WSAB Lessons Learnt Briefing - Self-Neglect

What is the WSAB?

Warrington Safeguarding Adults Board (WSAB) is the local strategic partnership responsible for:

"Warrington's Safeguarding Adults Board will oversee local arrangements to ensure that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and enabling adults at risk of neglect and abuse to have a voice".

Shirley Williams, Independent Chair WSAB

What is a Safeguarding Adults review?

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

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

The WSAB also has the freedom to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death and address, where appropriate, questions family or friends of the adult may have. This is so that lessons can be learned from the case, and those lessons applied to practice to prevent similar harm occurring again.

Cases can be referred to WSAB for consideration by completing the SAR referral form in the professional's area of the WSAB website . Anyone can refer a case for consideration.

What is this document?

This is a briefing sheet that WSAB have decided to use to cascade lessons learnt either from screening cases or conducting SARs. They will contain information that we think the front line needs to know alongside useful links to practice guidance that might support you in dealing with complex cases.

What should I do with this?

We are asking all practitioners and team mangers to reflect on the information in these briefings. We need everyone to consider how they relate to their practice and what they may need to do differently. You will find a feedback sheet at the end of the document to send back to us to evidence how you have used this information.

Alongside producing briefing SARs we also offer lunchtime workshops so that you can come along and hear about findings from a range of cases and audit processes. You can receive details of these sessions by emailing - wsabadministrator@warrington.gov.uk

How Can *YOU* make a difference?

By reading this document and considering your own practice or arranging to discuss this in a team meeting you are helping the WSAB share lessons learnt. You are also ensuring that these translate into meaningful changes in practice.

You might also identify from reviewing that there may be other issues or needs that arise and could share these with us. For example, you might identify a training or service gap that we want to hear about.

Further Reading:

1. www.warrington.gov.uk/wsab select professionals tab to see the self neglect policy nad resources available locally
2. SCIE resources for practitioners - https://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/
3. RiPFA – Self Neglect Tool for practice – a guide to working with those that self neglect https://www.ripfa.org.uk/resources/publications/practice-tools-and-guides/working-with-people-who-selfneglect-practice-tool-updated-2016/
4. Skills for Care provide tools and resources for self neglect focused arounf working those choosing to live at risk - https://www.skillsforcare.org.uk/Topics/Self-Care/Self-care.aspx

The Case Summary

Robert[1], 74, was admitted to Warrington Hospital after community staff identified a significant deterioration in his health. He sadly died of Chronic Obstructive Pulmonary Disease (COPD). He had a number of health issues which had affected his swallowing and ability to mobilise. Alongside these challenges he had other comorbidities including ulcerative colitis, cardio-myopathy, type 2 diabetes and a pulmonary embolus. These health issues resulted in a day to day pattern of sitting in a chair at home interacting only with his partner or the health staff allowed access to the home. When the ambulance was called Robert was noted to have a grade 3 pressure ulcer to his sacrum, he was unkempt and presented with deteriorating health conditions that had not received the treatment required. The community staff made a referral for a SAR after undertaking a reflection on their practice as they believed that we may have been able to work more effectively together to prolong Roberts's life. It was understood that regardless of interventions Robert was on the end of life care pathway and was ultimately going to die from his health conditions.

What happened Next?

The SAR referral was received by the WSAB team and a screening panel was called at the request of the Chair. The panel met on the 26th June 2018 to review a multi-agency chronology of agencies contact with Robert and his partner and discuss the case with the following organisations and practitioners:

- General Practitioner – Primary Care
- Safeguarding Adult Lead & Ward Manager – Acute Trust
- Safeguarding Adult Lead & Clinical Manager – Community Trust
- Advanced Paramedic - North West Ambulance Service
- Team Manager – Warrington Borough Council

Alongside the practitioner group the panel is made up of a variety of agencies to enable a range of expertise to consider whether or not the case meets criteria. On this occasion the panel did not feel that a SAR was warranted. This was because there was not clear evidence of abuse and neglect towards Robert. In this case, as will be outlined below, it was felt that agencies had attempted to engage with a couple who were reluctant to accept external support or interventions. Whilst we identified learning to share across our partnership there were clear attempts made to establish rapport with Robert and work collectively at points to manage his decision to live at risk. Therefore, it would not have been proportionate to conduct a statutory SAR. In agreement with the practitioners it was decided that the case should be highlighted to other professionals so that they can learn from the case. The following sections will outline key messages for practice as identified by the panel with practitioners involved.

Who was Robert?

Robert and his partner had lived in their own home in the same area for many years. Their children lived nearby with grandchildren. They were known to keep to themselves with Roberts's partner looking after a family member in later years leading to a routine of leaving Robert alone in their home during the day. Robert had always been reluctant to have any interventions from agencies, often needing to be cajoled into attending his GP surgery. Throughout the period of this review (November 2015 to February 2018) both Robert and his partner were recorded as declining the majority of interventions offered. This included assessments by social care, equipment to aid

[1] Pseudonym used to protect privacy.

Further Reading:

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mobilisation and pressure areas, specialist health services, mental health support, and district nurse interventions. On the occasions where the offer was accepted it was then later rejected. The one aspect that the couple appeared initially to engage with was the offer to support rehousing to a bungalow but Robert later stressed his desire not to leave their home. Over the period of review approximately 60 refusals of services / support can be seen. Whilst it was highlighted from the review that both Robert and his partner were uncomfortable with professionals in their home these offers were often facilitated through a community matron who had managed to establish sufficient rapport to enter the property and engage with them. Therefore, professionals were attempting to utilise a conduit that may have encouraged engagement.

Robert had experienced depression during his life and struggled with medication that was prescribed. He was clearly experiencing exacerbated mental health issues towards the end of his life as a result of his limited mobility, discomfort, and contact with professionals and deteriorating health state. What was clear to the panel was that Roberts's final months would have been challenging and unlikely to have provided a good quality of life.

Alongside these challenges Robert also lived within a home where hoarding was clearly a pattern of behaviour. It was unclear to the panel whether this was as a result of his partners needs or a state of living that had simply become normalised to the couple. The home was described as difficult to move about in, with several areas inaccessible such as bathrooms.

Professionals clearly identified that Robert was not keen to actively treat his conditions but let them run their course. He agreed with a DNACPR and had made his wishes clear that he wished to die within his own home when the time came.

Good Practice Points:

From the multi-agency chronology it was apparent that professionals had considered good practice guidance in their approach.

Community staff had recognised that the persistent refusals of service would not be overcome without investing time in building a relationship with the couple. There was evidence of a responsive service to Robert that recognised the need to respect their right to decline services whilst trying to establish a rapport that may allow further offers of support to be accepted.

There was evidence of agencies sharing information to enable joint visiting and support successful entry to the home. Albeit this was predominantly visible within the health sector.

There was evidence of perseverance by a range of professionals when it came to refusal of services. Whilst there is finite resource and a balance to be achieved between continued offers of support and respecting an adult's right to decline this seemed to be managed in this case. Health professionals used education and information to encourage engagement and ensure informed decisions to refuse treatment were supported. This was clearly challenging for staff members that could see the detrimental impact on Robert but they effectively used sharing of concerns to manage these often competing stances. This demonstrated an underlying recognition of the making safeguarding personal ethos.

There were also examples of appropriate escalation to safeguarding processes and reconsideration of these as circumstances changed.

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Overall, there was some clear insight into working with self-neglect demonstrated. Professionals were persistent but respectful of an adult's right to make unwise decisions.

Nevertheless, as will always be the case the review identified some potential areas for learning and missed opportunities which are explored below.

Key Learning Point 1: Mental Health vs. Physical Health

In 2016 Robert was struggling with his depression and had made comments suggesting he wanted to harm himself. Over the period of the review this continued at different points. The panel reflected on whether or not due to his complex health issues his mental health needs had been overshadowed. Discussions with the practitioners demonstrated some awareness and the chronology indicated offers of counselling being declined. There was evidence that at points his mental health had been considered but then been eclipsed by his growing physical health issues. The case demonstrates how in complex cases it is a challenge for practitioners to maintain focus on the impact of depression. The panel were able to reflect on this with practitioners to identify that this could be vital when unwise decisions are being made due to its impact on executive decision making.

Professionals need to ensure that where mental health issues are identified these are responded to and recognised as potentially detrimental to executive decision making.

Key Learning point 2: Understanding the Dynamics of the Household

The panel noted that from the multi-agency chronology it was unclear what the nature of the relationship between the couple was like. The recording indicated both elements of controlling behaviour by Robert's partner and caring actions. It was only through discussion with the various practitioners that the more complex picture emerged accurately.

Robert and his partner both appeared to be strong characters in terms of how they wished to live. Whilst some professionals saw his partner as controlling access and providing poor care others saw a partner respecting Robert's own wishes. The reality appears to lie somewhere between these two viewpoints. Whilst there were some concerns that coercion and control[2] may have been missed the reality appeared to be a partner who was obstructive to professionals potentially at Roberts request and in line with his views as well as her own desires. There was evidence from other professionals that Robert was not always compliant with care which again changes our understanding of a partner not carrying out care as requested by professionals. Sadly we cannot know for certain if Robert's partner was being obstructed herself or was struggling to care as required for other reasons. What is clear is that a potential pitfall for professionals

[2] The cross-Government definition of domestic violence and abuse outlines controlling or coercive behaviour as follows:

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

You can find more information here

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is not fully understanding the dynamics of a home and how this might impact on decision making.

One potential missed opportunity around this area was when his partner requested to meet professionals away from the home to avoid "stressing" Robert out. Professionals focused on the process of not exploring client's options without the client and missed the opportunity to understand his partner further and potentially establish a relationship with her. This may have allowed the dynamics to be better understood and subsequently managed. Likewise professionals may have had the opportunity to identify her own support needs at that point. Judgements regarding persons of interest may be made incorrectly if we don't fully understand the unique relationships households have.

Professionals should ensure they have reflected on the dynamics in a household and how these may impact on behaviour and decision making.

Key Learning point 3: The role of the MDT

Practitioners involved in the case identified at least two points where a multi-disciplinary meeting may have supported their practice; post discharge from the hospital with services declined and emerging concerns with the care provided at home. Whilst these meetings may not have changed Robert's engagement or the final outcome they would have offered professionals the opportunity to sense check their assessments and views. Although these meetings did appear to happen at times either in one sector, such as health, or between a few practitioners they were not routinely used to support practice.

The panel was able to see how a professionals meeting may have shared responsibility, allowed group review and reflection. There is a concern that professionals did not recognise that they were able to hold professionals meetings even when safeguarding responses are not triggered. As noted in the previous section it was only by speaking to the GP, ward manager, community service and social care that the panel felt a clear picture of the couple emerged. Therefore, by not regularly bringing agencies together professionals had potentially hindered their understanding of the case and increased their individual burden.

The panel heard how the Stockton Heath GP practice regularly utilised single sector MDT for cases. This was noted as good practice and an area that could be utilised as a forum for multi-agency meetings.

Professionals should utilise multi-agency professional meetings to support practice in complex cases to ensure robust information sharing, shared responsibility and regular opportunities to reflect on practice.

Key Learning point 4: What's in a record?

Record keeping can easily be minimised as a priority in a busy working environment. The dangers of this are that communication suffers and in some cases legal responses are hampered. Whilst on this occasion this was not the case it did become evident that records could not give a clear picture of the case from the adult's perspective and carried some statements that could bias practice.

For example, the way records had been written it was difficult to see that anyone had asked Robert what he wanted or understood his views. However, on talking to professionals it was clear that conversations had been had with him about this. Similarly, subjective statements were included that may bias peoples response to Robert and his partner. For example, it was often recorded that "she

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would not allow" or "services were declined". The panel reflected that for other professionals reading these records it was not clear who had said what and whether Robert was in agreement or passively accepting decisions made by his partner. If clear and concise records are not kept then it is difficult for other professionals reading them to understand the dynamics and the associated risks.

Professionals must ensure that their recording is clear, factual and provides evidence for professional judgements[3].

Key Learning point 5: Supervision & Escalation

There were times during the screening process that it was evident that professionals were not satisfied with the decisions made by others. However, we could not see evidence of the escalation policy being utilised. Good multi-agency practice means we all have to be open to feedback about our decision making. The escalation policy is in place to encourage all professionals to feel empowered to challenge a decision made. This is vital as a check and balance in the system. The policy can be accessed on the Board website on the professional's page.

The policy encourages professionals to discuss concerns with their managers if they are unable to resolve directly. This can then lead to senior managers in organisations discussing decision making. In cases where disputes cannot be resolved then Board members and the chair will review decisions made. In this case professionals could have utilised the escalation policy during their supervision sessions to seek clarification on why certain actions were not taken. Although escalation will not always lead to changes in decision making it does ensure that decisions are appropriately challenged and rationales reconsidered in complex cases.

Professionals should receive regular safeguarding supervision that enables reflective practice on complex cases and appropriately triggers the WSAB escalation policy as needed.

Key Learning point 6: When is enough?

The panel could see that professionals had attempted to engage Robert. They had clearly thought to try and establish a rapport over time in an effort to achieve better engagement with services offered. The challenge of self-neglect is the resource commitment needed to establish a relationship that may lead to engagement. Professionals in the meantime have to recognise and accept the person will live at risk.

The panel could see that professionals would have benefitted from greater clarity around what is expected in such cases. This would enable them to have a framework when conducting professionals meetings and reflecting on work to date. Although we would wish to see effective engagement and positive outcomes in all cases it is likely that despite professionals acting appropriately and effectively that some service users will still choose to live at risk. In these cases professionals need to be empowered to identify when to continue would be to infringe the person's right to make unwise decisions. Staff could have accessed the self-neglect tools and assessment documents on the SAB website for support but do not appear to have done so.

The Board needs to develop a clear framework of expected practice in self-neglect cases that offers professionals a clear understanding of expected actions.

[3] Effective recording guidance can be found from SCIE at: https://www.scie.org.uk/publications/nqswtool/information/

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someone else will make the referral

Key Identified actions:

After screening this case the panel identified the following as key actions to take forward:

1. Development of practice guidance for MDT meetings lead by a lead professional
2. Development of practice guidance on what practice is expected in self-neglect cases
3. Primary care to consider expanding surgery based MDTs to invite wider professionals outside of the health sector
4. Deliver some practice briefing lunchtime workshops to encourage professionals to discuss lessons learnt & identify additional tools & resources that may aid local practice

Messages for practice:

When working with self-neglect always consider the dynamics within the household and how they might be impacting on decision making.

Don't forget the other adult – individuals support needs may not always be in focus especially in cases of past trauma or bereavement.

Just because it isn't a safeguarding case does not mean professionals cannot work together to reflect on issues and approaches.

There are three core pathways to statutory intervention; lack of capacity, mental health concerns, inherent court of jurisdiction. It is useful to consider and rule out each in complex cases.

Whenever an adult experiences or is at risk of possible abuse and neglect safeguarding referrals should be made to the Local Authority via 01925 443322 – don't assume

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Practice Guidance and Further Reading

The Human Rights Act outlines the state's responsibilities to both safeguard and respect its citizen's rights to life, liberty, property, due process and privacy – all of which are particularly relevant in self-neglect situations, placing a responsibility on the state to only intervene where necessary. With the implementation of Safeguarding Adult Reviews (SARs) the level of scrutiny on professional practice has been clarified making it crucial that basic practice expectations are clear to all. To support this the SAB developed clear expectations within its Self-Neglect policy statement. Some of these are outlined below and can be read in more detail by reviewing the document and tools on the SAB website by clicking here or using the link below in item 1 of the further reading list.

According to the Social Care Institute for Excellence there is no one clear view of self-neglect as an issue. It can be described across a spectrum from psycho-medical condition to a socio-cultural issue of values. In reality the models used to help define it draw on mental, physical, social and environmental factors to help professionals understand how a person comes to reside in unsafe living conditions with an apparent lack of insight into the risks (SCIE report 46).

Whilst there is no one single effective intervention model, learning suggests professionals need to establish relationships over time and utilise risk assessment tools sensitively. Focus and activity around daily living tasks may also be more beneficial to achieve longer term change. Guidance suggests that the individual needs to be able to demonstrate not only that they understand their situation, but that they are also actioning the decisions they make in relation to their circumstances. Things to be alert for in your practice:

- The perception that this is simply a 'lifestyle choice'.
- Over reliance on previous assessments or decisions about eligibility, engagement, risk or capacity
- Lack of multi-agency working and information sharing
- Lack of engagement from the individual or family
- Challenges by the individual/ family to activity that minimises risk
- Making unsupported assumptions about family/ carer or other support available
- De-sensitisation to/from well-known cases, resulting in minimisation of need / risk

It is recognised that hoarding can be a distinct illness, or part of another health problem, for example, part of the symptoms of dementia. However, professionals should not assume that hoarding is always a sign of a mental health need, as there is no distinct type of individual that may hoard and in each case the materials collected will vary. The nature of material collected can be categorised into 3 types; inanimate objects, animals or data (including physical equipment and electronic data). Individuals who display hoarding behaviour may well appear well-presented and when outside of their home give no indication of the issues they have. Others may neglect both aspects of their life.

SCIE research into self-neglect practice is clear that there are key aspects to an effective approach in practice:

- the importance of establishing good rapport and non-judgemental relationships
- 'finding' the person
- legal literacy
- creative interventions
- practical support
- patient and persistent negotiation
- respectful curiosity and challenge
- effective multi-agency working

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Some of these approaches were seen in the case outlined in the previous pages. To promote this approach in practice the SAB developed core principles of practice that set out expectations for practice, these are shared below. They are not meant to create a distinct set of rules as each case needs to be considered individually but they set out the basics for a robust defensible approach to practice.

1. All professionals must work in partnership to achieve the best outcome for the adult with a focus on person centred engagement and risk management.
2. Agencies need to ensure that flexibility is applied in cases that require time and patience. While this may present challenges, it is essential that practice in these cases follows research guidance and allows for rapport and relationships to be established
3. Where there are concerns about risk to the adult or others and there are significant challenges to identifying a pathway to support reduction of the risks; professionals need to create an appropriate forum for case discussion to take place. They should utilise internal opportunities for discussion including supervision and agency escalation procedures in order that they can be supported, interventions reviewed and developed and risks escalated.
4. All agencies are responsible for triggering multi agency meetings to share concerns and to facilitate a case discussion where the most suitable lead agency can be identified based on relationships with the individual.
5. Where cases meet safeguarding thresholds then the multi-agency safeguarding procedures will be followed. Considerations will include the level of assessed risk and the adult's ability to protect themselves by controlling their own behaviour. Safeguarding Strategy Managers will lead on coordinating a safeguarding response.

These rely on basic expectations of working practice that include:

- DNA must be considered in light of potential barriers such as literacy or capacity issues
- Professional curiosity should be part of our everyday practice
- Risk assessment and management processes should be in place
- Working knowledge of the adult's rights in law (see Self-Neglect resources on the SAB webpages)
- Understanding the application of MCA and MHA
- Endeavouring to always work in partnership with the adult

In such cases if it becomes necessary to end involvement before any significant improvements have been made then staff should always reflect on the following points to ensure basic expectations are met:

a) Efforts made are proportionate to known presenting risks
b) All reasonable attempts to engage are exhausted
c) No-one else is at risk
d) 'vital interests' are not compromised (consider risk of death, major harm, serious crime or coercion)
e) Clear evidence of ongoing discussion of risk with the adult and their understanding of it
f) Clear evidence of discussion of withdrawal with appropriate managers and other agencies so it is an agreed response
g) If there remain ongoing risks with withdrawal the only option that this is reported to the SAB for consideration

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WSAB Lessons Learnt Briefing - Self-Neglect

Learning Lessons - Feedback Sheet

Please return completed feedback to: wsabAdministrator@warrington.gov.uk

Your Name	
Agency	
Date	
This briefing was cascaded to:	(e.g. District nurses, duty social workers etc.)
This briefing was used in:	(e.g. supervision, team meeting with X number of staff etc.)
Action taken as a result of the learning:	
Other feedback or discussion points:	

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