2020, April 2022, twice in May 2022. According to ASC, they did not refer to his self-neglect specifically as an issue of safeguarding which explicitly it is. CCS had been concerned about Adult J’s mental health given he was at risk from oxygen impairment due to his reliance on cylinder oxygen and lack of oxygen may have been affecting his cognitive functioning. There were nine assessments of his mental capacity completed by the CCS respiratory nurses and each time he was deemed to have capacity. Requests were also made to the GP by CCS for mental health assessment or dementia reviews to take place, but they did not.

8.10 He was admitted to hospital on at the beginning of May 2022 just as it was being agreed there should be a S42 professionals’ meeting following an escalation from paramedics. He died in hospital.

8.11 The CCS nurses were the most consistently involved professionals with Adult J. They worked with the allocated social worker, housing departments in Luton and Dacorum, the GP, the hospital respiratory service, BOC healthcare and Penrose and they also convened multidisciplinary meetings to discuss his needs and tried to help resolve his wish to move. CCS was the main agency consistently involved with Adult J over time.

8.12 Generally, there was a lack of full consideration by all agencies of his hoarding behaviour and self-neglect as a safeguarding matter, with the exception of CCS which consistently recognised hoarding and self-neglect, and actions were implemented to support and reduce the risk, which would be in line with the local and national safeguarding adult procedures. The local adult safeguarding procedures (at Point - 3.11.5), should have been applied at an earlier stage; it is set out in the procedure that self-neglect may be considered a safeguarding issue:

- Where lack of mental capacity is suspected
- In extreme situations
- Or where there is a failure of agencies to work together.

In Adult J’s case, as the procedure sets out, the safeguarding enquiry would be required to coordinate a multi-agency forum to share information, assess risk and establish a lead agency to work with the person concerned. This would have been a much more effective means of ensuring that intervention was proactive and jointly

managed. As it was, the agencies, particularly ASC, CCS, the Housing agency and the GP were working in isolation without shared objectives and actions which a multiagency safeguarding plan could have provided. CCS convened multi-agency meetings on 3 occasions from November 2021 – January 2022 and ongoing multi-agency communication occurred outside of the meetings but these were not formal adult safeguarding meetings as set out in the safeguarding procedures.

9 Key Findings of the Review

9.1 Self-Neglect and hoarding were not appropriately identified as safeguarding matters as a result the local adult safeguarding procedures were not followed.

They were both living in extreme and squalid conditions which placed them, and potentially others, at physical risk and these issues needed to be resolved urgently. It was evident from the views expressed by practitioners as part of this review that there was frustration about the failure of agencies to respond to these cases as significant safeguarding concerns and to work together and significant degree of silo working. Living in squalor with evidence of their self-neglect were clearly safeguarding issues and were highly likely to be related to their mental health and limited cognitive capacity as evidenced by some of their actions and unwise decision-making.

Their behaviour and problems with engagement evidenced several aspects of self-neglect as identified in the research:

- •Lack of self-care to an extent that it threatens personal health and safety.
- •Neglecting to care for one's personal hygiene, health or surroundings
- •Inability to avoid self-harm
- •Failure to seek help or access services to meet health and social care needs
- •Inability or unwillingness to manage one's personal affairs

(Manchester Adult Safeguarding Partnership –Resources, self-neglect)

They were extremely vulnerable and at risk living alone.

9.2 Intervention was not effective in the longer term and agencies tended to act in isolation. These were complex cases. There were some examples of good practice in intervening to support these two men. There were significant delays, stop-start interventions were not well coordinated. The impact of COVID-19 lockdown played a small part in this but in Adult J's case, the nurses persevered to see him. The local safeguarding system did not work effectively enough to ensure that timely and decisive action was taken to safeguard them. The intervention was not successful in the mid to longer term with significant outstanding problems such as unidentified mental health needs which are likely to have led to them making unwise decisions and to deteriorating still further. For the most part, agencies acted singly and when they tried to collaborate to address the needs, this was not accepted or insufficiently prioritised by other agencies.

9.3 Overall, there was a lack of effective multiagency working so each case lacked a clear plan to safeguard these men and there was a lack of shared

intervention and risk management. There were MDT meetings about Adult J but these did not involve Adult Social Care (ASC). The issue about when and whether to intervene on a multiagency basis is difficult though the requirement is clearly set out in the local multiagency adult safeguarding procedures. When the person concerned is determined that generally they do not want agencies to be involved or they are only willing to cooperate in a limited way, the question of risk and their lived experience is relevant to consider alongside and concerns about their cognitive and decision-making capacity. Self-neglect especially over a long period is associated with adverse outcomes and a deterioration in physical and mental wellbeing. An issue is to consider whether these men's mental capacity was impaired and therefore whether or not they were able to act or not in their own best interests. In both cases, a lack of mental capacity and cognitive impairment was suspected and there was evidence of this in their actions and behaviours. The challenges presented by these two men made it difficult for professionals to work with them but this should have been overcome with all professionals working together at pace with a shared agenda and remit to resolve the safeguarding concerns for them.

9.4 There was inconsistency in the way these two cases were dealt with.

In both cases, even when the self-neglect was recognised, it was not fully understood by all agencies and should have been fully explored as a safeguarding matter in line with the local interagency procedures. In one of these cases, Adult I, there was very limited detailed personal history and exploration of his home conditions. In that case, there was a high reliance on self-report with his home circumstances mainly seen by housing officers, the police and fire service. In Adult J's case the refusal of services was explored and the issue was revisited through the regular involvement of visiting nurses and by a short term social work intervention. There was good practice in understanding his needs and in forming supportive relationships with him.

In Adult I's case there appeared to be much less professional curiosity exercised including why he disengaged from contacts at times and did not continue to ask for services. Frustratingly, it appears that he did not meet the referral criteria for the diabetic and obesity services to which the GP referred him. It appears Adult I did access other health services via his GP but he did not have access to more specialist services which may have provided more information about his full circumstances. Overall, in Adult I's case, there was a lack of concerned curiosity, to inquire into his lived experiences, to recognise and explore the impact of past experience on current engagement. Such assessment as there was of Adult I did not address the layering effect of protected characteristics notably his race and culture or other relevant factors such as alleged harassment. However, it appears that the alleged harassment was only known to some agencies – ASC, for example, had not been informed about it.

9.5 The mental health of these two men was of concern and there appears to have been a lack of access to appropriate support for other professionals to have the men's mental health and cognitive capacity assessed. The relationship between mental capacity and cognitive impairment was relevant to the approach to their chronic self-neglect and cluttered squalid living conditions and hoarding. Both men were self-neglecting and it was not necessarily assumed that they had mental

capacity. This was checked for Adult J and his mental capacity was assessed on several occasions. Apparently having capacity did not necessarily mean that Adult J and Adult I were making wise decisions about their circumstances and whether they should accept help. This was a real dilemma for the staff involved.

The National Review of SARs (2022) found that "*There were consistent misunderstandings related to self-neglect and mental capacity. Agencies were aware that X was self-neglecting, however, they also assumed that X had mental capacity, and consequently (and erroneously) decided that an intervention was not possible*."

In Adult I's case, there was no apparent testing of his mental health / cognitive capacity until he was in custody even though there were indications, through his behaviour, that his cognitive capacity was impaired. For Adult J, professionals were frequently considering whether he had capacity though they also sought a mental health review via the GP unsuccessfully. People who are self-neglecting (with alleged capacity) need a complex, dynamic approach and the support of the multiagency safeguarding system is required to provide this. The point is that whatever the view about someone's capacity, the Care Act Guidance that suggests individuals who are no longer able to protect themselves are still owed a duty of care.

9.6 Changes to practice and visiting during COVID lockdown limited the degree of intervention with both men as face-to-face interventions were stalled resulting in even more deterioration in their circumstances. Adult **J** in particular prevented professionals coming into his home for some time. The lockdown led to more reliance on individuals self-reporting and on telephone assessments and generally there is still the need for triangulating information and using observation. In Adult I's case in particular, when he did not respond this was not always pursued or followed up.

10. Conclusion

10.1 There was some positive practice in these cases but there was also delay and indecision in one case and inaction in the other. In cases of serious chronic self-neglect, thorough and robust joint risk assessment and planning is required – including a clear shared safeguarding plan - with regular multiagency review to support effective collaboration between agencies.

10.2 The current local multiagency Safeguarding Adults Procedures are being reviewed and updated. They will need to place greater emphasis on the need to consider self-neglect and hoarding behaviours as safeguarding matters. As in other safeguarding cases, they require regular Safeguarding meetings/Case conferences to be held with a clear Lead Professional identified and for the Safeguarding Plan to be shared and reviewed.

10.3 Such self-neglect cases need to be higher up on all agency agendas in terms of urgency and risk.

10.4 One of the most concerning aspects of these cases is the apparent lack of a consistent appreciation of and institutional desensitisation to their lived experience in

what were described as smelly, dirty and unsafe accommodation and the urgency required to resolve this to protect them and to improve their circumstances. Unless agencies escalate such concerns across the multiagency safeguarding system and work together, individual practitioners are left to manage the professional and emotional impacts on them. The facts are mentioned in the agency reports but not the impact on him as a person which is important as he was unable to recognise it himself.

10.5 There needs to be an increased shared understanding across all agencies of the legislative options available to intervene to safeguard a person who is self-neglecting with legal advice being sought at an early stage. This is not to say that legal options would be appropriate but it is important to clarify and consider the degree and seriousness of concerns to define a plan of action. In Adult I's case his deteriorating mental health and the risks to himself and others was not sufficiently identified and risk assessed on a multiagency basis.

10.6 There was evidence in Adult J's case of the professionals being aware of, and applying the Mental Capacity Act, to assess him. We know that experienced practitioners with expertise and legal literacy can work confidently together to make decisions in complex areas with compassion and focus. However, in both cases, professionals would have benefitted from greater support and an agreed understanding about the nature of cognitive impairment and its impact on the level of functioning particularly in relation to the significant medical conditions which both men suffered from. In addition, they would also have been helped by having speedy access to legal advice on a particularly challenging mental capacity assessment.

11 Learning / Recommendations and suggested Actions

11.1 Learning from this review should be shared locally and interactive workshops held to disseminate the findings.

Action:

- Learning summary of the findings to be shared locally and placed on the LSAB website.
- Multiagency workshops should be held to use these cases as case studies for learning.

11.2 New Safeguarding Procedures on self-neglect should be developed which identify chronic self-neglect as a safeguarding matter. Practice in self-neglect cases needs to be proactive not just a series of reactions to events with agencies working in isolation. The Safeguarding Adults' Procedures are being reviewed by the Safeguarding Partnership. This case has shown the need for them to provide a clearer framework across all agencies for the response to chronic self-neglect.

Action:

The new interagency Safeguarding Adults' Procedures must explicitly provide professionals with:

1. clear criteria in relation to self-neglect defining the safeguarding thresholds including definitions for the level of risks identified and their appropriate intervention including consideration of compulsory intervention – this is not about descriptors of concern but about levels of safeguarding risk requiring intervention.
2. flowcharts to show this process of assessment, planning and decision-making.
3. consistent language to safeguard individuals who self-neglect and who are as a result at risk in the community.
4. full multidisciplinary assessment of vulnerable adults' needs are required in cases of self-neglect.
   - the assessments must include full involvement of the wider family and social context if this is judged by professionals to be in the individual's best interest or the public interest, even if the individual has not consented. However, consent should be sought whenever possible and the individual's capacity and cognisance should be considered and advice sought.
   - This family involvement should include:
     - regular updates with the family
     - holding family group conferences, if possible, to discuss options and to provide the family with full advice.
5. there should be regular audits of cases to evaluate the quality of assessments and the degree to which family members are being involved.
6. specific timeframes for responses and multiagency intervention
7. advice about how to escalate concerns beyond a single agency when there is delay and urgent concerns remain for that practitioner or agency.
8. There should be at least quarterly oversight of safeguarding cases involving self-neglect - and preferably through a multiagency process - of such high risk cases which have met the threshold of the safeguarding procedures and the safeguarding framework to monitor the safeguarding plan in place to enable practitioners and managers to challenge and reflect upon cases through their supervision process.
9. Where there is a designated lead agency they should convene a 'multi agency risk management meeting' which can provide a forum for all agencies involved, and the adult themselves together with their representative, to consider a proportionate response to the risks identified and make a plan to address these. For clarity and to ensure that risk and progress are regularly monitored and that professionals are supported such "whole system" meetings (including the family) are required to consider how to manage the challenges.
10. There should be regular audits by the LSAB of compliance with the procedures in self-neglect cases.

11.3 LSAB to produce a policy and relevant training for all those working with vulnerable adults on engaging "uncooperative" adults and on how to develop an effective assessment of cognitive functioning.

In these cases, there was not just the safety and well-being of these individuals to consider but there was also public health risk and safety concerns to consider. Both men were living in accommodation, which was cluttered, dirty and prone to infestation which could affect their near neighbours. In Adult I's case, his behaviours and isolation resulted in a direct risk to public safety. When individuals like Adult I and Adult J refuse services or fail to cooperate fully, it is important to consider why they might be refusing and the steps that might be taken to promote their engagement. This will include consideration of mental capacity, any evidence of cognitive impairment and safeguarding risk from the start. There is also a need to ensure that the individuals understand the implications of their refusal to cooperate and that this is recorded. At the same time, all professionals and agencies need to make a decision using a best interest decision making process when it appears that the individual is unable to make safe decisions for themselves.

Action:

- Develop guidelines for working with individuals who appear to be difficult to engage; these should include consideration of mental capacity and cultural needs.
- The barriers to engagement experienced may have been mitigated by the appointment of an advocate were these people to have been considered under the s42 duty.
- Following this review, specific workshop training for practitioners is required to ensure they have information about the learning from this thematic SAR and that they are clear about:
    - The requirement to consider and apply thresholds for single or multiagency involvement from supportive preventative safeguarding measures to formal adult protection. Full adult protection processes may be required if the risks to the individual or to others are high, even if it is against the wishes of the subject.
    - What they need to and can do together to promote the best interests of high risk vulnerable adults.
    - How mental capacity needs to be considered and assessed at the earliest possible stage and regularly.

In conclusion, it is for the local agencies 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.

APPENDICES

Appendix A

The Care Act 2014 and Adult Safeguarding Duties

- Care Act statutory guidance 2014 formally recognises self-neglect as a category of abuse and neglect – and within that category identifies hoarding.
- This enables local authorities to provide a safeguarding response, including the duty to share information for safeguarding purposes; the duty to make enquiries (S42) and the duty to provide advocacy, where a person has no one to advocate on their behalf.

Safeguarding duties apply to:

- any adult who has care and support needs (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of abuse and neglect (including self-neglect); and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The duties apply equally whether a person lacks mental capacity or not. So, while an individual's wishes and feelings are central to their care and support, agencies must share information with the local authority for initial enquiries to take place.

Enquiries may take place even when the person has capacity and does not wish information to be shared, to ensure abuse and neglect is not affecting others, that a crime has not been committed, or that the person is making an autonomous decision and is not being coerced or harassed into that decision. Safeguarding duties have a legal effect in relation to many organisations and the local authority may request organisations to make further enquiries on their behalf.

The purpose of a safeguarding enquiry (S42) is initially for the local authority to clarify matters and then decide on the course of action to:

- Prevent abuse and neglect from occurring
- Reduce the risk of abuse and neglect
- Safeguard in a way that promotes physical and mental wellbeing
- Promote choice, autonomy and control of decision making
- Consider the individual's wishes, expectations, values and outcomes
- Consider the risks to others
- Consider any potential crime
- Consider any issues of public interest
- Provide information, support and guidance to individuals and organisations
- Ensure that people can recognise abuse and neglect and then raise a concern
- Prevent abuse / neglect from re-occurring
- Fill in the gaps in knowledge

- Coordinate approaches
- Ensure that preventative measures are in place
- Co-ordinate multi agency assessments and responses

Appendix B

Safeguarding Adult Reviews (SAR) National Requirements

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

"(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.
(2) Condition 1 is met if—
(a) the adult has died, and
(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to:
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases."

The Care Act 2014 Guidance explains that the purpose of a review is to:

i. Develop learning that enables the safeguarding adults' partnership future.
ii. Ensure that lessons are learnt and lessons are applied to future situations to improve local practice, procedures and services together with partnership working to minimise the possibility of circumstances similar to this happening again.
iii. The purpose of the review is not to apportion blame or hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, and the General

Medical Council.

The following principles apply to all reviews:

● there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
● the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
● the individual (where able) and their families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
● the Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
● reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and
● professionals/practitioners will be involved fully in reviews and invited to share their perspectives.

Appendix C

Terms of Reference for the Thematic Safeguarding Adult Reviews for Adults Adult I and Adult J

Introduction: Luton Safeguarding Adults Board ['LSAB'] has commissioned this thematic SAR following the deaths of Adult I and Adult J.

Adult I (Dob: 20/08/1965) – Adult I was a 56 year old man of Black / African ethnicity originally from Rwanda. He moved to the UK in 1975. On the 21st April 2022 at approximately 4:30am BFRS were notified of a serious fire in the flat where Adult I resided. Bedfordshire police were already in attendance at the address. The deceased was found on scaffolding outside of the building. Fire started deliberately with accelerant used to aid the fire development. He 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. A Rapid Review meeting was held on 30/06/2022.

Adult J (Dob: 01/01/1947) – Adult J was a 75 year old man born in Hemel Hempstead and who moved to Luton in the 1980s. He lived on his own in a rented semi-detached house and had a number of health issues. The Ambulance Service were called to J's home; the general hygiene of Adult J's home was extremely poor. He had COPD, was incontinent of urine had swollen ankles and was on oxygen daily. The neighbours reported to the Ambulance crew that Adult J had not been out of his home in months. Adult J was subsequently taken to hospital but died on 5th May 2022. A Rapid review meeting was held on 21/07/2022.

Independent Reviewer: Amy Weir

Membership of the Review Panel: The role of the panel is to contribute to and scrutinise information submitted to ensure that the review is evidence based and factually accurate. The panel will be made up of partner agencies involved in the cases, specifically:

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

- Bedfordshire Ambulance
- Luton MASH

Involvement of family and friends: The reviewers will seek to meet with their family and friends.

Scope of the review: The review will cover the following periods:

Adult I - March 2020 – 21st April 2022 – his death

Adult J - December 2019 – 5th May 2022 – his death

The key lines of enquiry will be:

- Is there clear guidance within the safeguarding system about the thresholds for and methods of intervention in relation to severe self-neglect and hoarding? Were the criteria for a Section 42 considered? How did the local authority satisfy itself that an enquiry was not needed to help it to decide what action to take to support and protect the persons in question?
- Did practitioners demonstrate a good understanding of the lived experience and circumstances of these two individuals and if not, what were the barriers to this?
- Was the intervention provided timely or were there delays in responding, and if so, why?
- Did practitioners fully consider whether these two men had “capacity” to manage their daily lives and to keep themselves safe?
- Do practitioners know who they can turn to for expert advice and support (including through a trusted assessor approach) in these areas if an adult is at risk but uncooperative and inconsistent in their engagement with services?
- How well does commissioning function across the partnership to facilitate identification or creation of accommodation-based support that can meet complex needs and how responsive is this to periods of crisis?
- How does local availability of resources impact on care planning and safeguarding?

Methodology: This is a review of the safeguarding adults system. The purpose of a review is not to hold any individual or organisation to account, but rather to inform and improve local multi-agency practice by acting on learning and developing best practice in order to reduce the likelihood of similar abuse or neglect occurring again. The reviewer will also highlight any good practice.

The reviewer and LSAB propose to use a learning together methodology. The reviewer will produce a background report drawing together information from a composite chronology prepared and any available reports from all agencies involved. *The reviewer will then have separate conversations with practitioners and senior managers across the partnership* to explore what helped or hindered multi-agency safeguarding practices in this case. A final report will be systems focused, providing clear, SMART recommendations.

Legal Considerations and parallel investigations: TBC

Publication of the SA Review Report
The expectation is that the final report will be published, though it may prove necessary to anonymise and redact information of a personal or commercially sensitive nature. LSAB's Chair and the reviewer will, if necessary, seek legal advice in respect of any redaction. Any subsequent action plan will be monitored by LSAB's sub-groups and reported within the LSAB's annual report.

Timeline and key dates of the review:

10.01.23	First SAR panel meeting to agree terms of reference, review provisional timeline and discuss the identity of the frontline practitioners and senior managers to attend the learning events.
13.02.23	Any additional agency learning reports documentation to be provided to
the	reviewer
13.03.23	Reviewer to produce a background report, to frame discussions during
the	learning events.
26.04.2023	Meeting with single authors
02.05.2023	Second Panel meeting to discuss early findings.
09.05.2023	Practitioner learning events
TBC	Meeting with family – call in June 2023
TBC	Senior manager learning event.
03.06.2023	Reviewer produces draft systems findings report.
07.06.2023	Third SAR panel meeting to review draft report and systems learning.
June 2023	Case review group review systems report, begin action planning and decide publication strategy.
August 2023	Report presented to Safeguarding Adults Board for sign-off.

Appendix D: References

Barnett Deborah (2016) Hoarding and self-neglect – what social workers need to know – Community Care.

Buckinghamshire Multi-Agency Policy and Procedures

Buckinghamshire Thematic Review of Safeguarding Cases around self-neglect/hoarding – updated May 2020

Day, M.R., Leahy-Warren, P. (2008) Self-neglect 1: recognising features and risk factors. Nursing Times; 104: 24, 26–27. 12 June 2008

IRISS Robert Sanders - An Overview of Self-Neglect Aug 2022

LGA Analysis of Safeguarding Adult Reviews (2022) - April 2017 – March 2019 Findings for sector-led improvement

Luton Multiagency adult safeguarding procedures (2017) http://lutonsab.org.uk/wp-content/uploads/2018/04/BBC-CBC-LBC-SA-Policy-and-Procedures-2017-2018.docx-2.pdf

Manchester Adult Safeguarding Partnership - Resources – self-neglect

SCIE - Self-neglect at a glance - At a glance 71. Published October 2018.