SOMERSET SAFEGUARDING ADULTS BOARD THEMATIC SAFEGUARDING ADULT REVIEW

SELF-NEGLECT

A SUMMARY OF THE LEARNING

Suzy Braye: Independent Lead Reviewer
Emerita Professor of Social Work, University of Sussex
Independent Safeguarding Adults Consultant

The six individuals featured in this review

Mr X	63	3rd March 2020	Found deceased at home: cause of death - diabetic ketoacidosis and pneumonia
Sandra	64	12th October 2021	Died in hospital: cause of death - complication of caecal volvulus
Cora	59	21st October 2022	Died in hospital: cause of death - cardiac arrest during post-operative rehabilitation
Daisy	58	29th November 2022	Found deceased at home: cause of death - diabetic ketoacidosis
Heather	79	21st December 2022	Found deceased at home: cause of death - ventricular hypertrophy, frailty, dementia
Judy	74	19th August 2023	Died in hospital: cause of death - aspiration pneumonia, motor neurone disease

Terms of reference: a systemic approach

A dual focus for the review

Case-based focus: what happened and why?

- Scoping information from agencies
- Chronologies of involvement
- Reflective/evaluative reports
- Family perspectives

Current self-neglect practice: strengths and challenges

- 'Temperature check' event bringing together practitioners, operational managers and senior leaders to report on current practice

Thematic analysis
SAR panel reflection and contribution
Feedback to families
SAB quality assurance processes
SAB approval

Good practice in the work undertaken

- Attention to acute and ongoing health needs
- Meeting needs from disability, including appointment location
- Risk management through equipment provision
- Family communications and involvement
- Practitioner skills:
  - Professional curiosity
  - Persistence
  - ‘Think family’
- Fire safety
- Police risk assessments using BRAG
- Proactive interagency communications

But …

How well were needs met?

- Focus on immediate/acute physical health, not the holistic picture
- Poor attention to mental health
- Reactive: absence of longer-term strategy
- Commissioned care insufficient
- Challenges of engagement
- Delay in acting on information
- Failure of timely response to deterioration

Was the underlying picture explored?

- Knowledge of personal histories missing
  - The underlying ‘logic’ of behaviour not explored
  - The reasons for disengagement not understood
- Knowledge of the nature and degree of impairment lacking
- Limited exploration of how individuals felt about their situation
- Addressing the ‘what’ but not the ’why’

Were protected characteristics recognized?

- Relatively little information on protected characteristics recorded (and some not accurate…)
- Disability/mental illness more commonly noted
- Age and disability recorded only 'where thought to be relevant'
- No mention of sexual preference or religion
- Despite recognition of disability, necessary adjustments not always made

The Equality Act 2010

Were views and wishes taken into account?

Failure to secure and to question the individual's views:

- Means of communication not appropriate
- Reliance on a third party
- Refusal taken at face value; no plan to tackle disengagement
- Lack of persistence at building relationship, 'finding the person'
- Acceptance of refusal without risk level discussed
- Absence of challenge to denial of risk
- Absence of advocacy

- Over-emphasis on the right to privacy?
- Convenience?
- Workflow that limits time and focus?

Was mental capacity considered?

- Capacity not assessed even in high-risk situations
- Assessment sometimes seen as necessary but not undertaken
- Executive function not considered despite risk factors
- Lack of clarity about the decision-maker and who should undertake the assessment
- Unresolved disagreements on whether capacity was present
- Lack of capacity did not lead to a best interests process

Was risk assessed and managed?

- Absence of formal risk assessments
- Risk level not recognized or escalated
- Risk management strategies:
  - Insufficient for the level of risk
  - Ineffective because of client disengagement
  - Not seen as urgent - too little too late
- Failure to make timely use of legal rules

How were safeguarding processes used?

- Safeguarding referrals not made, despite levels of concern
  - Self-neglect not recognised as a safeguarding concern
  - Advice from safeguarding advisers not sought
- Referrals raised but
  - Triaged out at referral stage
  - Pursued through multidisciplinary meetings or s.9 assessment rather than s.42 processes
  - Initiated too late
- Lack of proactive action
  - Not worrying enough
  - Not acting, even when risks apparent

Did work take place with families?

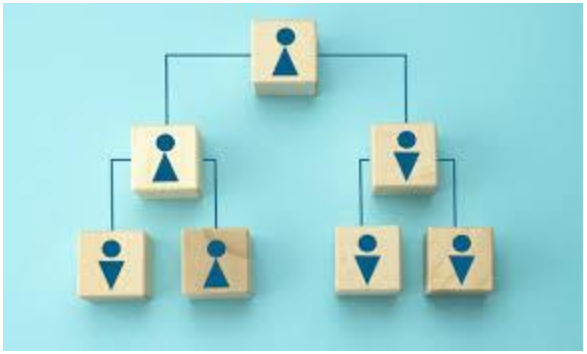
- Varying degrees of contact:
  - Frequent contact and involvement through to no contact
- Family as mediator/facilitator to gain access or assist communications
- Reliance on a third party for communication with the individual a barrier to seeking the individual's own views

How well did agencies work together?

- Absence of multiagency discussion/meetings
- Little leadership from any coordinating agency
- Absence of joint visits that could have facilitated assessment
- Even when multiagency discussion took place:
  - Some agencies not in attendance
  - No intervention strategy – much talk, no action
  - Disagreements not resolved
  - Actions and timescales not allocated; no minutes
  - Agreed actions not undertaken; no feedback on outcomes
  - Outside the meetings, agencies worked in silos
  - No escalation when no change was achieved

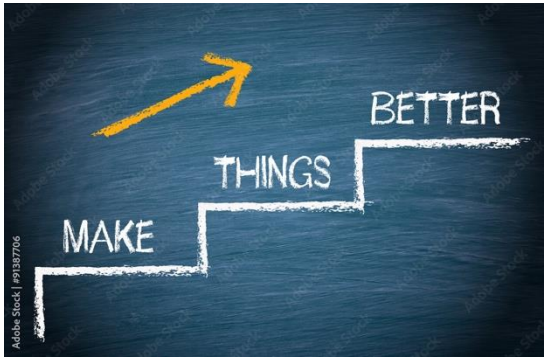
What contextual factors influenced practice?

- Resources (of all kinds)
- Organisational structures
- Organisational policies
- IT systems
- Levels of staff guidance and support on self-neglect
- At national level, Covid 19 pressures



How can we make things better?

The report sets out improvement priorities in the following areas, recommending that the SAB provides leadership to:



1. Improve assessment tools:
   - Holistic picture
   - Environmental needs
2. Review impact on safeguarding of Right Care Right Person
3. Ensure safeguarding is an effective pathway for self-neglect
4. Greater consistency in awareness and use of advocacy
5. Develop ways of working with reluctance to engage
   - Professional curiosity
   - Assertive outreach
6. Improve recording and observance of protected characteristics
7. Foreground mental capacity
   - Audit assessment practice
   - Develop protocol for specialist advice
   - Review SAB resources / guidance
   - Carry out measures to boost awareness and practice

8. Identify and address patterns of specialist housing shortage
9. Strengthen interagency working
   - Audit and further develop the MARM pathway
   - Ensure written records and monitoring of interagency decisions
   - Review/relaunch the SAB Resolving Differences Protocol
10. Provide guidance and standards on home visiting safety for staff
11. Strengthen training:
   - Review self-neglect content currently available
   - Seek NHS England strengthening of levels 1 and 2 safeguarding training
12. Monitor changes already implemented within organisations
13. Lead on review of safeguarding system preparedness for impact of external pressures
14. Give consideration to specialist teams with in-depth self-neglect expertise

Further information

Please address any queries about this SAR or the improvement actions underway to

Somerset Safeguarding Adults Board:

ssab@somerset.gov.uk