**Key Learning**

Research into self neglect describes the risk identifiers for self neglect as a complex interaction of physical, mental, societal, personal and environmental factors. Lists vary but often include the following and are pertinent to Adult P:

* Living alone with no known close relationships
* Unemployed with few identified activities
* Limited economic resources
* A traumatic event(s) like Adult P’s serious head injury in 2002. It is not known if that resulted in him losing his employment as a coal miner, often described as employment that endowed community status and forged strong friendships
* Diminished social networks
* Someone who never quite ‘fits’ health, particularly mental health, and social care support services criteria
* Wearing ‘fierce independence’ as a ‘badge of honour’ whilst care and control over self and environment is visibly deteriorating

**Background**

Adult P was a white British, 67yr old man, known to have some vulnerabilities. He was found, by police, dead on the floor of his home in Edlington in January 2019. He lived alone in the St Leger property since 2013. Little is known of his family; he had been a coal miner and had suffered a serious head injury 2002. His neighbour who provided care and support to Adult P had withdrawn support.

Adult P had some contact with the Wellbeing Service from 2013, primarily over finances and began to be of increasing concern over fire risk, weight loss, part clothed/ soiled presentation, and risk of exploitation by others.

Seen at home by a consultant community geriatrician, a social worker and community nurses in the week before death. All had concerns about his presentation, and doubts about his mental capacity, but not about any immediate life threatening issues.

Coroner’s office recorded death as a result of pneumonia and ischaemic heart disease as a ‘natural’ death.

**Recommendations**

1. DSAB should continue to build on the good work already undertaken to embed an effective response to self-neglect.
2. DSAB should consider commissioning a multi-agency staff development event, including all agency practitioners, using this SAR as a case example, to update staff on research, to test out the clarity of the Doncaster’s Self Neglect procedure and its relationship to Safeguarding and Mental Capacity assessment processes; and to engage front line staff in developing / improving practice in identifying and supporting adults who may be neglecting themselves.
3. All partner organisations should provide evidence to the Board that they have a programme of staff training/development that includes practice-based workshops on use of the Mental Capacity Act (MCA). Workshops in relation to MCA should be regular, brief and ‘case based’. Opportunities to fully understand the distinction and connection between decision making capacity and executive function capacity and the balance of rights under the Human Rights Act (ECHR) need to be included.
4. DSAB, should consider as part of the Board quality assurance programme an audit of a sample of cases where self neglect is identified but not referred to safeguarding to identify good practice and areas where greater scrutiny is required.
5. DSAB should seek assurance from health partners that where an adult has had any serious head injury that regular health checks are undertaken and procedures are in place that where there is non- compliance with health checks a referral for further enquiries should be made given the evidence of greater risk of additional cognitive impairment as a person ages.
6. Partner agencies, particularly housing, social care and health agencies should review their policies and procedures for identifying and offering support to non family unpaid ‘carers’ as well as family. This is particularly relevant during the Covid-19 pandemic.
7. All agencies need to encourage and provide training and support to staff to find ways in engaging with people and to be persistent in their curiosity as to why self neglect seems to be taking place.
8. The DSAB should consider its relationship with third sector/community based organisations which may have been able to offer Adult P more activity/interest based support.
9. The DSAB should seek a review of its SAR process, particularly in relation to requirements for, and quality of critiqued chronologies from all relevant divisions of partner agencies and the use of efficient electronic platforms to communicate with SAR authors.



On the 8th November 2018 a safeguarding social worker and the Wellbeing Officer visited Adult P. He was ‘dishevelled’, dirty, naked from the waist down, and lost weight. An area of his sofa was covered in faeces. He said he had money stolen from him by a man who lived in the flats, but did not want to report this to the police. He confirmed he had received his ‘Winter Warmth’ payment, but had no hot water as his gas had been turned off, but said he didn’t want any support. The two staff held a meeting after the visit where it was agreed that the SNARM ‘Tool’ would be completed given the rising level of risk, as well as a Care Act community care assessment undertaken

Deterioration in Adult P’s condition coincided with being ‘targeted’, along with other older people in the area, by an unnamed individual, who was believed to have his own vulnerabilities. The Wellbeing officer and other community staff believed some of the items that appeared to be ‘being stored’ in Adult P’s house may have been stolen by this person, whom Adult P initially described as his friend. It is thought that this person stole money but Adult P did not want any action to be taken, and at that stage the concerns were not reported to SYP

On 27th December the Safeguarding social worker and the Wellbeing Officer also visited Adult P and carried out a further mental capacity assessment (MCA). The assessment confirmed that he did not have capacity with regards to meeting his care and support needs and that a Best Interests meeting was needed.

On 4th January 2019, the Wellbeing Officer and the Communities Officer visited Adult P at 9.30am with the aim of checking up on him and doing some shopping for him. They couldn’t get an answer and during the course of the day they checked with Doncaster Royal Infirmary to see if he had been admitted to hospital, visited two local shops, where he was well known, to check if he had been seen, talked with his neighbour, and finally phoned for police support. The Police entered the property and found Adult P had sadly died.

**Good Practice**

**There were a number of areas of good practice by staff and also systems of support that indicated knowledge of what works well with people who have indicators of self neglect.**

* **The Wellbeing Service, through an experienced and person centred staff member who built a trusting relationship with Adult P, offered low level, practical and ‘checking on’ support to him and other adults with a range of vulnerabilities that were below the threshold of needing social work/safeguarding interventions. This support continued in a joint working relationship after social work/safeguarding staff became involved.**
* **There was Identification of the need for continuity in a named social worker to build a trusting relationship with Adult P**
* **SYFR responded efficiently and sensitively to their referral to check out Adult P’s fire risk and did a follow up visit identifying a raised level of concern.**
* **The Community physician/geriatrician carried out a thorough assessment and demonstrated compassion and persistence in engaging with Adult P, and identified a detailed plan of action to further assess and support him.**