1. Background

Mr M was a 74-year-old man who died in September of 2020 from Sepsis.

Mr M had been laying on the floor for a period of 2 days, he had placed himself on the floor – he had done this previously when depressed.

Mr M had a history of self-neglect when his mental health was deteriorating.

2. Safeguarding Adult Review

Mr M's death met the criteria for a Safeguarding Adult Review.

Mr M had care and support needs, he had died and there were lessons that could be learnt about how agencies had worked together to safeguard him.

The Safeguarding Adult Review can be read here.

3. Recommendations

The Independent author of the Safeguarding Adult Review made a number of Multi-agency recommendations which have been put into an action plan that will be monitored by the Partnerships Joint Case Review Group.

There were also some learning points for agencies and practitioners that are highlighted in this learning briefing.

4. Partnership working

There were times when Practitioners were working in isolation and Mr M and his wife did not receive a co-ordinated and timely response.

Having a multi-disciplinary team meeting at the earliest opportunity will help practitioners to work together to support adults who self-neglect.

Guidance on calling a Multi-disciplinary meeting can be found in Shropshire's Self-Neglect Guidance

5. Early Warning Signs

Sometimes called "relapse signatures" are the individual signs a person might show when they are becoming unwell again. Knowing what these are and how to respond is important. Mr M had been known to lie on the floor for long periods of time when he was suffering with poor mental health.

Agencies should record when a person has a behaviour that indicates a decline in their mental health and what has helped previously. This will promote earlier positive change

6. Responding to Self-Neglect

Responding to Self-neglect in Shropshire is a practitioner's guide to working with people who self-neglect.

This guidance should be used alongside the Working with Risk Guidance.

These guides will support practitioners when assessing risk and making decisions with people who self-neglect.

7. Supervision and learning

Staff supervision should help build professional development by including:

- Case supervision
- Practice observation
- Reflective practice

There should also be opportunity for Shadowing, mentoring and coaching

8. Carers

Mr M's wife like many people cared for her husband on an informal basis, but she did not receive a carers assessment and was not offered one.

Had a carers assessment been completed other services could have been offered which if accepted may have been positive in this situation.

Practitioners should identify informal carers and offer carers assessments.

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9. Struggling to reach

Practitioners working with Mr M and his wife did not appear able to find a way which supported them to engage with services.

This led to them often only asking for help when situations reached crisis point.

Practitioners should be respectfully persistent when working with individuals who self-neglect.

10. Professional Curiosity

There were times when professionals could have exercised more professional curiosity in relation to why Mr. M and his wife were reluctant to engage in support that was being offered.

Being professionally curious is essential is helping professionals to look beyond the behaviour and determine what is actually happening for the individual. Use the Professional curiosity management and practice guidance to support you.

11. Mental Capacity

Practitioners did not always appear to recognise the need to fully explore Mr M's capacity to make decisions for himself.

Mental capacity is time and decision specific. When recording that someone has capacity to make a specific decision professionals should be clear about what decision the individual has capacity to make at the time of the assessment. It should include how they supported the person and how they concluded whether the person had capacity or not.

16. Key points

If there is a delay in making contact, ensure that the reasons for doing so has been risk assessed.
Use previous information/interventions to help understand what has worked for that person but also take the opportunity to look afresh.
When someone does not wish to engage, ask why, consider what reasons they might have and if possible, discuss – "safeguarding is a series of conversations"
Explore with other agencies what they know and jointly review the plan.

12. Mental capacity and self-neglect

Self-neglect can be difficult to navigate as a professional. An unwise decision does not necessarily indicate that someone lacks capacity however it may indicate a need for a capacity assessment (the new draft Mental Capacity Act Code provides advice on this)

This webinar on Mental Capacity and self-neglect may help with some of the challenges faced by professionals.

15. Calling for help – No Wrong Door

Mr M's wife was told by one service to call another during a period of crisis. It would have been of benefit in this situation if the service had made the call with her knowledge on her behalf.

When individuals are in a crisis situation and services are required from different agencies then professionals should consider if it is beneficial to make the call rather than signposting.

14. Advocates and Community services

Some local and community services may have been able to provide services that Mr M and his wife were more comfortable in accepting (as opposed to statutory services).

Advocates should also be considered for individuals whose capacity may fluctuate or those who have limited understanding of services.

13. Think Family

There were other family members who may have been able to provide some insight into the care and support needs of Mr M and his wife.

Confidentiality is not breached by receiving background information which may support risk assessments and decision making relating to people who self-neglect. Information gathering is different to information sharing.

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