Self-Neglect: SAR Hazel

LIVERPOOL SAFEGUARDING ADULTS BOARD

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Section One: Introduction

1.1. Hazel (a pseudonym) died on 29th December 2020, age 55. She had a medical history of alcohol-dependence and hepatitis, cirrhosis of the liver, diabetes and hypertension. No inquest has been held. Cause of death was certified as metabolic ketoacidosis, alcohol liver and pancreatic disease, and ischaemic heart disease.

1.2. A Safeguarding Adult Review (SAR) referral was submitted by Merseyside Police Service (MPS). The referral form in use did not require the date of referral to be recorded. This makes the tracking of the timeliness of decision-making more difficult. **Recommendation One:** Liverpool Safeguarding Adults Board (LSAB) should consider revision of the SAR referral form to enable oversight of the timeliness of decision-making about SAR referrals and commissioning.

1.3. Hazel's father had found her cold and unresponsive in her flat. Paramedics from North West Ambulance Service (NWAS) attended and pronounced life extinct. The MPS referral highlights that Hazel's property was in a poor state of repair, with accumulated rubbish. She was lying in her own faeces. The referral observes that Hazel had been subject of medical intervention in the days leading up to her death but ultimately had refused treatment. She had previously been discovered by MPS in a similar state in November 2020. A vulnerable adult referral was considered but was not sent to partner agencies due to the help Hazel was already receiving from her father and neighbours.

1.4. This SAR was commissioned as a mandatory review, the criteria in Section 44 (1) (2) (3) being fully met. A SAR panel, comprising senior leaders from the services involved and from LSAB partner agencies agreed that the key line of enquiry would be how close practice with Hazel, and with self-neglect cases generally, aligned with an established evidence-base. This evidence-base is outlined in the next section of this report. A key focus would be on the enablers of best practice, and on the obstacles or barriers to bets practice.

1.5. The SAR panel identified particular themes for analysis, namely:

1.5.1. How services responded when Hazel declined assessments of her care and support needs;
1.5.2. How services responded to her alcohol-dependence;
1.5.3. How services responded to evidence of self-neglect;
1.5.4. Whether any formal mental capacity assessments had been completed;
1.5.5. Whether Hazel's falls were considered in the context of her alcohol-dependence;
1.5.6. Whether there were missed opportunities to share information to safeguarding Hazel from abuse/neglect, particularly in response to her self-neglect;
1.5.7. Whether historically Hazel had been referred to MARAC as a result of domestic abuse.

1.6. Hazel's father was notified of the SAR and invited to contribute. He declined because of family circumstances. Hazel's son was also notified of the SAR and invited to contribute. At the time of writing this report, no response has been received from him.

1.7. One learning events was held. It involved practitioners and managers who knew Hazel and/or whose work routinely involved responding to self-neglect. The focus was on the evidence-base and how closely procedures and practice corresponded with it. A second learning event is

envisaged that will focus on disseminating the findings and learning from this SAR and on relaunching LSAB's self-neglect procedures.

1.8. The agencies that worked with Hazel provided statements of their involvement and answered additional questions posed by the independent reviewer and SAR panel. It was agreed that the main focus would be on the last year of Hazel's life, with reference to significant episodes of involvement prior to that.

Section Two: Self-Neglect Evidence-Base

2.1. The evidence-base is drawn from research and findings from SARs[1] that enable a model of good practice to be constructed in relation to adults who self-neglect. This model enables a whole system exploration of what facilitates good practice and what act as barriers to good practice. It comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect.

2.2. It is recommended that direct practice with the adult is characterised by the following:

2.2.1. A person-centered approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[2];

2.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[3];

2.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis; contact should be maintained rather than the case closed so that trust can be built up;

2.2.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[4], which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

2.2.5. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[5];

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[1] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[2] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[3] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[4] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[5] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

2.2.6. Where possible involvement of family and friends in assessments and care planning[6] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;
2.2.7. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[7];
2.2.8. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;
2.2.9. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
2.2.10. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[8]; taking into account the negative effect of social isolation and housing status on wellbeing[9].

2.3. It is recommended that the work of the team around the adult should comprise:

2.3.1. Inter-agency communication and collaboration, working together[10], coordinated by a lead agency and key worker in the community[11] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[12]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[13];
2.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
2.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
2.3.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[14];
2.3.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for

6 Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

7 NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

8 Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

9 NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

10 Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

11 Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

12 Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

13 Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

14 Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[15];

2.3.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

2.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

2.3.8. Clear, up-to-date[16] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[17].

2.4. It is recommended that the organisations around the team provide:

2.4.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

2.4.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

2.4.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

2.4.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

2.4.5. Attention to workforce development[18] and workplace issues, such as staffing levels, organisational cultures and thresholds.

2.5. SABs:

2.5.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[19]; strategic agreements and leadership are necessary for the cultural and service changes required[20];

2.5.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

2.5.3. Include social housing providers in multi-agency policies and procedures[21];

2.5.4. Establish systems to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

2.5.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

2.5.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

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15 Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

16 Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

17 Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

18 Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

19 Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

20 Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

21 Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

Section Three: Chronology

3.1. Statements of involvement submitted by agencies that had provided services for Hazel contained some background information. According to Royal Liverpool University Hospital Foundation Trust (RLUH), Hazel presented on nine occasions to an Emergency Department between 2010 and November 2020. One attendance related to alcohol misuse (January 2016), one concerned a fall and two were a consequence of hypoglycaemia. She had appointments with alcohol misuse services in 2016, with a fracture clinic (14 occasions between 2014 and 2019), and with hepatology in 2018. She had seven appointments with a liver clinic between 2011 and 2021 and six with clinical chemistry during 2019 and 2020. She had eight appointments with gastroenterology/liver between 2018 and 2020. There were also appointments for musculoskeletal assessment and for physiotherapy. Hazel was also an inpatient in 2011 (three occasions), 2014 and 2016, for which no electronic records are available. She was an inpatient for an endoscopy in 2018. In early November 2019 she was seen for a ward appointment at RLUH for Zoledronic acid infusion[22]. Primary diagnosis was osteoporosis; no changes were made to her medication. **Commentary:** it is clear that Hazel's physical health was poor.

3.2. Mersey Care's statement of involvement recorded five referrals between May 2014 and July 2020 to district nurses for removal of sutures/clips, review of pressure areas and provision of equipment. District nurses were unable to gain access/make contact on a couple of occasions. **Commentary:** the challenge of making contact with Hazel will be a theme in this chronology.

3.3. Between May and October 2019 Hazel was referred to wheelchair services for assessment. From 2017 to the end of her life, there were multiple visits by phlebotomy services when access was gained. Over the same time period, Hazel was seen regularly by the diabetic specialist nurses for diabetic control and management. There were several failed contacts in 2020. **Commentary:** there are no references to whether there were any safeguarding concerns arising from self-neglect, including substance misuse.

3.4. Between July 2013 and the end of her life Hazel was seen regularly by occupational therapists and physiotherapists (2013 to 2016) for provision of equipment and support with mobility. In 2017 she was seen by occupational therapy for equipment provision and the dietician for weight management; Hazel refused or accepted intervention intermittently. There was physiotherapy input in 2018 and 2019 to support with mobility issues; on a few occasions Hazel cancelled or rearranged appointments. **Commentary:** there is no reference to any referral to Adult Social Care (ASC) for a care and support assessment[23].

3.5. Merseyside Police Service (MPS) background information began in 2010 with a record of domestic abuse that referred to alcohol misuse and mental health issues that were being treated. There were further references to incidents of domestic abuse in 2013 and 2014, the latter noting mental health issues (disassociation), about which Adult Social Care (ASC) was informed. Also in 2014 MPS recorded an incident involving a dispute with a neighbour/carer. Both Hazel and the neighbour were reportedly drunk. ASC was informed. **Commentary:** MPS records do not indicate the outcome of informing ASC. ASC's own statement of involvement does not refer to any contact with Hazel prior to 2015.

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[22] Used to treat bone diseases, including osteoporosis.
[23] Section 9, Care Act 2014.

3.6. Between February 2015 and February 2016 MPS recorded eight occurrences of domestic abuse and/or harassment and/or theft by a former partner/carer or new partner. On some occasions Hazel and her former partner were recorded as having been intoxicated. On one occasion Hazel was observed to have been vulnerable, nervous and naked. In February 2016 MPS implemented a care plan, focused particularly on preventing abuse by her ex-partner. The plan was closed in June 2016 as there had not been any further incidents. Referrals were made to ASC on each occasion that MPS were involved. **Commentary:** referrals to ASC by MPS were good practice. The initiation of a care plan by MPS was also good practice.

3.7. ASC's record of involvement begins in January 2015 following referred concerns for physical and financial abuse, which are recorded as having been substantiated. Hazel is recorded as having declined support from ASC. **Commentary:** it is possible that Hazel's decision-making was influenced by coercive and controlling behaviour, or undue influence. Her decisional capacity might have been affected by her misuse of alcohol, which over time can impact on executive functioning.

3.8. In March and April 2015 ASC's statement of involvement recorded allegations of sexual abuse and a safeguarding referral for physical, sexual and financial abuse. Alcohol and drug misuse were noted. Safeguarding enquiries did not progress on either occasion owing to a lack of contact with Hazel, including attempted home visits. **Commentary:** home visits to make contact were good practice. However, persistent outreach is sometimes necessary to establish contact. ASC's statement of involvement contained no further entry for 2015 or 2016. It is unclear, therefore, what action was taken in response to MPS safeguarding notifications in that time. The MPS and ASC chronologies then fall silent until 2019.

3.9. Hazel was a tenant at Registered Social Housing. She lived alone. Records from January 2019 onwards indicate that she was in rent arrears. During 2019 there are references to Hazel telephoning the housing provider regarding payment of rent. There is also a reference to Housing provider writing to Hazel. It does not appear that housing provider staff visited the property.

Detailed chronology: December 2019 to December 2020

3.10. The pattern with Housing provider continued into 2020, with Hazel recorded as having made telephone calls to make payments towards her rent, and rent variation letters being sent.

3.11. On 8th May 2020, Hazel reported to MPS an argument with her father who was refusing to leave her flat. She made a second call soon after to say he had left; they had argued about her son going to university. Hazel was reassured; no offences were disclosed. Hazel refused consent to share information about the incident with partner agencies. **Commentary:** if this episode was seen as an adult safeguarding concern, consent would not have been required to make a referral for an adult safeguarding enquiry.

3.12. In early June, Housing provider records note that Hazel had contracted Covid-19 and had returned from hospital. The housing provider sent a text message on 26th June offering support. **Commentary:** offering support was good practice. In the context of the pandemic, a follow-up home visit might have been ruled out; in other circumstances, it might have been considered.

3.13. On 1st July, NWAS received an emergency 999 telephone call for reduced consciousness and hypoglycaemia. Hazel was transported to hospital. RLUH records indicate that Hazel was hypoglycaemic, complaining of right leg pain. Past medical history was recorded as cirrhosis and Insulin dependent diabetes. She was treated with IV dextrose and oral intake was encouraged. From 2nd July until 11th July Hazel was an inpatient at RLUH as a result of a fractured femur. Initially surgery had to be postponed because of her high blood sugar levels. She was reviewed routinely by diabetic nurses and, following surgery, physiotherapists. She required assistance to mobilise. She was discharged having declined the offer of an intermediate care bed. She also declined a care package from ASC, as a consequence of which her case was closed. The risks of declining a care package were explained. She was referred to district nurses for wound checks, with outpatient follow-up envisaged in three months. RLUH records indicate that she did accept community rehabilitation as she wished to become independently mobile. **Commentary:** it is not clear how Hazel sustained a broken right neck of femur. RLUH records, however, note a previous fractured right neck of femur in 2014 for which she had surgery. NWAS cannot trace a contact for a fall so this may have occurred in a public place[24]. Both NWAS and RLUH statements of involvement observe that Hazel had decisional capacity but it is unclear whether mental capacity was formally assessed and, if so, whether an assessment included her ability to use or weigh what staff observed in terms of her executive functioning. Follow-up by ASC post-discharge would have been good practice.

3.14. On 16th July, NWAS received an emergency 999 telephone call from a delivery driver attending the property for concern for Hazel's welfare. She was at home after a hip operation and awaiting district nursing for wound care. NWAS records document that she had been drinking but appeared to be alert and have capacity. The same record documents a past medical history of alcohol cirrhosis. Hazel reported that she had everything she needed and wished to stay at home. NWAS submitted a safeguarding concern. **Commentary:** the alert from the delivery driver was good practice. The NWAS submission of a safeguarding concern was good practice. A cumulative picture was beginning to build, indicating that care and support, and/or safeguarding referrals were indicated.

3.15. On 24th July, ASC transferred Hazel's case for allocation following the NWAS referral of self-neglect.

3.16. On 26th July, NWAS received an emergency 999 telephone call for hypoglycaemia (low blood sugar). She had been found by a neighbour. Hazel was transported to hospital. RLUH's statement of involvement records that Hazel was an inpatient between 26th and 29th July for severe hypoglycaemia and collapse. During this admission she was seen by an alcohol specialist nurse. As with the previous admission in July, she was recorded as stating that she normally "bum shuffles" around her flat and hasn't mobilised properly for several years**.** **Commentary:** neither NWAS nor RLUH raised a safeguarding concern. Although her history of alcohol abuse was known, it appears that the picture Hazel presented, of now just being a social drinker, was accepted. It appears that reliance on Hazel's self-reporting was unreliable. RLUH records observe that she reported that the community diabetes team reviewed her at home. However, when contacted by hospital staff, the team had not reviewed Hazel at home since March 2020.

[24] NWAS would be unable to trace this contact without further information about the incident such as date of fall and location. As NWAS records are address based, more information is needed to locate incidents in public places.

3.17. On 29th July, ASC made telephone contact with Hazel who declined a home visit. **Commentary:** there was no further follow-up with Hazel by ASC at this time. This might have been helpful as she had agreed, when in hospital, to discussion about how she had been managing at home. RLUH records contain statements about how she was managing at home, including the adjustments she had made as a result of her physical disabilities and the stairs in her flat. She had also indicated the level of support that she received from her father and son but no approach to them was made at this time. She was not observed in her flat prior to formal discharge so assessment and decision-making was reliant on her self-report about being able to manage all activities of daily living at home, and on what staff could observe and assess in the hospital.

3.18. For July and August, Mersey Care's statement of involvement records referral to the emergency response team for therapy services, with multiple failed attempts to visit, as a result of which Hazel was discharged. **Commentary:** case closure might be an understandable response in the context of demand on services but is not advised without multi-disciplinary or multi-agency discussion and attempts to engage by drawing on the support of other practitioners and/or relatives and friends.

3.19. On 28th August Housing provider records note that a voicemail message was left as Hazel's rent arrears were creeping up. This may have been the result of a bedroom tax shortfall. This was followed up with a letter.

3.20. On 8th September, ASC contacted Hazel again by telephone. Once again she declined any support. **Commentary:** outreach is good practice in an attempt to build a relationship of trust. A home visit might have yielded more information.

3.21. Housing provider records for 9th September note that Hazel had sustained a broken hip. She called to agree a payment plan with respect to the rent arrears. She agreed to a referral to check whether she was eligible for further welfare payments, already receiving Personal Independence Payment (PIP) and Employment and Support Allowance (ESA). An attempt to contact Hazel on 17th was unsuccessful, Housing provider records observing that a discretionary housing payment (DHP) or room assistance exemption might be appropriate. A voicemail message was left and text message sent. Contact was made on 21st September when Hazel telephoned regarding payments against her rent arrears. Hazel did not pick up when telephone calls were made on 1st October as booked to discuss welfare benefits. **Commentary:** attempts to maximise Hazel's income were good practice.

3.22. On 5th October, the allocated social worker requested to speak with Hazel's GP. The GP called back on 16th November to advise that Hazel had capacity to make decisions about her care and support. **Commentary:** it is unclear whether the GP had formally assessed Hazel's mental capacity at this time. There was also delay in information-sharing by the GP with the social worker.

3.23. Housing provider records note that contact was made with Hazel and an appointment booked to review her welfare benefit position. This assessment was completed on 19th October. Full ESA and PIP enhanced daily living were in place. Hazel had a shortfall on housing benefit due to under occupancy. She said that her friend came to stay with her at least once/week to help during the night. She undertook to check with her friend that she could disclose this so that application could be made for a room exemption. Otherwise the plan was to apply for DHP. Hazel agreed to provide an update the following week. She stated that she was not on the priority register with utilities and would appreciate help to check this.

3.24. Efforts by the Money Advice Team to follow this up with Hazel were unsuccessful on 21st and 26th October, with voicemail messages left. Support to make contact was requested from Housing provider staff. Contact was eventually made by Money Advice on 5th November when, because Hazel's friend was not visiting to provide overnight care, it was concluded that a room exemption application could not be made. Due to the highest PIP and highest ESA payable being in place, Hazel was very unlikely to be awarded DHP as she agreed that she could afford to pay this. Money Advice practitioner spoke at length with Hazel and discussed care, cooking and isolation difficulties. She said her father visited twice per week. She was offered referral to GP/Social Services to check if they could look into a care package, but she refused. She said her friend worked at a local school and she agreed that contact could be made with the friend to explore what support they could offer. This information was shared with Housing provider, with a plan to set up a direct debit to address the rent arrears. Although Hazel had refused help, safeguarding advice was also sought by email. **Commentary:** efforts to maximise Hazel income were appropriate. It was good practice to offer referrals and to seek safeguarding advice.

3.25. Housing provider records note that Money Advice staff were informed that no further safeguarding action was required. A welfare telephone call to Hazel was unsuccessful. A voicemail was left. **Commentary:** Hazel has not been seen at home, it would appear. A home visit might have been appropriate to assess the position.

3.26. On 17th November, MPS officers attended following a call that a delivery driver was refusing to leave her address. They found evidence of alcohol misuse and prescription drugs. Hazel was lying in her own faeces. Her living conditions and her mental health were recorded as poor. Officers commented on the poor state of the home with clutter, particularly a fire hazard due to the amount of packaging, food cartons and general rubbish. Hazel stated that she could see the delivery driver sitting on the sofa, staring at her; however, no-one else was in the premises. She was unable to focus on one conversation and seemed to officers to be in the midst of a mental health episode, but adamant she could care for herself with the support of neighbours and a weekly visit from her father. There was plenty of food in the house which was warm. No onward referral was made as Hazel refused consent to share information with partner agencies, and was receiving support from family and a neighbour. **Commentary:** this was a missed opportunity to consider a referral for care and support assessment[25] for which consent is required, and/or for a safeguarding enquiry on grounds of self-neglect[26] for which consent is not required. It does not appear that a mental capacity assessment was undertaken. Nor does it appear that a mental health referral was contemplated.

3.27. Also on 17th November, NWAS received an emergency 999 call. Hazel was unwell and was transported to hospital. Home conditions were poor. Her immobility was documented as was her willingness now to receive help. Paramedics indicated that a safeguarding concern would be sent; however, no concern is recorded on the NWAS system. **Commentary:** this was a missed opportunity.

3.28. Housing provider recorded that Hazel's father made contact on 18th November. He advised that Hazel had been admitted to hospital the previous day as she was very confused. He undertook to let Housing provider know when she was due out and what care package was in place.

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[25] Section 9, Care Act 2014.

[26] Section 42(1), Care Act 2014.

3.29. RLUH's statement of involvement records that Hazel was an inpatient between 18th November and 4th December as a consequence of acute decompensated liver disease, hypokalemia and self-neglect. RLUH records for this admission include observations that Hazel was covered from head to toe in foul smelling dried faecal matter. There was a grade 1 pressure sore to her sacral cleft. She was confused and reported visual hallucinations. Empty wine bottles had been found in her flat near the mattress on the floor where she slept but Hazel denied consumption. Once again it was known she could not access her kitchen and therefore was not eating adequately to manage her diabetes. Her father, when contacted, described the state in which she was living. **Commentary:** safeguarding concerns were identified and there is a first mention of a diagnosis of Wernicke Korsakoff Syndrome. However, RLUH did not submit an adult safeguarding concern. This was a missed opportunity. RLUH records indicate that the alcohol team attempted to assess Hazel. Due to fluctuating confusion staff were unable to ascertain a clear alcohol history. RLUH's statement of involvement observes that no capacity assessment was completed. This was a missed opportunity.

3.30. On 23rd November, ASC was notified of Hazel's hospital admission. She declined support on 2nd December and was consequently discharged from hospital without a care package. **Commentary:** it does not appear that the repeating pattern of refusing care and support was explored with Hazel. There is increasing evidence that she was unable to cope with at least some activities of daily living.

3.31. Housing provider records for 2nd December note that telephone contact was made with Hazel. She was still in hospital and hoped to be home soon. She was adamant she did not need any help and assistance in the flat but the practitioner disagreed. Hazel was asked to stay in touch and Housing provider know when she got home.

3.32. On 4th December, NWAS Patient Transport Service transported Hazel home. No care package was in place and she was non weight bearing. Her property had a soiled mattress on the floor; she appeared to have been living on the mattress. There was no landline or working mobile telephone for Hazel to contact help if needed. The property was insecure as the door was left unlocked. She refused to be returned to hospital. A safeguarding concern was raised. Hazel was left in the care of her father and the hospital was informed. The concern was telephoned through as urgent to ASC and an electronic concern was also sent. Feedback was received that the incident would be followed up by Careline. **Commentary:** the safeguarding referral was good practice, as was the immediate feedback. More questionable is the adequacy (urgency) of the safeguarding response given what was known.

3.33. On 6th December, a welfare call was made as part of discharge planning by a hospital social worker. The call unsuccessful as Hazel's mobile phone was not working. A letter was sent to her home address. On 10th December, another telephone contact was attempted (family confirmed her phone was fine at the time). There was no answer. The following day, a telephone call was made by a Careline customer advisor to Hazel with her father present. She was not happy with social services making contact and she was adamant that she did not need any help. Her father was prompting her to agree to help but Hazel declined. **Commentary:** attempts to engage Hazel were good practice but home visits might have better enabled a relationship of trust to develop and/or an exploration of her reluctance to accept care and support. There was clearly some engagement with Hazel's father in an attempt to work with Hazel. This was good practice.

3.34. GP records for this time note that there were unsuccessful attempts to contact Hazel on 7th and 8th December after her hospital discharge for a medication review. Text messages were left and

a letter sent. On 9th December Hazel is recorded as having contacted the GP surgery for a telephone review. Her insulin dose was reviewed and ongoing monitoring discussed. The GP recorded that she demonstrated clear understanding about her treatment and that there were no concerns about her mental capacity. She was referred for blood tests and to community diabetic nurses for support.

3.35. On 14th December Money Advice staff spoke with Hazel when she telephoned. She said that she was out of hospital. She was upset and the practitioner had difficulty understanding the issues over the phone. There were no outstanding benefit issues and Hazel was advised that Money Advice would email a housing officer to advise she was out of hospital and to request a home visit. Hazel was very emotional and crying, and trying to talk about issues with a neighbour and a friend. It was very difficult to understand what she was trying to tell. Money advice sent an email to Housing provider to ask her that urgent contact be made with Hazel, preferably face to face to understand what was being said. **Commentary:** there is no record that this was followed up before Hazel died.

3.36. On 26th December, Hazel's father and son called NWAS. Hazel was recorded as being confused and as refusing transportation to hospital. It is possible that she had not been taking her insulin. She was sleeping on a mattress on the floor. Her flat was full of rubbish and dirty linen. Paramedics sent a safeguarding referral. NWAS records note that Hazel had decisional capacity. Worsening advice was provided. Her family were noted to be checking on Hazel regularly. She also refused a referral to her GP. Paramedics documented that they warned Hazel of the risk of high blood pressure and of strokes, heart attack and death. She was able to retain and relay information and still refused advice. She signed a refusal statement but agreed to a safeguarding concern. Feedback was received by NWAS that the concern would be followed up by Careline. **Commentary:** the safeguarding referral to ASC was good practice. Although obtaining consent to a safeguarding referral is good practice, sharing information without consent is permitted in order to safeguard a person[27]. Feedback from ASC in response to the safeguarding referral was good practice. However, a repeating pattern is evident, given the events recorded for 4th December.

3.37. In December 2020 Mersey Care recorded a referral from RLUH for physiotherapy. Hazel was on a waiting list to be seen when she died. On 28th December, ASC allocated Hazel's case following the most recent safeguarding concerns of self-neglect from NWAS. On 31st December the allocated worker managed to make contact with Hazel's father in order to arrange a joint home visit. Knowing Hazel's past history of not engaging with services, it was thought that involving a family member would help to facilitate the visit. **Commentary:** it was good practice to consider family involvement, given the history. However, it was sadly too late as on 29th December, Hazel had been found deceased by paramedics at her flat. Her father had notified MPS.

[27] Data Protection Act 2018.

4. Thematic Analysis

4.1. Using the evidence-base as a framework for analysis, themes arising from the chronology, submissions from the services involved and from the learning event are analysed here.

4.2. Those practitioners and managers who attended the learning event observed that the onset of the Covid-19 pandemic made what might have been a typical case of self-neglect exceptional in the sense that services were having to adapt and work differently. Practitioners and managers were "in unknown territory." Particularly during lockdowns, a norm of conducting home visits was replaced with telephone calls and it proved difficult for some practitioners and services to engage with Hazel via this medium. It was acknowledged at the learning event that face-to-face meetings with Hazel (and with other patients/service users too) would have been beneficial. **Commentary:** one lesson from the pandemic is that guidance for practitioners and operational managers needs to be clear on when face-to-face visits are appropriate in order to complete a statutory duty[28].

Direct work

4.3. Person-centred approach. Research has identified that practitioners should adopt a relationship-based approach that seeks to understand what may lie behind people's behaviours, such as service refusals and repeating patterns. The research advises that practitioners should consider whether individuals are unwilling and/or unable to engage, and why this might be. Practitioners can become inured to or normalise risk when what is being presented is repetitive[29].

4.4. The practitioners and managers who attended the learning event recognised that services are not always person-centred in how they are configured and that there might have been missed opportunities to express curiosity with Hazel about her repeated refusals of offers of assessment and support. It was suggested that services might have been expecting refusal or disengagement, and might not have considered more assertive outreach.

4.5. The challenge of working out how to respond to service refusals and/or disengagement was seen at the learning event as a systemic issue. Not all practitioners, it was suggested, would have the confidence to raise their concerns with patients/service users, to express professional curiosity and to ask potentially uncomfortable questions. A training need was identified here, with an emphasis on seeking to understand the person's journey to the present day.

4.6. Similarly, uncertainty was expressed at the learning event about how to respond to constant refusals in the sense of when it might be appropriate to close down the case for one's agency. Anxiety was expressed that persistence could make subsequent attempts at engagement even more difficult. Conversely, it was recognised that every contact provided an opportunity to explore someone's feelings about accepting care and support. Practice, especially outreach, was made more complicated by services having different approaches to referrals without consent and to responses to missed appointments. It was acknowledged that different services had different thresholds

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[28] Salford SAB (2021) SAR Kannu.

[29] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

regarding where/when they are able to offer support, and the need for all agencies to be aware of other services' limitations.

4.7. Little sense was gained from the statements of involvement from services about Hazel's lived experience or of what lay behind her consistent response to offers of assessment, care and support. The reliance on telephone contact meant that her living situation was not observed. Her self-neglect was obscured from view. MPS took a photograph of her living conditions in May 2020 when, as the combined chronology noted, Hazel refused consent to the sharing of information. As statements of involvement observed, her wishes were respected. However, this is only part of the principle of making safeguarding personal. Little additional information about Hazel's life journey emerged from the learning event.

4.8. RLUH's statement of involvement includes detail of the social history that Hazel gave when in hospital in July 2020. She was recorded as a social drinker and as managing in her accommodation. As the statement of involvement observes, it would become apparent that her drinking was more than social and her managing around the house was questionable. Observing her real world circumstances at this time, including a pre-discharge home assessment, and seeking her father's views also (see thinking family below) might have proved helpful in efforts to persuade Hazel to accept support. Hospital records include her statement that she had been unable to go down stairs for several days due to hip pain and had therefore not eaten prior to this admission.

4.9. RLUH's contribution to the review also observes that there is no record that any environmental visits took place prior to Hazel's November discharge. Her father had shared his concerns with staff on admission in November 2020. He described in detail her current living conditions. These conditions were repeatedly referred to within the records but were never further challenged, in part due to the belief that Hazel the right to make "unwise decisions" and therefore return home. It is hard to disagree with RLUH's conclusion, namely that there appeared to be a lack of professional curiosity and desire to ask the additional why question, in an effort to delve a little deeper into why Hazel was living in the way she did. **Commentary:** there is a link to legal literacy and to mental capacity here. The Mental Capacity Act 2005 does not give people the right to make unwise decisions. The principle within the Act is clear that a person should not be treated as incapable of making a decision because their decision might seem unwise.

4.10. Thinking family. Several of the services involved with Hazel knew that she received support from her father and/or a friend. On one occasion a social worker enlisted the support of the father in an attempt to persuade Hazel to accept an assessment and potentially a package of care. RLUH records note that hospital staff spoke with Hazel's father in November when he indicated that her alcohol-dependence had been longstanding. He described her inability to mobilise, for example to use a commode and therefore how she attempted to manage her toilet needs using pads and wet wipes. There is no evidence that he was offered an assessment as a carer[30], despite shopping for Hazel and being a full-time carer for his wife.

4.11. Housing provider also knew from Hazel that a friend sometimes stayed in order to provide night-time care but again it is unclear what precisely this entailed and the implications do not appear to have been explored when Hazel said that she could not rely on this support being available. At the learning event it was acknowledged that more could have been attempted in terms of thinking

[30] Section 10 Care Act 2014.

family, not least to build a picture of Hazel's journey and lived experience, and how this might help to explain her reticence to accept support.

4.12. Risk assessment. Risk assessment and risk management are crucial, with plans preferably co-designed with service users/patients and shared across partners. There was a pattern of risk and in the final months of Hazel's life the risks appear to have been escalating. There might have been missed opportunities to complete risk assessments, such as when Hazel was admitted to hospital following a fall, or when safeguarding concerns were referred. There were missed opportunities to share information about risk with other agencies, such as when MPS officers were concerned about her welfare but Hazel withheld her consent. As a result, agency responses did not effectively address or reflect the urgency associated with the apparent deterioration in her living situation and physical/mental health.

4.13. GP records contain an entry for 21st July 2020 documenting a hospital admission on 5th July with a fractured neck of femur. The hospital discharge letter states this was as a result of a fall, but there was no mention of whether alcohol was a contributing factor. The RLUH analysis of involvement observes that Hazel had an existing diagnosis of osteoporosis. She had sustained a fragility fracture of her right distal femur in 2014. In July 2020 her injury was described as an atraumatic intracapsular fractured neck of femur, indicating the fracture was not the result of a trauma/fall. Seen in this light, the focus might then have turned to the implications for her mobility and ability to manage activities of daily living.

4.14. At the learning event it was suggested that agencies look at risk differently and that the development of a risk assessment template would be helpful. **Recommendation Two:** LSAB should consider developing multi-agency risk assessment materials for use in self-care cases.

4.15. Mental capacity assessment. There were few references to mental capacity assessment in the chronology, which is perhaps surprising given that the Code of Practice[31] refers to symptoms of alcohol or drug use in the context of disorders of mind or brain. Where mental capacity was mentioned in statements of involvement submitted by the services involved, for example by her GP, RLUH when the risks of discharged without a care package were explained, and by NWAS, it was stated that Hazel had decisional capacity. Thus, for example, NWAS stated that: "*NWAS did not conduct a formal mental capacity assessment. At all incidents attended by NWAS prior to the critical incident the crews documented that Hazel had capacity, and did not demonstrate any behaviours which might indicate otherwise.* GP records note that Hazel had mental capacity on four occasions, in August 2014, July 2015, and 16th November and 8th December 2020.

4.16. The RLUH statement of involvement, when itemising the assessment and treatment given in November 2020, indicates the difficulty in engaging in conversation with Hazel to complete an assessment due to drowsiness, confusion and confabulation. It records that there is no evidence that a mental capacity assessment was conducted, although a social worker, therapist and hospital case manager requested that assessment be undertaken. In its conclusions RLUH comments that there was a belief throughout Hazel's inpatient journey that she had mental capacity and therefore the right to make her own decisions; this was despite both factual and professional concerns being raised questioning her decision making. Those individual practitioners who questioned her mental

[31] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office.

capacity appeared to be dependent on "another" to complete this assessment, when in fact each one could/should be considered a decision maker. It is recorded that Hazel was "mildly" confused and that she was confabulating (making false memories); again neither were challenged.

4.17. It is also unclear whether her executive functioning had been considered as part of any assessment. There were also missed opportunities when a formal mental capacity assessment might have been appropriate. One such occasion was when MPS officers found her lying in faeces amidst poor living conditions. Another was when her father described Hazel as confused but declining to go to hospital. A third was when NWAS transported her home from hospital, witnessed the very poor state of her flat and were concerned about her ability to cope. She refused to return to the hospital.

4.18. Three questions arise that LSAB should consider with partner agencies as part of its statutory mandate to seek assurance that adult safeguarding services are working effectively in preventing abuse and neglect, including self-neglect. Firstly, is there an understanding of executive capacity? Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[32], with subsequent discussion to assess whether someone can use and weigh information.

4.19. Secondly, is sufficient recognition given to the impact of trauma and adverse childhood experiences? Thirdly, is drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making or possibly invoking considerations of mental capacity and self-neglect? **Recommendation Three:** LSAB should consider commissioning multi-agency audits of mental capacity assessments and with partner agencies agree an action plan to address the findings.

4.20. Care and support assessment. As the combined chronology indicates, there were occasions when Hazel was allocated a social worker and/or offered an assessment. She consistently declined. She does appear to have agreed to a care package before hospital discharge in November 2020. This generated discussion between social work and healthcare practitioners as to whether a package of care was necessary as Hazel had previously stated that she could manage all activities of daily living. In any event, having indicated agreement on one occasion, she then told therapy team staff that she could manage alone. When other agencies referred Hazel for a care and support assessment, she declined and no such assessment was completed. As already observed in this section of the report, this pattern did not prompt either formal risk assessment or a change in approach given that reliance was mainly placed on telephone communication.

4.21. It was known to various agencies and practitioners that Hazel was "bum shuffling" in order to get around her flat, which included having to manage stairs. It is not apparent from statements of involvement from the services involved whether professional curiosity, concerned challenge, was expressed as to the impact on managing activities of daily living, such as maintaining a habitable environment and meeting her toilet and dietary needs. It would have been appropriate to have explored this in her living environment rather than relying on her self-report.

[32] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

4.22. Section 11(2) Care Act 2014 requires a local authority to complete an assessment where the individual lacks capacity to refuse and an assessment is in their best interests, or the adult is experiencing/or is at risk of abuse or neglect, including self-neglect. At no point was Hazel assessed as lacking capacity. However, concerns about self-neglect were well known. At the learning event, uncertainty was expressed about when using this statutory provision might be a viable tool and what the threshold might be in the context of high caseloads.

4.23. Responses to substance misuse and mental distress. Individuals in the grip of substance misuse do not find change easy to achieve and this realisation should be factored into how services are set up to provide support. This reinforces the commentary on executive decision-making and mental capacity assessment above. Hazel appears to have had prolonged dependence on alcohol, or at least a history of substance misuse. There is limited information in the statements of involvement about what assessment and treatment Hazel was offered, other than from RLUH in their chronology of involvement when Hazel was admitted in November 2020. Then she was seen on several occasions by practitioners in an alcohol team. No signs of alcohol withdrawal were observed but reliance appears to have been placed on what Hazel self-reported. The risks of continued use of alcohol were clearly discussed, for example as part of a hepatic encephalopathy nurse review. There has been some uncertainty about whether Hazel was formally referred to substance misuse services. However, RLUH's statement of involvement makes reference to a referral from gastroenterology to "Attend Anywhere" on discharge for ongoing support. Hazel could not be contacted before she died[33]. It remains unclear what lay behind her substance misuse. NWAS, in its statement of involvement, observed that there is no pathway currently for that service to refer directly to substance misuse providers.

4.24. At the learning event there was limited understanding of her alcohol misuse, its impact on her life and the background to it. It was believed at the learning event that there had not been any referral in respect of Hazel's alcohol abuse. This prompted discussion as to whether or not Hazel was alcohol-dependent and/or whether the level of her usage was obscured because most services did not see her living situation, which does appear to have deteriorated quite significantly in the last seven months of her life[34]. A view was offered that usually agencies make appropriate referrals when there is evidence of alcohol dependence and/or mental distress. However, experience was also reported of referral bouncing in respect of people with dual diagnosis. It was recognised that a multi-agency strategy meeting would have been useful and could have included a focus on her substance misuse.

4.25. Some practitioners and managers at the learning event made a link between Hazel's substance misuse and the challenges encountered in engaging her, and suggested that not everyone would be aware of referral pathways and services available. However, healthcare records from 2011 onwards indicate that Hazel was being seen periodically in outpatients and emergency departments for liver and gastro problems, so the absence of any attempt to assess and/or work with Hazel on her use of alcohol remains perplexing.

4.26. Hazel had a mental health history, for example of "disassociation" in 2014. Although, as the combined chronology indicates, there was concern in the final months of Hazel's life about her

[33] This was an attempt to have a video consultation with Hazel. A message was left for Hazel to contact the team. This was not followed up.
[34] The independent reviewer has been shown photographs taken by MPS officers in May and December 2020.

mental wellbeing, no referral was made. The RLUH chronology of its involvement observes that in November 2020, during Hazel's inpatient stay, a social worker requested a mental health assessment. This does not appear to have taken place. Concluding its contribution, RLUH observes that on 18th November 2020 it was documented that she presented with the impression of Wernicke's Korsakoff syndrome but this was never re-visited. Support from mental health services was never apparently considered.

4.27. Again, at the learning event, a view was offered that referrals are made, for example from hospital clinicians to mental health practitioners. Despite concerns from NWAS and MPS about self-neglect and mental wellbeing, no referrals for mental health assessment and support were made. One explanation offered was that different practitioners saw Hazel at different times, understandably because of shift patterns, with the result that, sometimes subtle, changes in her presentation were masked. **Recommendation Four:** LSAB should consider seeking assurance from all partners concerning recognition and response when individuals present with co-morbidities. This is to ensure that appropriate referrals are made and that services work together rather than in silos.

4.28. Responses to physical ill-health. Hazel had a history of physical health concerns. Between late 2015 and mid-2020 ASC and MPS had no contact. However, Hazel's physical health remained a concern, most especially her diabetes. Prior to the final months of her life, she attended emergency departments where hypoglycaemia was diagnosed. RLUH in their statement of involvement recorded that in July 2020 she was admitted with severe hypoglycaemia. It is not clear from agency submissions whether links were made with her alcohol usage or consideration given to the impact, at least temporarily, on her mental capacity.

4.29. Hazel was seen periodically by district nurses, diabetic nurses, dieticians, occupational therapists and physiotherapists. Nothing abnormal appears to have been recorded when Hazel was seen at home. This may partly be explained again by community services operating a shift system with the result that she was seen by different practitioners. Nonetheless, at the learning event, those attending questioned whether enough was known and shared about diabetic management with Hazel.

4.30. Assessments and treatment responses by RLUH staff during all hospital admissions, but especially in November 2020, were generally thorough, appropriate and timely. This included referral to specialist nurses, routine monitoring, tests, plans and responses to risk, such as refeeding syndrome. However, RLUH's commentary observes that dieticians' requests for weight recordings and monitoring of dietary intake by ward staff "*fell short of the standard we would normally expect.*" There was a failure to provide an accurate weight and monitoring of her dietary input was often incomplete or in direct contrast to what Hazel would recall. This was "*particularly significant given that she was an insulin dependent diabetic and raises the question if her diet is poor in the controlled environment that the hospital provides, what might this look like once discharged*." Moreover, due to her complex care needs, there were multiple specialities involved in delivering her care but often in silos[35]. This clearly links with what follows in this analysis, namely the team around the person.

Team around the person

35 RLUH analysis.

4.31. Working together. In the chronology there is one instance when a social worker contacted Hazel's GP. There was then a delay in information being shared between the GP and social worker (5th October to 16th November). This delay was unfortunate but perhaps reflected lack of clarity about the level of risk. In its commentary RLUH observes that nobody took the lead and the concerns of "self-neglect" were somehow lost during her inpatient journey.

4.32. Feedback from the learning event was that there was some perceived uncertainty about which service should take the lead when there were several agencies involved. It was observed that no service took the lead in Hazel's case, the result of which was silo working. Some uncertainty was also evident regarding which of several pathways to use when there were concerns surrounding hospital discharge and/or substance misuse, and which service should take the lead in bringing the multi-agency system together to share concerns.

4.33. It was suggested that services were making appropriate referrals but then letting other agencies take a responsive lead. Housing practitioners and managers felt that they were often left out of the picture but in a case like self-neglect and hoarding would have a great deal to offer. Discussion also focused on barriers to accessing/liaising with other agencies; for example, different shift patterns and uncertainty of who to contact within other agencies.

4.34. Information-sharing. Those attending the learning event acknowledged the presence of some uncertainty about information-sharing, including when it was lawful to share information without consent. As a result there was a reluctance to share information. There is a clear link here with legal literacy (see below) and the Data Protection Act 2018. A perspective was also offered that information-sharing was not always patient-centred and often depended on available staff resources.

4.35. In Hazel's case the absence of information-sharing meant that services were not aware of when safeguarding concerns had been referred to the local authority.

4.36. Multi-agency meetings. Some practitioners and managers attending the learning event felt that there were missed opportunities to convene strategy meetings, and that multi-agency risk management meetings were not used consistently. The absence of joined-up working in Hazel's case, and the fact that risks and needs were missed in part because she declined assessments and supports, meant that there was no trigger for a multi-agency meeting. By contrast, there were accounts of where multi-agency meetings had been used effectively. **Recommendation Five:** LSAB should consider reviewing available guidance about multi-agency risk management meetings and conducting a multi-agency audit to determine whether such meetings are being convened and used effectively.

4.37. Safeguarding literacy. Paramedics who attended Hazel on 4th December 2020 raised a safeguarding concern notification with consent. This highlighted concerns that Hazel was alcohol-dependent and that she ordered takeaways in order for alcohol to be delivered to the property. A previous safeguarding concern notification was raised by a crew on 16th July 2020. This documented a description of the property, including that Hazel was surrounded by wine bottles. On 26th December 2020 NWAS raised a third concern. It was noted that Hazel had refused both hospital admission and a referral to her GP but had agreed to a safeguarding concern which was raised as urgent. These referrals were good practice. All three referred safeguarding concerns described the conditions in which Hazel was living and the level of self-neglect, namely sleeping on a soiled

mattress on the living room floor and an inability to walk that meant that Hazel was shuffling around the property on her bottom. The concerns variously also described that the mattress was surrounded by wine bottles, food, drink, medication, and a bed pan, and that her accommodation was insecure as she could not get to open a locked front door, and that she had no means of summoning help. Flies were noted within the property, and Hazel was observed to be unkempt. Hazel and her father also told a crew that she did not eat daily even though she was an insulin dependent diabetic. Paramedics used the clutter rating scale to reinforce the information about the conditions in which Hazel was living.

4.38. Feedback to the NWAS concern raised in July was that contact would be made with Hazel to offer support. NWAS was advised that the concern raised in early December would be followed up by Careline. Feedback to the concern raised later in December was that the concern would be followed up by Careline and was passed to a named individual at social services. It is not clear to NWAS what help was offered to Hazel as a result of these concerns, or whether any changes were implemented.

4.39. ASC in its statement of involvement has indicated that there should have been an immediate response to the adult safeguarding concern referred at the beginning of December 2020, a missed opportunity to instigate an adult safeguarding enquiry. There were attempts to offer care and support by ASC and concerns about safeguarding her. There were referrals but these did not progress when Hazel declined the offer of assessments and support. On one occasion, at least, she appeared annoyed that she was being asked to consider support. Given the sequence of events, and what was known, the criteria in section 42(1) Care Act 2014 were clearly met and an adult safeguarding enquiry would have been an appropriate response.

4.40. RLUH in its contributions to the review has observed that no referral was made under section 42(1) and this would be considered a missed opportunity. Historically also, when safeguarding concerns had been referred to ASC, no protection plan had resulted, not least because Hazel had declined support.

4.41. Several concerns emerged at the learning event. Firstly, about delays in responding to referred concerns and using triage that resulted in decisions not to progress to safeguarding enquiries. Secondly, that safeguarding enquiries did not always seek out the views on risk from services holding information. Thirdly, that the lack of feedback about referrals meant that referrers were unaware of outcomes and of the appropriateness of the action they had taken. **Recommendation Six:** LSAB should consider conducting an audit of the response to referred safeguarding concerns and addressing the findings.

4.42. Legal literacy. At the learning event it was questioned whether practitioners understood the interface between the right to private and family life (Article 8, European Convention on Human Rights, integrated into UK law by the Human Rights Act 1998) and section 11 Care Act 2014. There were also questions about consent with respect to referrals for care and support assessment (section 9 Care Act 2014) and/or of safeguarding concerns (section 42).

4.43. Hazel sometimes refused consent for information about concerns to be shared. In fact, consent is not required for referrals of adult safeguarding concerns, although ideally it should be sought, and the Data Protection Act 2018 permits the proportional sharing of information to safeguarding an adult at risk.

4.44. Recording. The absence of shared systems across services involved with adult safeguarding meant that no-one would have a complete picture. For example, RLUH social workers can add to the patient hospital records but hospital staff cannot access the local authority's electronic recording system. Mersey Care mental health and community practitioners, along with GPs, can access the same system but not with acute hospital trusts except for the discharge letter to GPs. Community nurses can access this system; however, this does not always give the full picture. In similar cases it would be essential to ensure that services had offered all the support options available, and that this was clearly documented within records. On mental capacity assessments, full details should be recorded of the decision for which an assessment was undertaken, the time it was conducted, and how the outcome was reached.

Organisational support for the team

4.45. Supervision and management oversight are core components of the evidence-base for best practice. Safeguarding discussions were held when Hazel was in hospital in November 2020 but the impact of the pandemic on staffing levels appears to have delayed completion of a capacity assessment and the referral of safeguarding concerns. It was unclear what level of supervisory and management oversight was available to other practitioners.

4.46. Workforce and workplace development are other components of this part of the evidence-base. There was general agreement at the learning event that there were currently unmet training needs around legal literacy (knowledge of, and use of legislation, including information-sharing), using multi agency risk management meetings, developing skills of professional curiosity and escalation of concerns, ensuring that practitioners have up-to-date knowledge about self-neglect, and thinking family. A recommendation concerning training follows below but strategic and operational managers must ensure that practitioners can practise subsequently the knowledge and skills acquired through training.

Governance

4.47. Those attending the learning event suggested that LSAB could usefully assess the need for a multi-agency training programme and for clearer pathways when people present with a constellation of complex and challenging needs.

4.48. There was agreement that protocols concerning hoarding and multi-agency risk management meetings, developed by the Merseyside Safeguarding Adults Board, had been useful, but were not widely known or used. Now that LSAB has been re-established, revision and then dissemination of such protocols would be helpful in providing a framework for best practice. It was also suggested that LSAB should develop risk assessment templates and other tools to support the identification of and response to self-neglect, alongside the well-known clutter rating scale. Such templates and tools, it was argued, might help to prompt the use of multi-agency risk management meetings.
Recommendation Seven: LSAB should consider whether revision is required to available policies and procedures on self-neglect and on risk assessment, and its approach to dissemination and auditing the effectiveness of such policies and procedures.

4.49. It was suggested at the learning event that more opportunities to learn from SAR findings and complex and challenging cases would be useful. Also suggested was monitoring through audit and assurance reporting of the use of multi-agency meetings.

5. Revisiting the terms of reference: conclusion

5.1. Derived from research, SARs, practitioner accounts and feedback from people with lived experience, there is an established evidence-base for best practice when working with people who self-neglect. Those attending the learning event were asked to reflect on how closely practice, and the management of practice, were aligned to the evidence-base.

5.2. A variable picture was presented. Practitioners and managers felt that there was some very effective multi-agency working, for example surrounding adult safeguarding enquiries (section 42) and professional challenge. However, in contrast, views were expressed that services needed to work better together, that agencies were not coming together to share information. In conclusion, further work is necessary to align practice, the management of practice and multi-agency working with the evidence-base.

5.3. Discussion at the learning event focused in part on how to evidence an individual's situation and living environment – documentation within notes, discussion between colleagues, referrals to other agencies, body worn cameras and photos taken. More reliable evidence could create less subjectivity and a better understanding between agencies.

5.4. Turning to the terms of reference for the review, there was little by way of concerned challenge or professional curiosity in response to Hazel's consistent refusal to engage with assessments of her care and support needs. Little is known as to why Hazel was so reluctant to accept support, even when encouraged to do so by her father. Reliance was ultimately placed on her self-reporting that she could manage activities of daily living, notwithstanding her mobility difficulties. The evidence-base described in section 2 above is clear that persistence and professional curiosity are key components of best practice.

5.5. Focusing on mental capacity, there might have been a misunderstanding of the principles within the Mental Capacity Act 2005. Moreover, Hazel's decision-making was not assessed in her home environment and reliance was placed on what she said without observing her executive functioning. It was documented that she had a long-term dependency on alcohol and prescription drugs but there is no evidence to suggest that these behaviours were considered likely to negatively affect her decision-making. Executive functioning should be a documented feature of all mental capacity assessments.

5.6. Focusing on Hazel's alcohol-dependence, although substance misuse specialist practitioners did see Hazel when she was in hospital, there is no evidence of a sustained focus on her use of alcohol. There does appear to have been one onward referral on discharge from her final hospital stay but this was too late. Guidance is available on best practice with people with longstanding misuse of alcohol but this was not followed[36].

5.7. The risk of falls is one feature of alcohol-dependence, with consequent follow-on risks of head injury and brain damage. This might have been a feature in this case, although it is also apparent

[36] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. Preston-Shoot, M. and Ward, M. (2021) *How to Use Legal Powers to Safeguard Highly Vulnerable Dependent Drinkers in England and Wales*. London: Alcohol Change UK.

that Hazel's osteoporosis was implicated. Either way, there are links back to consideration of care and support, and mental capacity assessments.

5.8. There were missed opportunities to share information, and to convene multi-disciplinary and multi-agency risk management meetings at which information could have been shared and a plan formulated. There does appear to have been some uncertainty about when consent is (not) required to share information and to send referrals.

5.9. Cases of self-neglect are challenging. Especially in situations where individuals are assessed as possessing decisional capacity, ethical dilemmas arises for practitioners who must strike a balance between an individual's autonomy and fulfilling a duty of care. The evidence-base, outlined in section two above, and the research from which it is derived, describes core components for managing this challenge, involving relationship and person-centred practice, concerned curiosity, skilled questioning and exploration, multi-agency meetings and supervision. There were missed opportunities to explore with Hazel her living situation from a position of concerned curiosity and to convene "the system" to decide which service would lead the multi-agency approach and to obtain a holistic view of the situation.

5.10. Analysis of SARs[37] has also found that self-neglect is often not recognised or explored. It is a complex condition that often involves a combination of poor physical and mental health, substance misuse, poverty and social/environmental factors. Hazel's self-neglect was not explored sufficiently and may even have not been recognised or lost from view.

5.11. Concluding, whilst some components of the evidence-base for best practice when working with people who self-neglect were found in this case, and were observed more generally at the learning event, there were also shortfalls. As one participant in this review concluded, "more could have been done." The independent reviewer has heard that this case is not unique, which suggests that LSAB should work with partners to ensure that complex, challenging and high risk cases are identified, with subsequent work coordinated and routinely reviewed. **Recommendation Eight:** LSAB should consider conducting a multi-disciplinary audit of self-neglect cases using the components of the evidence-base in order to identify enablers of best practice and obstacles or barriers to best practice that the SAB with partner agencies can then address. **Recommendation Nine:** LSAB should consider commissioning multi-agency training to develop the knowledge and skills of practitioners and managers for working with people who self-neglect.

[37] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

Recommendations

Recommendation One: Liverpool Safeguarding Adults Board (LSAB) should consider revision of the SAR referral form to enable oversight of the timeliness of decision-making about SAR referrals and commissioning.

Recommendation Two: LSAB should consider developing multi-agency risk assessment materials for use in self-neglect cases.

Recommendation Three: LSAB should consider commissioning multi-agency audits of mental capacity assessments and with partner agencies agree an action plan to address the findings.

Recommendation Four: LSAB should consider seeking assurance from all partners concerning recognition and response when individuals present with co-morbidities. This is to ensure that appropriate referrals are made and that services work together rather than in silos.

Recommendation Five: LSAB should consider reviewing available guidance about multi-agency risk management meetings and conducting a multi-agency audit to determine whether such meetings are being convened and used effectively.

Recommendation Six: LSAB should consider conducting an audit of the response to referred safeguarding concerns and addressing the findings.

Recommendation Seven: LSAB should consider whether revision is required to available policies and procedures on self-neglect and on risk assessment, and its approach to dissemination and auditing the effectiveness of such policies and procedures.

Recommendation Eight: LSAB should consider conducting a multi-disciplinary audit of self-neglect cases using the components of the evidence-base in order to identify enablers of best practice and obstacles or barriers to best practice that the SAB with partner agencies can then address.

Recommendation Nine: LSAB should consider commissioning multi-agency training to develop the knowledge and skills of practitioners and managers for working with people who self-neglect.