Croydon
Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW
‘Ben’

2023

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1. INTRODUCTION

1.1. Ben died in 2019 aged 39 years old. He was well educated and had been active in local politics. Ben's cause of death was hepatic encephalopathy, a neuropsychiatric syndrome caused by liver failure.

1.2. Ben lived in Croydon but his GP was in another London borough. Ben had a history of high blood pressure for which he was prescribed medication. In 2014 he reported, on an alcohol consumption questionnaire, that he was drinking around 25 to 28 units of alcohol per week. The recommended limit is 14 units. Ben was diagnosed with panic disorder and depression. In 2014 and 2015, Ben attended four Improving Access to Psychological Therapies Service (IAPTS) sessions since he was experiencing panic attacks. Ben was prescribed medication (Citalopram) which is an antidepressant. Ben was provided with details of the Counselling and Psychological Therapies Service and was discharged from mental health services to his GP in April 2015.

1.3. Ben was brought to the attention of adult social care in Croydon during September 2018 by his friends who were concerned about him. Ben was considered to be self-neglecting and a deep clean of his flat and a mental health assessment were offered and were initially accepted by Ben. However, these did not progress since Ben did not respond to subsequent attempts at contact or he cancelled appointments. In July 2019 the mental health services closed the case.

1.4. In August 2019 Ben's friends contacted the police, concerned about him since they had not seen or heard from him for several weeks. Ben was found in bed in a poor state; he was incontinent, confused and unable to talk. Ben's flat was described as, "squalid" and hoarded (rated as 5 on the clutter index scale). Ben was taken to an acute hospital where at first there was hope that he might recover. Despite this, Ben's condition deteriorated and he died in hospital.

2. SAFEGUARDING ADULTS REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Croydon Safeguarding Adults Board to commission and learn from SARs (Safeguarding Adults Reviews) in specific circumstances, as laid out below, and confers on Croydon Safeguarding Adults Board the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. All Croydon Safeguarding Adults Board members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.3. This case was referred to the SAR Sub-group of the Croydon Safeguarding Adults Board on 25th August 2021 and considered for a Safeguarding Adults Review at the meeting on 11th November 2021 and on 29th March 2022 the decision to conduct a mandatory SAR was confirmed.

2.4. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Croydon Safeguarding Adults Board, or its partner agencies.

2.5. **The review**

This Safeguarding Adults Review commenced on 28th November 2022.

2.9 Key areas to be addressed by the review were:

- Were there any issues in respect of cross boundary working (eg. living in one borough; GP in another) that increased the risks to Ben;
- Did the contacts with Ben and offers of support meet expected standards, including consideration of mental capacity (where appropriate);
- Were the indicators of self-neglect sufficiently understood as a safeguarding issue;
- The interface between mental health services and adult social care, as relevant to the facts of this case.

2.10 **Contact with family and friends**

2.11 The SAR author spoke with Ben's mother, who chose the name used in this report and provided information about Ben's background and history. Ben's mother wishes to thank the police officers and ambulance crew who took Ben to hospital on 19th August 2019.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology for this Safeguarding Adults Review covered the period from 3rd September 2019 to 14th September 2019 slightly over one year.

3.2. The following services were involved with Ben during the time covered by the chronology:

- Ambulance Service
- GP
- Police
- Adult Social Care
- The Acute Hospital Trust
- The Mental Health Team: The role of the SLAM Croydon MHYA Safeguarding Team is to screen referrals for adults aged between 18 and 65 years old, who may be at risk of, or experiencing, abuse and neglect.
- Substance Misuse Service

3.3. **Ben**

3.4. Ben died in 2019, aged 39 years old. Ben's cause of death was hepatic encephalopathy, a neuropsychiatric syndrome caused by acute or chronic liver failure.

3.5. Ben had a Batchelor's degree from the London School of Economics and a Master's degree from Birkbeck College. Ben loved to read books, to attend cricket and football matches and was a Fellow of London Zoo. Ben had twice stood for election as a Councillor and was vice-chair of his local political party. Ben's father died at a young age four days after the death of his own mother, when Ben was 23 years old. Ben was close to his father and grandmother and received an inheritance which he used to travel abroad.

3.6. Ben worked in a variety of public services including a national arts organisation, health regulatory bodies and for the NHS.

3.7. Ben appears to have moved to Croydon in 2014, but his GP was in another London borough. Ben had a history of high blood pressure for which he was prescribed medication. In 2014 he reported, on an alcohol consumption questionnaire, that he was drinking around 25 to 28 units of alcohol per week. The recommended limit is 14 units). Ben was diagnosed with panic disorder and depression.

3.8. In 2014 and 2015, Ben attended four Improving Access to Psychological Therapies Service (IAPTS) sessions since he was experiencing panic attacks. Ben was prescribed medication (Citalopram) which is an antidepressant. Ben was provided with details

of the Counselling and Psychological Therapies Service and was discharged from mental health services to his GP in April 2015. Ben told his GP that he was receiving therapy privately, via his work.

3.9. Ben notified his GP surgery that he was living in Croydon in December 2017 and they advised him to register with a local GP surgery. Ben, however, wished to remain with the same GP surgery.

3.10. Ben had been in irregular contact with his GP Surgery in 2017 and 2018 and did not respond to five requests for blood test monitoring and blood pressure checks. Ben was warned that it would not be safe for the GP Surgery to continue prescribing medication unless this was done.

3.11. Ben last visited his GP Surgery in December 2017. His last telephone contact was in 2019. As part of the SAR process, the GP surgery identified that there was nothing to suggest self-neglect. Since Ben was seen rarely, never disclosed alcohol consumption and did not have his blood tests as requested, the GP Surgery considered that it was difficult to have identified Ben's liver disease and deteriorating mental health. When Ben's mental health was discussed with his GP, Ben described reasonable stability and no significant safety concerns.

3.12. On 3rd September 2018 a friend of Ben's telephoned the Croydon Council Centralised Duty Team (CDT) to report his concerns about Ben's self-neglect, highlighting that:

3.12.1. Ben was not taking his antidepressant and blood pressure medication as prescribed and was experiencing "panic attacks" and was "depressed"

3.12.2. Ben had not seen his GP for some time and was still registered with a GP out of the area. Ben's friend was unsure of Ben's exact date of birth.

3.12.3. Ben appeared to be struggling with personal care and was described as "disheveled" and "malodorous" at times.

3.12.4. Ben's living conditions were "squalid" and a "health risk". There was evidence of hoarding with large amounts of rubbish and rotting food covering floor and surface in the kitchen and lounge.

3.12.5. Ben lived alone and was currently unemployed.

3.13. The CDT attempted to contact Ben by telephone on 6th and 7th September 2018 to gain consent for its involvement and to gather more information. There was no answer and no evidence that Ben responded to messages left for him.

3.14. On 7th September 2018 Ben's friend spoke with the CDT again stating that he was very concerned about Ben's low mood and anxiety levels. Two staff members of the CDT agreed to undertake a visit to Ben later that morning to check on Ben's welfare.

3.15. Ben was at home and appeared to the CDT workers as "safe and well". Ben stated that he was embarrassed about the condition of his flat and therefore invited the CDT

staff members into the hallway area only. The CDT workers noted that it was evident, from what they could see, that the flat was in need of a deep clean. Ben agreed to be supported by adult services with this.

3.16. When asked how he was feeling, Ben said that he had been in contact with his GP and had been referred for psychological therapy. When asked by the CDT workers for contact details of his GP, Ben declined to disclose these and said that the only help he wanted was with cleaning his flat. Ben gave consent for the CDT workers to tell his friend about the outcome of their visit.

3.17. On 7th September 2018, the CDT referred Ben to Croydon Council's Staying Put team, which then contracted a cleaning agency, 'Scrubbers', to visit Ben. Scrubbers attempted contact by telephone but had no response from Ben. They visited his home address on two occasions and posted a note with their contact details through his door. Staying Put notified the CDT that Ben had not responded to attempts at contact.

3.18. The CDT emailed the SLAM (South London and Maudsley NHS Trust) Croydon MHYA A and L (Mental Health Younger Adults Assessment and Liaison) Team requesting an assessment of Ben's mental wellbeing and possible self-neglect. Ben was allocated for an assessment.

3.19. Ben had declined to disclose his GP details to the CDT. The CDT telephoned Ben's GP practice on 14th September 2018 and gave Ben's approximate date of birth. They were advised that Ben was not a registered patient. Ben's true date of birth was not known until he was admitted to hospital eleven months later.

3.20. A MHYA A and L Team Care Coordinator (CC) arranged to see Ben at home on 25th September 2018.

3.21. On 25th September 2018, however, the CC telephoned and spoke with Ben, who said that he was "ok but feeling a little down". Ben denied hearing voices, delusions or suicidal thoughts. The home visit planned for later that day was cancelled because Ben agreed to attend for an assessment at the MHYA A and L Team offices on 25th October 2018. On 27th September 2018, a letter was sent to invite Ben to the assessment.

3.22. On 10th October 2018, Ben's friend telephoned Croydon Adult Social Care. He had returned from three weeks' holiday and was worried about Ben, whom he had not been able to contact and intended to telephone the police about this. Ben's friend was unhappy that a blitz clean of Ben's property had not been done and was told that Scrubbers had been unable to make contact with Ben. Ben's friend was also unhappy that the appointment with the MHYA A and L Team was not until 25th October 2018.

3.23. On 24th October 2018, the CC telephoned Ben to remind him of the appointment the next day and left a voice mail message. Ben telephoned back later the same day to cancel the appointment since it was no longer urgent and he had work commitments. No further appointment made and Ben's statement about work was not questioned despite his friend's statement that Ben was unemployed. There was no further contact from or with Ben until February 2019.

3.24. Ben did not attend for a blood test at his GP on 18th January 2019 and was sent a text message requesting him to rearrange the appointment.

3.25. On 15th February 2019, the MHYA A and L team wrote to Ben asking him to make contact as the team had been attempting to contact him. The letter included the SLAM Crisis Line telephone number.

3.26. 6th March 2019, the CC discussed Ben in a team meeting since no response had been received from him.

3.27. On 14th March 2019 MHYA A and L Team Manager and the CC made an unannounced visit to Ben at home. Ben opened the door but entry was not gained. They a noted a smell of damp and mould. Ben was described as polite and agreed to a further appointment for an assessment and confirmed that he would like his flat cleaned. Ben explained that he had changed his telephone number hence the difficulty contacting him by telephone.

3.28. The Care Coordinator planned to write to Ben with a further assessment date and to telephone him on his new telephone number to gather more information from him. The Care Coordinator was also to contact Croydon Adult Social Care and request that the blitz clean be rebooked.

3.29. On 15th March 2019 Ben was telephoned by his GP practice, which sent him a text message requesting that he contact the practice and arrange an appointment for medication review.

3.30. There were further attempts at telephone contact by the MHYA A and L CC with Ben, however there was no response from him.

3.31. The last contact with Ben by a GP was by telephone on 23rd April 2019. The GP noted that they discussed the need for Ben to complete his blood test. Ben responded that he planned to do this but he did not attend for this blood test.

3.32. On 24th May 2019, the CC attempted to contact Ben via telephone with no success.

3.33. On 1st July 2019 the CC ended Ben's involvement with the MHYA A and L service due to Ben's non-engagement.

3.34. On 19th August 2019, Ben's friends contacted the Metropolitan Police. They had not seen or heard from Ben for three weeks and were worried about him. They explained that Ben was an alcoholic, was obese, lived with self-neglect and in a state of squalor. Police Officers attended Ben's flat and after repeated knocking at the door with no answer forced entry under section 17 PACE 1984 (Police And Criminal Evidence Act, which allows police officers to enter a property to save life or limb).

3.35. Ben was found to be in bed alive, but he appeared unwell. He was confused and unable to talk. An ambulance was called and Ben was taken to hospital that day.

3.36. Ben's flat was described as extremely dirty with mould on many surfaces. There was no electricity and it appeared as though the shower/bath had not been used for some time and Ben's bedding was soiled, with litter in every room. There were many empty alcohol bottles. The Police notified Croydon Adult Social Care which began a s42 safeguarding enquiry.

3.37. In hospital, Ben was found to have multiple organ failure with alcohol related brain shrinkage, brain functional changes and chronic liver disease. Initially there was hope that Ben would recover but his condition worsened and he died in hospital on 14th September 2019

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The analysis of Safeguarding Adults Reviews by Michael Preston-Shoot (2017) and The Local Government Association Analysis of Safeguarding Adults Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. There is, for example, a considerable amount of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discretely. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, this SAR will consider both the research and practice evidence for working with people who self-neglect in the context of alcohol and substance use.

4.7 Alcohol-use findings from safeguarding adults reviews

4.8 The extent of Ben's alcohol use and the impact of this and, possibly associated, self-neglect was not fully recognised until his admission to hospital on 19th August 2019. It is useful, however, to consider Ben within the context of other Safeguarding Adults Reviews in which alcohol was a prominent feature.

4.9 The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*", analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, further

SARs, for example, Andrew, Staffordshire and Stoke, 2022 and Brian, Swindon, 2022 have identified eleven shared themes.

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Traumatic events triggering alcohol intake
- Lack of family involvement
- High levels of alcohol intake and over-reliance on alcohol use to explain the adult's
- presentation
- Regular contact with ambulance services and
- Unpopularity with the local community or concerned neighbours

4.10 The Alcohol Change UK July 2019 report also identified several practitioner perceptions that affected the way that services responded to these themes:

- Behaviours were seen as personal choice
- The extent of alcohol consumption was underestimated
- Lack of service capacity
- Commissioning of services so that they are available and effective
- High thresholds for support and for safeguarding concerns
- Understanding of the Mental Capacity Act and legal literacy

4.11 The extent to which these themes and perceptions were present in Ben's case will be considered.

4.12 **Self-neglect practice guidance**

4.13 In addition to using a large quantity of alcohol Ben was self-neglecting.

4.14 Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Of especial relevance to Ben, the loss of a loved-one is one of the two most common experiences cited by individuals who self-neglect (the other is being a victim of violence) (Lien et al, 2016). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance.

4.15 There is extensive research into, and guidance on, working with people who self-neglect largely but not exclusively produced by Suzy Braye, Michael Preston-Shoot and David Orr. For the purposes of this SAR, it is sufficient to focus only on a summary of this guidance. Readers keen to explore the research basis for this guidance will find several of the publications listed in the bibliography to be of value.

4.16 The guidance is that practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and coordinate agencies with specialist expertise to contribute towards shared goals.

4.17 In order to do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started
- Be proactive and identify and address repeated patterns of behaviour
- Try different approaches, use advocates (of all kinds, including friends, formal advocates for particular functions including Care Act advocates and community, citizen and peer advocates) and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Ongoing assessment and review of mental capacity.

4.18 **Individual characteristics**

4.19 Ben was a young white British man who lived alone. He had two groups of friends, one from his time at university and another, more recent, from a pub quiz team of which he was a member. This latter group contacted London Borough of Croydon and the Metropolitan Police with concerns about Ben's welfare. During the process of this Safeguarding Adults Review, it was found that Ben's father and grandmother, whom Ben was very close to, had both died 15 years ago. One of the two most common experiences cited by individuals who self-neglect is the loss of a loved-one (the other is being a victim of violence) (Lien et al, 2016). Since there was no discussion with Ben about his background and life experiences it is not possible to determine the impact of the loss of his father and grandmother on him.

4.20 There is also a growing literature on the difficulties faced by men (Baker et al 2015), which include seeking help less often than women (Wang et al, 2013) and facing preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson. 2011). Practitioners and managers recognised in hindsight that the perception and understanding of Ben's needs may have been affected by these barriers.

4.21 **Self-neglect, mental capacity and freedom of choice**

4.22 All the contacts with Ben took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.23 Safeguarding Adults Reviews (amongst others Andrew, Staffordshire and Stoke, 2022; Harold, Brent 2022; Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998, the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 1983.

4.24 At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is a question of prioritising freedom of choice or prioritising protection from harm (essentially Articles 8 and 2 of the Human Rights Act 1998). The guidance on working with people who self-neglect helpfully challenges the either/ or nature of this question by asking practitioners to consider:

4.25 Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

4.26 Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable

4.27 **Decisional and Executive Capacity**

4.28 The extent to which a person who self neglects can put whatever decisions they make into effect should also be considered. In Ben's case there were concerns about his self-neglect and mental wellbeing yet he either did not respond to attempts to contact him or cancelled appointments. Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

4.29 After Ben's admission to hospital on 19th August 2019, tests revealed that Ben had several neurological and physical conditions associated with prolonged high-level

alcohol use. There is also growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

4.30 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

4.31 Significantly, these cognitive deficits are unlikely to be detected using the verbal questions frequently used in mental capacity assessments. Whilst Ben's mental capacity was never formally assessed, there was a mismatch between his expressed intentions and his actions. Some of this might have been due to a desire to placate social care and mental health practitioners so that they would then leave him alone, but may also have indicated an inability to turn intention into action.

4.32 The proposed revised Code of Practice for the Mental Capacity Act will, subject to consultation, include guidance on assessing mental capacity where there is an impairment in executive functioning and a mismatch between what a person says and what they do. The proposed revisions include that, "A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information".

4.33 **The Care Act 2014 and self-neglect**

4.34 Section 1 of the Care Act states that, "*The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being*". A definition of well-being is provided (see appendix 2) but with relevance to Ben, it is sufficient to note that well-being includes personal dignity (including treatment of the individual with respect); physical and mental health and emotional well-being; and suitability of living accommodation.

4.35 Section 9 of the Care Act (2014) states that where it appears to a local authority that an adult may have needs for care and support, the authority must assess (a) whether the adult does have needs for care and support, and (b) if the adult does, what those needs are. This Care Act duty applies regardless of the authority's view of (a) the level of the adult's needs for care and support, or (b) the level of the adult's financial resources.

4.36 If an adult refuses an assessment, then under Section 11, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or neglect (s11.29(b)). This includes self-neglect. There are other circumstances in which assessment must be made despite refusal, which are not relevant to this SAR.

4.37 The Care Act also empowers local authorities to meet urgent needs without an assessment (section 19(3)). This is a discretionary power and so does not have to be used but the reasons for the decision to use or not to use this power must be recorded.

4.38 Consequently, the Care Act makes provision to, and allows some flexibility in how to, promote the wellbeing and meet the needs of adults who, like Ben, self-neglect.

4.39 **The local strategic context for effective work with people who self-neglect**

4.40 The effective implementation of the practice guidance and the local learning require a supportive strategic context. The guidance on working with people who self-neglect identifies that the policy, procedural and organisational environments that foster effective ways of working are likely to have the following characteristics:

- Agencies share definitions and understandings of self-neglect.
- Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems
- Longer-term supportive, relationship-based involvement is accepted as a pattern of work.
- Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice

5. ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Ben.

5.2 Ben and the response of services to him, shared a number of characteristics with the cases identified in the Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*". These were as follows:

5.3 **Agencies' struggle to engage with Ben**

5.4 Between 6th September 2018 and 14th March 2019 there were three episodes of attempts to engage with Ben. The first was between 6th and 7th September 2018 when a London Borough of Croydon CDT member telephoned and visited Ben at home. The outcome of this was that Ben agreed for a deep clean to take place and was referred to the MHYA A and L (Mental Health Younger Adults Assessment and Liaison) Team since he was self-neglecting and to assess his mental wellbeing. No safeguarding concern was raised despite the presence of self-neglect and no referral for an assessment of need under the Care Act 2014 was made. It is unclear what the referral

to the MHYA A and L service aimed to achieve. Ben did not respond to attempts by the cleaning agency to contact him.

5.5 The second attempt to engage Ben took place between 25th September 2018 and 24th October 2018 when the MHYA A and L Care Coordinator telephoned Ben in response to the referral from the London Borough of Croydon CDT. On the basis of this telephone call, the Care Coordinator cancelled the planned home visit since Ben agreed to attend the MHYA A and L team office for an assessment. Ben, however, cancelled this on 24th October. The appointment visit was within the 28-day SLAM time frame for initial assessment, but since the referral had been made due to concerns about Ben's potential self-neglect, a home visit rather than a telephone call may have been preferable. There was no further follow up.

5.6 On 10th October 2018, Ben's friend telephoned the London Borough of Croydon again raising concerns about Ben and the perceived lack of action but this does not appear to have been shared with the MHYA A and L team and might have been an opportunity for a joint visit or intervention. There was no further follow up.

5.7 There was then a gap until January 2019 when Ben did not attend a GP appointment. There was no contact between Ben's GP in Wandsworth and social or health services in Croydon. Ben and his friend had not given the correct date of birth and so the GP and services in Croydon were not aware of each other's involvement.

5.8 The third attempt to engage with Ben began on 15th February 2019 when the SLAM MHYA A and L team wrote to Ben and received no reply. On 14th March the Care Coordinator and Team Manager visited Ben at home. They spoke to Ben at the door but did not gain entry. The Care Coordinator planned to contact Ben for a further assessment and to contact London Borough of Croydon to arrange a deep clean, which Ben had agreed to again.

5.9 On 24th May 2019, the Care Coordinator attempted to contact Ben to arrange an assessment. The other actions following the home visit on 14th March, however, do not appear to have been carried out. On 1st July 2019 the Care Coordinator closed the case due to Ben's non-engagement. There is no evidence that Ben, London Borough of Croydon, Ben's GP or Ben's friends were made aware of this decision. There was no Multi-Disciplinary Team discussion of the potential risk of closing Ben's case. Since Ben had not been assessed it also appears that he was not discussed in supervision sessions.

5.10 During the process of this Safeguarding Adults Review, practitioners and managers identified that they are encountering an increasing number of people with high levels of alcohol consumption but who are otherwise in employment and appear to be independent and self-organising. Consequently, the interactions with Ben are not unique and emphasise the need to follow up on actions and to share information across organisations. Whilst Ben appears to have been considered as low risk, in hindsight it would appear that his true circumstances were not explored because Ben appeared plausible.

5.11 **Self-neglect**

5.12 Ben was described as self-neglecting and it would appear, in hindsight, that this was connected with his use of alcohol.

5.13 The approach to Ben seems to have been task orientated rather than aimed at *seeking to understand the meaning and significance of the self-neglect, taking account of the individual's life experience*. For example, there was a lack of history taking to understand Ben's life and to place his current attitudes and behaviours in any form of context and to use this as a means for engaging with him. Efforts were made to arrange to assess Ben but these were frustrated by difficulties engaging with him. No further understanding was developed of Ben's past and what might have influenced his current situation and the decisions he made.

5.14 There was a missed opportunity for history taking in the two contacts with Ben's friends. Ben had two friendship networks, one from his time at university and the other a pub quiz team that he was part of in Croydon. Nether friendship network appears to have overlapped with, or to have been in contact with, the other but a member of one group of friends contacted London Borough of Croydon Adult Social Care on two occasions to raise concerns about Ben. These were opportunities to have found out more about Ben, to have explored the concerns about him further and to have formed a supportive alliance with his friends.

5.15 Ben's friends were evidently concerned about him and whilst there was a responsibility to establish their motivations, which in discussion with practitioners as part of this review were revealed to be entirely honourable, they may have helped in a number of ways. These include assisting in identifying moments when Ben might be motivated to engage with services, in discussing with him why it was important that he attended to his health and social care needs and made use of the services available and in keeping services updated on changes or developments.

5.16 In addition, contact could have been made with Ben's family who would have provided more information about Ben and his background. Ben could have been asked for permission to contact his family. Ben did not discuss his circumstances with his mother and appears to have tried to give the impression that all was well to her but family involvement may have helped to develop a better understanding of Ben and how to work with him.

5.17 During the process of this Safeguarding Adults Review, practitioners reflected on the challenges when working with Ben, and people like him, who are young, eloquent and at least superficially convincing. Ben gave the impression of autonomy and of being able to make decisions about his life and his engagement with services. This meant that there was a belief that he would be able to make use of the services available to him if he needed them.

5.18 This was not, however, evidenced in practice. Ben agreed to services when he was met face to face (for example on 7th September 2018) but then either did not respond

to them (for example he did not reply to contact with him by Scrubbers) or cancelled them (for example the appointment for a MHYA assessment 28th October 2018). Despite this, there was no escalation of assertiveness in contacts by services with him or consideration of reasons for this mismatch between Ben's decisions and his actions.

5.19 **Exploitation of a vulnerable person**

Little was known at the time about Ben's life but it does not appear that he was being exploited. Ben's friends were concerned for his welfare and were the ones who ultimately precipitated, telephoning the police, the actions that resulted in Ben's admission to hospital on 19th August 2019.

5.20 **Domestic and Child abuse**

No information was gathered on Ben's childhood, or any adult experiences of domestic abuse, by the organisations that tried to work with him. Ben appears to have had a happy childhood and was not in a relationship. The Safeguarding Adults Review found no evidence that domestic or child abuse had been features in Ben's life.

5.21 **Chronic health problems**

Ben had chronic high blood pressure but did not adhere to treatment for it. Ben had not told his GP that he was not taking prescribed medication and his friend noticed unused medication in Ben's home on 28th August 2018. This was also noticed on 19th August 2019 when Ben was admitted in hospital. Ben was found to have multiple physical health problems which ultimately proved to be fatal.

5.22 **Mental health conditions**

5.23 Ben had been prescribed medication for long term anxiety/ panic disorder and depression. He had previously been referred to mental health services. This information does not appear to have been shared since Ben's GP surgery was in Wandsworth whilst the social and mental health services that tried to work with him were in Croydon. Ben would not share contact details of, or information between, his GP and services in Croydon and so they acted independently and unaware of each other.

5.24 Ben did not have a mental health assessment in Croydon, although two appointments were made to do this, which Ben cancelled or did not respond to.

5.25 **Traumatic events triggering alcohol intake**

5.26 The only record of Ben's alcohol consumption was taken in 2014 when it was approximately twice the recommended daily limit. After this, there does not appear to have been any awareness of the extent of Ben's alcohol consumption. Ben did not mention this to his GP, London Borough of Croydon ASC or the MHYA A and L team.

5.27 There was no exploration of the extent to which Ben's earlier life had exposed him to traumatic events, with Ben, his friends or his family. There was no exploration of what

had led to Ben's excessive use of alcohol or of his life history. During the process of this Safeguarding Adults Review, it was found that Ben's father and grandmother, to whom Ben was very close, had both died when Ben was 23 years old. It is not possible to assess the impact that these deaths had on Ben and it appears that otherwise his childhood was happy and he had enjoyed some financial independence. However, Ben appears to have had difficulty holding down jobs, appears to have dissipated much of his inheritance and not to have formed any close personal relationships.

5.28 **Lack of family involvement**

5.29 The involvement of family, and friends, is a feature in both the Alcohol Change UK report of 2019 and in the guidance on working with people who self-neglect. The only contact with Ben's mother took place as part of this Safeguarding Adults Review. Ben's friends raised concerns about Ben but otherwise were not involved in assessments of Ben's needs or the risks he faced. Ben gave consent for CDT workers to notify his friends of the outcome of the CDT's visit on 7th September 2018 but Ben's friends were not included further in attempts to engage with Ben. Consequently, in terms of the guidance on working with people who self-neglect, there was little evidence of thinking *flexibly about how family members and community resources can contribute to interventions, building on relationships and networks*.

5.30 The Care Act sets out the wellbeing principle in section 1 and states that, "*the core purpose of adult care and* support *is to help people to achieve the outcomes that matter to them in their life*". Section 2.18 of the Care and Support Statutory Guidance for the Care Act states that promoting a person's wellbeing, "*should include consideration of the role a person's family or friends can play in helping the person to meet their goals"* and "*Local authorities should consider whether the adult is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships*" (s6.106 (g) of the Care and Support Statutory Guidance)

5.31 Consequently, working with Ben's family and friends to support Ben would have been consistent with the duty to promote his wellbeing. Ben would have needed to consent to this but it appears that he was not asked. Even if Ben had refused to give consent for information to be shared or for his family and friends to be involved, they could still have been asked about Ben's life and about their concerns for him. There is a distinction between a practitioner disclosing personal data (which includes health information) to a person's family or friends against the person's wishes and receiving information from a person's family or friends.

5.32 In doing this the General Medical Council warns that, "*You should, however, consider whether your patient would consider you listening to the views or concerns of others to be a breach of trust, particularly if they have asked you not to listen to specific people. You should also make clear that, while it is not a breach of confidentiality to listen to their concerns, you might need to tell the patient about information you have received from others – for example, if it has influenced your assessment and treatment of the patient. You should also take care not to disclose personal information unintentionally – for example, by confirming or denying the person's perceptions about the patient's health*".

5.33 High levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation

5.34 Very little was known about Ben's alcohol intake and it did not influence the response of services to him.

5.35 Regular contact with ambulance services

5.36 The only contact with the ambulance services was when Ben was taken to hospital on 19th August 2019, so this theme did not feature.

5.37 Unpopularity with the local community or concerned neighbours

5.38 There does not appear to have been any concerns or problems raised by Ben's neighbours or the community in which Ben lived, but Ben's friends raised concerns about him on two occasions and precipitated, by telephoning the police on 19th August 2019, Ben's admission to hospital.

5.39 Summary of the analysis of the research and practice evidence base

5.40 Considered in the light of both the Alcohol Change UK 2019 report and other safeguarding adults reviews, Ben's case cannot be considered to be unusual or unique and his circumstances further confirm the pattern already identified:

- non-engagement with services;
- self-neglect;
- chronic health problems;
- mental health problems;
- traumatic events triggering alcohol intake;
- lack of family involvement;
- unpopularity with the local community or concerned neighbours. In Ben's case, his friends raised concerns about him.
- high levels of alcohol intake

The presence of some or all of these factors may indicate the need to explore if any of the other the factors and risks are present. In Ben's case the following factors do not appear to have been present:

- over-reliance on alcohol use to explain the adult's presentation
- exploitation (although this does not appear to have been a factor for Ben)
- domestic and child abuse;
- Regular contact with the ambulance service

5.41 These findings further refine the understanding of which themes might be predictive of poor outcomes unless different approaches are taken. They show that even when the extent of alcohol use is not fully recognised, a cluster of characteristics may be present which might prompt further enquiry about alcohol use and other risks, which in turn might lead to interventions that result in better outcomes.

5.42 In addition to alcohol use, the terms of reference of this Safeguarding Adults Review set out to explore the extent of the impact of Ben's use of services across two London Boroughs; the extent to which the approaches to support Ben met expected standards and how services worked together, including consideration of Ben's mental capacity, and the extent to which Ben's self-neglect was understood to be a safeguarding matter.

5.43 **The approaches taken when working with Ben.**

5.44 There was considerable evidence of working *patiently at the pace of the individual* with Ben who was not pressured or persuaded unduly and was approached on a consensual basis. There does not appear to have been attempts to *make the most of moments of motivation to secure changes,* at least partly because there was very little contact with Ben and very little known about him. Ben's needs do not appear to have been understood or formulated beyond a recognition in Croydon that he was self-neglecting and that his mental wellbeing should be assessed, and in Wandsworth that he had high blood pressure.

5.45 **Exploration of legal options for working with Ben**

5.46 The attempts to contact Ben did not reach a stage at which any legal options were considered since there does not appear to have been a recognition of the extent and impact of Ben's self-neglect.

5.47 **Adult safeguarding concerns and responses**

5.48 There was no use of adult safeguarding processes despite Ben being identified as self-neglecting on 7th September 2018. A safeguarding enquiry was begun, however, when Ben was admitted to hospital on 19th August 2019.

5.49 Since no safeguarding enquiries were made following these concerns it is not possible to predict the extent to which safeguarding enquiries, if they had been made, might have resulted in different outcomes for Ben. The purpose of an enquiry under Section 42 of the Care Act is to decide, "*whether any action should be taken in the adult's case and, if so, what and by whom*" and this may have prompted a more joined up multi-agency approach to engaging with Ben and assessing and meeting his needs. At the time of Ben's contact with London Borough of Croydon ASC on 7th September 2018, there does not appear to have been any recognition that Ben required more than support with a deep clean and for his mental wellbeing to be assessed.

5.50 These concerns, the fact that Ben would not allow anyone to see his flat and the concerns raised by Ben's friends could have prompted greater curiosity and inquisitiveness. There could have been further exploration of Ben's circumstances and

why someone who otherwise appeared persuasive and self-organising would need help with keeping his property clean.

5.51 **Multi-agency working with Ben**

5.52 Three agencies were in contact with Ben: his GP surgery, London Borough of Croydon ASC and the SLAM MHYA A and L Team. There was also relatively brief contact with London Borough of Croydon's Staying Put tenancy support service, which commissioned another agency to carry out a deep clean of Ben's home. All worked independently of each other and there was little contact with each other.

5.53 This was exacerbated by the location of Ben's GP in a different London Borough. The London Boroughs of Wandsworth and of Croydon are not far from each other but there was no contact between Ben's GP surgery and Croydon Borough Council and SLAM. This meant that, for example, services in Croydon were unaware of Ben's mental and physical health needs and the GP in Wandsworth was unaware of concerns about Ben's mental wellbeing and that he was self-neglecting. No services appear to have been aware of the extent of Ben's alcohol use. Consequently, Ben's lack of response to requests to attend for blood pressure checks, which were necessary due to his high blood pressure and prescribed medication, were not understood within the wider context of self-neglect. Similarly, Ben's self-neglect and mental wellbeing were not understood in the context of his physical and mental health needs.

5.54 Greater awareness of these concerns across the services Ben was in contact with may have prompted more assertive multi-agency approaches. Ben did not give the details of his GP or his correct date of birth to services in Croydon and could not be forced to do so. A discussion with Ben's friends when they raised concerns about him might have revealed that Ben had moved from the London Borough of Wandsworth but it is improbable that this would have assisted in identifying his correct date of birth. Ben's GP was aware that Ben had moved to Croydon, had encouraged him to register with a GP there but was unaware of Ben's contact with services. In the absence of any processes for identifying involved agencies across boroughs, Ben became the key link for information exchange.

5.55 **Understanding Ben's mental capacity to make decisions**

5.56 Ben's refusals to share his GP details and correct date of birth, to allow people into his flat and his decline of interventions were not considered within the context of mental capacity. Whilst the first principle of the Mental Capacity Act is the presumption of capacity unless proven otherwise, there was little evidence of keeping constantly in view *the question of the individual's mental capacity to make self-care decisions*. Ben's mental capacity to make decisions does not appear to have been formally considered.

5.57 Practitioners and managers involved in this Safeguarding Adults Review agreed that Ben appeared to be high functioning, independent and able to make his own decisions. They also recognised that Ben, and men like him, may struggle to realise that they need support because they are otherwise functioning highly in other areas of their lives. In these cases, careful attention to executive capacity and patterns of decision making may help to identify situations in which to question whether a person has

made a capacitous decision. In Ben's case this might have been, for example, when he continued to avoid contact with services despite the concerns raised about him.

5.58 Since there was a lack of awareness of the extent of Ben's alcohol consumption, there was no consideration of the potentially coercive and controlling impact of alcohol use upon Ben's decision making.

5.59 **Case leadership and ownership of responsibility for meeting Ben's needs**

5.60 There was little attempt to assert leadership over contact with Ben, who was left to make contact with services for prolonged periods of time. Whilst this approach is consistent with the consensual and liberal law, policy and resource context in which services operate, there were some indications that a more assertive approach may be necessary. These include the concerns raised by Ben's friends and that Ben was self-neglecting. There was hand-off between London Borough of Croydon ASC and the SLAM MHYA A and L Team without a clear agreement of their roles that each would play and what information would be shared between them. Consequently, both tended to work in silos and there was no clear understanding of which agency was taking the lead with Ben.

5.61 **Good Practice**

5.62 The actions of the Metropolitan Police and the London Ambulance Service in response to the concerns raised by Ben's friends on 19th August 2019 were highly efficient, appropriate and recognised the need to take urgent protective action and to take Ben to hospital. Although Ben was later to die in hospital, the actions of the emergency services meant that there was an opportunity to diagnose and attempt to treat Ben's health conditions which had previously not been recognised. Ben's mother thanks the police officers and ambulance crew for their intervention.

6. CONCLUSIONS

6.1 This Safeguarding Adults Review set out to explore the extent of the impact of Ben's use of services across two London Boroughs; the extent to which the approaches to support Ben met expected standards and services worked together, including consideration of Ben's mental capacity, and the extent to which Ben's self-neglect was understood to be a safeguarding matter.

6.2 **Services across two London boroughs were unaware of each other and this impacted negatively on recognition of risks in Ben's life.**

6.3 Ben's GP was in the London Borough of Wandsworth whilst the social and mental health care services he was in contact with were in his home borough of Croydon. This meant that there was no understanding of the range of Ben's needs. Ben did not give details of his GP and correct date of birth to services in Croydon and there does not appear to have been any further attempt or any means to discover them. This presents a significant challenge when assessing and meeting the needs or managing the risks faced by other people who have an out of area GP and do not share details

of them. The NHS Spine Portal can be used to find details including GP registration and could have been used to find Ben's GP **(Recommendation 1).**

6.4 **There was a lack of coordination between services within Croydon to understand, assess and meet Ben's needs.**

6.5 London Borough of Croydon's Adult Social Care and Housing and the SLAM MHYA A and L Team did not coordinate their responses to Ben or agree which organisation would take the lead on meeting his needs. There appears to have been a collective underestimation of the extent and impact of Ben's health needs and self-neglect. Neither was there awareness of the extent and impact of Ben's alcohol use. No attempts appear to have been made to engage with Ben's landlord.

6.6 As a result, no full understanding of Ben's needs or risks was developed and shared. Practitioners and managers involved in this review identified that there is a need to build relationships between professionals across services so that each know the responsibilities and aims of each other and can agree who will take the lead when working with people who, like Ben, may have masked and unidentified health and social care needs. The formulation of themes identified in section 5.40 of this report may assist in identifying clients and patients where this may be the case. **(Recommendation 2)**

6.7 **Approaches taken to support Ben**

6.8 Within this context, the approaches taken to support to Ben relied on his willingness to engage with services and to request help. Interventions such as a deep clean were proposed to, and accepted by, Ben, who then did not engage further with them. Assessment appointments were offered to Ben, who then cancelled or did not respond to them. When Ben did not respond to attempts by the MHYA A and L Team to contact him, his case was closed without notifying London Borough of Croydon ASC. (**Recommendation 3)**

6.9 People have the right to refuse both health and social care services, regardless of how severe their needs appear to be. Services need to be careful to uphold and not to infringe, for example, an individual's Article 8 Human Rights Act right to respect for their private and family life. The approaches taken to support Ben appear to have done this until the intervention on 19th August 2019 which resulted in his admission to hospital

6.10 Practitioners and managers who were in contact with Ben, or who made decisions about him, recognised in the process of this review that in hindsight there had been a need to have found out more about Ben and to have explored further why he was not engaging with services. This curiosity might have led to more persistent attempts to obtain details of Ben's GP, or to his GP enquiring why Ben was not attending appointments. It might have led to further attempts to work with Ben's friends. It might have led to less reliance on telephone calls and letters and to more attempts to meet Ben unannounced. Prior to his admission to hospital, the only two face to face contacts with Ben on 7th September 2018 and 19th March 2019 had been made in this way. (**Recommendation 4**)

6.11 It might also have led to questions about Ben's mental capacity.

6.12 **Ben's mental capacity to engage with services and protect himself was not explored**

6.13 Ben's mental capacity appears, in compliance with the first principle of the Mental Capacity Act, to have been assumed. It was, however, never tested despite concerns that Ben was self-neglecting. Ben's cancellation of appointments and lack of follow through of actions he was assumed to have understood and to have agreed with did not raise questions about his mental capacity to make decisions about engaging with services and keeping himself safe. Ben was understood by practitioners to be able to engage with services if he wanted to. There is a challenge in identifying the support needs and risks faced by people who can give at least a superficial impression of being able to act as a consumer of services, able to access them when they need to. Factors that could have alerted practitioners that Ben may not be able to do this, such as the difference between how Ben spoke during meetings at his door and the other sensory evidence of mould and damp and the concerns raised by his friends were not recognised. (**Recommendation 5).** The Voice of the People subgroup of the Croydon Safeguarding Adults Board is currently working on how to empower local communities to raise concerns.

6.14 Ben's mental capacity to make decisions about his health and care needs and to keep himself safe may have been affected by his alcohol use. Following Ben's admission to hospital, he was identified as having brain changes consistent with long-term high level alcohol use. There is extensive research on the impact of life trauma and of alcohol use on the frontal lobe of the brain and associated increases in risk taking behaviour and impulsivity. The Alcohol Change UK Report 2020, Safeguarding Dependent Drinkers states, "*Many patients with frontal lobe damage are wrongly considered to have capacity, because in a simple assessment environment they know the correct things to say and do. When they need to act upon that knowledge in the complex setting of the real world they are driven by impulse and, therefore, can no longer weigh up options*").

6.15 There was little awareness of the extent of Ben's alcohol use prior to his admission to hospital. The information gathered during this Safeguarding Adults Review, including the reflections of practitioners and managers, suggests that the presence and impact of alcohol use should be considered as a factor be explored further in future cases. Doing this might prompt consideration of mental capacity, including functional capacity, and recognition of the need for a more assertive response to self-neglect, including the use of adult safeguarding processes. (**Recommendation 6**)

6.16 **Ben's self-neglect was not understood as a safeguarding concern**

6.17 Despite having been identified to be self-neglecting on 7th September 2018, no safeguarding concern was raised. Self-neglect is one of the ten categories of adult safeguarding in the Care Act 2014 Statutory Guidance, but it appears that Ben's self-neglect was considered to be within the context of his mental health needs, although it is unclear why this was the case. Since no safeguarding concern was raised, it is not possible to judge if any other actions could have be taken. However, it might have

opened up other routes for intervention and further discussion. London Borough of Croydon, for example, has a Safeguarding Consultation process, within which cases of self-neglect where there is a lack of engagement must be discussed. There may also have been the possibility of a referral for discussion at the Risk and Vulnerability Multi-Agency Panel If Ben did not engage. All of these options might have prompted more coordinated multi-agency working. (**Recommendation 7)**

7. RECOMMENDATIONS

7.1 **Recommendation 1:** SLAM and Social Services should use the NHS Spine to check GP registration. The NHS Spine Portal can be accessed either internally or through a request to the ICB (Integrated Care Board) through the safeguarding team.

7.2 **Recommendation 2:** The SAB should promote the use of the themes set out in section 5.35 of this review by practitioners to identify potential cases where there are likely to poor outcomes unless other approaches are taken. This should also be included in training on working with people who self-neglect.

7.3 **Recommendation 3:** SLAM should identify how to avoid 'discharge to no service' when, for example, someone with whom agencies struggle to engage has not attended appointments. These include management review and approval before case closure of people who minimise and feign compliance, the need for more curiosity, the use of flagging systems on electronic client databases to alert practitioners and managers to the need to do this and consider a face-to-face home visit.

7.4 **Recommendation 4:** Practitioners should use face to face contact with people who self-neglect and who do not act on decisions they have made in agreement with practitioners. This should prompt consideration of mental capacity and this should be included in the criteria for, for example, holding a safeguarding consultation in the London Borough of Croydon.

7.5 **Recommendation 5:** Practitioners should consider the whole range of sensory information when working with people who self-neglect and triangulate this with other sources of information. This should be included in training on working with people who self-neglect.

7.6 **Recommendation 6:** The presence and impact of alcohol use should be considered and explored in cases of self-neglect even when there is currently no evidence of it and especially when access to someone's home has not been gained. SLAM has introduced the use of the AUDIT alcohol use questionnaire and this could be adopted more widely.

7.7 **Recommendation 7:** Adult Safeguarding process should be used for self-neglect to prompt multi-agency working and the use of the Risk and Vulnerability Multi-Agency Panel to coordinate interventions.

APPENDIX 1: WELLBEING

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2: HUMAN RIGHTS ACT

All public sector bodies, directly or indirectly funded by the UK Government, have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights. Some of the most relevant to adult safeguarding are:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons.

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
    - Understand information about the decision to be made, or
    - Retain that information in their mind, or
    - Use or weigh that information as part of the decision-making process, or
    - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 4: LITERATURE REVIEW

The literature review was conducted using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources

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