Redbridge Safeguarding Adults

Redbridge Safeguarding Adult Board (RSAB)

Thematic Safeguarding Adult Review (SAR): Self-Neglect

"Deborah" and "David"

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1. Introduction

1.1. This thematic review looks at self-neglect in Safeguarding Adult Reviews (SARs) by reviewing the cases of 'Deborah' and 'David' (anonymised). The cases are not connected but when considering the requirement to undertake a SAR in both cases similar concerns relating to issues of self-neglect were identified.

1.2. The Redbridge Safeguarding Adult Board (RSAB) has also undertaken several SARs since 2022 where aspects of self-neglect have been present. This Review also considers those findings and progress on responding to the recommendations of those SARs.

2. Safeguarding Adult Reviews

2.1. Under Section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies because 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. If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

2.2. The purpose of conducting a review is to enable members of the SAB to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies to make recommendations for future action.

2.3. The aims of a SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis of the findings (what went wrong and what went right) in these cases. By further consideration of previous learning identified in other SARs undertaken in the Borough, recommendations have been made to continually develop practice in managing self-neglect.

2.4. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

3. Methodology

3.1. The RSAB Independent Chair has been requested to review the cases of 'Deborah' and 'David' in the context of the findings of other SARs undertaken since 2022.

3.2. The SAR has been informed by summary evidence submitted by key agencies and from this, a chronological approach was taken to understanding and analysing key events. In the case of 'Deborah' there was substantial information already available from the Inquest[1] which had taken place in August 2023.

3.3. The Review then reflected on what is already know about the multiagency response to self-neglect from other SARs that have taken place in the borough and nationally.

3.4. A Round Table Event was held to bring together professionals from both senior and frontline practice to reflect the findings of 'Deborah' and 'David's' cases and consider the actions that have been undertaken in response to previous SARs both local and National.

3.5. In the context of the information provided the event considered; as a system are we making the right responses to improve multiagency practice in response to self -neglect and what could enhance current practice across the system and address barriers that are experienced.

3.6. The Round Table Event identified several actions it considered would support to improve practice in response to self-neglect.

4. Self-Neglect

4.1. The recognised definition of self-neglect in adult safeguarding, as outlined in the Care and support statutory guidance, February 2025, is:

> *Self-neglect is a wide range of behaviours where an individual neglects to care for their personal hygiene, health, or surroundings. This can include behaviours such as hoarding.*

[1] An inquest is a judicial inquiry in common law jurisdictions, particularly one held to determine the cause of a person's death.

4.2 Self-neglect is often associated with underlying issues such as mental health problems, physical illness, social isolation, and past trauma. It poses significant risks to the individual's health and safety, and addressing it requires a compassionate, multi-disciplinary approach[2].

5. Hoarding Disorder

5.1. Hoarding disorder is described as the persistent difficulty discarding or parting with possessions, regardless of their actual value.[3] This difficulty is due to a perceived need to save the items and distress associated with discarding them.

5.2. Key features of hoarding include:

- Excessive Acquisition: Often involves the accumulation of items that may or may not be needed.
- Difficulty Discarding Items: The individual finds it very hard to dispose of items, leading to clutter.
- Cluttered Living Spaces: The excessive accumulation of items significantly impacts the living spaces, often making them unusable for their intended purposes.
- Distress or Impairment: This behaviour causes significant distress or impairs social, occupational, or other important areas of functioning.

5.3. Hoarding can be linked to various underlying issues, including:

- Mental Health Disorders: Such as anxiety disorders, depression, and obsessive-compulsive disorder (OCD).
- Trauma and Loss: Previous traumatic experiences or significant losses can contribute to hoarding behaviour.
- Social Isolation: Loneliness and lack of social support can exacerbate hoarding tendencies.
- Addressing hoarding often requires a multi-disciplinary approach, including mental health support, social services, and sometimes legal interventions to ensure the individual's safety and well-being.

6. The Cases

6.1 'Deborah'

[2] https://www.scie.org.uk/self-neglect/at-a-glance/

[3] 1.1. American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC: APA.

6.2 ‘Deborah’ died in hospital in December 2022 from sepsis relating to leg ulcers and pressure sores following admission to hospital in September 2022 when she became critically unwell at home, with clinical signs of sepsis. On admission ‘Deborah’ was observed to present with signs of severe self-neglect. ‘Deborah’ was fifty one years old at the time of her death.

6.3 ‘Deborah’ had numerous lesions to her skin on her chest, armpit, anterior lower legs and the entirety of her posterior lower limbs reaching her sacral area. ‘Deborah’ had an ungradable pressure sore along with other lesions on her buttock.

6.4 ‘Deborah’s’ limbs were severely oedematous and the skin on her legs and feet had extensive cellulitis which had caused chronic ulceration, discoloration and a tree bark texture. Her toenails were long and infected.

6.5 ‘Deborah’ had extensive uterine fibroids that had progressed to a stage that had impeded her mobility and continence.

6.6 Despite interventions, which included surgical intervention to debride the dead ulcerated skin and tissues, ‘Deborah’ succumbed to infection and passed away.

6.7 Information provided to the coroner identified self-neglect and refusal of intervention by ‘Deborah’ over a substantial period.

6.8 The area of concerns identified by the corner that needed responding to prevent future deaths included:

- ‘Deborah’ was provided with domiciliary care commissioned by the local authority since 2020, at the time of her death they were twice a day. ‘Deborah’ was known to use the care provided to deliver fast food to her home and no personal care was being delivered. The care agency had escalated their concerns to the local authority that ‘Deborah’ refused to accept personal care and her living conditions.

- In the months leading up to her death ‘Deborah’ was visited and assessed on a regular basis by district nurses, the community matron and her GP. No steps were taken to escalate the care she received to mitigate the risks.

- ‘Deborah’ was assumed to have capacity and consequently it was determined that no practical steps could have been taken to improve her care. No formal capacity assessments were ever undertaken or considered.

- No formal referral was ever made to mental health services to consider why she did not take up any offers of care.

- The coroner also raised concerns that NELFT did not consider undertaking a Serious Incident Investigation as the pressure sore was insufficiently significant to warrant investigation. The pressure sore was much more serious than appreciated in the community.

6.9 'Deborah's' cousin made a statement to the coroner about 'Deborah', describing her as a pleasant, witty, well poised and self-determined person. As a young person she had attended education and gained employment. In her twenties 'Deborah' struggled with the effects of a fibroid which had a negative impact on her lifestyle as it had grown hugely. She was reluctant to have an operation to remove it and declined less intrusive intervention (which her mother offered to source privately). The fibroid grew visibly larger, and she remained reluctant to have it operated on. Her gait became slower, and 'Deborah' started to use a walking stick to mobilise.

6.10 'Deborah' was reported not to have friends and became reclusive during her twenties. Her finances were held in trust and provided monthly. 'Deborah''s home environment started to become noticeably cluttered and she regularly declined her cousin access to her home. Hoarding was reported to be prevalent during the period that 'Deborah' lived with her mother before her death in 2010. 'Deborah' had had her home decluttered in 2017 as part of a discharge plan following rehabilitation. Indicating that 'Deborah''s problems with not engaging with necessary health care (self-neglect) and hoarding were longstanding.

6.11 **'David'**

6.12 'David' was forty-seven when he died. At the time of his death, he had multiple mental and physical health diagnosis for which he was receiving medication. 'David's' history is not clear, but it was established after his death he has a mother who lives in the United States of America (USA) and a brother in the UK. It is known that 'David' had a history of substance misuse and had served a twelve-year custodial sentence in the USA for armed robbery and kidnap following which he was deported back to the UK in 2018. Information for this Review has only been sourced for the two years prior to his death.

6.13 At the time of his death, he was living temporarily in a hotel in Ilford, accommodated by the Home Office, following a move from a House of Multiple Occupation (HMO) property in the London Borough of Bexley in 2023. From information made available

from the Drug and Alcohol Service in Bexley, 'David' reported to be in North London following his arrest and eviction from his property for exposing himself to neighbour.

6.14 On the day prior to his death, 'David' was found unresponsive by a member of the hotel staff and transferred to hospital where he died the following day, with pneumonia and possible sepsis in June 2024.

6.15 It appears that 'David' had only lived in Bexley from around October 2022 having previously been living in Enfield. Whilst in Bexley he had some engagement with the local Drug and Alcohol Service, to whom 'David' reported that he had a history of methamphetamine use 15 years prior, and had been diagnosed with schizophrenia, he reported that he suffered anxiety and history suicide attempts, liver disease, pancreatitis. 'David' had experienced multiple hospital attendances due to alcohol issues and had treatment and support interventions. 'David' sustained abstinence for the period of treatment in Bexley and successfully discharged from there service in June 2023.

6.16 'David' had a second presentation to the Drug and Alcohol Service in Bexley in October 2023, when he was referred by the court on a Drug Rehabilitation Requirement and Alcohol Treatment. One month into his treatment 'David' relapsed to drinking. In December 2023 'David' reported that he had moved to North London.

6.17 In January 2024, 'David' attended the Emergency Department (ED) at Barking, Havering and Redbridge University Hospital Trust (BHRUT) with mental health problems. Due to physical health complications, 'David' was admitted and discharged a few days later following a mental health assessment and subsequent referral to the Redbridge Community Mental Health Team (CMHT).

6.18 At the beginning of April 2024, 'David' was admitted to hospital again following his attendance at the ED with abdominal pain and distension. During admission it was identified that he had chronic liver disease secondary to his alcohol use. 'David' was seen by the Alcohol Liaison team and referred on for support.

6.19 Following this admission 'David' was assessed and invited to attend psychosocial interventions at Via (Drug and Alcohol Service). He only attended twice and as per organisational policy a re-engagement process was commenced including a welfare check the day before his death.

6.20 'David' had also been referred, with his consent, to the Redbridge Mental Health & Wellness Teams (MHWT) in mid-January 2024 by the Psychiatric Liaison Service (PLS) for community mental health support and was also referred to Via to address his substance misuse issues that were identified during assessment. Following screening

later that month the referral was accepted for a routine telephone triage then signposting to Via. The triage contacts never happened until April 2024 when it was picked up as part of caseload cleansing that it had been missed.

6.21 A telephone assessment took place with 'David' on 27 April 2024. The risk assessment, when completed was low, and it was based on the information provided by 'David' during the assessment. 'David' declined a referral to Via to support his abstinence from drugs and alcohol and he only wanted a medical review by a psychiatrist. The care plan involved booking a face-to-face medical appointment and update the risk assessment. 'David' did not attend the arranged appointment.

6.22 At the time of his death, 'David' was known to the National Probation Service (NPS) following his attendance at Bexley Magistrates Court in October 2023 for the offence of Common Assault of an Emergency Worker. He received a twelve-month Community Order with requirements of 20 days Rehabilitation Activity Requirement and a 3-month Alcohol Treatment Requirement. 'David' was reporting to the Probation Office on a weekly basis, where he would often report drinking heavily and not complying with his medication because of this.

6.23 From the information provided to the review the following area of concern have been identified:

- 'David' moved frequently and was in temporary accommodation in Redbridge. There is no evidence of any handover of information before he moved into the Borough. This gives rises to concern given 'David''s disclosure to the drug service in Bexley that he had exposed himself to a neighbour, in addition to the loss of continuity of support for 'David'.

- There appears to be little multi-agency working to support 'David' to the services working with him (Mental Health Service, Via, NPS and GP), including gathering historical information from other boroughs.

- The delay in assessment of three months following referral to the CMHT.

7. Findings and recommendations from SARs already undertaken in Redbridge

7.1. The following SARs undertaken locally identified learning in relation to self-neglect:

- SAR 'Barbara'
- SAR 'Caleb'
- SAR Family 'A'
- SAR 'Hilary'

7.2. In response to the findings the following actions have been taken in relation to self - neglect:

- Development of the Community MARAC and the Multi-Agency Cuckooing Guide and Pathway;
- Development of the locality based Complex Case Panel Meetings in Adult Health and Social Care;
- Strengthening links with the Redbridge Community Safety Partnership;
- Review of the Multi-Agency Self-Neglect and Hoarding Protocol;
- Development of a 'Think Family' Briefing' (delivered as part of the RSCP Training Programme);
- Development of the Local Authority Safeguarding Adults Hub; and
- Development and publication of the 7 Minute Briefing on Professional Curiosity.

8. National Findings on Self Neglect

8.1 The Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 noted a marked increase in self-neglect (45% to 60%) and that self-neglect peak in the mid-years, this is reflected locally in the ages of 'Deborah' and 'David'.

8.2 The analysis identified the following key themes that also resonate with local SARs:

- Professional culture and negative attitudes: risky/distressed behaviour viewed as 'lifestyle choice', attention-seeking, non-compliance/engagement. Professional appeared resigned and had low expectation of change.

- Safeguarding that was not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs left out of decisions/discussions about their support.

- Failure to recognise the significance of repeated patterns of engagement followed by disengagement. Some agencies lacked flexibility in their expectations/approach for engagement.

- Multiple SARs noted shortcomings in relation to risk; absence of risk assessment was common.

- Uncertainty about when and how to share information without consent; and examples of where key information had not been shared with other agencies as it was viewed too sensitive.

- SARs showed there is a significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding.

8.3. Self-neglect - Learning from Safeguarding Adult Reviews, research and lived experience (Professor Michael Preston-Shoot, 2022) made the following recommendations:

- In Multi-agency Risk Management Meetings (what do we mean by autonomy, risk etc.?)
- Legal literacy – consider all legal options
- Maintain a shared record of decision making, having evaluated options
- Make persistent offers of support & respectful challenge (be cautious about case closure)
- Maintain updated risk & executive capacity assessments (including how beliefs & experiences shape wishes)
- Consider mental health, risk to others and dignity

8.4. The research also identified best intra-organisational practice as:

- Providing guidance on balancing autonomy with a duty of care
- Clear information sharing and communication expectations
- Working together on complex, 'stuck' and 'stalled' cases
- Use of multi-agency meetings and safeguarding enquiries
- Clear roles and responsibilities (lead agencies and key workers)
- Shared record keeping

9. Findings

9.1. The Roundtable Event reflected on the cases of 'Deborah' and 'David' in the context of what has been put in place following local recommendations and the national findings and identified the following areas of practice where further development is needed.

9.2. In the case of 'Deborah':

- Understanding and enactment of roles and responsibilities in relation to poor engagement in terms of escalation and risk management; and
- Use of the Mental Capacity Act 2005, including knowledge and understanding of fluctuating and executive capacity.

9.3. In the case of 'David':

- Maintaining oversight when people frequently move between local authority areas and temporary accommodation.
- Addressing social isolation when there is no evidence of a friends and family network of support.
- Utilising and sharing risk assessments when considering the accommodation changes.
- Multiagency working to identify repeated patterns of engagement followed by disengagement, including gathering the history from other local authorities.
- Multiagency working would highlight issues such as the delay in an assessment of three months following referral to the CMHT.

10. Barriers and challenges

10.1. The thematic review has identified the following barriers and challenges in Redbridge to supporting best practice:

- Absence of shared risk management – no Multi-Agency Risk Management (MARM) Framework in place for Redbridge.
- Lack of joint recording/case management system between mental health and adult social care.
- Disjointed care between Primary Care and other health services due to lack of a shared record which doesn't support a holistic response to individuals.
- The lack of a Trauma Informed Practice approach across the whole 'system' to improve understanding, particularly of behaviours and engagement issues.

11. Recommendations

11.1. The RSAB has undertaken several reviews, all of which echo some or all the national findings. This Thematic Review has provided the opportunity to consider a systemic approach to responding to self-neglect, considering the underlying barriers and challenges. At the present time, the RSAB does not have a Multi-Agency Framework to support anyone working with an adult where there is a high level of risk of harm and the circumstances sit outside the statutory adult safeguarding framework.

11.2. Cases of self-neglect are complex and require a multi-agency response and management oversight. On a single agency basis, a response to self-neglect is unlikely to be able to provide effective support and solutions to the situation.

11.3. The following recommendations are made to enhance the progress already made in response to local SARs.

11.4. **Recommendation 1**

The RSAB should develop, publish and embed a frame work and guidance for a Multi-Agency Risk Management (MARM) approach to guide and support professionals in management cases from low to high level risk. The guidance needs to be underpinned by outlining professional roles and responsibility; escalation and responses to "non-engagement"; consideration of autonomy, mental capacity and addressing information sharing challenges. The framework should include the ongoing monitoring of risks, to inform decisions about case closure and escalation.

11.5. **Recommendation 2**

The RSAB Self-Neglect and Hoarding Protocol (2nd Edition) to be revised in tandem with the development of the MARM guidance and to be underpinned by a "Think Family" model and Trauma Informed Practice. The revised Protocol should also include reference to gaining access to a home in order to support an adult at risk.

11.6. **Recommendation 3**

The RSAB to review the use of the language 'Professional Curiosity' with 'Compassionate Enquiry' or 'Compassionate Curiosity', to help explore why services are not able to engage with a service user and help identify where support may be needed and understand wishes and feelings.