North Yorkshire Safeguarding Adults Board

‘Alice & Peter ’ SAR 7 Minute Key Learning Briefing

1. Background

Alice and Peter were a couple in their 70’s. Alice was known to services around mental health, self-neglect and hoarding. It was not known she was living with Peter, who did not have any professional involvement of his own. Alice died in their flat, at which point professionals identified the severe level of hoarding and self-neglect within the property. After an initial arrest and release without charge, there was professional disagreement around Peter’s vulnerability and level of need. He returned to the flat and died there the following week.

2. Risk Management

The report identified that, due to perceived thresholds and professional disagreement on responsibility for Peter’s accommodation needs, Peter returned to his home which put his health and wellbeing at significant risk due to hoarding and environmental concerns. A partnership approach to risk management is required to ensure that risk is managed effectively and no single agency is left holding a risk they cannot resolve.

3. Trauma Informed Care

The report identifies key experiences in Alice’s past which may have been traumatic. This included previous mental health detentions, the ending of a significant relationship, loss of her job and the death of her mother. The latter appeared to be a catalyst for self-neglect and hoarding behaviours. Understanding past trauma can help professionals identify what is driving presentation and support in building trusting relationships. This in turn may help them plan interventions to support the individual in a personalised way.

4. Mental Capacity

The report emphasises that whilst Alice’s capacity for care and support was presumed, there is no evidence that this was not the right decision. However, it is important to note that capacity can often be complex in self-neglect cases. A key message is that presumption of capacity should not become an end point for support; people making what may be considered unwise decisions often remain at high risk. It also highlights the importance of considering executive function and taking a longitudinal approach to assessing capacity, especially for those who may not wish to engage in such an assessment.

5. Self Neglect & Hoarding

For Alice, hoarding was affecting her health and wellbeing. The report emphasises that consent is not needed to raise a safeguarding where concerns relate to self-neglect and that cases should be escalated to multi agency forums to discuss risks. It also promotes the use of the Clutter Rating Scale to support discussions with people and professionals with a universally understood picture of what extent hoarding within a property has reached. Practitioners can refer to the Self-Neglect and Hoarding Practice Guidance for support in this area including advice on what our legal duties are in this area.

6. Managing Different Professional Perspectives

Key learning for Peter involves how agencies manage differences of opinion on what should be done, and who holds responsibility, for a person. The report identifies that Police were left inappropriately holding the risk for Peter, leading to him returning to a flat which was uninhabitable and posed significant risk to his wellbeing. NYSAB’s Managing Different Professional Perspectives and Mutual Challenge guidance offers support to practitioners on how to respectfully challenge other agencies and how to escalate unresolved situations involving risk to an individual.

7. Positive Practice

12 Safeguarding meetings were held for Alice and, though there is some learning in terms of ensuring all relevant professionals are involved, it showed a real persistence in trying to keep Alice safe. Attempts were made to involve her in these meetings and she had legal representation.
Workers were aware of Alice’s preference to be contacted via text message and did so to support engagement.
Practitioners who knew Alice spoke of her with fondness and had tried their best to build relationships with her under difficult circumstances.

Support For Professionals

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1. Risk Management and Professional Perspectives: This report highlights the impact that professional disagreement and lack of resolution in managing risk can have on outcomes for the individual at the centre. Where there is an immediate critical risk to an individual, the safeguarding leads of the relevant organisations should be notified. Otherwise, professionals are encouraged to review the NYSAB practice guidance on Managing Differing Professional Perspectives. This guidance provides practical tips on planning for conversations where professionals may respectfully challenge the position of another agency. Where this is unsuccessful, it contains a clear escalation route for reaching a resolution. You can access this guidance here: www.safeguardingadults.co.uk/working-with-adults/practice-guidance/professionals-resolution/

2. Trauma Informed Care: This case highlights the importance of recognising how past trauma influences behaviour. Building trauma-informed approaches can enhance trust and tailor support more effectively. Trauma Informed responses recognise that behaviours may be survival strategies rooted in past trauma, for example Alice's reluctance to engage with services may stem from a fear of what she feels may happen 'to' her if she shared the extent of her difficulties. Professional curiosity helps professionals understand the **why** behind behaviours, rather than judging or reacting. This supports **non-triggering, empowering interactions** that avoid re-traumatisation. Further information on trauma-informed care can be found here: The Five Key Principles of Trauma Informed Practice

3. Self Neglect & Hoarding: The report emphasises the importance of professionals knowing and understanding the signs of self-neglect and what they should do where this is known or suspected. NYSAB Self-Neglect Practice guidance sets out a definition and signs of self-neglect and explains how to raise a safeguarding concern in response to this (please note you do not need consent to raise a safeguarding where the concern is self-neglect). It also includes advice on relevant legislation, practical tasks you can try with the person and links to tools (such as the Clutter Rating Scale) that support practice in this area. It can be accessed here: www.safeguardingadults.co.uk/self-neglect-practice-guidance-north-yorkshire-and-city-of-york/

3. Mental Capacity: The report recognises that understanding and assessing mental capacity in cases of self-neglect and hoarding can be complex. Consideration of someone's executive function if often key and NYSAB's One Minute Guide on Executive Function provides support for practitioners. It can be accessed here: www.safeguardingadults.co.uk/working-with-adults/one-minute-guides-omg/executive-capacity/