Thematic Review of Self-Neglect

This Safeguarding Adults Review looked at the experiences of two adults, Charles and Bridget (not their real names) who died in early 2021. Charles and Bridget died in separate circumstances, however the partnership recognised that self-neglect was a theme in both cases and commissioned a thematic review.

Read the full report on the KBSP website

10 agencies took part in the review.

Agencies submitted information, meetings were held with practitioners and operational managers and conversations took place with family members.

The report authors made 14 recommendations to KBSP and partner agencies.

Key Learning

The impact of the Covid-19 pandemic and increasing resilience

- Pressure on resources during the Covid-19 pandemic resulted in inconsistencies in safeguarding services, which impacted on the capacity of affected services to effectively manage and mitigate safeguarding risks. Leaders should take the opportunity to build on some of the partnership working and community engagement developed during the pandemic to strengthen system resilience.
- Risk assessment tools should be made available to front-line officers who regularly carry out home visits, and these officers should understand when a safeguarding referral should be made or re-referred.

Professional understanding of the risks associated with self-neglect of health conditions and nutrition

- There needs to be a common goal across primary and secondary health and social care to tackle complex health issues with a psychological component, such as a psychological functional disorder, addiction to pain medication or medical self-neglect.
- A lack of coordination between hospitals and primary health care providers can undermine efforts to treat opioid dependency and may negatively impact the relationship between patients and their treating clinicians in the community.
- A common language and strategy needs to be agreed between professionals on individual cases, to ensure that a consistent message is provided to patients on the rationale for and health benefits of reducing pain medication.

Involving informal carers/ family members

- Health and social care practitioners perceived family members as facilitators or barriers to access to the individual in need of care and support, rather than working with them collaboratively to develop an effective safety plan or carrying out a holistic assessment to understand the family members' experience of trying to support or care for the individual.
- Practitioners are trained to identify situations where a vulnerable person may be experiencing abuse and expected to make safeguarding referrals. However, a more freethinking approach should be employed, particularly where practitioners have themselves experienced a reluctance from the cared for person to engage with treatment or social care plans.
- Where concerns arise that someone's care and support needs are not being met by an informal carer, an assessment should be carried out that focusses on understanding the experience of caring for that person, as well as the carer's capacity to meet their needs and what information and practical support they might require.
- Better recording of informal carer details is needed, including recording on health and social care ICT systems so the details can be passed through to Connecting Care.

Use of the safeguarding process to reduce risk

- The perception that Bridget and Charles were self-neglecting, as opposed to their care and support needs not being met, or not being provided in the way they needed, may have led to them feeling judged and misunderstood and less likely to accept professional support.
- The absence of a long-term psychologically led specialist service can mean that practitioners become trapped in a cycle of unsuccessful short-term interventions that fail to mitigate risk, are resource inefficient resulting in practitioners and the adults at risk of self-neglect becoming frustrated and disengaged.
- The resulting episodic approach to safeguarding and the practice of closing cases after non-attendance at appointments resulted in inter-agency disputes in respect of safeguarding responsibility or a single agency left to manage risk in isolation. A multi-agency approach to risk management from an early stage is essential to mitigate harm in cases of self-neglect.
- Practitioners from any provider agency can utilise the **multi-agency escalation process** if they believe that insufficient action has been taken across the partnership to mitigate identified risk.
- Practitioners are reminded to refer to the **multi-agency self-neglect policy** that illustrates national standards of best practice and facilitates appropriate assessments.