Self-Neglect Gap Analysis
Safeguarding Adults Review

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1. Introduction

1.1 This safeguarding adult review (SAR) has been commissioned by the Hampshire Safeguarding Adults Board, (HSAB), to extract the learning from the circumstances surrounding the deaths of three adults in Hampshire between September 2021 and August 2022. Before their deaths, safeguarding concerns were raised about each person, particularly relating to self-neglect, engagement with services and their decision-making capacity.

1.2 The three adults subject of this SAR are two men and a woman, they were all of a white British ethnicity. All three people lived alone, Alice and William were elderly with Joseph being 64 years old when he died. Pseudonym's have been used for all 3 adults.

1.3 The HSAB identified an increasing number of SAR referrals following deaths that were related to self-neglect. In response to this, HSAB had commissioned a self-neglect thematic SAR in 2021 to review six deaths involving self-neglect that had been deemed to meet the mandatory SAR criteria under section 44 of the Care Act 2014. The thematic SAR was finalised in March 2022. It was an extensive piece of work that led to action plans being developed and which are now being embedded across the partnership.

1.4 Whilst the thematic SAR was in progress, HSAB received three further SAR referrals that met the criteria for SARs under section 44 of the Care Act 2014. Two of these referrals were prior to completion and publication of the thematic SAR, with one shortly after. The decision to commission a further thematic Gap Analysis SAR for these referrals was confirmed by the independent HSAB Chair in 2022.

1.5 Under section 44 of the Care Act 2014, a Safeguarding Adult Board must arrange for there to be a review of a case involving an adult in its area with need of care and support, (whether or not the Local Authority has been meeting any of those needs), if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions, worked together to safeguard the adult and
- the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect, whether or not it knew about the abuse or neglect before the adult died, (the neglect incudes self-neglect).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

i. identifying the lessons to be learned from the adult's case, and,
ii. applying those lessons to future cases.

2. Terms of reference

2.1 To use gap analysis to identify if the three new cases provide any new learning, including examples of good practice, that is different from that already identified by the previous thematic SAR.

2.2 To consider the learning that emerges in the light of what is understood already through national self-neglect research and self-neglect SARs.

2.3 To understand to what extent the learning from the original thematic SAR has been embedded.

2.4 To develop a ‘questions for the board’ section which will allow key challenges for the partnership to be teased out and presented to the board for them to consider how they need to respond. The questions will be shaped through a co-production style of working between the independent reviewer and the Learning and Review subgroup (LRS).

2.5 The time periods subject to review are:

- Alice; starting in March 2019 and ending with her death in October 2021.
- Joseph; starting in March 2019 and ending with his death in September 2021.
- William; starting in July 2019 and ending with his death in August 2022.

2.6 Three additional key lines of enquiry were identified:

- **Alice**- To understand the reasons for any weakness in relation to multi-agency joint working in relation to the intended plan.
- **Joseph**- To understand the challenges experienced by professionals in relation to their duty of care, (and decision to withdraw services), and how that can be applied in cases where the adult is deemed to have mental capacity, refusing services and yet is living with a level of risk.
- **William**- To understand how well agencies worked with the Court of Protection process and plan, and the reasons why the plans were not effectively delivered for William.

3. Methodology

3.1 The methodology used was a ‘short SAR model’. This methodology uses a systems-based approach and is intended to build upon existing reports. In this case, the ‘Self-Neglect Thematic Review’, (March 2022).

3.2 Each Organisation compiled a report using an agreed template to review their contact with each person and to critically analyse their own practice against the key lines of enquiry. The themes identified within the three cases under review were then developed during a practitioner learning event, facilitated by the Independent Reviewer and supported by the HSAB SAR Co-ordinator. The practitioner event also considered specific questions relating to the nine themes previously identified in the Self-Neglect Thematic Review, (March 2022), with a view to understanding how the learning from the earlier SAR was being embedded within relevant agencies.

3.3 A draft report was presented to the LRS to draw out conclusions about the key learning that has emerged, to test how common the issues identified are thought to be across the local safeguarding partnership and to develop 'questions for the board'.

4. Family involvement

4.1 The Hampshire SAB and involved partners were unable to identify family members for the three people subject of this SAR who would wish to be engaged with the process. The Learning and Review Subgroup ensured that any available knowledge of the adult's views are included and considered within the review.

5. The three people

Alice

Alice was an 81-year-old lady when she was found deceased at her home address in October 2021. Her lifestyle was described as reclusive by professionals. There is a documented history of mental health issues and it is noted that Alice had been detained under section 2 of the Mental Health Act for assessment in 1995. The records would suggest that there was minimum involvement with services, including the Community Mental Health Team (CMHT), or the General Practitioner (GP), following the 1995 assessment primarily due to her non-engagement with services.

During 2019 concerns were raised about the state of Alice's property, including the smell of decomposing urine and faeces. Alice would not engage with services or grant access to her premises; it is noted that the Winchester City Council housing department had to obtain a lifetime injunction to carry out the annual gas service. Social workers from HCC Adults Health and Care (AHC),

had visited the address and whilst the conditions within the premises were identified as poor, it was considered that Alice had capacity with respect to her living conditions and that no intervention was required at that time, an assumption was also recorded that Alice would not have engaged with any services offered.
Further concerns about Alice's welfare were raised in early 2020, resulting in police visiting the address on 26 March 2020. The attending police officers recorded their concerns for Alice on a public protection notice 1, (PPN1) which is a form that front line police officers can use to report safeguarding concerns. These forms should be risk assessed and then shared with relevant safeguarding partners as appropriate. On 1 April 2020, AHC record a proposed joint agency visit to Alice's address with housing and CMHT once the covid 19 restrictions were lifted but there was no further contact with Alice until January 2021. CMHT first became aware of Alice in January 2021.

On 14 January 2021 concerns were raised by housing who had accessed Alice's property in connection with a leak that was impacting on another flat. The contractor reported no heating or lighting, cat faeces throughout the flat and a strong smell of urine. Alice was described as being in a confused state and unwashed. Housing agreed with AHC that they would contact the GP, who subsequently visited Alice's address on 19 January 2021 but couldn't get a response from Alice. The address was visited the following day by a social worker from AHC. Alice was not deemed to be confused but suffering from a long-term mental illness and living a reclusive lifestyle. The Older Persons Mental Health (OPMH) team were contacted with a view to a seeking a mental health assessment but OPMH did not believe that there was a role for them as Alice had a history of not engaging with services and following discussion with housing, GP and adult health and care OPMH recorded it was agreed that there was no current role for OPMH and social needs would be addressed in the first instance and that housing should pursue further engagement as a less restrictive option.

There is no further contact with Alice until 23 August 2021 when housing convened a Multi-Agency Risk Management meeting, (MARM) following concerns raised by both housing and the GP, both of whom had been unable to access Alice's premises. The GP had also made a referral to the OPMH team requesting that a mental capacity assessment be conducted in respect of Alice, primarily relating to her property. OPMH record that Alice was known not to engage with professionals and this led to the MARM decision that housing would pursue an injunction to access Alice's property, OPMH and AHC would accompany housing to carry out assessments. It is noted that there were no timescales agreed to achieve this although OPMH contacted housing on 13/09 for an update on the injunction date.

The injunction was served on 5 October 2021 but Alice was found deceased and in a decomposed state in the property. There is no recorded contact by any agency after the MARM on 23 August 2021.

Joseph

Joseph was a 64-year-old male living alone when he was found deceased at his home address by South Central Ambulance Service (SCAS) staff on 22 September 2021. The post-mortem examination determined that Joseph had died from 1a Septicaemia, 1b bronchopneumonia, cellulitis, osteomyelitis, 1c deep sacral pressure sore and 2 diabetes mellitus.

Joseph was known to professionals prior to 2019. He had regular contact with health providers, particularly for wound dressing, this was primarily through attending his GP practice until his mobility was severely reduced in 2018 through osteoarthritis. He was subsequently treated at home by community nurses (CN). A safeguarding referral made with respect to Joseph in 2018 was the only time that his circumstances were considered under section 42 of the Care Act 2014.

Throughout 2019, Joseph had regular contact with professionals from AHC and health providers with concerns being raised about his self-neglect, poor living standards and his medical conditions, including pressure ulcers to the sacrum. Professionals noted Joseph's increasing use of alcohol and his reluctance to engage with services offered. The Clinical Commissioning Group (CCG - now the Integrated Care Board), records report that Joseph's mental capacity was assessed recurrently and unless he was intoxicated, it was felt that he had capacity to make decisions regarding his care, despite the high risk of deterioration.

The 2020 CCG records show that Joseph was admitted to hospital in January, October and twice in November, Hampshire Hospital Foundation Trust have confirmed there were a total of 10 admissions over a 2-year period the key issues being identified as hyperglycaemia and a grade 4 pressure ulcers to the sacrum. The Southern Health Foundation Trust report challenges in communicating with acute trust colleagues, the absence of community-based staff in discharge planning and Joseph being discharged on occasions with no ongoing care provision in place. The records suggest a reduced level of contact between professionals and Joseph during 2020 as this coincided with the national covid restrictions which would have impacted on some service provision. It is also noted that the Multi-Agency Safeguarding Hub (MASH) received a referral from a community nurse with respect to concerns about Joseph which the MASH determined did not meet the section 42 criteria.

In January 2021 community nurses were visiting Joseph on a daily basis due to concerns about the risk of Sepsis, (also known as septicaemia and blood poisoning), Joseph was reported to be drinking alcohol heavily. It is noted that Joseph was becoming increasingly unpleasant and often aggressive towards the nursing team staff. Joseph was admitted to hospital in late January with osteomyelitis and discharged in February 2021.

AHC report a MARM meeting being held on 23 February 2021 to consider the concerns about Joseph who had significant medical, self-neglect and alcohol misuse issues, concerns were also expressed about his mental capacity. A decision was made to refer Joseph for a mental health assessment but there is no record of either the referral being made or of any outcome.

In March 2021 the GP was asked to assess Joseph's mental capacity due to serious self-neglect and alcohol misuse concerns. Joseph was deemed to have mental capacity with respect to decisions relating to preventing the deterioration of his health and support needs. The AHC records also state that a continuing healthcare (CHC) assessment on 11 March 2021 records that Joseph was refusing services and that he was acutely depressed. The entry concluded that this would have a significant impact on his health and wellbeing. Joseph declined an offer of a hospital admission.

Joseph was again admitted to hospital in April 2021 with a grade 4 pressure ulcer and faecal incontinence. It was noted that although Joseph was consistently assessed as having mental capacity by professionals, most of these assessments were conducted whilst Joseph was in hospital and not influenced by alcohol.

A further MARM meeting was held on 28 May 2021. The minutes state that Joseph's condition was worsening, he was misusing alcohol, declining services and abusive towards community nurses and carers who were jointly visiting Joseph due to this behaviour. It is also noted that the GP stated that Joseph was end of life but there is no record of this being discussed with Joseph or a plan being put in place with other agencies to manage Joseph's care.

In July 2021 there were three referrals into the Multi-Agency Safeguarding Hub from SCAS, following on from three similar referrals in June, all of which were forwarded to the community nursing team for the information of the key worker. Despite the concerns raised about self-neglect, alcohol misuse and the impact on his wellbeing, Joseph was not considered in need of a section 42 enquiry. Joseph had declined a hospital admission in early July, professionals noting that his refusal to enter the hospital may have been his recognition that he would not be able to access alcohol; this could cast doubt on his ability to exercise capacity. There were numerous hospital admissions over the summer of 2021 including on 22 July 2021 when Joseph was encouraged to be admitted

to hospital and was discharged four days later on 26 July. Professionals reported that Joseph was self-neglecting and unsafe at home.

Joseph was referred to the Midlands Partnership Foundation Trust who provide the local inclusion service (MPFT) through community-based alcohol and drug treatment support and behaviour change services, in July 2021. This followed his hospital admission on 15 July 2021. The referral related to his alcohol abuse and associated physical health issues. MPFT records suggest that Joseph had previously been offered referrals to them but had declined. MPFT spoke to Joseph by phone on 29 July 2021 but he declined to engage with the service offered. MPFT then discharged him from their inclusion service on the basis that Joseph had declined to commence treatment.

Joseph was found by a postman collapsed on the floor of his property and he was again admitted to hospital on 10 August 2021. Assessments carried out by mental health staff whilst Joseph was in hospital, and therefore unable to access alcohol, concluded that Joseph was motivated to stop drinking and that he had mental capacity to understand information relating to his admission, treatment and discharge plan. He was discharged on 25 August 2021. The AHC records suggest that there was no AHC commissioned care plan in place for Joseph and discharge records state that he did have community nurses visiting him daily.

On 22 September 2021, Joseph was found deceased in his property by transport staff who were intending to convey Joseph to the wound clinic.

William

William was a 70-year-old male who was living alone at the time of his death. He was known to a number of agencies as having care and support needs, he had mental health issues and his property exhibited clear signs of extreme hoarding. William was found deceased at his home address on 4 August 2022 by police officers following concerns for his welfare from neighbours. His body was in a decomposed state. A cause of death has not yet been concluded by the coroner.

William had held a tenancy with VIVID homes since 1994. Their records describe him as a prolific hoarder and that he had been previously diagnosed with schizophrenia but was not using medication through his own choice. William had consistently refused VIVID homes staff access to the property to carry out gas servicing tasks. VIVID applied to the County Court for a possession order, the County Court then referred the case to the Court of Protection.

William’s first recorded engagement with HCC AHC team was in 2015. William was believed to have been treated in hospital for paranoid schizophrenia prior to this date. Initially William engaged with adults’ health and care but from around 2020, records suggest that agencies found it very difficult to engage William.

Hampshire and Isle of Wight Fire and Rescue Service (HIWFRS) had contact with William between 2015 and 2021, reporting significant hoarding in October 2015 and in contact going forward to 2019. HIWFRS record a professional’s meeting in July 2019 where William’s extreme hoarding was discussed. It is noted that HIWFRS attempted to complete ‘safe and well’ visits at William’s address in August 2019 and again in February 2021, in both cases they were unable to contact William and the ‘safe and well’ visits were closed without William being spoken to.

By 2020, AHC’s records report that William was very difficult to engage. Court proceedings had been commenced due to the state of William’s property which led to a referral to the Court of Protection due to concerns about William’s capacity to consent to assessment and support. The social work team and AHC’s legal services worked with the Court of Protection to put a plan in place to gain entry and assess William’s care and support needs. This plan subsequently changed to one that proposed the removal of William to a specialist residential placement, but despite a residential placement being arranged, there were significant delays resulting in the plan not being delivered against. Some of the delays were caused by external factors beyond the agencies control, but there is also evidence suggesting that some practitioners were unclear about their roles and responsibilities within the process; this included misunderstandings between VIVID and AHC staff, a psychiatrist initially declining to be involved in the plan due to disagreement about their remit, and the role of the police in supporting its execution. The intention was for Hampshire Police to be present when the plan was actioned, however, the social worker was advised by the police that they could not plan for resources to be available at a specific time, notification would need to be sent 2 days prior to officers being needed. Officers would be deployed if resources and priorities allowed at the time. This created difficulty in achieving a planned approach in these circumstances.

The minutes of a section 42 safeguarding review meeting held in December 2020 record that an independent social worker, appointed by the Court of Protection, reported that they had been unable to engage with William but deemed him to lack capacity to manage his tenancy, environment and care act needs, they also expressed doubt around maintaining his personal care. A decision was made to not carry out a mental health assessment although the rationale for this is not recorded, OPMH were present at the meeting. The Chair made a decision to keep the section 42 enquiry open to monitor the progress of the ongoing Court of Protection process with a further meeting planned for April

2021, there is no record that such a meeting took place. This may have been a missed opportunity to better co-ordinate the cross-agency use of the court of protection process in this case.

AHC report carrying out a number of visits to William's address although a timescale isn't provided. On one occasion William was spoken to and presented as unwell, in the view of the social worker, consistent with his understood diagnosis of paranoid schizophrenia. The social work team report that they had been in contact with OPMH with respect to both the Court of Protection plan and to request a mental health assessment but it would appear that no assessment took place.

William was well known to the police who had contact with him over a significant period of time, there was a warning marker on the police record for William stating that he suffers from paranoid schizophrenia, most police contacts with William were filed on that basis. Police officers who met with William in July 2021 submitted a public protection notice, PPN1, to Adults Health and Care on 3 July 2021 to highlight their concerns for William but there is no record as to any safeguarding action that resulted from it.

On 4 August 2022, Police and Fire Service attended William's address following reports from neighbours relating to a strong smell coming from the property. Fire Service staff entered the premises and initially were unable to get into the property due to the large number of hoarded items. William's body was located in the property under a large pile of books.

6. Findings and Analysis

6.1 The impact of covid.

Whilst the deaths of the three people subject of this SAR occurred outside of the National covid 'lockdown', a significant amount of the relevant time periods for this review coincide with the pandemic lockdown restrictions. The first national lockdown began on 23 March 2020. The second on 5 November 2020 and the third on 6 January 2021. The lockdowns, and the associated restrictions, impacted on service delivery for a range of reasons including the level of demand, health and safety changes to working practices and staff absence through sickness or self-isolation. Although the level of referrals nationally reduced significantly during the pandemic restriction periods, practitioners at the workshop highlighted the fact that they increased quickly in the periods where the restrictions were lifted. They also reinforced the fact that agencies did not stop doing face to face visits where the need was identified.

Whilst practitioners contributing to the workshop spoke of the challenges faced in delivering services during the pandemic, they also highlighted the significant improvements in the use of virtual platforms for conducting and engaging practitioners in multi-agency meetings.

The wider impact on relevant agencies and their teams is adequately covered in the March 2022 Thematic SAR so this report will not repeat this learning.

Although there were attempts made by professionals to engage with Alice during 2019, there is no recorded contact following the police (Hampshire Constabulary) attendance at her address on 27 March 2020 until mid-January 2021, despite police officers raising concerns about Alice in March 2020 and AHC recording a decision in April 2020 to carry out a joint agency visit.
The contact with Alice in January 2021 was initiated following housing staff attending her address to deal with a leak issue. Whilst there is no recorded decision making relating to the absence of contact, as it sits within the three lockdown periods, it would be reasonable to assume that it was influenced by the pandemic restrictions.

In William's case, there was minimal contact with professionals before, during and after the covid restriction periods so it would be difficult to describe a significant impact on his health and wellbeing from the pandemic. In both William and Alice's cases, they led a reclusive lifestyle with no contact with known family or friends before the lockdowns, again there is no evidence to show that this was impacted by the covid restrictions.

Whilst Joseph had contact with services during 2020 and early 2021, the records suggest that the face-to-face contact reduced during this time, it was specifically noted that the mental capacity assessments, even though conducted whilst Joseph was in hospital, were carried out by telephone. This is discussed in more detail under mental capacity. The March 2022 Thematic SAR describes those people subject of that SAR who had pre-existing alcohol issues, escalated their alcohol use during the covid lockdown period. Joseph had identified alcohol issues prior to March 2020 but the records clearly describe Joseph significantly increasing his use of alcohol during the pandemic period. His abuse of alcohol during 2020 and early 2021 would appear to contribute to his reluctance to engage with services offered.

6.2 Engagement

The professionals involved with the three people subject of this SAR had difficulties in achieving engagement with them.

Alice had a documented history of mental health issues, she lived a reclusive life style and refused to engage with services throughout the period subject of this review. During this period, March 2019-October 2021, Agencies attended Alice's address on a number of occasions but on each occasion, the visits were carried out by a single agency acting alone. Although in April 2020 a decision is made by AHC to jointly visit Alice with Housing, this doesn't take place. All of the visits were concluded by Alice either refusing access or there being no answer at the door. There were limited 'windows of opportunity' during this period but where housing gained access to the address in January 2021 to deal with a leak issue, other agencies were not involved and a potential opportunity to engage with Alice face-to-face was missed.

William also led a very reclusive lifestyle, had a documented history of mental health issues and refused to engage with services throughout the period under review, July 2019-August 2022. Again, the recorded visits made to William's address are carried out by a specific agency working alone. AHC report one occasion where they were able to engage with William face-to-face, although this is undated, where the social worker reports William as being unwell, consistent with a previous diagnosis of paranoid schizophrenia. There were 'windows of opportunity' to engage with William; AHC had commenced proceedings with the Court of Protection to secure entry to his premises to enable William's care and support needs to be assessed although this was never carried out. The need to secure access to carry out gas servicing through VIVID homes may have created a window of opportunity for agencies to have direct contact with William, to perhaps build some form of relationship but certainly to carry out the required assessment of care and support needs.

Joseph differed from Alice and William in that he was younger, did not have a significant mental health history or reclusive lifestyle prior to the period under review, March 2019-September 2021, although he was effectively housebound from 2018 due to physical health issues. Most contact with Joseph prior to 2021 related to health services, primarily through the community nursing team. Although there were a number of safeguarding concerns raised, they were all referred by the MASH to the community nursing team key worker. The first recorded multiagency working was through a MARM in February 2021 despite the concerns about mental capacity, self-neglect and alcohol misuse and their impact on his significant physical health issues. Throughout the period under review, Joseph refused to engage with services offered other than assistance with dressings provided at home. There were a number of 'windows of opportunity' to engage with Joseph, this included several periods of hospital admission as well as the access to his home address with the community nurses to assess Joseph in his home environment.

Professionals found Joseph hard to engage with, a key element of this would appear to be due to Joseph's alcohol addiction and at times volatile behaviour towards practitioners. Professionals accepted Joseph's lack of engagement as a lifestyle choice, despite the potential serious impact on his recognised health conditions. Ward and Preston-Shoot, (W and PS) provide guidance in their safeguarding vulnerable dependant drinkers report (2020). They describe dependent drinkers who are not only hard to engage but are also vulnerable and have a significant impact on public services.

W and PS make a number of key points; firstly, the Care Act does apply to people with alcohol problems and particularly the inclusion of self-neglect will encompass many of this client group. Whilst this report will deal with mental capacity later, it is important to address the issue of 'choice' when considering the refusal or reluctance to engage with services. There are misconceptions amongst professionals that dependant drinkers are making a lifestyle choice, this is a particular issue where self-neglect is present. In Joseph's case, professionals considered/assessed Joseph to have mental capacity and to be making a lifestyle choice despite his identified dependency on alcohol, his refusal to address this and the impact of his self-neglect on his progressively more serious physical health issues. Within the hospital alcoholism would be seen as an illness and Joseph was seen by alcohol liaison nurses.

Whilst recognising that efforts were made to engage all three of the people subjects of this SAR, and in particular, Joseph, the practitioners workshop attendees agreed that there could have been more opportunity to engage with these people and that in similar situations now, professional curiosity should lead to further assessment and, where appropriate, risk escalation, to try and engage with the person. In each case, practitioners appear to develop a belief that the service user is making a capacitated choice without understanding and assessing the impact that mental health or addiction have on making that 'choice'. Decisions didn't take into account the likely consequences for the physical health and wellbeing of the person in question. Where cases of high-risk self-neglect involve service users who refuse to engage, the relevant agencies cannot simply disengage on the assumption that the person is making a capacitated choice to refuse support. The reviewer noted that culturally, some practitioners struggled with the time and resource needed to break down barriers to engagement, due to ongoing and significant demand on resources. Comments that the persons decision to not engage should sometimes be respected to avoid unwelcome interventions provides evidence of the ongoing challenge in achieving a balance between a person's autonomy and managing risk.

W and PS recommend the use of assertive outreach teams to try and engage with dependent drinkers who are either difficult to engage with or who refuse to accept services offered. The use of assertive outreach resources to attempt to engage with service users, not just those who are alcohol

dependent, but particularly those where high-risk self-neglect is identified, was accepted by the workshop practitioners as best practice. It was identified that during the relevant periods for this SAR, there was no assertive outreach capability. Practitioners did speak in very positive tones during the workshop about the 'Enhanced Support Service', a pilot being led by AHC, to provide outreach services, taking referrals directly from the MASH, with specialist resources who have the skills and capacity to build supportive relationships with those service users identified as hard to engage and to overcome the barriers leading to their self-neglect. Importantly 'this takes patience and time, a luxury that is challenging for most Health and Social care teams' (Self-neglect: At a glance/SCIE).

6.3 Professional curiosity and legal literacy

Professional curiosity is widely recognised as helping practitioners avoid making assumptions about people's lifestyle, the decisions they make and what is important to them. In each of the three cases practitioners made assumptions about the people concerned making lifestyle choices without considering how mental health, addiction or perhaps shame about their environment or circumstances may have influenced those 'choices'.

Although Alice had a documented history of mental illness, she was deemed to have capacity and was described by professionals to be reclusive, this was seen as a lifestyle choice. As the professionals involved with Alice believed that she was making a lifestyle choice and exercising her right to not engage with services, they did not feel that there were legal grounds to engage her with those services. It was noted that at that time, there was no access to an assertive outreach capability.

William was known to a number of agencies as a person who had care and support needs, suffered from mental health issues and showed evidence of extreme hoarding. Prior to 2019, there was a level of engagement with services but from this point, records suggest that agencies found it very difficult to achieve engagement with him. Whilst there were some visits to his address, and some limited engagement on one occasion, there is little evidence of professional curiosity as a means of understanding William's lifestyle and his reluctance to engage with services. Although a section 42 enquiry is commenced in 2020, there is no multiagency plan to secure engagement other than the application to the Court of Protection.

Joseph had significant contact with professionals throughout the period under review, indeed for much of the time he had daily visits from community nurses, he was also admitted to hospital on a number of occasions. Concerns were raised about Joseph's self-neglect, alcohol use and the impact that this, together with his refusal to engage with most services offered, were likely to

have on his significant physical health conditions. He was deemed to have mental capacity by professionals and to be making a lifestyle choice, despite the likely consequences for his physical health. Practitioners described their frustration around Joseph's desire to return home from hospital in order to return to his alcohol addiction. Greater use of professional curiosity, perhaps through the use of assertive outreach and intensive support had it been available, may have enabled a better level of engagement and subsequent outcome. W and PS suggest the commissioning of alcohol services that meet the needs of clients who require safeguarding or lack mental capacity be through persistent, assertive services built on relationship building, harm reduction and motivational interventions.

Assessing mental capacity was a significant challenge in each of the three cases subject to this review, it was an important issue highlighted in the Thematic Review on Self-Neglect, 2022, and it was recognised as a continuing challenge by practitioners. The wording of the Mental Capacity Act 2005, namely '*A person is not to be treated as unable to make a decision merely because he makes an unwise decision',* is often misconstrued by practitioners as meaning that people have a right to make unwise decisions. Professor Preston-Shoot and others, in their paper 'Effective work with adults who self-neglect', (2020), advise us that capacity is decision specific and time specific. '*A person lacks capacity if they have an impairment or disturbance in the functioning of the mind or brain, as a result of which they are; unable to make the decision, unable to understand, retain, use or weigh relevant information or communicate the decision'.* The report describes the need to include both 'decisional capacity and executive capacity' to assess capacity. Specifically, this means that when working with self-neglect, practitioners should not only consider the person's ability to understand and reason through the elements of a decision in the abstract but they also need to consider the person's ability to realise when a decision needs to be put into practice and to execute it at the appropriate moment.
Furthermore, when considering executive capacity, W and PS emphasise the fact that addiction may impair a person's executive capacity, particularly their ability to weigh and use the information. This is reinforced in case law, the judge in NHS Trust v L and Ors, (2012), EWHC found in his judgement that compulsive behaviours may impair someone's executive capacity, these compulsive behaviours could include self-neglect and hoarding.

Practitioners also need to remember that assessment of mental capacity is decision and time specific. In Joseph's case, the mental capacity assessments are carried out whilst he is in hospital and unable to access alcohol. The issues relating to his self-neglect and physical health needs were being met by hospital staff but the assessment needed to consider the wider knowledge and known pattern that when not under the influence of alcohol Joseph had mental capacity, but when he returned to his home environment, he was unable to execute his decision, from the perspective of his alcohol

addiction which is a compulsive behaviour and his ability to use information as part of his executive capacity.

The workshop held with practitioners from a range of agencies considered the issue of mental capacity and in particular, how that applied in cases of self-neglect, including the circumstances of Alice, Joseph and William. It was evident that mental capacity was often assumed as a default position and that there was a limited understanding of executive capacity amongst front line staff. AHC reported that there had been a significant improvement of understanding and use of the mental capacity act amongst their front-line practitioners, but this was not reflected to the same extent across partner agencies. There was a general view from attendees that more training and the availability of specialist advice would provide a greater confidence in applying the executive capacity element of mental capacity assessments.

The workshop discussed the use of the Court of Protection, both in terms of securing access to William's address and as a tool for working with cases in the present tense. Practitioners were also asked about the use of section 135 warrants under the Mental Health Act 1983 where appropriate to enable people with serious mental health issues to be assessed. Attendees from AHC demonstrated an understanding of the Court of Protection, the Multi-Agency Safeguarding Hub, (MASH) use the Court of Protection process for decisions on a regular basis. The understanding of the process was not well understood by many practitioners, particularly those outside of AHC. The OPMH team had a good understanding of the section 135 MHA powers. The level of understanding of the legislation and how it might be used was more limited in partner agencies.

The use of the court of protection, CoP, was discussed with the Learning and Review Subgroup, (LRS) who emphasised the need for practitioners to understand when, why and how to engage with the CoP. It was also important that front line staff were able to identify the level of decisions that should rightly be referred to the CoP and where appropriate, use the process with confidence. It was clear that in William's case, agencies were unclear as to their roles and responsibilities within the process, and whilst some of the delays were caused by external factors beyond their control, an improved understanding and better cross agency co-ordination may have enabled the plan to have been delivered more effectively.

6.4 Making safeguarding personal

The health and safety measures introduced during the pandemic reduced the level of face-to-face contact that many professionals had with the public and would appear to have impacted on the contact with Alice, William and Joseph as covered in section 6.1 of this report. Engagement with all three people

presented a very real challenge for practitioners trying to deliver a person-centred approach.

In William's case a section 42 enquiry had been initiated, as we will examine later in this report, a section 42 enquiry may have been justified in Alice and Joseph's cases. Where a section 42 enquiry has been initiated, section 68 of the Care Act 2014 states that the local authority has a duty to appoint an advocate if the person may have substantial difficulty in being involved with their safeguarding. Appointing an advocate for the person may increase the potential to engage with them and ensure that their voice and perspective is heard. Practitioners at the workshop reported that adult health and care are working on improving their processes to ensure advocacy support where appropriate and that people who meet the Sec 42 criteria are always spoken to directly with a person-centred approach adopted. The practitioners were clear that the principle of making safeguarding personal underpins service provision system wide.

6.5 Section 42 enquiries

In their report, 'Analysis of safeguarding adult reviews April 2017-March 2019' Preston-Shoot, Braye and others found that 45% of SARs commissioned in England during that period related to self-neglect. The detail provided about all three adults subject of this review would meet the criteria under section 42 of the Care Act 2014, in William's case the section 42 framework was in place, with respect to Alice and Joseph, decision making was through a MARM process.

The statutory guidance, DHSC chapter 14.17, states *'it should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend upon the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'.*

In both Alice and Joseph's case Sec 42 criteria was deemed not to be met. Professionals sought to use the Multi-Agency Risk Management, (MARM) process instead. This process is underpinned by robust guidance which supports the person-centred approach and multi-agency co-operation in managing/mitigating risk. It is not however subject to the statutory duties, including the duty to co-operate or the section 68 duty to commission an advocate that a section 42 enquiry involves.

The issue of section 42 enquiries was explored at the workshop with practitioners. Determining whether self-neglect meets the criteria for a section 42 enquiry is a subjective decision but where there is evidence of compulsive

behaviours, one needs to consider how that will impact on the person's ability to protect themselves by controlling their own behaviour. In both Alice and Joseph's cases, high risk self-neglect was identified and although neither person could be described as having the ability to protect themselves by controlling their own high-risk behaviour, they were not considered as meeting the criteria for a section 42 enquiry.

However, it was agreed by professionals, that where a person is self-neglecting, is physically/mentally unwell and presenting with potentially life-threatening risk, the section 42 duty would apply. This suggests that learning relating to this issue from the March 2022 thematic review is being embedded. This has been supported by work undertaken to review the MARM framework and ensure clarity about when to use MARM and when to use the Sec 42 framework.

The workshop practitioners suggested that the criteria for a section 42 enquiry were widely understood across Adult Health and Care, (AHC) but were not so well understood across partner agencies including Mental Health and Housing. Whilst practitioners from AHC had a clear understanding of the section 42 criteria, there were still challenges in applying the criteria to some individuals, particularly where they did not 'fit neatly' into the process. In the view of the review author, this would include supporting people who are self-neglecting and exhibiting compulsive behaviours.

The workshop also discussed the issue of making safeguarding referrals. Professionals appeared confident in terms of the process or route for making referrals and if there was some doubt, they were sighted on internal safeguarding teams for guidance. Whilst practitioners identified that there had been a reduction in safeguarding referrals during the covid period, the level of safeguarding referrals has increased significantly, with more referrals identifying self-neglect concerns, suggesting that learning and awareness of self-neglect from the thematic review is having an impact. There were concerns about the ability to determine when self-neglect reached a level where it became a safeguarding issue requiring a section 42 referral, this will be examined later in this report. There were also concerns raised with regard to people who refuse to engage with practitioners observing that the standard guidance and 'tool kits' are not effective in such circumstances. This is covered at section 6.2 of this report.

Both the practitioners, and the LRS, identified the quality of information contained within safeguarding referrals as a key issue. Whilst the level of referrals was increasing, the quality of information within those referrals was inconsistent. The lack of relevant information in some cases had a direct impact on the effectiveness of the risk assessments completed with respect to those individuals by the receiving practitioners.

The LRS reflected on the current methodology being used within the section 42 framework, particularly in relation to the holding of section 42 meetings and agencies responding to agreed terms of reference in silos rather than working effectively in a multi-agency approach. Section 42 should provide a framework that enables multi-agency leadership, co-ordination and a shared responsibility rather than agencies working individually. The LRS also noted that the number of section 42 meetings does not appear to reflect the increasing level of referrals.

6.6 Understanding self-neglect and hoarding

Practitioners reported that they found the hoarding guidance and clutter rating, implemented since the 2022 review, a useful tool kit and that they were more confident of identifying cases of hoarding. They also found high risk cases of self-neglect/hoarding to be more visible and therefore easier to identify whereas some practitioners were less confident of being able to identify the lower-level self-neglect cases.

Practitioners highlighted the fact that training for most staff with respect to hoarding cases suggested that identified cases of hoarding should be referred to the Community Mental Health Team (CMHT). This creates confusion and a level of frustration as CMHT cannot accept the referral as the referral should be for specialist services in their view. This is a clear identified gap in service provision that requires further exploration by the relevant HSAB members.

In all three cases examined within this report, high risk self-neglect was identified and additionally extreme hoarding in William's case. Although the risk was identified, professionals assessed that this was a lifestyle choice made by a capacitated decision in both Alice and Joseph's cases. It was also noted that practitioners at the workshop felt that what constituted high risk was a subjective decision and that different professionals would not necessarily view levels of risk in the same way. HSAB provide guidance with respect to responding to self-neglect which is helpful but could provide more robust guidance on issues such as determining high risk self-neglect, the impact of compulsive behaviours and working with those who services find difficult to achieve engagement. The guidance in place at the time was published in June 2020, more than a year before Alice, Joseph or William died and has since been updated.

6.7 Alcohol misuse

The abuse of alcohol was only an issue for Joseph of the three people subject of this SAR. Most of the alcohol related issues relating to Joseph have been adequately covered within the previous sections, the impact of covid, engagement, and professional curiosity and legal literacy so I will confine this section to considering the response from practitioners at the workshop.

The practitioners were asked to consider how confident they were in talking to people about alcohol misuse, including those with potential dual diagnosis issues. Some practitioners, mainly from the police and health, believed that their practitioners were confident in talking to people about their alcohol use, describing experience and training in this field as important factors. Colleagues from adult health and care and housing were not so confident with a lack of training being identified as a key factor in this. Some practitioners explained that alcohol affects people differently, in some cases there could be a volatility that may be misconstrued as aggression or non-engagement. Others felt that there was a stigma attached to substance misuse that impacted upon how professionals viewed dependent drinkers and that increased vulnerability wasn't always recognised.

The issue of dual diagnosis, (alcohol/substance misuse together with mental health issues), was discussed, practitioners expressing the view that support services sought to deal with one issue in isolation rather than tackling both together. There appeared to be limited understanding of dual diagnosis amongst practitioners although they were supportive of improving their working knowledge. The reviewer noted that the 'Dual-Diagnosis Good Practice Guide, (DH 2002), recommends that dual diagnosis services are mainstreamed, with joint planning between mental health services and those providing substance/alcohol services with mental health teams taking primary responsibility.

In Josephs case, he was not diagnosed with a mental illness and thus not considered to be suffering from dual diagnosis. That said, there were concerns expressed about his mental capacity and the fact that his alcohol addiction was impacting upon the 'choices' he made as previously discussed. Referrals were made to specialist services to try and address Joseph's alcohol misuse but he declined to engage with them, it is noted that the contact that the specialist service providers had with Joseph was by telephone. Practitioners need to consider that where a person has a history of challenging engagement, good practice may be to have a plan based on face-to-face contact and assessments.

7. Conclusion and questions for the board.

7.1 The terms of reference require the reviewer to consider:

- Any fresh learning from the three cases subject of this review, including good practice, that is different to that identified by the 2022 Thematic SAR.
- The learning that emerges in the light of what is understood already through national self-neglect research and self-neglect SARs.
- To what extent the learning from the original thematic SAR has been embedded.

7.2 It is important to reflect on the fact that two of the people involved in this review, Alice and Joseph, died before the original thematic SAR was completed in March 2022, and although William died in August 2022, most of the period under review in his case preceded the previous SAR. Understandably, many of the issues identified through closer examination of these three cases are reflected within the previous thematic SAR.

7.3 In all three cases, the people involved were difficult for professionals to engage with. Alice and William both led what are described as reclusive lifestyles and either refused or were very reluctant, to engage with services. In both cases there were 'windows of opportunity' had there been a more joined up, co-ordinated cross agency response. This includes when housing gained entry to the addresses of both Alice and William that could have provided the opportunity for joint visits and other professionals to have face to face engagement and to carry out assessments. Whilst in both cases, it is recognised that practitioners attempted to engage with Alice and William, more could have been done to achieve engagement with them. Where cases of high risk of self-neglect involve people who refuse to engage with services, professionals cannot simply disengage with them on the assumption that they are making a capacitated choice. There are a variety of reasons why front-line practitioners may accept a person's refusal to engage at face value but workload pressure may be a significant factor in making the investment of time to build a relationship with a person in these circumstances a particular challenge. The use of assertive outreach teams, with resources who have both the time and training to try and address the barriers with those 'hard to engage with' individuals was recognised by practitioners at the workshop as best practice, albeit this was not a resource available during the time periods under review.

7.4 In Joseph's case, there was regular contact with services, particularly the community nursing team, but services had increasing difficulty with engagement with from 2020 which coincided with a significant increase in his use of alcohol. Professionals appeared to accept Joseph's lack of engagement as a lifestyle choice despite the recognised impact on his physical health

conditions. As discussed at 6.2 in this report, research questions the ability of dependent drinkers, or indeed those people with compulsive behaviours, to make genuine choices. Ward and Preston-Shoot, in their ‘Safeguarding dependent drinkers report (2020), recommend the use of assertive outreach teams to try and engage with those dependent drinkers who refuse to engage with services.

7.5 Practitioners at the workshop accepted this as best practice and pointed to the ‘Enhanced Support Service’ pilot led by adult health and care. It was noted that within the numbers of cases referred to the service there is high success rates for engagement and low numbers of cases requiring risk escalation due to unsuccessful engagement during the pilot period. The workshop raised the fact that this remained a gap for OPMH. Whilst the LRS highlighted the sustainability of the ‘Enhanced Support Service’. The funding having been extended only for a further year, they also supported the view that a more integrated, system wide approach should be explored.

7.6 **Question for the board- Do the board have clarity with respect to the outreach services available across the system and would a more integrated provision ensure these services are effective and responsive to the themes raised in the review?**

7.7 The assessment of mental capacity, particularly in those cases where services found engagement with the person difficult to achieve, was a significant issue within the three cases subject of this review, and indeed an issue identified within the 2022 thematic review. In the specific cases under review, all three people were assumed by professionals to have mental capacity, although there is limited evidence recorded of mental capacity assessments being conducted. As discussed at 6.3, research and case law remind us, professionals need to consider both decisional and executive capacity and that mental capacity is both decision and time specific. When working with a person who is experiencing self-neglect, it is important to not only take into account the person’s ability to understand the decision in the abstract, but also look at their ability to realise when a decision needs to be put into practice and to be able to execute it at the appropriate moment. Furthermore, addiction and compulsive behaviours may impair someone’s executive capacity, compulsive behaviour can include self-neglect and hoarding.

7.8 At the workshop, it was evident that mental capacity was often assumed as the default position by practitioners. AHC reported that there had been a significant improvement amongst front line teams in terms of their understanding and use of the mental capacity act but that this was not reflected across partner agencies. Practitioners had a limited understanding of executive capacity and how that should be applied when assessing mental capacity.

7.9 **Question for the board-What measures can the board take to support practitioners in working with executive capacity? Should partners commission additional training and guidance for front line staff on this issue?**

7.10 Although practitioners informed the review that the Court of Protection process was regularly used by staff within the MASH and that staff within the AHC used the Court of Protection when required, there was limited understanding of the process, particularly across partner agencies. The Court of Protection was felt to be a useful tool for practitioners in appropriate circumstances, it was agreed at the workshop that further training to enhance knowledge and confidence of safeguarding practitioners in its use, together with the availability of expert advice and guidance, would be helpful. This was supported by the LRS.

7.11 **Question for the board - Is the board assured that professionals, system-wide, understand the role of the Court of Protection, how to access it, the level of decision making that should be referred and the opportunities that the process provides practitioners, particularly when working with high-risk self-neglect?**

7.12 Research identifies that 45% of SARs commissioned in England between April 2017-March 2019 relate to self-neglect, suggesting that responding effectively to self-neglect is a significant issue for safeguarding agencies nationally. Providing an effective response to self-neglect was identified in the 2022 thematic SAR and was a key issue within the three cases studies considered within this report. During the workshop, it was recognised that whilst practitioners from AHC had a clear understanding of the section 42 criteria, there were still challenges in applying the criteria to some individual cases, particularly where the person did not neatly fit into the process. It was also clear that the section 42 criteria were not so well understood outside of AHC. In the view of the review author, this would include supporting people who are self-neglecting and exhibiting compulsive behaviours.

7.13 Both the practitioners and the LRS identified the fact that although the level of referrals was rising, the quality of information within the referrals was inconsistent, the lack of information on occasions having an impact on the effectiveness of risk assessment and decision making.

7.14 Practitioners described having a sound knowledge of the process for making safeguarding referrals, this level of confidence was consistent across the range of partners. The issue of concern for some professionals focussed on identifying when self-neglect became a safeguarding issue. It was felt that defining high risk self-neglect was a subjective decision and that there may not be consistency in how individual professionals assess risk. It was noted that

HSAB provide guidance with respect to responding to cases of self-neglect but that this guidance could be more robust on issues such as determining high risk self-neglect, the impact of compulsive behaviours and managing those who services find achieving engagement difficult.

7.15 The LRS were concerned about the methodology being used within the section 42 framework, particularly in relation to the holding of section 42 meetings and agencies responding to agreed terms of reference as a single agency rather than working effectively in a multi-agency approach. Section 42 should provide a framework that enables multi-agency leadership, co-ordination and a shared responsibility rather than agencies working individually. The LRS also raised concerns about the number of section 42 meetings not reflecting the increasing level of referrals.

7.16 **Question for the board: Is the board confident that practitioners understand how to apply the section 42 criteria in cases involving self-neglect and what measures could the board take to improve the quality of section 42 referrals system-wide?**

7.17 **Question for the board: Is the board assured that the methodology being used within the section 42 framework is effective, in particular, the level of section 42 meetings being held and that agencies are responding in a joint, co-ordinated manner rather than operating in silos?**

7.18 **Question for the board: Is the board satisfied that the HSAB Self-Neglect guidance is suitably robust with respect to determining high risk self-neglect, the impact of compulsive behaviours and managing those people who services have difficulty in achieving engagement?**

7.19 Practitioners reported that they found the hoarding guidance and clutter rating a useful tool kit and that confidence in identifying hoarding cases had increased. It was also highlighted that training for most practitioners with respect to hoarding suggested that the referral route for such cases was to the Community Mental Health Team, CMHT, which created some confusion and frustration as CMHT will not accept the referrals as they believe that the referral should be to specialist services, although no specialist service is commissioned in Hampshire.

7.20 **Question for the board: There is an identified gap in the provision of services within the escalation pathway for cases of hoarding across the system, how can the board address this?**

7.21 Alcohol addiction was a key issue in the case of Joseph, including the ability of professionals to understand and manage the impact of addiction, (compulsive behaviours), on mental capacity, engagement and self-neglect. Joseph's case may also be seen to demonstrate the need for a greater investment in trying to encourage a person dependent on alcohol use to engage with alcohol addiction services, this was supported by research suggesting the need for focussed outreach services to be utilised. Practitioners reported that some partners, (Health and the Police), were much more confident in dealing with alcohol related issues than practitioners within other agencies. Alcohol and other substance misuse made mental capacity assessments more challenging and impacted on engagement with services. There was limited knowledge of 'dual diagnosis', in discussions between the reviewer and practitioners, with some practitioners reporting that this remained an issue with agencies working in silos when working with these cases.

7.22 **Question for the board: Is the board satisfied that the skills, knowledge and confidence are in place across the wider system to deliver positive outcomes for dependent drinkers who decline engagement with inclusion?**

8 Appendices

Appendix 1. Questions for the board.

Question no.	Issue.	Question for the board.
1.	Achieving engagement with service users.	Do the board have clarity with respect to the outreach services available across the system and any would a more integrated provision ensure these services are effective and responsive to the themes raised in the review?
2.	Executive capacity.	What measures can the board take to support practitioners in working with executive capacity? Should the board commission additional training and guidance for front line practitioners on this issue?
3.	Court of Protection.	Is the board assured that professionals, system-wide, understand the role of the Court of Protection, how to access it, the level of decision making that should be referred and the opportunities that the process provides practitioners, particularly when working with high-risk self-neglect?
4.	Section 42 Care Act 2014 (raising concerns)	Is the board confident that practitioners understand how to apply the section 42 criteria in cases involving self-neglect and what measures could the board take to improve the quality of section 42 referrals system-wide?
5.	Section 42 Care Act 2014 (enquiries)	Is the board assured that the methodology being used within the section 42 framework is effective, in particular, the level of section 42 meetings being held and that agencies are responding in a joint, co-ordinated manner rather than operating in silos?
6.	Section 42 Care Act 2014.	Is the board satisfied that the HSAB Self-Neglect guidance is suitably robust with respect to determining high risk self-neglect, the impact of compulsive behaviours and managing those people who services find achieving engagement difficult?
7.	Hoarding.	There is an identified gap in the provision of services within the escalation pathway for cases of hoarding across the system, how does the board propose to address this?
8.	Alcohol misuse.	Is the board satisfied that the skills, knowledge and confidence are in place across the wider system to deliver positive outcomes for dependent drinkers who decline engagement with inclusion?

Appendix 2. Glossary.

AHC	Adult Health and Care, (Local Authority).
CCG	Clinical Commissioning Group, (now Integrated Care Board, ICB).
CHC	Continuing Healthcare assessment.
CMHT	Community Mental Health Team.
CoP	Court of Protection.
CN	Community Nurses.
DHSC	Department of Health and Social Care.
GP	General Practitioner.
HIWFRS	Hampshire and Isle of Wight Fire and Rescue Service.
HSAB	Hampshire Safeguarding Adults Board.
LRS	Learning and Review Subgroup.
MARM	Multi Agency Risk Management meeting.
MASH	Multi Agency Safeguarding Hub.
MHA	Mental Health Act.
MPFT	Midlands Partnership Foundation Trust.
OPMH	Older Persons Mental Health team.
POLICE	Hampshire and IOW Constabulary
PPN 1	Public Protection Notice.
SAR	Safeguarding Adults Review.
SCAS	South Central Ambulance Service.