CONFIDENTIAL

Croydon Safeguarding Adults Board

Safeguarding Adults Review (Mary)

Final Report

Led by: **Eliot Smith, Independent Reviewer**

March 2025

CONTENTS

INTRODUCTION

Background

Safeguarding Adults Reviews and the SAR referral
One of the statutory functions of a Local Safeguarding Adults Board is to arrange Safeguarding Adults Reviews. The aim of the Safeguarding Adults Review is to learn from individual cases to produce evidence-based findings and recommendations which are applicable to the whole system. Mandatory Safeguarding Adults Reviews must take place 'when an adult in its area dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual' [1]. The Terms of Reference for this Review were signed off in April 2024 and initial evidence for the review was gathered during August 2024.

Information about the case
Individuals referred to in this report have been anonymised through the use of a pseudonym selected from a list of common girls names in the year of Mary's birth. Where necessary identifying information has been disguised or omitted to protect confidentiality and anonymity.

This Safeguarding Adults Review concerns Mary, a woman in her 80's who was found deceased at her home in Croydon in February 2024. It was clear Mary had been deceased for some time. She was found in an unsecured property with very little furniture, kitchen cupboards were bare and with very little possessions. There was an absence of TV or radio/entertainment. In August 2021 ASC were involved with regards to alleged financial abuse by two unknown adults as she had lost £850 but it didn't progress to a safeguarding enquiry and Mary called in police regarding this incident. Mary had a 1 hour per week shopping call, but this ended in August 2022 as Mary requested this to be cancelled. August 2022 social care completed an assessment and indicated some form of self-neglect and that she may be struggling but she declined support. Age UK assisted in buying some furniture.

Police were called by an informant who was walking past Mary's property and noted that the front door was slightly ajar. The informant entered Mary's home and noted that Mary was clearly deceased on the sofa inside. The SAR request was completed by the police due to similarities to concerns raised in 2021 in relation to living conditions/neglect that were still seen at the time of finding Mary deceased. Concerns that she had been deceased for what is provisionally estimated to be over a year by LAS. Last known signs of life were August 2022 by way of her Oyster card usage. Bank accounts not used since summer 2022.

About the Reviewer

This Safeguarding Adults Review has been led by an Independent Author, Eliot Smith, who is a Health and Social Care Consultant with a background in social work, mental and physical health, and safeguarding. Eliot Smith has no prior connection to the case, Safeguarding Adults Board, or partner agencies in Croydon.

METHODOLOGY

Principles

Safeguarding Adults Reviews should be conducted in line with principles set out in paragraph 14.167 of the Care and Support Guidance:

- "There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively" [1]

Assumptions

The Safeguarding Adults Review methodology is based upon a number of assumptions about the purpose and aims of Reviews, the evidence provided to the Review, and about learning and improvement in safeguarding systems.

- Assumptions about the case: It is assumed that the case of Mary provides a fair and representative example of practice in Croydon.
- Safeguarding Adults Reviews are not a reinvestigation of incidents or performance: the purpose of a Safeguarding Adults Review (SAR) is "not to hold any organisation or individual to account" [1].
- Reliability of documentary evidence: It is assumed that evidence provided to the review was contemporaneously recorded and provides a full, honest, and accurate account of events
- Practitioner's views and opinions: The views and opinions of practitioners are taken as heard, and reflect personal subjective opinions and recollections
- 'People come to work to do a good job': It is assumed that most practitioners who work with people with care and support needs are committed, compassionate, and 'come to work to do a good job'.
- Systems-focused learning: Individual practice in health, social care, and safeguarding is influenced by the system within which people work. Effective learning and improvement take place when Reviews adopt a systems focus and generate findings from individual cases that are applicable across the system.

Limitations

Passage of time
There was a gap in contact of approximately eighteen months leading up to the discovery of the body of Mary. While the passage of time in this case means that evidence from the case provides relates to a system that is significantly out of date, it is believed that the learning from Mary's case remains relevant to practice in the current system. The SAR methodology can be adapted to combine the experiences of Mary with practitioner and organisational experiences of the current system, ensuring that findings and recommendations are evidence-based and applicable to the current system in place in Croydon.

Emerging themes and the learning context

The Safeguarding Adults Board have identified a number of areas about which the case of Mary may provide learning:

a) Management of self-neglect and mental health.
b) Financial abuse
c) Communication and multi-agency work
d) Escalating high-risk cases.
e) Learning from the Catherine Review[1]

Analysis of initial information, in the context of the specific areas above highlighted a number of emerging themes in the case. Figure 1 provides a visual representation of these themes, and their prominence in the case:

Figure 1: Emerging themes in the case of Mary

[1] https://www.croydonsab.co.uk/wp-content/uploads/2021/10/Croydon-SAR-Catherine-Final-pdf.pdf

The inter-connections between themes and specific areas of enquiry produce a learning context for the Safeguarding Adults Review consisting of three learning areas. The learning context is used to provide structure to the review and helps in the organising and analysis of evidence gathered from organisations and practitioners involved in the case.

Learning area	Description
Opportunities for engagement	Learning from the type and quality of contacts and consideration of individual factors in service user-professional relationships. Decisions about closing cases due to 'disengagement' and the balance between respecting individual choice and a need to keep sight of a vulnerable person at risk of harm arising from self-neglect or exploitation.
Multi-agency and escalation processes	When and how to identify and escalate a case as high-risk. The challenge of safeguarding in the context of self-neglect: when to prompt and when not to prompt a safeguarding response to the risk of self-neglect. Identifying multiple types of abuse and links between self-neglect and vulnerability to (financial) exploitation.
Factors influencing self-neglect	Exploring the links between mental health, mental capacity, and self-neglect and what this means for work with individuals at risk. This theme may also bring other themes together.
Learning from the Catherine SAR	The Catherine SAR was published in October 2021 and concerned a woman who was found deceased at her home in circumstances of self-neglect and allegations of financial exploitation. The SAR produced 16 recommendations, a number of which are relevant to the case of Mary.

Table 1: Learning context in the case of Mary

Methods

The Safeguarding Adults Review gathered evidence from organisations in Croydon who worked with or had significant involvement with the case of Mary. Depending on their level of involvement in the case, organisations were asked to provide an Individual Management Review (IMR) either the full or short template. The following agencies provided information to the review:

IMR full template

- Croydon Council Adult Social Care and Health
- Croydon Health Service
- Metropolitan Police
- South London & Maudsley NHS Trust

IMR short report or case summary

- Age UK Personal Independence Coordinator Service
- Allfor Care Croydon
- Croydon Council Housing
- General Practitioner
- MIND in Croydon

A practitioner event was also held to gather the views and opinions of individuals working with the case. The practitioners event was structured around the learning context where participants were encouraged to collaboratively explore the three domains of the learning context and "contribute their perspectives without fear of being blamed for actions they took in good faith" [1].

FINDINGS

Findings are conclusions and insights drawn from the analysis of data and evidence gathered in the course of the review. The aim of a findings in Safeguarding Adults Reviews is to enable "lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again" [1]. This section applies theoretical frameworks to practice in order to generate findings that can be applied to the safeguarding adults system. Findings are structured against the learning context.

Learning area: Opportunities for engagement

Learning from the type and quality of contacts and consideration of individual factors in service user-professional relationships. Decisions about closing cases due to 'disengagement' and the balance between respecting individual choice and a need to keep sight of a vulnerable person at risk of harm arising from self-neglect or exploitation.

Background

The last contacts with Mary were in 2022 when services had closed her case for support, and when there was last activity on her bank accounts and Oyster card. Between August 2022 and February 2024 when her body was discovered at her home address there had been no contact or attempts at contact with Mary. At one time, Mary had been known to health and social care services, including her GP, District (Community) Nursing service, pharmacy, and mental health support. Mary had been in contact with a Social Worker, Occupational Therapist, Age UK, MIND, and other commissioned services.

Mary had a known condition of hypothyroidism for which she was prescribed long-term medication. Mary denied any symptoms of hypothyroidism and consistently declined medication but without treatment there was a likelihood that she would experience symptoms. While services were working with her there is evidence that professionals worked hard to maintain their engagement with her – responding to her interests, needs, and priorities. There is evidence that practitioners were persistent, communicative, and creative in their attempts. However, over time services withdrew or closed her case – due to disengagement, loss of contact, or Mary actively declining further input. Practitioners who worked on her case have reflected on why this may have happened – the Covid-19 pandemic may have had an impact – however it is clear that Mary fell out of contact with a number of agencies across the health and social care system. Mary's withdrawal from contact with services was not sudden, nor dramatic, but gradual, taking place over a period of time and without raising professional concerns at the time.

Learning

During the last months or years of her life Mary was not open to services. At the time of her discharge from various services, Mary's case had not been subject to formal multi-agency processes (such as the mental health Care Programme Approach, or safeguarding) which meant that agencies closing her case did so in relative isolation, with little in the way of multi-agency communication.

Without risking hindsight bias it is not possible to identify how much longer agencies would have needed to have kept her case open, or at which point services would have needed to have reopened her case to prevent harm. However, there are two areas where agencies might have done things differently to increase the probability of preventing harm: mechanisms for continuing to review cases for any changes in circumstances, and a checklist of actions at the point of closing a case.

Routine review

Within the current health and social care system there are multi-agency forums for the discussion of vulnerable or high-risk cases but, by design, they do not have the capacity or infrastructure to hold-cases or keep under regular review – there is no mechanism for the regular or routine review of 'quiet' or closed cases. In most cases there would be no need for such a process: once an episode of care has been completed, or a case has been closed, the individual would return or re-approach a professional to ask for further input, or for their case to be reopened.

For some individuals this is not a reliable route. Many individuals may be vulnerable, and their cases may have been reluctantly closed by the service due to loss of contact or disengagement or a refusal to accept support. In these cases, it may be very unlikely that the individual would reapproach a professional for their case to be reopened. In such cases there is merit in occasional or sporadic contact or a review of what is known about the case to test out whether they would be more amenable to receiving support, or whether risks have increased to warrant a more assertive approach to engagement.

Finding 1: Routine Review

Context
Mary had a known physical health condition and was prescribed medication to help her manage this, however Mary often refuted her diagnosis and was reluctant to accept medication despite attempts by healthcare professionals to encourage her to accept treatment. With no grounds to compel her to accept treatment or remain in contact with services at some point, her case would need to be closed – or made dormant.

In the current system there is no mechanism for a multi-agency review of closed, or dormant, cases where individuals may be vulnerable, at risk, or where for other reasons a review of their case would be warranted. Existing systems, such as Annual Health Checks, or GP Huddle may provide a space to discuss the small number of dormant cases that warrant a routine review.

Recommendation
Review the terms of reference for the GP Huddle, annual health checks, or a similar process, and consider whether additional capacity could be created to review closed, or dormant cases.

Closure checklist

Different organisations across the system have different functions and criteria for working with individuals and for when to accept a case or close a case. Some organisations in Croydon already utilise a closure checklist to support practitioners to cover all steps in safely closing a case or reducing their level of input. In some universal services a case may never fully be 'closed' although the amount of time spent offering interventions or maintaining engagement may reduce. Services may also take a responsive approach – they are always available to the individual on request but are dependent on the individual seeking them out.

Decisions about whether a case is open or closed may be a collaborative decision involving the service and the service user. If a service user does not want to accept support there would need to be a good reason not to close their case, but to continue to offer a service or contact that the person does not want. Exceptions to this usually focus on an individual's needs or risks and rely on a legal framework to govern the engagement of an individual's human rights. Examples of legal frameworks that allow continued interference in an individual's private life despite their wishes to be left alone include the Mental Health Act 1983, Mental Capacity Act 2005, and the safeguarding provisions of the Care Act 2014, in particular in the context of self-neglect. In these circumstances, the decision to close a case and in the knowledge that the individual is likely to continue to decline treatment and support, is multifaceted and based upon balancing a range of sometimes conflicting considerations:

Domain	Key considerations
Autonomy	Right to self-determination Freedom of choice
Professional obligations	Duty of care and professional accountability Safeguarding responsibilities including whether the adults is able "protect themselves by controlling their own behaviour" [1]
Risk assessment	Severity of self-neglect, immediate vs long-term risks Risk mitigation or protective factors Impact on others and environmental factors
Multi-agency context	Views of other services Consistency of approach Multi-agency discharge planning and shared risk management
Mental capacity	Decision-specific capacity Fluctuating capacity Executive functioning Understanding consequences
Engagement approaches	Building trust Advocacy involvement Family/community support Options for re-referral, engagement, or re-opening case
Legal Framework	Human Rights Act 1998 Mental Health Act 1983 Mental Capacity Act 2005 Care Act 2014

Evidence from the review was that when Mary's case was closed, or agency input reduced or ceased, this was done as a single agency act. Closure decisions were taken in isolation with each organisation applying its own service criteria without communication with others or a check on whether other organisations were to remain involved. In a relatively short period of time Mary began to decline support and cease her contact with services. This meant that agency by agency her professional support network reduced until she was left isolated with no professional oversight of her care. In some instances, organisations made closure decisions based upon a false sense of safety that other organisations were involved which may have masked unmet needs. While some organisations already use a checklist (or have a checklist available), practitioners in the learning event agreed that a consistent system-wide checklist and closure process would be useful, to include a check on the risk factors involved in the closure decision. This may include a check on whether other organisations were involved, and on any gaps in knowledge or support, for example any unmet mental health needs.

Finding 2: Closure Checklist

Context
Decisions about whether a case is open or closed will often be a collaborative decision involving the service and the service user. If a service user does not want to accept support there would need to be a good reason not to close their case, continuing to offer a service that the person does not want. Exceptions to this will focus on an individual's needs or risks and rely on a legal framework to govern the engagement of an individual's human rights.

In the context of self-neglect, the decision to close a case and allow someone to decline treatment and support is multifaceted and based upon balancing a range of sometimes conflicting considerations. Where an individual may be at heightened risk of harm without care and support, closing a case needs to be done carefully and thoughtfully, and following an assessment of risk. This may include a check on the individuals professional support network, how the system could maintain oversight of their case, and whether the individual may continue to have unmet needs. A checklist of common considerations may act as an aide memoir to support professional decision-making when considering a case for closure in the context of self-neglect.

Recommendation
Organisations should work together to standardise their checklists of considerations for closing cases, especially where continuing risks of self-neglect or unmet needs are foreseeable.

Learning area: Multi-agency and escalation processes

When and how to identify and escalate a case as high-risk. The challenge of safeguarding in the context of self-neglect: when to prompt and when not to prompt a safeguarding response to the risk of self-neglect. Identifying multiple types of abuse and links between self-neglect and vulnerability to (financial) exploitation.

In statutory guidance, self-neglect is defined as "a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings" [1]. Local safeguarding policies across England and Wales include a broader working definition of self-neglect encompassing three distinct elements of self-neglect. In the London Multi-Agency Adult Safeguarding Policy & Procedures [2] these are summarised as:

- **Lack of self-care:** this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or wellbeing
- **Lack of care of one's environment:** this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g., health or fire risks caused by hoarding)
- **Refusal of assistance that might alleviate these issues**: This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment.

Research into self-neglect on the causes and risk factors for self-neglect often focuses on health-related or underlying medical causes connected to an individual's own capabilities, illnesses, and mental health or as a result of the undue influence of others' or the outcomes of exploitation [3, 4]. Individuals may also self-neglect as a result of extreme poverty and lack of financial resources, food insecurity, or as a result of influence or abuse by others. While there are many reasons that individuals make unwise choices or decisions, it is extremely rare that a person chooses to neglect themselves: self-neglect is usually the consequence, not the decision [5].

The policy sections on self-neglect recognise the complex and diverse nature of self-neglect, and encourage a multi-agency approach over single-agency responses, and again considers the balance between "respecting the adult's autonomy and meeting the duty to protect their wellbeing" [2].

For abuse and neglect, the criteria for decision-making on a safeguarding enquiry is clear: a Local Authority must make or arrange an enquiry when certain criteria are met[2], a different approach is taken in cases of self-neglect. Care and Support Guidance notes that self-neglect 'may not prompt a section 42 enquiry' but that this decision 'depends on the adult's ability to protect themselves by controlling their own behaviour' [1]. The additional room for interpretation may offer practitioners across the system the ability to personalise their response on a case-by-case basis and may support creativity and a relationship-based approach, but it could also lead to less consistency in how cases of self-neglect are managed.

[2] "A person has care and support needs; they may be experiencing or at risk of abuse and neglect; they are unable to protect themselves from that abuse and neglect because of those care and support needs" 2. Board, L.S.A., *London Multi-Agency Safeguarding Policy & Procedures*. 2019..

The case of Mary demonstrates this well. Self-neglect had been identified in two domains; self-neglect in relation to self-care, and of her environment – characterised by a minimal existence and lack of goods and property to enable human habitation. A review of agency responses did identify some creative and flexible practice, in particular regarding engagement approaches and attempts to form and maintain rapport and professional relationships. However, a lack of clarity on process and threshold for escalation to a safeguarding enquiry is also evidenced. The responses to self-neglect in the case of Mary tended to be agency-specific and practical by nature, blitz cleaning, a package of care, and single-agency responses to allegations of a crime of theft, however her case was not identified for a multi-agency response such as safeguarding, despite concerns being shared across agencies. Evidence from professionals during the learning event revealed that one of the main issues is a lack of clarity of the thresholds for safeguarding enquiry – given the uncertainty created by the statutory guidance and policy framework.

With the benefit of hindsight, most practitioners felt that Mary's case had been complex enough, or risky enough to warrant a multi-agency safeguarding approach but there remains a lack of clarity on how to interpret the determinants of complexity or risk in the case to create a consistent threshold for safeguarding. The determinants of complexity and risk in the case of Mary included her underlying health conditions, insight and acceptance of diagnoses and treatment, environmental risks due to living conditions, the number of agencies involved and coordination of response, and social isolation and a limited social network. A common experience in this case (mirrored in other Safeguarding Adults Reviews across England and Wales) is a lack of feedback on self-neglect referrals – not only on the management of a specific case, but on the appropriateness, completeness, and quality of the referral. At the same time, referrals in cases of self-neglect can lack detail or the means to accurately assess the impact of self-neglect and risk of harm. The combination of these two experiences is that neither referrers, nor decision-makers, have a clear understanding of what makes a good referral, on whether self-neglect is being under- or over-referred, or on what cases would meet the criteria or threshold for a multi-agency safeguarding enquiry or a multi-agency risk-based approach.

Finding 3: Thresholds for multi-agency approaches to self-neglect

Context
In relation to safeguarding enquiry, a different approach is taken in cases of self-neglect than other forms of abuse and neglect. Care and Support Guidance notes that self-neglect 'may not prompt a section 42 enquiry' but that this decision 'depends on the adult's ability to protect themselves by controlling their own behaviour' [1]. A lack of clarity about the interpretation of safeguarding thresholds for self-neglect means can lead to a lack of consistency on how self-neglect cases are managed. Limited feedback on the quality of self-neglect referrals, prevents agencies being able to adjust or adapt their threshold for referring cases of self-neglect for a safeguarding or other multi-agency response.

Question to the members of the Safeguarding Adults Board
How can a system of feedback on referrals be developed so that referrers are able to undertake their own quality assurance and ensure that they are providing the information and level of detail needed by Adult Social Care?

Learning area: Factors influencing self-neglect

Exploring the links between mental health, mental capacity, and self-neglect and what this means for work with individuals at risk. This theme may also bring other themes together.

Research on the causes of self-neglect often focus on health conditions – especially mental health – addictions, and mental impairments, physical health deterioration and loss of ability, social determinants, poverty, food insecurity, the lack of resources, and the undue influence of others. Commonly cited causes in the literature include, but are not limited to:

- Mental disorder
- Obsessive Compulsive Disorder
- Learning disability
- Dementia
- Brain injury
- Physical illness, reduced energy levels, attention, or organisational skills and motivation
- Reduced motivation as a side effect of medication
- Addictions, including alcohol, illicit substances, gambling
- Homelessness
- Social isolation
- Mistrust of others especially those in authority
- Traumatic life events, such as loss and bereavement
- Adverse childhood experiences [3, 4]

Mary's experience of self-neglect manifested in a lack of care and acceptance of treatment for her health conditions and her domestic environment. A key factor for Mary may have been an underlying mental health condition – a historical experience of a persistent delusional disorder which may have had an impact on her decision-making. In the past this had reached a degree of impact that had warranted compulsory assessment and treatment in hospital, but which later was not felt to warrant or justify continued attempts at treatment against Mary's wishes. This meant that later in the SAR review period, due to Mary's reluctance to accept mental health support from any agency, this remained an unmet need – something that not all organisations were aware of. In relation to self-neglect, an underlying mental health condition is a common vulnerability factor alongside those listed above – especially to the extent that a "low-level" mental health need may have a hidden impact on a person's decision-making. In relation to her health, concerns focused on Mary's denial of a condition of hypothyroidism and a refusal to take medication. Mary neglected her environment through a failure to maintain or use necessary systems for living – for example broken appliances, utilities, fridge, not using her bed, wardrobe, or heating. Without adequate furniture of property, Mary's living environment was insufficient to meet her daily needs. The self-neglect that resulted from her decisions to live in this way led to professional concerns about her mental state, learning needs, or the presence of a mental impairment. During Mary's history of involvement with services there had been suggestions of a number of causal factors in her experience of self-neglect including loneliness, a history of trauma, unmet mental health needs, impact on mental capacity, unmet physical health need (untreated hypothyroidism[3]) and apparent functioning (veneer) masking true level of self-neglect.

[3] Symptoms may include fatigue, weakness, increased sensitivity to cold, weight gain, muscle ache, joint pain, dry skin, depression, memory problems, difficulty concentrating, anxiety, and irritability.

The rationale behind some of Mary's decisions led to professional concerns about her ability to make certain decisions, and concerns that a mental disorder or disturbance of mind as contributory to her self-neglect however her mental capacity was not explored fully. In some cases, this came down to a lack of knowledge about Mary's history of a delusional disorder, or professionals who had not received training in using the Mental Capacity Act and who would not be expected to make an assessment in their role. With less knowledge of Mary's history and of the use of the Mental Capacity Act practitioners may have been less confident at assessing capacity, asking for support, or arranging for her mental capacity to be assessed by a colleague. This may have been accompanied by a reluctance to, or a belief that they could not, challenge 'unwise' decisions.

Safeguarding Adults Reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. In the case of Mary, one area in which agencies and professionals could have acted differently is in the analysis and exploration of the underlying causes of self-neglect in her case. This exploration may have included a more in-depth assessment of mental capacity, Mary's mental health concerns, and the impact of untreated hypothyroidism.

Finding 4: Exploring the underlying causes of self-neglect

Context
Research on the causes of self-neglect often focus on health conditions and unmet needs – especially mental health, addictions, other mental impairments, and physical health deterioration, and the associated loss of ability, social determinants, poverty, food insecurity, and lack of resources.

Rationale
Professional concerns about Mary focused on her physical health, mental state, learning needs, and the presence of a mental impairment. During Mary's involvement with services professionals may have had a broad understanding of possible causal factors for her self-neglect, but there was no systematic exploration of these in detail, or an analysis of unmet needs.

Recommendation or questions to the Safeguarding Adults Board
1. A scoping of Training Needs Analysis in should identify where agencies or professional groups are not trained or able to carry out assessments under the Mental Capacity Act 2005 and may therefore need additional support or assistance.
2. The Board should consider how to raise awareness of the self-neglect guidance and develop practice tools to support the systematic analysis of underlying reasons for an individual's self-neglecting behaviours.

Learning from the Catherine SAR

The Catherine SAR was published in October 2021 and concerned a woman who was found deceased at her home in circumstances of self-neglect and allegations of financial exploitation. The SAR produced 16 recommendations, a number of which are relevant to the case of Mary.

The following is taken from the Catherine 7-minute briefing document:

"Catherine was an 85-year-old women, born in Ireland and a widow, her husband died in 2002. She owned her own property, a flat which was situated above a business premises which she also owned and rented out. Her first contact with mental health services was in 1974 when she had a diagnosis of Paranoid Schizophrenia. She had further contact with Mental Health Services between 2002 –2011 receiving both inpatient and community services, she was last seen by her GP in 2014. She was referred to Adult Social Care in 2003, 2004 and 2008. Catherine was a vulnerable adult who had been in receipt of services throughout her life."

The methodology for the Catherine SAR involved content analysis of information supplied by organisations overseen by a SAR Panel. The report analysis follows a chronological narrative approach highlighting opportunities for learning and recommendations for the agencies involved in Catherine's care. The Safeguarding Adults Review made sixteen recommendations for the specific agencies involved and for the Safeguarding Adults Board. While recommendations are specific to the case, or to agency practice, there are a number of recommendations that amplify the findings of this review including recommendations concerning:

- Completing assessment work before closing cases to safeguarding procedures
- Ensuring feedback is provided to safeguarding referrals
- Production of an escalation policy

This Safeguarding Adults Review seeks to build on the agency-specific findings of the Catherine SAR, considering the findings of the case of Mary in the context of the wider system findings and learning that can support practitioners to aspire to effective multi-agency safeguarding practice with individuals who are at risk of self-neglect.

SUMMARY OF RECOMMENDATIONS

No.	Learning area	Finding	Recommendation or question to the SAB
1.	Opportunities for engagement	Routine Review	Review the terms of reference for the GP Huddle, annual health checks, or a similar process, and consider whether additional capacity could be created to review closed, or dormant cases.
2.	Opportunities for engagement	Closure Checklist	Organisations should work together to standardise their checklists of considerations for closing cases, especially where continuing risks of self-neglect or unmet needs are foreseeable.
3.	Multi-agency and escalation processes	Thresholds for multi-agency approaches to self-neglect	How can a system of feedback on referrals be developed so that referrers are able to undertake their own quality assurance and ensure that they are providing the information and level of detail needed by Adult Social Care?
4.	Factors influencing self-neglect	Exploring the underlying causes of self-neglect	1. A scoping of Training Needs Analysis in should identify where agencies or professional groups are not trained or able to carry out assessments under the Mental Capacity Act 2005 and may therefore need additional support or assistance. 2. The Board should consider how to raise awareness of the self-neglect guidance and develop practice tools to support the systematic analysis of underlying reasons for an individual's self-neglecting behaviours.

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