From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Robert

The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Does my organisation have robust policies and processes in place to support people who self-neglect?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Robert's Case

- Robert had physical health needs (hypothyroidism and reduced mobility). There had been concerns about Robert's self-neglect in the two years prior to his death and Robert had been moved out of his home for six days whilst a deep clean took place. Robert returned home on 2/5/18 and then on 21/5/18 was moved to other more appropriate accommodation. Care and support was provided from 30/5/18, but following a review the care ceased on 21/6/18. There was no further Adult Social Care (ASC) input and Robert had intermittent contact with the District Council Housing Department. Robert was found at his home dehydrated, hypothermic and confused on 4/2/19 by a General Practice (GP) Paramedic. Robert died in hospital on 6/3/19.

- Robert's self-neglect and his mental capacity to make decisions about his care and welfare were not explored by any professionals in contact with him.
- No consideration was given to whether hypothyroidism caused an impairment or disturbance in the functioning of his mind or brain, which in turn would have affected his capacity to make decisions.
- More curiosity about a possible connection between Robert's health condition, non-adherence with treatment and his self-neglect might have prompted a more coordinated approach to assessing and meeting his needs.
- At no time did all the agencies involved with Robert come together for a multi-agency, multi-disciplinary meeting to generate ideas and explore how best to support Robert.
- Robert's case was closed too soon without sufficient safeguards in place to detect and respond to continuing self-neglect.
- More involvement of Robert's family by professionals may have prompted faster escalation of concerns about Robert's ability to meet his own needs.
- Robert may have been feigning compliance about taking medication and being motivated to attend to his self-care, and by avoiding practitioners and not letting them in to his property.
- Robert's cessation of medication for his hypothyroidism did not prompt follow up, nor did missed appointments for blood tests prompt further investigation or enquiry. Robert's disengagement with the assessment and treatment of his health condition may have been an early indicator that something was amiss.

Key considerations for practice arising from the review:

Self-neglect and mental capacity

- When self-neglect is evident and someone is making "unwise" decisions, be prompted to assess their mental capacity to be able to make decisions about their care and welfare.
- For individuals who self-neglect, consider whether a physical or mental health condition has caused an impairment or disturbance in the functioning of their mind or brain.
- In complex cases bring together multi-agency, multi-disciplinary thinking to explore ideas and interventions.
- Be wary of closing cases without safeguards in place to spot continuing self-neglect.
- Follow your organisation's self-neglect practice guidance.

The Human Rights Act 1998

- Remember the need to balance the right to life (Article 2) and the right to respect for private and family life - autonomy of decision making - (Article 8) and recognise that there may be circumstances where you have a duty to protect life more than the right to autonomy. This can be challenging but attention should be given to developing an understanding of a person's previous choices, decisions and way of life, and with compassion for them rather than as an abstract exercise.

Think Family

- Think how you can work with family members as partners in meeting their relatives' needs and how they may be supported to do so.

Missed appointments, avoidance and feigned compliance

- When people who cannot look after themselves or self-neglect miss appointments, follow this up. Explore why and consider what support can be put in place to ensure their physical, mental health and welfare needs are promoted.
- Be alert to feigned compliance and avoidance. People may try to convince you that they are working with you and are motivated to "comply" with the interventions put in place by services, but in reality, they don't. If they avoid you, be curious about why.

Further information

Somerset Safeguarding Adults Board:

- Self Neglect Practice Guidance

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	