safeguarding adults at risk
a cumbria partnership

Safeguarding Adults Review

Mr and Mrs Z

Overview Report
02 September 2016

Moira Wilson
Report Author and Independent Reviewer SAR Panel

Acknowledgements

This independent review under Cumbria Safeguarding Adults Board Safeguarding Adults Review Procedure would not have been possible but for the ready co-operation and information supplied to the Panel by those invited to contribute to its thinking and the administrative and professional support provided by the Board Administrator.

This report reflects the views of the Review Panel whose involvement and professional expertise have been invaluable throughout the process.

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1. INTRODUCTION

Reason for this Safeguarding Adults Review

1.1. On 28 November 2015 Mr and Mrs Z were admitted to hospital following concerns expressed by a neighbour to Cumbria Police. It was reported that they both suffered from health problems and had not been seen for a few days. Police attended and made the decision to force entry to the house where they found Mr and Mrs Z in their bedroom in a malnourished and poor condition.

1.2. Mrs Z died in hospital on 3 December 2015. Mr Z remained in hospital until his death on 7 February 2016.

1.3. There was no coroner involvement in the deaths of Mrs or Mr Z.

1.4. Cumbria Safeguarding Adults Board initiated a Safeguarding Adults Review following agreement that the criteria for a review under the Cumbria Safeguarding Adults Board Procedure of July 2015 had been met, namely that:

- An adult in the area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

Purpose of a Safeguarding Adults Review

1.5. The purpose of a Safeguarding Adults Review is not to reinvestigate or apportion blame but to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard adults who have experienced abuse or neglect. The focus of safeguarding adults reviews, in line with both multi-agency policy and national legislation and guidance[1], is to:

- Determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death;
- Learn lessons and apply those to future cases to prevent similar harm occurring again;
- Support a culture of continuous learning and improvement across the organisations that work together to safeguard adults;
- Consider what needs to happen to achieve understanding, remedial action, and very often provide answers for families and friends of people who have died or been seriously abused or neglected

Terms of Reference

1.6. The terms of reference for the review were drafted by the Cumbria SAB review panel in conjunction with the Chair of Cumbria Safeguarding Adults Board and the Independent Reviewer. They were confirmed following the first Panel Meeting on 15

[1] Care Act 2014 and Care and Support Statutory Guidance 2016

January 2016 and subsequently revised on 7 April 2016 following the death of Mr Z in February 2016. They were:-

1. To consider the effectiveness of the involvement of agencies with Mrs Z and her husband Mr Z from the initial referral in March 2015 until the time of the death of Mrs Z on 3 December 2015 and the death of Mr Z on 7th February 2016

2. To consider whether any information relating to Mr or Mrs Z's situation was available to agencies in the months preceding this period, from January 2014, which may have alerted agencies earlier.

3. To consider whether any action could have been taken by any agencies, to prevent the death of Mrs Z or Mr Z or the circumstances of their deaths.

4. To consider whether there were any other agencies that could have contributed to preventing or mitigating the situation which occurred.

5. To consider issues relating to communicating information sharing or service delivery that may have contributed to the situation which occurred.

6. To consider any issues related to decision making capacity, self neglect and agency involvement or engagement.

7. To consider the effectiveness of the processes of referral, assessment, decision making and adherence to CSAB safeguarding procedures by the agencies involved.

8. To consider the family perspectives on the situation and how they could influence the action plan.

9. To consider any practice issues arising in this review, and how any improvements to such practice can be made.

10. Having considered the above and identified learning from the review, the Independent Chair will make recommendations for the Board to consider and include in a development plan to be implemented by agencies and overseen by the Board.

Membership of the Review Panel

1.7. Cumbria Safeguarding Adults Board commissioned an independent person to undertake the review and produce the overview report.

1.8. Each agency that had been identified as having involvement in the case was invited to nominate a senior representative of their organisation to sit on the Panel and take responsibility for the production of individual management reports (IMRs). The review panel consisted of:-

Chair of SAR Sub – Group	HM Prison Service
Independent Reviewer	Social Care and Health Consultant
Interim Adult Safeguarding Lead	NHS Cumbria CCG

Named Nurse Safeguarding Adults Lead	Cumbria Partnership NHS FT
Detective Chief Inspector	Cumbria Police
District Lead Adult Social Care	Cumbria County Council
Safeguarding Adults Service Manager	Cumbria County Council

Individual Management Reports and other documentation

1.9. IMRs were received from:

Named GP for Safeguarding	NHS Cumbria CCG
Quality and Safety Lead	Cumbria Partnership FT
Team Manager	Cumbria County Council

1.10. Following the initial SAR panel meeting in January 2016 it was clarified that there had been no direct involvement with Mr or Mrs Z by North Cumbria University Hospital's NHS Trust, prior to their hospital admission on 28 November 2015 and therefore an individual management report was not required. An IMR was also not requested from Cumbria Police given that their only involvement had been on 27 November 2015 when the couple was admitted to hospital.

1.11. Borough Council Environmental Health Services confirmed that they had not received any service requests in relation to Mr and Mrs Z

1.12. In addition to the IMRs received the Panel had access to referral documentation from Cumbria Police and the inpatient discharge summary from North Cumbria University Hospitals NHS Trust.

Family involvement

1.13. The offer of involvement in the safeguarding adults review process was made by the independent reviewer to Mr and Mrs Z's family on several occasions by letter and follow up telephone calls. However it has not been possible to make contact to enable contribution to the review.

2. OVERVIEW OF INFORMATION KNOWN TO AGENCIES

25 March 2015

2.1. Mr Z contacted adult social care to request support in maintaining the cleanliness of his property. A referral was made to Age UK for this service and the referral to adult social care was closed.

26 March 2015

2.2. A further contact was made to adult social care by an acquaintance of the family expressing concern around cleanliness of the home and personal care for both Mr and Mr Z. The referrer felt that the couple lacked capacity and were at risk, and did not feel that the referral to Age UK was an appropriate response, as there was no landline in the house and Mr and Mrs Z were not reading mail. The person was advised that their concerns would be passed to a Team Manager.

27 March 2015

2.3. District Nurses made a home visit following concerns made to them by a member of the public. They found that Mr Z had a sore toe for which an appointment was made for follow up treatment. The district nursing service confirmed that Mr and Mrs Z were living in poor conditions and were quite unkempt. There was a letter in the property from Neighbourhood Care; the district nurses supported Mr and Mrs Z in arranging an appointment for 7th April. This information was relayed back to adult social care who advised that Mr and Mrs Z were declining all other services at this stage, but that a trusted assessor could refer back in to Adult Social Care if Mr and Mrs Z consented.

30 March 2015

2.4. The GP made a home visit as requested by Mr Z. The GP diagnosed gout and noted non-compliance with thyroid medication. The general state of neglect of Mr and Mrs Z and of the house was noted. However both denied any problems coping and appeared to have capacity.

1 April 2015

2.5. The results of Mr Z's blood tests indicated the need for further investigation. The GP was unable to contact the family by phone and asked the District Nursing service to undertake a follow up visit.

2 April 2015

2.6. A further visit was made by district nursing to take another blood sample and to explain the referral for further investigation. Mr Z was advised to contact the GP for further information. However he stated he was unable to do this until the following week as his friend was not coming until then. A referral to social services for help with cleaning and assessment was discussed but Mr Z declined this, saying that

someone in town had offered to clean for them which he was considering. Mrs Z was not seen on this occasion as she was still in bed at the time of the visit, 11.00 am.

3 April 2015

2.7. Further blood tests revealed a need for ongoing investigation and hospital referral.

10 April 2015

2.8. District nursing undertook a follow-up visit to Mr and Mrs Z. Both were up and in living room. Mr Z reported that his gout was feeling improved, on medication. The district nurse offered to order more tablets but Mr Z said he did not like taking tablets and advice regarding this was given. Age UK have visited but the couple declined any intervention. District nursing asked Mr Z if he had heard anything about a hospital appointment but he said he had not. Following this visit district nursing agreed no further intervention at present.

6 May 2015

2.9. Letter received by GP from hospital stating that Mr Z had failed to attend for his urgent appointment on 22 April 2015 and that a further appointment would be sent out.

9 June 2015

2.10. Phone calls received by GP from both a neighbour and a local Councillor, on behalf of a workman who had been into Mr and Mrs Z's house, expressing concern about the squalor in which they were living. It was reported that the toilet was blocked and there were faeces everywhere.

10 June 2015

2.11. GP visited in the afternoon and spoke to Mr and Mrs Z on the doorstep of their house as they would not let the GP enter. Both were dressed in dirty nightwear. However they were rational in conversation, showed mental capacity and agreed to a referral to social services.

11 June 2015

2.12. GP contacted adult social care to request a social work assessment. The living conditions of the family were described in detail, and it was stated that although the couple presented as neglectful they gave reasons for not taking up follow up medical appointments. The GP reported that the couple had agreed for an assessment from Adult Social Care with the proviso that they could refuse any services offered should they so wish after completion of the assessment. The GP also passed on the concerns that had been raised by the neighbour and Councillor.

2.13. Adult social care also received a phone call on the same day from Mr and Mrs Z's daughter in law who reported that the couple did not seem to be eating properly or carrying out personal care/grooming tasks. Their house was very unkempt and it was

believed that medication for health conditions were not being taken properly, if at all. There appeared to be a problem with the water supply and there was no working phone in the property. Mr and Mrs Z's daughter in law reported that the couple's daughter had visited two weeks previously and tried to make the house more presentable, tidying the kitchen and clearing rubbish which was lying around; this included lots of fish and chip papers. Adult social care advised that they were aware of the situation but that, due to confidentiality, details could not be discussed with her. However the concerns would be passed to the relevant Social Worker.

2.14. Further information was also obtained by the adult social care duty worker in respect of the visit which had been made on 7 April 2015 by Neighbourhood Services. The worker confirmed that she found Mrs Z to present as very frail and very thin and unsteady, with long fingernails and yellow fingers from constant smoking. She had gained entry to the property into the dining room and sunk into the floor as the floorboards were rotten. When she said that this would need looked at, the couple responded that a workmen was coming to repair the damage. The curtains of the room were drawn, with just semi-daylight and the room was filled with smoke. Mrs Z was very defensive about their living conditions stating that they could manage. They confirmed that they only ate one meal a day, with Mr Z stating that they don't need to eat much at their age as they could not burn it off. They said that they had family close by. The neighbourhood services worker felt that the couple did have capacity and understood what services could be offered if they were willing to accept them, but these were declined with the couple stating that they were managing their daily living even though she felt there was evidence to suggest the alternative was true.

2.15. Feedback was also obtained from the Local Councillor who stated that he had been approached by a local tradesman with concerns about the living conditions of Mr and Mrs Z. He attended the property in response to a water leak from pipes which was flagged up by a neighbour. He said that he was shocked at the living conditions to such an extent that he took photos, which the Councillor had viewed and said were not pleasant viewing. The couple had stated that their daughter visits, but the property was in such a state that the tradesman found this hard to believe. The name and phone number of the tradesman was given with a suggestion that contact was made directly for further information.

2.16. A discussion with Environmental Health was also held. It was recorded in the case notes that adult social care would need to make a Freedom of Information request via email to environmental health before they would release any information they may hold.

2.17. The duty social worker reviewed the information and discussed the details with an adult safeguarding officer who recommended that the referral be accepted on the basis of self neglect and that a visit by a Social Worker would be required to the couple at their property.

2.18. It is also recorded in the GPs notes of the conversation with adult social care that he had been told that without a phone contact adult social care would not engage, to which the GP had reacted negatively. Feedback was later given to the GP that the contact would be logged as a referral for assessment and that a social worker would

be visiting, although a date was not given, other than to say that it would not be today.

18 August 2015

2.19. A visit was made by a social worker but no one was in. It was noted that, although the garden was extremely overgrown, views through the window of the property did not shown signs of cluttering and the house appeared tidy. Follow up calls were made to family members and the visit was rearranged for the following week.

26 August 2015

2.20. A social worker visited Mr and Mrs Z at 2.30 pm. Neither was dressed as they had recently just got out of bed. Their daughter had confirmed in earlier discussion that they did not usually get up until 1pm. The couple initially refused the social worker entry but after a discussion they invited him in.

2.21. The house was described as being dark and untidy but not, in the social worker's opinion to the extreme that was reported. The couple stated that they wanted to be left alone and were coping fine. They said they had no problems washing and showering although both admitted as they were getting older this was not a priority but this was their choice. They both stated their appetites were low because they were getting older; they went out to the village every day to eat fish and chips, get any shopping and cigarettes for Mrs Z. The couple were offended that people were raising concerns and wished to be left alone. Both Mr and Mrs Z were clear about this and both in the social worker's had capacity to make this decision. They refused any suggestions or referrals for assistance. Contact details were left and they assured the social worker that they would phone if they felt they needed help.

2.22. Feedback on the visit was given to GP by the social worker. The GP recorded that social services had done an assessment that morning and all seemed to be well. It was recorded that it seemed that the couples' daughter, and possibly also the son, had helped to get the house tidied up.

27 November 2015

2.23. A neighbour reported to the police that Mr and Mrs Z had not been seen for a few days. The police attended, and when unable to contact the couple, or their relatives, decided to force entry to the house. They found Mr and Mrs Z in the front bedroom of the bungalow in a malnourished and poor condition. Both were admitted to hospital by ambulance. Cumbria Police subsequently made a referral on **28 November 2015** for consideration of a Safeguarding Adults Case Review.

3 December 2015

2.24. Mrs Z died in hospital. The diagnosis given was community acquired pneumonia.

7 February 2016

2.25. Mr Z died in hospital. The cause of death was recorded in the GPs notes as heart failure caused by ischaemic heart disease, although pneumonia was also recorded in the hospital notes.

7 March 2016

2.26. Safeguarding Office informed of the death of Mr Z. Information was provided that indicated it was likely that the circumstances of Mr Z's admission may have been a contributory factor to his death. Following discussions with the SAB chair and the independent reviewer it was agreed that Mr Z should also be included in the Safeguarding Adults Review.

3. FINDINGS AND ANALYSIS

3.1 Concerns first began to be raised about Mr and Mrs Z's ability to care for themselves in March 2015. Prior to this they had not been known to adult social care services, although they were registered with primary care. However there had been no contact with the GP practice since 2012 (Mr Z) and 2013 (Mrs Z). On both occasions non-compliance with medication was noted.

3.2 Little is known about the couple's circumstance, apart from the fact that they had previously been farmers. They were described by neighbours as not being very involved in the local community.

3.3 Following the contacts made to general practice and district nursing, appropriate action was taken to follow up health issues identified for Mr Z, although there appears to have been less focus on Mrs Z. However when the practice was informed that Mr Z had not attended for his hospital appointment in April 2015 there was no form of follow up, which would have been reasonable given the circumstances and history of non-compliance with medication.

3.4 The district nursing team responded to the concern that had been raised by a member of the public and made a number of follow up visits to try to engage the couple and liaise with relevant agencies.

3.5 There needs to be careful consideration of action to be taken when patients are not engaging, are non-compliant or it is assumed incorrectly that another agency are involved. There was a culture of optimism around the standard of care as this was not fully assessed and documented. District nurses listened to Mr and Mrs Z and recognised that they had the ability to make their own decisions, however they took what they said at face value without sense checking the information and outcomes; for example that Mr and Mrs Z were considering employing a private cleaner and that they had arranged for a plumber to fix the problem in the bathroom. Assurance or evidence that this had happened was not sought. In addition the fact that the district nursing service closed their intervention in April 2015 was not fed back to adult social care.

3.6 At around the same time Mr Z had self referred to adult social care for support to maintain the cleanliness of his property. The decision to refer to a voluntary organisation for support was an appropriate action at that time. However feedback

on the outcome of the referral and the visit made by neighbourhood support in April 2015 was not received until June 2015 when further concerns were raised. Adult social care was therefore unaware that the support offered had been declined.

3.7 The interventions during April which, while reasonable by the individual agencies involved, were not sufficiently coordinated. It was clear that the couple did have capacity and their reluctance to accept ongoing help resulted in closure by each agency once their individual actions had been completed. If there had been more discussion about the family situation at this early stage, a plan to try to engage with the family more actively may have been devised. The fact that Mr Z had referred himself for support was an indication that he did have some insight into the difficulties he and his wife were facing; however this was not built upon in order to prevent further deterioration. Braye et al conclude that "Early intervention, before self neglectful behaviour becomes entrenched, is seen as important" [2] It is regrettable that this did not occur with Mr and Mrs Z.

3.8 By June 2015 Mr and Mrs Z's situation had deteriorated significantly with a number of different concerns being raised by the GP, neighbours, local councillor and family member. Although self neglect was identified and it was proposed that a referral under safeguarding should be made there is no clearly recorded decision on the rationale not to proceed with a home visit to complete a safeguarding enquiry under S42 of the Care Act. Instead the family was referred for allocation for a social care assessment, and there appears to have been no assessment of the level of urgency ascribed to the case. The levels of concerns being raised from a number of sources in June 2015 should have triggered a more urgent response.

3.9 The Care Act 2014[3] gives local authorities a duty to carry out a needs assessment in order to determine whether an adult has needs for care and support. The assessment:

- must be provided to all people who appear to need care and support, regardless of their finances or whether the local authority thinks their needs will be eligible
- must be of the adult's needs and how they impact on their wellbeing, and the outcomes they want to achieve and
- must be carried out with involvement from the adult and their carer or someone else they nominate. The adult may need an independent advocate provided by the local authority to help them with the assessment process

3.10 Neither was the contact recorded as a safeguarding alert at this time, which meant that the safeguarding pathway was not followed to investigate the concerns. Had this framework been followed, it would have assisted in developing a multi-agency strategy response to monitor the situation more closely, define professional roles and responsibilities and to explore the opportunity to enlist the support of family members.

[2] Braye et al Self Neglect and Adult Safeguarding: Findings from Research. SCIE 2011
[3] Care Act 2014 Factsheet 3 : Assessing needs and determining eligibility

3.11 The social work assessment visit did not take place until 24 August 2015, two months after the June referral. There is no indication of the reason for this delay or whether any monitoring of cases awaiting allocation was being carried out in the intervening period. The delay by adult social care in responding to the concerns raised, whether as a general assessment of need or as a safeguarding concern was a significant missed opportunity to become involved to prevent further deterioration.

3.12 The response to the family member that information could not be shared due to confidentiality was also inaccurate. If a more proactive approach had been taken it may have been possible to enlist the help of the family and concerned neighbours to persuade Mr and Mrs Z accept the support they so clearly needed.

3.13 By the time the visit was made in August 2015 the family had been partly successful in supporting Mr and Mrs Z to take steps to clear some of their home, and resulted in the assessment by the social worker that the situation had improved. It is not clear from the records whether the original problems with plumbing and water supply had been resolved at this point. The outcome of the visit stating the improvement noted was fed back to the GP by the adult social care worker, which may have created a false sense of optimism about the couple's ability to cope on their own.

3.14 The principle of presumption of capacity was followed largely without question with Mr and Mrs Z. This presumption and people's rights to make unwise decisions is a recurrent theme throughout the involvement of all agencies.

3.15 Whilst capacity of an individual must be assumed and is decision specific, it is of concern that a capacity assessment was not completed until an adult social care visit took place on 26th August 2015, 11 weeks following the initial referral received on 11th June 15. All of the agencies concerned with Mr and Mrs Z were clear that they did have capacity. However there was an assumption that because they did have capacity nothing could be done to intervene to support them. In situations of self neglect there is a significant role for staff in considering mental capacity when balancing rights and risks. Central to this is that individual must be supported to understand the implications of their decisions. The principles of the MCA and especially principle two[4] as set out in the MCA code of practice[5] are relevant to Mr and Mrs Z.

3.16 Whilst it is positive that the agencies involved raised their concerns, these appear to have been raised in isolation and not escalated to the most appropriate source. There was no multi-agency co-ordination which could have been supported by consideration of the Safeguarding Adults Pan Lancashire framework.

3.17 Finally the levels of concern being raised by neighbours and others such as work men was underestimated and not followed through. The duty of well-being and the general principles of local authorities in prevention, including providing information and advice to support individuals and communities to access support, are now

[4] Principle 2 of the MCA, 2005: "the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions".

[5] Department of Constitutional Affairs, (2007). "Mental Capacity Act 2005: Code of Practice". London: TSO.

enshrined in the Care Act[6]. The wider aspects of the new duties of local authorities at the first point of contact did not appear to be well understood.

Views of family members

3.18 The relationship between Mr and Mrs Z and their immediate family does not appear to be a close one. A number of attempts by letter and by phone have been made during the review to involve family members. However, it has not been possible to discuss the issues in more detail with them.

4. CONCLUSIONS AND LESSONS LEARNED

4.1 There are a number of lessons to be learned for all agencies involved with Mr and Mrs Z. The issue of understanding and engaging with people who self neglect is the central theme of this review.

4.2 Concerns about how Mr and Mrs Z were managing were first raised as a self-referral and, at the same time by a concerned member of the community. This was an early opportunity to try to engage with the couple, recognising the challenges of understanding the causal factors of neglect which may be "a *complex interplay between mental, physical, social and environmental factors"* [7]and then identifying how to best to support the person.

4.3 Research into self neglect emphasises the importance of building good relationships with the person and maintaining contact over a period of time to allow interventions to be accepted. Neighbourhood services and primary care responded positively in their early contacts with the family; however neither was able to reach a point where support was accepted.

4.4 Each agency involved focused on their own areas of responsibility, resulting in a less than rounded picture of the full situation. Primary care services responded proactively to try to find ways of supporting the couple. However the response by adult social care was very focused on eligibility for service, and there was no evidence of a joint approach to assessment and trying to find a solution. The benefits of a multi- agency approach to assess the risk of harm in cases of self-neglect, determining roles and responsibilities of all agencies were not realised.

4.5 The lack of interagency communication when interventions were closed was a cause for concern, together with unresolved issues of when information can be shared whilst respecting the confidentiality of the person. This latter point was illustrated in the discussion between adult social care and environmental health staff regarding options for involvement with the family.

4.6 Following the further contacts received in June 2015 the adult social care response was not of the standard to be expected in making an initial assessment of needs, gathering further information and determining a course of action. Although advice

[6] Care Act 2014 Factsheet1 : General responsibilities of Local Authorities: prevention, information and advice and shaping the market of care and support services

[7] Braye et al: Self neglect and Adult Safeguarding: findings from research. SCIE Report 46 September 2011

was sought from the safeguarding manager, the feedback that this should be investigated as a safeguarding concern was not followed through, and there was no explanation for the two month delay in undertaking an assessment visit.

4.7 Application of the requirements of the Mental Capacity Act in practice and understanding the interrelationship in situations where people are self neglecting needs further work, together with the importance of assessing capacity early on, taking account of the least restrictive options throughout, and weighing up the potential broad range of legal frameworks available to promote the six fundamental principles of safeguarding.

4.8 Having considered that Mr and Mrs Z did have capacity there was some hesitancy on the part of the professionals involved to consider opportunities to intervene, for example where they did not attend appointments or manage medication appropriately. The sense of optimism created by the improvements in living conditions over the summer and the couples' assertion that they were managing meant that there was no further contact with the family until their health and environment had deteriorated to a critical point in November.

4.9 Finally although family members were in touch on two occasions and concerns continued to be expressed by neighbours, the opportunities to get a more in depth understanding of the situation from them were not sufficiently followed through. The importance of engagement with carers and informal networks in situations where people are reluctant to accept support should not be overlooked.

Areas of good practice

4.10 There were areas where good practice was demonstrated in attempting to support Mr and Mrs Z. District nursing responded positively to concerns from a member of the public, visited to assess needs and made several follow up attempts to secure support for them.

4.11 The GP similarly made several visits to encourage the couple to support help, looking beyond the presenting medical need of Mr Z to the wider social and environmental situation, and worked closely with district nursing colleagues to this end.

Conclusion

4.12 Mr and Mrs Z were already both in poor health at the time of the original referral to agencies in March 2015. Efforts by health professionals to support them and to encourage them to accept help were not successful. The importance of early intervention in situations where people are self neglecting has been highlighted in research findings; it is also one of the most challenging aspects of practice to undertake. It is not possible to say with certainty whether earlier intervention would have resulted in a more positive outcome. However a better joint approach to information sharing and problem solving may have helped to find ways forward which the couple were prepared to accept.

4.13 The lessons learned from the detailed review of the circumstances of Mr and Mrs Z's deaths should be used both to improve multi-agency working through implementing the action plans, but also to raise awareness, understanding and skills in meeting the needs of people who self neglect. Research commissioned by the Social Care Institute for Excellence[8] demonstrates the need for a strong person centred approach and joint working to address such complex issues:-

> *"It is clear that self-neglect policy and practice is as complex and as varied as self neglect itself. From the experiences of those who have contributed to this research – whether as people who use services, practitioners or managers – it seems that effective practice combines three key sets of factors:*
>
> - ***Knowing,*** *in the sense of understanding the person, their history, the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.*
>
> - ***Being,*** *in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, and care, being present, staying alongside, keeping company, being human.*
>
> - ***Doing****, in the sense of balancing hands-on and hands-off approaches, seeking the tiny element of latitude for agreement, doing things that will make a small difference while negotiating for the bigger things, and deciding with others when intervention becomes a requirement.*
>
> *The importance of creating a strategic inter-agency infrastructure to facilitate such practice cannot be over-estimated; referral pathways, discussion mechanisms, flexibility in work allocation practices, training and support all have a key role to play, as does an ethos of shared ownership between the agencies whose interventions can make a difference. That this is difficult is well established; that it can be done is now evidenced by this research."*

The Panel recommendations which follow are intended to assist the Safeguarding Adults Board in creating such a structure for Cumbria.

[8] Braye S, Orr D and Preston-Shoot, M: Self Neglect Policy and Practice: Building an Evidence Base for Adult Social Care. SCIE November 2014

5. PANEL RECOMMENDATIONS

5.1 All agencies have identified some recommendations in response to this Safeguarding Adults Review. Some have influenced the overall recommendations, and some are specific to that agency. The panel recommendations reflect the key learning points identified in the individual management reports and the analysis and conclusions section of this report.

Developing multi-agency practice in relation to self neglect

5.2 Within 3 months of the publication of this review Cumbria County Council Adult Social Care, Cumbria Partnerships Foundation Trust, NHS England and Cumbria CCG – The Group Medical Practice should provide Cumbria Safeguarding Adults Board with progress on individual action plans based on the agency recommendations drawn up as a result of this review. CSAB should monitor the implementation of the individual agency action plans on a quarterly basis and ensure that all actions are implemented within twelve months of the approval of the action plans by the Board.

5.3 Within 6 months of publication of this review, Cumbria Safeguarding Adults Board should develop multi-agency policies and practice guidance in relation to people who self neglect or who are at risk of doing so. The policies and procedures should incorporate guidance and best practice in line with the Care Act 2014, associated statutory guidance and emerging research evidence on self neglect.

5.4 A multi-agency learning lessons event should be organised to enable the findings from the SAR to be shared and to involve people directly in action planning and developing policy and practice guidelines on working with people who self neglect.

5.5 Continuous professional development opportunities should be offered on a multi-agency basis to support staff in implementing the policy, sharing best practice and evaluating the impact of interventions where people are self neglecting.

Access to services

5.6 Cumbria County Council adult social care should review practice on how the first point of contact operates to ensure that referrals about safeguarding concerns are appropriately received, screened and allocated, including feedback to referrers or agencies.

5.7 Cumbria County Council should review its operation of the safeguarding adults pathway to ensure that its operation is in line with the Care Act and accompanying care and support statutory guidance, embraces the principles and practice of Making Safeguarding Personal, and promotes a multi- agency response in practice to self-neglect concerns.

Use of the Mental Capacity Act 2005

5.8 Cumbria County Council and Cumbria CCG should undertake a stock take of the application of the Mental Capacity Act and how professionals are using it to support adults who may be in danger of self neglect. This should include reference to the importance of assessing capacity early on in cases of self-neglect and review of the current policy as required.

5.9 The results of the stock take should also be used to draw up training and development plans regarding self neglect, use of the Mental Capacity Act and best interests' assessments. This should be offered to relevant staff to strengthen awareness, joint working and confidence in working with complex risk situations.

Communication and information sharing

5.10 CSAB information sharing protocols should be reviewed to ensure that information is shared appropriately in line with legislative requirements, for example Freedom of Information and Date Protection Act, and that staff are trained as needed on the use of the protocols to support effective joint working to safeguard adults.

Engagement with communities and raising awareness

5.11 The positive awareness demonstrated by concerned members of the community and elected representatives in this situation should be used to inform wider awareness raising strategies on safeguarding adults who may be experiencing or at risk of abuse or neglect, and how to support people in their local communities.

REFERENCES AND RESOURCES

Cumbria Safeguarding Adults Board: Guidance Paper 6 Safeguarding Adults Review Procedure July 2015

Pan Lancashire and Cumbria Safeguarding Adults Boards Procedures Manual July 2015

HM Government: Mental Capacity Act 2005

Department for Constitutional Affairs: Mental Capacity Act Code of Practice 2005

Department of Health: Care Act 2014

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GLOSSARY

Association of Directors of Adult Social Services	ADASS
Cumbria Safeguarding Adults Board	CSAB
Cumbria County Council	CCC
Cumbria Partnerships Foundation Trust	CPFT
Cumbria Clinical Commissioning Group	CCG
Cumberland Infirmary Carlisle	CIC
Department of Health	DH
Individual Management Report	IMR
Safeguarding Adults Review	SAR