SAFEGUARDING ADULT REVIEW for MR I

2022

Reviewer: Rachel Evans

Table of Contents

1. INTRODUCTION 3
2. SAFEGUARDING ADULT REVIEWS 4
3. CHRONOLOGY 5
4. TERMS OF REFERENCE 10
5. SELF-NEGLECT – THE CONTEXT FROM RESEARCH, POLICY AND GUIDANCE 12
6. ANALYSIS 16
7. CONCLUSION 32
8. RECOMMENDATIONS 33
9. BIBLIOGRAPHY 35

1.0 INTRODUCTION

1.1 To help protect the privacy of the man this safeguarding Adult Review is about, as well as other people in his life I will refer to him throughout this report as Mr I. Mr I was a 70-year-old man from Shropshire who had one son. Mr I was a popular member of his local community and members of the community have kindly contributed to this review.

1.2 Mr I was described as a 'very special man' by one of his friends who contributed to this review. This was a sentiment that was shared by others and postings on social media revealed a wider sense of respect and appreciation of Mr I. On behalf of Shropshire Safeguarding Community Partnership, I would like to offer my condolences to Mr I's family and friends.

1.3 Contact has been made with Mr I's son and estranged wife to offer them the opportunity to ask questions and contribute to this review. The family have chosen not to become involved, and the Partnership fully respects this decision at such an incredibly difficult time but would be able to meet with them at any point in the future.

1.4 Mr I sadly died at the age of 70 on the 24/05/2021. He was found at home by paramedics who had been contacted by neighbours who were concerned that they had not seen Mr I for some time. There is contradictory information in relation to whether there was evidence of possible alcohol dependence. This will be explored later in the report. There was evidence of both hoarding and living in insanitary conditions. Mr I had also lived without electric, gas and water, in his home, for a number of years.

1.5 Initial information suggested that lockdowns during the COVID 19 Pandemic prevented Mr I from being able to use the facilities at pubs which had been part of his daily routine, providing companionship, food, drinks, washing and toilet facilities. Concern had been raised by a local shopkeeper about self-neglect, health and wellbeing to Adult Social Care in January 2021. This resulted in some contact with Adult Social Care and Primary Care, however, both agencies had difficulties engaging with Mr I who responded by saying that he was fine, did not require support and that he would make contact if he did need support.

1.6 The social worker raised an urgent safeguarding concern on the 01/02/2021 regarding self-neglect including Mr I's living conditions. This was considered by the adult safeguarding team; however, it was concluded that the safeguarding team did not need to become involved as a social worker was already allocated to Mr I, and it was felt they could determine how best to safeguard Mr. I.

1.7 Mr I was previously known to Adult Social Care in 2017 when the police had raised concerns. The police, in turn, had responded to a concern about Mr I's welfare. This resulted in a hospital admission as Mr I's mobility was poor, he had limited food and water and the home conditions were considered to be unsafe. The worker at the time reported hoarding to the extent that Mr I was unable to cook in his home, nor was he able to wash or shave. Support was provided over a period of months which included a deep clean and

clearance of the home. His case was closed in 2018. It was expected that Mr I would arrange to have his utilities reconnected following these interventions.

2.0 SAFEGUARDING ADULT REVIEWS

2.1 The following criteria for a SAR under S44 of The Care Act 2014[1] was deemed to have been met.

'(1) A SAB[2] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a)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

(b)condition 1 or 2 is met.

(2) Condition 1 is met if—

(a)the adult has died, and

(b)the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a)the adult is still alive, and

(b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.'

2.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future.

2.3 Shropshire Safeguarding Community Partnership has further detailed information on how the SAR process works, including details of where to find completed SARs and how the partners work together to complete this work. This can be found at Safeguarding Adult Reviews — Shropshire Safeguarding Community Partnership

2.4 This SAR was led by Rachel Evans, who works for NHS Shropshire, Telford & Wrekin Integrated Care System, as the Deputy Designated Adult Safeguarding Nurse. Rachel was chosen as she had no previous involvement with any of the agencies involved with Mr I.

2.5 This case was referred to the Joint Case Review Group who undertook the initial scoping work to help determine that a SAR was required.

[1] Care Act 2014 (legislation.gov.uk)

[2] SAB refers to Safeguarding Adult Board and in Shropshire the name of the SAB is the Shropshire Safeguarding Community Partnership (SSCP). This body also performs other duties for children's safeguarding and community safety.

3.0 CHRONOLOGY

3.1 Mr I was born in Salford, Greater Manchester. This is where Mr I started working in banking prior to transferring to Shropshire.

3.2 Mr I lost his father at an early age when his father died following a heart attack.

3.3 Mr I divorced in 1995. It was reported by a friend that the divorce was not an amicable one. The police report that alcohol consumption was felt to be a factor in the separation.

3.4 Mr I's friends had different understandings of how much contact he had with his son after the marriage ended. It has been reported by the landlord that after University, Mr I's son moved, and contact was maintained though phone calls or texts and they would meet up once a year.

3.5 Mr I lived alone since his divorce. He did not have visitors to his house. The police described Mr I as a loner, however, this would appear to be an assumption and is not supported by further information provided by others who described Mr I as a sociable man and who was a popular member of his community.

3.6 It was thought that Mr I attended Mass every Sunday wearing his suit, and he is understood to have been Catholic. He would then get his newspapers, have dinner at one pub then go to another pub to watch football.

3.7 Mr I visited various pubs and cafes where he had many friends. The social interaction was very important to Mr I. Mr I was an avid Manchester United supporter and enjoyed all football in general. Discussing football was a main subject of conversations with people. Whilst at the pub he would have meals and drinks. The landlord/friend emphasised that Mr I drank tea and coffee in the pub most of the time and had some alcoholic drinks. Being without utilities at home Mr I would use the toilets and washing facilities at the pub.

3.8 Mr I had worked in banking. His role was to go into banks as a problem solver to help ensure improvements in operation. He was described as very intelligent. He took early retirement in 1997/1998 and there was a gap in employment at this time. The exact reason for taking early retirement is unknown. However, this is only 2-3 years following his divorce and appears to be the time when self-neglect in relation to personal care appears to have started.

3.9 Mr I owned his home. Significantly since around 2001 Mr I has not had any gas, electric or running water to his house.

3.10 Mr I also held a number of other jobs which included working at a local car retailer. His role there was unknown. Mr I worked at a number of pubs before he started working for Royal Mail. Mr I retired on the 04/12/2015.

3.11 The police visited Mr I on the 07/04/2011 following concerns raised by Mr I's employer. The police considered that MR I's house looked as though no one was living in it. They found that the curtains were drawn, and letters piled up to the height of the letter box. Mr I did not answer the front door. Neighbours confirmed that he regularly did not answer the door and was often not seen for long periods. They also informed the police that he had no gas or electric.

3.12 The police found that the rear of the property was not secured and managed to speak with Mr I who confirmed he was off work due to arthritis and had self-certified for 7 days. Mr I disclosed that he had no friends or family, no landline or mobile phone and no transport. Mr I confirmed he could get to his GP and use a payphone if he needed to speak with anyone.

3.13 At this time the police shared concerns with Social Services. When it was established that Mr I was not open to Social Services a referral was made to Mr I's GP instead. Mr I's GP spoke with Mr I who confirmed he could make contact with his GP if needed. There was no further action taken at this time.

3.14 The police were next contacted by a member of the public on the 25/02/2017. An ambulance was called due to concern for Mr I's well-being (he was feeling unwell due to arthritis). The house was recorded to be uninhabitable due to cobwebs, belongings and rubbish, there were no utilities. Details in relation to the type of belongings is not provided except for the recording of litter and a large pile of carrier bags. Mr I had not eaten any food and his supplies of water were running low. The officer was to contact Adult Social Care, but this did not happen.

3.15 A further concern was reported to the police on the 05/03/2017 when Mr I had come home from hospital. It was at this stage that Adult Social Care was made aware of a significant level of self-neglect. This was responded to over the following months to support Mr I to improve his situation. His health was significantly impacted at the point of 2017 referral; however, his health condition improved, and his home environment was addressed with his engagement along with a deep clean and a clear out of the property.

3.16 The shopkeeper who Mr I was friendly with reports that Mr I allowed her into his home until the last 2-3 years of his life and she reports that the condition of his home was reasonable at this time. This period coincided with the deep clean and clear of the property.

3.17 In 2020 adult social care team arranged a welfare visit to Mr I in recognition that the first lockdown had closed the resources Mr I relied upon for meals, use of washing facilities

and social interaction. There was no further information in relation to any outcomes from this visit.

3.18 Members of the community, the author spoke to, stated that lockdown was the downfall for Mr I, causing him to become socially isolated. Mr I was well liked, and he would sit and chat to people over a coffee. He was known to many people. A friend explained that when pubs were able to serve food outside, Mr I did not want to eat outside. When Mr I was seen prior to his passing he was described as looking 'more dishevelled' and it was clear he wasn't looking after himself. One good friend thinks he probably died of loneliness and just gave up.

3.19 On the 29/01/2021 the shopkeeper raised concerns to First Point of Contact, Shropshire Council. This was forwarded to Adult Social Care, a Social Worker went to the shop prior to visiting Mr I. Concerns were expressed around Mr I's health; he was described as having a grey complexion. It was reported that when his food was delivered that afternoon, Mr I had answered the door in a coat, hat and gloves. He had ordered a large amount of water and batteries. This raised concern that he did not have any water supply or heating. The shop had been charging Mr I's mobile phone for him. He declined any other support.

3.20 The Social Worker visited Mr I on the 29/01/2021. Mr I spoke to the Social Worker through his letterbox. She asked Mr I if she could enter his home, but he declined explaining that he wanted to sleep. Mr I could be seen wearing full winter clothing including gloves and a hat. The Social Worker explained that she could feel the cold coming from the letterbox and enquired if he had heating or electric. Mr I responded that he had been disconnected some time ago. When asked how he managed and if he would accept support, he declined assistance and explained that he managed fine.

3.21 The social work found Mr I to be breathless and he was asked about this. He admitted to having been breathless 'for a little while now' and planned to call his GP on Monday. An offer to call the GP for assistance at this time was declined.

3.22 Food and water could be seen. There was a rubbish bag by the door and a musty odour was evident. The Social Worker explained that she would call and check on him again due to the concerns she had.

3.23 The Social Worker's team manager reviewed the case note entry and advised that a safeguarding concern was raised due to self-neglect risks and unwillingness to engage. This was raised on the 01/02/2021. The response was that at this stage Adult Social Care should follow the local procedure flow chart in the Self Neglect Guidelines and a copy of this was forwarded to the Social Worker. The safeguarding concern was then closed.

3.24 The next contact was on the 10/02/2021 when the Social Worker contacted the shopkeeper to enquire about contact with Mr I. The shopkeeper reported that she had received a phone call from Mr I who was angry that concerns had been raised with Adult

Social Care and she felt that this had ruined their friendship. He cancelled his papers and refused any food which was offered, however, he continued to have shopping delivered.

3.25 The Social Worker received supervision on the 12/02/2021. This included discussing workload and that a number of people who required a high level of work, this includes court work and a number of duty contacts which had been quite intense. Support discussed included bringing the caseload down.

3.26 On the 24/02/2021 the Social Worker visited Mr I. On this occasion Mr I remained upstairs and shouted responses that he was fine and was having a sleep. The Social Worker asked if she could bring what appeared to be kindling into the house for Mr I but he said he would get this later. The one bin bag remained and there was a build-up of mail. Fresh water and bread could be seen. The Social Worker left her details and asked if she could call again and check in with Mr I which he agreed to.

3.27 The Social Worker attempted to call Mr I on his mobile phone on the 26/02/2021, however, the phone was switched off.

3.28 She then contacted the GP Practice also on the 26/02/2021 explaining that Mr I had advised that he had made an appointment for the end of January as he had been breathless. Mr I did not keep this appointment. Having visited again on the 24/02/2021 the social worker had been unable to establish his condition but found that Mr I had taken to his bed. She requested a discussion with a GP.

3.29 On the 01/03/2021 a Physician Associate undertook a home visit. He was denied entry but spoke to Mr I at his door. He found Mr I not presenting as being acutely unwell. Mr I said that he was well apart from a sore knee due to gout. Mr I assured the practice that he would contact them if required. Note: the practice referred to a previous hospital admission in 2011 due to gout. It does not appear that any medical assistance was offered in relation to gout and the symptom of a sore knee. Mr I was considered to have the mental capacity to refuse to allow the healthcare professional entry to his home for assessment/examination. The capacity assessment pertaining to the decision to refuse entry to the healthcare professional was based on the functional test of capacity. The description provided by the GP Practice includes that they found Mr I to have 'full mental capacity after being given information about why the physician's associate had been out to visit him, he was able to weigh this up, retain the information and communicate back his decision to refuse entry to the healthcare professional. It was therefore difficult for us to assess him fully in his home with regards to things such as his personal needs.'

3.30 His case was discussed with a senior supervising GP. An email was sent to the Social Worker on the day of the visit. This included that the current situation appears to be a social issue rather than a medical one and suggested that the Social Worker contacts Mr I again.

3.31 On the 02/03/2021 Mr I rang the Social Worker to thank her for her contact and to ask that no further home visits occur. Mr I stated that he has the Social Worker's number in case he needs her, but he does not at this time. Mr I provided a new mobile number and said he could be contacted on this number.

3.32 On the 09/03/2021 a further visit was made by the Physician Associate who offered the Covid Vaccination. Mr I declined to have the Covid Vaccination and was assumed to have capacity to make this decision. Entry to the house was declined.

3.33 On the 12/03/2021 and the 14/04/2021 the Social Worker attempted to call Mr I. The mobile phone went to answer machine on which messages were left to acknowledge Mr I's voicemail and informing him that the calls were to check in with him.

3.34 On the 12/04/2021 records from the GP Practice show that Mr I was given the AstraZeneca vaccine, but it is not known where or who this vaccine was given by. The practice surmise that it may have been a district nurse. A neighbour has provided information that a friend had taken Mr I for this vaccine. Mr I probably attended a Covid Vaccination Drop-In Clinic.

3.35 The next entry in the adult social care notes is on the 16/04/2021. It states case closure/transfer and notes that there will be ongoing work to support Mr I and to obtain access to the property. It confirms that Mr I's situation is recorded on the hoarding forum spread sheet. It doesn't, however, specify who this will be allocated to.

3.36 On the 21/05/2021 the Adult Social Care NW Area bi-weekly meeting was held. During the meeting the hoarding risk information on the spreadsheet pertaining to Mr I was reviewed. Subsequently the extent of Mr I's situation became apparent. This led to the Manager accessing Mr I's records and ascertaining that a more robust response was required.

3.37 On the 24/05/2021 at 14.09 hours, the ambulance service was flagged down by a neighbour of Mr I's after attending a separate incident around the corner. Neighbours were worried that Mr I had not been seen for about 3 to 4 weeks. A neighbour has informed the review that 3 men were enquiring after Mr I. One of the men asked her if she had seen Mr I as he said he hadn't seen him since taking him for his Covid vaccination 5 weeks earlier and this is why the ambulance service were approached. It was not known who the 3 men were.

3.38 The ambulance service requested assistance from the fire brigade to gain entry, via the police. Access was gained at 16:40 hours as the back door was found to be unlocked secured by a golf club. Sadly, they found Mr I deceased. It was clear that Mr I had been there for some time. The fire service was stood down. There were no suspicious circumstances apparent. The police then attended to take charge of the body. The ambulance service provided confirmation to the police of the deceased's details and the sudden death information. Mr I's son and estranged wife were both informed of his death.

3.39 The ambulance service provided the following description of the circumstances to the police: 'Mr I had been located sat in a chair in his lounge. He was wearing a woolly hat and a single glove. He was covered in some blankets and wearing boxers (underwear). He was surrounded by bottles containing urine. The property was a health hazard and in poor state through hoarding. The toilet was filled with faeces.'

3.40 At the Inquest Hearing on the 16/07/2021, the following information was recorded in relation to Mr I' s death. The date and place of death was 24/05/2021 at home. The cause of death was unascertained; however, the death was considered it to be of a natural cause.

4.0 TERMS OF REFERENCE

4.1 Scoping Period

4.1.1 The review has concentrated on the period from 01/01/2021 – 24/5/2021. However, any relevant information prior to this time may be included if considered necessary.

4.2 Methodology

4.2.1 The following methodology was agreed at the onset of the Safeguarding Adult Review:

4.2.2 The Independent Reviewer alongside the SAR Panel will carry out the review and analyse the findings.

4.2.3 Background documents evidencing national and local policy and where possible, any existing evaluations of practice in relation to the themes identified will inform the review.

4.2.4 Participating agencies will all prepare and submit a detailed Individual Management Review (IMR).

4.2.5 Participating agencies will provide all relevant background information and documents.

4.2.6 Participating agencies will provide a context of the structures, processes and procedures during this timeframe.

4.2.7 Consideration will be given to engaging with key practitioners who have been involved in the case to look at what was happening at the time and understand more about why things happened as they did.

4.3 Agencies Contributing to the Review

- Shropshire Fire and Rescue Service
- Shropshire Adult Social Care
- GP Practice
- Environmental Health
- Private Sector Housing
- West Mercia Police

4.4 Key Lines of Enquiry for the Safeguarding Adult Review

4.4.1 Specific lines of enquiry were agreed by the SAR Panel. Initial lines of enquiry considered Mr I's life circumstances, other needs and responses to these and are as follows:

4.4.2 To explore the previous engagement points with Mr I to identify if there is any learning associated with engaging him to explore how his experiences had impacted upon his lifestyle behaviours that created concern from others e.g. living without utilities and not engaging with services designed to offer health and social care support.

4.4.3 What do we know about Mr I's wishes, beliefs, views, choices and decisions he made around health matters including any mental health needs? - This to include engagement to address any need for treatment; as well as other factors affecting Mr I's ability and choices around shopping, eating, drinking, cooking, cleaning, tidying, disposing of rubbish, personal care, using the toilet, utilities, paying bills (including the financial ability), and anything else of significance.

4.4.4 How much alcohol did Mr I consume prior to the pandemic and during the pandemic? Was alcohol a significant factor in Mr I's life at any time? What support was offered to identify and address alcohol issues?

4.4.5 What impact did the Covid 19 pandemic have on Mr I?

4.4.6 Did Mr I's circumstances place him at any significant fire risk and if so, was this identified and responded to?

4.4.7 Identify any areas which professionals found particularly challenging in relation to assessing and or supporting Mr I?

4.4.8 To determine if the voice of the community was heard and if, how this was responded to had any impact on the outcomes.

4.4.9 What categories and severity of self-neglect were agencies aware of in relation to Mr I's situation?

4.4.10 Which agencies (health, social care and others) had been informed and/or involved with Mr I in the context of self-neglect and in what capacity?
4.4.11 Consider how Keeping Adult's Safe in Shropshire Board's Self-neglect guidance and procedures supported practitioners to work with Mr I?

4.4.12 Has this review identified any further self-neglect research which could be embedded into Shropshire's self-neglect guidance and procedure?

4.4.13 What learning from other similar SARs is helpful to draw upon to understand what contributed to difficulties in supporting Mr I and what could improve SSCP's response to similar circumstances in the future?

4.5 Analysis and Reporting Arrangements

4.5.1. The Independent Reviewer with the assistance of the SAR Panel will be responsible for producing an overview report.

4.5.2 Findings and recommendations will be agreed with, and monitored by, the Joint Case Review Group on the behalf of the SSCP.

4.5.3 Learning Briefing to be developed for dissemination to partner agencies and uploading on to websites and intranets.

5.0 SELF-NEGLECT – THE CONTEXT FROM RESEARCH, POLICY AND GUIDANCE

5.1 This section attempts to provide information about the prevalence and impact of self-neglect. This includes the impact it can have on the person and others. Additionally, it draws upon best practice guidance in relation to how services can respond most effectively.

5.2 Self-neglect was included within the 10 safeguarding types of abuse under The Care Act, 2014, enacted April 2015. Prior, to this self-neglect was not considered a safeguarding matter. This inclusion under safeguarding abuse types was in response to the Law Commission's[3] recommendation to include self-neglect.

5.3 The Care Act Statutory Guidance (14.17) describes self-neglect as: 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.'

[3] The Law Commission Adult Social Care Report, 2011

5.4 Several causes and risk factors associated with hoarding behaviour that might lead to the onset of and continuation of hoarding behaviour have been identified[4]. These include:

- ‘Genetic factors
- Traumatic life events or life changing experiences
- Cognitive factors and impairments, including dementia
- Beliefs
- Emotional factors
- Executive functioning and impairment
- Addictive behaviours and substance misuse’

5.5 Causes and risk factors in relation to self-neglect identified within include[5]:

- ‘older age
- isolation
- lack of social support
- poverty
- personality disorders
- hoarding
- mental disorders: dementia, depression, substance abuse
- physical illness: stroke, diabetes, nutritional deficiency
- functional impairment’

5.6 Self-neglect was found to be the most common SAR abuse type representing 45% of all SAR’s included within the Local Government Association Analysis of Safeguarding Adult Reviews from April 2017 – March 2019[6].

5.7 This report found that there was a distinct difference between the high numbers of self-neglect SAR’s and low number of self-neglect Section 42 Enquiries[7]. A recommendation was made to consider the interface between the duties to undertake Section 42 Enquiries and SAR’s.

5.8 The Care Act Statutory Guidance (14.17)[8] outlines that self-neglect may not prompt a Section 42 Enquiry. Individual assessment should take place. Determining whether a safeguarding response is needed should be based upon the adult’s ability to keep themselves safe.

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[4] What do we know about hoarding behaviour and treatment approaches for older people? A thematic review - Research Portal, King's College, London (kcl.ac.uk)

[5] Martineau_et_al_2021_Social_care_responses_to_self_neglect_among_older_people.pdf (kcl.ac.uk)

[6] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

[7] A Section 42 Enquiry is required where an adult ‘has care and support needs, is experiencing or is at risk abuse or neglect and is unable to protect themselves due to their care and support needs.’ Care Act 2014 (legislation.gov.uk)

[8] Care and support statutory guidance - GOV.UK (www.gov.uk)

5.9 Self-neglect data specific to Shropshire has been accessed from the Safeguarding Adults NHS Digital Data 2020-2021[9]. This includes 5 concluded Self-Neglect Section 42 Enquiries. Self-neglect Section 42 Enquiries represented 3% of all (135) concluded Section 42 Enquiries in Shropshire. Shropshire also currently have other ongoing SARs.

5.10 The analysis of SAR's found that many SARs are completed in isolation from other information relating to Self-Neglect which has been identified in other SARs and Section 42 Enquiries. It would be helpful if SSCP were to consolidate themes/learning from completed SAR's and Section 42 Enquiries pertaining to self-neglect to ensure a joined-up approach to learning and improvement.

5.11 Guidance on Self-Neglect and Hoarding Approaches

5.11.1 Key factors highlighted in recent reports considering self-neglect and hoarding approaches include[10][11][12]:

- ensuring sufficient time to build a trusting relationship with the person to identify causes of the self-neglect
- multi-agency working
- using a variety of approaches
- assessment including risk assessment as early as possible
- risk management approaches
- holistic assessment considering the person's individual situation and conditions and identifying any mental health needs
- effective self-neglect training
- supervision for practitioners
- Senior Manager oversight and access to specialist advice
- multi-agency self-neglect policies are not being followed
- the importance of agencies providing early help to people at risk of self-neglect and/or of developing harmful hoarding behaviours

5.11.2 It is the taking of small steps which has been identified as being a successful approach in harm reduction. However, forced interventions including decluttering and clear-outs were found to be generally unsuccessful and often only a temporary solution. They were also likely to damage the relationship between the person and practitioners[13].

5.11.3 Shropshire's Self-Neglect Guidance, 2019 outlines these key areas within its approach covering:

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[9] Safeguarding Adults - NHS Digital

[10] What do we know about hoarding behaviour and treatment approaches for older people? A thematic review - Research Portal, King's College, London (kcl.ac.uk)

[11] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

[12] Adult safeguarding managers' understandings of self-neglect and hoarding - Research Portal, King's College, London (kcl.ac.uk)

[13] What do we know about hoarding behaviour and treatment approaches for older people? A thematic review - Research Portal, King's College, London (kcl.ac.uk)

1) The importance of relationships
2) Finding the adult
3) Legal literacy
4) Creative interventions
5) Effective multi-agency working
6) Risk assessment and planning

5.11.4 These best practice areas had been identified from research and evidence-based practice in the field of self-neglect.

5.11.5 Shropshire Safeguarding Community Partnership are currently reviewing their Self-Neglect Guidance and the author of this review is part of the working group and has been able to make suggestions based on areas identified within this review which will enable improvements to be made in a prompt manner. Shropshire Safeguarding Community Partnership have also completed a Self-Neglect Multi-Agency Case File Audit and again this approach has highlighted areas of improvement (some similar in area to this review) which are also being responded to.

5.12 Mental Capacity Act and Executive Capacity

5.12.1 The circumstances of a person's self-neglect can be the result of a number of smaller decisions where the person may have had capacity but has not foreseen the overall outcome on their situation. It may be the person does not have the capacity to understand this situation or to be able to change it. The difference between the decisions an individual makes, and their executive capacity should be explored to inform the response needed to the self-neglect issues. It was imperative in Mr I's situation that the wider impact of the smaller decisions which Mr I made was considered to fully understand the risk which this would place him or others under.[14]

5.12.2 It is accepted that the emotional aspects of capacity are difficult to capture but may impact the person from being able to use and weigh information to make the decision. Examples of this may be fear of losing independence or shame of others seeing the extent of the hoarding conditions. [15]

5.12.3 It is common particularly within the context of self-neglect that some people will 'talk the talk but not walk the walk'[16]. It is imperative to ensure that satisfactorily detailed capacity assessments are carried out in situations where a person appears to have capacity to make decisions but does not carry out the actions which they have specified. This is referred to as 'executive functioning'. Where there is evidence that the person is not carrying out the actions identified within their decision making it is important to consider the reasons for this with the person to try to ascertain why this is happening and what can address this.

[14] DoLS: Mental capacity assessment | SCIE
[15] Brown H, (2011) quoted in DoLS: Mental capacity assessment | SCIE
[16] Mental-Capacity-Guidance-Note-Capacity-Assessment-January-2022.pdf (39essex.com)

5.12.4 This guidance in responding to this challenging area concludes that the person may be deemed to lack capacity in situations where there is documented evidence of repeated situations where the required actions which the person describes are needed are not taken and how this relates to the functional tests in the MCA. Therefore, describing how the inaction demonstrates that the person cannot understand, retain, use and weigh relevant information or communicate their decision.

5.12.5 It emphasises that there may be challenges for professionals in engaging with the person and especially when self-neglect is present. Distinguishing whether the person is unwilling or unable to participate in the capacity assessment is important. Various methods should be attempted where the person appears to be unwilling to participate in an attempt to find the best way to engage with the person in the process. These attempts should be recorded. A multi-agency approach to considering different options will be advantageous. Where it has not been possible to engage with the person it should be decided whether there is sufficient evidence to consider that the person lacks capacity and if so, how to proceed in relation to how to act in the person's best interest within the Mental Capacity Act. This would include consideration of whether the person can understand why they are unable to carry out the actions which they were able to decide upon. Where a person's situation involves high risk an application to the Court of Protection should be made where the court will decide if the person has or lacks capacity to make the relevant decision.

5.12.6 Essex Chambers provides guidance on the relevant information for different categories of decisions, and this includes hoarding[17]. It includes the consideration of the following areas when deciding whether a person has capacity to make decisions in respect of their items and belongings:

a) the amount of belongings and whether rooms can be used as per their purpose
b) safe access and use of the living areas
c) hazards which includes maintenance and safety of utilities, hygiene of key areas such as toilets, food storage and preparation, infestations, fire risk and escape routes.
d) safety of the building
e) whether removal/disposal of an unsafe levels of belongings is considered and would be agreed to

6.0 ANALYSIS

6.1 Self-neglect

6.1.1. It has been difficult to ascertain the exact nature and severity of self-neglect impacting Mr I in the period of the review. What is clear is the domestic environment has included a lack of utilities, squalid living conditions and hoarding and which will clearly have had an impact upon Mr I. Mr I had been living without utilities for a significant amount of time (at least since 2011).

[17] Mental-Capacity-Guidance-Note-Relevant-Information-for-Different-Categories-of-Decision-September-2022.pdf (39essex.com)

6.1.2 There were signs that Mr I wanted to improve his living situation. Cleaning products, air freshener and insect repellent are evident from the pictures taken by Environmental Health at Mr I's home on the 03/06/2021.

6.1.3 Mr I appeared to have slept latterly in the living room as the bedroom looked as if it was not being used and was neat and tidy. The chair where Mr I's body was found was surrounded by piles of clutter of a similar height to his chair. This included bottles which appeared to contain urine.

6.1.4 The toilet and sink were blocked and full of detritus. There was insect infestation evident on windowsills and the edges of the room. The front and back doors of the house were not able to be locked. A cricket bat was used for the front door and the back door by a plank of wood. Fire risks have been highlighted. The garden and exterior of the house was not attended to. Any maintenance which had been completed had been carried out by neighbours.

6.1.5 Mr I had received assistance back in 2017 when similar conditions were found. The property was cleaned and cleared, and it was anticipated that Mr I would have his utilities reconnected. However, this did not happen. Mr I's case was closed without a risk assessment being in place. In addition, there was no follow up by any agency to either establish if utilities had been reconnected or to monitor how Mr I managed after the property clearance and to consider if any early warning signs that previous risks were returning. Steils et al 2022 in their consideration of hoarding and treatment approaches for older people found that a stand-alone property clean/de-clutter does not provide long term positive change[18]. People are likely to continue to collect items and the impact of this is likely to result in mistrust in services and a reluctance to engage with services in the future.

6.1.6 This domestic environment would make it difficult for Mr I to have visitors even though this review has found that Mr I enjoys the company of others. This would have been further compounded during Covid when pubs, cafes, churches and other public places closed preventing ways of socialising with others.

6.1.7 There has been a health aspect of self-neglect, the level of which is difficult to ascertain with the limited information, however, there has been reference to Gout[19] and Arthritis. Impacts of gout on Mr I have resulted in him requiring time off work and becoming housebound on occasions.

6.1.8 In the photographs of Mr I's home taken by Environmental Health on the 03/06/2021 there are a number of bottles of Gaviscon and one box of Naproxen (with a pharmacy label with another person's name). In 2021 the Shopkeeper and subsequently the Social Worker had concerns about Mr I's health, he was described as grey and having difficulty breathing. Mr I admitted that he was unwell at this time and said he would arrange a GP appointment. It was subsequently found that he had not done this.

[18] What do we know about hoarding behaviour and treatment approaches for older people? A thematic review - Research Portal, King's College, London (kcl.ac.uk)

[19] Gout is a type of arthritis which causes sudden, severe joint pain. Gout - NHS (www.nhs.uk)

6.1.9 The Social Worker contacted the practice herself and a Physician Associate called at Mr I's house. Mr I refused entry to his home to allow for assessment/examination. The Physician Associate spoke to Mr I at his door and was not concerned about his health. Mr I did say that he had a sore knee and that this was due to Gout. There was also many bottles of Gaviscon which suggests that Mr I was suffering from heartburn or indigestion as well as Naproxen[20], a non-steroidal inflammatory drug (used to treat Gout). Mr I assured the practice that he would contact them if required.

6.1.10 The practice was aware that Mr I had a diagnosis of Gout going back at least 10 years when Mr I had had a hospital admission for this. Treatment for recurrent gout includes taking uric acid-lowering medication. It is not clear if this had been considered with Mr I. Mr I had a box of Naproxen which had not been prescribed for him which suggests he was trying to manage the symptoms of gout himself. There is also lifestyle advice in relation to diet, limiting alcohol consumption, drinking plenty of fluid and regular exercise which can prevent or reduce attacks and it is unclear if Mr I has received this information. This may have been an opportunity to attempt to engage with Mr I.

6.1.11 There is no evidence of Mr I contacting the practice himself to make any appointments around his health. Mr I had informed the Social Worker on Friday the 29/01/2021 that he would contact his GP on Monday the 01/02/2021 when he was found to be unwell. He did not do this and instead the Social Worker contacted the practice on his behalf and arranged a home visit. This was good practice and demonstrates information sharing and collaborative working between the Social Worker and the GP Practice.

6.1.12 This contact with the GP Practice was made following a further visit three weeks after Mr I had said he would contact his GP. The Social Worker could have practiced 'Professional Curiosity'[21] earlier by contacting the GP and asking if Mr I had made an appointment.

6.1.13 It is significant that the last time the GP spoke to Mr I prior to 2021 was in 2011. This was when the practice contacted Mr I following concerns raised by the police. It is noteworthy that Mr I had said the same then that he would contact the practice if needed. He did not do this in 2011 nor at any time in the 10 years which had passed.

6.1.14 This demonstrates that Mr I was not someone to contact his GP despite various health issues. This has included an injury from falling off his bicycle when working for the Royal Mail, symptoms of Gout, the symptoms for which the Gaviscon[22] is used for and feeling unwell (breathless) at the end of January 2021. The practice report that Mr I did not respond to letters inviting him to health checks.

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[20] Naproxen: a medicine to treat pain and swelling - NHS (www.nhs.uk)

[21] Professional curiosity is the skills used to explore and understand with what is happening with an individual or family. It involves maintaining respectful uncertainty rather than making assumptions or accepting things at face value. SSCP professional-curiosity-guidance.doc

[22] Fast acting heartburn and indigestion relief | Gaviscon

6.1.15 Therefore, when Mr I informed the Physician Associate in 2021 that he will contact the practice, if need be, the practitioner cannot rely on Mr I doing this. The practitioner should have been 'professionally curious' in relation to considering this response. This would have determined that Mr I does not make contact with his GP. This could then have been explored to enquire as to why Mr I does not contact the practice for health assistance despite various health issues. This may have led to ascertaining why Mr I does not ask for help and the considering of possible solutions. This also may be useful multi-agency information as other agencies such as Adult Social Care and the Fire Service also had difficulty engaging with Mr I.

6.1.16 It was good practice that the Physician Associate called again 8 days after the initial home visit in 2021 and offered a COVID Vaccination. Even though this was declined regular contact could have assisted in building a relationship. This is often a prerequisite to building trust, rapport and better engagement and thorough this affecting change.

6.1.17 Eating and drinking would have been difficult for Mr I given he had no utilities, he would be unable to easily heat food up, he did not have running water. We know that Mr I used cafes and pubs when possible, to provide meals and drinks. The concerns in this area arose when pubs and cafes closed during pandemic lockdowns and also when Mr I was unable to leave his home due to health issues. What has helped to mitigate the risk here is the local shop doing deliveries to Mr I and this includes additional prepared food and also support from neighbours.

6.1.18 According to the coroner's investigation, he was part of a bowel cancer trial. It is possible that this information relates to the NHS Bowel Screening Programme which offers people between the ages of 60-74 years of age a home testing kit every 2 years.[23]

6.1.19 There is a record that Mr I had one Covid vaccination on the 12/04/21. It is understood through information provided by a neighbour, that a friend supported Mr I to this appointment.

6.1.20 Mr I's personal history includes various of the aforementioned possible causes and risk factors. It is important that professionals are aware of possible causes and risk factors so that approaches considered can take these into account. This includes: older age, isolation, lack of social support, hoarding, physical illness and life events. Life events including, loss through the death of his father at an early age, his divorce and loss of his family (wife and child) may have been traumatic for him, and the shopkeeper made a link to his divorce being at a time when signs of self-neglect were first noticed.

6.1.21 We know that Mr I was affected by physical illness through the symptoms of gout. The Covid pandemic and lockdowns removed Mr I's ability to gain social support in the café's and pubs. Covid as well as occasions when Mr I was unable to leave his home due to physical ill health would have caused him to be isolated. Mr I appeared to hold strong belief's in relation to not having interference of others in his life to provide help and support unless on his own terms such as the shopkeeper and staff from the shop. Functional

[23] Bowel cancer screening - NHS (www.nhs.uk)

impairment is not known and it appears possible that he has been affected by alcohol dependence when his marriage broke down.

6.1.22 Martineau et al in their research into self-neglect highlight two significant factors as mental capacity and safety[24]. This involves considering if the person has mental capacity to make the relevant decisions and if the person, (and others), are safe to continue in the manner in which they are currently living. It is imperative that safety to the person and others is considered as important as the person's capacity to make relevant decisions to prevent someone deemed to have capacity being left to live in the way they appear to be choosing and with the risks that they appear to understand.

6.2 Hoarding

6.2.1 Hoarding is now recognised as a mental disorder. The NHS states that a 'hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner, usually resulting in an unmanageable amount of clutter'.[25]

6.2.2 Hoarding becomes a significant concern when it interferes with everyday living, for example, a person cannot use their kitchen or bathroom as intended. It can also cause the person to become socially isolated as it can affect relationships and impact upon visitors to their home. Other impacts of hoarding can include mental health problems and health and safety risks.

6.2.3 The charity Mind outline the following areas which may lead to a doctor or healthcare professional to diagnose hoarding disorder [26]:

- Unable to get rid of belongings. Belongings may not be worth anything.
- Has a strong need to save items.
- It is stressful thinking about decluttering.
- Areas of the home cannot be used due to the level of clutter.
- Continues to add collect further items.
- Is impacted detrimentally by their situation.
- Hoarding is not linked to another health diagnosis.

6.2.4 Since 2013, hoarding disorder has been included in the 'Diagnostic and Statistical Manual of Mental Disorders: DSM-5' (DSM-5). Initially hoarding disorder was considered to be a variant of obsessive compulsive disorder (OCD) or obsessive compulsive personality disorder (OCPD). This was until the 11th revision of the International Classification of Diseases in 2021 when hoarding disorder was considered to be a specific mental health disorder[27].

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[24] Martineau_et_al_2021_Social_care_responses_to_self_neglect_among_older_people.pdf (kcl.ac.uk)

[25] Hoarding disorder - NHS (www.nhs.uk)

[26] Recognising hoarding - Mind

[27] What do we know about hoarding behaviour and treatment approaches for older people? A thematic review - Research Portal, King's College, London (kcl.ac.uk)

6.2.5 The studies undertaken by Kings College suggest caution in relation to consideration of obtaining a hoarding disorder diagnosis and reflect that although this may open up access to treatment and support this could cause the over-reliance of a mental health cause and response. Instead, they emphasise learning about the person and why they hoard.

6.2.6 Shropshire Safeguarding Community Partnership's Guidance on Responding to Self-Neglect, 2019 includes a Clutter Image Rating Tool which assists to identify the level of clutter and the risk associated with this. The Clutter Index Rating is highlighted within Section 2.7 of Shropshire's Self-Neglect Guidance and forms part of the practitioner's assessment with the person[28]. It highlights that in addition to considering the quantity of items the health and safety risks such as out of date food, faeces, infestation, and flammable items may also affect the action needed.

6.2.7 As neither the Social Worker or the Physician were able to access the home they were unable to apply the clutter rating which would have assisted to identify the scale of the clutter, the risk that this poses and the required response. However, there were sufficient signs of clutter and known history to consider this to be an area of concern.

6.2.8 The allocated social worker had recorded Mr I's circumstances on a hoarding spreadsheet which the adult social care team were utilising to record people with hoarding risks. However, Mr I was not picked up for 5 weeks. Once the information was picked up it was considered to be concerning and a response was to be made, however, sadly Mr I died soon after this. The North West Area Manager has developed the team's processes in the areas of hoarding and self-neglect. This has included that the information captured relating to timescales and risk ratings has now been improved. Workers meet twice a week to discuss people identified. A Hoarding Champion Role has been developed. A paper has been submitted to the Senior Management Team detailing the scale of this hoarding issue in Shropshire, level of resource, time required and possible solutions. A recommendation has been made to establish what impact this has had and whether other teams could benefit from similar actions.

6.3 Discussing needs/accepting help or support

6.3.1 The police found that Mr I engaged well with police officers. This was in relation to 2 contacts in 2017 when Mr I was particularly unwell. On the first contact the police arranged an ambulance, and Mr I was admitted to hospital for 2 days. The second contact was 6 days following discharge a neighbour raised concerns as Mr I had had a lift into town from her husband and since eating in a local pub that day had not been seen. Mr I's mobility was reported to be particularly poor; he had no water and couldn't go out to buy food. A neighbour provided water and the police sergeant agreed to arrange for the local PCSO to link in with local community groups for help with shopping. Mr I consented to his needs being assessed in order to obtain the right help. A discussion about meals with the police resulted in Mr I explaining that he was able to pay if help was available to provide pre-prepared food. What is notable at the time of both contacts was that Mr I appeared accepting of help at times when he was particularly struggling.

[28] 13526.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

6.3.2 This differs from the experience of the Social Worker and Physician Associate. People are likely to respond differently to professionals in different roles. It is also possible that someone may agree to an intervention one day and refuse the same intervention another day. What is crucial is an approach that is persistent and includes gentle engagement. A multi-agency response would also ensure that any approach is joined up, priorities agreed and information is shared between agencies.

6.3.3 Shropshire Self-Neglect Guidance[29] provides a local procedure flowchart which includes attempting to engage the adult throughout, it includes risk assessment, multi-agency working, Care Act Needs Assessment[30] consideration and what to do if this is refused. If the adult is not engaging with what is offered and there is a high level of danger to the adult and/or others, then a safeguarding concern should be raised at this stage.

6.4 Care Needs Assessment

6.4.1 Mr I's Social Worker was unable to complete a Care Needs Assessment due to not being able to engage with Mr I. Section 11 of the Care Act[31] covers the refusal of assessment and Section 11(2) requires the local authority to carry out a needs assessment even when refused if:

> '(a)the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or
>
> (b)the adult is experiencing, or is at risk of, abuse or neglect.'

6.4.2 There was no completion of a needs assessment even though Section 11 of The Care Act covers this.

6.4.3 Shropshire's Guidance on Responding to Self-Neglect, 2019 determines that following the Care Act, Section 9 needs assessment, a support plan should be implemented. If the person accepts the support plan, this is monitored and reviewed to ensure there is continued engagement and effectiveness. If the person rejects the plan and remains at high risk of harm as a result, then a Section 42 Enquiry should be undertaken. This approach would have ensured that there was a clear process to follow.

6.4.4 Other actions should have been considered. This could have included further exploration of mental capacity in relation to making decisions to refuse the assessment and to refuse support offered. Discussions could have taken place with the Social Worker involved with Mr I in 2017 and what worked at this time. The previous Social Worker could have been asked to visit. Martineau et al 2021 Social care responses to self-neglect among older people through their review of literature considering Adult Social Care responses to

[29] 13526.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

[30] Section 9 of the Care Act 2014 requires that where an adult appears to have needs for care and support the Local Authority should assess these needs and determine what these needs are. Care Act 2014 (legislation.gov.uk)

[31] Care Act 2014 (legislation.gov.uk)

self-neglect relating to older people identified 2 primary themes[32]. One was the 'importance of building relationships' and the other 'effective multi-agency working'. This building of a relationship and rapport with the person was considered to be the 'primary intervention'.

6.5 Mental Capacity Act

6.5.1 The guidance identifies that whilst mental capacity should be assumed for all adults, where self-neglect risks are serious the assumption of capacity must be duly considered by completing thorough capacity assessments. No capacity assessments have been provided by the Social Worker or the Physician's Associate.

6.5.2 Shropshire's Self-Neglect Guidance emphasises that when assessing mental capacity it is important to consider the views and understanding of the adult about their living circumstances and the risks associated with this but also to consider if this is reflected in what the person does (executive functioning) including observations of the person's appearance and living situation and previous actions taken or agreed. This triangulates the information to consider what is said, what is observed and what the history/records tell us.

6.5.3 Shropshire's Self-Neglect Guidance also emphasises that different professionals may find that the person presents differently and therefore, sharing information from their assessments may provide a more accurate picture. It has been identified that the response which the police received from earlier interactions with Mr I appeared more accepting of help. This included allowing the police access to his home, agreeing to assessments and help with accessing hot food.

6.6 Recording

6.6.1 It can be extremely difficult to have an opportunity to enter the house of a person who self-neglects. This can be for many reasons such as embarrassment and not wanting to receive help or support. When an agency does manage to have access into the person's home it is imperative that they capture as much information as they can.

6.6.2 Capturing information about the personal appearance/hygiene of Mr I when he was unable to leave his home in 2011 and 2017 is equally important. If they had been able to do this and if the information had included concerns in these areas this may have helped inform consideration of risk when Mr I may become housebound again in the future due to poor health or lockdowns during the Covid Pandemic.

6.7 Sharing information

6.7.1 In 2011 information was shared by a member of the public to the police. The police shared health and self-neglect concerns with the GP but it appears that no further

[32] Martineau_et_al_2021_Social_care_responses_to_self_neglect_among_older_people.pdf (kcl.ac.uk)

information sharing occurred with any other agency. The police have reflected that this information should have been shared with the Local Authority. The police acknowledged that safeguarding systems and processes (including Multi-Agency Safeguarding Hub (MASH)) are now in place to share information and respond from a multi-agency approach.

6.7.2 The chronology demonstrates that the contact in 2017 involved a member of the public sharing information with the police. Information was also shared with the ambulance service, adult social care, Private Sector Housing and Shropshire Fire and Rescue Service.

6.7.3 There was no information sharing with Shropshire Fire and Rescue Service (SFRS) after the 16/03/2017. Shropshire Self-Neglect Guidance[33] within Section 6.10 states that advice should be sought from the fire service where a risk of fire is considered. When there were further contacts with Mr I in 2020 and 2021 information should have been shared with SFRS. Appendix 3 of this guidance is a Fire Safety Checklist and Partner Agency Referral Form. Hoarding is one of the risk criteria specified within the checklist.

6.7.4 When Adult Social Care made contact with Mr I in 2020 of their own accord there was no information sharing with any other agency.

6.7.5 In 2021 when the shopkeeper raised a safeguarding concern which was allocated to a Social Worker the Social Worker and Physician's Associate shared information with each other and with their line managers. The Social Worker also raised a safeguarding concern. However, there was no information shared with any other agency. It is possible that further information sharing at this point could have led to an exploration about arranging a multi-agency discussion and risk assessment.

6.8 Multi-agency working

6.8.1 Shropshire Self-Neglect Guidance advocates for joint working by different services, especially where people's circumstances have been identified as being complex and how this helps to complete a picture of the extent and impact of the self-neglect. It would have been advantageous to have called a multi-agency meeting, shared information, considered risk and co-ordinated approaches in response to the difficulties in responding to Mr I's situation.

6.8.2 In circumstances where there are concerns in relation to hoarding, as a minimum the following agencies should work together: Adult Social Care, Housing, Environmental Health, Fire and Rescue Service, Primary Care and Secondary Care.

6.9 Family

6.9.1 Mr I had shared his home with his wife and son. Self-neglect concerns appeared to begin when he began to live alone. There are discrepancies in the information about how much contact Mr I had with his son following this separation. It appears that his son was living abroad when Adult Social Care first became involved in 2017.

6.9.2 There is no known involvement with any other family members.

[33] 13526.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

6.10 Alcohol

6.10.1 The police recorded that Mr I was alcohol dependent. However, this information appears to have been an assumption for the following reasons:

- neighbours informed the police that Mr I had gone to the pub every day and had used the phrase 'to top up'
- bottles containing urine had originally contained alcohol

6.10.2 Police have also confirmed that there were no recorded signs of alcohol misuse e.g. alcohol containers in or around the home; intoxication; incoherence; incontinence or similar, during historic contact with Mr I.

6.10.3 Adult Social Care have no supporting evidence of any concerns around alcohol dependency.

6.10.4 Both a publican/friend and the shopkeeper who knew Mr I well both confirmed that alcohol was not a significant factor in Mr I's life.

6.10.5 A neighbour reported to the police that Mr I would go drinking, but never caused any problems. Local police teams have also confirmed that they were not aware of any problems with Mr I or his social drinking habits. When the sad news of Mr I's death was shared on social media, the responses from people who knew Mr I from either his working or visiting local pubs were very positive about him.

6.11 Covid-19 Pandemic

6.11.1 The first Covid-19 infections in the UK were reported in January 2020, on the 16/03/2020 the Prime Minister Boris Johnson announced that there would be restrictions implemented to stop the spread of the virus.[34] The first lockdown began on the 23/03/2020 closing 'non-essential businesses'. This had a significant impact upon Mr I. It caused Mr I to be isolated. Periods of lockdown closed the cafés and pubs which were essential to Mr I. They provided Mr I with friendship, companionship, food and drinks, toileting and washing facilities.

6.11.2 In 2020 the adult social care team arranged a welfare visit to Mr I due to recognising that the lockdown which had closed pubs would have on Mr I. There was no record of what the outcome of this visit was. There is no further information provided to the review in relation to the impact of this visit. The visit was clearly good practice, however, as no actions appear to have resulted from the visit. It seems that this was a missed opportunity to implement the Self-Neglect Procedure Flowchart which should have included working with the adult, assessing and managing danger to the person and others and considering if any other agencies are involved.

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[34] Lockdown 1.0 and the pandemic one year on: What do we know about the impacts? - House of Lords Library (parliament.uk)

6.11.3 A risk assessment should have been completed as a result of this visit and to inform next steps. This should have included the impact upon Mr I of pubs and café's being closed and the loss of the daily living amenities which were of such importance to Mr I.

6.12 Community

6.12.1 Following Mr I's sad death, there was a local newspaper article where local pub landlords' paid tribute to Mr I. Mr I was described as a 'true gentleman' and someone who would be 'sorely missed'. He was said to be a 'character' and someone everyone in town knew. A friendly man who would stop and talk to people. His love of sport including football and being a huge Manchester United fan was highlighted. He would cut articles about other teams out of the newspaper so that he could discuss teams others supported with them.

6.12.2 There was also a tribute on social media. In response to this there were 35 comments from members of the community with fond memories of Mr I.

6.12.3 One of the landlords had known Mr I for 15/16 years. He was clear that the main reason for Mr I's visits to the pubs and cafés were for company and to talk about football and were not for alcohol. Mr I was as happy with a cup of coffee. He spoke about Mr I's son and explained that there was regular contact following the divorce. The landlord provided the following information: that Mr I's son lived with Mr I for a short period, then went to university and then moved to Birmingham. He said that following university, Mr I and his son would text about once a month and meet up about once a year.

6.12.4 A local church was contacted but was unable to help with the review as Mr I was not a regular member of the congregation and that it was possible that he attended occasionally.

6.12.5 The local shopkeeper was hugely helpful to the review. She had known Mr I for 35 years originally meeting Mr I when he worked at a Bank. She confirmed that Mr I was not coming into the shop. The shop was delivering his order. She expressed that alcohol was not a significant factor in Mr I's life. She shared fond memories of contacts with Mr I. She said that Mr I had allowed her into his home until the last 2/3 years. She knew that Mr I did not have utilities. She assisted with charging his phone at the shop and provided him with prepared food.

6.12.6 Mr I's neighbour explained that Mr I had 3 friends who called at Mr I's home, and this is what led to calling the ambulance. She confirmed that one of the friends had taken Mr I for his Covid vaccine. She spoke of her concern for Mr I and shared information relating to support which other neighbours had also provided to Mr I. She also knew that Mr I did not have utilities.

6.12.7 It is notable since 2011 that various members of the community have provided support in many forms to Mr I. This has included practical, emotional and friendship as well as raising concerns to relevant agencies requesting assistance for Mr I. This support has been provided by publicans, cafés, an employer, friends/acquaintances, neighbours, the shopkeeper and staff at the local shop. Both the police and Social Worker praised members

of Mr I's community who provided key information about Mr I, his background, risks and support which the community provided to Mr I. This demonstrates that Mr I had support networks in his local community and that different individuals attempted to seek assistance for Mr I in various ways which should have resulted in Mr I receiving appropriate support from agencies in line with Shropshire's multi-agency procedures for responding to self-neglect[35].

6.12.8 The support around Mr I is evident from information which the police have provided to the review. This includes that the police incident in February 2017, began with the notable absence of Mr I from a local pub being reported to police.

6.12.9 During police involvement in March 2017, police officers made enquiries regarding Mr I's sightings and recorded that after Mr I had recently been given a lift into town by a neighbour, Mr I had later been seen eating some food in a local pub.

6.12.10 The chronology section demonstrates that agencies have responded to concerns raised in the community. What this review recommends is that Shropshire's Self-Neglect Guidance must be followed for each self-neglect concern whatever the source.

6.13 Utilities

6.13.1 Mr I is thought to have had no utilities for approximately 20 years. As reported above it was anticipated that Mr I would have his utilities reconnected following assistance in 2017 which resulted in his property being cleaned and cleared. However, this did not happen.

6.13.2 Mr I appeared to manage through accessing washing and toilet facilities as well as food and drink through pubs, cafes, the local shop and neighbours/shopkeeper providing food. It was when the Covid Pandemic prevented access to these sources that the impact of living with no utilities increased.

6.13.3 As stated previously, in 2020 the adult social care team arranged a welfare visit to Mr I due to recognising the risk which the lockdown would have upon Mr I. It is not known what action was taken in response to this visit. However, this change of circumstances should have prompted the implementation of both Self-Neglect and Working with Risk Guidance leading to various actions. This would have included consideration of Mr I having no utilities and the risks associated with this.

6.13.4 The privations associated with living without utilities for nearly 20 years had a significant impact. Mr I had no source or warmth, cooking or washing facilities and the consequences of this upon his wellbeing does not appear to have been sufficiently considered.

6.13.5 Shropshire Safeguarding Community Partnership in its Multi-Agency Working with Risk Guidance[36] includes a 'lack of some essential home amenities or lack of access to

[35] 13526.pdf (shropshiresafeguardingcommunitypartnership.co.uk)
[36] multi-agency-working-with-risk-guidance.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

essential amenities' equating to a moderate level of harm. However, if there are 'little or no essential home amenities or hoarding prevents safe use of any amenities within the home' this equates to a high level of harm.

6.13.6 Mr I's situation equated to a high level of harm which would require a reporting of a safeguarding concern to Shropshire Council. This was raised on the 01/02/2021. The response was that at this stage Adult Social Care should follow the local procedure flow chart in the Self Neglect Guidelines and a copy of this was forwarded to the Social Worker. The safeguarding concern was then closed. This response from the Safeguarding Team was appropriate as these areas had not been followed for Mr I and would have resulted in working with Mr I around the concerns, risk assessment and management, multi-agency working and Care Act Assessment.

6.14 Condition of the Home

6.14.1 The police report of 24/05/2021 found that the front garden was overgrown, however, from the street the internal issues would not be obvious. The property was found not to be secure. A cricket bat was used to secure the front door and a golf club secured the back door. This had clearly been the case for a number of years as the police had previously accessed Mr I's home through the inadequately secured back door.

6.14.2 The poor state of the bungalow quickly became apparent. The contents of the kitchen were described as being 'filthy and mouldy' and there was 'more rubbish than anything else'. There was no 'proper food'.

6.14.3 Surrounding Mr I, in the living room were a 'mountain of bottles', up to the height of Mr I's shoulders. The bottles were full of urine. It appeared that Mr I had been sleeping in the chair in this room for a long time.

6.14.4 The bedroom appeared unused. It was considered to be the 'cleanest room in the house'.

6.14.5 The bungalow was described as being in a 'horrendous state' and the police considered the home to be a health hazard. Environmental Health were contacted and visited on the 03/06/2021 but did not consider the house to be a health hazard so had no further involvement.

6.14.6 Photographs taken by Environmental Health demonstrate that the kitchen and bathroom were unable to be used for the purpose which they should serve.

6.15 Private Sector Housing

6.15.1 The Private Sector Housing Team have explained that they are constrained in the way they respond to complex situations such as is the case of Mr I. Constraints include time due to limited staffing as well as other statutory work of the team. Housing legislation is limited,

and it is not considered suitable for responding to hoarding/self-neglect issues. The funding of any remedial work is a protracted process.

6.16 Risk Assessment

6.16.1 There were clear risks associated with Mr I's self-neglect. A risk assessment does not appear to have been undertaken with Mr I in 2021 to determine the level of risk and the management of this. Shropshire Safeguarding Community Partnership's Multi-Agency Guidance: Working with Risk, 2019 provides the necessary process for this. It states that 'when a person is referred into the adult safeguarding process in Shropshire; the Adult Social Care Safeguarding Team assess the level of danger to the adult; using the level of danger matrix' within this guidance. As previously referred to the risks identified for Mr I in 2021 would have identified a high level of harm requiring robust multi-agency risk management.

6.16.2 This case highlights the critical need for all workers to be fully confident and trained in identification of those at risk and the processes to follow.

6.17 Fire Risk

6.17.1 Police shared concerns with Adult Social Care on the 05/03/2017 that Mr I's house, **'**was a potential fire hazard, as it was very cluttered and unclean, and would make escape difficult, as the front door was also inaccessible due to clutter. There was no electricity, so escape would prove even more difficult in darkness.'

6.17.2 The Private Sector Housing team had offered to arrange a Safe and Well Visit[37] by Shropshire Fire and Rescue Service (SFRS). The purpose of such visits is to consider potential hazards and the response to these and are non-judgemental. Mr I declined the visit so 2 smoke alarms had been provided to Private Sector Housing who had arranged to visit Mr I on the 14/03/2017 and were able to fit the alarms during this visit. The Private Sector Housing team informed SFRS that the property had approximately 12 inches of various items spread around the floor in most areas of the property and emphasised that 2 rooms were particularly heavily cluttered. A property clearance was being arranged. SFRS asked to be informed once the clearance had been completed as they would then offer another Safe and Well Visit.

6.17.3 SFRS confirmed via email on the 16/03/2017 to Private Sector Housing that Mr I property had been recorded onto SFRS turnout system in order to ensure that if Firefighters were dealing with an emergency at this property, they were aware of the hoarding risk.

6.17.4 During the Social Workers visits in 2021 significant hoarding was evident. The Social Worker on the 24/02/2021 found what appeared to be kindling on the doorstep. This possibly means that Mr I was having a source of heating but also raises concerns in relation

[37] Safe and Well visits are available from the Fire Service to consider potential risks within the home and provide advice around the management of these risks. Safe and Well Visit | Shropshire Fire and Rescue Service

to this being an additional risk of fire. This alongside the absence of utilities would have placed Mr I at significant risk of fire. Shropshire Self-Neglect Guidance within Section 6.10 states that advice should be sought from the fire service where a risk of fire is considered.

6.17.5 There was no further correspondence or dealings with Mr I by SFRS after the 16/03/2017.

6.17.6 Shropshire Safeguarding Community Partnership's Guidance on Responding to Self-Neglect implemented in 2016 and updated in 2019 provides a Fire Safety Checklist and Partner Agency Referral Form which asks about open fires, obstructed escape routes and the 2019 update included whether there are any sings of hoarding. Further development of this checklist to incorporate adding the clutter rating score and whether utilities are disconnected (specifying which ones) would assist in identifying hoarding/self-neglect risks.

6.18 Case Closure/Transfer

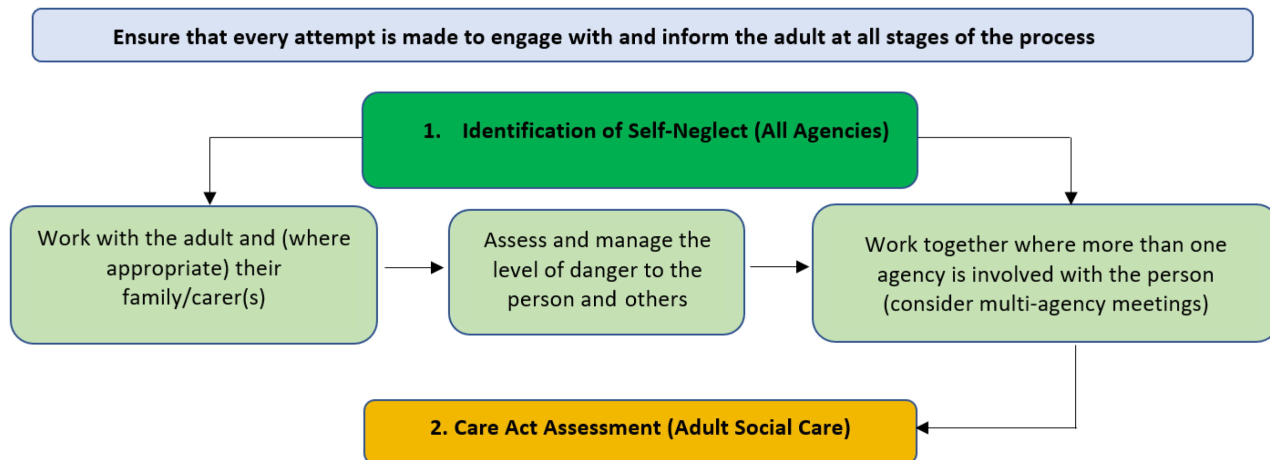
6.18.1 An entry in the Adult Social Care notes on the 16/04/2021 states, 'Case closure/transfer April 2021'. It refers to 'Ongoing work to support Mr I and to be able to access the property and that Mr I is on the hoarding forum spread sheet.'

6.18.2 The case closure summary does not have a team manager comment section. This was a critical time especially when self-neglect risks were apparent, This additional oversight would be helpful to consider the risk(s), whether sufficient action has been taken and whether any other action is required.

6.18.3 It is not clear who would do the ongoing work to support Mr I and to be able to access the property was allocated to. As discussed earlier in the Care Needs Assessment section when following the Shropshire's Self-Neglect Guidance[38], Mr I's situation would not meet criteria for case closure. This is because in section 1 (see image below) all 3 actions are needed in addition to the requirement for a Care Needs Assessment.

[38] 13526.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

Appendix 2: Local Procedure Flowchart



6.18.4 Mr I was not picked up again until the 21/05/2021 when the Adult Social Care NW Area bi-weekly meeting was held and the hoarding risk information on the spreadsheet relating to Mr I was reviewed. The Manager became concerned about Mr I's situation and realised that action was required. Sadly, Mr I passed away on the 24/05/2021 before the team could respond.

6.18.5 It has been identified by Adult Social Care that instead of closing Mr I's case, keeping it open with periodical monitoring may have prevented a deterioration in his living conditions.

6.18.6 It is prudent to note that the Social Worker had significant health reasons for no longer being able to be involved with Mr I and why the actions around support and access to Mr I's property as stated above (6.18.1) were to be allocated to another worker.

6.19 Self-Neglect Process and Training

6.19.1 Shropshire's Self-Neglect Guidance, 2019 provides a process to follow when self-neglect risks are apparent, and this process attempts to engage the adult throughout. It includes risk assessment, multi-agency working, Care Act Assessment consideration and what to do if this is refused. If the adult is not engaging with what is offered and there is a high level of danger to the adult and/or others, then a safeguarding concern should be raised at this stage. As this review has identified this process was not followed. This left Mr I at significant risk.

6.19.2 Multi-agency work in the context of self-neglect may include social care, primary care, voluntary organisations, safeguarding, health services, community mental health, housing, environmental health, police and fire.

6.19.3 The review has considered why all areas of procedure have not been followed when adult social care became involved with Mr I in 2021. The following reasons have affected

the application of this process: a heavy caseload, the unavailability of the practitioner, the case was not explored during supervision and the case handover summary (when a transfer was required) did not highlight the urgency this case required. The level of scrutiny of the case through the management oversight process would have benefited from a more robust approach. However, contact could have been made with the Safeguarding Team to arrange this.

6.19.4 When Mr I's case came to the attention of the Team Manager it was immediately reallocated and made a priority with a visit and multi-agency team approach instigated. It was reallocated but Mr I was found deceased shortly afterwards.

6.19.5 Self-neglect specific training is only mentioned by Adult Social Care who refer to joint training sessions on hoarding.

7.0 CONCLUSION

7.1 Agencies must work together and share information to ensure they are able to draw on all the available information held within each agency to build a full picture of the risk and extent of self-neglect.

7.2 Assessment and providing assistance at the earliest opportunity is important. The longer a person has been self-neglecting the more difficult it will be to intervene.

7.3 Concerns were raised by the community and responses to these concerns from each agency were prompt. What has impeded good practice has been the lack of application of the Shropshire Self-Neglect Guidance which provides a process built on good practice. Had this been utilised when concerns have been raised this may have provided better practice/outcomes.

7.4 A key aspect of the response to self-neglect needs to be a persistent approach and alongside this the practitioner needs to be building rapport with the person to develop a good relationship. This should assist the individual to open up about their history and what has led up to their current circumstances. It is also about finding out what is important to the person so that you ensure that this information is critical whilst planning approaches.

7.5 Interventions need to respond to the causes of self-neglect not solely to the symptoms. If the response only deals with the symptoms of self-neglect, this is unlikely to be a long-term solution.

7.6 Self-Neglect and hoarding are complex areas and have many causes. It appears that Mr I had many of the risk factors which can increase the risk of self-neglect and hoarding. The research into self-neglect and hoarding recommend that a variety of approaches are tried and that there is a multi-agency approach to agreeing this response. This review has demonstrated that no individual professional or friend/member of the local community will be able to successfully respond to self-neglect and hoarding as the person will have a complex situation requiring a multi-agency individualised approach.

7.7 It is imperative that self-neglect is recorded and escalated when required. Any agency who obtains access to the house of a person who self-neglects must capture information relating to risk. Using a consistent tool to measure this and to assess the risk will ensure a risk-based approach.

7.8 When serious self-neglect risks are present, mental capacity assessments should be completed.

7.9 There must be robust processes in place around case transfer and case closure to ensure that this is safely managed.

7.10 In Mr I's situation his friends and his community are a key part of responding to his self-neglect and hoarding but at times when they were less able to support him due to ill-health or the Covid Pandemic this is when Shropshire's self-neglect procedure needed to be implemented and unfortunately this procedure was not instigated in the robust manner in which it was needed.

7.11 It is hoped that through the recommendations from the learning outlined in this review that someone at significant risk due to self-neglect or hoarding risks will in future be provided with an individualised approach based upon the good practice highlighted within this review.

8.0 RECOMMENDATIONS

8.1 Each organisation to make sure that all staff involved in self-neglect work have access to supervision, specialist advice and an escalation process/ Senior Management oversight of people where circumstances are complex and/or there is significant risk.

8.2 Adult Social Care should ensure that all practitioners have the necessary knowledge around the duty to complete a S11 assessment when required.

8.3 Each organisation should ensure that staff have the necessary knowledge to implement the processes set out within: Responding to Self-Neglect in Shropshire: Good Practice Guidance and Local Procedure and Shropshire's Multi-Agency Working with Risk Guidance.

8.4 Where applicable organisations should make sure that safe processes are in place around any transfer and closure processes. Where significant risk is a factor, a named practitioner should remain involved and periodical monitoring should take place.

8.5 All agencies should ensure that executive functioning is considered when assessing mental capacity.

8.6 The self-neglect group to review risk tools to capture wider self-neglect and hoarding risks. This should include clutter rating.

8.7 Shropshire Fire and Rescue Service to consider further development of the Fire Safety Checklist and Partner Agency Referral Form to incorporate adding the clutter rating score and whether utilities are disconnected (specifying which ones) would assist in identifying hoarding/self-neglect risks.

8.8 All agencies to ensure that the Fire Safety Checklist and Partner Agency Referral Form is completed and submitted to Shropshire Fire and Rescue Service during any contact when fire risks are apparent.

8.9 Adult Social Care to share the outcome of any actions as a result of the paper delivered to senior management about the prevalence and impact of hoarding. All agencies working with individuals who self-neglect to consider implementing across the county the good practice initiatives in addressing self-neglect and hoarding.

8.10 The Self Neglect Priority Group and adult safeguarding team to consolidate themes/learning from this SAR report to ensure a joined-up approach to learning and improvement. This should take account of the findings from the fact that self-neglect is such a prevalent theme in SAR reports.

8.11 The Partnership (via Rachel Evans in the first instance) to liaise with utility providers to better understand what their arrangements are for the disconnection of supplies to vulnerable individuals and their families and what safety measures they put in place by liaising with Social Care.

8.12 The Partnership considers publicity in place for members of the public to ensure that if they have a safeguarding concern which may include self-neglect and/or hoarding, that they know how to report this.

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