Learning On One Page (LOOP)

Safeguarding Adults Review (SAR22A) William – January 2024

Background/circumstances leading to the Review

- William was in his 80's when he died in circumstances of severe self-neglect. William had lived in his own house for many years and had been a carer for his mother until her death.
- Prior to 2020, William had gone out regularly to visit a local café. However, this ended following the restrictions from the COVID-19 pandemic.
- William had multiple physical health needs along with long-term mental health needs. In the last 3 years of his life, these conditions significantly impacted on his life. His limited mobility and sight impairment made it difficult to go out. He had very limited contact with friends or family but was supported by neighbours. He often talked about feelings of loneliness and isolation.
- William was well known to Health and Social Care services and they, along with the fire service, had had long-standing concerns about William's care of himself and of his environment.
- William could be proactive in seeking health care. However, he would also decline many aspects of care and treatment or not follow through on health advice. William also repeatedly declined social care packages of support. Though he was financially secure, he did not wish to pay for care.
- The risks from self-neglect were known but services found difficulty in engaging William in change.

Good practice

- There was good evidence of practitioners listening to William and respecting his views and wishes.
- There was good demonstration of care and compassion in trying to support William to reduce risks to his health and wellbeing.
- Practitioners consistently considered William's capacity for the relevant decision. When assessed William was believed to be capacitous. However, assessments may have benefitted from more specialist advice.
- There were many examples of practitioners identifying indicators of self-neglect and referring to other services.
- William was offered a high level of support and overall, services were responsive to concerns. This often led to visits to William at home, enabling a fuller assessment of William and his home environment.

What did not go so well?

- **Episodic approaches** meant the whole picture of William's escalating risks were not seen. Practitioners repeated actions that had already proved to be unsuccessful.
- **Lack of consistent Health and Social Care practitioners** limited the opportunity to build trust and engage William in change.
- **Lack of adequate multi-agency responses**. The multi-disciplinary meetings that were held, did not deliver a robust assessment or plan of action. The Vulnerable Adult Risk Management process was not initiated, although the criteria was met. No Safeguarding Adult Enquiry was initiated despite the criteria being met.
- **Balancing the Safeguarding Adult Principles**. The principle of empowerment, (including Making Safeguarding Personal) was not balanced with the other principles including that of Protection, Proportionality, Partnerships and Accountability.
- **Accountability.** There was a lack of escalating concerns to senior managers or using policy to consider waving charges for care.

Key Learning Themes

- **Building an effective rapport** is key to understanding the reasons why a person may self-neglect. This can take time to achieve and often requires a consistent practitioner. However, investing in this relationship may be necessary before the person is able to engage in change.
- There is a need to balance all the Safeguarding Adult Principles – **Making Safeguarding Personal does not mean walking away** where a (capacitated) adult, declines services but high risks remain. Duty of care requires continued reasonable attempts to engage the adult in change, as proportionate to the nature and degree of risks. There is a duty on adult social care to make enquiries where the S.42 criteria is met. This is not dependent on consent.
- **Robust multi-agency working should be the default position** when working with adults who self-neglect. There needs to be shared understanding of when risks from self-neglect should be managed as a Safeguarding Adult Enquiry.

DSAB recommendations

1. The DSAB should seek assurance from Health and Social Care Services that their systems allow additional time and, wherever possible, a consistent practitioner to enable them to build and sustain a relationship with the adult (in circumstances of severe self-neglect).
2. Derbyshire Adult Social Care and Health should revise their practice guidance for charging and ensure that is it being referred to and implemented by practitioners and their line managers.
3. Learning from this review should feed into the DSAB's review of the VARM process, to create:
   i) A clearer pathway for responses to self-neglect according to complexity and risk.
   ii) A pathway underpinned by balanced application of Safeguarding Adult Principles
   iii) That multi-agency working is the default way of working across all levels of the pathway