The Isle of Man Safeguarding Board Response, to the Serious Case Management Review – Thematic Review of Self- Neglect

This Serious Case Management Review (SCMR) concerns the lives of seven people, who all died in circumstances of self-neglect. Not all of these individuals had been known to services, and only one of the individual's situations met the criteria for a SCMR. However, the Isle of Man Safeguarding Board wanted to explore how effectively services and communities in the Isle of Man work together to support people who may be self-neglecting and use the learning from a thematic review to improve multi-agency responses and service delivery.

Self-neglect' refers to a range of behaviours, and may include lack of self-care in areas such as personal hygiene, dietary needs and health needs. Self-neglect may also relate to lack of care to one's environment – for example unsafe or unhygienic home conditions; clutter arising from hoarding resulting in risks to health and safety and fire risks. Self-neglect may be shown in refusal of assessments and interventions by services that may alleviate the issues.

This Thematic SCMR was commissioned in 2021 by the Isle of Man Safeguarding Board in line with the Safeguarding Board Act 2018 and 2019 Safeguarding Together Guidance. The purpose of a SCMR is to identify learning and apply this to improve safeguarding systems and practice. The Board commissioned Sylvia Manson, an experienced independent reviewer with particular expertise in evaluating and improving responses to self-neglect, to complete this SCMR.

The review process consisted of agencies providing reports of their involvement with the individual adults, where relevant and two practitioner events were held to assist in evaluating agencies current response to self-neglect. Importantly, the review also involved engagement with the families of a number of the individuals. The review process was supported by a Panel of independent senior staff from involved agencies, who provided the necessary context on organisational policies and practice.

The agencies involved in the process were:

Isle of Man Constabulary

Isle of Man Fire & Rescue

Environmental Health Unit, Department of Environment, Food and Agriculture

Manx Care- Health

Manx Care – Adult Social Care / Adult Safeguarding Team.

GP practices

Independent Sector Care Agency

Volunteers Befriending Scheme

This review covers a period from April 2018 to February 2022, and spanned the last two years of each person's life. Agencies were asked to provide any relevant historical information from the person's background and information was made available from the Coroner's reports, regarding individual circumstances relating to their deaths

The review recognised that, defining self-neglect can be open to interpretation, with subjective judgements about what are 'acceptable' standards. Practitioners need to make professional judgements about levels of risk but weigh this as part of wider considerations about the adult's wellbeing.

The report and its recommendations were agreed and accepted by the Isle of Man Safeguarding Board. The report has been published by the Safeguarding Board along with this Board response.

The review identified a number of learning themes in the following three areas:

- **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 and self-neglect.
- **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.
- **Working across agencies & communities**
  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.

Recommendations

1) The IOMSB, on behalf of the IOM Government, should lead a strategy and implementation plan for self-neglect, with sign up by the relevant IOM Government Departments. The strategy and implementation plan should deliver:
    - A clear Pathway that builds a "Team around the Adult" approach to self-neglect that involves Wellbeing Hubs; families and communities and clarifies the role of 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 for Supervision.
    - Improved resources to support this work e.g. Housing strategy; psychological assessment and consultation; improved advocacy; clarity about third sector resources and a multi-agency panel to support practitioners in dealing with complex cases.
    - Improved involvement of Families and Communities in dealing with self-neglect.
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.

Actions Taken to Address the Learning and Recommendations.

There have already been a number of actions taken to improve systems and practice and these are as follows:

The Safeguarding Board was already working to update the multi-agency Safeguarding Adult Procedures and the specific self-neglect procedures. Work has also been completed to develop a signed Information Sharing Protocol between all the Board agencies, that reinforces the importance of openly sharing information to safeguard citizens from abuse and neglect. Additionally, Information Sharing Guidance is now available for all professionals to support appropriate information sharing: https://www.safeguardingboard.im/safeguarding-children/information-for-professionals/information-sharing/

As a direct result of this review, the Safeguarding Board agencies have commissioned a specific piece of work to engage all sectors in improving the response to self-neglect aligned to the review recommendations. This will include partner agencies working together with individuals and their support network, to ensure that their needs are met in line with recognised procedures. A training programme for self-neglect and mental capacity is planned and a campaign to raise public awareness of adult safeguarding, including who to contact with any concerns. Advice and contact numbers are available on the Safeguarding Board website.

Manx Care has new leadership and is focusing on strengthening Safeguarding Adults across Health and Social Care with clear management accountability for standards of practice, developing operational guidance and risk assessment tools, and embedding Safeguarding in day-to-day practice. There have been new Designated Safeguarding Adult posts within Health, providing leadership and developing systems to improve responses by health services.

Manx Care is planning to establish a multi-agency safeguarding hub (MASH) in partnership with the Isle of Man Constabulary. This will improve the response to Safeguarding Adult referrals by collating information across partners and improving the multi-agency decision making. At time of the review, there was a business case to approve funding for additional specialist posts to support the MASH. There are also plans to establish a Vulnerable Adults Risk Management Panel.

Manx Care is also developing Wellbeing Partnership Hubs across the Island. These Wellbeing Partnerships, cluster agencies together to coordinate care. There are new roles of Local Area Coordinators that help to reach out to people and connect them to services and communities.

The Department of Infrastructure (DOI) Housing, contributed to the review and confirmed that their intent to is to further develop their Housing Support offering, in response to the Housing and Communities Board's first Action Plan, which includes a Manx version of Housing First model as a potential intervention across the sector.

The Department of Health and Social Care is working to bring in new legislation on mental capacity, which will greatly assist practitioners in determining whether individuals have the capacity to make their own decisions about their care and support needs. In the interim whilst work on the capacity legislation is taken forward, Manx Care have updated their capacity policy to support staff in assessing mental capacity.

The Safeguarding Board will be engaging further with politicians, agencies, sectors and communities; to ensure that the message that "safeguarding is everyone's business" is better understood. Also, that everyone is aware of the need to make contact about any individual where there are concerns about self-neglect. The contacts for agencies that can provide advice and support can be found here https://www.safeguardingboard.im/reporting-a-concern/

This response is fully endorsed by all members of the Board:

Lesley Walker, Independent Chair, Safeguarding Board

Teresa Cope, CEO Manx Care

Dan Davies, CEO Department of Home Affairs

Graham Kinrade, CEO Department of Education, Sports and Culture

Stuart Quayle, Interim CEO Department of Health and Social Care

Gary Roberts, Chief Constable

Terri Banks, Head of Safeguarding, Health, Manx Care

Madeleine Sayle, Head of Public Health Intelligence, Public Health

Board Independent Members.