Jersey

Safeguarding Partnership Board

Serious Case Review

‘Mr Hunter’

Overview Report

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Executive Summary

1. Introduction

1.1. The serious case review (SCR) relates to a man who is referred to as 'Mr Hunter,'a pseudonym.

1.2. Mr Hunter was an 89 year old man who had lived for over 40 years in Jersey off grid in accommodation that had increasingly fewer basic amenities.

1.3. Mr Hunter's living conditions were described by some agencies as 'squalid'. They were concerned he was putting his own health and safety, and the health and safety of others at risk. Mr Hunter disputed this and was very happy with his lifestyle – neither he or his next of kin accepted that he was neglecting himself.

1.4. Mr Hunter was well known to the parish who had tried over the years to support him.

1.5. In 2017, a referral was made to Jersey Adult Social Care single point of referral under the multi-agency self-neglect guidance.

1.6. Agencies worked together to try and reduce risks to him as well as to the public. This response included condemning his caravan under Environmental Health regulations, against Mr Hunter's wishes.

1.7 Mr Hunter accepted some help but also declined many services. Sadly Mr Hunter developed an infection and decided against having the surgery that was needed to save his life.

1.8. This review explores how agencies worked together with Mr Hunter and identifies learning that may help when working with others in similar circumstances.

2 Summary of the Learning Points from the Review

The review used research into self-neglect as a framework to evaluate practice. The review also considered how learning from previous SCRs relating to self-neglect had been acted upon.

2.1 Practice Responses to Self-Neglect: Summary of Learning Points

2.1.1. There was evidence of agencies and individuals spending time trying to develop constructive relationships with Mr Hunter. However, Mr Hunter's cousin's view was that no-one was really able to take the time needed to fully understand him.

2.1.2. In the period preceding the referral for a multi-agency response in 2017, significant efforts were made by the parish and the States of Jersey Police to support his welfare. The States of Jersey Police made efforts to encourage Mr Hunter to accept Adult Social Care, support which he did not want to accept.

2.1.3. The Safeguarding Adults Partnership Board (SAPB) multi-agency guidance on self-neglect was in place from January 2016.[1] Had a referral been made through this guidance at an earlier stage, this may have enabled other agencies to engage at an earlier point, though it is likely Mr Hunter would still have resisted any involvement.

2.1.4. When the multi-agency self-neglect meetings were initiated, there was evidence of good multi-agency practice. However, this would have been strengthened by greater involvement of his next of kin to fully consider his wellbeing and a proportionate response to the risks presented.

2.1.5. Those involved tried to engage with Mr Hunter in a shared plan and used opportunities when he may have been more motivated toward change. The risks were known by agencies though there were challenges in how to manage them

2.1.6 There was a difficult balance in respecting Mr Hunter's wishes whilst reducing risks to himself and others. There was sound evidence that agencies acted within the legal framework including considering mental capacity. Agencies confirmed that Mr Hunter was making informed decisions regarding the choices he made.

2.1.7. Agencies worked together to try to find creative ways to help him, maximising his control even when regulatory enforcement action was taken. Though Mr Hunter was able to make his needs known, advocacy may have helped him process and voice decisions during a very trying time for him.

2.1.8 There was learning about the need to coordinate Mr Hunter's health needs under the multi-agency response and the role of the relevant health agencies in this. There was also learning regarding the expectations of the Lead Worker, what this role entailed and who it should be assigned to. A recommendation was made to review the guidance in relation to this role.

2.1.9. The review highlighted the different perspectives that may be held regarding risk and the tensions that can exist in responding to this. Multi-agency assessments need to apply some rigour in ensuring the actions taken are promoting the wellbeing of the person, alongside considerations of public safety. Explicit application of the safeguarding adult principles can help guide these difficult decisions.

2.2. Strategic Responses to Self-Neglect: Summary of Learning Points

2.2.1. The response to Mr Hunter was directed by the multi-agency self-neglect guidance produced by Jersey SAPB in 2016.[2] The SAPB had also carried out work in trying to understand prevalence of self-neglect on Jersey. This strategic work was good practice.

2.2.2. The multi-agency guidance was effective in supporting practice. However, the positive practice was also reliant on commitment from individuals that was not necessarily supported by resources.

[1] Safeguarding Partnership Board (2015), *Self-Neglect Guidance and Tools*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-Self-Neglect-Guidance_FINAL.pdf [Accessed: 22-01-18]
[2] Ibid.

2.2.3. In order to provide the most proportionate response and make best use of limited resources, the SAPB may wish to further support the development of the self-neglect pathway and procedures to include:

- Preventative work through single agencies, supported by an early help co-ordinator/navigator role and directory of resources
- Maintaining the self-neglect multi-agency meetings
- A process to manage longer term cases beyond the immediate safeguarding protection plan

2.2.4. For the few, higher risk and more complex cases this will necessarily require commitment from agencies for sustained involvement, freeing up and promoting the creative use of resources.

2.2.5. The States of Jersey and the SAPB needs to support agencies to achieve this.

2.3. Applying Learning from other Jersey's Self-Neglect Serious Case Reviews

2.3.1. Although there was much positive practice in evidence, the recommendations from earlier SCRs on other self-neglect cases remained valid. This included:

- Multi-agency based training on self-neglect
- Sampling cases to assure partnership working
- Implementation of the Capacity and Self-Determination (Jersey) Law 2016
- Allocation of resources to manage self-neglect including access to specialist resources
- Work with the parishes to aid their understanding of and responses to self-neglect

2.4. Summary of the Conclusion

2.4.1. Mr Hunter had chosen a lifestyle that was out of kilter with how many would choose to live their lives.

2.4.2. There is substantial evidence that Mr Hunter understood the risks associated with his lifestyle and the likely implications of not accepting help with his health and social care needs.

2.4.3. The task of agencies was to try and engage with Mr Hunter, reducing the risks he was living with whilst respecting his chosen lifestyle and maintaining public safety.

2.4.4. Ultimately, Mr Hunter died due to complication arising from his health conditions and his declining treatment. The evidence is that he had full understanding of the implications of not accepting treatment.

2.4.5. This review has highlighted the very challenging practice and ethical dilemmas of working with people defined as self-neglecting and how those agencies tried to navigate through this.

2.4.6. The review highlighted many examples of good practice by agencies working together and the care and compassion shown by individuals. The review also highlighted areas that will strengthen multi-agency work in responding to self-neglect.

Main Body of the Report

3. Context of Serious Case Reviews

3.1 Jersey Safeguarding Adults Partnership Board (SAPB) will arrange for a Serious Case Review (SCR) when an adult (with needs for care and support) dies from, or has experienced serious abuse or neglect and there is concern about how the SAPB, members of it or other persons with relevant functions worked together to safeguard the adult.[3]

3.2. The purpose of SCRs is to promote learning and improvement between agencies to safeguard people more effectively. SCRs are not concerned with attributing blame and are not part of any disciplinary matters.

3.3. A SCR enables all of the information known to agencies to be seen in one place. This is beneficial to learning though recognises that this hindsight knowledge was not all available to individual practitioners at the time.

4 Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1 The specifics of this review are as follows:

Terms of Reference
The review will consider the care and responses to Mr. Hunter during: **1. The years pre-dating the referral to the Health and Social Services Safeguarding Adult Service, (as relevant to responses to care and self-neglect).** **2. From Winter 2017 when the referral to Health and Social Services Safeguarding Adult Service was made** **The review will address the following issues:**
• **How did responses to Mr. Hunter benchmark against best practice in self-neglect?[4]**

[3] Safeguarding Partnership Board (2016), *Serious Case Review Procedures*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-joint-SCR-procedures-FINAL-REVIEWED.pdf [Accessed: 22/01/18]

[4] Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-neglect Policy and Practice: Research Messages for Managers*;

- **How has the learning from self-neglect Serious Case Reviews been acted upon?**
- **What has changed in the last three years and what needs to change to improve future responses to self-neglect?**

4.2. Methodology

4.2.1 In agreement with members of the SCR sub-group, the Independent Chair of the SAPB, Glenys Johnston OBE commissioned an independent author to carry out this review. The author, Sylvia Manson, is an experienced author of reviews, holds a professional background in Social Work, mental health services and safeguarding adults and is independent of the SAPB and its partner agencies.

4.2.2 The Independent Author was supported by a Chair. Neither the Chair nor their agency had had any prior involvement with Mr. Hunter. The review was also supported by a panel from the SAPB partner agencies. This brought a further level of expertise and scrutiny of the individual agencies' reports. The panel membership was:

- Chair: Executive officer, Jersey Employment Trust
- Police: Head of Crime, States of Jersey Police
- Social Services: Head of Adult Services
- Hospital: Designated Nurse for Safeguarding

4.2.3 The methodology applied to this SCR combined reports from each agency with a learning event. The learning event brought together managers and frontline practitioners from the agencies to benefit from their knowledge and experience in this case and to draw out recommendations for improvement.

4.2.4 Understanding the experiences of those receiving support from agencies is central to learning. The review benefitted from feedback that Mr Hunter had provided to Health and Social Services before his death in the form of a questionnaire. This related to his views about the safeguarding responses from agencies and the outcome from their interventions. These views are incorporated into the review and the questionnaire is also included as Appendix 1.

4.2.5. The review benefitted greatly from the involvement of Mr Hunter's cousin who was his next of kin and knew him very well. The SAPB is indebted to him and his views are included throughout the report.

4.2.6. SCRs should be conducted in a way respects the person's dignity and the privacy of the person. A pseudonym has been used to refer to Mr Hunter. Professionals and specific places are not named. Dates are deliberately generalised while retaining enough information to provide a context.

Ibid, *Self-Neglect Policy and Practice: Research Messages for Practitioner*, Both available from: https://www.scie.org.uk [Accessed: 22/01/18]

4.2.7. Participating agencies were encouraged to apply a systems approach[5] to the review i.e. explore all contributory factors as well as individual practice factors.

4.2.8. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement	
Department of the Environment	Responsible for investigating situations where there is potential for a statutory nuisance. The team are legally required to investigate such situations including public health concerns. The Environmental Health Team was involved with Mr Hunter from 2017 and was part of the core multi-agency self-neglect group. *Provided a report to the review and attended the learning event*
Family Nursing and Home Care	A Jersey charity providing nursing and home care in the community. The service was involved with Mr Hunter in the two months preceding his death and attended the last multi-agency meeting. *Provided a report to the review and attended the learning event*
GP	Had provided Primary Care to Mr Hunter since 2013 and referred onto secondary healthcare as required. The GP's involvement was not made known to the multi-agency group and so the GP was not involved in the meetings. *Provided a report to the review and attended the learning event*
States of Jersey Parish Constable	The Constable is the elected head of the Parish. Mr Hunter had been known to the Parish Constable for over 30 years. The Parish Constable was part of the core multi-agency self-neglect group. *Provided a report to the review and attended the learning event*
States of Jersey Fire and Rescue	Fire and Rescue were involved from 2017 and were part of the core multi-agency self-neglect group. *Provided a report to the review and attended the learning event*
States of Jersey Health and Social Services	Jersey Hospital and Ambulance had had some involvement with Mr Hunter throughout the years as outpatient and inpatient. They were part of the core multi-agency self-neglect group. *Provided a report to the review and attended the learning event*
	Adult Social Services co-ordinated the multi-agency response in 2017 through Adult Safeguarding, an allocated Social Worker and an Occupational Therapist. *Provided a report to the review and attended the learning event*
Honorary Police	Honorary Police Officers are elected by parishioners to assist the Constable of the Parish to maintain law and order. Mr Hunter was known to the Honorary Police Centeniers for many years but had not presented any problem to them and they were not concerned about him. *Provided a report to the review*
States of Jersey Police	Had some involvement from 2015, visiting Mr Hunter on welfare grounds and were initially involved under the multi-agency response. *Provided a report to the review and attended the learning event*
States of Jersey Social Security Dept (SSD)	Mr. Hunter was in receipt of pension. *Attended the learning event*

[5] SCIE (2017), *Learning Together*, Available from: http://www.scie.org.uk/children/learningtogether/about.asp [Accessed:22/01/18]

5. Mr Hunter and the Background for This Review

5.1. This section provides an insight into Mr Hunter's lifestyle and the events leading up to his death. The subsequent section provides an analysis of these events, including how agencies worked together with Mr Hunter.

5.2. Mr Hunter was an 89 year old man of Irish origin. He had a good relationship with his cousin who was based in the UK and his family were well established in Jersey.

5.3. His cousin described him as a cultured and well educated man having studied electrical engineering at university. He was described as a strong minded and proud person, '*his own man*,' who liked to be near to nature and to live a quiet life.

5.4. Mr Hunter had originally moved to Jersey in 1940, just before the German occupation, then left to work abroad, returning to Jersey approximately 50 years ago. He had lived within the same parish since that time in "off-grid" accommodation, initially in wooden containers from which he gained some income by renting out to others.

5.5. Mr Hunter had been a part-time small dairy farmer until new Health and Safety regulations were introduced in the 1980's. He then switched to a variety of projects including collecting cars, breeding cats and growing fruit.

5.6. His mother lived in Jersey and periodically encouraged him to move to a more conventional accommodation and lifestyle but he resisted this.

5.7. Mr Hunter had been well known to the parish. The report from the parish describes the pastoral care offered to him over many years.

5.8. Mr Hunter was described in some of the reports as '*something of a character*'. His cousin highlighted that he brought a lot of happiness to those who knew him and he and his family greatly respected him.

5.9. It is understood that Mr Hunter was financially secure, having inherited funds from his mother in the 1990s and subsequently drawing a pension. However, he chose to live with increasingly limited means including in the latter period, no sanitation or water.

5.10 The Honorary Police, Parish Constable and tenant farmer on whose land the caravan was kept, maontained a 'watching brief' through weekly visits.

5.11. In 2005, Mr Hunter lost all his belongings in a fire – he was not at home at the time. The parish stepped in to provide him with a caravan. Though the local tenant farmer had allowed him to reside on the land, the caravan did not have any planning permission and was not permitted under Jersey law.

5.12. Mr Hunter had a number of health care needs. He had been registered with the same GP for four years and periodically attended with various health needs. His GP made onward referrals for outpatient treatment and on some occasions, Mr Hunter was admitted to hospital though did not always accept treatment.

5.13. Mr Hunter came to the attention of the States of Jersey Police in 2015 due to driving a defective car. The States of Jersey Police noted the conditions he was living in and referred this through their internal route as an 'Adult Protection Notice.' The referral was not progressed through multi-agency safeguarding procedures as the self- neglect was not seen as meeting the criteria i.e. it was not third party abuse.

5.14. The States of Jersey Police did seek Mr Hunter's permission to refer him to Adult Social Care – he declined. The States of Jersey Police recorded that he had capacity in making this decision and so respected his choice.

5.15. The States of Jersey Police did however, consult with Adult Social Care and visited again to encourage Mr Hunter to accept support from them. He again declined confirming he had support from a friend, his cousin and his GP. He was clear that he had enough finances and that he did not want his personal life interfered with.

5.16. The States of Jersey Police negotiated with Mr Hunter to accept fortnightly visits from them to check on his wellbeing. Mr Hunter accepted this.

5.17. **By 2016**, there were signs that Mr Hunter's health was deteriorating. His eyesight was beginning to fail and there were some indications that he may be more open to accepting help.

5.18. During one States of Jersey Police visit, Mr Hunter did agree for his details to be shared with Adult Social Care. The States of Jersey Police liaised with them and returned with accommodation referral forms for him. Mr Hunter did not complete these.

5.19. In **Mid-Winter 2017**, Mr Hunter's cousin contacted the States of Jersey Police. Mr Hunter had rung his cousin to say he was in pain. The States of Jersey Police attended and called an ambulance and he was admitted to hospital.

5.20. The ambulance crew noted the poor conditions Mr Hunter was living in and submitted a safeguarding adult self-neglect referral to Adult Social Care.

5.21. Mr Hunter received initial treatment with follow up treatment to be self-administered at his home. At this time he said he did not want to go back to his caravan as it was cold and lacked a flushing toilet which would be a necessary element of his post hospital care.

5.22. The hospital phoned the Shelter Trust to request a bed. However, when the ambulance took him there, Shelter had no record of the referral and had no rooms available. The ambulance crew contacted the hospital to ask for him to be returned but this was declined so the ambulance conveyed Mr Hunter back to his caravan. On viewing the condition of his property, the ambulance crew tried to make alternative arrangements. Meanwhile, Mr Hunter's condition deteriorated again so the crew returned him to hospital.

5.23. Within two days, Mr Hunter was medically fit and the ward were looking to discharge him. Mr Hunter was not willing to remain in hospital. The discharge co-ordinator assessed Mr Hunter as having the capacity to make this decision.

5.24. Two days after his admission to hospital, Mr Hunter was discharged to a residential care facility, funded for two weeks by Social Care.

5.25. The discharge co-ordinator initiated the SAPB self-neglect referral and an emergency multi-agency meeting was convened for the following day.

5.26. The decision from this first emergency meeting was for Environmental Health and the Fire Service to visit Mr Hunter's property to carry out a Public Safety Interest Assessment. This assessment was carried out the same day and information fed into the first multi-agency self-neglect meeting held the next day.

5.27. A decision from this self-neglect meeting, was that Environmental Health would apply to the Minister for an abatement notice, requiring clearance of the site and to prohibit use of the site under Environmental Health conditions.

5.28. A further self-neglect multi-agency meeting was held the following day.

5.29. Professionals' reported that Mr Hunter initially appeared to settle into the care home reasonably well, though he continued to express concern about the cost. He did not want to fund his residential care.

5.30. A third multi-agency self-neglect meeting was held one week later. Mr Hunter attended. He was informed that the Minister had granted the abatement notice. This gave authority to prohibit Mr Hunter's return to the site, subject to specific Environmental Health requirements. Steps were initiated to remove the caravan and clear the site.

5.31. Mr Hunter was very unhappy about this decision. He remained of the view that he wanted to return to his caravan.

5.32. As a temporary measure, Mr Hunter moved to a room in a local hotel where he remained for four weeks. His cousin saw him regularly over this period. His cousin describes him as very unhappy there, viewing it as a barren environment. He would take him back to the parish for occasional visits.

5.33. During this period, Mr Hunter also had regular and lengthy meetings with his Social Worker and a Social Work Assistant, helping him consider his care needs and the options open to him. He also met regularly with Environmental Health and with the Parish Constable.

5.34. The agencies worked to try and find alternative accommodation. However, this proved challenging. Mr Hunter did not wish to follow up a referral to the Housing Gateway. He did not want to live with others or live in an urban setting where housing may have been available nor

did he wish to fund private accommodation or residential care. There was no legal authority to compel him to live somewhere without his consent.

5.35. By the beginning of **Spring 2017** and in the absence of alternative options, the parish tried to source a portacabin so that Mr Hunter could return to live in the same area of the parish. Concerns were expressed by some agencies about the lack of basic facilities for him and the conflict with building control regulations. Nonetheless, as there were limited alternatives, this was the plan agreed by the multi-agency group, subject to Ministerial approval.

5.36. The Parish Constable offered to adapt the portacabin for Mr Hunter so it would have the necessary basic facilities. The plan was for Mr Hunter to remain at the hotel until these adaptations were in place.

5.37. During this period, Mr Hunter's health was declining. He was admitted to hospital with heart failure and pressure damage to his heel and remained there for one week.

5.38. Mr Hunter was discharged back to the hotel with planned follow up from Family Nursing and Home Care. This service visited him from the point he was discharged from hospital and scheduled visits twice a week though Mr Hunter was often out.

5.39. A fourth multi-agency risk management meeting was held a few days after his hospital discharge. The multi-agency plan included:

- Adaptations to portacabin and environment
- OT assessment and interventions
- Access to Long Term Care benefit
- Meals on Wheels
- Welfare checks
- Day centre referral
  Health checks – onward referrals

5.40. Within a fortnight, an ambulance was called to attend Mr Hunter at the hotel due to a cut foot. The District Nurse had attended the previous day and given advice about his foot. The ambulance crew noted signs of self-neglect including that he did not appear to have eaten.

5.41. Mr. Hunter was taken to the hospital Emergency Department for treatment. The hospital report records:

> ***"Despite being unkempt and making irrational lifestyle choices, he does have capacity agreed by two doctors. Discharged to hotel".***
> **Hospital Report**

5.42. Mr Hunter remained at the hotel for three more weeks but then informed the District Nurse he had decided to move back to the Parish into the portacabin, even though it was not completed e.g. still no heating or lighting or refrigeration in place. He declined any further treatment for his foot. The nurse updated his Social Worker.

5.43. The Social Worker visited the day of his move and the District Nurse began twice weekly visits. These visits continued beyond the point the nurse would usually keep a person on their

caseload. The Occupational Therapist (OT) had also become involved and was working closely with Mr Hunter.

5.44. A fifth multi-agency meeting was held the week following Mr Hunter's move to the portacabin.

5.45. During this period, Mr Hunter also saw his GP, supported in his attendance by his OT, and was referred for treatment. He did not attend all appointments or follow through on treatment, despite considerable health problems. It was at this point that the GP was informed of the multi-agency involvement but advised no action was required.

5.46. In the three weeks leading up to Mr Hunter's death, his health had deteriorated further. He was visited at the portacabin by his GP, Nurse and Tissue Viability Nurse. The Family Nursing service contacted his Social Worker to notify of Mr Hunter's failing health and that he had possible infection and needed a residential placement if he would accept this.

5.47. Mr Hunter's GP admitted him to hospital the same day. He had developed a blood clot in the arteries of his right leg and had ulceration. His compliance with his blood thinning medication had been questionable.

5.48. Mr Hunter remained in hospital for the final two weeks of his life. His cousin was with him for much of this time. Mr Hunter was advised that the poor condition of his leg and foot meant that amputation was the only option.

5.49. Mr Hunter declined to have the amputation. He was made comfortable and died a few days later. May he rest in peace.

6. Analysis and Learning

6.1. Context

6.1.1. The term 'self-neglect' covers a wide range of behaviour. It includes people, either with or without mental capacity, who demonstrate:[6]

- lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- lack of care of one's environment – squalor and hoarding, and/or refusal of services that would mitigate risk of harm

6.1.2. It is noted that Mr Hunter would not have defined himself as self-neglecting and nor did his next of kin.

6.1.3. Research has highlighted the significant challenges that individual practitioners, agencies and safeguarding partnerships have in responding to self-neglect.[7]

6.1.4. Historically, in the UK and in Jersey, Safeguarding Adult Boards have had different approaches to managing self-neglect. Some Boards managed self-neglect under their Safeguarding Adults procedures. Other Boards determined that Safeguarding Adult procedures should be reserved for abuse or neglect perpetrated by a third party with self-neglect being managed through alternative multi-agency arrangements.

6.1.5. The Care Act 2014 (England and Wales) statutory guidance did reference self- neglect as a type of abuse. [8] However the guidance recognised that self-neglect could be addressed through different routes and should be considered on a case by case basis.

6.1.6. The Care Act has an over-riding well-being principle:

> *(1)* ***The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being.***
>
> ***(2)"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following—***
> ***(a) personal dignity (including treatment of the individual with respect);***

[6] Definition: 'Self-Neglect', SCIE (2014), *Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: 22/01/18]

[7] Ibid.

[8] Care and Support Statutory Guidance (2017) Ch14.7, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: 22/01/18]

(b) physical and mental health and emotional well-being;
(c) protection from abuse and neglect;
(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
(e) participation in work, education, training or recreation;
(f) social and economic well-being;
(g) domestic, family and personal relationships;
(h) suitability of living accommodation;
(i) the individual's contribution to society.

Care Act 2014 (England and Wales) Part I, Section I

6.1.7. The Care Act statutory guidance[9] references the safeguarding adult principles that should work together and be applied when working with adults in addition to the well-being principle. These principles are applied by the Jersey Safeguarding Partnership Board.

Empowerment:	**People being supported and encouraged to make their own decisions and informed consent.**
Prevention:	It is better to take action before the harm occurs
Proportionality:	The least intrusive response appropriate to the risk presented
Protection:	Support and representation for those in greatest need
Partnership:	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability:	Accountability and transparency in delivering safeguarding

6.1.8. Within Jersey, the SAPB introduced multi-agency self-neglect guidance and tools in January 2016.[10] This guidance was applied in the response to Mr Hunter.

6.1.9. In considering the effectiveness of the practice with Mr Hunter, this review is drawing on learning from the research into self-neglect, published by the Social Care Institute for Excellence (SCIE) in 2015.[11]

[9] Ibid
[10] Safeguarding Partnership Board (2016), *Self-Neglect Guidance and Tools*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-Self-Neglect-Guidance_FINAL.pdf [Accessed: 22-01-18]

[11] SCIE (2014) *Self-neglect Policy and Practice*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: December 2017]

6.1.12. • Practice Responses to Self-Neglect

Examining how agencies worked together: opportunities for early intervention with Mr Hunter and the effectiveness of the multi-agency response from February 2017

6.1.13. • Strategic Responses to Self-Neglect

Examining the wider systems and processes that support partnership working.

6.1.14. The review will then consider how learning from previous Serious Case Reviews has been acted upon.

6.2. Practice Responses to Self-Neglect

6.2.1. The table below summarises the factors highlighted in the SCIE research that led to more successful practice responses to self-neglect.[12]

Practice Factors Most Successful in Self Neglect
1. Time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement
2. Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history
3. Working at the individual's pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small
4. Understanding the nature of the individual's mental capacity in respect of self-care decisions
5. Having an in-depth understanding of legal mandates providing options for intervention
6. Being honest, open and transparent about risks and options
7. Creative and flexible interventions, including family members and community resources where appropriate
8. Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals.

6.2.2. In the months leading up to Mr Hunter's death, there were a significant number of agencies and professionals with some involvement in his care:

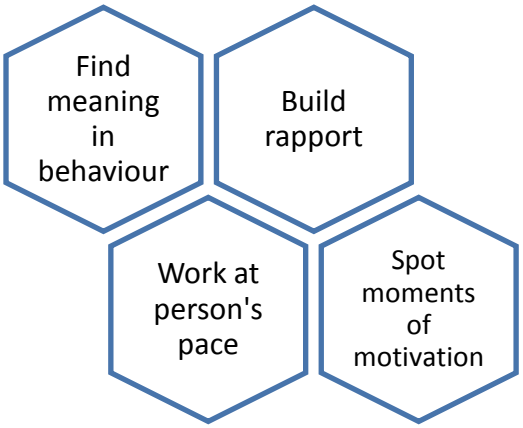
[12] Ibid

HSS Safeguarding	Parish Constable & Honorary Police	Environmental Health & Planning	Fire Service
State Police	Hospital - ED, wards & Outpatient	Ambulance	GP
HSS Occupational Therapy	Care Home	Social Security	Ministers
HSS- Social Work	Day Services	Housing Gateway	Family Nursing

6.2.3. The interventions by these agencies are considered against the best practice factors, grouped under headings below.

6.2.4.

- Building Relationships and Using Relationships to Facilitate Change



6.2.5. There was good evidence of agencies and individuals spending time trying to develop relationships with Mr Hunter. However, Mr Hunter's cousin's view was that none of the agencies really got to know Mr Hunter properly.

6.2.6.

- **Period pre-dating 2017 and referral through self-neglect procedures**

6.2.7. In the period leading up to 2017, Mr Hunter did have some well-established relationships – with his GP, the parish and the States of Jersey Police.

6.2.8. The GP electronic records date back to 2013. The records indicate Mr Hunter would access medical support when needed and that the GP tried to use these opportunities to encourage him to follow through with treatment – this had variable success.

6.2.9. The following extract from the hospital report gives a flavour of Mr Hunter's independent nature and indicates some frustrations from hospital Doctors when he declined care for treatment of a hernia.

> ***Hospital Consultant communication to GP***
> ***"Mr. Hunter as usual has a different reason and different ideas about nutrition and all different things. I think we all had these discussions before already with xxx (Doctors name) a long time back. We were getting nowhere. So I think the best thing is that you will see him and discuss at length. If he wants anything doing please let us know and we would be happy to operate on him".***
> **Hospital Report**

6.2.10. The information provided to the review indicated the relationship that the Parish Constable and Honorary Police had had with Mr Hunter for many years.

6.2.11. The parish tried to support Mr Hunter both financially and socially, providing a 'watching brief,' with regular visits to his caravan. The parish worked hard to help Mr Hunter sort out problems that arose while respecting his preference for being independent and trying to maintain his dignity. This is demonstrated well in the extract below:

> ***In 1982 following new hygiene regulations his milk was no longer accepted by the JMMB. I saw the Manager, [x], and he agreed to collect his milk, discard it, return the churns and pay Mr Hunter £50 a month. A few months later Mr Hunter complained "why was he paid exactly £50 each month"!***
> **Parish Constable Report**

6.2.12. Similarly, the States of Jersey Police demonstrated sensitivity and tenacity in trying to engage with Mr Hunter – visiting fortnightly from 2015, gently trying to encourage him to accept support from Adult Social Care and stepping up their visits in the winter months.

6.2.13. The States of Jersey Police decided to allocate the same officer for these welfare checks to try and build the relationship with Mr Hunter. The records indicate the compassion shown by this officer, for example, buying him a hat and gloves for Christmas.

6.2.14. A question discussed at the review learning event was whether these positive relationships could have been used to introduce other agencies at an earlier stage.

6.2.15. Mr Hunter had lived in the same way for many years. His lifestyle had not changed but the risks associated with his chosen lifestyle were gradually increasing. His health and mobility were deteriorating as he became older; his belongings and waste were accumulating; the condition and safety of his equipment and caravan was deteriorating and he had increasingly fewer basic amenities.

6.2.16. The parish clearly knew Mr Hunter well and their interventions were a good example of the welfare based approach of this parish. However, the parish could have used their positive relationships to try and involve other agencies. This would have given access to resources and

expertise beyond what the parish could provide. This *may* have enabled other agencies to develop relationships with him at an earlier stage.

6.2.17. Similarly, the GP and hospital could have considered earlier referral through multi-agency procedures based on Mr Hunter's neglect of his healthcare and references from hospital out-patient discharge letters that he was unkempt.

6.2.18. Whether Mr Hunter would have accepted any involvement is questionable. His cousin periodically asked him if he would prefer to move to a more comfortable house. He described Mr Hunter's response as pointing to the trees and fields and natural habitat surrounding him and saying:

> ***'If I didn't wake up with this in front of me every morning, I'd be out of sorts. This is where I want to be.'***
> **Interview with Next of Kin**

6.2.19. The States of Jersey Police did try on several occasions to encourage Mr Hunter to accept a referral to Adult Social Care. There were occasional 'windows' when Mr Hunter appeared more open to this, typically when winter was coming or when he had poor health.

6.2.20. At the review learning event, the States of Jersey Police Officer reflected he had missed an opportunity in 2016 when Mr Hunter had agreed to a referral to Social Care for accommodation forms. The Police Officer was provided with the forms by Adult Social Care and took them to Mr Hunter for him to complete. The officer flagged that this was an opportunity he could have used to complete the forms with Mr Hunter.

6.2.21. Adult Social Care was aware of Mr Hunter and the concerns the States of Jersey police had about his self-neglect. This was also a missed opportunity for them to have offered to carry out a joint visit with the officer, capitalising on the moment of motivation to help Mr Hunter consider alternative accommodation.

6.2.22. It is also noted that the multi-agency self-neglect guidance was in place at this time - introduced in January 2016. The guidance promotes information sharing between agencies, even in the absence of consent, due to the public safety interest that is one of the referral criteria. This guidance should have been implemented by the GP, hospital, parish, States of Jersey police or Adult Social Care.
[Recommendation 1.2.]

6.2.23. At the review learning event, the Parish Constable highlighted the need for parishes to be more aware of the SAPB self-neglect guidance and the resources that they could call on to help their welfare role in their parishes. This point is discussed further in section 6.3 below.
[Recommendation 1.3]

6.2.24.
- **Period from 2017 and referral through self-neglect procedures**

6.2.25. Establishing relationships with Mr Hunter once he had been referred through the Jersey self-neglect procedures in Winter 2017, was challenging for the agencies.

6.2.26. Safeguarding adult interventions should be carried out in a way that are personal to the individual i.e. not imposing safety measures but working with the adult to achieve the outcomes that they want. This is central to the safeguarding adult principle of 'empowerment' and to the over-riding well-being principle described in 6.1.5 -6.1.6. above.

6.2.27. Such approaches are part of a national agenda in the UK called Making Safeguarding Personal.[13] This is equally important in responding to self-neglect but is challenging to deliver when working with a person who may be presenting risks to themselves and others but is resistant to services.

6.2.28. It was clear from the feedback he gave, that Mr Hunter didn't want any formal involvement and accepting any intervention was under duress.

> ***'I am very well thank you and happy with how social workers have worked with me. I have no complaint about [safeguarding SW] input in my case. He had included me in meetings and has been to see me many times. However, I did not want this process to be started and I am unhappy that I now cannot live in my home.'***
>
> - ***Question: The people I wanted were involved?***
> - ***Response: No, I didn't want anyone involved.***
>
> **Mr Hunter's Individual feedback Record – Guided Conversation 2017**

6.2.29. The above extract demonstrates how the Social Worker from the Safeguarding team tried to maximise Mr Hunter's involvement in the self-neglect meetings. The bigger issue was that Mr Hunter did not want any involvement from agencies – he found this intrusive and unwarranted.

6.2.30. There were other positive examples of how agencies tried to engage with Mr Hunter. The records reflect the time invested by his allocated Social Worker in trying to build a relationship and understand the factors that were important to his wellbeing. There was also consideration of diversity in deciding to introduce a male support worker.

6.2.31. Nurses from Family Nursing also considered gender and allocated male nurses, and maintained visiting beyond when they would usually have closed their involvement. Mr Hunter's cousin specifically referred to their very kind response to him in difficult circumstances.

6.2.32. The OT spent considerable time establishing a relationship with Mr Hunter and appears to have been skilled in doing so. The records indicate the hours the OT spent in a single visit, trying to encourage Mr Hunter toward small changes and gently getting him to a point where he could accept he needed some support with activities of daily living. The OT also played a key facilitative role in helping Mr Hunter to access his GP.

6.2.33. At the review learning event, the OT observed the importance of working at Mr Hunter's pace, helping him translate the many decisions and actions he needed to take into simple steps.

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[13] SCIE Making Safeguarding Personal https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp accessed Dec 2017

6.2.34. This was not about Mr Hunter's ability – he was a very intelligent and able man. It did however, recognise the major life changes being imposed on a man in his late 80's who had lived in the same way for 40 years. The OT's approach was clearly valued by Mr Hunter. When the OT informed him his role was ending, Mr Hunter remarked it was a great pity and said *'I find you uplifting.'*

6.2.35. Some of the relationships were, by nature, authoritative and imposed – for example, the duties carried out by the Environmental Health Officer, Planning Enforcement and Fire Service Officer.

6.2.36. Mr Hunter's cousin had strong views about the role of these agencies and that there was a conflict between the wellbeing of the person and steadfast adherence to the rules. Mr Hunter's cousin's impression was that the authorities saw him as *'an item to be fixed'* rather than truly understanding his wellbeing. The cousin recalled Mr Hunter saying *'I am just litter to them.'* Mr Hunter's cousin's view was in considering the various elements that constitute a person's wellbeing (as outlined in 6.1.6) Mr Hunter's psychological wellbeing and personal dignity were subjugated to concerns about his physical health. Mr Hunter's cousin's view was that as a consequence, agencies did not act in a way that made safeguarding personal to him. The conflict between personal wellbeing and public safety is considered further in the following section.

6.2.37. The records do indicate however, that Environmental Health and the Fire Service took a supportive role while trying to meet their statutory duties, for example, taking an active part in the multi-agency plan for alternative accommodation. This included almost daily conversations with Mr Hunter, assisting him to try to find alternative accommodation.

6.2.38. The Parish Constable continued to be a key relationship for Mr Hunter during this period and Mr Hunter sought him out for support. Mr Hunter's cousin highlighted how valued his role had been.

6.2.39. This relationship was capitalised on within the multi-agency response. The Parish Constable made a significant contribution to the multi-agency plan and was also appointed as the 'Lead Worker.' An extract from the self-neglect guidance describes this role:

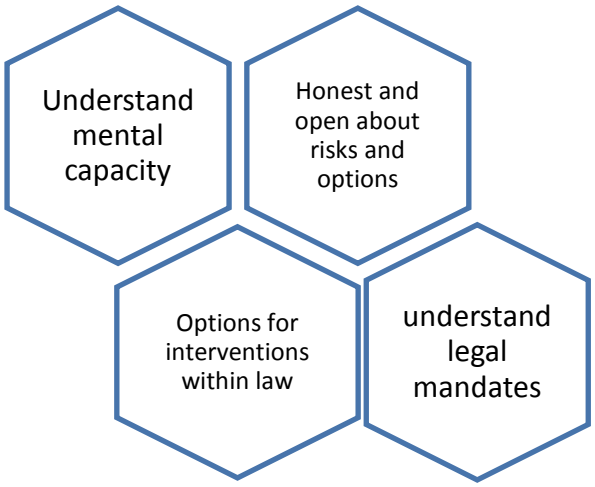
> ***6. Role of the Lead Worker***
> ***The Lead Worker can be from any agency that has a role in working to support the person. Their role is to:***
> 1) ***Ensure the person is aware of the process and the risk management plan.***
> 2) ***Try to build effective relationship with the person with the support, advice and guidance of the Safeguarding Adult Team and relevant others in the team supporting the person e.g. Substance Misuse Worker.***
> 3) ***Share relevant and proportionate information with all those engaged in supporting the person and who are part of the risk management plan.***
>
> **Safeguarding Partnership Board Self-Neglect Guidance and Tools Published Jan 2016**

6.2.40. The appointment of the Parish Constable to this role was in some respects good practice – trying to work through a person who had an established relationship.

6.2.41. However, there is a question of whether it was reasonable to expect the Parish Constable to take on responsibility for this coordination/communication role and whether he was best equipped to communicate across the statutory agencies. This point is considered again in 6.2.103 in relation to the procedures. **[Recommendation 3.2.]**

6.2.42.

- Managing Risk within Legal Frameworks



6.2.43. The agency records reference that Mr Hunter was living in a highly risky environment. The risks identified at the first multi-agency meeting were:

Risk	Risk Indicators	
High Risk Environment	• No electricity • No sanitation, no toilet • No running water • Presence of rats • Clutter ++ • Not weather proof • Isolated in a field • Right to remain – questionable	• Unhygienic • Defecating in a bucket • Waste spread on compost heap (friend assists) • Possibility of dwelling being condemned • Actively feeding rats/ sees rats as pets • No cooking, eats from tins
Fire risk	• Butane gas, and archaic heater • Previous fire in habitat	• No lighting, using candles and tea lights • Multiple combustibles
Health impact	• Recent hospitalisation • Large hernia	• Should not lift – has been a seen carrying large amount of water.

6.2.44. The impact on Mr Hunter's health was assessed as high. He was also viewed as being at high risk of serious injury or death due to the environmental and fire hazards. All agencies had significant concern about his health and wellbeing.

6.2.45. Mr Hunter however, did not see any problems with his lifestyle and was dismissive of concerns expressed. His cousin reflected that people have different standards and that Mr Hunter did not have a problem using a bucket for a toilet.

6.2.46. Though others expressed concern about his nutrition, Mr Hunter's cousin clarified that he was very well read in nutrition and applied this knowledge, eating fresh food and using nutritional drinks along with using canned food as part of his diet. Mr Hunter's Social Worker recalled spending a lot of time talking to him about risks of infection or ill health eating contaminated food. His simple and irrefutable answer was '*yes but I haven't become ill have I*?'

6.2.47. The Fire Service and Environmental Health Agency spent significant time trying to explain the serious fire risks he was exposing himself to for example, using butane gas and candles within his very cluttered environment. They also tried to explain the dangers to himself and others from the rats and contamination of his surroundings. Mr Hunter remained unconcerned. He viewed the rats as no different to the birds around him and said they were like pets. He expressed confidence that he could get out of his property if there were a fire

6.2.48. Mr Hunter's cousin acknowledged it was an unconventional lifestyle but also challenged the view that Mr Hunter was at risk or that his living conditions were having any adverse effect on his health. He noted that Mr Hunter had lived in that way 365 days of the year for the last 40 years and '*was strong as an ox*.' His view was he was careful and understood fire risks given his background as an electrical engineer.

6.2.49. Mr Hunter was acting in a way that others viewed as highly risky and unwise. He was viewed as unrealistic in what he thought he could cope with and was dismissive of evidence put to him by experts. When he did agree to some actions, he did not always follow these through.

6.2.50. However, his response did not of itself mean that he was *unable* to make decisions for himself. Adults have the basic right to self-determine their affairs, including making decisions about their welfare even though those decisions may appear to others to be unwise.

6.2.51. Adults may have different perspectives on risk – risks that may enhance their lives, for example, taking on new challenges; risks the person is willing to tolerate and risks the person wants help to minimise.

6.2.52. In Jersey, these basic rights were in Common Law but are now set out in statute under the Capacity and Self-Determination (Jersey) Law 2016 due to be implemented in 2018.[14] During the review scope period, practitioners were guided by the Jersey HSS Mental Capacity Policy and Procedures.[15] The Jersey SAPB policy sets that there should be a presumption of capacity but

[14] Capacity and Self-Determination (Jersey) Law 2016, Available from: https://www.jerseylaw.je/laws/enacted/Pages/L-30-2016.aspx [Accessed: 22/01/18]
[15] The States of Jersey, Department for Health & Social Services (2014), *Mental Capacity Policy and Procedures*, Available from:

that a two-stage test for capacity that should be carried out if there is doubt about a person's ability to make a specific decision at a specific time.

> ***Test One:***
> - ***Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting how their mind or brain works?***
>
> ***Test Two:***
> - ***If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? This means to have capacity to make a decision a person must be able to:***
>   - ***I. Understand the information relevant to the decision (including the reasonably foreseeable consequences of making or not making a decision) and***
>   - ***II. Retain that information (long enough to make the decision) and***
>   - ***III. Use or weigh the information (as part of the decision making process) and***
>   - ***Iv Communicate the decision (in any recognisable way)***
>
> ***A person is not to be treated as unable to make a decision merely because they make an unwise decision***
>
> **Safeguarding Adults Partnership Board: Multi-agency Capacity Policy and Procedures (Jersey) Updated October 2016**

6.2.53. There was evidence that Mr Hunter's capacity was consistently considered by the agencies involved. There was no evidence that Mr Hunter had any mental impairment that was affecting his ability to make decisions. He was therefore a capacitous adult.

6.2.54. There were references in the hospital report to the lack of recording of capacity assessments. However, as there was no indication of any mental impairment, practitioners would not be required to go beyond this first step of a capacity assessment.

6.2.55. Recording consideration of capacity should be standard practice where a person has declined care. In cases that present higher risk, the detail of documentation should reflect the risk i.e. making explicit that the person has capacity in relation to each of the principle risk factors.

6.2.56. Training for practitioners on the new Capacity and Self Determination (Jersey) Law 2016, including capacity assessments and recording practices will be an important aspect of the implementation.
[Recommendation 1.4]

6.2.57. The health and social care professionals involved demonstrated a good understanding of risks but also that the management of those risks must be within the law. This meant that Mr Hunter could not be compelled to accept care or be required to live somewhere without his consent. The focus of the law was on protection through enforcement of Environmental Health and Fire and Safety regulations.

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http://www.proceduresonline.com/jersey/adults/pdfs/mental_capacity_policy.pdf [Accessed: 22/01/18]

6.2.58. This was challenging for professionals as the understandable inclination of professionals is to care and seek to reduce harm. Exercising a duty of care for a person with capacity involves taking all reasonable steps to help the person access the services they need, and understand options open to them and the likely consequences of not accepting care. Mr Hunter's cousin's view was that though there may have been no legal authority to compel him to live in a place, his experience was different in that he felt forced to live somewhere he did not wish to be.

6.2.59. Duty of care is also about protecting the person's rights and freedoms - sometimes in the face of criticism from public and media who may be less informed of legal limitations. **[Recommendation 1.5]**

6.2.60. One good practice example was when Mr Hunter had been admitted to hospital early in 2017 and the Ambulance Service had made the first referral for self-neglect. Agencies were very concerned about his living conditions and did not want him to return to the caravan. However, Mr Hunter was clear that this is what he intended to do.

6.2.61. The Safeguarding Adults Social Worker was pressing for Mr Hunter to remain in hospital to allow time to carry out an assessment, assess risks and develop a protection (risk reduction) plan.

6.2.62. English case law has warned practitioners against taking an 'outcome' approach to capacity assessments i.e. the assessment of capacity must be an objective assessment and must not be swayed by the gravity of the risk involved in the decision.[16]

6.2.63. The hospital discharge coordinator was clear that Mr Hunter had capacity and therefore the hospital had no right to prevent him leaving – it would have been unlawful for them to do so.

6.2.64. The action that was taken was appropriate – offering Mr Hunter alternative care and helping him explore the likely consequences of his actions. The agencies then convened an emergency multi-agency meeting.

6.2.65. The multi-agency meetings were used to good effect.

6.2.66. There was a difficult balance to be struck in respecting Mr Hunter's choices and the lifestyle that he wanted while trying to reduce risks to him and to the public. Different individuals and agencies are likely to hold different perspectives of risk.

6.2.67. Mr Hunter dismissed the risks to himself. His cousin shared this view and also believed the actual risk to the public was minimal - his caravan was not adjoining other properties and to his knowledge, neighbours were not concerned. The cousin's view was that the removal of his home had a far greater detrimental effect on Mr Hunter's health and wellbeing than had he remained living in his caravan, however unsuitable it was.

[16] *PC v City of York Council [2013] EWCA Civ 478, Court of Appeal*

6.2.68. Other agencies such as Environmental Health and the Fire Service had very different perspectives. The task of the multi-agency meeting was to debate these perspectives with some rigour.

6.2.69. The Safeguarding Adult Principles should be applied to assist this debate:

- Empowerment: How well Mr Hunter could be supported and enabled to make his own decisions
- Proportionality: Whether the intrusive nature of the response was appropriate to the risk presented and supported by law
- Protection: Whether Mr Hunter required protection; nature of any public protection concerns

6.2.70. There was evidence that these factors were debated but it is not clear how strongly the voice of Mr Hunter or his cousin was within this. Perhaps inevitably, there were some tensions between those involved in how they viewed risk and the required response.

6.2.71. For some agencies such as Environmental Health and the Fire Service, they had specific duties regarding public safety regulations – these were requirements to act rather than discretionary powers. However, there is evidence of them trying to apply these duties in the least restrictive way.

6.2.72. The decision to apply to the Minister for an abatement notice under Environmental Health regulations enabled a more phased approach to clearing Mr Hunter's environment than had a fire regulations enforcement order been used. This allowed a slower stream approach to try and work with Mr Hunter with the caveat that he got the site environment to an acceptable level.

6.2.73. Mr Hunter's residence in the caravan and then the Portakabin, was also in contravention of Jersey's planning and building regulations. This lack of planning approval was discussed at the review learning event.

6.2.74. In trying to progress a solution at pace regarding Mr Hunter's accommodation, the agencies were in the invidious position of disregarding the regulations in organising the Portakabin. Whilst their actions cannot be condoned, the context was that Mr Hunter had lived on the parish without planning permission for over 40 years. He was 89 years old and wanted to live out his remaining life there. Mr Hunter's cousin commended agencies for taking this enlightened and common-sense approach.

6.2.75. The review was informed that Planning and Building Services were invited to multi-agency meetings but were represented via Environmental Health. Had Planning and Building Services been involved at an earlier stage, they may have considered use of their powers thus avoiding any regulatory conflict. Environmental Health highlighted the importance of not making assumptions about an agency's response and that the Planning Department were keen to find an exception for Mr Hunter to allow the Portakabin to remain on site whilst not setting a precedent for anyone to live illegally.

6.2.76. The multi-agency plan that was drawn up at the first meeting and developed in subsequent meetings was well considered and tried to square off these competing needs. There was good evidence that agencies were transparent with Mr Hunter helping him understand the consequences of his actions and seeking wherever possible to work with him within the constraints of the regulations.

6.2.77. During this period, Mr Hunter had lots of life changing events. The OT and Social Worker spent a long time helping him to accept the events that he had no control over (such as having the caravan condemned) and the decisions he needed to make such as his future accommodation.

6.2.78. At the review learning event, attendees discussed the role that advocacy could have played, recognising that in this highly conflictual situation, Mr Hunter may well have benefitted from an advocate to help represent his wishes. This option was not available as advocacy services are not contracted to provide this service in situations such as Mr Hunter's.
[Recommendation 3.4.]

6.2.79. The extract below from Mr Hunter's feedback is relevant to use of the legal framework and being honest, open and transparent about risks and options:

- ***Question: I had the information I needed, in the way I needed it?***
- ***Response: Yes.***

- ***Question: Professionals helped me to plan ahead and manage the risks that were important to me?***
- ***Response: No.***

- ***Question: The people I wanted were involved?***
- ***Response: No.***

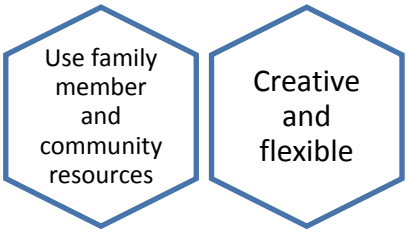
- ***Question: I had good quality care – I felt safe and in control?***
- ***Response: No.***

- ***Question: I understand the reasons when decisions were made that I didn't agree with?***
- ***Response: Yes, sort of.***

Mr Hunter's Individual feedback Record – Guided Conversation 2017

6.2.80.

- Creative interventions



6.2.81. In reviewing the multi-agency plan, there were examples of trying to work creatively and flexibly with Mr Hunter, within the confines and restrictions of the Environmental Health abatement notice and resources available.

6.2.82. In enforcing the abatement notice, the Parish Constable, Fire Service and Environmental Health negotiated with Mr Hunter, using a spray can to mark possessions that could be removed as opposed to those that were of greater value to him.

6.2.83. The planning for Mr Hunter to return to the parish to live in a Portakabin is a further example of trying to be flexible and creative having exhausted alternative accommodation options. This again involved the community as the Portakabin was donated by a member of the parish.

6.2.84. This option was not an optimum solution, and as noted, conflicted with planning regulations. The multi-agency group took a pragmatic approach and were creative in working out how to make the Portakabin habitable in a way that minimised rather than eradicated risks.

6.2.85. Examples were:

- Fitting Ventaxia to aid ventilation and avert carbon monoxide poisoning
- Provide external gas supply
- Hire portaloo – positioned near road for regular emptying
- Solar panel/external electric hook up
- Source water system – delivery options/watt butt
- Lower the Portakabin to improve accessibility

6.2.86. Involvement by Mr Hunter's local community was central to this with the Parish Constable taking responsibility for the majority of these adaptations. Mr Hunter's cousin remarked on how valuable members of his local parish had been.

6.2.87. Alongside this, Adult Social Care continued to try and overcome barriers to Mr Hunter accepting services including his reluctance to pay. The Social Worker had checked that his reluctance to spend money was not due to coercion by others. The Social Worker then negotiated for Social Security to carry out a joint visit to see him.

6.2.88. This involvement by Social Security was discussed at the review learning event. It is clearly not feasible for Social Security to provide this bespoke home visiting service to all. However, there are circumstances such as Mr Hunter's that warrant this additional effort. It was good practice that Social Security were able to provide this on this occasion.
[Recommendation 3.3]

6.2.89. As Mr Hunter would not accept residential care, the Social Worker encouraged him to access day care so that he could wash and have the option of hot food. Referral for Meals-on-Wheels was a further solution to support his alternative lifestyle.

6.2.90. The records do indicate Mr Hunter had a history of choosing not to take prescribed medication and there were references to out of date medication in his accommodation. A medi-box *may* have prompted his concordance with prescribed medication and was an option worth pursuing by the health agencies involved.

6.2.91. Given Mr Hunter's health needs and the ongoing resistance to care, the involvement of Family Nursing was an important resource. However, this service did not become involved until late on; four months after the first multi-agency self-neglect meeting was held. The involvement of health services in the care planning is considered in more detail in the following section on multi-agency working.
[Recommendation 2.1]

6.2.92. In relation to involvement of the family, Adult Social Care did make some contact with Mr Hunter's cousin but it is not clear how extensive this was. Mr Hunter's cousin was actively involved and had a very good relationship with him. He also had a clear view about Mr Hunter's wellbeing and the detrimental impact that forcible removal from his property was having. It would therefore have been beneficial to have included him more (with Mr Hunter's consent) and fed his views into the multi-agency meetings.
[Recommendation 3.1.]

6.2.93.

- Multi-agency Working

6.2.94. The examples in the sections above demonstrate that there was positive multi-agency working, bringing together the expertise from different agencies and co-ordinating this under the self-neglect guidance.

6.2.95. Given the considerable challenges of working with Mr Hunter, there was real commitment by agencies to work together in a collaborative way and contribute to the care plan. The pressures this put on professionals' workloads is discussed further in section 6.3 below.

6.2.96. Coordination and communication across agencies is a pre-requisite to effective multi-agency safeguarding practice and is a recurring theme in SCRs. This review is no exception and has identified a number of learning points where this could have been strengthened.

6.2.97. The first is the need for earlier referral through the self-neglect procedures as referenced in 6.2.22.

6.2.98. The author of the hospital report also raised missed opportunities when Mr Hunter was first admitted in Winter 2017 and then attempted discharge to Shelter. They were unclear why Mr Hunter had not been admitted to the hospital at this point. This was particularly the case given the hospital's knowledge that Mr Hunter had been given laxatives and had rudimentary toilet facilities, lighting and heating at his home. The hospital report author noted that understanding of self-neglect was not consistent across the hospital emergency department and that it appeared staff had disconnected his physical health needs from social conditions on this occasion. This learning needs to be reflected in improved discharge planning. The good practice of the ambulance crew in their response is recognised.
[Recommendation 1.2.]

6.2.99. Similarly, in relation to the GP responses there was no evidence of responses by the practice that were aimed particularly at self-neglect as it appears they were not aware of the referral routes for self-neglect.
[Recommendation 1.2.]

6.2.100. A notable gap in the multi-agency response was the co-ordination and oversight of Mr Hunter's health care. Mr Hunter's health needs had been highlighted in the initial risk assessment and therefore active management of his health needs should have been at the centre of the multi-agency self-neglect planning process.

6.2.101 At the review learning event, it emerged that the Safeguarding Adults team had not been able to find which GP Mr Hunter was registered with and assumed he was not registered with one. Mr Hunter's cousin pointed out that this information was readily available from Mr Hunter and from himself, further underlining the need for active involvement of the person and their representatives.

6.2.102 The hospital was aware that Mr Hunter was subject to a multi-agency self-neglect plan. The hospital was also in regular contact with his GP. However, this information was not put together and fed into the multi-agency meeting.

6.2.103 It is notable that following the first emergency multi-agency meeting, the hospital was invited to the next four self-neglect meetings but there was no representation from them. There was also no other health professional attending these meetings. This was not acceptable practice.

6.2.104 What is now known is that the GP was very involved and was one of the few key relationships that Mr Hunter had. No contact was made in relation to the multi-agency work until four weeks before Mr Hunter died. The absence of the GP's involvement meant there were significant

missed opportunities to understand all his risks and co-ordinate his health and social care needs.

6.2.105 A more co-ordinated approach would have enabled missed health appointments to be followed up at an earlier stage, for example, through Family Nursing or working through others who were in contact with him such as his family, Social Worker or Parish Constable.

6.2.106 Family Nursing did latterly get involved and they, and the hospital safeguarding lead, attended the final multi-agency meeting. However, it is not clear whether their remit was limited to the involvement of their agency or whether they were acting as a health representative to liaise with other health partners to ensure coordinated health care for all Mr Hunter's health care needs.
[Recommendation 2.1.]

6.2.107 At the beginning of the process, the multi-agency self-neglect meetings were very frequent in order to establish the management plan. Following the first three meetings, there were then six weekly gaps between the meetings.

6.2.108 This frequency may have been appropriate as there was a clear plan in place that agencies were progressing. However, there remained a need for robust communication and co-ordination between agencies in the gaps between these meetings.

6.2.109 This required a lead professional who was familiar with the remits and structures of the agencies, professionally trained in risk assessment and able to coordinate the agencies.

6.2.110 The Parish Constable had been appointed to the role of 'Lead Worker.' However, as referenced in 6.2.38, given the level of co-ordination required during this period, it was not a reasonable expectation that the Parish Constable should deliver this.

6.2.111 Mr Hunter's cousin's view reinforced this need for a lead role to coordinate the response. He expressed Mr Hunter's experience of lots of different people coming from different agencies:

> ***'There appeared to be a screaming need for one person to channel through – for this person to inject themselves into the situation and respond with some humane understanding.'***
>
> **Interview Mr Hunter's Next of Kin**

6.2.112. Aspects that could be strengthened within the multi-agency risk management guidance are considered further in 6.3 below.
[Recommendation 3]

6.3. Strategic Responses to Self-Neglect in Jersey

6.3.1. As referenced, working with self-neglect is a challenging area for agencies and Mr Hunter was no exception. The SCIE research identified the following factors as important in supporting practice:

Organisational Factors to Support Practice in Self Neglect
1. **A clear location for strategic responsibility for self-neglect**
2. **Data collection on self-referrals, interventions and outcomes**
3. **Clear referral routes**
4. **Systems in place to ensure coordination and shared risk management between agencies**
5. **Time allocations within workflow patterns that allow for longer-term supportive relationship-based involvement**
6. **Training and practice development around the ethical challenges, legal options and skills involved in working with adults who self-neglect**
7. **Supervision systems that both challenge and support practitioners**

6.3.2.

- Strategic Leadership and Procedural Guidance

6.3.3. In Jersey, there was a clear location for strategic responsibility for self-neglect. This was with the Jersey SAPB.

6.3.4. The SAPB had set up a task and finish group to establish the self-neglect guidance and tools that were implemented in January 2016. The SAPB had tried to understand the prevalence of self-neglect on Jersey, writing to parishes to gather data and using this to inform their strategic planning.

6.3.5. This was good practice and more advanced than in many Safeguarding Adult Boards in the UK.[17]

6.3.6. This data collection was still in the early days and though all Parishes had been contacted by the SAPB to ask for information about self-neglect, not all had provided a return.

6.3.7. In July 2017, SAPB led quality assurance work to evaluate the effectiveness of the self-neglect guidance.[18] This work identified that during 2016 there were forty-eight referrals for self-neglect, fourteen of which had progressed to a Self-Neglect Risk Management Meeting.

6.3.8. There was therefore evidence that the self-neglect referral route was being used. However, the evidence from this review is that further work is needed to develop a shared understanding of self-neglect and when referral through the self-neglect guidance is appropriate.
[Recommendation 1]

6.3.9. The feedback from agencies in the SAPB evaluation (July 2017) was that once a referral was made, the self-neglect guidance generally worked well as a process.

6.3.10. Learning from this review supports this view. However, as outlined in 6.2, there is a need to revisit the role and expectations of the 'Lead Worker' including who may be best placed to hold this role.

6.3.11. Learning also highlighted the conflictual and challenging nature of working with people in Mr Hunter's circumstances. Guidance needs to reinforce application of the Safeguarding Adult Principles.[19] This needs to be done with some rigour to ensure responses are lawful, focused on the individual's wellbeing and take account of wider public protection responsibilities. Mr Hunter's cousin highlighted that procedures should not be prescriptive and obscure the need for a flexible approach to the person's needs.
[Recommendation 3]

6.3.12. Learning also reinforced other findings from the SAPB's evaluation of the guidance. This had flagged the need for a more comprehensive SAPB pathway and procedures that included:

- Preventative work through single agencies, supported by an early help co-ordinator/navigator role and directory of resources[20]
- Maintaining the self-neglect multi-agency meetings
- A process to manage longer term cases beyond the immediate safeguarding protection plan **[Recommendation 3]**

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[17] NHS Digital, (2017) *Guidance for completing the Safeguarding Adults Collection (SAC) 2016-17*, Available from: http://content.digital.nhs.uk/media/20178/Safeguarding-Adults-Collection-SAC-2016-17-guidance/pdf/SAC_guidance_1617_v1.3.pdf [Accessed: October 2017]

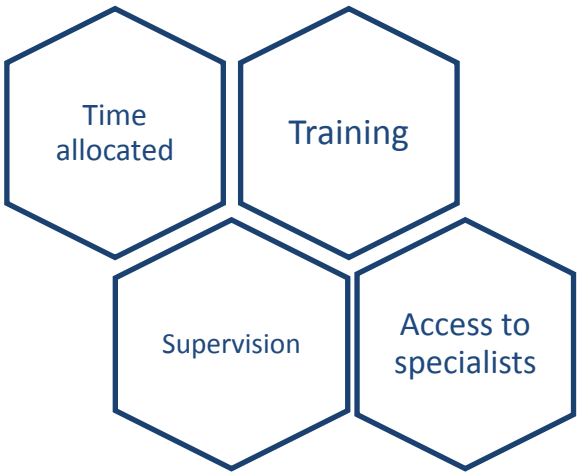
[18] Safeguarding Partnership Board (2016), *Self-Neglect Guidance and Tools*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-Self-Neglect-Guidance_FINAL.pdf [Accessed: 22-01-18]

[19] Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2017]

[20] For example British Psychological Society 'A Psychological Perspective on Hoarding: DCP Good Practice Guidelines'.

6.3.13.

- Resourcing and Supporting Practitioners



6.3.14. Effective management of self-neglect requires significant commitment: commitment by agencies to be part of the process; commitment to work in new and creative ways; commitment to access specialist resources and personal commitment from caring individuals to go over and beyond what their role required of them.

6.3.15. There were many examples of good practice demonstrated in this review.

6.3.16. The level of resources required for effective engagement with people who self-neglect is well-established.[21] This cannot be under estimated. Practitioners are called upon to make very difficult decisions, often in the face of significant scrutiny and pressure from other bodies, the public and the media.

6.3.17. Effective multi-agency working is essential when working with higher risk self-neglect cases and needs to be supported by training and supervision. This is more challenging to achieve in times when agencies are having to do more with less resources.

6.3.18. Attendees at the learning event highlighted the hours spent trying to engage with Mr Hunter and that this put additional pressure on them and their work load. Some practitioners were supported by their managers to work with Mr Hunter beyond the role they would usually offer. Others had a more challenging task of convincing their managers that their involvement was justified.

[21] Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-Neglect Policy and Practice: Research Messages for Practitioner*, Available from: https://www.scie.org.uk [Accessed: 22/01/18]

6.3.19. One attendee at the learning event applauded the commitment from all in relation to Mr Hunter but was concerned that this was not supported by joint policy. Their concern was that in other cases, agencies may pull-out leaving one practitioner with an impossible task to achieve on their own. Another attendee flagged the need for support workers to shoulder some of the practical tasks.

6.3.20. Self-neglect can be a high cost to the individual's wellbeing. It can also be a high cost to the public purse, for example, through cost associated with environmental problems, fire or serious health conditions. Time and resources spent can be a sound economic as well as ethical investment.

6.3.21. There is a need for the proportionate allocation of stretched resources. Many cases can be managed by single agencies, with appropriate guidance. However, there will also be a few complex and high risk cases that merit a more intensive response. Public sector agencies should be required to commit resources to these cases. This may include access to specialist expertise for consultation, for example mental health services. It may also involve the expectation that agencies offer a more flexible approach than would be their standard practice – the response by Social Security was a good example of this.

6.3.22. Environmental Health also emphasised the benefit of their Director and Chief Executive Officer visiting the site in order to understand the complex and challenging nature of such a case. This understanding helped officers access support in undertaking the necessary steps.

6.3.23. The States of Jersey should support the SAPB and the constituent agencies in their efforts to deliver this.
[Recommendation 4]

6.4. Applying Learning from other Jersey's Self-Neglect Serious Case Reviews

6.4.1. During 2016-17, the SAPB commissioned three SCRs where there were issues of self-neglect.[22] Some of the recommendations arising from two of these SCRs were relevant to this review.

6.4.2. The table below references the relevant recommendations (summarised) from these SCRs and provides comments against the findings from this review.

SCR Recommendation	Findings From Mr Hunter Serious Case Review
Introduce scenario-based multi-agency training on self-neglect (Mr Fisher)	Multi-agency training is not in place (though is in the SPAB training schedule for 2018). Understanding of self-neglect remains variable within and across agencies **[Recommendation 1.1.]**

[22] Safeguarding Partnership Board (2016), *Serious Case Review Procedures*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-joint-SCR-procedures-FINAL-REVIEWED.pdf [Accessed: 22/01/18]

Review a sample of self-neglect cases to be assured of effective partnership working (Mr Fisher)	SAPB has carried out assurance work. Evidence from this review indicated some effective practice but a need to develop involvement of Primary and Secondary Health. **[Recommendation 2.1.]**
Reviewing application of the SAPB's guidance on mental capacity (Mr Fisher)	There was evidence that mental capacity was consistently considered. Reference to self-neglect needs to be built into a comprehensive programme to roll out the implementation of the Capacity and Self- Determination (Jersey) Law **[Recommendation 1.4]**
Raise public awareness – not always possible to act where someone with capacity declines services (Mr Fisher)	This is a continued need. Public awareness of individual's rights to self-determination needs to be built into a comprehensive programme to roll out the implementation of the Capacity and Self-Determination (Jersey) Law **[Recommendation 1.5.]**
Consider how to engage people with similar characteristics and build relationships (Ms Evans)	There was evidence of significant efforts to build relationships. Practitioners continue to be under pressure with insufficient resources to manage self-neglect **[Recommendation 3 and 4]**
Adult Mental health Service availability for consultation and advice (Ms Evans)	Access to mental health services was not indicated in this case but access to specialist professional advice remains relevant in the development of self-neglect pathway. **[Recommendation 3.3.]**
Environmental Health consider any further legal changes that would safeguard adults while not encroaching on basic rights. (Ms Evans)	Environmental Health took a full and active role. There were tensions regarding public duties and rights of the individual including understanding mental capacity. The Capacity and Self- Determination (Jersey) Law is due for implementation in 2018 **[Recommendation 1.5.]**
Community and Social Services to meet with parish leaders regarding supervision to parish staff in carrying out their welfare role. (Ms Evans)	The Parish contributed significantly to the multi-agency response to Mr Hunter. Further work is needed to ensure Parishes have a shared understanding of self-neglect and are aware of when to make referral through the self-neglect guidance. **[Recommendation 1.3.]**

7. Conclusions

7.1. The review has examined the sad circumstances surrounding the final weeks of Mr Hunter's life.

7.2. Mr Hunter had chosen a lifestyle that was out of kilter with how many would choose to live their lives. He was an independent person who was content with his lifestyle. There is substantial evidence that Mr Hunter understood the risks associated with his lifestyle and the likely implications of not accepting help with his health and social care needs.

7.3. The task of agencies was to try and engage with Mr Hunter, reducing the risks he was living with whilst respecting his chosen way of life and maintaining public safety. This was not an easy task for agencies. It involved them using every avenue open to them and using their relationships to try and reach solutions with Mr Hunter's consent.

7.4. Although Mr. Hunter lived in poor conditions regarding hygiene, safety and sanitation, he had lived in this way for 40 years and lived to an advanced age of 89 years. There is no evidence that his death was directly associated with his living conditions.

7.5. Mr. Hunter suffered with significant cardiovascular disease and had an irregular heart rhythm. He developed a blood clot in the arteries of his right leg, which became unsalvageable without surgery. Mr. Hunter declined treatment and it was clear he had the mental capacity to understand the implications and likely outcome of this.

7.6. The last months of Mr Hunter's life were very difficult for him. His next of kin's view was that the intervention by agencies to prevent him living in the way he wished was disproportionate to risk and that the intervention adversely effected his wellbeing.

7.8. This review has highlighted the very challenging practice and ethical dilemmas of working with people defined as self-neglecting and how those agencies tried to navigate through this.

7.9. The review highlighted many examples of good practice by agencies working together and the care and compassion shown by individuals. The review also highlighted the valuable contribution that the parishes can play in safeguarding, a role which needs political support to extend and develop.

7.10 The SAPB has already taken positive steps to address self-neglect in Jersey. The review has identified areas that may further strengthen multi-agency work in responding to self-neglect. The recommendations reflect some changes that need to take place in front line practice but also identify strategic developments that the SAPB and Ministers are asked to support.

8. Recommendations

Some of the agencies made recommendations for their own agency. These are detailed in appendix 2.[23] The author has taken these into account and made some additional recommendations for the partnership to take action on.

Recommendations	
The SAPB should oversee and seek assurance that the following recommendations are implemented	
1.	**Multi-agency training relating to self-neglect.**
1.1.	The SAPB and constituent agencies should use learning from this review to share the good practice and dilemmas highlighted in this review. This could support the implementation of scenario based SAPB multi-agency training that has been recommended in earlier serious case reviews.
1.2.	Partner agencies should ensure that relevant staff are trained in self-neglect as part of mandatory training and that they can demonstrate competence in identification and responses to self-neglect.
1.3.	The Minister for Health and Social Services should consult with the Comité des Connétables to see whether training on self-neglect guidance should be provided to Parish officers to support their welfare role. This would assist officers with identifying self-neglect and understanding what resources may be available to support prevention/early intervention of such cases, and when a referral through multi-agency procedures is required.
1.4.	The implementation programme of the States of Jersey Capacity and Self-Determination (Jersey) Law 2016 should assist practitioners in understanding their responsibilities and limitations where a capacitous person is resistant to care. Competencies should include: i) Recording standards when a person with capacity is resistant to care ii) Recording standards when a capacity assessment has been carried out.
1.5.	The implementation programme of the States of Jersey Capacity and Self-Determination (Jersey) Law 2016 should include awareness for the public as well as relevant agencies of the new law including the rights of people with capacity to make unwise decision.
2.	**Coordination of Health and Social care**
2.1.	Community and Social Services Safeguarding Team should work with the Health Designated and Named Safeguarding leads and Jersey's Primary Care Medical Director to ensure appropriate contribution to multi-agency self-neglect meetings and the risk management plan. The desired outcome is

[23] Note: some agencies included in their reports, recommendations for other agencies. These have been taken into account as part of the review but only the recommendations agencies made for their own agency are included in appendix 2

	i) There is a full understanding of health needs of the person and ii) There is a coordinated approach across Primary and Secondary Health services and with Social Care to meet those needs.
3.	**Development of Multi-Agency Self-Neglect Pathway and Resources to Support the Work**
3.1.	The SAPB through the Chair of the Adult Policy, Procedure and Performance sub-group, should build on the existing self-neglect guidance to develop a pathway that is proportionate to need and risk and formalised within the SAPB procedures. This may incorporate: i) Preventative work through single agencies, supported by an early help co-ordinator/navigator role and directory of resources ii) Maintaining the self-neglect multi-agency meetings iii) Process to manage longer term cases beyond the immediate safeguarding protection plan The application of the safeguarding adult principles and focus on wellbeing (in the fullest sense), must be embedded in every part of the pathway along with maximising the involvement of the person, their families/representatives.
3.2.	The role of the Lead Worker should be reviewed as part of the self-neglect procedures. The Lead Worker should be a suitably qualified person that is able to fulfil the functions of ongoing assessment (including risk assessment), coordination and communication across services.
3.3.	The SAPB should work with its partner agencies to gain commitment to release resources required for self-neglect. For cases of greatest complexity or risk this may include: • Access to specialist advice • Commitment to flexible working beyond standard access criteria • Commitment to liaise with partner agencies prior to terminating engagement
3.4.	Health and Social Services should consider commissioning independent advocacy services to include advocacy for people who are subject of the multi-agency self-neglect meetings.
4.	The Serious Case Review should be shared with relevant Ministers so that the findings can be considered in the development of Jersey policy and in the allocation of finances to the agencies working with self-neglect.
5.	The SAPB should receive assurance from agencies on the implementation of the recommendations made within their own agency reports for this review (appendix 2)

Sylvia Manson,

Date: February 2018

Sylman Consulting

Appendix 1: Feedback from Mr Hunter

Individual feedback record – Guided Conversation

This questionnaire is designed to discuss how well desired outcomes have been achieved, and the difference that was made, at the end of safeguarding activity. It can be used as part of the normal review or closure of a case. The adult at risk should be consulted as to which professional they wish to have this conversation with.
Use it to enable a guided/structured conversation between the person safeguarded and the practitioner, involving a supporter and/or advocacy worker where appropriate; check out understanding and arrive at the most accurate answers to the questions, avoiding a straight 'question and answer' session.

People worked together to reduce risk to my safety and well being

	Yes	No	Partly
I had the information I needed; in the way that I needed it	Yes		
Professionals helped me to plan ahead and manage the risks that were important to me		No	
People and services understood me- recognised and respected what I could do and what I needed help with		no	
The people I wanted were involved		no	
I had good quality care –I felt safe and in control		no	
When things started to go wrong, people around me noticed and acted early		no	

(This was a self-neglect case)

I am very well thank you and happy with how social workers have worked with me. I have no complaint about P's input in my case. He has included me in meetings and has been seen to see me many times.

However, I did not want this process to be started and I am unhappy that I now cannot live in my home.

Do you understand the reasons why you can't live at home? (his caravan was condemned under an article 9 due to rat infestation and self-neglect) No I don't. I was fine. I have lived there for many years. I don't mind living in a hotel but it is costing me money and that is the bit I don't like

People worked together and helped when I was harmed

	Yes	No	Partly
People noticed and acted	Yes – although I didn't want them to.		
People asked what I wanted to happened and worked together with me to get it	*yes*		
The people I wanted were involved		*No I didn't want anyone involved*	
I got the help I need by those in the best place to give it	*yes*		
The help I received made my situation better		*no*	
People will learn from my experience and use it to help others		*no*	
I understand the reasons when decisions were made I didn't agree with			*Yes sort of*

What will happen to this record?

• This individual feedback record should be kept on the person's case file.

• The answers to the rating scale element may be extracted and reported anonymously in an aggregated form.

• With the consent of the individuals concerned, the free text may be used to provide anonymised stories to accompany data provided to managers and Safeguarding Partnership Board, to ensure that the meaning of people's experiences is communicated.

Appendix 2: Recommendations made by agencies contributing to the review[24]

Department of Environment	
1.	Provide oversight of referrals into the self-neglect policy beyond social services. There is a risk of SS becoming the gatekeepers to the pathway and environmental health factors to not be considered under the public interest test as this falls outside of the traditional SS skills
2.	Site visits by Directors in such cases in order to fully understand the conditions.
Honorary Police	
1.	Recommendations: although this is not relevant to the case of Mr Hunter, it would seem that maybe subject to Data Protection there could be better information sharing between States Departments and the parishes, as there must be other individuals living a similar existence to Mr Hunter. This is part of a much wider issue and could take time to implement.
Jersey Health and Social Services – Community and Social Services	
1.	C&SS instigate and lead on the development of an integrated care pathway for self-neglect. This will provide an agreed framework and standards for practitioners and agencies to work to. It could incorporate checks and balances which will support lawful effective and equitable interventions for people at significant risk of self-neglect.
2.	The guidance provided by the Self-Neglect Management Guidance be revised and upgraded to a policy or protocol. This will increase the relevance to practitioners and add weight to this issue. The use of minimum data sets, how and what to record and report etc. will assist in case work, enable thematic reviews and increase health and social care intelligence.
3.	Multi-disciplinary and multi-agency training in self-neglect be a prioritised learning objective.
4.	H&SS and or C&SS to consider developing an ethics or panel to provide a wider organisational forum to assist in decision making in complex situations where there is significant risk and uncertainty for the person, their loved ones and the staff working with them.
5.	Action plans following case reviews are uploaded to the safeguarding website. This will provide additional transparency and provide evidence of H&SS commitment to learning.
Jersey Health and Social Services – Hospital and Ambulance Service	

[24] Note: some agencies included in their reports, recommendations for other agencies. These have been taken into account as part of the review but only the recommendations agencies made for their own agency are included in appendix 2

1.	Capacity and Self-Neglect • Implement e-learning on Self Determination and Capacity Law 2017 for all staff by July 2018, • Pilot for ward sisters, Discharge Coordinator and pool trainers by February 2018
2.	Multi-agency Working • Multi - agency workshop to share learning using case studies to challenge practice
3.	Medical Staff • Share learning from this SAR via the Morbidity and Mortality forum to reach medical workforce
4.	Supervision • Safeguarding supervisor Training February 2018 • System of supervision agreed for Discharge coordinator, and ED staff by February 2018
5.	Accountability • Clarify accountability and responsibility for self –neglect
6.	Training • Complete Training Needs Analysis for all hospital and ambulance staff to ensure mandatory safeguarding training is appropriate to individual job roles. By April 30th 2018 Lead: Named Nurse Children • Development of the Pool Trainer role to ensure each area has a trainer by April 30th 2018 Lead: Designated Nurse
Family Nursing and Home Care	
1	**Capacity and Self-Neglect** Support staff participation in training on Self Determination and Capacity Law 2017 for all staff by July 2018,
2	**Multi-agency Working** Participate in Multi - agency workshop to share learning using case studies to challenge practice
3	**Supervision** Continue to roll out group safeguarding supervision for adult nursing staff with frequency increasing to quarterly attendance for registered practitioners in 2018
4	**Training** Support staff to attend multi agency training in self neglect once developed by SAPB and informed by revised self neglect policy
States of Jersey Parish Constable	
	No recommendations
States of Jersey Police	

<table>
<tr><td>1.</td><td>To continue to be alert to safeguarding incidents and follow established procedures as was the case with Mr Hunter.</td></tr>
<tr><td colspan="2">States of Jersey Fire and Rescue Service</td></tr>
<tr><td>1.</td><td>Recommendation 1. A clear form submission from the Service should include the risks identified, supporting photographs, immediate actions and further actions required with dates attached. (This is not an initial referral form for self-neglect. This is a risk form following inspection once a case has been initiated)

An example would be

<table>
<tr><th>Risk</th><th>Reason</th><th>Initial action taken and date completed</th><th>Further actions required to be completed by</th></tr>
<tr><td rowspan="2">Inadequate early warning of fire</td><td rowspan="2">No Smoke Detection fitted</td><td>Smoke Alarm fitted</td><td>None</td></tr>
<tr><td>01/11/17</td><td></td></tr>
<tr><td rowspan="2">Excessive fire load and portable heater in caravan resulting in unsafe escape</td><td rowspan="2">High volume of newspaper next to unsecured portable heater</td><td>Discussion with occupier / heater fixed to wall</td><td>Follow- up inspection by</td></tr>
<tr><td>01/11/17</td><td>1/12/17</td></tr>
<tr><td colspan="4"></td></tr>
</table>
</td></tr>
<tr><td>2.</td><td>Recommendation 2. Following the initial Fire and Rescue Service visit the Service needs to make an initial decision whether Article 9 Prohibition is necessary or not. (no decision was made on this in Mr Hunters case)</td></tr>
<tr><td>3.</td><td>Recommendation 3. The Fire and Rescue Service have been playing a fully involved role in the multi-agency resolution of self-neglect.

I believe the Service’s role in the future should be confined to:
• initial advice on the risk presented to the panel
• occupier advice
• reporting and dealing with an Article 9
• fitting of a smoke alarm</td></tr>
</table>

References:

- British Psychological Society (2015) A Psychological Perspective on Hoarding: DCP Good Practice Guidelines https://thepsychologist.bps.org.uk/volume-28/august-2015/psychological-perspective-hoarding [Accessed: 28/02/18]

- Capacity and Self-Determination (Jersey) Law 2016, Available from: https://www.jerseylaw.je/laws/enacted/Pages/L-30-2016.aspx [Accessed: 22/01/18]

- CARE ACT 2014, s.10, Available from: http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted [Accessed: October 2017]

- Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2017]

- NHS Digital, (2017) *Guidance for completing the Safeguarding Adults Collection (SAC) 2016-17,* Available from*:* http://content.digital.nhs.uk/media/20178/Safeguarding-Adults-Collection-SAC-2016-17-guidance/pdf/SAC_guidance_1617_v1.3.pdf [Accessed: October 2017]

- *PC v City of York Council [2013] EWCA Civ 478, Court of Appeal*

- Safeguarding Partnership Board (2016), *Self-Neglect Guidance and Tools*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-Self-Neglect-Guidance_FINAL.pdf [Accessed: 22-01-18]

- Safeguarding Partnership Board (2016), *Serious Case Review Procedures*, Available from: https://safeguarding.je/wp-content/uploads/2016/12/2016-10-11-joint-SCR-procedures-FINAL-REVIEWED.pdf [Accessed: 22/01/18]

- SCIE (2014), *Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care*, Available from:
- http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: 22/01/18]

- Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-neglect Policy and Practice: Research Messages for Managers*, Available from: https://www.scie.org.uk [Accessed: 22/01/18]

- Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-Neglect Policy and Practice: Research Messages for Practitioner*, Available from: https://www.scie.org.uk [Accessed: 22/01/18]

- SCIE (2017), *Learning Together*, Available from: http://www.scie.org.uk/children/learningtogether/about.asp [Accessed:22/01/18]

- The States of Jersey, Department for Health & Social Services (2014), *Mental Capacity Policy and Procedures*, Available from: http://www.proceduresonline.com/jersey/adults/pdfs/mental_capacity_policy.pdf [Accessed: 22/01/18]

About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care front line services and management.

Sylvia was the Department of Health NHS lead for safeguarding adults during 2010-11, developing Health guidance published by the DH in 2011 and the Safeguarding Adults principles now contained in the Care Act 2014 statutory guidance. Past roles have also included Department of Health regional implementation lead for Mental Capacity Act 2005; Deprivation of Liberty Safeguards and Mental Health Act 2007.

In addition to independent work, Sylvia Manson is Head of Safeguarding in a Clinical Commissioning Group and a specialist lay member of the Mental Health Tribunal

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