Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review "Maureen"

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Contents

1. Introduction

1.1. Legal context for the review

Lewisham Safeguarding Adults Board (LSAB) has commissioned this Safeguarding Adults Review (SAR) to meet its statutory duties under Section 44 of the Care Act 2014, i.e.:

'To commission and learn from a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)…… if the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect'.

Maureen was found to have passed away in her home in the London Borough of Lewisham on 27 July 2023.

The review covers the period from 1 July 2022 to the 27 July 2023 and reports to the Lewisham SAB Case Review Sub-Group. Its content is in line with Lewisham SAB Safeguarding Adults Review Policy & Procedures and the London Multi-Agency Adult Safeguarding Policy and Procedures.

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

The concerns raised in the SAR Notification include:

- Maureen self-neglected, and there is an indication that there had been a deterioration in her presentation in the months before her death.
- Several organisations were aware of/ working with Maureen, and we believe that there is potential to use learning from this case to improve multi-agency practice and partnership working.

It was agreed at the 18 April 2024 Lewisham Safeguarding Adults Board Case Review Sub-Group meeting that the mandatory criteria were met for this case and that a mandatory review would be conducted under Section 44 (1) & (2) Care Act 2014.

The review process will be conducted with the following underpinning principles and guidance in mind:

- Evidence of Making Safeguarding Personal;
- Evidence of, or consideration of Mental Health Act & Mental Capacity Act Assessments;
- Evidence of, or consideration of the use of Advocacy.

1.2. Specific areas of enquiry

1. Review and provide an assessment of the Individual Management Reviews (IMR's) and combined chronology and any agency records, care plans and risk assessments (as required).

2. Consider whether the care provided by all organisations and professionals was consistent with expected standards, and in line with primary legislation, statutory guidance and local guidance including:

   - Care Act 2014;
   - Mental Health Act 1983;
   - Mental Capacity Act 2005;
   - Equality Act 2010;
   - Human Rights Act 1998;
   - London Multi-Agency Adult Safeguarding Policy & Procedures;
   - Lewisham Adult Safeguarding Pathway;
   - LSAB's Multi-Agency Self Neglect Policy, Practice Guidance and Procedures.

Mental Capacity

3. Did practitioners consider the need to determine if Maureen had the mental capacity to make decisions with regards to her health and wellbeing?
4. Explore if there may be a misinterpretation of any of the principles in the Mental Capacity Act 2005 by front line staff.

Risk Recognition, Risk Assessment, Risk Management and Mitigation

5. Determine which risk assessment, risk management and mitigation tools were being used at the time, or that had been used previously and may be relevant to this review.
6. Is there evidence of case closure without risk assessment or mitigation of known risks?

Safeguarding System Response

7. Provide an assessment of how well the local safeguarding system responds to the needs of adults whose risk is increasing when self-neglect occurs.

Challenge of Engagement

8. Is there evidence of professionals exploring the reasons Maureen gave for declining help, care, and support?
9. Whether self-neglect was viewed as a "lifestyle choice" thus inhibiting professional curiosity when faced with Maureen's refusals of care and support?
10. Did the agencies involved have engagement policies that dealt with the challenges of engaging Maureen in a structured way?

Communication, Information Sharing and Working Together

11. Assess if there was adequate communication and information sharing between agencies, and was the need to share safeguarding information and risk fully understood?
12. Determine and provide insights into the way organisations worked together in this case (including examples of good practice) to safeguard Maureen.
13. Did professionals experience barriers to their practice?

Legal Literacy

14. Did agencies collectively consider how their legal powers and duties could be exercised in a joint multi-agency strategy to reduce the risk of harm and self-neglect.
15. Is there a need to refresh knowledge for front line Adult Social Care professionals of the provision in Section 11 Care Act 2014?

Neurodiversity Specialist Advice and Support

16. What local support is available?
17. Is specialist support and advice available to professionals working with neuro diverse adults?

Management Oversight

18. Was there suitable management oversight, case direction, and escalation where necessary?

Self-Neglect

19. There are records that indicate that Maureen was exhibiting signs of self-neglect. Establish and assess the response by agencies in relation to this subject.
20. Is there sufficient consideration of Maureen's neurodiversity when attempting to engage Maureen with regards to neglecting herself.

Equality

21. Was consideration given to Maureen's protected characteristics and whether this may have provided further insight into Maureen and her care and support needs?
22. What reasonable adjustments were made to support Maureen?

The Analysis of Practice (Section 5) covers each of these points, though some have been merged together to save repetition.

2. Methods

Imogen Blood, an Independent Reviewer, was commissioned to carry out the review, which took place between May and December 2024.

2.1. Individual Management Reviews

The following agencies, which had significant involvement with Maureen during the period of the review, were asked to produce an Individual Management Review, reflecting on key questions related to the specific lines of enquiry. They were also asked to provide a summary of their agency's involvement with Maureen during the review period (a 'chronology'), and an agency-level action plan in response to learning from the internal review:

- GP practice;
- London Borough of Lewisham Adult Social Care;
- Lewisham Homes (from October 2023, London Borough of Lewisham Housing Directorate);
- South London and Maudsley (SLaM) NHS Foundation Trust.

The following agencies had been asked to provide information about any recorded contact with Maureen during the period of the review and a decision was made in the light of this that the level of contact did not warrant an IMR:

- London Ambulance Service NHS Trust;
- London Fire Brigade;
- Metropolitan Police Service.

2.2. Learning and reflection session

The agencies which carried out IMRs were invited to join a learning and reflection session, which was facilitated by Imogen Blood and supported by Martin Crow, LSAB Business Manager. This 2-hour session was conducted via Microsoft Teams on 9 October 2024.

Housing and the GP practice were very well-represented, Adult Social Care sent a representative, but they were not able to fully participate due to illness; SLaM did not send a representative, though the Trust had minimal involvement with Maureen during this period.

2.3. Family involvement

A key part of undertaking a SAR is to ensure that families are integral to the review process, since families can provide views and insights that professionals may not have, and these can help to create a fuller picture. Maureen is not known to have contact with any living blood relatives; she has a goddaughter and a friend with whom agencies were in touch regarding Maureen's case in the final months of her life. The reviewer contacted them both during December 2024 and they both fed into this review including recommending that her first name be used in this report, which was proposed by the Case Review Sub-Group, and approved by the LSAB Board.

2.4. Supplementary evidence

Specific to the review, the reviewer has also read and considered a range of other policies, reports, and relevant evidence, including but not limited to:

- Lewisham SAR's 'Maria' and 'Arthur';
- Second national analysis of SAR reports, 2019-2023 (Local Government Association, July 2024);
- LSAB Multi-Agency Self Neglect Policy, Practice Guidance and Procedures;
- LSAB Outcome of Enquiries for another parallel case;
- LSAB Performance Reports, Q4 (2023/4) and Q1 (2024/5);
- Resources relating to mental capacity and executive function, including publications by ADASS, Lancashire SAB, National Mental Capacity Forum; Autism and Executive Function; Self-neglect, including a Making Safeguarding Personal/ Research in Practice webinar and a national review of SAB self-neglect policies;
- Lewisham All-Age Autism Strategy, 2023 – 2028.

3. Maureen: Context and Background

Maureen was a 66-year-old woman from a Black Caribbean ethnic background. She lived alone in a social tenancy provided by the local authority/ Lewisham Homes since 2011.

Maureen's friend since childhood and her goddaughter explained that Maureen had been a very intelligent, resourceful woman, who was excellent with money and had cared for her parents, her brother and other family members. In her younger years, she had kept herself and her home clean and was a keen sewer – her goddaughter noticed she still had her antique sewing machine on the table in June 2023, the month before she died.

Her friends felt Maureen had always experienced some challenges with her mental health and were aware that she had become increasingly withdrawn, isolating herself from others over the past decade. Maureen had experienced a number of losses – a relationship breakdown in her 20's (from which she apparently never fully recovered and remained single for the rest of her life); then - over a relatively short space of time - the deaths of both her parents, her brother (who was found dead in his flat, having suffered a heart attack) and a close friend (the mother of Maureen's goddaughter) who always used to invite her over for Christmas. She apparently has one living brother in the USA whom her friends are keen to find, and another brother, who moved into sheltered housing in Lewisham.

According to assessments completed under the Mental Health Act 1983 as part of a previous court order, Maureen had diagnoses of primary neuro-developmental disorder - Autistic Spectrum Disorder (ASD) and a learning disability or low IQ. In the past, funding had been obtained for Maureen to receive ASD psychological treatment; however, there is no record of this taking place.

It was perhaps in response to the losses she had experienced that Maureen took to feeding local pigeons and would also bring them into her home. This affected the cleanliness and condition of her property and impacted on people living in the same block of flats. Feeding the birds led to Court action being taken against Maureen for Anti-Social Behaviour (ASB) in 2009 & 2017 and court action was also instigated in November 2022 for breach of her tenancy with regards to the condition of the property. The Court had previously ordered that Maureen should have a Care Act 2014 Assessment which was completed but Maureen subsequently declined all offers of care and support. Maureen had also served a prison sentence for continuing to feed the birds, breaking a previously imposed court injunction.

When asked by professionals about feeding and keeping birds, she either denied the behaviour or appeared to have no insight into the condition of her living environment which, certainly during the period of the review was described by her friend as 'squalid', lacked basic facilities, was heavily infested, and covered with bird faeces and litter. Her friend, who visited the flat with professionals in June 2023 was shocked and horrified by the state of the property – the door was open, a window was broken, there were birds flying around and filth, bird faeces, litter, and cockroaches everywhere – the heating was on full, despite it being a very hot day and it was almost impossible to breathe in the flat.

There is a history of agencies failing to engage Maureen; she declined offers of care and support, and only appeared to participate in assessments when ordered or requested by the Court.

There was considerable multi-agency activity during the last year of her life; the professionals in contact with Maureen during this period noted many concerns including in relation to her:

- Mental health - reports include her being confused in the street, experiencing hallucinations, and concerns that she may have dementia.
- Physical health and general appearance – she lost weight, reported only eating bread and if hungry would drink water. She was unkempt, appeared unclean, and there was a marked deterioration in her general appearance.
- Living environment - there were loose pigeons, pigeon faeces everywhere, a severe cockroach infestation, no electricity, no water, no telephone, the front door was often unlocked.

On 27 July 2023 the police attended the property and found Maureen deceased in her home; she appeared to have been dead for some time.

4. Key Events During the Scoping Period

15-19/07/22: Housing contacted Adult Social Care (ASC) to see if Maureen's case was open to ASC, given challenges accessing the property and concerns about infestation/ house condition; ASC advised Housing to contact GP since concerns about mental wellbeing. At this time, London Borough of Lewisham also confirmed they would not take action under the provisions of Environmental Protection Act 1990, due to Maureen's vulnerability.

19/10/2022: Maureen attended the GP surgery for seasonal influenza vaccination.

25/11/2022: Further referral to ASC from Housing stated previous Autism diagnosis and shared photos of property. Case allocated to social worker for Care Act 2014 assessment, but unable to contact via telephone and referred to GP to refer to ASD team at SLaM, given concerns for mental wellbeing.

27/11 – 23/12/2022: ASC contacted GP to say they could not reach Maureen and were closing the case as she had a history of non-engagement. GP surgery wrote to Maureen to contact Care Coordinator and sent text reminders for an appointment which she Did Not Attend (DNA) on 23/12/2022.

11/01/2023: Maureen discussed at MDT meeting (typically involving Housing, GP, Mental Health, ASC) – confirmed she was closed to ASC, decision to make home visit.

26/01/2023: Attempted home visit by Care Coordinator, DNA health check, early February.

16/02/2023: Care Coordinator spoke to Maureen in doorway of home, but not allowed in. Maureen very unkempt and strong smell, but assured worker she is fine.

27/02/2023: Email from Department for Work and Pensions (DWP) to ASC, concerned that Maureen is becoming forgetful, attending on wrong days, and is inappropriately dressed for the weather.

28/02/2023: Housing solicitor sent legal warning letter to Maureen regarding tenancy and housing staff were able to inspect the property, which was in extremely poor condition (pigeon faeces, general waste on floor, clutter, no electricity). Maureen did not seem to appreciate severity of situation.

08/03/2023: Maureen discussed at MDT – Housing to proceed with legal action due to severity of home condition and impact of infestation on neighbours; ASC to continue trying to engage Maureen and support her to reduce risk of homelessness, considering supported housing instead.

16/03/2023: Allocated ASC worker unable to contact Maureen by phone, decision to close ASC case as she had not engaged, and home environment sounds inappropriate to send carers into.

24/03/2023: Maureen taken to hospital by ambulance following hallucination: safeguarding referral made to ASC, as property in very poor condition, neighbours concerned, Maureen forgetful. In Emergency Department, psychiatric liaison nurse had clear concerns about self-neglect and felt referral to primary care mental health team needed, but not clear if this happened or was followed up; did not make a safeguarding referral to ASC as aware ambulance crew had already done so.

29/03/2023: Leak reported to Housing coming from Maureen's property and affecting other properties – various attempts to gain access to fix the leak.

03/04/2023: Housing concerned that Maureen started over-paying rent in erratic payments.

05/04/2023: Notice Seeking Possession served on Maureen in hope that this would prompt engagement and allow alternatives to be considered.

17/04/2023: Maureen allocated to social worker for Care Act Assessment via joint visit with Housing.

26/04/2023: Housing repairs team finally granted access to fix leak and raised Safeguarding Concern – pigeons flying around property and bathroom unused due to clutter.

28/04/2023: Social worker and Lewisham Homes Safeguarding and Tenancy Sustainment Manager met to discuss concerns and plan a coordinated response; however, attempts at a joint visit were unsuccessful as Maureen did not answer the door.

14/05/2023: Police contacted ASC Emergency Duty Team following visit to Maureen's home – she had been found wandering in the local area and her home was felt to be uninhabitable. This was the second concern raised by Police about Maureen within a few days.

15/05/2023: Social worker discussed case with the Multi-Agency Safeguarding Hub, who identified that Maureen was known to mental health team and had previously

been sectioned under the Mental Health Act 1983 – suggested GP review and further referral to Mental Health Team.

25-26/05/2023: Further attempted home visits but Maureen did not grant full access to property though cockroaches very evident from front door – referrals to environmental health.

13/06/2023: Friend of Maureen got in touch with Housing for first time. Professionals' meeting between Housing and ASC: planned for ASC to attempt to engage Maureen, with police welfare visit/ commence eviction proceedings if unsuccessful. Advocacy referral and deep cleanse of property were considered. Housing shared details of Maureen's friend with ASC.

16/06/2023: Joint home visit with ASC, Housing and Maureen's goddaughter – door was left open and property in very poor condition but Maureen not at home. Fortnightly social work visits agreed.

30/06/2023: ASC concerned that front door now locked, neighbours had not seen Maureen for a couple of weeks. Housing also tried to visit. Professionals' meeting held. Police welfare check sent an urgent referral to ASC raising concerns for Maureen who looked underweight and unkempt but replied coherently to their questions and declined support.

07/07/2023: Maureen did not answer the door to ASC welfare visit and Estate Property Manager confirmed Maureen not been seen pushing shopping trolley full of bread for some time.

26/07/2023 – Housing served Notice Seeking Possession through letterbox as no reply.

27/07/2023 – Housing reported MP missing and the Police found her deceased.

5. Analysis of Practice

5.1. Mental Capacity

Did practitioners consider the need to determine if Maureen had the mental capacity to make decisions with regards to her health and wellbeing?

Explore if there may be a misinterpretation of any of the principles in the Mental Capacity Act 2005 by front line staff.

There is no mention of any mental capacity assessments within the chronology provided – this is an issue also raised in another case considered by the Lewisham Safeguarding Adults Board (Arthur, an 81-year-old man), and lack of consideration of mental capacity is a common theme in SARs relating to self-neglect nationally[1]. In Maureen's case, there is however, evidence of the principles of the Mental Capacity Act being applied by professionals involved, for example, IMR reports highlight that workers started from the point of assuming Maureen had capacity to make decisions and that her making 'unwise decisions' (e.g. to keep pigeons in her home) did not

[1] Making Safeguarding Personal videos: Self-neglect: https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/videos

lead to assumptions that she lacked capacity. However, the focus on applying these principles of autonomy may have got in the way of the safeguarding response (as discussed in section 5.3 below).

Maureen had been assessed in the past on two occasions (in 2010 and 2017) by clinical psychologists, both of whom had reached the same conclusion, i.e., that Maureen had an Autistic Spectrum Disorder (ASD) (specifically Asperger's), which "affected her social, problem-solving skills, expressive and receptive language skills, motor skills to a mild degree, qualitative impairment in non-verbal social cues, social interaction and stereotypical behaviour in her compulsive bird feeding behaviours"[2]. The second psychologist highlighted how her condition might mean she would struggle to retain and consider information about the consequences of her actions, in relation to her tenancy and related court orders. This meets the first stage of the 3-step test of the Mental Capacity Act 2005 for an impairment or disturbance in the functioning of the person's mind or brain. Research[3] evidence confirms that aspects of 'executive function', such as planning, working memory, inhibition and flexibility tend to be reduced in individuals with ASD, though there is huge individual variation.

Based on the material shared with the reviewer, there are no formal records regarding professionals' assessments of Maureen's time-and decision-specific mental capacity during the period under review. There were clear challenges accessing Maureen to have the sort of conversations which would ideally inform formal assessments. Nevertheless, professionals from several agencies did have some contact with Maureen and may have been opportunities here to carry out what has been described as a '3D capacity assessment'[4], drawing more systematically on the observations and reports of a range of different people, ideally including some who also knew Maureen in the past, as well as current conversations with her.

The chronologies provide evidence that there were reasons to question Maureen's capacity to decide that she did not want any support during the last few months of her life. She is consistently described as 'confused' and 'forgetful' during this period, she experienced a 'hallucination' and was found 'wandering', with changes to her behaviour reported such as over-paying rent, dressing inappropriately for the weather, attending DWP on the wrong days, or her reported perception of her situation (e.g., that she was 'fine' or that the flat 'just needed a bit of tidy'). It was in line with the Mental Capacity Act 2005 (MCA) principles that workers did not assume from this that Maureen lacked capacity in relation to *all* her decision-making, but these observations should trigger questions[5]as to whether her apparently coherent responses to questions could be taken at face value, given the level of risk resulting from her 'unwise decisions'.

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[2] ASC IMR, Relevant information outside of scope of review

[3] Hemmers J, Baethge C, Vogeley K, Falter-Wagner CM. Are Executive Dysfunctions Relevant for the Autism-Specific Cognitive Profile? Front Psychiatry. 2022 Jul 18;13:886588. doi: 10.3389/fpsyt.2022.886588. PMID: 35923452; PMCID: PMC9342604: https://pmc.ncbi.nlm.nih.gov/articles/PMC9342604/

[4] Neil Allen, Executive functioning, and the MCA 2005 https://autonomy.essex.ac.uk/wp-content/uploads/2023/04/NMCF-S2E4-Exec-Dysf-SLIDE-DECK.pdf

[5] Mental Capacity Act 2005 - Code of Practice: 4.34: "It is important to carry out an assessment when a person's capacity is in **doubt"**.

There is increasing focus in research and practice guidance on the implications of impaired executive function for the assessment of mental capacity. As Lancashire's Safeguarding Adults Board's 'grab sheet'[6] on the topic explains:

"Fundamentally, in unwise decision making, the person is fully aware but consciously disregarding or giving less weight to certain facts relevant to the decision. In executive impairment, the person cannot access and integrate the correct pieces of information and use them in a meaningful way to make the decision".

Making these nuanced assessments of mental capacity requires a more longitudinal and holistic approach, checking that the individual's self-reports are congruent with their performance in everyday life. This does not fit well with the legal framework for time-and decision-specific assessments. Some advice from a psychologist or psychiatrist could have been helpful for the multi-disciplinary team trying to engage Maureen.

As the GP surgery's IMR reflects:
"It would have been useful to formally document that Maureen's mental capacity had been assessed and to document whether or not she was deemed to have capacity and the reasons for deciding either way".

In cases like Maureen's, where engagement is challenging and mental capacity is ambiguous, it is important that the multi-disciplinary team discusses, consciously observes, or questions, shares, records and reflects on (ideally with expert psychological input) the question of mental capacity. Repeat and recorded examples of Maureen being unable (or able) to retain and apply information about the offer of support or her responsibilities as a tenant and the consequences of her actions could have been used – as ADASS SW suggest[7] – to build a longitudinal picture. If Maureen was ultimately assessed to lack the capacity to make decisions about her accommodation and support, the best interests process provides a legal framework for decision-making with Maureen at the centre. Instead, obtaining Maureen's 'consent' was felt to be an automatic barrier to considering supported housing options. For example, in the case of 'Adult Z' (which was the subject of a Lewisham SAR in 2021[8]) an Approved Mental Health Professional, psychiatrist, police and paramedics attended Z's home and assessed them as lacking capacity to make decisions about their care and in immediate need of medical care. They were taken to hospital under the authority of S5 and 6 of the MCA and improved following this.

Learning Points

- In cases where challenges with engagement mean there are limited opportunities for formal MCA assessment, it is important for multi-disciplinary teams to take collective ownership of mental capacity assessments: reflecting, observing, asking questions, and recording their judgements and views at each step of the chronology.

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[6] Lancashire SAB: MCA Guidance: Executive Functioning, April 2021: https://www.lancashiresafeguarding.org.uk/media/19288/executive-functioning-grab-sheet-mca-guidance_v10_apr2021.pdf

[7] ADASS South West (2024) Executive Function: Practice Note for Mental Capacity Assessments: https://proceduresonline.com/trixcms1/media/13576/executive-function-practice-guidance-final.pdf

[8] See LSAB (2021) 7 Minute Briefing: Safeguarding Adult Review. Adult Z at: https://www.safeguardinglewisham.org.uk/assets/2/lsab_7_minute_briefing_-_adult_z.pdf

- Second tier advice for this process from a clinical psychologist or psychiatrist is extremely helpful to build skills and confidence, provide expert input and challenge.

- Whilst the principles of assumed capacity and the right to make unwise decisions seem well-embedded in practice, awareness of executive function and its implications for mental capacity assessment require further development.

5.2. Risk recognition, assessment, management, and mitigation

Determine which risk assessment, risk management and mitigation tools were being used at the time, or that had been used previously and may be relevant to this review.

Is there evidence of case closure without risk assessment or mitigation of known risks?

The chronologies and IMRs supplied by different agencies suggest that workers identified and communicated to each other the sources of risk which Maureen faced. However, there was no direct mention of risk assessment tools in the documents provided, other than a RED rated Merlin issued by the Police, which indicates a risk assessment of 'critical' – ' Harm is life threatening or likely to have permanent detrimental impact on health and well-being'[9].

The Hoarding Assessment Tool/ Clutter Image Rating Scale, which is contained in LSAB's Multi-Agency Self Neglect Policy, Practice Guidance and Procedures, is highly relevant in Maureen's case. The chronologies refer to a 'large amount of clutter' and the overall picture presented is one of Level 3 (see p.22 of the policy) – the highest level of - risk/ (potentially correlating to Clutter rating 7-9 (see p.27/8) given reports of: electricity not connected, heavy insect infestation, animals in the property at risk, bathroom not usable given clutter, general household waste on the floor, offensive odour in the property, concern for mental health, the person refuses to engage with necessary services where their health and wellbeing is being affected. It would be useful if those attending the property had recorded an assessment against this scale, then risks could have been consistently monitored over time.

The London Multi-agency Adult Safeguarding Policy & Procedures suggest that a robust risk assessment, preferably multi-agency and informed by the views of the adult and their support network, is crucial to decision-making in cases of self-neglect. They suggest that the risk assessment might cover:

- Capacity and consent;
- Indications of mental health issues;
- The level of risk to the person's physical health;
- The level of risk to their overall wellbeing;
- Effects on other people's health and wellbeing;
- Serious risk of fire;
- Serious environmental risk e.g. destruction or partial destruction of accommodation.

[9] See here for information from the Metropolitan Police on the creation of Merlin reports.

These headings could have provided a useful framework for monitoring, managing and, crucially, trying to mitigate the risks which Maureen faced. For example, the London Fire Brigade reported that they had not received a referral for a home fire safety check for Maureen since the last one was carried out in 2013. Housing explained that a referral to the fire brigade – or a joint visit with their in-house Fire Safety Team – did not feel appropriate ahead of engaging Maureen and obtaining her consent. This is understandable, though it is also possible that fire safety may have been a way to engage Maureen.

There are examples of Maureen's case being closed, apparently without assessment or mitigation of risk. According to another agency, Adult Social Care explained they had closed Maureen's case in November 2022 as she had a 'history of non-engagement' and had declined previous offers of support. In Adult Social Care's own records though, the reason for closure was that the concern related to mental wellbeing and the case should be referred by the GP to the ASD service instead.

In March 2023, and in response to concerns raised about Maureen's wellbeing by DWP, Adult Social Care stated that the case was closed because they had not been able to establish contact with Maureen and that 'based on the record, Maureen's environment is not suitable for carers to provide support in'. This suggests a rather narrow interpretation of eligible needs, shaped by the current service offer, and overlooking the serious risks which Maureen was facing due to self-neglect. Adult Social Care reflect in their IMR that, had a longitudinal approach to risk been taken, there might have attempts to follow-up on the recommendations of the psychologist from 2017, after which Maureen's case had been closed.

Learning Points

- The Hoarding Assessment Tool/ Clutter Image Rating Scale, which is contained in LSAB's Multi-Agency Self Neglect Policy, Practice Guidance and Procedures should be used to assess and monitor risk consistently in cases of self-neglect and hoarding.
- Cases of self-neglect would benefit from a longitudinal approach to risk, in which risks are reviewed (e.g. Using the headings of the London Multi-Agency Safeguarding Policy & Procedure, listed above) when case closure is considered and where further referrals are received/ a case is re-opened. The risk assessment tool should inform decisions about case closure, and also risk management/ mitigation plans.

5.3. Safeguarding system response to self-neglect

There are records that indicate that Maureen was exhibiting signs of self-neglect. Establish and assess the response by agencies in relation to this subject.

Provide an assessment of how well the local safeguarding system responds to the needs of adults whose risk is increasing when self-neglect occurs.

It is not clear why Maureen's case did not proceed to a Section 42 Enquiry and then on to a Safeguarding Plan; though the Lewisham Safeguarding Adults Board Self-Neglect Policy, Practice Guidance and Procedures outline that at 'moderate risk' level, this formal approach to multi-agency safeguarding should be initiated. Many aspects of Maureen's living environment and circumstances align with the Red/

Level 3/ High Risk indicators on p.22 of this policy, i.e. well-above the threshold for 'moderate risk'. The IMR from Adult Social Care recognises that a Section 42 Enquiry would have been 'good' (but not necessarily that it should have been standard) practice.

Workers have identified and recorded high levels of risk arising from the state of the property – both to Maureen and her neighbours - in the agency records, yet there was a sense from the Adult Social Care IMR that this was a 'typical self-neglect case'. Other agencies had sufficiently high levels of Safeguarding Concerns that they made a point of following up on their concerns (e.g. DWP) or, in the case of the Police on 3 July, issued a Red Merlin report. The LSAB Inter-Agency Escalation Policy was approved in July 2023; had this been in place at the time and other agencies had been aware of this, it could have created the mechanism and confidence for agencies outside of Adult Social Care to challenge decision-making, providing a clear timescale for escalation to line and senior managers. In the Learning and Reflection session, the challenge presented by the sheer volume of Safeguarding Concerns that are received by London Borough of Lewisham was raised, not all via the correct channels or containing a sufficient level of detail to triage risks. Equally there are examples of missed opportunities in Maureen's case to raise Safeguarding Concerns by health professionals in secondary and primary care settings. There is a shared responsibility to ensure that both referrals and the response to them are appropriate.

One of the learning points raised by the author of the IMR at the GP Surgery was 'the need for clear outcomes and actions after MDT meetings identifying if there is a shared priority across the MDT and working out which agency needs to action this'. Meanwhile the Adult Social Care IMR author reflected that it '*would have been good to have involved health professionals in the multi-agency meetings' and that 'there was no evidence of access to specialist knowledge and support [e.g. in relation to Neurodiversity] within the period of this review'*.

A formal Safeguarding Plan would have given the statutory impetus to convene the full range of multi-agency partners, including mental health, learning disability/ autism, and police in addition to Adult Social Care, housing, and primary healthcare staff. This could potentially have unlocked access to the expert psychology/ psychiatry advice which would have provided support and challenge to the frontline workers trying to support Maureen, even if the combination of diagnostic thresholds, waiting times and the challenges of engaging Maureen made it difficult for Maureen to access direct support from these professionals. The Safeguarding Plan could then have provided a clear framework for allocating, monitoring, and reviewing the actions of different multi-agency partners.

The IMRs suggest a low level of awareness of the Lewisham Safeguarding Adults Board Self-Neglect Policy, Practice Guidance and Procedures which, although recently refreshed, had been in place at the time of Maureen's case. For example, IMR authors suggest that the council should 'consider setting up guidelines for supporting clients who self-neglect'.

There is a record of the allocated social worker having a conversation with MASH (the Multi-Agency Safeguarding Hub) on 15 May 2023. At that stage, MASH advised that Maureen had previously been sectioned under the Mental Health Act and that Maureen would need to be reviewed by her GP and re-referred to mental health services. This is in line with the council's procedure: any Safeguarding Concern

where mental health issues form a key concern are referred to the Adult Mental Health Team (council employed staff but seconded with SLaM). However, the procedure creates an additional step in cases like Maureen's where the GP has had limited success in engagement. It is not clear from the chronologies provided that the GP was asked to review Maureen at this point and make the further referral.

There had also been a decision by ASC to manage the Safeguarding Concerns under case management and allocate a social worker 'due to the challenges of engagement and the mental health/ learning disability issues'. Having an allocated worker who can take a lead and proactive role in relation to engagement was good practice; however, the backing and resources of a Safeguarding Plan could have strengthened this approach and provided oversight of the levels of risk: it should not be a case of either/or.

There were clearly enormous challenges engaging Maureen to even broach the subject of whether she consented to the safeguarding process – and these are discussed in more detail in the next section. However, by waiting to try and engage Maureen first and involve her in the process – which would have been the ideal position – a key window for more decisive safeguarding actions was tragically missed. The agency records suggest that there was a case to override the need for Maureen's consent to a Safeguarding Enquiry, in relation to Vital Interests (the risk of serious harm arising from her living conditions and self-neglect); Public Interests (the risks arising for neighbours from the state of her property) and potentially (as discussed in the section on Mental Capacity) also on the grounds of Best Interests. Similar themes have emerged from the parallel SAR for 'Maria' in which safeguarding referrals raised by several agencies in relation to self-neglect and abuse did not proceed to a Section 42 Enquiry and the Safeguarding Adults Pathway was therefore not used, because Maria did not consent to this.

The 2nd National Analysis of Safeguarding Adults Reviews in England tells us that 60% of cases being reviewed (i.e. usually following death) involve self-neglect, although only 6-8% of operational Safeguarding Section 42 Enquiries are for this subject.

There is a clear need for greater awareness raising, oversight and culture change in relation to use of the Safeguarding Pathway for adults at high risk from self-neglect in Lewisham, as elsewhere in the country. It has been encouraging to receive feedback from Adult Social Care over the course of the review about the steps which have since been taken. A new Self-Neglect High Risk Panel was established in Lewisham in September 2024, to provide a regular multi-agency problem solving forum to discuss the well-being of individuals who are at risk of significant harm due to self-neglect. However, all standard safeguarding processes need to have been used and exhausted before a case can be referred to this. Senior managers in Adult Social Care have been communicating to MASH the need to ensure moderate and higher risk self-neglect cases can proceed through the safeguarding pathway where appropriate. Open self-neglect cases are routinely monitored by senior managers to enable discussions about whether cases should be taken to the high-risk panel. The data suggests this effort is having an impact – at least in terms of numbers and processes. From 1 April 2024 to end of Oct 2024, there has roughly been a three-fold increase in the number of Safeguarding Concerns relating to self-neglect that have progressed to a Section 42 Enquiry, compared to the previous year.

Learning Points

- There is a clear need for ongoing awareness raising, staff development, and culture change in relation to self-neglect to ensure the safeguarding pathway is used appropriately and the new high risk self-neglect panel where this has not resulted in reducing risk.
- The proactive performance management of self-neglect safeguarding cases seen in recent months appears to be helping and this needs ongoing monitoring and evaluation.
- Ongoing communication with partner agencies to bolster their understanding of the self-neglect policy and the legal framework which underpins it, how to refer effectively and how to escalate where needed to ensure Section 42 Enquiries are carried out where the risks are significant.

5.4. Challenge of engagement

Is there evidence of professionals exploring the reasons Maureen gave for declining help, care, and support?

Whether self-neglect was viewed as a "lifestyle choice" thus inhibiting professional curiosity when faced with MP's refusals of care and support?

Did the agencies involved have engagement policies that dealt with the challenges of engaging Maureen in a structured way?

Engagement was clearly a huge barrier to working effectively with Maureen, given that she was often out and about in the neighbourhood during the day and, when home, was not willing to invite professionals into her home. Her phone appears not to have been working during the whole of the review period, though her friend explained that she often would sometimes answer it at 4 or 5am.

LSAB has since (January 2024) produced Guidance for Improving our Approach to Adult and Family Engagement which should apply to all of the agencies involved in Maureen's SAR. This sets out engagement principles and next steps. Awareness of this document by IMR authors seems to be low, since some highlight the need for a joint and more structured approach to working with people who are hard to engage, and a plan of action if risks are high and engagement continues to be unsuccessful.

The LSAB engagement principles were followed to varying degrees in Maureen's case: on a positive, a lead professional was identified (social worker) in the last few months of Maureen's life, and most agencies did not appear to assume that 'someone else was dealing with it' (though again, a Safeguarding Plan would have helped to coordinate health input at this stage). A range of methods were used (phone, visits, letters); however, information about the best ways to contact Maureen (e.g., that her phone was not working, the best times and locations to find her out in the neighbourhood) could have been shared and acted on more proactively and at an earlier stage. Mental Capacity and Safeguarding – as discussed elsewhere in the report were not considered sufficiently as emphasised in the engagement principles.

There is evidence of persistent efforts by the Housing Tenancy Sustainment Team during the review period and for some years prior to this to engage with Maureen, despite her initial reluctance to do so. The Care Coordinator at the GP Surgery was able to have a reasonably in-depth conversation with Maureen, albeit in the entrance to her flat in February 2023. It was positive that the social worker took on the role of

lead professional trying to engage Maureen in the final months, whilst liaising and coordinating the approach with multi-agency colleagues. This social worker made 5 visits to Maureen's home between 17 April and 27 July, 2 of which were joint with Housing – they were only able to speak to Maureen once (from behind a door as she was not dressed) and access the property once in her absence as the door was open.

However, there was a 2-week delay in allocating a social worker due to a lack of resources and the start of engagement was then fairly slow – it took a further fortnight before the first home visit was attempted, possibly again due to lack of resources, and the time it took to share information about the case between agencies. There was evidence of the social worker taking the initiative to gather information from others – from the property estate manager, from neighbours and from Maureen's friend. Housing shared photos of Maureen and details of locations where she fed the birds with the social worker, but it is not clear from the records whether these places were visited.

There was a good level of inter-agency communication going on behind the scenes during this period, but for Adult Social Care to successfully engage and build the trust of someone who had withdrawn from social contact to the extent that Maureen had at this stage, a more proactive and assertive approach with several visits a week and attempts to engage Maureen at other places where she visits (e.g., bird-feeding locations, DWP, shops) would have been needed. This may go beyond what is possible within current social work caseloads, but if so, a different approach is needed in such cases. This might perhaps involve commissioning a specialist support provider to work in this more intensive relational way, or in cases where risks are high, recognising early on that engagement will be a slow and labour-intensive process and taking a more decisive approach to escalation.

Maureen's friends recognised the challenges of trying to find and engage her and described various unsuccessful visits themselves; the friend who attended a joint visit with housing and Adult Social Care was also struck by how evident it was that these workers came from a position of care and wanted to help Maureen. Maureen's goddaughter took the view that a slow relationship-building approach to engagement was unlikely to have worked in the necessary timescales to protect Maureen from harm. She and Maureen's friend felt that eviction from the flat, combined with intensive support from them and professionals to move her to a supported housing model might have worked.

The LSAB engagement guidance urges professionals to be 'careful what you record about engagement with an individual, or the lack of it'. The Adult Social Care chronology is well-written from this perspective – attempts to contact Maureen are described factually and without judgement. There are a few points in the IMRs when Maureen is described as having a 'history of non-engagement' and professionals should be careful about such labels, since there is a risk of locating the responsibility with the client and judging the likelihood of future engagement based on the past – both points go against the LSAB principles.

A key message from national research[10], practice guidance[11] and local policy is the importance of trying to understand the function of the self-neglect for the individual

[10] Making Safeguarding Personal video: self-neglect https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/videos

[11] Research in Practice: Practice Tool – Working with people who self-neglect

and get to know the person 'behind the mess'. Aspects of Motivational Interviewing may be helpful here, for example in affirming how it is clear that the pigeons matter enormously to Maureen - as a first step, Maureen might have been willing to accept practical support if she felt it might improve the pigeon's welfare. Noticing other skills and strengths – the sewing machine on the table as evidence of Maureen's past domestic skills – might help to reduce shame and open up conversations in which the workers' perception of the risks are shared (what Preston-Shoot has termed 'Care-frontational' questions), and very small goals are negotiated. All of this is admittedly challenging around a half-closed door, and it is hard to assess the quality of practice in professionals' interactions with Maureen from the chronologies provided. In future cases like Maureen's though, it will be important for managers to ensure staff have the values, skills, permission, and support to take a psychologically informed approach to their practice, sharing knowledge and observations of the person (as well as the risks) across agencies and reflecting together on how to use these creatively.

It is not clear that Maureen really understood what sort of support might be available to her, including what 'advocacy' might look like or mean for her (though the agency records state that this was discussed at one of the professionals' meetings).

Learning Points

- Ongoing awareness raising of the existing Guidance for Improving our Approach to Adult and Family Engagement and its key principles.
- Increasing workers' confidence and skills (e.g. drawing on approaches such as Motivational Interviewing, psychologically informed approaches, such as Adult Attachment) and clinical supervision to engage with people who self-neglect.
- People who self-neglect with a high level of risk and where engagement by standard methods is not working need more intensive resourcing, whether by social workers or a commissioned specialist support agency, e.g., allowing for several visits a week and including assertive outreach methods.

5.5. Communication, information sharing and working together

Assess if there was adequate communication and Information Sharing between agencies, and was the need to share safeguarding information and risk fully understood?

Determine and provide insights into the way organisations worked together in this case (including examples of good practice) to safeguard Maureen.

Did professionals experience barriers to their practice?

There were examples of good practice in coordination between Housing and Adult Social Care in the final months of Maureen's life, with joint visits, regular meetings to share information and plan, and examples of information such as the contact details of Maureen's friends being shared appropriately between agencies. Housing shared photos of Maureen with Adult Social Care in mid-June 2023 and details of locations where she typically fed the pigeons to support a more assertive outreach approach to engagement.

Prior to that though, there are examples where information does not appear to have been shared so effectively, for example (as flagged by SLaM in their IMR) there was a missed opportunity at triage in A&E for the psychiatric liaison nurse and/or the GP to follow up with and chase a referral to the primary mental healthcare team. Maureen was handed a leaflet to contact the team, but given the risks flagged by the ambulance team, this was insufficient.

There were also examples in which agencies might have better shared information about how best to contact Maureen – for example, Maureen had told the GP surgery that her phone was not working in February 2023, yet automated reminders and messages were still sent by the surgery, and Adult Social Care were interpreting her not answering the phone in March 2023 as a sign of lack of engagement. Recording systems may act as a barrier here but again a Section 42 Enquiry/ Safeguarding Plan could have provided staff with the impetus and confidence to share information about how best to engage Maureen to try and keep her safe. As identified in the Adult Social Care IMR, health colleagues were not involved in multi-agency meetings about Maureen after 15 May 2023 and there was no indication that the outcome of visits was shared with health to escalate the request for medical and mental health reviews.

When the SAR author contacted Maureen's friends to explain the SAR process and invite them to feed into it, it transpired that they did not know of her death and had been travelling up to London regularly over the past 16 months trying to find Maureen. They were understandably very upset not to have been able to take part in – and had been willing to organise – Maureen's funeral. They understood issues around confidentiality, given that they were not official next-of-kin, but equally felt 'cut out' by the council, with whom they had left contact details and asked to be informed of further developments. Maureen's goddaughter explained that it was frustrating that 'we were the only people she had at that stage, and I couldn't help the workers, and they couldn't help me because they couldn't tell me anything, and so neither of us could help Maureen'. Maureen's friend felt that her goddaughter was probably the only person who could have persuaded Maureen to move to a more suitable and supported environment. A joint visit was carried out with the goddaughter, the social work and housing staff; however, unfortunately Maureen had not been home though the door was open, and they looked inside the property.

Learning Points

- Raising awareness about the potential for the statutory Safeguarding Enquiry and planning processes to enable greater involvement of and information sharing between the full range of agencies: since these are frequent frontline frustrations in self-neglect cases, this may improve take-up of the safeguarding pathway.
- Clear policy around what information can be shared and who is responsible for doing this with friends and neighbours who are not registered as next of kin following a death.

5.6. Legal literacy

Did agencies collectively consider how their legal powers and duties could be exercised in a joint multi-agency strategy to reduce the risk of harm and self-neglect?

Is there a need to refresh knowledge for front line Adult Social Care professionals of the provision in Section 11 Care Act 2014?

There is evidence of agencies collectively discussing how some of their legal powers and duties could be exercised in a joint multi-agency strategy, for example in relation to housing around whether and when to proceed to a Notice Seeking Possession, and how the council might help prevent Maureen from becoming homeless. As stated above, Section 42 of the Care Act 2014 and the Mental Capacity Act 2005, seem to have received far less attention.

Section 11 of the Care Act 2014 outlines what happens when an adult refuses to have an assessment of their needs or care. The local authority is not required to carry out an assessment if an adult refuses. However, the authority must carry out an assessment if the adult is experiencing or is at risk of abuse or neglect.

Adult Social Care triaged the referral from Housing raising concerns about Maureen's living conditions in November 2022 and decided to carry out a Care Act Assessment, which is good practice. However, the case was closed because the concerns were about mental wellbeing and a referral via the GP was needed. In March 2023, Maureen's case was re-allocated to the same worker but closed within a couple of weeks because they had been unable to get hold of Maureen by phone and because Maureen's 'environment would not be a suitable environment to send carers to'. This case closure did not appear to have been risk assessed.

Maureen did not explicitly refuse the Care Act Assessment during this period, according to the notes; however, by not answering her phone, she was deemed effectively to have refused, and the case was closed, which was not good practice given the Safeguarding Concerns which had been raised by several agencies. The case was again allocated in April 2023 for a Care Act Assessment, and the worker was trying to engage Maureen to conduct this assessment up until she died.

Section 11 may not be wholly relevant here if Maureen did not explicitly refuse the assessment; however, there is a sense from the chronology that there is little point pursuing an assessment with someone who has a history of 'non-engagement' and for whom none of the standard service offers may be suitable anyway. The state of Maureen's living environment was arguably enough to demonstrate care and support needs, and a high level of safeguarding risk to Maureen. Cases like Maureen's are hugely challenging for Adult Social Care which receives a high volume of referrals and is experiencing a lack of resources with which to respond to them. However, prioritising those who do answer the phone and do ask for help leaves people like Maureen left in high-risk situations.

Learning Points

- The importance of challenging assumptions that there is little point pursuing Care Act Assessment where standard service offers may not be suitable and/or accepted by the person – broadening out the focus of assessment onto wellbeing outcomes, and safeguarding risks – in line with Section 11 and Section 42 of the Care Act.

5.7. Neurodiversity

What local support is available? Is specialist support and advice available to professionals working with Neuro diverse adults?

There does not appear to have been any specialist support or advice in relation to neurodiversity for the professionals working with Maureen during the period of the review. The GP surgery IMR flags a lack of specialist services to support neurodiverse individuals. A referral to the SLaM Autistic Spectrum Disorder/ Learning Disability outpatients service[12] was considered, though it was recognised there was a 3-year waiting list for assessment at the time and this does not appear to have been pursued. As the GP surgery reflected in both its IMR and in the joint Learning & Reflection session, the risks, and social issues for Maureen needed addressing regardless of waiting for further diagnostic confirmation. There was discussion about the value of referring Maureen to the national ASD outpatients service, but this does not seem to have been followed up. Similarly, the referral to the primary care mental health team, which was identified as necessary when she attended A&E in March 2023, was either not made or not followed up.

The clinical underpinning of Maureen's needs was somewhat unclear, with potential for Autism, mental health issues and possibly cognitive impairment or temporary confusion resulting from dehydration or infection to each be contributing to her mental state during the review period. There is a particular risk that individuals with multiple needs, where each of these may not in its own right reach the threshold for service intervention, do not receive the specialist psychological support they need. It was unclear which if any of these services could have effectively engaged and supported Maureen and the fact that waiting lists are so long must surely have contributed to professionals' lack of action in making and chasing up referrals. It is possible that – as mentioned above – a Safeguarding Planning process might have been able to draw in second tier specialist support from psychologists; if not, this is also an area for development, along with ongoing training for primary care, housing, and Adult Social Care staff in relation to neurodiversity – an action identified by Housing.

There is some evidence since Maureen's death, that there has been an attempt to improve the provision of services in the borough. In September 2023, Lewisham's new Autism strategy was published, to be overseen by a multi-agency Autism Partnership Board[13]. This contains a commitment to roll-out autism awareness training for health, care, and other professionals in the borough. It also aims to ensure that reasonable adjustments are made for people with autism attending health and care appointments and improve the suitability of community support, including supported housing. The Partnership Board has commissioned the Lewisham Autism Hub[14] which can provide advice to professionals working with cases like MP's, and a resource hub for those affected by Autism.

[12] Presumably this service, also referred to as the '3 boroughs' service: https://slam.nhs.uk/service-detail/service/croydon-lambeth-and-lewisham-adult-attention-deficit-hyperactivity-disorder-adhd-and-autism-service-213/

[13] See https://lewisham.gov.uk/mayorandcouncil/community-support/making-lewisham-an-autism-inclusive-borough

[14] See https://www.resourcesforautism.org.uk/lewishamautismhub/

5.8. Management oversight

Was there suitable management oversight, case direction, and escalation where necessary?

Each agency participating in the review felt that there was an appropriate level of involvement from senior managers in their organisation. There was evidence of managers' involvement from Adult Social Care, for example the case was discussed in supervision at least once in May 2023, managers took part in professionals' meetings with Housing and sent emails to Housing and the GP. This makes it all-the-more concerning that adult safeguarding processes were not followed in line with the LSAB self-neglect policy and suggests a need for a shift in organisational culture.

5.9. Equality

Was consideration given to Maureen's protected characteristics and whether this may have provided further insight into Maureen and her care and support needs?

What reasonable adjustments were made to support Maureen?

Is there sufficient consideration of Maureen's neuro diversity when attempting to engage MP with regards to neglecting herself?

As an older woman from a Black Caribbean background with some degree of cognitive impairment and/or mental health condition, Maureen was at risk of intersectional discrimination. Research from the US[15] suggests that there may be higher levels of self-neglect amongst black and minority older people living in poverty, perhaps due to cumulative disadvantage and a lack of trust in professionals to respond in an anti-discriminatory, culturally competent way. We can only speculate as to Maureen's experience of discrimination over a lifetime and whether and how this may have shaped her attitude towards those perceived as being in authority. There seemed to be a slight reticence to reflect on these issues in both the IMRs and the Learning and Reflection Session, which is understandable given the nature of the review. However, it is important to ensure that reflection on equality issues in such cases is a standing agenda item in supervision and multi-disciplinary team meetings and that staff are encouraged to create a safe space and use this to reflect on the potential for unconscious bias or institutional discrimination. For example, might workers have been so concerned to avoid imposing norms on Maureen or over-riding her rights to autonomy, given her age and ethnicity that they held back from questioning her mental capacity?

Anxiety and uncertainty can be barriers for Autistic people in seeking help from health and social care[16]. Navigating complex systems with their jargon about processes such as 'assessment', not knowing what to expect, embarrassment and

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[15] Dong X, Simon MA, Evans DA. Prevalence of self-neglect across gender, race, and socioeconomic status: findings from the Chicago Health and Aging Project. Gerontology. 2012;58(3):258-68. doi: 10.1159/000334256. Epub 2011 Dec 21. PMID: 22189358; PMCID: PMC3362301. https://pmc.ncbi.nlm.nih.gov/articles/PMC3362301/#:~:text=Among%20men%2C%20the%20prevalence%20of,%25%20CI%203.01–6.80

[16] Haydon, C., Doherty, M., and Davidson, I.A. (2021) Autism: making reasonable adjustments in healthcare, British Journal of Hospital Medicine, vol. 82, no 12 https://www.magonlinelibrary.com/journal/hmed

shame may also make it difficult for a person with Autism to ask for help from professionals, as recognised by the GP's IMR.

There were examples of reasonable adjustments being made. It was positive that Lewisham Homes had flagged Maureen as potentially 'vulnerable' right from tenancy sign-up, due to a 'diagnosis of Autism and low IQ'. There were clear attempts to communicate complex information (such as the Notice Seeking Possession) face-to-face as well as by letter. The GP surgery took steps to allocate a consistent Care Coordinator to Maureen. The housing and social care workers involved Maureen's friend in a home visit in the hope this might reassure Maureen. In relation to Human Rights, the social worker respected Maureen's privacy when she said she could not open the door because she was not fully clothed and agreed with her to return the following day. However, whilst this decision respected her dignity, it may ultimately not have served Maureen's best interests, since this was the only and last opportunity for face-to-face engagement by Adult Social Care. It might have been better to give Maureen time to get dressed and then asked to be invited in.

However, as highlighted previously, the workers do not seem to have taken the diagnosis as a cue to assess Maureen's mental capacity and pursue the Safeguarding Pathway on the basis that her self-neglect may be driven more by care and support needs than by 'lifestyle choice'.

Learning Points

- Ensure that reflection on equality issues is a standing agenda item in supervision and multi-disciplinary team meetings and that staff are encouraged to create a safe space and use this to reflect on the potential for unconscious bias or institutional discrimination.
- Ensure that workers are aware of what support they can access and how, from the Autism Hub in relation to their casework.

6. Recommendations

There is already a suite of relevant policies and processes within Lewisham to support multi-disciplinary safeguarding practice in cases such as Maureen's. However, as the SAR has highlighted, awareness of these is still limited – even amongst operational managers. High turnover of staff is likely to get in the way of the dissemination of guidance, yet the findings of the review also suggest that certain assumptions and ways of working may have become ingrained in the organisational culture, exacerbated by lack of resources. For example, that there is little point referring to mental health or ASD services due to length of waiting times or pursing a Care Act Assessment if the standard offer is unlikely to be relevant.

Building on the resources already in place and the actions taken since this review, Lewisham SAB, working closely with Adult Social Care and other partners, should **continue:**

1. Promoting awareness of the Multi-Agency Self-Neglect Policy, Practice Guidance and Procedures, the Inter-Agency Escalation Policy, Safeguarding Pathway, and Guidance for Improving Adult and Family Engagement.

2. Raise awareness about the potential benefits of the Safeguarding Enquiry and planning processes, e.g., to enable greater involvement of and information sharing between the full range of agencies; since these are frequent frontline

frustrations in self-neglect cases, this may improve take-up of the safeguarding pathway.

3. Proactively performance manage self-neglect cases to ensure the safeguarding pathway, and the new high-risk panel are being used effectively.

4. Encouraging consistent multi-disciplinary use of the Hoarding Assessment Tool/ Clutter Image Rating Scale.

5. Ensuring that workers are aware of what support they can access from the Autism Hub in relation to their casework.

Consider:

6. Implementing a framework for the ongoing monitoring of risks, perhaps using the headings set out in the London Multi-Agency Safeguarding Policy and Procedure, to inform decisions about case closure and escalation.
7. How resources can be identified to support more frequent, 'assertive outreach' to people at high risk from self-neglect and where engagement by standard methods is not working, whether by social workers or commissioned specialist support providers.

Address the following learning & development needs highlighted by Maureen's case:

8. Empowering multi-disciplinary teams to take collective ownership of '3D' mental capacity assessments where there are limited opportunities for a formal expert assessment: reflecting, observing, asking questions, and recording their judgements and views at each step of the chronology.

9. Executive function and its implications for mental capacity assessment.

10. Increasing workers' confidence and skills (e.g. drawing on approaches such as Motivational Interviewing, psychologically informed approaches, such as Adult Attachment) and clinical supervision to engage with people who self-neglect.

11. Develop a clear policy around what information can be shared and who is responsible for doing this with friends and neighbours who are not registered as next of kin following a death.