Camden Safeguarding Adults Partnership Board

Safeguarding Adults Review Sidney[1]

Author: **Eliot Smith, Independent Reviewer**
Date: **May 2025**

[1] The names in this report have been pseudonymised. Sidney was a pseudonym selected for this case by the family members of the subject of the review.

CONTENTS

INTRODUCTION

One of the statutory functions of a Local Safeguarding Adults Board is to arrange Safeguarding Adults Reviews 'when an adult in its area dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual', and other cases involving adults with care and support needs where this will help "to promote effective learning and improvement action to prevent future deaths or serious harm occurring again" [1].

The Safeguarding Adults Board should weigh up the type of review process that will achieve the aim of effective systems learning. In 2023 the Camden Safeguarding Adults Partnership Board considered that Sidney's case met the mandatory criteria for Safeguarding Adults Reviews under section 44 Care Act 2014. The aim of the Safeguarding Adults Review is to use and bring together perspectives and experiences of individuals involved in the case to produce evidence-based findings and recommendations which would be applicable across the local system and lead to change and improved outcomes for other cases.

The case of Sidney, a 52-year-old white British man who was a resident of the London Borough of Camden, was referred to Camden Safeguarding Adults Partnership Board by Adult Social Care on 17 May 2023. On 24 January 2023, Sidney had been admitted to hospital after family visited him at his at home to find him in a very neglected state. Sidney died in hospital two days later. The cause of death was confirmed to be "Organ failure main cause with septic shock and pneumonia as contributory factors." Sidney's case did not go to Coroner's Inquest. Camden Safeguarding Adults Partnership Board determined that Sidney's case meets the criteria for a mandatory Safeguarding Adults Review under section 44 Care Act 2014 due to concerns about how agencies worked together to safeguarding Sidney from self-neglect.

Background to the case

Sidney had multiple health and social care needs arising from mental health and substance misuse issues, chronic obstructive pulmonary disease (COPD), and mobility problems. There were also concerns about self-neglect. Following an admission to hospital, Sidney was referred to a step-down reablement placement, to support him to regain independent living skills and, in part to address the neglect of his home environment and carry out cleaning and long-standing repairs on his property. January 2023 he was again admitted to hospital. At this time, his home environment was in a severely neglected condition with reports of missing locks to the front door, urine and faeces-stained sofa, no electricity, gas supply, or heating and presence of vermin. Sidney himself had lost weight and was malnourished, he was admitted in an unhygienic and neglected state, and suffering from pressure sores, and sepsis.

About the Reviewer

This Safeguarding Adults Review has been led by an Eliot Smith, an Independent Health and Social Care Consultant who has no previous involvement with this case, or prior connection to the Camden Safeguarding Adults Partnership Board, or partner agencies. Eliot Smith is an Independent Health and Social Care Consultant with experience as a Social Worker and strategic leader in Local Authority and NHS Services. Eliot has practice experience across child and adult care groups and has conducted over twenty Safeguarding Adults Reviews as training and consultancy services. Eliot is trained in quantitative and qualitative research methods with interests in Safeguarding Adult Review methodologies.

Organisational involvement

Organisations and practitioners who had a role in safeguarding and promoting the wellbeing of Sidney were invited to contribute to the review in the spirit of a continuous learning and improvement. Practitioners involved in the case were invited to a Practitioner Learning Event on 10 July 2024 to "contribute their perspectives without fear of being blamed for actions they took in good faith" [1]. The following organisations contributed to this review by providing chronologies and additional information:

- Adult Social Care (Local Authority)
- Housing Services (Local Authority)
- GP Practice
- Crisis Team (Mental Health)
- Acute Hospital
- Ambulance Service
- Reablement Care Agency
- Domiciliary Care Agency

Family involvement

Sidney's family members were invited to contribute their views on Sidney's experience of care and support in Camden. They were consulted on the Safeguarding Adults Review's terms of reference, offered the opportunity to share information about their experiences, views and opinions, and were offered the opportunity to comment on the review findings and final report. A letter written by the family for this Review can be found at the conclusion of this report.

Parallel processes

The purpose of a Safeguarding Adults Review (SAR) is "not to hold any organisation or individual to account" [1]. In the case of Sidney where concerns were identified about practice, they have been referred to the relevant agency and the appropriate processes have been put in place. This allows the Safeguarding Adults Review to remain focused on generating systems findings of interest to organisations in Camden who have a role in safeguarding vulnerable adults from abuse and neglect, including self-neglect.

Methodology and limitations

The review methodology is based upon systems learning theory and evaluates evidence from a range of sources including but not limited to:

- Organisational chronologies of events
- Assessments
- Case summaries
- Practitioner learning event
- Sidney's family were also invited to contribute their views and experiences.

The Review benefited from the input of members of the SAR Sub-Group who met as a panel during the review process to add expertise, review the report for factual accuracy and local relevance of the findings. The Safeguarding Adults Review considered the period from 1 May 2022 to 26 January 2023, which included an admission to hospital, the commencement of input from Adult Social Care, Sidney's discharge from hospital and admission to the reablement placement, and then a period back at home leading up to his death in January 2023.

Contextual information outside of this timeframe was sought in order to make sense of decisions-made during the period under review. This included relevant information about Sidney's experience of mental health services: Sidney had been known to mental health services from May 2008 to July 2018.

Analysis

The Review used research techniques and qualitative data analysis (QDA) software to organise, structure and segment data to produce learning themes, to analyse different types of data and evidence, and to produce findings that are evidence-based in terms of the experience of Sidney, previous Safeguarding Adults Reviews in Camden, learning from national SAR Reviews on self-neglect, and a literature search of current research and best practice. Following initial scoping the circumstances of the case lent themselves to an analysis of three time-periods in Sidney's life and episodes of care:

- Historical context and pre-review period: Sidney had been well-known to services in Camden, having received treatment of mental illness over a number of years in the context of co-existing alcohol dependency and concerns about self-neglect and independence in activities of daily living.
- Admission for reablement: In June 2022, Sidney was referred to Adult Social Care, and after a hospital admission in September 2022 he was admitted to a reablement placement while issues with his accommodation were addressed. Sidney's reablement admission was considered to be a stable time for him, and effective in meeting his needs.
- Post-reablement support: Following discharge from the reablement placement Sidney was largely unsupported and his health deteriorated until his admission to hospital in January 2023.

Specific terms of reference

Terms of reference for Safeguarding Adults Reviews are agreed by Safeguarding Adults Boards for any review they commission. Terms of reference provide clarity from the outset about what questions the Safeguarding Adults Review is going to address. Specific terms of reference can provide structure to the collection, organisation, and management of evidence gathered for the review. Using the key practice episode framework, the Safeguarding Adults Review considers a number of practice themes on which the case of Sidney can shed light. The specific terms of reference for this Safeguarding Adults Review to address included the following:

1. Management of co-existing conditions: How effectively do health and social care services in Camden manage the complexity of co-existing conditions, including mental health, alcohol dependency, and physical health conditions?
2. Multi-agency and partnership working: How do agencies work together to support individuals with care and support needs, vulnerabilities, and risks across different care environments and settings? This includes informal multi-agency arrangements and formal partnerships, for example under section 75 (National Health Service Act 2006).
3. Decision Making in the context of self-neglect: How effective are safeguarding arrangements in Camden at addressing concerns and risks of self-neglect? How do agencies use legal mechanisms for intervention, and balance vital and public interest against personal autonomy and self-determination? This will include specific consideration of the provisions of mental health and mental capacity legislation.

CASE REPRESENTATIONS

Thematic analysis

The Word Cloud in figure 2 was created using content analysis and shows how often key themes in the case of Sidney appeared in documentary evidence and during practitioner and family discussions.

Figure 1: Word Cloud showing key themes in the case

Practice context

The Safeguarding Adult Review concentrates on a relatively short time-period in Sidney's life in the context of what was known about his health and social care needs between 2009 and 2018, when he was supported by the Mental Health Rehab and Recovery Service. Sidney had long-standing health conditions including a respiratory condition, reduced mobility, an acquired brain injury, bi-polar affective disorder, depression and anxiety. His health condition was exacerbated and complicated by alcohol dependence and the experience of frequent falls and seizures. In July 2018, Sidney was discharged from mental health services following a 'lack of engagement' but with the view that his bi-polar affective disorder was well-controlled by medication and 'in remission'.

It was in this context that in June 2022 Sidney was admitted to hospital and treated for a fall, worsening of his chronic obstructive pulmonary disease (COPD), anxiety, suicidal ideation, and auditory hallucinations. He was seen by the mental health liaison team and specialist alcohol team. He was found not to be suffering from mental illness, and when he was ready for discharge, he was referred and to a reablement placement, in September 2022.

Figure 2 describes the practice context of the case of Sidney in the three key periods identified: the historical context, admission for reablement, and post-reablement support.

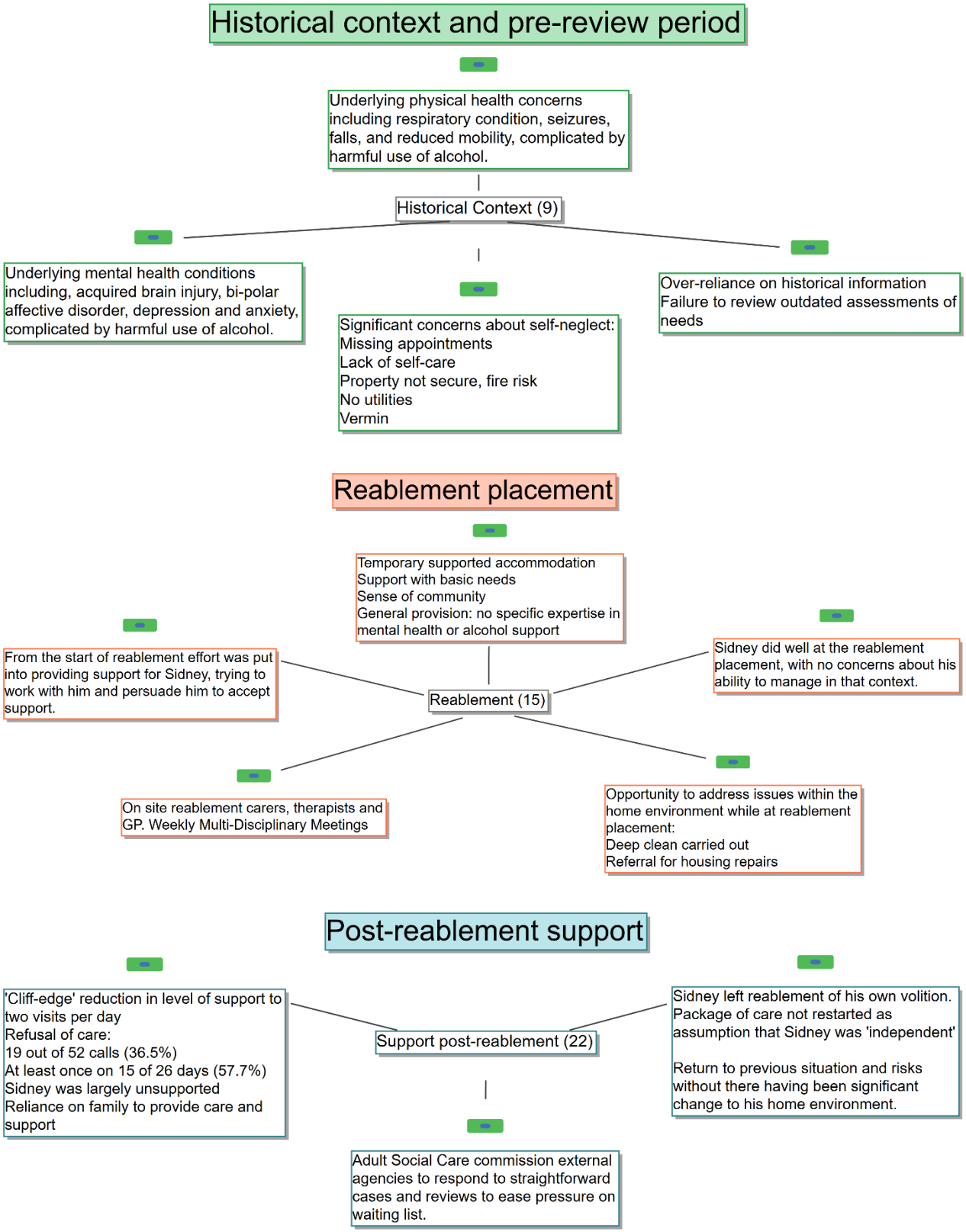

Figure 2: Sidney: Practice Context (2009 – 2022)

FINDINGS

This section takes events and examples of practice in the case of Sidney and considers them in the context of the wider system. The aim of findings in Safeguarding Adults Reviews is to enable "lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again" [1]. Previous Safeguarding Adults Reviews and their recommendations were reviewed as part of the analytical process and were helpful in providing a historical context to practice in self-neglect. The historical findings on self-neglect related to previous systems and differed from the findings in the case of Sidney.

This section applies theoretical frameworks to practice in order to generate findings that can be applied to the safeguarding adults' system. Findings are structured against the specific questions in the terms of reference, and additional learning that is relevant to the local system.

TOR 1: Management of co-existing conditions

How effectively do health and social care services in Camden manage the complexity of co-existing conditions, including mental health, alcohol dependency, and physical health conditions?

This finding explores how the health and social care system responded to Sidney's needs in the context of 'co-existing conditions', formerly termed as dual diagnosis. Sidney had established diagnoses including mental illness and alcohol dependency, that had a combined adverse effect on his health and his ability to look after himself and his environment.

Background

The most recent survey of mental health in the UK found that 1 in 6 people had experienced symptoms of a common mental health problem, and that the prevalence of mental health conditions in the UK has been increasing since 1993 [2]. Of those, 2% of the population experience a lifetime prevalence on bipolar disorder which effects 1.3 million, or 1 in 50 people.

Alcohol is a part of many of our lives. We use it for celebration, for comfort, to socialise, to wind down, to cope. It's legal, socially acceptable, even encouraged [3]; it has been described as 'the UK's favourite coping mechanism', and many of us do drink to try and help manage stress, anxiety, depression or other mental health problems [4].

The combined effect of mental illness and alcohol dependency can have serious impacts. A 2019 report 'Learning from Tragedies' on learning from alcohol-related Safeguarding Adults Reviews found that:

> *"Most of the adults featured in these reviews had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, [and] unfit living conditions... In almost all cases, support services failed to cope with that complexity"* [5].

A key issue for practitioners is that clients with complex needs, at high risk of serious harm or death, and with fluctuating capacity due to alcohol misuse, are often resistant to, or don't engage with, services [5].

Learning

Sidney had established diagnosis of bi-polar disorder, a serious and long-term condition which is usually characterised by episodic depressed and elated moods, and increased activity (hypomania or mania) [6]. Bi-polar disorder is often associated with self-neglect, exhaustion, and dehydration, and alcohol and substance misuse. During his admission to hospital in September 2022, Sidney reported feeling a "pressure" in his head which triggered drinking. Sidney reported experiencing auditory hallucinations of celebrities. He also presented with the early signs of alcohol neurotoxicity[2].

Vicious cycle

During the learning event, practitioners reflected on the strong correlation between Sidney's experience of mental illness, alcohol intoxication, falls, and self-neglect. Sidney's home environment and living conditions[3] had an impact on his mood and mental health, and worry. Use of alcohol exacerbated his anxiety, physical health, and ability to manage his environment. Sidney experienced a vicious cycle of self-neglect, poor mental health and use of alcohol. As with many chronic behavioural cycles it is not always possible or meaningful to identify a starting point or trigger, or a 'primary issue' to which to attribute the remaining difficulties. A holistic response is needed to address the cycle as a whole, in order to achieve long-term and sustained change.

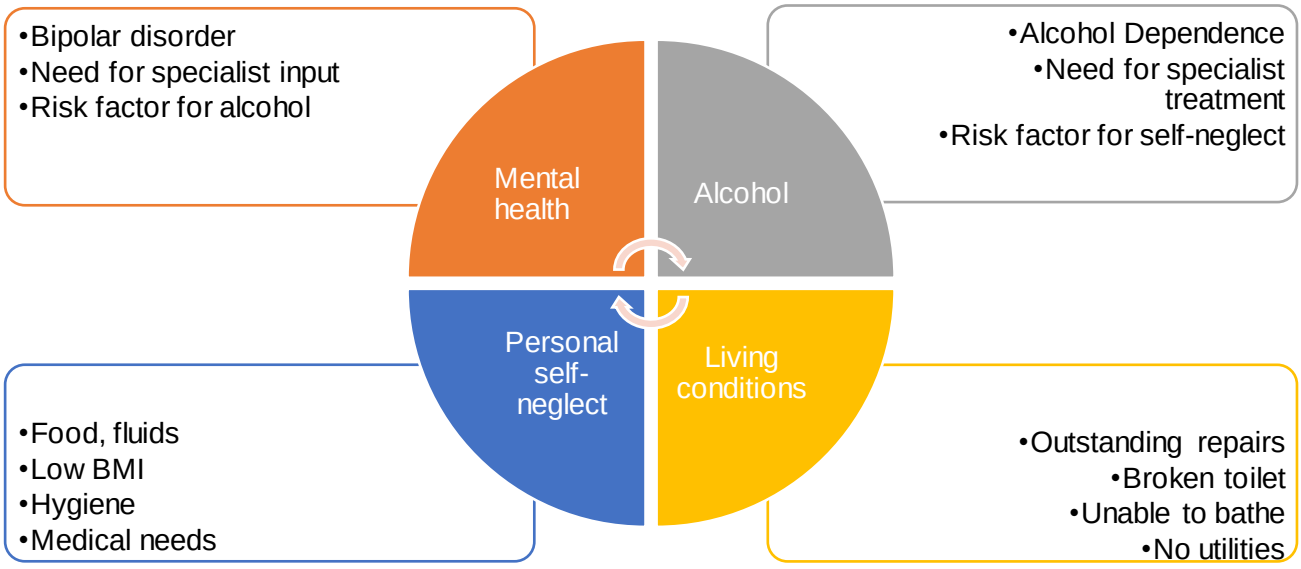

Figure 3: Sidney experienced a vicious cycle of self-neglect, poor mental health and use of alcohol

Sidney was admitted to a reablement placement, in part, due to concerns about self-neglect and his living conditions as a result of alcohol use, mental health difficulties, and an inability to care for his health, hygiene, and physical health problems.

A five week supported reablement placement, from 23 September to 28 October 2022,provided Sidney with a degree of improvement; his living environment was significantly better, on-site

[2] Alcohol can have a toxic effect on a person's brain leading to neurological problems, neuropathic symptoms, and ultimately Alcohol-Related Brain Damage (ARBD)

[3] Long-standing housing issues included no heating or toilet, also impacting on ability to attend to personal hygiene.

support helped him to care for himself, his mental health improved, and his alcohol use decreased. The Learning from Tragedies Report considered how professionals viewed the issue of alcohol. In many cases, the misperceptions of these vulnerable adults by local services and practitioners may have contributed to a failure to fully grasp the role alcohol was playing in the situation [7]. In the case of Sidney there was also a failure to understand the role played by underlying mental health problems and his living conditions. The limited response to specific issues, such as a deep clean and limited repairs to his home, failed to address the whole cycle or underlying vulnerabilities and coping mechanisms, such as anxiety, depression, and patterns of alcohol use.

Finding 1: Co-existing conditions and their outcomes

Context

In the case of Sidney there was a clear correlation between his experience of mental illness, alcohol intoxication, falls, and self-neglect. Sidney experienced a vicious cycle of self-neglect, poor mental health and use of alcohol. Due to assumptions made about his progress and ability, the role of mental illness, alcohol use, and living conditions was not grasped or fully understood. Agencies failed to make the most of the opportunity provided by his reablement placement to address underlying vulnerabilities of mental health and alcohol dependence, poor living conditions, support for daily living skills, and social isolation.

Rationale

Mental health and alcohol problems are often linked and exacerbate each other and are both known to contributory factors in experiences of self-neglect. A full assessment of need should include not only presenting needs and underlying factors but should also be explicit about the setting in which needs and risks arise. Actions should have addressed underlying mental health or alcohol needs or self-neglect behaviours in addition to addressing practical concerns.

Recommendation

This could be achieved through:

- Developing guidance or a protocol for multi-agency assessments
- Providing training and raising awareness of staff on the multiplier effect of mental health and alcohol use on self-neglect
- Providing specialist mental health and alcohol / substance misuse input and advice to support reablement placements

Impact and measurement

The impact of this recommendation could be measured through a case sample to determine how many individuals with co-existing conditions and self-neglect have received a contextual assessment during admissions to temporary placements.

TOR 2: Multi-Agency and partnership working

How do agencies work together to support individuals with care and support needs, vulnerabilities, and risks across different care environments and settings?

This finding considers multi-agency and partnership working in its different forms and addresses the partnership and multi-agency arrangements in Camden.

Background

Health and care services are increasingly being delivered in more joined up and integrated ways. This delivers care for patients and service users in a more efficient and effective way [8]. Partnerships in health and social care can take a variety of forms from integrated care and formal partnership arrangements to case-based teams and ad hoc arrangements.

Structural integration

The two main models of integrated care involve structural and virtual integration. Structural integration requires that different organisations either be merged or have some sort of formal partnership or joint-venture arrangement. Virtual integration requires only that the organisations work closely together [9]. An example of structural integration in Camden includes the section 75 agreement (NHS Act 2006) which formalises integrated Mental Health Services, allowing the Mental Health NHS Trust to provide NHS and Local Authority services in an integrated Community Mental Health Team. Between 2009 and 2018 Sidney received mental health support from a Community Mental Health Team. At the time this was through an integrated NHS and Local Authority service by virtue of a section 75 agreement (NHS Act 2006). The Community Mental Health Team offered health services and treatment of his bipolar disorder and local authority social care.

Virtual integration

Virtual integration can be seen in multidisciplinary teams (MDTs), ‘groups of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings’ [8]. Multidisciplinary teams tend to keep to a regular schedule of meetings and may discuss multiple cases. Virtual integration is the most common model of multiagency working for individuals with complex needs who need the support of multiple agencies or professionals. The benefits of integrated care include improved outcomes for patients through high-quality care from well-trained local teams in relation to reductions in hospital admissions, delayed discharges, and reduced wait for social care assessment and interventions [9].

During Sidney’s stay at the reablement placement he was supported by a multidisciplinary team who met weekly, to monitor and review progress and make decisions about health and care. The multidisciplinary team usually includes medical professionals, staff from the reablement service, and is often regularly attended by mental health services and Adult Social Care. Allocated workers from existing health and social care services are able to share information, knowledge, and consistency to the multidisciplinary team.

Case-based arrangements
Case-based arrangements are when groups of professionals come together as an ad hoc team around a specific case. Professionals meetings and safeguarding arrangements fall under this category. Case-based multi-agency working also includes joint-work between professionals, for example joint visits, joint assessments, communication and information-sharing. Prior to his admission to the reablement placement, Sidney was supported at home through a package of care. Unlike during placement, the majority of individuals in the community are not supported by a package of care but by each agency working separately, but with the ability to maintain ad-hoc or regular communication with each other through correspondence, telephone communication, or joint-visits.

Partnership and multi-agency working
Integrated care can support effective partnership and multi-agency working. Partnership is one of the statutory principles underlying safeguarding practice [1]. Partnership in safeguarding means working with local communities to prevent, detect, and report abuse and neglect, including self-neglect. It is about how personal and sensitive information should be treated in confidence, sharing only what is helpful and necessary, and about professionals working together, and with individuals, to get the best result for the adult at risk [1]. There are three key components of effective partnership working in the context of safeguarding: information sharing, professionals working together, and professionals working with the adult, and their family where appropriate.

Learning

Information sharing
Information sharing is a recurring theme in Safeguarding Adult Review recommendations about inter-agency working[10]. The London Multi-Agency Safeguarding Policy & Procedures [11] provide some guidance for practitioners and organisations on information sharing, but this tends to focus on duties and obligations to share safeguarding information and the lawful basis for information sharing. There is less emphasis on *how* to share information or good practice. A National Analysis of Safeguarding Adult Reviews considered good practice, noting that effective information-sharing was more likely when practitioners made use of multi-layered communication channels, using *"both formal and informal processes, such as meetings, and informal approaches to collaboration in which practised relationships play an important part"* [10].

Examples of failings in information-sharing often related to individual poor practice – a failure to follow an established process, gaps in information or incomplete sharing of key data, or situations where information was known but not understood by the practitioner. Failures in information-sharing can result in the over- or under-sharing of an individual's confidential, sensitive, and personal data. In 2015 HM Government issued guidance on information sharing to reduce the likelihood of such failures, this guidance was most recently updated in May 2024 and states that information sharing should be only that which is "necessary, proportionate for the intended purpose, relevant, adequate, and accurate[4]" [12].

In the case of Sidney, information-sharing, rather than being 'multi-layered' appeared to be rushed and inadequate, with too much reliance on third-party or out-of-date sources.

[4] Nb. The HM Government Advice document is not statutory guidance.

Attendance at multidisciplinary team meetings was poor and commissioned services and providers often received only limited information about Sidney's current needs and the way his conditions affected him; often only his diagnoses and summary of assessed needs was shared. Experiences of physical and mental illness, and dependence disorders are often highly subjective and contextual to the individual. Sharing only that a person has bipolar disorder, or an alcohol dependence can lead to assumptions being made about a person based upon those labels. The addition of risk information about self-neglect paints a portrait of an individual lacking in depth and accuracy. As a result, service users and family members may have to repeatedly tell their story to update others on their needs and experiences.

Finding 2.1: The importance of effective information-sharing

Context

Effective information-sharing is more likely when practitioners make use of multi-layered communication channels. Government guidance states that information sharing should be only that which is "necessary, proportionate for the intended purpose, relevant, adequate, and accurate" [12]. In the case of Sidney, information-sharing, rather than being 'multi-layered' appeared to be rushed and inadequate, with too much reliance on third-party or out-of-date sources. Attendance at multidisciplinary team meetings was poor and commissioned services and providers often received only limited information about Sidney, risking assumptions being made based upon labels of mental illness, alcohol dependence, and self-neglect.

Rationale

A commitment to good information sharing using multi-layered communication channels, can help professionals to work more effectively with service users, to build engagement and rapport, and to avoid assumptions about a person based upon their behaviours or medical diagnoses. Interactive communication can also enable a discussion of risk and opportunity for joint assessments. Practitioners working in health and social care, especially in a safeguarding context, could benefit from guidance, not only on the lawful basis of information sharing and consent, but on good practice and effective information sharing.

Recommendation and a question to the Safeguarding Adults Partnership Board

Recommendation: The Safeguarding Adults Partnership Board should consider publishing good practice guidance on effective information sharing.

A question: should the pan-London Multi-Agency Safeguarding Policy & Procedures be revised with a greater emphasis on *how* to share information effectively, given the findings of the National SAR Analysis?

Impact and measurement

If accepted, a measure of this recommendation could include confirmation of publication of guidance for practitioners, and a practitioner sample – are practitioners aware of guidance on information sharing? Measures should focus on what information is shared as well as how.

Working together and with family

The case of Sidney identified learning about how agencies worked together and how they worked with family. Despite the existence of a Multidisciplinary Team process in the reablement placement, and Sidney's presentation to and engagement with health and social care services, agencies failed to make the most of this opportunity to work together in an effective way. While it would also be usual for practitioners to attend the multidisciplinary team on a weekly basis when they had a service user there, in the case of Sidney his social worker visited on one occasion during his month-long stay. Organisations were happy to give and receive feedback and information however often appeared to receive information at face value, failing to look deeper into the situation, or relied on others to take action including Sidney's GP or family.

The case of Sidney evidenced a need for better joint working between the adult social care and NHS functions of mental health services. For example, an opportunity for effective communication was missed in June 2022 after a mental health assessment identified significant concerns of self-neglect and risk appropriate for a referral to Adult Social Care under safeguarding. Rather than making a referral directly – allowing for a conversation and exploration of the issues, the safeguarding referral was 'actioned' to Sidney's GP who was asked to make the referral on their behalf.

Decisions about working with individuals and their family are often made in the context of assessment – gathering information, in the context of risk – engaging family members in main-carer or primary-carer roles, or as protective factors. Practitioners provided examples of good practice used in Camden such as the Family Group Conferencing model: independently facilitated meetings where the adult and their family make plans and decisions. Traditionally used in Child Safeguarding, they are also available for use in the adult sector. Sidney's home environment and were therefore seen as protective factors – 'supportive family members who had helped him go home from the reablement placement and who would alert services if any support was needed'. Yet this had not been checked out fully with them; their role as a 'safety-net' was not openly discussed and agreed (only assumed), no formal plan was put in place about what should be done should Sidney began to deteriorate, family members had not been provided with sufficient information to act in this capacity. They were also not offered a carer's assessment which should have been considered under section 10 Care Act 2014.

Sidney's positive experience of the reablement environment and his ability to complete daily living tasks in this context was taken as a demonstration of his ability to be independent and that he could manage without support, as at that time he was sober – despite concerns held by reablement staff and family members about his ability to sustain these improvements in his own home, especially without adequate input and support from paid carers. Instead, there was a view that Sidney's family members would be able to step-in and support his return to community living, or alert services should he be unable to manage alone.

While there may have been specific practice issues identified by organisations in this area, what became apparent through the review process was that there had developed a culture of reliance on others; on Sidney to maintain his independence without the support he had previously received, or benefited from during his reablement placement, on other professionals to share information and make referrals, and on family members to address concerns within his home environment, support his discharge, and to raise the alarm if he were not able to manage without support.

Finding 2.2: Working together and with the adult and family

Context
It became apparent through the review process that there had developed a culture of reliance on others; reliance on Sidney to maintain his independence (and mental health and sobriety) without the support he had previously received, or that he had benefited from during his reablement placement, on other professionals to share information and make referrals, and on family members to address concerns within his home environment, support his discharge, and to raise the alarm if he were not able to manage without support.

Rationale
Working in genuine partnership with individuals and their families to agree health and social care support plans is good practice. Where individuals have supportive family members who may be able to play a role in the care and support of the adult at risk, there should be a meaningful offer of partnership and collaboration. This entails open communication with individuals and families about the role family members may play, in line with the safeguarding principle of accountability.

Recommendation
Producing a guide to working with families may make it easier for practitioners across agencies to feel more confident at including families in care and treatment planning processes[5]. This should include advice on care planning, managing confidentiality and information-sharing, carers rights, and the support available from statutory and non-statutory services. Carers groups and networks should be included in the drafting of any guidance.

Impact and measurement
The impact of practitioner guidance could be measured through feedback from practitioners, carers groups and family members.

[5] Or equivalent core processes

TOR 3: Decision-making in the context of self-neglect

How effective are safeguarding arrangements in Camden at addressing concerns and risks of self-neglect? How do agencies use legal mechanisms for intervention, and balance vital and public interest against personal autonomy and self-determination?

Background

Care and Support Guidance defines self-neglect as encompassing "a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding" [1]. There has been a significant amount of research into self-neglect, adding to the statutory description of self-neglect three recognisable forms of self-neglect. Camden's Multi-Agency Self-Neglect Toolkit [13] summarises these as follows:

a) **lack of self-care** – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing; and/or

b) **lack of care of one's environment** – squalor and hoarding; and/or

c) **refusal of services that would mitigate risk of harm**

Research into self-neglect on the causes and risk factors for self-neglect often focuses on health-related or underlying medical causes connected to an individual's own capabilities, illnesses, and mental health. Commonly cited causes include, but are not limited to:

- Dementia
- Brain injury
- Mental disorder
- Learning disability
- Obsessive Compulsive Disorder
- Physical illness, reduced energy levels, attention, or organisational skills and motivation
- Physical health and frailty brought on by old age
- Reduced motivation as a side effect of medication
- Addictions, including alcohol, illicit substances, gambling
- Social isolation
- Extreme poverty and lack of financial resources, food insecurity, or as a result of influence or abuse by others.
- Traumatic life-change, such as a loss of a carer or loved one [14, 15].

A Safeguarding Adults Review in Cumbria has noted that while "there are many reasons that individuals make unwise choices or decisions… people rarely choose to neglect themselves, such that self-neglect is the consequence, not the decision" [16]. Robust assessments of mental capacity are therefore vital in cases of self-neglect where an individual has an impairment or disturbance in the function of mind or brain. In the context of addictions and the symptoms of alcohol use, it is important that professionals pay particular attention to the likelihood of fluctuating mental capacity correlated to the use of drugs or alcohol. A longitudinal approach and consideration of mental capacity over time and in different settings will be an important safeguard for individual's whose mental capacity may fluctuate.

Learning

Sidney experienced a vicious cycle: mental health, alcohol, self-neglect. From 2019, Sidney began to apologise to visiting professionals about the state of his flat. At that time his toilet had stopped working, he had no heating, and he had been unable to care for his personal hygiene. Due to his anxiety, he had difficulty letting people into his flat. Three years later, his house was in total disrepair and problems with his bathroom and heating had not been resolved. Sidney himself presented as frail and underweight. Neighbourhood housing officers had attempted to visit but had not been able to gain access to effect repairs. Sidney's family reported continued and serious self-neglect: that Sidney was in a 'very unhygienic and distressed state', that his sofa was soaked in urine and faeces, he had lost weight, had missing locks on his front door, no electricity or gas, no heating, and mice in his flat.

A number of risk factors were present including underlying mental health problems, physical health limitations, alcohol dependence, loss, and social isolation. Throughout the chronological period of the review, a number of agencies identified and recorded a risk of self-neglect. This included a **lack of self-care** and **lack of care of one's environment**.

Agencies made referrals directly to Adult Social Care or did so via his GP. His Neighbourhood Housing Officer visited on numerous occasions and also attempted to pass on concerns to Adult Social Care. A lot was made of Sidney's alcohol use as the main cause of his difficulties however this does not take into account the complex role alcohol plays and the interconnectedness of other vulnerabilities – Sidney's risk of self-neglect had proven to be chronic and long-standing, even during periods of reduced drinking and sobriety. Some of the outstanding repairs needed to his home dated back over three years. Over this time there were few attempts to support Sidney to access mental health services or alcohol treatment, or to fully analyse and address underlying contributory factors to the cycle of self-neglect.

"Independence"
According to Qureshi [17], the term independence is used in current policy documents as though it were unproblematic, where in fact a confusion exists between independence as autonomy, and independence as self-sufficiency. Independence as autonomy means that through the exercise of autonomous decision-making, an individual may still experience independence even when they require care and support from others to complete tasks. The emphasis is on the right to receive support to achieve participation in ordinary life, rather than self-sufficiency [17].

Improvements in Sidney's ability to complete daily care tasks during his reablement placement were viewed simplistically. The feedback that Sidney was independent in daily care tasks (albeit in a supported environment with staff supporting his autonomy) was viewed simply as an ability to be self-sufficient. Likewise, he was assumed to have mental capacity to be able to make decisions without due consideration to the likelihood of fluctuating mental capacity or the impact of increased use of alcohol. Taking this at face value, services formed a belief in Sidney's self-sufficiency, and he returned home without support. The failure to fully consider fluctuating mental capacity and decision-making ability was compounded by a failure to consider the historical context, the long-standing and chronic nature of his self-neglect, complex role mental health and alcohol played in his life, and the contextual nature of behaviours of self-neglect. This failure to dig deeper, and failure to act represents a failure in professional curiosity.
Professional curiosity

Curiosity, n. **1** a strong desire to know or learn something. **2** An unusual or interesting object [18]

Professional curiosity, n. "the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value" [19, 20]

Professional curiosity is a term which has been used often in Safeguarding Children Serious Case Reviews and Child Practice Reviews, and increasingly in Safeguarding Adults Reviews. It is often used to describe the situation where evidence or signs of abuse or self-neglect have been missed, or where explanations have been accepted that rely on evidence taken at face value – that are simplistic, or which turn out to be false. Identifying failures in professional curiosity often requires a degree of hindsight, and combined with the focus on individual professional practice, it is important that the concept of professional curiosity is used to encourage rather than to judge. Research has shown that, rather than negligence, a lack of professional curiosity can often describe a situation where there are barriers to professionals taking action [20].

Barriers to action	Description
Accumulating risk	Professionals deal with risk and incidents in isolation, rather than viewing the increase or repeating risk in cumulation.
Confirmation bias	Professionals look for evidence that supports their preconceived or existing ideas and views. Any new information is interpreted in a way that supports the existing viewpoint.
Rule of optimism	Rationalising new or escalating risks, even though there may be evidence to the contrary.
Disguised compliance	Individuals, including family members may give the appearance of engaging with professionals to reduce or deter involvement.
Knowing but not knowing	Professionals sense that something is not right, but not knowing exactly what. Can be difficult to take action.
Uncertainty	Unsubstantiated claims, retracted disclosures, contested accounts and inconclusive evidence. All common and temptation can be to discount concerns where there is no substantial proof.
Managing tension	Disagreement, defensiveness disruption and aggression can deter professionals from getting to the real issues.

Table 1: Professional Curiosity: Barriers to action, adapted from Cumbria Safeguarding Adults Board resources: a joint learning session on professional curiosity [21]

Nurturing professional curiosity means cultivating a strong desire to find out about what is happening in an individual's life and taking action when evidence of abuse or neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.

Finding 3.1: Nurturing professional curiosity

Context
Professional curiosity is "the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value". In the case of Sidney professionals were quick to take an optimistic view of his ability to be self-sufficient, and once this view had formed a tendency to confirmation bias. In assessing the risk of self-neglect, professionals failed to consider the historical context, the long-standing and chronic nature of his self-neglect, the complex role mental health and alcohol played in his life, and the contextual nature of behaviours of self-neglect. The failure to act on the evidence of chronic and long-standing risks of self-neglect represents a failure in professional curiosity.

Rationale
Nurturing professional curiosity means cultivating a strong desire to find out about what is happening in an individual's life and taking action when evidence of abuse or neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.

Recommendation
Nurturing a culture of professional curiosity which should form a theme throughout organisations' safeguarding training, and reflective supervision offers.

Impact and measurement
This recommendation could be measured through an audit of training and supervision materials.

Safeguarding: a mainstream or specialist task?
"Safeguarding is everybody's business" is a common principle that seeks to remind professionals across the health and social care system that they have a role to play in safeguarding adults from harm, abuse, and neglect – including self-neglect. With a statutory backing through the Care Act 2014 and associated Guidance, safeguarding is also often seen as the process or separate task, even as an 'add-on' rather than an integral part of day-to-day practice. The interpretation of the role that practitioners play also varies across profession and organisation. For many practitioners outside of Adult Social Care the safeguarding role is often viewed as that of informant, alerter, or referrer, identifying abuse and sharing concerns with the Local Authority: agencies seemed to interpret the principle as 'safeguarding is everybody's business. but the Local Authority's responsibility'.

There were occasions where agencies took little further action once concerns had been shared, and others where the task of sharing concerns itself was actioned to another agency. The separateness of safeguarding can also be seen in how safeguarding concerns were managed once received by the local Authority. Safeguarding and care management were treated as separate workflows. Once a Social Worker is allocated a case under the safeguarding workflow, they will not necessarily review the individual's assessment of need if an existing care management process is in place. For Sidney there was a need to review how effective (or not)

care management interventions were addressing risks of financial abuse and exploitation[6] and self-neglect. In Sidney's case the Social Worker considered the risks of financial abuse and exploitation and self-neglect but did not review or consider his care.

Finding 3.2: Safeguarding is everybody's business *and* responsibility

Context
Most organisations now accept that "safeguarding is everybody's business", that everyone has a role to play. Risk management is an integral part of daily practice in most organisations across the health and social care system, yet safeguarding is often seen as the process or a separate task. In the case of Sidney safeguarding was actioned to others or managed within its own separate workflow.

Rationale
Responding to risks of abuse and neglect, including self-neglect often requires multi-agency cooperation, strategy and planning meetings, and specific protective actions from the moment that concerns are identified. Safeguarding activity should not be seen as the single agency responsibility of Adult Social Care, nor as a separate to care management and regular treatment, but as an integral part of professional activity. 'Safeguarding is not simply what you do, but why you do it'.

Recommendation – a question to the Safeguarding Adults Partnership Board
- How can the Safeguarding Adults Partnership Board influence the culture of safeguarding in Camden to ensure that safeguarding is an integral part of practice?

[6] The Safeguarding concerns reported to Adult Social Care included an allegation of financial exploitation by someone in his neighbourhood to whom he had given his bank card.

CONCLUSION

The case of Sidney illustrates the importance of taking time to fully understand the context in which people self-neglect.

Sidney had experienced long-standing issues of mental health and alcohol misuse, which combined with his domestic environment led to chronic self-neglect. Following an admission to hospital and a reablement placement, health and social care agencies were given an opportunity to intervene in the cycle of self-neglect, use of alcohol, poor mental health and physical deterioration that had led to his admission in the first place.

While it is sadly the case that many individuals are unable to break out of these cycles (even with significant care and support), in the case of Sidney agencies failed to grasp the impact of his underlying health conditions, and the role his home environment played on his sobriety and ability to care for himself. Sidney was sent home without a package of care and support after agencies failed to assess his abilities in context and foresee the risks of Sidney returning to previous patterns of living.

Eliot Smith
February 2025

A LETTER FROM SIDNEY'S FAMILY

"The Death of My Uncle, [Sidney]

My uncle was an amazing intelligent and kind man, that loved poetry and music. In his earlier years before his mental health deteriorated he ran a community youth football team and he also raised money for a child that needed a guide dog.
Despite his issues he remained polite and considerate of others. He always worried about others and never wanted to be a burden on anyone.

He was loved by everyone that ever met him.

He was deserving of the dignity and care that should have been guaranteed to him. It was duty of all services involved to ensure his well-being, particularly after he returned to his home. However, it is clear that this duty of care was not fulfilled by any of those involved. After his return, there was no follow-up or continued checks on his health and welfare, which he desperately needed. I cannot help but feel that if proper checks had been carried out, he might still be alive today.

I am writing to express my profound distress and disappointment regarding the lack of care that my uncle, [Sidney], received in the time leading up to his passing. I firmly believe that the lack of appropriate and consistent care contributed to his untimely death, and I cannot accept that he is no longer with us, when he should be.

The responsibility to ensure his safety and provide the necessary care was entrusted to the services, yet that responsibility was not upheld. I feel that a lot of the people who worked with my uncle failed him, and that failure ultimately led to the undignified loss of his life. This is something I cannot simply accept or move on from.

I appreciate this thorough review as to why this lapse in care occurred, and how something like this will be prevented from happening to others. The circumstances surrounding the loss of our uncle is an unbearable tragedy for our family. We believe it is vital to address the failings that contributed to his death

Yours sincerely…"

SUMMARY OF RECOMMENDATIONS

No.	Finding	Rationale	Recommendation / questions	Impact and measurement
1.	Co-existing conditions and their outcomes	Mental health and alcohol problems are often linked and exacerbate each other and are both known to contributory factors in experiences of self-neglect. A full assessment of need should include not only presenting needs and underlying factors but should also be explicit about the setting in which needs and risks arise. Actions should have addressed underlying mental health or alcohol needs or self-neglect behaviours in addition to addressing practical concerns.	Developing guidance or a protocol for multi-agency assessments Providing training and raising awareness of staff on the multiplier effect of mental health and alcohol use on self-neglect Providing specialist mental health and alcohol / substance misuse support to reablement placements	• Multi-agency case sampling • Number of contextual assessments completed
2.1	The importance of effective information-sharing	Mental health and alcohol problems are often linked and exacerbate each other and are both known to contributory factors in experiences of self-neglect. A full, contextual assessment of need incudes not only an assessment of need and underlying factors but is explicit about the context in which needs and risks arise. Actions should address underlying mental health or alcohol needs in addition to addressing practical concerns.	**Recommendation:** The Safeguarding Adults Partnership Board should consider publishing good practice guidance on effective information sharing. **A question:** Should the pan-London Multi-Agency Safeguarding Policy & Procedures be revised with a greater emphasis on how to share information effectively, given the findings of the National SAR Analysis?	• Direct evidence • Multi-agency practitioner survey
2.2	Working together and with the adult and family	Working in genuine partnership with individuals and their families to agree health	Producing a guide to working with families may make it easier for practitioners across agencies to feel more confident at	• Direct evidence • Multi-agency practitioner survey

No.	Finding	Rationale	Recommendation / questions	Impact and measurement
		and social care support plans is good practice.	including families in care and treatment planning processes[7]	
3.1	Nurturing professional curiosity	Nurturing professional curiosity means cultivating a strong desire to find out about what is happening in an individual's life and taking action when evidence of abuse or neglect is found. Practitioners need good support, training, and reflective supervision to overcome the barriers to professional curiosity, which often reflect human nature, and organisational culture and practice.	Nurturing a culture of professional curiosity which should form a theme throughout organisations' safeguarding training, and reflective supervision offers.	Audit of training and supervision materials
3.2	Safeguarding is everybody's business *and* responsibility	Safeguarding activity should not be seen as an add-on to core practice, but as an integral part of professional activity. 'Safeguarding is not what you do, but why you do it'.	How can the Safeguarding Adults Partnership Board influence the culture of safeguarding in Camden to ensure that safeguarding is an integral part of practice, rather than an add-on?	

[7] Or equivalent core processes

REFERENCES

1. DHSC, *Care and Support Statutory Guidance (updated 18 February 2025)*. 2025, TSO: London.
2. McManus, S., et al., *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. A survey carried out for NHS Digital by NatCen Social Research and the Department of Health Sciences, University of Leicester.* 2016.
3. Alcohol Change, U., *The alcohol change report*. 2018: Alcohol Change UK.
4. Cornah, D., *Cheers? Understanding the relationship between alcohol and mental health.* Mental Health Foundation, 2006.
5. Alcohol Change, U., *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017.* Alcohol Change UK, London, 2019.
6. NICE. *Clinical Knowledge Summaries; Bipolar Disorder*. 2024.
7. UK, A.C., *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017.* Alcohol Change UK, London, 2019.
8. England, N., *Guidance on Information sharing in Multidisciplinary Teams (MDTs)*. 2022.
9. Grant, J., *What does it take to make integrated care work?* McKinsey Quarterly, 2010.
10. Preston-Shoot, M., *On (not) learning from self-neglect safeguarding adult reviews.* The Journal of Adult Protection, 2021. **23**(4): p. 206-224.
11. Board, L.S.A., *London Multi-Agency Safeguarding Policy & Procedures*. 2019.
12. Government, H., *Information Sharing, Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers*. 2024, HM Government London.
13. Board, C.S.A.P., *Multi-Agency Self-Neglect Toolkit*. 2020.
14. SCIE, *Self-neglect at a glance*. 2018, Social Care Institute for Excellence: London.
15. Abumaria, I.M., *Self-neglect: Causes and Risk Factors*. 2020.
16. Halliwell, A., *Safeguarding Adults Review 'Miss B' Overview Report*. 2022.
17. Vernon, A. and H. Qureshi, *Community care and independence: self-sufficiency or empowerment?* Critical Social Policy, 2000. **20**(2): p. 255-276.
18. OED, *Oxford English Dictionary*. 6th ed. 2006, Oxford: Oxford University Press.
19. CSAB, CSPC, and SaferCumbria, *Professional Curiosity Guidance (Version 3)*. 2022.
20. Phillips, J., et al., *Lifting the lid on Pandora's box: Putting professional curiosity into practice.* Criminology & Criminal Justice, 2024. **24**(2): p. 321-338.
21. CSAB, CSPC, and SaferCumbria, *Professional Curiosity learning session*. 2023: Youtube.