

**WEST GLAMORGAN SAFEGUARDING BOARD**

**SELF-NEGLECT POLICY AND GUIDANCE**

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**INTRODUCTION**

This document outlines the policy, procedures and guidance when concerns relate to an adult at risk who is believed to be self-neglecting. It is intended to be used in conjunction with each agency’s current policies and guidelines.

Self-neglect covers a wide range of situations and behaviours. It can be linked to numerous factors including:

* Physical Health Problems
* Mental Health Problems
* Substance Misuse
* Psychological And Social Factors
* Diminished Social Networks
* Personality Traits
* Traumatic Histories and Life-Changing Events.

An adult may be considered to be self-neglecting and therefore maybe at risk of harm where they are:

* Either unable, or unwilling to provide adequate care to an extent that there is a risk of harm to personal and health and safety.
* Not engaging with a network of support.
* Unable to or unwilling to obtain and receive necessary care or support to meet their needs.
* Unable to make reasonable, informed or mentally capacitated decisions due to mental disorder (including hoarding behaviours), illness or an acquired brain injury.
* Unable to protect themselves adequately against potential exploitation or abuse.
* Refusing essential support without which their health and safety needs cannot be met, and the individual lacks the insight to recognise this.
* Hoarding to the extent that retention of material impacts on their living space to the point where it puts themselves at risk of causing harm.

A failure to engage with adults who are not looking after themselves (whether they have mental capacity or not) may have serious implications for, and a profoundly detrimental effect on the adult’s health and wellbeing. It can also impact on the individual’s family and the local community.

Public authorities, as defined in the Human Rights Act 1998 and the Social Services and Well-being (Wales) Act 2014 in accordance with the wellbeing principle and safeguarding principle, must act in accordance with the requirements of public law. In relation to adults perceived to be at risk because of self-neglect and or hoarding, authorities are expected to act within the powers granted to them. They must act fairly, proportionately, rationally and in line with the principles of the Social Services and Well-being (Wales) Act 2014, the Mental Capacity Act 2005 and consideration should be given to the application of the Mental Health Act 1983 where appropriate.

**AIM OF THE POLICY AND PROCEDURES**

The purpose of this policy and guidance is to provide a framework for collaborative multi-agency working, which assists agencies who are working with and supporting the adult who is displaying self-neglecting behaviours. The aim is to reduce risk wherever possible, prevent serious harm or death of adults who are self-neglecting by ensuring:

* Adults who are self-neglecting are empowered, as far as possible, to understand the implications of their self-neglecting behaviours.
* A shared, multi-agency understanding and recognition of the issues involved in working with adults who self-neglect.
* Effective multi-agency working and practice, whether this falls within a Section 126 safeguarding enquiry[[1]](#footnote-1) or outside of this. Decisions will be made on a case-by-case basis as to whether the lead agency will be the local authority or another agency. Please refer to the flowchart in Appendix 1.
* Concerns receive appropriate prioritisation and a proportionate response to the level of risk for the adult at risk and others.
* Agencies and organisations uphold their duties of care.

This is achieved through:

* Promoting a person-centred approach which supports the rights of the adult to be treated with respect and dignity, to be in control of, and as far as possible, to lead an independent life.
* Aiding recognition of situations of self-neglect.
* Increasing knowledge and awareness of the different powers and duties provided by legislation and their relevance to the particular situation and adults’ needs; this includes the extent and limitations of the ‘duty of care’ of professionals.
* Promoting adherence to a standard of reasonable care whilst carrying out duties required within a professional role, in order to avoid foreseeable harm.
* Promoting a proportionate approach to risk assessment and management.
* Clarifying different agency and practitioner responsibilities and in so doing, promoting transparency, accountability, evidence of decision-making processes, action taken and promoting an appropriate level of intervention through a multi-agency approach.

**DEFINITIONS**

The following definitions are relevant to this Policy and Practice Guidance:

**Self-Neglect**

There is no accepted operational definition of self-neglect nationally or internationally due to the dynamic and complexity of self-neglect. The Social Services and Well-being (Wales) Act 2014 (SSWA 2014) does not provide a definition and statutory guidance encompasses self-neglect under the category of neglect.

Gibbons et al (2006)[[2]](#footnote-2) defined it *as ‘the inability (intentionally or unintentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and well-being of those who self-neglect and perhaps too to their community’*.

Social Care Institute of Excellence (SCIE) provided a framework for research into self-neglect identifying three characteristic areas:

* **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.

**An Adult at Risk**

Under s126 of the SSWA 2014, safeguarding duties apply to an adult who meets the following criteria:

1. is experiencing or is at risk of abuse or neglect,
2. has needs for care and support (whether or not the authority is meeting any of those needs), and
3. As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

**Adult Care and Support Services**

Includes all care and support services provided in any setting or context whether these are funded by a statutory agency or by the person themselves. It also includes the need for care and support (whether or not the authority or other agencies are meeting any of those needs).

**Risk**

Risk is determined on a case-by-case basis. The following indicators of harm may be used to gauge the level of risk posed:

**Significant Harm**

* Impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development
* The individual’s life could be or is under threat
* There could be a serious, chronic and/or long-lasting impact on the individual’s health physical/emotional/psychological well-being.

**Significant Risk**

Where there are indicators that increase in the level of risk is likely to occur in the short to medium term, appropriate action should be taken or planned. Indicators of significant risk could include:

* History of crisis incidents with life threatening consequence
* High risk to others
* High level of multi-agency referrals received
* Fluctuating capacity
* History of safeguarding concerns/exploitation
* Financial hardship, tenancy/home security risk; risk of eviction
* Likely fire risks
* Evidence of domestic violence
* Public order issues; anti-social behaviour, hate crime, offences linked to petty crime
* Unpredictable/chronic health conditions
* Significant substance misuse, self-harm
* Network presents high risk factors
* Environment presents high risks
* History of chaotic lifestyle; substance misuse issues
* The individual has little or no choice or control over vital aspects of their life, environment or financial affairs.

**Fire Risk – Home Safety Visits**

Where a person’s home environment unsafe due to excessive hoarding of items or neglecting household maintenance to the extent the property becomes dangerous (unsafe gas, electric, water or structural damage), the risk of a fire occurring increases and it is more difficult for the adult living with the property to evacuate safely or the health and well-being of the individual or another person visiting the property is a risk.

With the consent of the adult, the Fire and Rescue Service will undertake a home safety visit and provide the necessary guidance and advice regarding fire safety, and also where necessary will install smoke alarms and/or other specialist equipment. Any partner agency can make a referral for a home safety visit by contacting the Fire and Rescue Service in their area. The adult, or a friend or family member, may also make a self-referral.

**THE SCOPE OF THIS POLICY DOES NOT INCLUDE**

Issues of risk associated with deliberate self-harm. Appropriate support would be GP or other relevant health professional. However an adult at risk report would be appropriate where; the self-harm has occurred due to an act(s) of neglect or inaction by another individual or service; there appears to be a failure by regulated professionals or organisations to act within their professional codes of conduct; actions or omissions by third parties to provide necessary care or support where they have a duty either as a care worker, volunteer or family member to provide such care/support.

Where there is concern that any relevant agency has closed their involvement prematurely, or is not proactively engaging in multi-agency plans to address the concerns and risks for the individual, this will be escalated through the relevant processes for that agency

**KEY MESSAGES WHEN WORKING WITH AN ADULTS WHO SELF-NEGLECT**

The following key messages are drawn from research, practitioner’s experience and lessons learned from Safeguarding Adults Reviews:

* All agencies have a role in supporting people who self-neglect; multi-agency working is key.
* Finding out why the person is self-neglecting is key to understanding behaviour and interventions – this may be connected with trauma, grief, mental health episodes or other experiences.
* It is crucial to build a positive relationship with the adult at risk who is self-neglecting – sometimes this means a professional working with the adult at risk becomes to lead with face-to-face contact.
* It is important to understand the adult at risk’s history to find out what is important to them.
* Supporting an adult at risk who is self-neglecting is usually requires long-term involvement, moving at the pace of the adult at risk is key to achieve positive change.
* Consider the adult at risk’s family network and any community networks and think about how these might help support the individual (consider whether a Carer’s assessment is needed).
* Communicate regularly with all those involved with the individual.
* Professionals need to be clear about your role and responsibilities and those of others.
* Undertake a thorough Risk Assessment and explain your concerns openly to the person who is self-neglecting.
* Consider mental capacity in relation to the decision which need to be made – is the person able to understand information/retain it/weight it up/communicate their decision?
* Also consider the person’s ‘executive functioning’ – they may appear to understand but can they/will they see the decision through in practice?
* Consider whether advocacy is needed.
* Remember that ‘self-funders’ are just as entitled to a care and support assessment as those whose care is funded by the authority.
* As multi-agency members, be prepared to challenge decisions if you do not agree with them, and escalate if necessary.
* Do not dismiss self-neglect as a ‘lifestyle choice’ or take an initial rejection of support as final.
* Do not close a case simply because the individual refuses an assessment or will not accept a plan.
* Always remember to ‘think family’ and consider any risks to those living with or closely related to the individual who is self-neglecting.

**KEY INDICATORS OF SELF-NEGLECT**

Indicators when combined may indicate the presence of self-neglect. There is no clear point at which lifestyle patterns become self-neglect and the term can apply to a wide range of behaviours and different degrees of self-neglect. The following list is not exhaustive and should be considered in conjunction with the risk assessment.

**Indicators of Self-Neglect**

* Living in very unclean, sometimes verminous circumstances.
* Neglecting household maintenance which creates fire risks or hazards within and/or surrounding the property e.g. rotten floorboards, dangerous electrics.
* Portraying alternative lifestyles which some may perceive or judge to be eccentric behaviour.
* Obsessive hoarding or excessively cluttered environment which poses a fire risk and access difficulties.
* Poor diet and nutrition, e.g. little or no fresh food, or mouldy out-of-date food.
* Declining prescribed medication or necessary support from health and/or social care services.
* Refusing to allow access to health and/or social care staff in relation to personal hygiene and care.
* Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity).
* Repeated episodes of anti-social behaviour – either as a victim or source of risk.
* Being unwilling to attend external appointments with professional staff, whether social care, health or other organisations (such as housing).
* Poor personal hygiene, poor healing/sores, long toe nails, unkempt appearance
* Isolation.
* Failure to take medication.
* Repeated referrals to Environmental Health.

**N.B.** Whilst an aid to decision making, it is essential to recognise that the use of the key indicator list and risk assessment and referral tool are not eligibility mechanisms in their own right. There should always be the always be the overlay of sensitive application of professional judgement. A Chronology can aid to build a picture of the indicators and previous support offered, accepted or declined.

**CONTRIBUTORY FACTORS FOR SELF-NEGLECT**

Often the reasons for self-neglect are complex and varied, and it is important that health and social care practitioners pay attention to mental, physical, and social and environment factors that may be affecting the situation (Braye, Orr, Preston-Shoot, 2015). This will assist to identify the most appropriate way to intervene whilst assisting individuals to recognise and address the root causes of their circumstances. This list is not exhaustive:

Physical Health Issues

* Impaired physical functioning
* Pain
* Nutritional deficiency

Mental Health Issues

* Depression
* Frontal Lobe dysfunction
* Impaired cognitive functioning

Substance Misuse

* Alcohol
* Drug use

Psychosocial Factors

* Diminished social networks; limited economic resources
* Poor access to social or health services
* Personality traits; traumatic histories/life-changing events; perceived self-efficacy
* Fear, anxiety, pride in self-sufficiency

**EMPOWERING ADULTS WHO SELF-NEGLECT**

The starting point should be building a positive relationship with the adult who is self-neglecting is critical to achieving positive change for them whilst ensuring their safety and protection. This will support their right to be treated with respect and dignity, and to be in control of and, as far as possible, to lead an independent life.

**Key Principles of Engagement**

When engaging with an adult who is self-neglecting and who may have difficulty with their executive functioning (the ability to plan, organise and complete tasks), consider whether:

* They have information in a format they can understand
* Circumstances allow conversations to take place over a period of time and the building-up of a relationship
* Consider who (e.g. family, advocate, other professional) can support you to engage with the adult
* Always involve attorneys, receivers, or representatives, if the adult has one
* Check whether the person understands their options and the consequences of their choices (consider the person’s mental capacity)
* For adults who present with fluctuating capacity, aim to develop a plan of agreed actions or outcomes for the adult during a time when they have capacity for that decision
* Ensure the adult is invited to attend meetings, where possible

**The Challenge of Non-Engagement**

A frequent challenge encountered by professionals when working with adults who are experiencing self-neglect is when adults refuse, or are unable, to engage with or accept services to support them to minimise risk. There will often be competing demands between demonstrating respect for the adult’s autonomy and self-determination with the need to protect the adult from harm. Non-engagement can present in a variety of ways, including:

* Not attending appointments
* Not opening the door to professionals
* Being unable to agree to a plan of support to effect change and minimise risk
* Being unable to implement recommendations to reduce risk
* Being too substance affected to engage in any support

Self-neglect needs to be understood in the context of each adult’s life experience; there is not one overarching explanatory model for why adults self-neglect or hoard. It is a complex interplay between physical, mental, social, personal and environmental factors. It is likely that self-neglect is the result of some incident or trauma experienced by the adult, for example childhood trauma, bereavement or abuse. This may also lead to a person becoming demotivated and developing a poor self-image and low self-esteem, which will impact on their ability to engage with professional support. Positive outcomes can be achieved through approaches informed by an understanding of the unique experience of each person. It is imperative that all multi-agency practitioners remain non-judgemental, and have a shared and compassionate approach to understanding the complexity of the adult’s history and background and how this has led to their current circumstances.

Where an adult refuses support to address their self-neglect, it is important to consider mental capacity and ensure the adult understands the implications, and that this is documented. A case will not be closed solely on the grounds of an adult refusing to accept a support plan.

**Effective Interventions**

In multi-agency setting, it is important to consider who may be best placed to work creatively and proactively with an adult who does not wish to engage, and who can build a relationship of trust that may enable the person to accept support. For example, the adult may have already established a positive working relationship with another professional, such as a worker from a voluntary agency, or care agency or health service. In these situations, these workers have a crucial role in leading interventions which may help the adult to accept support, and in co-ordinating input from other agencies with specialist expertise. It is important that organisations have mechanisms in place for supporting these workers to undertake this role, and to escalate any concerns where necessary.

Staff who are supporting those presenting with self-neglect need to receive supervision of their work according to local policies. Group or team reflection of self-neglect cases and consideration of relevant research is also encouraged. In order to deliver high quality supervision, all supervisors and their managers should have an up-to-date working knowledge of these self-neglect procedures. This will ensure that managers and leaders are well equipped to deliver appropriate supervision, guidance and support to frontline staff. All staff should attend specialist self-neglect training where this is relevant to their role.

Finding the right approach to working with an adult who is experiencing self-neglect and seeking to understand the meaning and significance of the self-neglect for that adult is also critical in achieving the best outcomes. For example, adults who have lived during the war may see that everything has a value, or some who have inherited possessions from deceased relatives may find they cannot ‘sort’ these out due to a sense of loss. An over-directive approach is unlikely to support the development of a positive working relationship, since self-neglecting adults may have been living with shame and fear about their circumstances and as such may be sensitive to what presents as a criticising manner. Similarly, it is important to use appropriate language. Adults may prefer the term ‘collecting’ rather than ‘hoarding’, and the word ‘rubbish’ has a tendency to demean the items which may be important to the person.

‘At the heart of self-neglect practice is a complex balance of knowing, being and doing’ (Braye, Orr and Preston-Shoot, 2014):

* **Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.
* **Being**, in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company.
* **Doing**, in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for bigger things, and deciding with others when the risks are so great that some intervention must take place.

**MENTAL CAPACITY AND SELF-NEGLECT**

When concerns about self-neglect are raised, there is a need to be clear about the person’s mental capacity. Under the Mental Capacity Act 2005 (MCA) robust mental capacity assessments are critical in determining the approach to be taken by professionals, either to support the decision-making of the adult with capacity or to intervene to protect the best interests of an adult who lacks capacity. It is important to determine the adult’s mental capacity to understand and make informed decisions about the concerns raised, about not accepting care or not recognising self-neglecting behaviour.

Where it is felt intervention may be required due to a person’s self-neglect behaviour, any action proposed must be with the person’s consent where they are assessed as having mental capacity unless there are wider public interest concerns. For example, other people may be at risk of harm (fire risk or infestation affecting other properties).

The Mental Capacity Act 2005 provides a statutory framework for people who lack the capacity to make decisions by themselves. The Act has five statutory principles:

* A person must be assumed to have capacity unless it is established that they lack capacity.
* A person is not to be treated as unable to make a decision unless all practicable steps have been taken without success.
* A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
* An act done, or decision made under this act for, or on behalf of, a person who lack capacity must be done, or made in his or her best interest/s
* Before the act is done, or the decision made, regard must be had to as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive, of the person’s rights and freedom of action.

**Assessing Mental Capacity in Connection to Self-Neglect**

An adult should be presumed to have capacity. However, there may be cases where an adult may lack understanding and insight into the impact of their self-neglecting behaviour on their or other’s well-being. When an adult’s behaviour or circumstances cast doubt as to whether they have capacity to make a decision, then a mental capacity assessment should be carried out.

The professional responsible for undertaking the capacity assessment will be the professional who is proposing the specific intervention or action, and is referred to as the ‘decision maker’. Although the decision maker may need to seek support from other professionals in the multidisciplinary team, they are responsible for making the final decision about a person’s capacity.

Any mental capacity assessment in relation to self-neglect must be time and decision specific, and relate to a specific intervention or action. This assessment should be appropriately recorded. Good practice is to record the actual questions they were asked and the responses provided by the adult.

There may be circumstances in which it is useful to involve therapists in capacity assessments. For example, Occupational Therapists where the decision is around managing tasks within the home environment or Mental Capacity Act 2005 Speech and Language Therapists where the person has communication difficulties.

**Unwise Decision**

Principle 3 of the Mental Capacity 2005 enshrines a person’s rights to their own values, beliefs, preferences and attitudes. However, this right does not absolve an agency from their duty of care, and anyone supporting an adult who is self-neglecting must ensure they have met their professional responsibility. Where an adult has capacity and may be making what others consider to be an ‘unwise decision’ does not mean that no further action regarding the self-neglect is required, particularly where the risk of harm is deemed to be serious or critical.

The duty of care extends to gathering all the necessary information to inform a comprehensive risk assessment. It may be determined that there are no legal powers to intervene. However, it will be demonstrated that the risks and possible actions have been carefully considered on a multi-agency basis.

**Decisional and Executive Capacity**

SCIE report 46 ‘Self-neglect and adult safeguarding: findings from research’[[3]](#footnote-3) highlights the difference between capacity to make a decision (decisional capacity) and capacity to actually carry out the decision (executive capacity). Good practice includes considering whether the adult has the capacity to act on a decision they have made (executive capacity). Where decisional capacity is not accompanied by the ability to carry out the decision, overall capacity is impaired and interventions by professionals to reduce risk and safeguard wellbeing may be legitimate. It is good practice to consider or assess whether the person has the capacity to act on a decision that they have made (executive capacity).

**Best Interests Decision Making**

If the person is assessed as not having capacity to make decisions in relation to their self-neglect, then any decisions should be made following the best interests process, which includes taking into account the person’s views and taking the least restrictive action. Any best interests decisions should be taken formally, and involve relevant professionals and anyone with an interest in the adult’s welfare, such as family. Additionally, consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed. Best interests must be determined by what the person would want were they to have capacity.

“*Lacking capacity is not an off switch for freedoms*” Wye Valley NHS Trust v Mr B, 2015, EWOCP 60[[4]](#footnote-4). Therefore, in situations where an adult has experienced self-neglect over a long time and then loses capacity, previous behaviours must be considered when looking at the less restrictive options to keep the person as safe as possible.

In particularly challenging and complex cases, it may be necessary for the organisation to seek legal advice in order to refer to the Court of Protection (COP) to make the best interests decision. This includes where there may be a ‘reasonable belief’ of lack of decision-specific capacity in situations where an adult is not engaging or refuses an assessment.

**Fluctuating Capacity**

Fluctuating capacity should be considered and evidenced. This is particularly common in situations of self-neglect, it may occur as a result of an adult’s lifestyle or behaviour which lead them to making an unwise decision, for example;

* An adult may decline treatment for an overdose when under the influence of alcohol.
* An adult may prioritise a substance over a serious health need.
* An adult experiencing very high levels of distress and making unwise decisions such as those with emotionally unstable personality disorder.

This fluctuation can take place over days or weeks or over the course of a day. Consideration should be given to undertaking the mental capacity assessment at a time when the adult is at their highest level of functioning. For adults who have ongoing fluctuating capacity, the approach taken will depend on the ‘cycle’ of the fluctuation in terms of its length and severity. It may be necessary to review the capacity assessments over a period of time. In complex cases, legal advice should be sought.

Please Refer To Appendix 4 – Assessing Decisional and Executive Function of Mental Capacity

**CONSENT AND CHOICE**

Where an adult has mental capacity in relation to the relevant decisions, any proposed intervention or action must be with the person’s consent. The exception is if it is in the public interest where other people are affected or circumstances where a local authority or agency exercises their statutory duties or powers (See Appendix 6 – Legislation).

If the individual refuses to participate or engage with agencies or provide access, information obtained from a range of other sources may ‘hold the key’ to achieving access or to determining levels of risk.

Where a self-neglecting individual chooses not to accept a positive change to their circumstances, professionals working with them have a responsibility to explore that choice through respectful challenge and tactfully express concerned curiosity. Professionals need to explore the extent to which “choice” is in fact chosen, taking into account potential contributory factors to the individual’s situation which may shed light on their resistance. Examples could be: undue influence by a third party being the reason that an individual declines intervention; a deep-seated fear of care home placement; or where the fear of losing one’s pets stops someone from accepting intervention.

In the most high-risk cases where an adult has been identified as potentially self-neglecting, is refusing support, and in doing so is placing themselves or others at risk of significant harm, a referral should be made as outlined in the self-neglect pathway in Appendix 1.

An adult at risk with no disturbance or impairment in the functioning of the mind may be entitled to the protection of the Inherent Jurisdiction of the High Court if he/she is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other factors such as mental disorder. Inherent jurisdiction is considered in extreme cases of self-neglect, i.e. where a person with capacity is:

* At risk of serious harm or death, and
* Refuses all offers of support or interventions, or
* Is unduly influenced by someone else.

The High Court has powers to intervene in such cases, although the presumption is always to protect the adult’s human rights. Legal Advice must be sought to consider this action.

**ADVOCACY AND SUPPORT**

It is essential to ensure all efforts are made to include the individual considered at risk of self-neglecting and ensure that they are consulted with and included in discussions. Concerns should be raised directly with the adult at the earliest opportunity. If there is concern that the person has substantial difficulty participating in any aspect of the process, the involvement of an independent advocate or appropriate friend or family member must be considered for the individual.[[5]](#footnote-5) The involvement of a family member does not negate a referral to an Independent Mental Capacity Advocate (IMCA)where relevant.

**DUTY OF CARE**

Safeguarding adults at risk of harm often creates a tension for professionals between promoting an adult’s autonomy and their duty to try to protect them from harm. Respect for autonomy and wellbeing should be taken into account. The duty of care can be summarised as the obligation to exercise a level of care towards an individual, as is reasonable in all circumstances, by taking into account the potential harm that may reasonably be caused to that individual or his property. It means supporting an individual to achieve their chosen outcomes while maximising safety as far as practicable.

The West Glamorgan Safeguarding Board has a responsibility to ensure that partner agencies protect residents from foreseeable harm with consideration being given to others who may also be at risk, at which point an individual’s autonomy may potentially be overridden in the public interest. The overall aim is not to be bureaucratic or paternalistic but to empower individuals to take control of shaping their own lives wherever possible and lead the pace of intervention.

Respect for autonomy does not mean abandonment. Working with self-neglecting adults often requires persistence over a long period rather than time-limited involvement.

**NB:** This policy requires that all cases of self-neglect and hoarding assessed as high-risk will not be closed prior to multi-agency agreement and a clear record of all protective measures and shared decision making should be kept.

**KEY AGENCIES AND THEIR ROLES**

It will be the responsibility of all agencies to prioritise Multi-Agency Meetings and to fully co-operate with the process, giving cases of Self-Neglect the same weight as those under the Adult Safeguarding Procedures.

**Community Health Based Professionals**

Community based nursing staff or therapists are often the first professionals to observe self-neglect related concerns. They can be key to identifying triggers and changes which are then fed into the multi-agency team. They can assess and report on how an adult’s self-neglect or environment impacts on their overall ability to be safe at home and help determine the level of risk posed to the adult and others (family members, neighbours).

If an adult is refusing medical treatment for their own sound reasons then health care practitioner must make every effort to ensure that the person fully understands the risks of the refusal and continue supportive efforts to engage the person if appropriate.

**Adult Social Care Services**

In the majority of circumstances, the Social Services and Well-being (Wales) Act 2014 Assessment procedures will be the best route to provide an appropriate intervention. If assessed as having mental capacity to make informed decisions on the issues raised, then the adult has the right to make their own choices. However, the social care practitioner must ensure that the person has fully understood the risk and likely consequences if they decline services. Involvement with the person should not stop at this point and efforts should be made to engage the person in the management of risks and to form a relationship with them to do this.

If the person is assessed as not having the mental capacity to make the relevant decisions then care should be provided in line with “best interest” principles[[6]](#footnote-6). If any proposed care package might amount to a deprivation of liberty, consideration must be given as to whether it would be necessary to obtain authorisation under the Deprivation of Liberties procedure or an Order from the Court of Protection.

Assessment of self-neglect should include assessment of any health issues such as impaired sight and mobility, pain issues, or long-term conditions that may be contributing towards the self-neglect.

**Ambulance Services**

Ambulance staff are called to people’s properties in emergency situations and often access parts of the property that other professionals may not ordinarily see. They are able to assess an individual’s living environment and physical health and often raise concerns with Adult Social Care Services and general practices. By its very nature, this is a brief observational assessment and may not give a holistic view.

**Children’s Services**

Safeguarding Children refers to protecting children from maltreatment, preventing the impairment of their health or development and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care. In particular, growing up in a hoarded property can put a child at risk by affecting their development and in some cases, leading to the neglect of a child, which is a safeguarding issue.

The needs of the child at risk must come first and any actions taken must reflect this. Therefore, where children live in a property where there is an issue with safeguarding and/or hoarding, a referral should be made to Children’s Services.

**Domiciliary Care, Reablement, Intermediate Care**

These services may be directly provided. Care agencies are commissioned by Adult Social Care Services or self-funded by individuals to provide support to people in their own homes. Those providing the services have a role in both identifying people who self-neglect and hoard and in working with them. They are likely to have an established relationship and could be best placed to successfully engage with the adult who is self-neglecting.

**Environmental Health**

Environmental Health have a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premises is materially affecting neighbouring premises.

Environmental Health is a frontline agency in raising alerts and early identification of cases of self-neglect. Where properties are verminous or pose a statutory nuisance, Environmental Health will take a leading role in case managing the necessary investigations and determining the most effective means of intervention. Where the individual is residing in conditions that only pose a threat to their own welfare, the powers available to Environmental Health may have limited or no effect. In cases involving persistent hoarders, the powers may only temporarily address and/or contain the problem. Therefore, utilising powers under public health legislation in isolation is often inappropriate due to the complexities of self-neglect and it may not be the most effective use of resources, particularly where a co-ordinated approach could provide immediate protection of the adult and others or promote a long-term solution.

**Strategic Housing**

Under Part 1 of the Housing Act 2004, housing departments have powers to take enforcement action where there is any risk of harm to the health or safety of an actual or potential occupier of a dwelling or house of multiple occupation which arises from a deficiency in the dwelling or house of multiple occupation or in any building or land in the vicinity (whether the deficiency arises as a result of the construction of any building, an absence of maintenance or repair, or otherwise). The housing department can require access to residential premises in their district to assess if such a hazard exists. The duty to inspect the property is restricted to where there is an official complaint made either to the Justice of the Peace or local council. However, where there is evidence that there is imminent risk of serious harm to the health and safety of the occupier, the local authority has emergency power to serve a remedial action notice or emergency probation notice prohibiting the use of the property.

There are also powers to serve a deferred action notice and take emergency remedial action. There is no requirement that the property is owned by the local authority, nor is the capacity of the inhabitant relevant to the exercise of these powers. However, use of these powers in isolation will have limited effect on those who have persistent behaviours. The Housing Act powers cannot be used to remove hoarded items or address any health and safety problems that are the result of the owner’s actions.

**Mental Health Services**

Mental Health Services have a crucial role as for many adults, hoarding or self-neglect are often the manifestations of an underlying mental health condition. Mental Health professionals may offer key insight into how best to intervene where the adult is self-neglecting or has a diagnosed mental health condition. Where relevant, powers conferred by the Mental Health Act 1983 (MHA) to Approved Mental Health Professionals (AMHP) enable the Mental Health Service to take such steps as they consider necessary and proportionate to protect a person from the immediate risk of significant harm.

**Police**

The police have powers of entry and may be pivotal in gaining access to conduct assessments if all else fails. Under section 17 (1) (a) of the Police and Criminal Evidence Act 1984, the police have the power to enter without a warrant if required to save life or limb; or prevent serious damage to property; or to recapture a person who is unlawfully at large whilst liable to be detained.

**Primary Health Services**

In some cases of chronic or persistent self-neglect, individuals who are reluctant to engage with Adult Social Care Services or other agencies may engage with primary health care services such as their GP, district nursing service etc. GPs and district nurses often carry out home visits to people with care and support needs and may be the first people to notice a change in the adult’s home environment. Alternatively, failure to keep health appointments or to comply with medication may indicate self-neglect. As well as raising alerts and providing information, primary health services can be very effective in forming a relationship with the person and in addressing underlying concerns.

Primary health services should monitor those individuals who are engaged with their service and show signs of significant self-neglect. Monitoring might include a regular check in with, and offer of intervention to, someone who is reluctant to engage. If deterioration is such that risks to the person or to others are assessed as high by the health professional then a multi-agency response will be required.

**Private De-Cluttering Companies**

There are a number of private companies and not for profit social enterprises who offer specialist deep cleaning, decluttering and garden clearance services. Their staff should be specially trained to understand the complexities of hoarding and how to respond appropriately in sensitive circumstances. This option should be considered as part of a co-ordinated multi-agency response, in cases where hoarding is apparent.

**Private Landlords/Housing Associations/Registered Social Landlords**

Private landlords/housing associations and registered social landlords have an obligation to ensure that their properties are in a good state of repair and are fit for human habitation. Where the tenant is responsible for the disrepair the landlord has a right of action, including ultimately seeking possession of the premises. The role of the landlord/housing association and powers afforded to them means that they have a key role in alerting the statutory authorities to particular cases and that consideration should always be given to their inclusion within multi-agency discussions.

**RSPCA**

Animal hoarders own a high number of animals for which they may be unable to provide adequate standards of nutrition, sanitation, shelter and veterinary care. Hoarders often care about their animals deeply but may not see or understand that the living conditions could result in animal neglect. This neglect can involve cramped, poor living conditions and in extreme cases, result in starvation, illness or death. Animal hoarders are often in denial about their inability to provide appropriate care for their animals and typically believe that no-one else can care for their animals like they do. Sensitivity is vital as animal hoarders often hold the belief that if they seek help, or allow external intervention, their animals will be euthanised or taken away from them. Professionals can contact the RSPCA who can offer advice and assistance to improve animal welfare, including giving people time to make improvements to their standards of care. Where assistance is declined, or in extreme cases of neglect, the RSPCA can consider prosecution under laws such as the Animal Welfare Act 2006.

**Fire and Rescue Service**

The Fire and Rescue Service is best placed to work with adults to assess and address fire risk and to develop strategies to minimise significant harm caused by potential fire risks in the home. The Fire and Rescue Service will also raise alerts when called to or visiting addresses where significant risk is identified or where homes have damage because of a fire and the individual continues to live at that address.

The Fire and Rescue Service will raise alerts, carry out Safe and Well visits and offer advice to individuals assuring them of the necessity and principles of fire prevention in the home. The Fire and Rescue Service have on occasion managed to enter a home for a referral where home access is refused to other services due to the trusted nature of their work.

**Utility Companies/Building and Maintenance Workers**

Utility companies/ building and maintenance workers have an important role in the identification of hoarding and self-neglect as they visit people’s homes to read meters, carry out inspections or carry out building/maintenance work. Engagement of utility companies and other companies/workers who enter peoples’ homes is therefore important so that reports of hoarding and self-neglect can be received and appropriate action taken.

**Support Available In the Community**

There is a wide range of support and guidance available in the community. One of the difficulties of providing a list of such services is that it would not be exhaustive and would need regular updates and amendments to remain accurate and of value to practitioners.

**INFORMATION SHARING BETWEEN PARTNERS: THE CONTEXT AND THE PRINCIPLES**

Sharing the right information, at the right time, with the right people, is fundamental to good safeguarding practice. Despite this, it is sometimes viewed as a difficult area by some staff when it is necessary to share information between different organisations. Although decisions about what information to share and with whom should be taken on a case by case basis there is legislation, professional guidance, and organisational policies to support this.

Sharing information between organisations as part of day-to-day safeguarding practice is already covered in the common law duty of confidentiality, General Data Protection Regulation (GDPR) and the Data Protection Act; the Human Rights Act 1998 and the Crime and Disorder Act 1998. Section 164 of the SSWA 2014 places a duty on organisations to share information necessary to safeguard an adult at risk if requested to do so by the local authority.

Staff are also required to adhere to their own organisations internal policy and guidance on confidentiality, data protection, information security and sharing. Different professional groups also have codes of conduct that they must adhere to, for example the NHS Confidentiality Code of Conduct, which incorporates the Caldicott Principles.

The first priority in safeguarding should always be to ensure the safety and wellbeing of the adult. It is therefore important to also consider the risk of sharing information. In some cases, such as domestic abuse or hate crime, it is possible that sharing information could increase the risk to the adult.

Staff should therefore seek advice from their line manager taking all of the above into account and carefully record the rationale for the decision to share or not share information.

**PROCEDURES**

Any organisation, professional or individual that is concerned about an ‘adult at risk’ believing to be self-neglecting should follow the Self-Neglect Pathway (Appendix 1). This is regardless of whether the concern falls within the scope of an s126 enquiry under the Social Services and Well-being (Wales) Act 2014.

**Assessment and Screening – Working With Individuals Who Self-Neglect**

An assessment of need and risk using the self-neglect risk assessment and referral tool (Appendix 2) should be carried out by the most appropriate agency, depending on the nature of concerns and proportionate to their role. In most instances, this would be the referring agency. For example, where an individual is severely neglecting their health, the most appropriate lead agency may be a health partner such as District Nursing or Practice Surgery. Alternatively, Housing services or Environmental Health may be the most appropriate agencies to address hoarding and infestation while Social Care Services would intervene where adults grossly neglect their personal care and other daily living activities.

The Assessment will be informed by the views of adult themselves, wherever possible and practicable this will include the views of carers and/or relatives. Assessment can also be carried out jointly on an inter-agency basis.

Where there are concerns that the adult at risk lacks or appears to lack the mental capacity to fully understand the risks related to their behaviour, a mental capacity assessment must be considered at an early stage in relation to the adult at risk’s ability to make informed decisions regarding the risk identified. Specialist input may be required to clarify certain aspects of the adult’s functioning and risk. This includes considering the request for a Mental Health Act assessment where this appears to be appropriate. Another example would be a referral for psychological input.

Building a positive relationship with individuals who self-neglect is critical to achieving change for them, and ensuring safety and protection. It is also key to maintaining the kind of contact that can enable interventions to be accepted in time. For example, if the adult has developed a trusting relationship with one professional but declines the intervention of other agencies, that one professional may be guided by colleagues to ask other questions or assess other risk aspects that are pertinent to their respective roles pending further attempts at engagement.

Consider all members of the household when assessing needs and risks as in some cases, more than one family member may need an assessment in their own right (Carer’s Assessment).

Addressing self-neglect requires time and patience; improvements often take time to fruition, sometimes weeks, months or even longer. Short-term preventative interventions are unlikely to succeed so professionals will need to allow flexibility in such cases.

It is not enough to solely write a letter offering intervention or asking the adult to make contact. People who self-neglect or hoard are unlikely to respond to written correspondence. The method of communication should be best suited to the individual taking into account any and all of their communication needs.

**Outcome of the Self-Neglect Risk Assessment and Referral Tool**

Responding to self-neglect will depend on the level of risk/harm that has been identified. In the majority of self-neglect cases, early intervention and preventative actions will negate the need for safeguarding adults’ procedures to be used. The Social Services and Well-being (Wales) Act 2014 emphasises the importance of using local community support networks and facilities provided by partner and voluntary organisations.

A timely initial response is crucial - Agencies will formally record (ideally within 24 hours) that these procedures are being applied.

Lower Level Risk/Harm – Preventative

If the adult’s self-neglecting behaviour is **low risk**, they do not require a referral to Adult Social Care, unless specific unmet needs are identified. The referring agency should continue with preventative intervention as appropriate and continue to monitor for changes in risk indicators. If the risk increases, following support, a referral to Gateway should be made.

Medium risk – Requires Multi-Agency Approach

If the self-neglect is determined to be **medium risk**, then a self-neglect referral is made to Gateway requesting Adult Social Care input, including a copy of the self-neglect risk assessment and referral tool (Appendix 2). Adult Social Care then carries out a person led assessment and comprehensive assessment with the person and a multi-agency self-neglect meeting is held with all relevant parties (to include the adult at risk and/or carers) to determine levels of risk and agree a self-neglect support plan. Where there are disagreements about any aspects of the plan, these should be resolved by consultation with a senior manager from the lead agency.

Review 6 weekly to monitor level of risk and continue with multi-agency response.

High risk

A **high risk** outcome of the self-neglect risk assessment and referral tool will involve the Gateway ascertaining whether there are any adult safeguarding concerns. The Gateway may speak to the referrer to gather further information and to determine if any immediate adult safeguarding concerns are identified. If adult safeguarding concerns are identified the concern will be referred to adult safeguarding team for s126 enquiry under the Wales Safeguarding Procedures.

If no adult safeguarding concerns are identified then Adult Social Care will carry out a person led assessment and comprehensive assessment with the person and hold a multi-agency self-neglect meeting with all relevant parties to determine levels of risk and agree self-neglect support plan.

If the concerns immediately present as high risk to the adult at risk or to other people, then action to mitigate risks must be taken. This may involve calling emergency services e.g. police, fire, ambulance.

**N.B.** If the multi-agency meeting determines higher or lower risk than when first referred, change to and follow the appropriate pathway.

**Consider Appropriate Procedure to Respond To the Risk**

There may be occasions when it is appropriate to follow another procedure to co-ordinate all or some aspect of the issues identified. Where the adult at risk’s ability to make the relevant informed decisions is in question, the principles of the Mental Capacity 2005 must be followed. Where it appears the adult at risk may be mentally unwell, the Mental Health Act 1987 processes must be followed.

If there are any child protection or child in need of care and support concerns these must be referred to Children’s Services as a matter of urgency.

If other processes are considered more appropriate to use to support the individual, the self-neglect procedure may be ended at this point and all issues handed over to the practitioner/service taking responsibility for addressing the self-neglect as well as the other concerns. There must be clear documentation to evidence the handover of responsibilities if this is the case.

Depending on the level and nature of risk identified, consideration may be given to the work of other agencies and practitioners being carried out in parallel with the self-neglect procedures. There must be a clear agreement about who has the lead for co-ordination of all the work and for bringing multi-agency/services together with the individual or their advocate to agree an action plan.

**COMPREHENSIVE ASSESSMENT OF SELF-NEGLECT (INCLUDING RISKS)**

An assessment should be completed using the policy and procedures of the lead agency with contributions from other agencies and services as appropriate to form a comprehensive assessment of the adult and of the risks identified. Specialist input may be required to clarify certain aspects of the individual’s functioning and risk. Key components of the comprehensive assessment of self-neglect may include:

* 1. A detailed social and medical history.
  2. Activities of daily living (e.g. ability to use the phone, shopping, food preparation, housekeeping, laundry, mode of transport, responsibility for own medication, ability to handle finances).
  3. Environmental assessment
  4. Cognitive assessment
  5. Mental Capacity and mental health assessments, if appropriate.
  6. A description of the self-neglect.
  7. A physical examination – undertaken by a nurse or a medical practitioner
  8. A historical perspective of the situation.
  9. The adult’s own narrative on their situation and needs.
  10. The willingness of the adult to accept support.
  11. The views of family members, healthcare professionals and other people in the adult’s network.
  12. The adult’s understanding of the consequences of risks and neglect.

**NB:** Record fully when and where the adult was assessed as having mental capacity to understand the consequences of their actions. The risks of not intervening must be explored, and documented.

For further information, please refer to Appendix 3 on what to include in the Assessment and possible questions to ask the individual.

**UNDERTAKING ASSESSMENT WHERE THE PERSON REFUSES AN ASSESSMENT**

As a matter of practice, it will always be difficult to carry out an assessment fully where an adult with mental capacity is refusing to be involved. Practitioners should record all steps that have been taken to carry out a needs assessment, including what steps have been taken to involve the individual and any carer. They should record whether the provision of care and support would contribute to the achievement of these outcomes.

In the case of an adult’s repeated refusal, it may not be possible to carry out a full needs assessment or provide care and support. Cases recording should evidence that all necessary steps have been taken to carry out the assessment and that these were necessary and proportionate. It should also evidence that appropriate information and advice has been provided to the adult, including how to access care and support in the future.

If the adult has refused an assessment or services and remains at high risk of serious harm, consideration should be given to invoking Safeguarding enquiries.

**ADULT SAFEGUARDING AND SELF-NEGLECT**

Self-neglect may not prompt s126 safeguarding enquiries, an assessment is made on a case by case basis. A decision whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own self-neglecting behaviour. There may come a point when they are no longer able to do this, without external support. Where an adult is engaging with and accepting assessment or services that will meet their care and support needs (including those relating to self-neglect), they are not demonstrating that they are ‘unable to protect themselves’ as set out in the criteria for an s126 safeguarding response.

However, where there is reasonable cause to suspect that the adult is unable to protect him or herself from self-neglect or the risk of it as a result of their care and support needs, and the risk is high or very high a Safeguarding concern should be triggered immediately. This will also be the case where previous attempts to work in a multi-agency way have failed to produce a reduction in risk.

**When Should An Adult Safeguarding Concern Be Raised?**

* When an adult is living in the community and all avenues of support via multi-agency agencies have been exhausted, yet the adult is placing themselves and others at risk of harm (i.e. this could be through environmental hazards).
* When an adult living in a care setting is refusing all support/encouragement to manage personal care needs including medication administration and all avenues of multi-agency support have been exhausted (i.e. GP/Dementia specialist team/crisis intervention/CPN etc.).
* When an adult is living in a care setting and the provider fails to engage support from other professionals in trying to reduce the risks of self-neglect.
* Attempts should still be made to seek the adult at risk’s consent for the safeguarding adults enquiry to take place, however where this is not provided, consideration should be given as to whether consent should be overridden given the seriousness of the concerns. This is so that the concerns can be fully explored on a multi-agency basis and reassurance can be provided that all possible options to manage risk have been attempted. If consent is to be over-ridden, the adult should still be advised of the decision to refer, unless it is believed that advising the adult will place them at further risk.

**When an Adult Safeguarding Concern Will Not Be the Pathway**

* When an adult is living in the community and no steps have yet been taken to support the adult and/or referred to multi-agency support services in an attempt to reduce risks.
* When an adult is living in a care setting and the provider has referred to appropriate multi-agency teams for support in addressing issues and reducing risks. There is evidence that the care provider is doing its utmost to support the adult and reduce the risks.

**In Self-Neglect Cases, The Safeguarding Adults Enquiry Should Include Specific Consideration Of:**

* The mental capacity of the adult at risk in relation to specific decisions.
* Involvement of the adult at risk (and/or their family/a representative), including in the development of the Care and Support Protection Plan.
* Consideration of use of advocacy throughout the process.
* A review of current arrangements for providing care and support. Does there need to be an assessment/re-assessment/review? This should include any informal carer arrangements and assessments/reviews for any carers.
* Options for encouraging engagement with the adult at risk (e.g. which professional is best placed to successfully engage? Who would the adult respond most positively to?).
* Any legal options available to safeguard the adult. Legal advice must be sought.
* Whether there are any other people at risk (including children) and what action needs to be taken if this is the case.
* A contingency plan, should the agreed Adult Care and Support Protection Plan not reduce the risks.
* How agencies/professionals will keep in regular communication with each other about any changes or significant events/incidents.
* Escalation/notification to senior managers of the case.
* Support for front-line staff delivering services to the individual.

**Person-Led Safeguarding**

Making Safeguarding Personal is about seeing people as experts in their own lives and working alongside them in a way that is consistent with their rights and capacity and preventing harm occurring wherever possible. Safeguarding should be person-led and outcome focused, engaging the adult at risk in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. Most importantly it is about listening and providing the options that support individuals to help themselves.

Whilst every effort must be made to work with adults experiencing abuse within the present legal framework, there will be some occasions on which adults at risk will choose to remain in dangerous situations. It may be that even after careful scrutiny of the legal framework, professionals will conclude that they have no power to gain access to a particular adult at risk.

In situations where the adult refuses to engage and their self-neglect places them at significant risk, professionals may need to meet and make plans without the adult present. This is only done as a last resort when risks are significantly high and cannot be mitigated through partnership working with the adult and multi-agency colleagues.

Professionals may find that they have no power to remove the adult from a situation of risk or intervene positively because the adult refuses all help or wants to terminate contact with the professionals. In these extremely difficult circumstances, professionals will be expected to continue to exercise as much vigilance as possible.

**MULTI-AGENCY MEETING**

Where a person has been identified as potentially self-neglecting, is refusing support, and in doing so is placing themselves or others at risk of significant harm (moderate or high/critical) it is recommended that a multi-agency planning meeting is convened. This will enable the effective sharing of information to consider the risk(s) of non-intervention and enable an action plan to be agreed. It is recommended that a multi-agency meeting, with a clear agenda for discussion will be organised within seven working days from the initial concerns being raised.

**Reasons for Arranging A Multi-Agency Meeting**

* Interventions have not reduced the level of risk and significant risk remains.
* It has not been possible to co-ordinate a multi-agency approach through work undertaken until this point.
* The level of risk requires formal information sharing to agree and record a multi-agency action plan.
* Timescales for achieving actions set at the multi-agency meeting will be specified within the formal written record of the meeting. This will include timescales for completing any outstanding or more specialist assessments. A date will also need to be set for a review meeting so that any further specialist assessments can be considered and any revised actions agreed.

**The Principles Of A Multi-Agency Meeting Are To Consider:**

* Capacity and consent
* Indications of mental health issues
* The individual’s view and wishes as far as known
* Co-ordinate information-sharing in line with the principles of information sharing
* The current level risk to the adult’s physical health and well-being
* Any effects on other people’s health and well-being
* Any risk of tenancy or mortgage breach, serious risk of fire or environmental risk e.g. destruction of accommodation
* Support planning to reduce current risks, any further assessments, information or actions required
* The on-going lead professional/agency who will co-ordinate this work
* Evaluate relevant information to inform the most effective action plan.

**Guidance for Multi-Agency Meeting**

The lead agency is responsible for convening the meeting and making arrangements such as venue, chairing and minute taking and will make arrangements to involve the individual concerned, if appropriate, using the most appropriate agency to support. The multi-agency meeting is collaboratively owned by participating agencies.

* Every effort must be made to engage with the individual and to enable them to communicate their views to the meeting.
* If the individual does not wish to attend the meeting, representatives will need to consider how their views and wishes are to be presented at the meeting e.g. by the appointment of a formal or invitation extended to an informal advocate.
* Participants from all agencies identified should attend the meeting with an understanding of their responsibilities to share relevant information in order to reach an agreement on the way forward.
* It is important to ensure that any actions agreed comply with legislation and statutory duties. Legal representation at the meeting may need to be considered to facilitate discussions around relevant legal options. This may include application to the Court of Protection where there are concerns about mental capacity or to the High Court (Inherent Jurisdiction) where the individual is believed to be mentally capacitated.
* An action plan should be developed and agreed by members of the meeting. Where there are disagreements about any aspects of the plan, these should be resolved by consultation with a senior manager from the lead agency.
* The Chair of the multi-agency meeting will ensure clarity is brought to timescales for implementing contingency plans, so that where there is legal and professional remedy to do so, risk is responded to and harm is reduced/prevented.

**NB:** The chair is not responsible for ensuring that identified action points are correctly followed up. It is the responsibility of the lead practitioner/each agency representative or where appropriate, safeguarding lead co-ordinator to ensure identified actions are implemented and followed up.

**Outcomes Of The Meeting Will Include The Following:**

Following the multi-agency meeting and comprehensive assessment, the risk to the adult should be evaluated. This should include:

* The adult’s desired outcomes
* Risks identified, likelihood and level of risk (low/medium/high)
* How risks will be managed, including the adult’s protective factors
* Agreement of ongoing monitoring and review arrangements and who is responsible for doing this (including timescale)
* Contingency plan if risk increases, including any legal advisors should be involved or an escalation process
* An agreement of a communication plan with the individual/other key people involved
* An agreement regarding which agency will take the lead in the case
* Agreement of any trigger points that will determine the need for an urgent multi-agency review meeting

The person at the centre of the concern will be informed, irrespective of the level of their involvement to date, using a method of communication which is best suited to the individual taking into account any and all of their communication needs. It will set out what support is being offered and/or is available and providing an explanation for this. Should this support be declined, it is important that the individual is aware that, should they change their mind about the need for support then contacting the relevant agency at any time in the future will trigger a re-assessment. Careful consideration will be given as to how this written record will be given, and where possible explained, to the individual.

**Multi-Agency Review Meeting**

The multi-agency meeting may decide to set a further meeting to bring professionals back for the purpose of revisiting the original assessments and safeguarding or support plan, particularly in relation to:

* current functioning,
* risk assessment, and
* known or potential rates of improvement or deterioration in:
  + the adult,
  + their environment, or
  + in the capabilities of their support system
* Decision specific mental capacity assessments will have been reviewed and are shared at the meeting. Discussion will need to focus upon contingency planning based upon the identified risk(s).

It may be decided to continue providing opportunities for the individual to accept support and monitor the situation. Clear timescales must be set for providing opportunities and for monitoring and who will be involved in this.

Where possible, indicators that risks may be increasing will be identified, and these indicators will trigger agreed responses from agencies, organisations or people involved in a proactive and timely way.

A further meeting date will be set at each multi-agency review until there is agreement the situation has become stable and the risk of harm has reduced to an agreed acceptable level.

If agencies are unable to implement support or reduce risk significantly, the reasons for this will be fully recorded and maintained on the individual’s file, with a full record of the efforts and actions taken. In these circumstances, Legal advice should be considered on a case by case basis.

Where the risks are **very high** legal advice must be sought and all available legal options must be considered including application to the Court of Protection where there are concerns about mental capacity or to the High Court where the individual is believed to be mentally capacitated.

**Case Closure**

There may come a point where all options have been exhausted and no further interventions can be planned. In these cases, mechanisms must be in place to monitor the ongoing risks with robust contingency plans to manage any escalation of risk.

The adult, carer or advocate will be fully informed of the support offered and the reasons why the support has not been implemented. The risks must be shared with the person to ensure they are fully aware of the consequences of their decisions, including the risk of death. Respect for the wishes of the adult does not mean passive compliance – the consequences of continuing risk should always be explained and explored with the person. The adult should be informed that they can contact the relevant agency at any time in the future for support.

**NB:** A case will not be closed solely on the grounds of an adult refusing to accept the support plan and the above options should be thoroughly explored.

**RECORD KEEPING**

The case record will include a summary record of the efforts and actions taken by all other agencies involved. Individual agencies will also need to keep their own records of their specific involvement.

Accurate records will be maintained that demonstrate adherence to this procedures, and locally agreed case recording policy and procedures.

**APPENDIX 1 – SELF-NEGLECT PATHWAY FLOWCHART**

**SELF-NEGLECT PATHWAY FLOWCHART**

Concern that person is at risk of self-neglect

Initial screening to consider level of risk

Review 6 weekly to monitor level of risk

Adult Social Care/Lead Agency undertakes person-led **Comprehensive Assessment**

Lead agency hold **multi-agency meeting** with all relevant parties (AAR and/or carer attend) to determine level of risk and agree Plan and update Self-Neglect Risk Assessment Tool

Outcomes

* Risk removed
* Risk reduced
* Risks remain

NO

Lead agency hold **multi-agency meeting**

YES

Proceed to **S126 Enquiries**

Local Authority may speak to referrer to gather further information, to determine if any adult safeguarding concerns are identified

Referring Agency completes Self-Neglect Risk Assessment Tool

MEDIUM RISK

HIGH/CRITICAL RISK

LOW RISK

Referring agency continues with intervention as appropriate and monitors for any changes in risk indicators

* If Multi-agency Meeting determines higher/lower level of risk then when first referred, change to and follow appropriate pathway

**APPENDIX 2 – SELF-NEGLECT RISK ASSESSMENT TOOL**

The individual must be included when carrying out the Self-Neglect Risk Assessment Tool

**SELF-NEGLECT RISK ASSESMENT TOOL**

| Date of Assessment: |  |
| --- | --- |
| Assessed by (name and organisation): |  |
| Name: |  |
| Date of birth: |  |
| Address: |  |
| Consent: |  |

| **PHYSICAL AND WELLBEING & MEDICATION** | |  | **Rationale for this decision** |
| --- | --- | --- | --- |
| **NO identified risk** | The individual is accepting healthcare intervention |  |  |
|  | The individual is taking prescribed medication |  |  |
|  | No evidenced of dehydration/weight loss |  |  |
|  | No evidence of infection/diarrhoea/vomiting/other which is impacting on their health and wellbeing |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | Sporadic acceptance of healthcare intervention – no identified impact on their health and wellbeing at this time |  |  |
|  | Sporadic taking of prescribed medication – no identified impact on their health and wellbeing at this time |  |  |
|  | The individual is not consistently eating and some evidence of dehydration/weight loss – no identified impact on their health and wellbeing at this time |  |  |
|  | Some evidence of infection/diarrhoea/vomiting/other – no identified impact on their health and wellbeing at this time |  |  |
|  | Some evidence of untreated skin conditions such as ulcers, skin sores etc. – no identified impact on their health and wellbeing at this time |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | Sporadic acceptance of healthcare intervention which is having a negative impact on their health and wellbeing |  |  |
|  | Sporadic taking of prescribed medication which is having a negative impact on their health and wellbeing |  |  |
|  | The individual is not consistently eating and some evidence of dehydration/weight loss which is having a negative impact on their health and wellbeing |  |  |
|  | Some evidence of infection/diarrhoea/vomiting/ which is having a negative impact on their health and wellbeing |  |  |
|  | Some evidence of untreated skin conditions such as ulcers, skin sores etc. which is having a negative impact on their health and wellbeing |  |  |
| Any other risks identified |  |  |  |
| **HIGH/CRTITICL Risk** | The individual is declining healthcare intervention which is compromising and impacting on their health and wellbeing and resulting in signification or life-threatening harm  e.g. evidence of open wounds and refusing to consent to treatment |  |  |
|  | The individual is refusing to take prescribed medication which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Evidence of significant dehydration/weight loss which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Evidence of infection/diarrhoea/vomiting/other which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Evidence of untreated skin conditions such as ulcers, skin sores etc. which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
| Any other risks identified |  |  |  |

| **MENTAL HEALTH** | |  | Rationale for this decision |
| --- | --- | --- | --- |
| **NO identified risk** | No concerns regarding mental health |  |  |
|  | The individual is accepting health/support services |  |  |
|  | The individual is attending health/support appointments |  |  |
|  | Taking prescribed medication |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | Some concerns regarding mental health – no identified impact on their health and wellbeing at this time |  |  |
|  | Attendance at health/other appointments is sporadic – no identified impact on their health and wellbeing at this time |  |  |
|  | Sporadic engagement with support services – no identified impact on their health and wellbeing at this time |  |  |
|  | Not consistently taking medication – no identified impact on health and wellbeing at this time. |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | Some concerns regarding mental health which is having a negative impact on their health and wellbeing |  |  |
|  | Attendance at health/other appointments is sporadic which is having a negative impact on their health and wellbeing |  |  |
|  | Sporadic engagement with support services which is having a negative impact on their health and wellbeing |  |  |
|  | Not consistently taking medication which is having a negative impact on their health and wellbeing |  |  |
| Any other risk identified |  |  |  |
| **HIGH/CRITICAL Risk** | Concerns regarding mental health which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Attendance at health/other appointments is sporadic which is compromising and impact on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Sporadic engagement with support services which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Not consistently taking medication which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
| Any other risks identified |  |  |  |

| **MANAGING AND MAINTAING NUTRITION** | |  | Rationale for this decision |
| --- | --- | --- | --- |
| **NO identified risk** | The individual is aware of own nutritional needs and is able to manage and maintain nutritional needs independently. |  |  |
|  | No evidence of weight loss/weight gain |  |  |
|  | Kitchen space is uncluttered and the environment is kept clean |  |  |
|  | Kitchen appliances suitable to persons needs are being used as and when required |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | The individual has some awareness of nutritional needs – no identified impact on their health and wellbeing at this time |  |  |
|  | Some evidence of weight loss/weight gain (consider health related issues) – no identified impact on their health and wellbeing at this time |  |  |
|  | Kitchen space is becoming cluttered and evidence that the person is not able to keep the environment clean – no identified impact on their health and wellbeing at this time |  |  |
|  | No usable appliances such a fridge freezer, cooker, microwave, kettle, toaster etc. – no identified impact on their health and wellbeing at this time |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | The individual has some awareness of nutritional needs, can access some food but this can be inconsistent which is having a negative impact on their health and wellbeing |  |  |
|  | Some evidence of weight loss/weight gain (consider health related issues) which is having a negative impact on their health and wellbeing |  |  |
|  | Kitchen space is becoming cluttered and evidence that the person is not able to keep the environment clean which is having a negative impact on their health and wellbeing |  |  |
|  | No usable appliances such as fridge freezer, cooker, microwave, kettle, toaster etc. which is having a negative impact on their health and wellbeing |  |  |
| Any other risks identified |  |  |  |
| **HIGH/CRITICAL Risk** | Evidence that food and drink is not a priority which is leading is concerns such as dehydration/malnutrition/significant weight loss etc. which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | No evidence of food in the property or evidence of mouldy and out of date food items which is compromising and impacting on their health and wellbeing and resulting in significant or life threatening harm |  |  |
|  | The individual is not able to use appliances (or no useable appliances) such as fridge, freezer, cooker, microwave, kettle, toaster independently and refuses support which is compromising and impacting on their health and wellbeing and resulting in significant or life threatening harm |  |  |
| Any other risks identified |  |  |  |

| **MAINTANING PERSONAL HYGIENE/BEING APPROPRIATELY CLOTHED** | |  | Rationale for this decision |
| --- | --- | --- | --- |
| **NO identified risk** | Evidence that the person is maintaining their personal hygiene |  |  |
|  | The individual is appropriately clothes for weather. For example, the person is clean, bathed and groomed regularly with clean, weather appropriate clothes |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | Is unable to maintain regular personal hygiene – no identified impact on their health and wellbeing at this time |  |  |
|  | The individual is wearing inappropriate clothing for the weather – no identified impact on their health and wellbeing at this time |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | Is unable to maintain regular personal hygiene which is having a negative impact on their health and wellbeing |  |  |
|  | The individual is wearing inappropriate clothing for the weather which is having a negative impact on their health and wellbeing |  |  |
| Any other risks identified |  |  |  |
| **HIGH/CRITICAL Risk** | Consistently fails to maintain personal hygiene which is compromising and impacting on their health and wellbeing and resulting in significant or life-threating harm |  |  |
|  | Wearing clothes inappropriate for the weather which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
| Any other risks identified |  |  |  |

| **MANAGING TOILETING NEEDS** | |  | Rationale for this decision |
| --- | --- | --- | --- |
| **NO identified risk** | The individual is able to manage and maintain own toileting needs |  |  |
|  | No evidence of skin breakdown |  |  |
|  | No identified risk to people providing support or services |  |  |
|  | Has full access to bath/bathroom |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine – no identified impact on their health and wellbeing at this time |  |  |
|  | Slight evidence of skin breakdown – no identified impact on their health and wellbeing at this time |  |  |
|  | Some identified risk to people providing support or services as a result of individual’s ability to meet toileting needs – no identified impact on their health and wellbeing at this time |  |  |
|  | No usable bath/bathroom – no identified impact on their health and wellbeing at this time |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine which is having a negative impact on their health and wellbeing |  |  |
|  | Evidence of skin breakdown which is having a negative impact on their health and wellbeing |  |  |
|  | Evidence of faecal matter and urine which is having a negative impact on the health and wellbeing of others including people providing support or services |  |  |
|  | No usable bath/bathroom appliances which is having a negative impact on the health and wellbeing of others including people providing support or services |  |  |
| Any other risks identified |  |  |  |
| **HIGH/CRITICL Risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine which is compromising and impacting on their health and wellbeing and resulting in significant or life threatening harm |  |  |
|  | Evidence of skin breakdown which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | Evidence of faecal matter and urine which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
|  | No usable bath/bathroom which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm |  |  |
| Any other risks identified |  |  |  |

| **MAINTAINIGN A HABITABLE HOME** | |  | Rationale for this decision |
| --- | --- | --- | --- |
| **NO identified risk** | Property is well maintained, usable and safe |  |  |
|  | Amenities such as heating, electricity and water are all usable and in fully working order |  |  |
|  | Fully usable kitchen and bathroom, appliances are safe and in working order |  |  |
|  | Organisations with an interest in the property, for example, staff working for utility companies (water, gas and electricity), housing service etc. have full access as required |  |  |
|  | No evidence of infestation such as rats, vermin, flies, maggots etc. |  |  |
|  | Animals in the property are well cared for and are not a concern for the individual |  |  |
| Any other risks identified |  |  |  |
| **LOW Risk** | Some evidence of neglecting household maintenance with no identified impact on health, wellbeing and safety at this time |  |  |
|  | Amenities such as heating, electricity and water may show signs of needing some maintenance or repair, no identified impact on their health and wellbeing at this time |  |  |
|  | Evidence of hoarding (refer to Clutter Image Ratings) |  |  |
|  | Not consistently allowing access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity), housing services etc. with no identified impact on their health and wellbeing at this time |  |  |
|  | Some evidence that animals with the property are not being fully cared for, no identified impact on the individual’s health and wellbeing at this time. (Contact RSPCA for advice) |  |  |
| Any other risks identified |  |  |  |
| **MODERATE Risk** | Evidence of neglecting household maintenance and therefore creating hazards which is having a negative impact on their health and wellbeing |  |  |
|  | Amenities such as heating, electricity and water need maintaining which is having a negative impact on the health and wellbeing of the individual and others including people providing support or services |  |  |
|  | Evidence of hoarding – (refer to Clutter Image Ratings) |  |  |
|  | Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity), housing services etc., which is having a negative impact on their health and wellbeing |  |  |
|  | Some evidence of infestation such as rats, vermin, flies, maggots etc. which is having a negative impact on their health and wellbeing (Contact Environmental Health) |  |  |
|  | Failure to meet an animal’s needs which is having an impact on the individual’s health and wellbeing (Contact RSPCA for advice) |  |  |
| Any other risks identified |  |  |  |
| **HIGH/CRITICAL risk** | No essential amenities which is compromising and impacting on their health |  |  |
|  | Evidence of hoarding which prevents safe use of any amenities within the home – which could compromise and impact on their health and wellbeing and result in significant or life-threatening harm |  |  |
|  | Evidence of the infestation such as rats, vermin, flies, maggots etc. which could compromise and impact on the individual’s health and wellbeing and result in significant or life-threatening harm (Contact Environmental Health) |  |  |
|  | Possible risk of fire which could compromise and impact on the health and wellbeing of the individual or another person visiting the property, (including people providing support or services), and result in significant or life-threatening harm.  Using your organisation’s partnership referral pathway, contact the Fire and Rescue Service or telephone directly and ask for your local district prevention team. They will visit the person to offer support, information and appropriate interventions. |  |  |
|  | Failure to meet an animal’s needs which is compromising and impacting on the individual’s health and wellbeing and result in significant or life-threatening harm (Contact RSPCA for advice) |  |  |
|  | Living areas are not usable due to unsanitary conditions or clutter which is compromising and impacting on the individual’s health and wellbeing and result in significant or life-threatening harm. |  |  |
|  | Neglecting household maintenance to the extent that the property becomes dangerous e.g. unsafe gas, electric, water or structural damage (unsafe floorboards, roof etc.) which is compromising and impacting on the health and wellbeing of the individual or another person visiting the property, (including people providing support to services). The extent of which may result in significant or life-threatening harm. |  |  |
| Any other risks identified |  |  |  |

Risk assessment summary

Please provide a tick in the relevant box below to indicate the highest level of risk recorded √

|  | No indicators higher than LOW risk |
| --- | --- |
|  | No indicators higher than MODERATE risk |
|  | ANY of the indicators are of HIGH risk |
| Decision Making and Rationale | |
| Actions to be taken and by who | |
| Review date (review if any change of circumstances or minimum of 6 months) | |

**APPENDIX 3 - COMPREHENSIVE ASSESSMENT**

* 1. Multi-agency Chronology (history of crisis incidents, previous referrals for support/raising concerns/safeguarding)
  2. A detailed social and medical history (including substance misuse)
  3. Activities of daily living (e.g. ability to use the phone, shopping, food preparation, housekeeping, laundry, mode of transport, responsibility for own medication, ability to manage finances)
  4. Environmental assessment
  5. Cognitive assessment
  6. Mental Capacity and mental health assessments, if appropriate
  7. A description of the self-neglect
  8. A physical examination – undertaken by a nurse or a medical practitioner
  9. A historical perspective of the situation
  10. The adult’s own narrative on their situation and needs
  11. The willingness of the adult to accept support
  12. The views of family members, healthcare professionals and other people in the adult’s network (does an IMCA need to be appointed?)
  13. Risks (including risk to self/others, risk reduction strategies/actions attempted or currently in place, unmanaged risks and serious of risk
  14. The adult’s understanding of the consequences of risks and neglect

Example Questions When Completing the Comprehensive Assessment

The following is a list of questions that could be asked where you are concerned about someone’s safety in their own home and where there may be a risk of self-neglect. Each question may lead to further questions such as finding out when the event occurred and what the outcome was.

1. How do you get in and out of your property, do you feel safe living here?
2. Have you ever had an accident, slipped, tripped up or fallen, how did it happen?
3. How have you made your home safer to prevent this (above) from happening again?
4. How do you move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)
5. How do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested?
6. How do you manage to keep yourself warm? Especially in winter?
7. Do you have an open bar fire or convection heater?
8. When did you last go out in your garden? Do you feel you want to go out there?
9. Are you worried about other people getting in to your garden to try and break-in? Has this ever happened?
10. (if applicable) Are you managing to look after your pets ok? How often do you feed them? Do they got wormed regularly? Do you have problems with their skin/fleas for example? Are you able to take them for walks?
11. Are you worried about mice, rats or foxes, or other pests? Do you leave food out for them?
12. Have you ever seen mice or rats in your home? If so, have they eaten any of your food? Or gotten upstairs and been nesting anywhere?
13. Can you prepare food, cook and wash up in your kitchen?
14. Do you use your fridge? Can I have a look in it? How do you keep things cold in the hot weather?
15. How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Do you have a wash, bath or shower?
16. Can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)
17. Where do you sleep? Are you able to change your bed linen regularly? When did you last change them?
18. What do you do with your dirty washing?
19. How do you keep yourself warm enough at night? Have you got extra coverings to put on your bed if you are cold?
20. Are there any broken windows in your home? Any repairs that need to be done?
21. Have you experienced weight loss recently? How long ago?
22. When did you last see your GP?
23. Do you drink alcohol at home?

The following are questions regarding the imminent risk of fire. If the answer to any of these questions is yes, then this must be reported as a matter of urgency to the fire service and raised urgently through your line management system

1. Has a fire ever started by accident?
2. Do you ever use candles or an open flame to heat or cook on a camping gas or a barbeque inside your home?
3. Do you use your gas cooker to heat your home?
4. Do you smoke at home e.g. in bed?
5. Are there continence products or skin emollients stockpiled in your property (Only a risk in conjunction with any of the previous three questions)

**APPENDIX 4 – ASSESSING DECISIONAL AND EXECUTIVE FUNCTION OF MENTAL CAPACITY**

| **Domains Of Self-Care And Self-Protection** | **Decisional Capacity** | | **Executive Capacity (Verification Of Task Performance)** |
| --- | --- | --- | --- |
| **Appreciation Of Problems** | **Consequential Problem Solving** |
| Personal needs and hygiene: Bathing, dressing, toileting and mobility in home | Has it been difficult, or do you need assistance to wash and dry your body or take a bath/shower? | If you had trouble getting into or out of the bathtub, how could you continue to bathe regularly without falling? | Physical or visual examination of hair, skin and nails with consent. Gait evaluation and screening for balance problems and recent falls. |
| Condition of home environment: Basic repairs/maintenance of living area and avoidance of safety risks | Do you have any trouble getting around your home due to clutter, furniture or other items?  Is it important to make basic repairs to one’s home; do any parts of your home need repairs? | What if you’re heating (or hot water, washing machine, etc.) stopped working; how would you fix the problem? | Third party reports of the home environment or a home safety assessment performed by an occupational therapist, fire service, domiciliary care agency, community health professional or other service. |
| Activities for independent living: Shopping and meal preparation, laundry and cleaning using telephone and transportation | Going to the store is important for buying food and clothing for everyday life. Do you have any problem going to the store regularly? | If you needed to call a friend (a taxi or other service) to take you to the store, how would you do that? | Ask individual to show you how they would use a phone to all a friend or other service to ask for a ride (individual should demonstrate all steps for making a call and getting information). |
| Medical self-care: Medication adherence wound care, and appropriate self-monitoring | Check awareness that people who forget to take their medications may end up having a worse health condition or need to see the doctor more often. Do you have problems remembering to take medications? | Consider if you had to have someone give your medications to you and watch you take them (or not). How would this affect your everyday life? | Ask to see all medication bottles from home, even empty ones.  Health professionals and domiciliary carers can review medication fill and refill dates and pill counts, or request a home medication assessment. |
| Financial affairs and estate: Managing cheque book, paying monthly bills and entering binding contracts | What difficulties do you have paying your monthly bills on time?  Who can assist you with paying your monthly bills or managing your finances | How could asking (cite individual) to help you with paying your bills be better than managing your monthly income and paying your bills yourself? What would happy if things continued as they are?  Are there any reasons why asking (cite individual) to manage your income might not help or might make things worse for you? | Third party reports of bank statements, uncollected debts, or bills. Can formally assess performance with routine financial tasks, such as 1 or 3 item transactions, including calculating change or conducting a payment situation. |

**APPENDIX 5 – PROPOSED AGENDA TEMPLATE (MULTI-AGENCY MEETING - SELF-NEGLECT PROCESS)**

**SELF-NEGLECT**

**MULTI-AGENCY MEETING**

**AGENDA**

Welcome and Introduction

* Apologies
* Roles of agencies/professionals/individuals represented

Details of the Adult at Risk of Self-Neglect

* Confirm whether the adult at risk is aware of the self-neglect procedures in place to manage concerns of self-neglect
* Views (if known) of the adult at risk and the outcomes they are seeking
* Agency involvement (in place/refused)

Self-Neglect and Background History

* Details and any background history of Adult at risk. This may include previous support offered, accepted or declined together with any reasons for refusing services.
* Chronology of previous referrals received.

Details of Mental Capacity

* Decision(s) and associated risks and consequences against which mental capacity (including ‘executive functioning’) has been assessed
* How capacity assessment was carried out, when and by whom
* If mental capacity has been assumed, how has this assumption been reached?
* Any identified concerns
* Is a legal view point required?

Assessment of Risk Indictors

* Agree severity of risks identified

Practical Support and Strategies to Minimise the Risks

* Discussion regarding practical support and strategies to minimise the risks

Agree Actions

* To manage risks and identify triggers for review

Communicating With the Person at Risk

* Agree who is best placed to talk to the adult at risk, empower them to make decisions and to take action

Agree Lead Agency/Lead Worker to Co-Ordinate Ongoing Work

Agree Self-Neglect Action Plan/Crisis Intervention Plan

Review

* Agree timescales for review

**You may want to consult with or invite to a multi-agency meeting:**

* Adult at risk and their representative(s)/advocate(s)
* Fire and Rescue Service
* Ambulance Service
* GP
* Health Colleagues
* Social Services
* District Nurses
* Learning Disability
* Environmental Health
* Housing Provider
* Community Wardens
* Care Agencies
* Community Safety
* Specialists drug/alcohol or clinical input
* Age Concern Community/Voluntary Sector Community Networks
* Legal

**APPENDIX 6 – LEGISLATION**

| **Agency** | **Legal Power And Action** | **Circumstances Requiring Intervention** |
| --- | --- | --- |
| **Unhealthy Homes? Home So Filthy Or Unwholesome Condition As To Be Prejudicial To Health Or Verminous** | | |
| Environmental Health | **Enforcement Notice (s.83-85 PHA 1936)** Notice requires person served to comply. Failure to do so can lead to council carrying out requirements, at own expense; though can recover expenses that were reasonably incurred | Filthy or unwholesome condition of premises (articles requiring cleansing or destruction) Prevention of injury or danger to person served.  (All tenure including Leaseholders/ Freeholders/Empty properties) |
| Environmental Health | **Litter Clearing Notice  (Section 92a Environmental Protection Act 1990)** Environmental Health to make an assessment to see if this option is the most suitable. | Where land open to air is defaced by refuse which is detrimental to the amenity of the locality. An example would be where hoarding has spilled over into a garden area. |
| Housing | **Housing Act 2004** and associated regulations establish the Housing Health and Safety Rating System (HHSRS) as the prescribed means whereby local authorities in England and Wales assess the seriousness of hazards to health and safety arising from deficiencies in the dwelling. | The operating guidance lists 29 potential hazards under four hazard profiles, including hazards which may be classified as either Category 1 or Category 2 Hazards. Action can take the form of an Improvement Notice, Prohibition Notice or Hazard Awareness Notice. |
| Environmental Health | **Prevention of Damage by Pests Act 1949 Section 4**  If an owner or occupier fails to take steps to get rid of an infestation within the time specified by the local authority, the authority may itself undertake the work and recover the expense incurred. | The local authority has a duty to ensure that all land within its area is free from rats and mice. This is used where land is open to air, for example large amounts of rubbish in a garden which may attract pests. |
| **Concerns Over Safety Of Property – Swift Action** | | |
| Fire And Rescue Service | **Powers of Entry Article 27. (1) Of the Regulatory Reform (Fire Safety) Order 2005** Concerns over safety of the property. | If any issues encroach on common areas of a premises believed to come under the Fire Safety Order, by virtue of the Order FRS can act by inspecting the premises |
| Housing | **Building Act 1984, s76**, provides the power to deal with defective premises with ruinous and dilapidated buildings. | Provides the power to deal with defective, ruinous and dilapidated building, premises where speed is important. |
| **Need Access To Adult/Property?** | | |
| Environmental Health | **Power of entry/ Warrant (s.287 Public Health Act 1936)** Gain entry for examination/ execution of necessary work required under Public Health Act Police attendance required for forced entry | Non engagement of person. To gain entry for examination/execution of necessary work (All tenure including Leaseholders/ Freeholders) |
| Environmental Health | **Power of entry/ Warrant (s.239/240 Public Health Act 1936)** Environmental Health Officer to apply to Magistrate. Good reason to force entry will be required (all party evidence gathering) Police attendance required | Non engagement of person/entry previously denied. To survey and examine (All tenure including Leaseholders/ Freeholders) |
| Mental Health Service | **Mental Health Act 1983**  **Section 13 (duty to arrange assessment)**  **Mental Health Act 1983 Section 135(1) (removing individual)** Provides for a police officer to enter a private premises, if need be by force, to search for and, if thought fit, remove a person to a place of safety if certain grounds are met. The police officer must be accompanied by an Approved Mental Health Professional (AMHP) and a doctor. NB. Place of Safety is usually the mental health unit, but can be the Emergency Department of a general hospital, or anywhere willing to act as such. | Evidence must be laid before a magistrate by an AMHP that there is reasonable cause to believe that a person is suffering from mental disorder, and is being   * Ill-treated, or * Neglected, or * Being kept other than under proper control, or * If living alone is unable to care for self, and that the action is a proportionate response to the risks involved. |
| Police | **Power of Entry (s17 (1) (e) of Police and Criminal Evidence Act 1984)** Person inside the property is not responding to outside contact and there is evidence of danger. Power to enter premises without a warrant | Gives power to enter premises without a warrant in order to save life and limb or prevent serious damage to property. |

| **Self-Neglectful Behaviour Causing Nuisance To Others?** | | |
| --- | --- | --- |
| Housing | **Anti-social Behaviour Act 2003** (orders/injunctions)  **Clean Neighbourhoods and Environmental Act 2005** (prosecution) | Powers exist to address self-neglectful behaviour that constitutes severe nuisance and annoyance to others. |
| Housing | **Anti-Social Behaviour, Crime and Policing Act 2014** A civil injunction can be obtained from the County Court if the court is satisfied that the person against whom the injunction is sought has engaged or threatens to engage in anti-social behaviour, or if the court considers it just and convenient to grant the injunction for the purpose of preventing the person from engaging in antisocial behaviour. | Conduct by the tenant which is capable of causing housing-related nuisance or annoyance to any person. “Housing- related” means directly or indirectly relating to the housing management functions of a housing provider or a local authority |
| Housing | **Housing Act 1985, Under Schedule 2, Grounds 2 and 3**  There are grounds to seek possession of a dwelling-house | This deals with seeking possession of the property. If the tenant is guilty of conduct causing or likely to cause a nuisance or annoyance.  If the tenant’s property has deteriorated due to due to waste or neglect. |
| **Animal Welfare At Risk?** | | |
| Animal Welfare Agencies Such As RSPCA/Local Authority e.g. Environmental Health/DEFRA | **Animal Welfare Act 2006 Offences (Improvement notice)** Education for owner a preferred initial step, Improvement notice issued and monitored. If not complied can lead to a fine or imprisonment | Cases of Animal mistreatment/neglect. The Act makes it not only against the law to be cruel to an animal, but that a person must ensure that the welfare needs of the animals are met. See also: http://www.defra.gov.uk/wildlife pets/. |

**APPENDIX 7 – CASE STUDIES**

**Ms Thomas – Assessment for Care and Support**

Ms Thomas lives alone. She has been diagnosed as having a severe compulsive disorder which manifests itself in hoarding. Ms Thomas experiences high levels of anxiety which impacts on her ability to attend to personal care and eat. There are unopened bags of cooked food that Ms Thomas says she has forgotten to eat. Ms Thomas says she is aware of the risk to her health and environment. She says she does not clean her home as it causes her anxiety to move things and throw things away. Ms Thomas gathers all her letters but does not open them. Ms Thomas only goes out to familiar places where there are familiar faces.

The Local Authority received a concern about risk of harm through self-neglect. After checking with mental health services, it was found that Ms Thomas had recently seen a psychiatrist. The psychiatrist was contacted and has a clear view that Ms Thomas has full mental capacity to understand these risks, how her mental disorder affects these risks and to make decisions about her care and support needs.

There is no reason to suspect that Ms Thomas is unable to protect herself from self-neglect, but the Local Authority still has a duty to undertake a needs assessment. The needs assessment was undertaken and Ms Thomas expressed a wish to try to continue to manage her needs herself, as she feels this is the best way for her to cope with her mental health in the longer term. The Local Authority provided information and advice on support services and how to access these. Outcomes were feedback to the psychiatrist who will continue to monitor Mr Thomas’ mental health.

**Mr James – Meets Low Level Threshold**

Mr James is 69 and lives alone in council tenancy. He is known to adult social care and mental health services. He had a mental health care co-ordinator, until he was closed to the service in the last month. He was admitted to hospital following a fall which resulted in injury to his arm. He was reported to be under the influence of alcohol and was reported to be covered in urine and faeces. Mr James discharged himself from hospital. The Police did a welfare call to Mr James and submitted an adult concern to the Local Authority, reporting that he was still in the same condition as when he left hospital and that his home was also dirty and soiled, with lots of empty alcohol bottles and cans.

Helen and Karen from the Adult Social Care visited Mr James, Mr James’ ex-partner Michelle had cleaned the property and put the soiled bedding into the washing machine. Mr James’ bed was very soiled and could not be totally cleaned. Michelle said she had some money to buy a second hand bed, however the community resource was now closed. Michelle was signposted to a new furniture service to buy a bed. Helen also picked up bedding from the Foodbank to have in reserve. Mr James did not want to attend formal services about his alcohol issues as he was too embarrassed and did not feel that there would be other people his age there. He did agree to a referral to a floating support service. It was agreed that the floating support service would see Mr James every Wednesday morning they would look at groups to keep Mr James busy during the day as well as strategies to manage Mr James’ alcohol use. It was agreed that the floating support would update Adults Social Care on Mr James’ progress.

**Mrs Evans – Meets Low Level Threshold**

Mrs Evans is an 89 years woman, with a physical disability, who normally resides with her sister in her owner occupied home. Mrs Evans was referred to the advocacy service by a Community Psychiatric Nurse for advocacy support around writing a formal letter in relation to the clearance of her home. The sisters were placed in emergency accommodation following concerns from emergency services regarding their home environment, after being called to the house when Mrs Evans experienced a fall. This was a situation commonly referred to as ‘extreme hoarding’.

Mrs Evans and her sister had agreed to their home being cleared, but items of furniture had been removed and disposed of without specific consent from Mrs Evans or her sister. In the first instance, their Advocate made enquiries with the local adult social care department and also the furniture removals and Storage Company, to identify missing items. The advocate also supported Mrs Evans to obtain a benefits cheque, following which a regular benefit had been paid to Mrs Evans, to which she had been unaware of her entitlement. The advocate continues to support Mrs Evans at meetings regarding her current placement and her expressed desire to return to her home and in negotiates with Adults Services around work that has been required on Mrs Evans’ home to clear, clean, make safe and upgrade the utilities, fixtures and fittings.

The house was finally ready for Mrs Evans and her sister to return to after a year. Unfortunately, her sister sadly passed away and Mrs Evans decided that she would prefer to remain in residential care (fully funded due to her financial circumstances). The advocate continued to liaises with social worker and health professionals in order to ensure the residential home was suitable for her needs on a permanent basis. Mrs Evans expressed that she had been very grateful for the help she had received negotiating difficult change in her life.

**Steven – Meets Significant Harm Threshold**

Steven is 62 and lives alone in a supported tenancy. He has multiple needs relating to a chest condition, depression, low motivation and obesity. He receives support from a Housing Support Worker to help with shopping and from a Home Care agency to help with domestic tasks and meal preparation.

He was admitted to hospital after he called an ambulance. There has been a signification deterioration in his health, he has developed a leg ulcer and his mobility is reduced. He meets the ambulance outside his property so paramedics do not see the inside of his home. In the hospital he tells the social worker that his home is ‘in a state’ and that he is very embarrassed by it. He agrees that the social worker can visit his home prior to his discharge. The social worker describes the property as ‘uninhabitable’. There was mould on the walls and on curtains which was due to a lack of ventilation. The kitchen and bathroom were filthy and there was a lot of rubbish all over the property, with evidence of vermin droppings. Steven’s bed did not have any sheets on it and was covered in faeces.

The case progressed to safeguarding enquiries, with two strategy meetings being held. However, it was discovered that this had not been escalated to line managers, nor had the deterioration in his health or the condition of his property. As no concerns had been passed onto management, the Home Care agency had undertaken a recent telephone review of Steven’s care which had not highlighted any issues. As a result of the safeguarding adults’ enquiry, the following safeguarding plan was agreed:-

* Front line staff were to report any issues around providing care/support to Steven to their line mangers.
* The Home Care and Housing agencies were to communicate with each other about any issues or changes.
* Adult Social Care carried out an assessment of need and increased his care package to include daily call around personal care.
* The Housing Support Worker (who assisted with shopping) was to encourage Steven to change his shopping habits which was felt to be contributing to his hoarding.
* A referral was made for a wheelchair to assist Steven in getting out and about.
* Emergency funding was sourced to get Steven some new clothes.
* The Home Care workers were to ensure the home was appropriately ventilated at each visit.
* The landlord (with Steven’s permission) undertook a deep clean of the flat. This included replacing all the flooring, furnishings and appliances. Steven’s fire was also subject to a safety check.

At the second strategy meeting, Steven has been home for a number of weeks and it was reported that all actions had been completed and everything was going well. The Housing and Home Care agencies would be responsible for monitoring the need to re-refer the case into safeguarding adults’ procedures. An annual face-to-face review would be carried out by Adult Social Care.

**Robert – Meets Significant Harm Threshold**

A referral is made by the Police for Robert following a recent attendance at his property. The Police were called following concerns from neighbours. Robert is 34 and known to misuse substances. He has a tenancy support worker. No formal mental capacity assessments have been undertaken. However, the Police have found evidence that suggest Robert is misusing substances which Police felt were affecting Robert’s ability to make decisions.

When Police arrived at the property they heard a disturbance from within but Robert refused the Police entry and so forced entry was required. On entering the flat, Police found squalid conditions; numerous flies in the property; there was an old mattress in the middle of the living room floor and numerous empty cans of alcohol and drug paraphernalia. Robert’s bedroom was ankle deep in rubbish and the whole property smelt strongly of waste. This is the fifth safeguarding referral in 9 months outlining similar concerns from a number of different agencies. Every previous concern had progressed to enquiries. The Safeguarding Adult Plans have centred on addressing the fire risk within Robert’s property; attempting to engage Robert in drug and alcohol services; continuing to attempt to engage Robert with his tenancy support worker; and ensuring regular communication between agencies. Due to the frequency of referrals and the fact that the previous safeguarding adults plans do not appear to have resulted in any change in Robert’s circumstances, it is decided that the case needs to progress to a multi-agency strategy meeting.

The Strategy Meeting ensured that all professionals involved with Robert were clear about his current situation and the level of risk. It was agreed that a Mental Capacity Assessment needed to be undertaken in relation to Robert’s ability to make decisions in relation to his accommodation (his tenancy was potentially at risk) and around his care and treatment. The Strategy Meeting discussed what had worked and what had not worked in the past in order to inform a safeguarding adults plan for the future (including contingency arrangements). The GP agreed to make a referral for a review of Robert’s mental health. Legal Services were present at the meeting in order that the potential legal options could be explored.

It was also felt that this case would benefit from progression remaining open to safeguarding in order that an evaluation could be made of how successful the safeguarding adult plan had been. The concerns at this stage did not suggest that Robert was at serious risk of harm but it was acknowledged that there could be the potential for risks to escalate. If this was to be the case there continued to be a lack of engagement with no legal options available, the case would be escalated to senior managers.

**APPENDIX 8 – LINKS AND FURTHER READING**

NICE [NICE | The National Institute for Health and Care Excellence](https://www.nice.org.uk/)

Clutter Image Ratings [Clutter Image Ratings - Hoarding Disorders UK](https://hoardingdisordersuk.org/research-and-resources/clutter-image-ratings/)

1. S126(2) Social Services and Well-being (Wales) Act 2014 [↑](#footnote-ref-1)
2. Gibbons, S., Lauder, W. and Ludwick, R. (2006) Self-Neglect: A Proposed New NANDA Diagnosis. International Journal of Nursing Terminologies and Classifications, 17: 1-18. Doi: 10.1111/j. 1744-618X.2006.00018.x [↑](#footnote-ref-2)
3. <https://www.scie.org.uk/publications/reports/report46.asp> [↑](#footnote-ref-3)
4. <https://www.bailii.org/ew/cases/EWCOP/2015/60.html> [↑](#footnote-ref-4)
5. Chapter 3, Social Services and Well-being (Wales) Act 2014 [↑](#footnote-ref-5)
6. S4 Mental Capacity Act 2005 [↑](#footnote-ref-6)