1. Background

Mr I was a popular 70-year old man who lived alone. He sadly died at home in May 2021, the cause of death was considered to be of a natural cause.

Mr I had lived without utilities since at least 2011. His home was insecure and there was evidence of hoarding and living in insanitary conditions.

The COVID Pandemic had a significant impact upon Mr I. Lockdowns 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.

2. Safeguarding Adult Review

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

Mr I 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 Adult Statutory Case Review Group.

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

4. Recording and Escalating

Concerns in relation to self-neglect should be recorded. Use the Clutter Rating Tool when this relates to hoarding link.

All staff involved in self-neglect work need access to supervision, specialist advice and an escalation process to escalate circumstances when complex and/or there is significant risk.

8. Assessment and Early Intervention

Assessment (including assessing risk) 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. Key agencies who should work together in response to hoarding concerns:

Adult Social Care, Housing, Environmental Health, Fire and Rescue Service, Primary Care and Secondary Care

Other agencies may be involved based on individual need.

6. Multi-Agency Working?

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.

The approach should follow SSCP's Multi-Agency Guidance: Working with Risk

5. Self-Neglect Guidance and Procedure

SSCP's Self-Neglect Guidance and Procedure link should be followed as soon as any concerns relating to self-neglect are raised. This ensures that the response is based on best practice.

All agencies should ensure that staff are familiar with our Self-Neglect Guidance and Procedure.

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9. S11 Assessment

Practitioners within Adult Social Care should have the necessary knowledge around the duty to complete a S11 Assessment when a needs assessment has been refused and the adult lacks capacity to refuse the assessment and it is considered to be in the adults best interests or the adult is experiencing, or is at risk of, abuse or neglect.

10. Mental Capacity Act

When serious self-neglect risks are present, mental capacity assessments should be completed. Executive functioning should be considered when assessing mental capacity.

Executive functioning is covered during this presentation from 20 minutes onwards.

11. Developing a good relationship

A key response to self-neglect needs to be a persistent approach. The practitioner needs to build rapport with the person to develop a good relationship.

Learning what is important to the person and the underlying causes of self-neglect informs approaches.

16. Mental Capacity Act Further Information

Mental Capacity Resources — SSCP

Mental Capacity Guidance Note Capacity Assessment March 2023.pdf (39essex.com)

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

Shropshire Safeguarding Community Partnership

12. Transfer or closure considerations

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.

15. Self-Neglect Further Information

Hoarding Page — SSCP

Social care responses to self-neglect among older people

What do we know about hoarding behaviour and treatment approaches for older people?

14. Further development of public knowledge of safeguarding

SSCP praises the community for the support they provided to Mr I and the safeguarding concerns they raised.

The Partnership will consider how to further increase public knowledge of raising a safeguarding concern which may include self-neglect and/or hoarding.

13. Fire Safety Checklist

Ensure that the Partner Agency Fire Safety Checklist is completed and submitted to Shropshire Fire and Rescue Service for any contact when fire risks are apparent.

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