Warwickshire Safeguarding

Self-Neglect Thematic Review Report

Version 1.0

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1. Introduction

This report was commissioned by Warwickshire Safeguarding in response to the partnership receiving five Safeguarding Adult Review referrals over a 10-month period between 2020 -2021 that had the common theme of self-neglect.

Warwickshire Safeguarding undertook a rapid review of each of the five referrals and concluded that the criteria for a Safeguarding Adult's Review was not met for these cases individually. It was, however, agreed that there was important learning to be gained from the circumstances leading up to the individuals' deaths.

A thematic review was therefore undertaken to identify learning to support continuous improvement in practice and, highlight any changes required to procedures when working with individuals who present with vulnerabilities.

2. Terms of Reference and Methodology

The terms of reference identified that the thematic review should identify improvements that can be made to better safeguard adults where self-neglect has been a factor in their lifestyles and to prevent, or reduce the risk, of recurrence of similar incidents.

Common themes identified by the panel across the five case studies were:

- The adult declining or was reluctant to accept offered support
- Mental capacity assessments and reviews of capacity were unclear
- There was no follow up and a lack of escalation from agencies involved

Using the case studies, the following Key Lines of Enquiry were agreed:

- There was limited evidence of a multi-agency approach and an indication that agencies were not clear about their role when dealing with service users such as the ones in the case studies, and the roles of other agencies.
  Q: How can agencies better work together to problem solve and support the individual?

- There was limited evidence of mental capacity assessments, especially executive capacity (the ability to use or weigh up information) in light of repeated unwise decisions.
  Q: How confident are you that your agency undertakes mental capacity assessments including executive capacity? From your agencies perspective what do you consider the barriers to be? Does your agency ever consider the use of expert mental capacity assessors; if not, what are the barriers? What can agencies do when someone, who is deemed to have capacity, continues to make unwise decisions?

- There was evidence that professionals did not explore why the individuals were rejecting assessments and support.

Q: What does best practice look like when working with people who self-neglect? What work is completed to understand the impact of loss and trauma and how is this information recorded and shared? How to agencies ensure the 'best person' is working closely with the individual?

- There was evidence that assessments did not reflect all risks and the historical context that was known.
  Q: How can agencies ensure that assessments include all risks, including the historical context, and how will this assist in seeing any accumulative risk? What is the best way to share this with relevant partners?

- There is evidence of a lack of curiosity and escalation.
  Q: In such circumstances, how can professionals use their professional discretion and curiosity to see past individuals decisions and recognise that they may have benefit from further engagement and involvement?

- There was evidence that escalation was not considered.
  Q: Were situations may seem to be stuck, how should escalation be considered and what are the barriers to utilising this process?

Agencies were asked to reflect on current practice by speaking with managers and practitioners within their services and answer the questions. The agencies selected were those who knew the adults within the case studies.

Operational managers and safeguarding leads from these agencies were then invited to a tabletop review to take part in a reflective discussion of the key lines of enquiry responses and a tabletop exercise.

Agencies involved in the Tabletop Review:

- Warwickshire Social Care and Support
- Warwickshire Police
- Coventry and Warwickshire Partnership Trust
- Integrated Care Board
- Warwickshire Fire and Rescue Service
- Warwick District Council
- South Warwickshire Foundation Trust

3. Case Studies

As well as the common themes identified within section 3 above, there were also a number of other presenting concerns and factors within the case studies which are listed below:

- Long standing concerns re living conditions and self-neglect expressed by professionals known to the adults
- Knowledge of domestic and financial abuse

- Deteriorating health i.e. mobility issues, body sores, emaciation, dehydration, infected ulcers etc
- Lack of accessibility to property preventing professionals from gaining a complete picture of the adults lived experience

4. Key Lines of Enquiry

The responses to the key lines of enquiry questions provided a qualitative dataset which indicated potential behaviours, processes and barriers that halted the mitigation of risks for the adults posed by self-neglecting.

The below tables highlight the common themes within the agency responses:

1. There was limited evidence of a multi-agency approach and an indication that agencies were not clear about their role when dealing with service users such as the ones in the case studies, and the roles of other agencies.
Q: How can agencies better work together to problem solve and support the individual?
• Increase practitioners' confidence to share information and respond to information shared by others • The importance of highlighting previous agency interventions in risk assessments • Development of a multi-agency approach and coordinated case management plan and contingency plans including a shared analysis of known information. • Co-ordinated multi-agency action plan and identification of a lead agency and key worker • Increased agency awareness of agency roles, pathways and prevention services • Better clarity around agency roles and responsibilities • Support for police when responding to / preventing mental health incidents

2. There was limited evidence of mental capacity assessments, especially executive capacity (the ability to use or weigh up information) in light of repeated unwise decisions.
Q: How confident are you that your agency undertakes mental capacity assessments including executive capacity? From your agencies perspective what do you consider the barriers to be? Does your agency ever consider the use of expert mental capacity assessors; if not, what are the barriers? What can agencies do when someone, who is deemed to have capacity, continues to make unwise decisions?
• There has been a lot of work undertaken within organisations to promote what the MCA is and train professionals on the MCA however, there is some professional uncertainty around who can conduct mental capacity assessments • A need for better awareness of executive functioning • The importance of building respectful, positive relationships to manage risk including using mindful language and professional curiosity • Promotion of relationship based practice

- Better guidance for the public around the agencies available to deal with mental health concerns when it is not an emergency

3. There was evidence that professionals did not explore why the individuals were rejecting assessments and support.

Q: What does best practice look like when working with people who self-neglect? What work is completed to understand the impact of loss and trauma and how is this information recorded and shared? How to agencies ensure the 'best person' is working closely with the individual?

- Best practice is person centred approach
- The importance of including family /carers friends within assessments where appropriate
- Building a trusting and positive relationship with the adult over time is key
- Working with the adult so they feel they are in control and can voice how they want support
- The 'best person' is not necessarily the one they work with the most, but who they trust and feel most comfortable with
- A trauma-informed and contextual approach to understand the reason behind why the adult does not want to engage
- Coordinated agency approach to mitigate risk

4. There was evidence that assessments did not reflect all risks and the historical context that was known.

Q: How can agencies ensure that assessments include all risks, including the historical context, and how will this assist in seeing any accumulative risk? What is the best way to share this with relevant partners?

- Multi-agency risk assessments should include comprehensive, historical and current circumstances, and share with other agencies / professionals known to the adult who may identify different risks
- A difference in views should be recognised and discussed
- The adult's voice should be central to the assessment
- Practitioners must recognise that risks cannot always be removed
- Focus should be given to what can and can't be done to reduce risks, rather than the management of them
- The importance of referrals to other agencies (when internal risk assessments are graded medium and above) and following up on the referral

5. There is evidence of a lack of curiosity and escalation.

Q: In such circumstances, how can professionals use their professional discretion and curiosity to see past individuals' decisions and recognise that they may have benefit from further engagement and involvement?
• Training and supervision should be utilised to reminder practitioners to be professionally curious • An understanding of the clients wishes, experiences, and desired outcomes, gained from robust assessment, will inform how best to engage the client • Supervision of supporting staff particularly In complex cases (Supporting how to respond appropriately and support the use of the escalation process • Improving the confidence of staff to have challenging conversations • Professionals need to recognise and acknowledge that the adult may not always engage but this should not sway them talking to the adult about concerns and explaining what support is available • Complete referrals for further support with the adult. A letter signposting adults who self-neglect to support does not work. • Training to improve professional knowledge around self-neglect • Recognising who is the best person to speak with the adult (Not necessarily the police)

6. There was evidence that escalation was not considered.
Q: Were situations may seem to be stuck, how should escalation be considered and what are the barriers to utilising this process?
• Professionals may be unclear about the escalation process or reluctant to challenge another professional's / agency's decision or views • Professionals may feel that nothing can be done if the adult is deemed to have mental capacity – even if this leaves the adult at significant risk because of their decision-making • More support is required for front line practitioners to help them work together in a more organised way, be supported to use the evidenced based approaches. • Emphasis on escalation or cases that should be escalated within peer group or supervision

5. Key Points of Learning

Learning point 1: The adult should be kept central in all decisions.

Engaging with the adult should be a person-centred and a trauma informed approach. Being professionally curious about historical and current circumstances, understanding of the clients wishes, experiences, and desired outcomes will inform how best to engage the client. The adult's voice should be central to all assessments and not just a focus on the problems and risks.

Language also matters and is crucial to building respectful and positive working relationships. It is important that self-neglect is not viewed by the professional as a lifestyle choice and that the adult is choosing to live the way that they do i.e. not referring to a person's possessions as rubbish.

It is important to recognise that the best person to engage with the adult is not necessarily the one they work with the most, but who they trust and feel most supported by.

Learning point 2: Multi-agency risk assessments need to be more robust.

Multi-agency plans must consider history, include the voice of the adult, be aware of each other's interventions and be timely in the information sharing. Clarity around the roles and responsibilities of agencies would aid a better coordinated approach to mitigate risk and action plan.

Professionals should identify and engage with family and friends who provide support to the adult who is self-neglecting. This approach could offer key information within the assessments, where appropriate.

Learning point 3: Gap identified in the professional understanding of mental capacity assessments

It was identified that there is a lack of understanding about the mental capacity act, who can conduct assessments and confidence in completing assessments can contribute to assessments not being as robust as they should be.

The case studies highlighted that capacity assessments must be clear in their decision, particularly in complex situations where circumstances change requiring different information to be understood and therefore requiring different decision makers.

Where appropriate, executive functioning should be considered. However, clarity around what this means can sometimes be muddled.

A number of agencies indicated that work is being undertaken to complete inhouse training to address ambiguity around the Mental Capacity Act and its application.

Learning point 4: Barriers for escalation

Support is required through supervision for practitioners working with complex cases to build confidence to respond appropriately, professionally challenge and utilise the escalation tool. A reluctance to challenge another agencies decision or lack of confidence to have challenging conversations with the adult leads to risks not being mitigated.

A further barrier for escalation is thresholds. Adults who do not meet thresholds for services, as they are deemed to have mental capacity, yet continue to be at significant risk due to their own decisions, may leave a professional feeling like nothing further can be done.

Not working directly with the adult and mailing a letter signposting them to further support does not work.

It is also important to recognise that the adult may not always want to engage, but this should not deter the professional talking about their concerns and being professionally curious.

Learning point 5: Public awareness raising in respect of mental health incidents that are not a risk to life

Police forces within the UK are migrating to a policy in which they will no longer be responding to incidents of mental health crisis, that are not a risk to life. [1]

Warwickshire Police identified that members of the public often contact the police because they do not know which agency to contact for support for incidents of non-emergency, particularly out of hours.

A police officer is not always the best person to work with or be the first responder as front-line police officers are not MCA trained and a uniformed officer can often be intimidating to the adult in crisis. Police officers also have no legal powers in someone's private premises unless they believe there is a crime or a breach of the peace occurring.

6. Recommendations

Recommendation 1: For Warwickshire to develop a Vulnerable Adult Risk Management Framework (VARM). This is a multi-agency framework to facilitate the management of cases with adults who are at risk due to their complex needs, where risk cannot be managed effectively by other processes/interventions and, where it has proved difficult to engage with the adult.

Recommendation 2: Implementation of a training program clarifying the Mental Capacity Act, its principles and how this relates to safeguarding would be beneficial for front line staff within Warwickshire.

[1] National Partnership Agreement: Right Care, Right Person (RCRP) Policy Paper, Published 26 July 2023