1. A Serious Case Management Review (SCMR) was commissioned to explore the experiences of 7 individuals who died in circumstances of self-neglect. The purpose of this review was to identify learning and apply this to improve safeguarding systems and practice.
- To understand common factors that led a person to self-neglecting.
- To understand enablers and barriers to practice on IOM
- Identify and extend good practice
- Make recommendations to the IOMSB to develop a strategy and resources for future practice

2. The People

Robin was a man in his 80s living alone at his time of death in a house in very poor condition. His self-neglect was recorded over a period of over 20 years and he was well known to services.

Andrea was in her 40s and living alone when she died. She had been diagnosed as a young woman with Schizoid Affective Disorder and was well known to services.

Emma was in her 50s. She too lived alone and was well known to services in relation to her physical and mental health.

Thomas was a man in his 30s living alone when he took a medication overdose with alcohol and died. He was known to drug and alcohol services and the mental health team.

James was in his 60s when he died of heart and liver issues but he was also malnourished and his home was in poor repair. He was known to mental health services.

Margaret was a woman in her 80s following a fall in her unheated house. She was not known to any services and didn't have a GP.

Harriet was in her 70s when she died of hypothermia at her home which was in a poor condition lacking even a working toilet. She was not known to any services.

3. The review identified some common themes

Building relationships and developing understanding.

The review found that, professionals had become desensitised to many of the issues; some of the individuals were lost from sight of the professionals; many of the individuals were isolated in the community; there was a clear need for relationships to be consistent and purposeful; there was a need for psychologically informed assessments and appropriate responses from services; and for practitioners to be mindful of the correlation between problem alcohol and substance use, mental health and self-neglect.

7. Recommendation 2

Manx Care mental health services should develop a policy to guide practice where service users do not attend appointments. The policy should include guidance on risk assessment, proportionate and reasonable measures for follow up, including communications with other agencies and family as appropriate. If you would like to read the full report please click on hyperlink below or go to www.safeguardingboard.im

Thematic Review SCMR Report

4. Working with Risk

The review found that there was an absence of safeguarding minded practice across agencies and a lack of application of safeguarding adult procedures; there was a lack of applying self-neglect guidance to practice, and limited use of risk assessment and risk management processes; there was limited evidence of awareness of the legal framework and use of formal capacity assessments; and an understanding that a professional duty of care remains where a person declines services.

6. Recommendation 1

The IOMSB should lead a strategy, and implementation plan for self-neglect. This plan should deliver:

- A clear Pathway – involving Wellbeing Partnerships; families and communities and Safeguarding Adult Enquiries
- Policy and Procedures that provide guidance on working with self-neglect and assessing risk.
- Training on self-neglect and mental capacity and clear standards on Supervision
- Improved resources to support this work e.g. Housing strategy; psychological assessment and consultation

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5. Working Across Agencies

The review found that there had been limited family involvement with agencies and lack of recognition of the value of informal networks for vulnerable people; there was a lack of involvement from GP practices; gaps in housing support from providers; limited multi-agency working, and missed opportunities to bring together networks of support.