Serious case review findings on the challenges of self-neglect: indicators for good practice

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Introduction

In England self-neglect has historically been excluded from statutory guidance on adult safeguarding, which focused exclusively on third party involvement in abuse and neglect (DH, 2000). The Care Act 2014 does not disturb that position but increasingly Local Safeguarding Adults Boards (LSABs) are nonetheless developing policies and procedures for self-neglect, drawing on an emerging evidence-base of effective practice (Braye et al., 2011; 2014). Statutory guidance to the Care Act 2014 may yet comment on the interface between self-neglect and adult safeguarding.

Whether addressed through adult safeguarding structures or adult social care, self-neglect commonly poses complex challenges to the agencies and practitioners involved. When an individual dies or suffers serious harm as a result of self-neglect, the LSAB may commission a serious case review (SCR) to identify what can be learnt but hitherto they have not been obliged to do so, or to publish the outcome. The Care Act 2014, which reforms adult social care and adult safeguarding law in England and Wales, now places a duty on LSABs (henceforth constituted on a statutory basis) to carry out and publish safeguarding adult reviews where serious abuse or neglect has contributed to the death or serious harm of an individual, and where there is reasonable cause for concern about how professionals and agencies have worked together. LSABs will also have a power to undertake reviews in other circumstances, such as self-neglect, the purpose throughout being to learn lessons and improve future practice.

Despite the valuable lessons for local practice that emerge from individual reviews, no analysis of the consolidated findings from SCRs in cases of self-neglect had been conducted, prior to the present study. The researchers analysed 40 SCRs that described situations of self-neglect. A previous paper (Braye et al, forthcoming) considered the type of self-neglect involved and the key characteristics of each case and SCR. It then reviewed the 32 reports that were either published or available to the authors, focusing on the frequency of, and themes within, different types of recommendations. Four domains of analysis were used, namely the adult and their household/family, the team around the adult, the organisations around the team and the LSAB around the organisations. The present paper extends this analysis and reports in detail on the content of the 32 self-neglect SCR reports, using the same four domains, to identify the professional and interagency challenges involved, and to extract learning that can be applied in developing notions of good self-neglect practice.

SCRs and accountability

Alongside retrieval of 40 SCRs from LSAB websites and personal contacts, searches of the Local Government Ombudsman website identified three self-neglect cases, none of which appear to have prompted an SCR (LGO, 2008; LGO, 2011; PHSO, 2011). Coroner Court statistics revealed 45 cases of neglect and/or self-neglect considered in 2011 and a further 32 in 2012. Some have been reported in the media (for example, Harding, 2010; Anon, 2011) but not all prompted an SCR. Some of the 40 SCRs, however, do refer to a parallel Coroner's Court investigation, but not all SCR cases involving a death were referred to the Coroner.

Arguably, some kind of review is necessary in cases of death from self-neglect to comply with positive obligations in Articles 2 and 3, European Convention of Human Rights. Such scrutiny should be prompt, independent and, where possible, involve family members, with

the aim of accounting for the circumstances of the case (Flynn et al., 2011; Preston-Shoot, 2014). The diverse routes to possible review of self-neglect cases may appear somewhat confusing. Indeed, some SCRs in the present study commented that better dialogue was required between the Coroner's Office and adult safeguarding services regarding cases that may need reviewing, and stronger links between Serious Untoward Incident investigations in health settings and the SCR process. Although mandates vary between the Coroner (to establish cause of death), the Ombudsman (to investigate complaints) and SCR (to learn lessons), further consideration appears necessary of how these different forms of inquiry should interface and, in relation to self-neglect cases, what criteria should govern whether an LSAB commissions an SCR or some other kind of review. Finally, the possibility of multiple forms of inquiry, conducted under different mandates and with different purposes, might deter practitioners and managers from offering case and contextual details for the purposes of learning and strengthening the evidence-base for good practice.

The adult safeguarding literature on SCRs is not extensive and detailed examination of their standards has been rare, although Scourfield (2010) provides one example. What has led LSABs to commission SCRs or other types of inquiry has not always been clear. Nor does the literature shed light on how the twin imperatives have been managed between holding practitioners and agencies accountable for their actions and inactions, and wanting to maximise learning for practice development and organisational development. However, there have been thematic analyses where learning disability (Manthorpe and Martineau, 2013) and housing issues (Parry, 2013) have been central.

Methods

Full details of the approach taken to retrieve and analyse the SCRs are provided in the companion paper (Braye et al, forthcoming). Table One reproduces key details of the 32 SCRs that form the focus of the present paper, which, as part of the overall sample of 40, were obtained through a systematic internet search of all English local authority and LSAB web pages (n = 152) and through personal contacts with LSAB Independent Chairs and Business Managers. Since SCRs currently do not have to be published, it is impossible to know what proportion of reviews into self-neglect cases has been captured by this sample. However, this sample does contain SCRs not captured in surveys by Manthorpe and Martineau (2011; 2013), Clay (2013) and Parry (2013).

Table One: SCR sample

Case	LSAB	Document details	Recommendations	Circumstances
1	Dudley (2010)	Executive summary, 7 pages	None but 16 key issues for an action plan	Died outdoors after requested hospital discharge
2	Dudley (2010)	Final Report, 12 pages	7	Died at home
3	Nottinghamshire (2010)	Executive summary, 19 pages	17	Died in hospital
4	Sheffield (2010)	Executive summary, 14 pages	9 with a further 7 sub-elements	Died at home
5	Cornwall (2007)	Executive summary, 9	11	Died in hospital

		pages		
6	Cornwall (2009)	Executive summary and action plan, 19 pages	4 with a further 8 sub-elements	Died at home
7	Surrey (no date)	Executive summary, 16 pages	19	Lived alone with family visits. Died in a house fire
8	Southampton (2012)	Executive summary, 14 pages	9	In Supported Living with some family contact. Died at home
9	Birmingham (2010)	Executive summary and action plan, 10 pages	9	Lived at home with family. Died in hospital
10	Birmingham (2012)	Executive summary, 15 pages	13	Died in a Care and Nursing home. Had family contact
11	Warwickshire (2010)	Serious Case Review, 63 pages	26, some with multiple elements, 6 broader and 3 national issues	Own tenancy with support. Murdered
12	Worcestershire (2010)	Executive summary, 8 pages	8	Own home but also lived with his mother. Died at home
13	Bath and North East Somerset (2011)	Summary report, 8 pages	6	Nursing home. Died of bowel complications
14	Gloucestershire (2012)	Executive summary, 12 pages	15	Lived alone with contact with son. Died in a house fire
15	Torbay (2011)	Executive summary, 11 pages	11 with 17 sub-elements	Some contact with mother. Died of liver failure
16	North Yorkshire (2012)	Executive summary, 22 pages	13	Died in a hotel room, having lived rough
17	Westminster (2011)	Executive summary, 49 pages	11	Lived with his wife. Died in hospital
18	Kent and Medway (2003)	Executive summary, 5 pages	12 with 11 action plan points for agencies	Lived with parents. Died in hospital
19	Kent and Medway (2013)	Executive summary, 8 pages	9	Died in hospital
20	Bournemouth (2010)	Executive summary, 8 pages	20	Murdered by her son-in-law

21	Dorset (2012)	Executive summary, 7 pages; 51 page overview report	11	Lived with husband. Died in care home of stroke
22	A Council (2011a)	Not published, 10 pages	13	Shared tenancy. Died at home
23	A Council (2011b)	Not published, 19 pages	18 key findings, 6 conclusions and 30 single or multi-agency recommendations	Admitted to hospital and then care home; health and well-being improved
24	Sheffield (2008)	Not published, 13 pages	4, with 12 sub-elements	Lived with son. Died of chronic obstructive pulmonary disease
25	B Council (2013)	Not published, Case review report, 8 pages	11	Died in hospital of burns from fire at home
26	Leeds (2009)	Executive summary, 15 pages	14	Died in a house fire
27	Northamptonshire (2010)	Executive summary, 13 pages	8	Married couple. Died at home
28	North Tyneside (2011)	Final report, 26 pages	8	Lived with her brother. Died in hospital
29	Lambeth (2012)	Executive summary, 14 pages	9	Died sleeping rough
30	C Council (2010)	Not published, SCR overview report, 54 pages	23	Lived with her disabled son. Died in hospital
31	C Council (2012)	Not published, Multi-agency review, 11 pages	None but 3 areas for consideration	Died in hospital
32	Slough (2013)	Executive summary, 9 pages	12	Died at home

The following research questions were identified:

1. What was the nature of the self-neglect cases reviewed through SCR processes?
2. What themes emerged from the SCRs and how do these add to understanding about professional intervention in cases of self-neglect?
3. How many and what kind of recommendations on self-neglect were made by SCRs and to which agencies were they addressed?

The 32 available SCRs were read independently by two researchers to develop an index of key themes, which were then applied to classify the content of the reviews. All the SCR data were then grouped by theme into the domain matrix, allowing all material coming under each theme to be considered together. The domain matrix recognises the multiple layers within complex cases, namely individual histories and chronologies; service commissioning and provision; organisational issues such as supervision and communication between agencies, and national policy and legislation. The matrix, therefore, shines some light on the context within which decisions are made – organisational, legal and ethical.

The reports were heavily oriented towards describing what took place rather than seeking to explain or appraise events (see also Flynn et al., 2011). This suggests that the methodology for analysing cases is still developing and faces similar challenges in seeking to account for outcomes to those in children's safeguarding. Greater case complexity does not necessarily result in a higher number of recommendations.

In the findings that follow, references to specific reports have not been used because not all SCRs have been published.

Findings

The themes emerging from the cross-case analysis are reported under the four domain headings and summarised in Table Two, with the focus placed on themes that were apparent in a significant proportion of the reports.

Table Two: Domain matrix

Domain	Themes (and the number of SCRs in which they appeared)
A. The practice interface with the individual adult (and their family/carer context)	Person-centred approaches to intervention (19)
	Assessment of mental capacity (14)
	Consideration of the individual's household, family and carers (19)
	Securing or maintaining engagement (15)
	History and patterns of behaviour (14)
B. The professional team around the adult	Interagency communication and collaboration (22)
	Information-sharing (14)
	Assessment, care planning, monitoring and review processes (19)
	Recording of information (10)
	Safeguarding literacy (21)
	Legal literacy (11)
C. The organisations around the professional team	Supervision and management (17)
	Organisational culture (5)
	Staffing (5)
	Organisational policies (6)
D. Interagency governance exercised through the LSAB	The process and function of SCRs (20)
	Monitoring and action planning (18)
	Interagency procedures and guidance (23)
	Training (19)

Domain A: The practice interface with the individual adult (and their family/carer context)

A dominant theme here was whether interventions had taken a **person-centred approach**, noting a failure to 'see the person'. Examples included cases where:

- the individual's views were not sought directly, nor was he engaged in discussion of the impact of his wishes on his treatment and prognosis; instead, assessment of his physical and mental health needs was based on information provided by his mother;
- a safeguarding strategy meeting had focused only on the individual within the context of his couple relationship, resulting in his individual needs and anxieties being masked by his partner's needs;
- agencies struggled to work with an individual's wife and carer, who was perceived as obstructing care, and lost any real focus on the individual himself almost disappeared; the possibility that she was complying with his wishes was not addressed;
- professional networks became excessively preoccupied with the search for a diagnosis that could explain the individual's vulnerability, or made assumptions about impairment that led to symptoms or behaviour change being discounted;
- the individual was seen merely as the sum of their problem behaviours.

Refusal of services, even in circumstances of evident and mounting risk, was taken at face value. Respecting an individual's wishes can of course denote person-centred practice, but several SCRs indicated that taking a person-centred perspective on decisions to decline services would, instead, have meant fuller exploration, over time, of those decisions with the individual involved. Several reports commented on:

- practice that lacked a person centred focus, noting little attempt to establish a relationship of trust and cooperation that could have facilitated greater acceptance of support;
- lack of insight into family background and no evidence of work by professionals to explore the motivation and understanding behind decisions to decline services;
- acceptance of refusals of service, leaving professionals working reactively to each crisis rather than proactively engaging with repeated refusals of support;
- failure to monitor changing needs in order to be ready to respond when the individual did recognise the need for help;
- missed opportunities to work with what the individual *was* prepared to engage about, commenting that attention to those perceived important issues might have facilitated a more positive relationship.

Essentially, an emphasis on relationship-building and trust through which on-going assessment could have been achieved became lost in the drive to find tangible solutions and services.

Mental capacity was another dominant theme, commonly failure to assess and record capacity appropriately, relying instead on assumptions, and (where capacity had been assessed) failure to re-assess as circumstances changed. In one case a psychiatrist assessed a person's capacity through interviews with the individual's mother, while he was sleeping, forming the view that he did have capacity to refuse hospital admission. Paradoxically, there was evidence too of professionals accepting that his mother was acting in his best interests, implying a view that he lacked capacity. A later capacity assessment resulted in a best interests intervention to amputate both his legs as treatment for gangrene.

Several reviews commented on lack of reference to legislation where it might be expected, raising concerns that the Mental Capacity Act was not being used as a framework (and therefore that insufficient attention was being paid to the possibility of best interests interventions). One report for example emphasised the need for professionals to understand

the limits of the family's decision-making role and to fulfil their own responsibilities to act in best interests. Similarly there were concerns that the principle of presumption of capacity to refuse services was being followed without question, with no evidence of support to understand information relevant to choices being made, or no re-examination of capacity even where rapid deterioration (in the case of body weight, for example) indicated it may have changed. Such omissions were seen as contributing to failure to intervene to mitigate risk, one SCR concluding that risky and self-neglectful behaviour *per se* engages a need explicitly to assess capacity. A number recommended guidance for when adults have capacity but place themselves at significant risk.

A further common theme was the attention paid to an **individual's household, family and carers**. SCRs pointed to both over and under involvement with carers. Carers' perspectives sometimes replaced seeking the wishes of the individual and deflected attention from what they may themselves have wanted, resulting in paralysis of action plans to address heightened risk.

In contrast, insufficient attention might be paid to engagement with family members, resulting in lack of knowledge about who was living with the individual, what the relationship with them was, how the family functioned, and what use was being made of direct payments. A number of SCRs noted the absence of a carer's assessment, or at least any evidence that such an assessment had in fact been offered, even in circumstances where the carer was struggling to cope. Occasionally there was little knowledge of systems that could support carers, or offers of re-assessments were not made despite considerable changes over time. Elsewhere, dilemmas about confidentiality meant that family or community members were not approached about management of risk or dangers arising from disconnection of utilities. Potentially concerning behaviour by members of the individual's network was not always followed up. Carers were not challenged and family dynamics not explored, despite concerns that individuals were being manipulated and intimidated, leading one SCR to comment that agencies effectively abandoned the individual to his family.

Difficulties of securing or maintaining engagement were a common theme. These could arise because the individual remained resistant to contact; for example one SCR warned against assuming that being '*hard to engage*', in the sense of declining services, was indicative of informed choice being exercised; it '*may be an alert that something is wrong which requires assessment and intervention*'. But commonly the SCRs commented on opportunities were lost through services' lack of responsiveness, for example where cases were closed while risk remained high, or long periods passed without visits being made, or missed medical appointments were not followed up. Consistency of approach was compromised by changes of worker with each re-referral, and by decisions on eligibility that were not based on re-assessment of needs. A reputation for being 'hard to engage' could prompt case closure and refusal to reassess. SCRs were critical here, noting that such cases should not be closed without assessment of risk and capacity, and exploration of reasons for non-engagement, through which possible alternatives could emerge. A number mentioned the importance of considering the role of **advocacy services** where engagement is hard to establish.

In some circumstances there was insufficient **attention to history**. SCRs reported incidents being treated in isolation rather than in the context of an unfolding pattern of behaviour; alternatively, presentations to different agencies were treated separately. Four cases exemplified how professionals did not have sufficient historical understanding:

- insufficient knowledge of the family and its dynamics led to misunderstanding of the potential for self-neglect;
- professionals missed the significance of references in past records that would have given insight into the individual's history (e.g., difficulties of engagement, negative experiences with statutory services, the relationship between expressed beliefs and cultural identity) and therefore into the reasons for his decisions;
- no concerted attempts were made to secure a biographical perspective or to use such a perspective to guide best interests decisions;
- insufficient exploration took place of the long-term impact of reclusive family behaviour, and the death of her mother, on an individual's ability to care for herself and her surroundings.

A final theme in the domain of the practice interface with the individual was highlighted in a small number of reports that drew attention to the **interface between children's and adult services**. They noted the need to share information on family patterns and support needs, or on transition planning, to allow for more rounded assessments of individuals' vulnerabilities and chronologies, and to facilitate a more personalised approach to their support.

Domain B: The professional team around the adult

Challenges of **interagency communication and collaboration** dominated here. Several SCRs noted the absence of overall ownership of any collaborative strategy. Practitioners operated in isolation within their own roles, failing to coordinate services even in circumstances where a case conference would have been warranted or where financial abuse required investigation. The absence of shared understanding, collaborative working or full multidisciplinary assessment meant that not all the risks in an individual's situation could be identified or addressed holistically, and it was unclear what key risks were, or who should take responsibility for issues such as capacity assessment. Professionals were confused about where responsibility lay between or even within agencies, and struggled to coordinate who would do what and when. The more agencies that became involved, the more marked was the failure to join up their efforts. Individual agency decisions, sometimes to limit interventions or responses, were taken in isolation. As one SCR notes, "*no single agency or individual was directly responsible for what happened to 'X', but rather no statutory single agency that had contact with 'X' took responsibility for taking preventative and protective action*".

Specific examples noted include:
- shared multi-agency assessments were absent, and processes for including a comprehensive range of agencies in discussion and shared decision-making were missing;
- individual agencies worked separately (and often well) on their own aspects of the situation, assuming other concerns would be addressed by someone else, or perhaps referring perceived problems onto adult social care but failing to follow this up;
- agencies failed to respond, for example to missed appointments, or did not sufficiently acknowledge the concerns expressed by others; in one example a decision that the individual referred did not have a diagnosis that made them eligible, and that they had capacity to choose their lifestyle, influenced other agencies in their own involvement;
- joint working or liaison was missing, or complex partnerships, for example between health, social work, mental health and learning disability services, and between children's and adult services, broke down;

misunderstanding about the roles and functions of other agencies led to critical referrals not being made;
- constructive challenge between agencies was lacking.

A linked concern was **information-sharing**, for instance the absence of formalised mechanisms through which professionals could share information in a timely and consistent way, or flag concern visibly to others, or construct a chronology that would connect isolated incidents and thus build a picture that might warrant intervention. In one case information was not effectively shared even between different parts of the same agency. In another, agencies often did not have access to information known to others; information-sharing appeared ad hoc rather than systematic. Other SCRs commented that sharing accurate information could have led to better coordination and joint working, or that its absence led to a significant sense of fragmentation.

Assessment, care planning, monitoring and review processes were in many cases found to be flawed. At the point of assessment:
- poor quality assessments meant that professional input lacked direction and purpose;
- it was not clear whether and how mental health and mental capacity legislation had been considered;
- no analysis of what might be causing particular behaviour was recorded;
- risk assessments were not routinely or systematically undertaken, some risks were clearly missed; nor did they appear to underpin decision-making;
- risk assessments were inconsistent, varying between practitioners;
- a longitudinal view was lacking; each assessment reacted to presenting issues rather than contributing to an emerging picture over time;

A frequently expressed concern was that assessments focused on establishing eligibility rather than a holistic understanding. Services were sometimes over-concerned with diagnosis as the threshold for access to services, particularly where an individual had a history of multiple and conflicting diagnoses. In one case the lack of relevant diagnosis and the misapplication of eligibility criteria, despite evidence of prior critical need, had ruled out an assessment and militated against the individual receiving timely and effective social care support. In another, while the individual did not meet criteria for safeguarding, an assessment if undertaken by either health or social services could have led to appropriate help being offered.

In relation to intervention:
- actions and timescales did not reflect levels of concern; for example, known risk of abuse did not result in a plan for protection;
- not all risks were formally acknowledged or followed up;
- immediate support needs were attended to at the expense of managing on-going risk patterns;
- contingency plans that had been agreed for escalating risks were not implemented when the situation deteriorated;
- when one potential legal remedy failed, other possible intervention routes were not revisited;
- formal reviews were rare.

Some reports commented on the approach taken by staff. One individual was admitted to a care home in a condition that evidenced inadequate prior professional care. Another report expressed concern at a lack of assertiveness and challenge in the face of service refusal, but

noted also that workers were not trained in ways of doing this. The tension between safety and choice in one case presented staff with a challenge that led to paralysis rather than to a search for the right balance to be struck. Another SCR commented that practice was too heavily weighted towards the right to choose rather than the duty of care. A related concern was a perceived failure to engage actively with the individual regarding lifestyle choices that were deemed risky.

The **recording of information** also drew comment. Missing or inadequate records, or divergent accounts of discussions between professionals, made it difficult to see patterns or escalation of risk or to account for practice. There were cases in which communications from other agencies were not placed on file. Written records did not routinely evidence what concerns were expressed, what help was offered and accepted or declined by the individual, what referrals were made and later followed-up, or what information was shared with others and what decisions taken. Records made reference to capacity assessment but did not consistently indicate whether an individual was deemed capable of making valid and informed decisions; records relating to best interests were sometimes contradictory, and did not evidence Mental Capacity Act compliance. The IT system in two cases did not allow flagging of adults who were vulnerable or involved in safeguarding.

The extent to which professionals showed **safeguarding literacy** was questioned. Many situations of self-neglect also showed abuse or neglect by a third party, yet safeguarding alerts were not triggered, with staff appearing unclear about when and how to report. Different professionals lacked awareness and/or understanding of safeguarding guidance and procedures, including those on the investigation of financial abuse, and the importance of taking adult protection concerns into account on hospital discharge. In one case when the individual denied that she was being exploited, agencies' recognition of her right to choose to put herself at risk resulted in failure to explore with her the impact of her vulnerability. Circumstances where safeguarding alerts had not been made but were deemed warranted included situations of addiction and dependency, accumulation of concerns over impoverished and squalid conditions, inadequate care and serious neglect and poor self-care, diet and medication with multiple indications of abuse where incidents were treated in isolation by the police.

Implementation of safeguarding procedures was also criticised. Safeguarding was seen as the responsibility of adult social care, other agencies sometimes showing insufficient understanding of their contribution to on-going measures. Intervention could be insufficiently well coordinated, as when both ambulance service and police did not ensure the safety of an older woman who was confused and disorientated following a domestic violence incident, with no urgent follow up by adult social care of possible financial abuse. In other cases, the needs of one vulnerable individual causing harm to another were not sufficiently taken into account.

Legal literacy was also questioned, with concerns expressed about varying and confused levels of understanding about:
• rules on information sharing;
• options for intervention, both with and without consent;
• failure to recognise the need for timely legal advice;
• mental capacity legislation and procedures, and the interface between the Mental Capacity Act 2005 and the Mental Health Act 1983;
• the need for assessment under both housing and community care legislation before judgements about eligibility for services;

- duties and powers towards carers (and in one case misunderstanding of carer's role in consenting to treatment on behalf of an individual);
- the status of statutory guidance.

Domain C: The organisations around the professional team

Supervision and management emerged as a significant theme, and were seen as serving two key functions - ***staff support*** and ***managerial case oversight***. There were situations in which staff felt isolated, particularly out of hours, and in high-risk situations without the support or authority to manage them effectively. In another case, frontline workers experienced difficulty deciding whether a case reached the adult safeguarding threshold, and needed support both to recognise the role that other agencies might play and to secure their involvement. In other cases, line managers and safeguarding leads did not recognise risks to staff or a care manager's lack of experience of safeguarding. Complex and high-risk cases require greater managerial coordination, with managers responsible for bringing objectivity and challenge, and for leading and monitoring practice, including the standard and content of records, implementation of agreed procedures, the use of training, and culture and processes within multiagency meetings.

Three additional organisational themes are important to mention, despite surfacing in relatively few reports. **Organisational culture** was seen as an important contributor to the environment in which practice took place, particularly in relation to the power dynamics of user/professional negotiations. In one case personalisation was seen as requiring significant culture change - a move away from eligibility based on diagnosis or IQ towards an approach based on need and risk, which considers the whole person. In another, everyone working with the individual appeared to respect - either from professional values or from powerlessness in the face of her intransigence - her right to decide the pattern of services and the level of risk present in her life. However, the SCR made the point that such sharing of power is complex and should not imply a 'take it or leave it' approach to service provision. While assessments needed to be built on a service user-led perspective, they needed too to explore and sometimes challenge reluctance to engage. Important too was a culture of challenge and debate between agencies, who were encouraged to seek clarity from each other, to escalate concerns, and to follow up on referrals made to others to ensure action is taken, rather than merely passing on concerns.

Staffing was significant in some situations, and seen as impacting on the kind of work that could be done, with vacancies and insufficient staffing levels leading to reactive rather than proactive work. Inexperienced staff in two cases failed to recognise the seriousness of the individual's situation and did not take appropriate action; the report emphasised the dangers of having too few experienced care workers and duty managers covering high risk and urgent situations. Other reports questioned reliance on single or part-time practitioners to manage complex risks and demanding cases over a lengthy period, and recommended co-working or changes of worker.

While interagency policies and procedures are considered in the final domain below, **single organisational policies** came in for criticism. Examples included:
- insufficient guidance to staff on how to respond if a tenant was thought to require health care;
- lack of attention to the need for a multiagency approach to be considered even where safeguarding thresholds were not met;

- absence of formal policies on up-to-date recording of visits and actions, referrals to others, discussions with managers, and all key decisions and their rationale, with records to be dated, with the author identified;
gaps in records by out of hours services.

Domain D: The local safeguarding adult board around the organisations: the exercise of interagency governance

SCRs were seen as a key means of improving services. Many reports commented on the **process of conducting reviews** and/or **the use to which they should be put**. Delay in conducting SCRs was noted, caused by lack of systematic processes for referral and communication between safeguarding officers, the Board and the SCR sub-group, and by misunderstanding of the interface between this process and police and Coroner investigations. SCRs were commonly informed by management reviews (IMRs), conducted in the individual agencies involved. There was a perceived need for staff training on the conduct of IMRs, improved timeframes for IMR completion, communication between the SCR panel and IMR writers, and guidelines on the format and level of detail required. One report required agencies to review their IMRs in the light of the SCR finding of inconsistencies in the IMR investigations.

Some reports indicated that the findings should be used in training or disseminated to all and/or some targeted agencies. Some recommended publication of executive summaries after being shared with family members and staff directly affected.

Action planning and monitoring of progress was commonly prescribed. The LSAB was positioned to hold agencies accountable for implementing recommendations, disseminating learning and ensuring procedural compliance. In one case the LSAB was to hold a final case conference review to assure itself that all the risks and issues raised in the SCR had been addressed. Sometimes the LSAB itself was allocated work to take forward, for example: exploration of ways of working with vulnerable adults with capacity who put themselves and others at significant risk of harm; and creation of a multiagency safeguarding hub to enhance cross-boundary work and engage in multidisciplinary critical practice conferences; audit of safeguarding training across agencies, looking for evidence of impact on practice. In two cases the composition of the LSAB itself required improvement, with representation from housing and from GPs seen as important.

Training came in for frequent mention. Specific topics identified as priorities included: adult safeguarding awareness and multiagency processes; carers' assessments; fire risks; alcohol dependency and issues of capacity and choice; principles and processes of capacity assessment and best interest decision-making; homelessness and eligibility criteria; legal frameworks; managing confrontation; data protection and a duty of care. Accurate records of who had received what training were deemed important, along with evaluation of its effectiveness. The importance of attendance by medical and health professionals, housing staff and emergency duty teams was emphasised. Joint training was highlighted to embed a shared safeguarding culture, reinforced by on-going refresher information, supervision and discussion.

The most dominant theme in Domain D, however, was the significance SCRs attached to **procedures and guidance**. Review of procedures was recommended with a view to clarifying the interface between self-neglect and safeguarding, and also to determine how they address service or treatment refusal or disengagement. Related to this was the need to

ensure that person-centred principles were embedded in all policies and guidance, along with procedures on risk recognition and management. These might include an identification and monitoring process for people who are vulnerable but do not meet safeguarding thresholds, review of definitions and triggers for safeguarding and use of a template for recording risk assessments and decisions at safeguarding meetings.

A large number of additional 'procedural gaps' were identified, with recommendations that LSABs should work to fill these. Gaps included:
- Protocols on information sharing, hoarding, out of hours services, GP involvement, fire risk, risk recognition, conduct of IMRs and provision of medical and social care;
- Systems for following up non-attendance at outpatient appointments, feedback to referrers, flagging concerns, accessing advocacy services and facilitating focused discussion in safeguarding meetings;
- Guidance on facilitating family involvement, working with abuse by family and friends in self-neglect cases, identifying vulnerable adults and making appropriate referrals, escalating multiple low-level concerns, assessing mental capacity, preventing homelessness and working with adults with drug and alcohol dependency;
- Joint agency agreement about no discharge from a service without a safeguarding meeting.

Paradoxically, while often recommending new or revised procedures, SCRs commonly found that staff awareness of those that already existed was problematic. Staff were either not aware of procedures, or did not use them when identifying levels of risk and the appropriate response, or engaging with mental capacity, or notifying safeguarding concerns. This prompted recommendations for measures to ensure stronger compliance.

Concluding discussion

Inevitably, given the focus of SCRs and the context in which they take place, the above analysis prioritises perceived needs for improvements in multiagency self-neglect practice. Sought improvements reside in all four domains of the analytic framework. Perhaps reflecting their different mandates, Coroner judgements and Ombudsman reports are more strident in their critiques of policy and practice. Coroners have referred to failures of communication and to contradictions and inadequacies in the legal rules which constrained a duty of care (Harding, 2010; Anon, 2011). However, judgements and reports also highlight similar concerns, including incomplete records, flawed assessments and care plans, and leaving unexplored people's decisions and resistance to help (LGO, 2008), and comment on failure to manage risks, to review assessments and to recognise incapacity when living conditions were deteriorating, and on inadequate supervision and unmanageable workloads (LGO, 2011; PHSO, 2011).

More complex is why such concerns emerge in self-neglect policy and practice. Certainly, working with adults who self-neglect is demanding and staff qualifications, experience and training may have proved insufficient; equally thresholds for involvement, particularly of an on-going nature in the light of service refusal, may have been set too high or applied too rigidly because of funding constraints (Manthorpe and Martineau, 2013; Braye et al., 2014). The emphasis on personalisation and the assumption of mental capacity may have influenced how practitioners approach questions of choice and lifestyle (Keywood, 2010). Faced with hostility, intransigence, resistance and aggression, agency responses may have come to mirror the same behaviour.

SCRs do not explore to any great degree the feelings, values and beliefs of those involved, or the forces whether ethical or organisational that underpinned action. Yet organisations' culture and resource context is central to practice. Equally fundamentally, self-neglect taps into unresolved ethical tensions, visible in legal powers that are (experienced as) ambiguous, even contradictory, use of autonomy without clarification of whether it is negative or positive freedom that is being prioritised, and worries about paternalism rather than consideration of safeguards when balancing human rights with state intervention as an expression of a duty of care (Scourfield, 2010; Preston-Shoot and Cornish, 2014). Perhaps that is why SCRs do not conclude that person-centred care may ultimately mean respecting choice that has been fully explored, but rather convey a tenor that more should have been done. Perhaps, too, it explains the move to further proceduralise, when evidence suggests that staff do not use what they already have in terms of legal mandates and guidance. Service users and staff are assumed to be rational actors who make sensible decisions when they are in fact social actors who mediate personal, social, psychological and political constraints on their choices. The next level of scrutiny needed by SCRs is, then, not just tangible mechanisms, such as workloads, training, procedures and supervision, but how values and beliefs, for example about responsibility, choice, autonomy and care, impact on individuals and multi-agency systems.

Thus, the four domains are interlinked and a whole system approach to change required. Maintaining engagement, for example, requires organisational structures that offer flexibility in care management arrangements. Effective information-sharing and multi-agency working depend on the procedures agreed by and relationships established in the LSAB. Legal and safeguarding literacy, and the thoroughness of individual mental capacity assessments, will be influenced by training and also subsequent management support. The majority of the SCRs where publication dates are known post-date implementation of the Mental Capacity Act 2005 and the training that accompanied it, reinforcing that training alone will not enable practitioners to acquire and retain skills, confidence and understanding. SCRs perhaps underplay the interface between their different recommendations and, by focusing on them, LSABs too might overlook a key lesson that system change requires all the many components of effective practice to develop in a co-ordinated fashion.

Complex challenges notwithstanding, the SCRs studied here also identified good practice, where procedures were followed, there was robust joint working on risk and capacity assessments, information was shared and alerts were raised. Sometimes they noted active and persistent efforts to engage individuals. Both the shortcomings and the strengths identified in the reviews, designed to learn lessons from often tragic circumstances, triangulate well with findings from other research designed to identify what can be learnt from positive outcomes (Braye et al., 2014). What emerges is that these are achieved when all domains – individual, team, organisation and interagency governance - are robust and are well-synchronised. Clear procedures and protocols can facilitate successful work by practitioners; locating self-neglect work within safeguarding policies promotes strong multiagency engagement; effective management oversight helps practitioners to manage the personal experience of this work; and good practice privileges building relationships over time, understanding the whole person, devising flexible interventions, and using multi-agency resources to assess risks and mental capacity. Systematic dissemination of SCR findings has yet to become routine, but may further inform policy development and practice standards. This paper offers one contribution for learning and service improvement.

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