Bexley Safeguarding Adults Board

Thematic Safeguarding Adults Review on Self-Neglect

6th November 2023 by Independent Chair and Author, Deborah Barnett

Abstract: Fixing the barrier - Preventing a person from addressing their own problems and difficulties

Why would a person who previously had a house, family and career stop self-caring?

Why would someone previously engaged in work, friendships and activities become reclusive?

Why when mental and physical wellbeing deteriorate rapidly, would a person appear to ignore anything that might heal them?

This thematic review aims to identify learning in relation to these significant questions.

Context: The person considered to be self-neglecting hasn't forgotten how to do these self-care tasks, but trauma has prevented them from concentrating on issues of self-care in favour of survival. The effort of survival is all consuming and exhausts the body and mind. Supporting a person to recognise that the threat is over and that they can be safe and well once more, will allow them to utilise previously used self-care skills. Nothing needs to be imposed or forced, a gentle caring understanding and re-engagement, supporting an identity outside of the impact of trauma is required.

The cause of the hoarding, self-neglect, living and personal hygiene conditions in these reviews (Like many reviews relating to self-neglect before them) went largely unexplored. No one asked the person what happened to them. Without an understanding of what happened, how it affected the person and what there is available to heal that injury, we can't find a solution. Agencies concentrate on the risks to others, environmental risks and managing the risks to the person. These things add to the trauma experienced by the person, rather than assisting in healing trauma. The agencies look to resolve risk associated with hoarding and self-neglect. This means further loss of control, guilt, embarrassment, and loss of identity, as the individual's goods and history are cleared. It appears to the person that no one cares about what happened to them, merely the risks that they pose to others.

Hugh England (1986) and Neil Thompson (2023) provide an overview of social work suggesting that,

'Everyone has problems, and they use practical solutions to resolve those problems. It is those who have problems managing their problems and difficulties in managing their difficulties that require the support of a social worker.'

Care management and onward referral processes with obvious practical solutions, that address the simplified version of a problem (Or difficulty) will not address what happened to the person (Trauma), leading to how and why the person struggles to achieve problem solution for themselves.

A person struggling to self-care and to engage with others would find attending appointments and maintaining contact almost impossible. This is particularly relevant when someone lived a good life with family, friends, work, and wellbeing and then they find themselves (following trauma) unable to self-care, manage affairs and maintain relationships. They still understand the theory of addressing the individual issues affecting them but cannot find it in themselves to solve the problem that they have in managing their own problem. Something changed because of that trauma, enabling the trauma and trauma responses to consume the person and their identity. Reinstating, restoring, or exploring new ways of building self-esteem, confidence, identity, and social networks helps the trauma to integrate rather than consume.

Agencies in Bexley identified that support is about fixing the barrier to the person solving their own problems, rather than taking control of the problems, or hoping that they will just go away.

Acknowledgements

It is important to note the level of dedication and commitment that Bexley SAB have had in learning lessons from SARs and changing processes and practice accordingly. In 2019, I first met with Bexley staff to work together on SAR Paul. I think that Bexley staff and I have symbiotically grown in our understanding of self-neglect over the years since SAR Paul 2020 was published. I can now see the rapid, detailed changes expected when practitioners begin to understand what works and the results are very exciting, with people engaging in support and measurable benefits being demonstrated with the family who are subject of this report. It is good to note the pride that practitioners have in achieving these outcomes. Self-neglect is one of the three-year Safeguarding Adults Board priorities commencing this year (2023).

I would like to thank all Board agencies for the hard work and concentrated effort put into establishing an understanding of the individuals lives reviewed throughout this process.

1. Definitions and clarity

Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain. Emotional trauma can affect the functioning of the frontal lobes[1] and executive brain functions. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities[2]. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions. When adversely affected by trauma, loss or bereavement, executive functions such as self-care, impulse control, task initiation, sorting and organising can be affected. Identification of difficulty with executive functions assists us in identifying indicators of trauma.

For the purpose of this report 'trauma' includes loss, bereavement, abuse, neglect, impact of war, discrimination / oppression, extreme poverty, and adverse experiences. These traumatic experiences create in people coping mechanisms to maintain life. The brain focusses on life preservation in favour of the more complex and processed brain activity (Executive brain function) required to self-care, order things, sort things, manage personal appearance / environmental appearance and thought through responses. Preserving life requires compulsive responses to attack, primitive life saving responses of fight, flight, freeze, and flop are commandeered by the brain. Our brains and bodies respond in the manner that all animals respond, impulsively, utilising our senses to respond immediately to any danger presented.

The brain activity that requires us to process information shuts down to exacerbate our sensory awareness and increase our chances of survival. After prolonged trauma experiences, or significant trauma, our brains can struggle to re-engage in this executive processing of information, perceiving continuous and / or perpetual attack. Eventually this results in self-neglect, hoarding, substance misuse, over / under eating, self-harm, suicidal ideation that consequentially result in homelessness, ill health, mental ill health, and early death. Our brains and bodies continue compulsive responses to preserve life, rather than processed responses to live life. Because our senses were so highly emphasised and because there is no chronology in the part of the brain that responds to danger, the brain can be triggered at any time by sensory experiences like those at the time of trauma. Our bodies and minds continuously respond in attack mode, not recognising that the trauma has ended.

Hoarding where there is mistrust of people and a lack of engagement, is an indicator of this coping mechanism following trauma (People have hurt the person but objects / animal's wont. Being attached to something is better than having no attachments). It is non-verbal communication demonstrating the extent of the trauma in the extent of the trauma response (hoarding, self-neglect, drinking excessive amounts of alcohol etc). This lack of trust comes from a lack of feeling in control of one's own life, choices, and identity after prolonged exposure to survival mode responses. Forcing a person to relinquish goods and clear the property means that the person will suffer an additional trauma and will collect more, reject services more

[1] https://www.coalitionbrewing.com/can-emotional-trauma-damage-the-frontal-lobe/?utm_content=cmp-true

[2] https://www.psychologytoday.com/gb/blog/the-mindful-self-express/202106/understanding-the-trauma-brain

and create a dangerous and riskier situation at home as a result. Working to heal the trauma means that the person no longer requires the coping mechanism of hoarding, and the person will choose to relinquish belongings and seek support to clear, order and clean. Being involved in this sorting, organising, and cleaning process is an important therapeutic opportunity to engage previously disengaged executive brain functions associated with order, chronology, and ability to plan a task affected by the trauma.

Self-neglect is used as a term throughout this report, due to the common use of this language within legislation (Care Act 2014). Self-neglect is an errant term that suggests that the person can care for themselves but is making a lifestyle choice. The term self-neglect is used in this report to facilitate the learning for practitioners and is therefore service centred use of language, which could cause distress to those struggling with the impact of trauma. The author of this report apologises to anyone affected or offended by the misrepresentation of the difficulties faced after traumatic events.

It is imperative that all agencies recognise that those affected by trauma, considered to be self-neglecting and isolating themselves, are demonstrating some symptoms of executive brain function difficulties, potentially because of trauma, or a mixture of reasons as you will discover for MW. The aspects of care and support that are declined, require capacity assessment relating to decision making regarding self-care, care for the home environment, care for children and engaging with agencies and other aspects of life affected by executive brain function. The responses suggest that the person struggles to achieve these things, although they may well be able to describe in theory the processes required, however, the way that the brain works when in survival mode means that it becomes very difficult to achieve this in practice, this is called the frontal lobe paradox.[3] This can occur as a result of trauma and / or brain injury.

The amygdala works as the brains alarm system alerting to danger. Triggered by these sensory assessments of danger, rather than processed assessment of risk, the brain sounds the alarm. Trying to analyse things, self-care, organise the house, attend appointments, remember dates and times can be as difficult as trying to do this with a fire alarm perpetually sounding. You may be able to speak of what you should do, but whether you could put it into action is another matter. The person's brain is screaming out to them danger, danger, the body is tense, the person struggles to sleep, thoughts and memories are jumbled, and the person cannot understand why it is so difficult for them to achieve things that others seem to do easily[4]. This means that the person is demonstrating that they 'can't' do the tasks – can't (Inability) as opposed to 'will not' (Informed choice).

An inability to do something to ensure ones' own wellbeing and safety because of a disturbance in the functioning of the mind or brain means that the person has eligible needs for care and support. Assessing whether these factors are at play allows us to correctly identify needs that are not being met because of trauma (Neglect rather than self-neglect). It is hoped that this report can contribute to the change in attitude towards and language used to represent those who struggle to cope with trauma. The following analogy demonstrates how trauma and sensory responses affect behaviours.

Recognising the cumulative impact of trauma

A war veteran walks down the street, and a car backfires. Many people not knowing about his history will respond saying, 'It's just a car backfiring, don't over-react.' Those knowing his history might offer reassurance, care, and support. The following day the war veteran is walking down the street, and someone drops a bin lid. The war veteran screams and runs for cover. Most people walk away, avoid him, and feel uncomfortable in his presence. The third day a war veteran is making breakfast, and his daughter drops a fork on the porcelain floor. He screams, grabs his daughter and dives under the table. If you only see his response to the fork dropping and try to persuade him to act otherwise, you will not succeed. These responses to sounds during war are now better recognised. Less well recognised are the isolation, lack of self-care and anxiety responses of trauma. Throughout this report the cumulative impact of trauma and trauma response is considered in relation to MW, GT, and the Family of 3 vulnerable adults.

[3] https://www.headway.org.uk/about-brain-injury/further-information/research/health-and-social-care/frontal-lobe-paradox-and-the-mental-capacity-act/

[4] https://www.psychologytoday.com/us/blog/in-the-body/201910/when-trauma-gets-stuck-in-the-body

A resource has been supplied in addition to this report which includes a snapshot of how trauma affects a person and their responses. The example is a fictitious representation of the impact of trauma. Recent studies into these triggered sensory responses in the context of addiction, known as somatic marker hypothesis[5] identifies the short term impulsive and compulsive responses of the brain without engagement with the long-term consequences.

2. The purpose of the report

This report presents findings from an analysis of the deaths of two people and the safeguarding arrangements for a family critically at risk of neglect. Safeguarding Adults Reviews (SARs) where self-neglect was a factor, the results of a review of the local authority records relating to individuals subject of this review, IMR reports, policy and guidance on adult safeguarding and meetings with the IMR authors provided information that was analysed against legislation, contemporary research, and good practice guidance.

English local authorities have a duty under S44 of the Care Act 2014[6] to arrange a Safeguarding Adults Review (SAR) where there are lessons to be learnt about the quality of joint working amongst local agencies in relation to an adult with care and support needs in its area. A review can take place when that person is thought to have suffered abuse or neglect and has died as a result (MW and GT) or is still alive but is thought to have suffered serious abuse or neglect (The family). The purpose of these reviews is not to apportion blame, but to learn lessons to improve practice. Analysis covered three key themes with several subthemes behind these titles. Praxis was used as the learning model.

The first IMR authors meeting on the 23rd of March 2023 explored the base line of where the authors / agencies were in relation to their understanding of self-neglect, identified in research and SAR publications and its application in practice with those persons subject of this SAR process. The second IMR meeting (23 May 2023) event was designed to present findings from SAR analysis that create cognitive dissonance[7] between the beliefs of the authors / agencies and the practice that occurred. The IMR authors then identified potential solutions.

A. The individuals:

- **MW overview Royal Borough of Greenwich services -**

In 2018 MW worked as a lecturer in a prestigious college, had a house, a family, and savings. There is no information about what happened resulting in MW losing his job and being separated from his family. MW fell in 2018 when intoxicated causing a pelvic fracture. MW suffered multiple health conditions including suspected arthritis, osteoporosis, and diabetes. In October 2021 MWs landlady raised concerns about MW not eating, or drinking, self-neglecting and hoarding. MWs GP identified the need for hospital treatment which he declined. MW was deemed to have capacity to make this decision by the ambulance service. The GP questioned MWs executive capacity to make decisions and raised the need for multi-disciplinary work.

The GP requested an urgent assessment of need from Greenwich local authority. MW had not washed for a year and was declining food and drink. MW refuse conveyance to hospital on a further two occasions and the ambulance service deemed him capacitated on each occasion. The same day the Joint Emergency Team (JET) GP and Social Worker visited finding MW disorientated in time and place. MW was admitted to hospital on the 15th of October 2021. MW had poor mobility, poor oral intake, was incontinent of urine and faeces and was emaciated. MWs BMI was 13.72 which is very low to critical.

Scans revealed that MW had a deformity on the left-hand side of his pelvis, emphysema with collapse in the lower lungs and severe small vessel ischemic disease. Small vessel ischemic disease affects brain function and can result in strokes, Dementia and death if not treated. There was evidence of old infarcts indicating a previous stroke that results in dizziness, difficulty with walking and coordination, tremors, and muscle

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4501162/

[6] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

[7] https://www.psychologytoday.com/us/basics/cognitive-dissonance

weakness. The person can also have trouble with executive brain function, language, disinhibited behaviours, and impaired vision. It was identified that there was no underlying cause for his loss of weight and general self-neglect was determined.

MW was discharged to a step-down unit. MWs landlady served notice on him two days after he was admitted to hospital, leaving him homeless. The landlady would only allow MW access to the property. Once discharged to the stepdown unit he was advised to get a van and collect his belongings within 24 hours otherwise they would be cleared from the property. MW was unable to achieve this and there is no further mention of what happened to his belongings.

An OT assessed MW using a mini mental state test and determined that he had reduced scoring on recall. The OT advised that he did not require further capacity assessments. A month after being discharged from hospital to the step-down unit, he was told that he had to leave and was given a list of hostels. It was determined the MW had no needs for care and support. MW had £45,000 in the bank and was determined to be a self-funder. A deadline of 12pm on the 3rd of October 2021 was given. MW had been referred to Greenwich Housing Team but was discharged from the team due to a lack of engagement. On the 20th of January MW was reported missing to the Police by his son. MW was found to be in a hotel. MW did not engage with any of the follow up appointments with his GP or dietician. Diabetic, osteoporosis, and rheumatology appointments were also missed. The GP service was made aware that MW had lost his phone but continued follow up calls via the telephone.

On the 3rd of May 2022 MW was found 'wandering the streets', confused with a right-hand injury, and was admitted to hospital. Acute confusion was noted by ward staff, along with secondary hypothyroidism, vitamin D and foliate deficiency. The Greenwich Safeguarding Advisor recommended that formal mental capacity assessments were required, a safe discharge and referral to an OT. A physiotherapist working with MW noted confusion and the discharge information identified similar issues with confusion and recall. No capacity assessments took place.

Physiotherapy assessment identified that MW could mobilise using a walking frame and support but lacked safety awareness. MW kept bumping into objects and had a fall when on the toilet. MW could not sit in a seat unaided as he kept slipping down. MW needed support with washing, dressing, medication, and incontinence. There were Dementia queries and MW was assessed by the homeless team to be lacking capacity to make decisions about place of residence. An IMCA was requested. The homeless team determined that MW would not be suited to private rented accommodation and required more support. This plan changed but there is no indication why these things were not actioned. MW was unaware of how much money was in his bank account at this point.

On the 13th of June 2022 a new Social Worker was allocated and attended the hospital to assess MWs capacity regarding a tenancy. MW was determined to have capacity to make decisions about his tenancy. On the 1st of July MW was given some housing options and a house of multiple occupancy in Bexley was identified as his new place of residence. MWs discharge was delayed slightly after he had a fall in the shower (3rd of July) whilst being supported by ward staff.

On the 5th of July the Social Worker visited the ward and MW signed his tenancy agreement. The following day the Social Worker collected the keys for the property. The Social Worker found that the property was not in a safe condition with floor tiles missing and the bathroom not fit for use. MW was diagnosed with Covid 19 the same day. The carers were asked to assist him in using the commode and to provide strip washes until the repairs were addressed, discharge was delayed as carers could not provide services until the 11th of July. A referral was made to the incontinence nurse.

Supporting MW the care workers identified:

- The property is unsafe for MW and care workers attending.
- It is a house of multiple occupancy (5 men)
- Cannabis is being smoked in the property.
- Care workers were approached aggressively by other residents.
- MW is bedbound and cannot get up to provide care worker's access.

- Resident in room 2 aggressive stating that he would not be answering the door to care workers anymore.
- MW not much food in room – bread and out of date items in fridge
- No bed linen – plastic over his bed
- Water leaking from room above onto MWs bed where he lay under a plastic sheet.
- No toiletries, towels, or flannels
- MW covered in faeces and declining support from the care workers.
- Bathroom / toilet inaccessible to MW and care workers
- Property in isolated area and "*There are always men hanging around.*"
- Every care worker attending has asked to be removed from his care.

The care service threatened to withdraw care, but at the request of the Greenwich social worker they continued care provision. The care package consisted of four daily calls with 2:1 support. On the 19th of July the Greenwich Social Worker contacted Bexley services requesting a transfer of care. The need for urgent and ongoing support was identified, support with shopping, rent payments, repairs and access to an advocate were also identified needs. The social worker stated that MW lacked motivation to do anything for himself including making decisions and deemed him to be capacitated but selective.

MW stated that he did not wish to move to Bexley, and he could not settle as he did not know where he was, or any of the people that he resided with. Care agency notes identify that MW was declining food and would not accept assistance to change out of soiled clothing and to clean up.

Bexley local authority contacted a GP in August 2022, and the GP was scheduled to review his care. Unfortunately, the GP was unwell, and the appointment cancelled. The GP practice was new to MW, records had not yet been made available to the surgery and his vulnerabilities were unknown. MW was unable to answer security questions to access his bank account and was unable to mobilise to get to the bank. There was an unexplained delay in the care agency identifying these concerns to the local authority. A subsequent Social Work visit identified that MW was no longer able to mobilise and would need court of protection proceedings to secure funds for his bills and accommodation. It was concluded that the accommodation was not suitable to meet his needs. MWs flat had no light or heating, and it was the coldest winter on record, his BMI was critically low and he lay under a plastic sheet with water dripping on him from the upstairs flat. MW previously stated that he couldn't afford to pay for food and bills, there is nothing to identify what happened to his money.

On the 7th of December a Bexley arranged care package commenced. On the 14th of December 2022 an ambulance was called by care workers and MW was admitted to hospital. An internal safeguarding referral was made after MW was found to be critically unwell and hypothermic. The following day MW sadly died.

Analysis MW

Within Preston Shoots[8] analysis of SARs relating to self-neglect, a framework of common themes and good practice guidance is offered. This SAR utilised this framework for analysis purposes. The following represents a snapshot of what was a much larger piece of work conducted by Bexley SAR panel analysing events in this thematic review in relation to previous national SAR findings identified by Preston Shoot.

Domain A: Practice with the individual in their social situation

Making safeguarding personal:

- Proactive person-centred engagement exploring wishes, feelings, views, experiences, needs and desired outcomes.
- Contact and continuity across teams and organisational boundaries.
- Communication skills, conveyed empathy and relationship building skills.
- A picture of the persons history

[8] https://www.emerald.com/insight/content/doi/10.1108/JAP-02-2019-0008/full/html

There is very little known about what happened to MW leading to his self-neglect. There is little continuity in his service provision with multiple changes of GP, Social Worker, and emergency workers. Carer workers regularly requested to be removed from his care. Despite having a good job, a home, and a family there is nothing to indicate why these things broke down. There is nothing to indicate an empathetic response toward MW and opportunities to build relationships and learn more (When son reported MW as missing) went unutilised. The Greenwich IMR report identifies that Social Workers and Social Care staff put MW at the centre of his care. To achieve this when someone is self-neglecting the cause of the self-neglect would need to be identified to establish a plan of support. This was not identified. The Greenwich IMR report also identifies that strength-based assessments were utilised, but if that was the case there would be more known about MWs working career, skills and abilities, family relationships and support dynamics.

There is nothing recorded about follow up after MW was asked to leave the step-down unit. There was no identified forwarding address. Physiotherapy, housing, and hospital staff all identified medical reasons for MWs confused state and unsteady walking, yet he was asked to leave with little more than a list of hostels. It was determined by the homeless team that he would not be suited to a house of multiple occupancy (HMO) and could not manage a tenancy. The Greenwich social worker does not appear to have gathered information and information was not shared by these agencies. MW was moved into an HMO in an area that he did not know (Bexley). MW was bed bound, living with aggressive people, unable to access his finances, unable to feed himself, with water dripping on him whilst in his bed and no toilet access. He had multiple severe health conditions including evidence of strokes. There is no light or heating in his room, and it was the coldest winter on record. It is unsurprising that by December 2022 he was admitted to hospital with hypothermia and subsequently died. MW lived in this state for 6 months leading up to his death. There were errors in assessment, a lack of understanding of the cause of MWs self-neglect and unsafe conditions for discharge.

On transfer of services from Greenwich local authority to Bexley, MW was not recognised as requiring critical allocation of a Social Worker and remained the responsibility of duty social workers awaiting allocation. This led to gaps in knowledge that were crucial in safeguarding MW.

Autonomy

- Loss and trauma often lie behind a person's refusal to engage.

Indicators of trauma went undetected:

- Not eating or hydrating sufficiently resulting in critically low BMI
- Not caring for himself
- Not washing or changing soiled clothing
- Not engaging with medical support for critical illnesses
- Multiple missed appointments
- Housing not suitable for habitation
- Threats to safety from cohabitees and others hanging around property.

Assessment

- Recognition of time to address the impact of adverse experiences, loss, and trauma.
- Address repetitive patterns.
- Mental capacity assessments considering executive functioning skills.

In October 2021 the GP recognised the need to consider executive functioning deficits when MW was declining attendance for treatment, care, and support. The GP also identified the need for a multi-agency approach. Reasonable belief capacity assessments conducted by ward staff and homeless services indicate a lack of capacity regarding making decisions about health care, support and housing. An OT conducts a mini mental state test and determines that MW has difficulties with recall. The OT confusingly advises that there is no need for further capacity assessment. The Social Worker conducts a capacity assessment regarding tenancy and determines MW to be capacitated. IMR authors in Bexley suggested that the knowledge and research relating to executive function deficits following trauma was not well known.

The Greenwich needs assessment focussed specifically on the physical needs, missing some critical information about MWs inability to sit in a chair, unsteadiness when stood without support and lack of

awareness of obstacles in his way. Needs relating to the impact of trauma on MWs ability to accept care and support were not assessed and needs relating to this went undetected. MWs ability to execute the plans that he made were not assessed so MW could not:

- Get his belongings from his flat
- Arrange suitable accommodation after discharge from the step-down unit.
- Manage his finances.
- Access his bank account.
- Access self-care skills
- Access the community.
- Manage a tenancy and to pay bills.
- Accept nutrition and hydration to maintain wellbeing.
- Accept medication and treatment after hospital discharge.
- Maintain personal hygiene.
- Use the toilet or the commode, even with support.
- Make safe use of his property.
- Maintain contact with family and friends.

MW was not safe or well and no safeguarding enquiries or arrangements were actioned.

Planning

- Care plans – thorough and reviewed regularly.
- Careful preparation at points of transition (Especially hospital discharge and placement commissioning).

SAR author also suggests the need for Social Work intervention rather than care management models of practice.

Care plans were not reviewed thoroughly on discharge from the step down unit following a hospital discharge, nor when transferred to Bexley local authority services. This caused MWs vulnerability and the severity of his needs to go unrecognised. MW was being held accountable for his own self-care which he was wholly unable to achieve.

Family and Social Context

- The involvement of family and friends in assessment is encouraged.
- Advocacy commissioned where relevant.

Opportunities to engage with MWs family after he was reported missing by his son were not taken advantage of. There was suggestion of the need for advocacy and multi-agency involvement, but this didn't transpire.

Legal literacy

- All legal options to be considered and decision making clearly recorded.

The author of this thematic review recommends the use of the Human Rights Act as a foundation legislation.

<u>Article 2: Right to life</u>

- the Government should take appropriate measures to safeguard life by making laws to protect you and, in some circumstances, by taking steps to protect you if your life is at risk.

- Public authorities should also consider your right to life when making decisions that might put you in danger or that affect your life expectancy.

The focus of the law on self-neglect, suggesting a personal choice to neglect oneself, creates a focus of attention on the environmental and personal risks. Practitioners assume capacity in the absence of a diagnosis to the contrary or become confused because the person seems incapable of doing things for themselves but can describe what should occur. MW repeatedly displayed this, but it was most obvious within

his capacity assessment for tenancy. Without understanding the cause of the self-neglect no cure can be identified. This presents risks to those whose brain function (Executive function) is affected by trauma (Trauma being the cause of self-neglect), who can in theory describe a process but in practice trauma prevents the execution of these described processes.

SAR repeat themes identify how often people considered to be self-neglecting die, requiring the review process. There are many thousands more affected by trauma living on our streets and within our prison systems who will die at a significantly younger age than those not affected by trauma. Trauma causes the continual erosion of physical and mental wellbeing if not supported appropriately. The right to life was not considered for MW when decisions were made about his care and support, imposed actions, and living conditions. A trauma informed approach is required maximising the persons power and control as soon as possible after trauma occurs. For MW recognition of his vulnerability seemed evasive and his holistic needs were undetected. The lack of recognition of what caused MW to dislike himself so much that he rejected nutrition, hydration, treatment, care, and support meant that he was placed in danger that reduced his life expectancy. Agencies in Bexley identified the need for safeguarding oversight and guidance with Human Rights based approaches that recognise the severity of the situation and the need for earlier intervention prior to the development of critical health care needs.

Article 3: Freedom from torture and inhuman or degrading treatment

Inhuman treatment or punishment is treatment which causes intense physical or mental suffering. Degrading treatment means treatment that is extremely humiliating and undignified. This concept is based on the principle of dignity - the innate value of all human beings.

Inhuman or degrading treatment could include:

- serious physical assault
- very severe detention conditions or restraints
- serious physical or psychological abuse in a health or care setting, and
- threatening to torture someone if the threat is real and immediate.

The only light that MW had in his property was that from the corridor, leaving him laying in bed in view of other residents which were unknown to him. MW had a critically low BMI, it was the coldest winter on record, there is no heating, he lay in a bed covered in his own urine and excrement, covered in a plastic sheet with water dripping on him from the flat above. MW could not mobilise and did not have access to a phone. Carers were concerned about unsavoury characters hanging around and felt unsafe. It is incomprehensible to consider how someone who had been a valued academic, with a family, a home and savings would feel being placed after hospital discharge in this situation, when confused and feeling unwell.

Article 8: Respect for your private and family life, home and correspondence

The courts have interpreted the concept of ‘private life’ very broadly. It covers things like your right to determine your sexual orientation, your lifestyle, and the way you look and dress. It also includes your right to control who sees and touches your body. For example, this means that public authorities cannot do things like leave you undressed in a busy ward or take a blood sample without your permission.

The concept of private life also covers your right to develop your personal identity and to forge friendships and other relationships. This includes a right to participate in essential economic, social, cultural and leisure activities. In some circumstances, public authorities may need to help you enjoy your right to a private life, including your ability to participate in society.

The right to private life also means the right to make autonomous decisions or to have justification in the form of a capacity assessment if this is questioned.

MW did not have access to the type of support required as the capacity assessments requested, in the manner advised did not take place. The only access to MWs accommodation was through workers asking other residence to allow access to MW. MW lay in full view of other residents within the property or lay in the cold and dark alone. MW had no access to the community and was residing in a place that he didn’t know with people he didn’t know.

Article 14: Protection from discrimination in respect of these rights and freedoms

Discrimination occurs when you are treated less favourably than another person in a similar situation and this treatment cannot be objectively and reasonably justified. Discrimination can also occur if you are disadvantaged by being treated the same as another person when your circumstances are different (for example if you are disabled or pregnant).

Because trauma was not identified as the cause of MWs self-neglect, reasonable adjustments in access to services and support relating to the impact of trauma on the brain were not realised. This meant the MW couldn't find suitable property for himself (After the step-down unit) resulting in him being found injured and confused on the streets. MW couldn't retrieve his belongings from his rented property resulting in the loss of his property. MW couldn't manage his finances leading to vulnerability and loss of funds. MW couldn't mobilise and didn't have support to access the community resulting in his liberty and freedom being affected.

Domain B: The professional team around the adult

Counteracting Silo Working

- Interagency communication and collaboration co-ordinated by a lead agency and key worker
- Whole system meetings – who is going to find the time t explore what happened to the person
- Muti-agency meetings

For MW there were no safeguarding arrangements in place which meant a lack of co-ordinate response, and a lack of oversight and guidance. Reasonable adjustments were not made in access to services, opportunities to use the hospital setting as a time for co-ordinated assessment were missed. There were no multi-agency meetings with collaborative information sharing and solution finding outcomes.

Information sharing

- All agencies to share the full picture rather than partial picture.
- Detailed referrals where one agency is requesting assistance from another to meet need.
- Common misconceptions addressed.

No agency had the whole picture. The needs assessment did not cover needs relating to trauma as the cause of self-neglect. It is a duty to make safeguarding referrals to the local authority if someone is self-neglecting and their safety and wellbeing cannot be maintained. The hospital chose an internal safeguarding referral rather than that identified within the Care Act. This may have been a lack of understanding relating to eligibility criteria for local authority referral. The lack of focus upon trauma meant that eligibility criteria for assessment, safeguarding, capacity assessment and the extent of care and support needs were never fully recognised across services. These common misconceptions prevail because the trauma, 'What happened to you' is often ignored.

Knowledge and use of safeguarding pathways

- Policies and procedures evident in the practice of practitioners and managers
- The duty to enquire.
- Access to specialist legal, mental capacity and mental health advice

MW was not referred for S42 enquiries by either Greenwich or Bexley. The Greenwich IMR report identifies that there were no safeguarding concerns raised during Greenwich intervention. Agencies in Bexley suggested that there was confusion over what enquiries would achieve when someone is considered to be self-neglecting. There is little to enquire about if the hypothesis is self-neglect and all agencies recognise and identify self-neglect. The hypothesis of trauma requires further exploration, assessment and determination and was required as the starting hypothesis to rule in / out. This would have provided more defensible decision making.

The Greenwich social worker tried very hard to find suitable accommodation for MW but without multi-agency support this was very difficult to achieve.

There was a lack of access to specialist advice.

Recording

- Clear and thorough records of assessments, reviews and decision making.

Compassion and a desire to understand the person and their story was disregarded in favour of practical responses to the environment and situation. A lot of hard work was aimed at managing risk without success, because to manage the risk MW needed to feel safe and want to achieve self-care once more. Actions taken had the opposite impact on him, creating less safety and deteriorating wellbeing. Recording reflects the time and effort that the Greenwich Social Worker dedicated to finding solutions to MWs situation, however, without clarity of the cause of the situation these actions would remain in vain. MW would reject any care and support, transfer of accommodation, or treatment.

B. The individuals:

- **GT**

GT was born in 1960 and described by the Police as having slight mobility problems. The Police report states that the property that he was living in had no Gas or Electric supplies (Only cold mains water) and no toilet facilities. The property was very overgrown with limited access to the front door. The land that the property sat on was full of rubbish / waste including a cylinder and human excrement. There was evidence of small fires on the land (Possibly set by youths within the area). The property was in an extremely poor state of dis-repair and Police classed all above as a potential fire risk with no evidence of anyone living there. The property had been owned by GTs mother who had died on the 6th of September 2011. GTs mother was admitted to hospital in 2011 and records indicate that hospital staff were concerned about her neglecting herself.

An incident that happened on in December 2020 and recorded by the Police identified that GT had been asleep and awoke to a male standing in his room holding a broken green glass bottle. The male said, "WE ARE TAKING YOUR SPARE ROOM" and threatened him with the green bottle. A previous visit from social services recorded the front door to have broken glass and has marks where the door had been kicked in. It was also reported that the front door where the letter box should be, was empty and it was just a hole. The property had several broken windows and looked in a poor state of repair and was identified as not fit for human habitation. The Police concern was viewed by the MASH Police and Graded amber. It appears that the vulnerability of GT was not taken into consideration in relating to this decision.

The next time that the local authority was informed of concerns about GT was on the 5th of April 2021 when the police report an incident at GTs property.

The report identifies that GT is,

> **‘*Being bothered by groups of youths, shouting at him saying they want his house. It was reported to the police that he was seen out of the house with a knife, which a neighbour managed to get him to put away and go back into the address. It was also reported that following a visit by from the police, it was observed that there was no gas and electricity in the property and that... the house... is in a very poor state of repairs and possibly dangerous to live in’*.**

On the 17th of March 2021 GT was admitted to hospital following a fall. He was identified as having unintentional weight loss, malnourished, left foot ulcer and neuropathy in both feet[9].

On the 8th of April 2021 the social worker sent an email to housing identifying the above concerns. The social worker states that the glass in the front door is broken and there are marks where it appears that someone has kicked the door in. There was a gap where the letter box should be, the windows were broken, and the property was not fit for human habitation.

The social worker goes on to state,

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[9] https://www.nhs.uk/conditions/peripheral-neuropathy/

"GT is very vulnerable, and it appears that local youths now know this and are targeting him. GT reports that he no longer feels safe at home as a result. There is also a current rat infestation at the property."

The social worker contacts environmental health services and accesses the hospital discharge passport which stated that GT did not have needs for care and support, which the social worker questioned. GT was not in receipt of benefits. A referral to mental health services was made. Contact with an Approved Mental Health Practitioner (AMHP) identified that GT did not have needs for care and support and didn't want support at home. The AMHP acknowledged that GT was living under threat but determined him capable of contacting the Police. The social worker contacts housing and several documents were requested from GT. It is unlikely that GT would have access to the documents requested, or that he would be able to organise a response to this. GT wanted to remain in his property until he could sell the land.

On the 22nd of April 2021 a safeguarding enquiry is opened. GT is recorded as being asked what outcomes he would like; no outcomes are identified, and the safeguarding enquiry is closed.

The records state,

"***I did not have any reason to doubt GTs capacity at this time of my visit. GT says that he does not need any support from Social Services but will contact us if he does.***"

A student Social Worker is allocated to GT who describes his appearance as unkempt with a strong smell of urine and faeces. GT told the Social Worker that he had lived in the property since 1987, it belonged to his mother, but his mother had since passed away. There is a discrepancy in the recorded council tax payments identifying two parties unknown to GT to be responsible for the rent, the reason for this was never determined. GT reiterated that youths had been bothering him, wanting to take over the property. A leak in the property was identified by GT with significant damp problems. The outcome of the visit was identified as closure at the request of GT. Referrals were made to environmental health, public health, and the fire service. During May 2021 these services visit GT noting the deterioration in the state of the property.

Concern is raised as GT had not been seen for a while and police visit. GT was found alive and well, but the conditions were described as the worst that the officer had seen. Local authority support was requested and video evidence of the state of the property shared. A request for rehousing was made. Police describe the conditions of the property as a health hazard. There was evidence of years of neglect, no electricity, involuntary running water, no working sinks, toilet, or kitchen. The property was dark, cluttered, and dilapidated. GT admitted that he went outside to defecate. The walls were damp, there was fungus growing in the corridors and there were many cobwebs. The state of the property eventually caused GT to begin living outside in his garden.

At the end of April Police visit with the Property Licencing and Private Sector Housing Standards agency. GT identifies that he has money as he was bought out of his previous property but is not in receipt of benefits. GT identifies that he feels threatened and at risk of losing his property.

On the 11th of October 2021 the safeguarding report identifies,

'GT is a vulnerable adult exposed to risks due to his living condition and does not accept support, hence in my opinion does not have the ability to protect himself. GTs only source of support is his previous girlfriend who has stated that she cannot provide him with support. GT is of the view that there is nothing wrong with his living conditions and has said that he is capable of looking after his health. GT is vulnerable due to his living condition, and I believe he does not have insight into the risk associated with how he lives. I have recommended support with a housing application and a package of care, but GT declined'.

A multi-agency meeting (CR MARAC) was convened in June and then another in July and GT was discussed,

'A home visit had been completed to establish if GT had any care / support needs and to establish why his property was in such a state. ASC could not identify any care and support

> ***needs, he is physically able, there is no mental health diagnosis, he has capacity and can manage his money and finances. GT says he prefers to live the way he does. The health and fire risks were discussed, and GT is fully aware. He is using his garden as a toilet which poses a health risk to the wider community. There is no gas or electricity running into the property and he buys food from local shops. It would be a long-term piece of work to engage him and assess his capacity further. A referral is being completed to the Complex Care Team who may feel he would benefit from a referral to mental health services even though he does not have a diagnosis currently. Claims he does not need a GP. Environmental Health were not interested in the case as there had been no complaints from the community. GT's mother owns the property…GT apparently lived in similar conditions in a previous property until the bank took control of the property and paid him out. Suggestion he may be waiting for the same thing to occur at this property'.***

IMR authors discussed the meeting and suggested that there is an underlying unspoken perspective of lifestyle choice, blame for the state of the property and impact on others and an accusation of using this situation for reasons of financial gain. The empathy, understanding of how trauma impacts on a person, the recognition that the person is unable to keep themselves safe and well and the skills to build self-esteem and self-confidence required to support the person to feel safe enough and cared about enough to relinquish the need for hoarding goods is not evident.

The meeting on the 8th of July 2022 it is identified that it is unlikely that a care agency would enter the property to provide care. The fire service identified charitable decluttering services. The Police identified calls from neighbours about young people getting into the property and threatening GT along with the risk of exploitation. Outcomes were to establish if mail is delivered to property, seek specialist hoarding and self-neglect support, share Police video footage, link with environmental health, liaise with local authority and escalate safeguarding concerns.

On the 12th of July 2022 the Police and social worker completed a home visit. GT was sitting outside of his house. GT appeared happy to see the social worker and requested an additional visit to discuss housing. GT said that he goes out to get a daily newspaper, he goes to a café for meals, and he goes to his neighbours house to cook. On other occasions GT indicates that he scavenges for food. In the CR MARAC meeting the same day as the visit Adult Social Care identify the need to develop a rapport with GT and then to conduct capacity assessments. The fire service continues to monitor. The outcomes from this assessment were to discuss the COVID vaccine, engage with GP, refer to Mental Health Services, joint visit with environmental health and check for smoke detectors and alarms.

On the 28th of July 2022 further safeguarding enquiries were conducted. GT was in his garden sitting under a tree. Accommodation was discussed and he said that he enjoys being under the tree and close to nature. GT declined a move of accommodation. GT said that he did not wish to be close to Government services as a he saw then as the enemy. He apologised if this caused offence. Records indicate that a mental capacity assessment was completed. The social worker states that GT was telling her what she needed to hear and that there was 'No parameter to weigh up the information' that he was relaying. GT said that it was his choice to live that way, but the social worker had the impression that GT was ready to explore other options. A plan for further capacity assessment and visits was made.

GT was drinking a bottle of Jack Daniels and said that this was his way to relax. It is noted that his speech is coherent and that he was articulate in his communication. GT stated that he went to a café for breakfast, or he bought takeaways in the evening and ate the remaining food cold for breakfast. GTs BMI was not assessed but remained very low. GT did not have any gas or electricity supply at the property. GT identified that he did not have any friends or family in the area. An offer of food and clothing and an additional meeting close to the council offices was accepted by GT.

Social Work notes identify that a man of 'African heritage' was seen entering GTs compound at 15.00. The social worker asked if he was from environmental or housing services. The man declined introduction but asked if they could "Walk towards Hush's house." The social worker notes concern that the man did not seem to know GTs name. The social worker left and returned 30 minutes later. The man was seen walking away. GT said that he didn't know the man, but he sometimes brings him food.

On the 5th of August 2022 the social worker requested the GP to support a referral to the community mental health team. The referral identifies that GT lived in a house with no running water, gas, or electricity. GT was described as wearing filthy, tattered clothing and to be living in an unhygienic home environment. It is identified that GT can verbally communicate his needs, but the information supplied could be unreliable and that there could be underlying medical issues.

On the 9th of August 2022 the social worker returned to GTs home, again finding him in his garden. Discussion about the commonwealth games and politics ensued. Records indicate that GT appreciated the delivery of food items and toiletries. GT was informed that he had been registered with a GP and he stated that he had a good immune system. GTs previous girlfriend was contacted, and she stated that she had other caring responsibilities and could not support GT. The same day a text was sent to GT from his GP surgery with an appointment made for 8th August 2022. Five further texts were sent, and no confirmation was received.

On the 10th of August 2022 CR MARAC identified considerable progress with a GP referral and a referral to the Mental Health Team. A visit by the social worker on the previous day identified that he seemed a bit more willing to accept support. Trust is gradually being developed. An unknown man was identified as being at the property during this visit and the man would not state who he was. GT did not know who he was but stated that he occasionally left him food. Two actions are identified relating to Mental Health referral.

There is no further information about GT until the Coroner informed services of his death, found at home on the 22nd of November 2022.

Analysis

Domain A: Practice with the individual in their social situation

Making safeguarding personal:

Hospital records indicate that GT had been raised by a mother who herself was displaying indicators of trauma, self-neglect, and hoarding. The impact of this on GT was not explored. The death of his mother and his attachment to her belongings were not discussed.

Desired outcomes were not explored in relation to trauma and GT felt threatened that he may lose his property as he had not been identified as the legal owner following his mother's death. GT declined services and proactive engagement did not occur.

Most of the planning and intervention focussed upon referral to services, but environmental health, public health and the Police may have seemed to him to be threats to his ability to maintain the property. The fire service did suggest a need to establish the root cause of his hoarding and self-neglect, but this was not followed up.

Contact, and continuity is not preserved across teams and organisational boundaries. Safeguarding concerns are raised and closed without reassurance that GT is safe and well.

A practitioner at the multi-agency safeguarding meeting identified the need to build rapport and trust before conducting capacity assessments, but there is no follow up to this. GT was supported to access a GP.

Autonomy

Adult Social Care could not identify any care and support needs stating,

> ***"He is physically able, there is no mental health diagnosis, he has capacity and can manage his money and finances. GT says that he prefers to live the way he does."***

Adult Social Care at this point determined that GT was making a lifestyle choice to live in a manner that caused his mental and physical wellbeing to deteriorate resulting in an early death.

During the multi-agency meeting this was challenged,

> ***'There are many issues that need to be unpicked and will require long term and multi-agency joint working.***

> ***It would be helpful if there were specialist support for GT or access to advice on hoarding and self-neglect.***
>
> ***There are likely to be different MCA assessments for different issues/aspects needed, i.e., finances, self- neglect, safeguarding, and they may need to be reviewed over the time. I would not want to enter a discussion about whether he does or does not have capacity at this stage, as this is a complex piece of work, and a one-off visit is not going to give us definitive answers. Yet, looking at the evidence it may indicate that in terms of the client's functional capacity there is a discrepancy between what he says and what he is able to put into practice'.***

This is good practice, however, the lack of a co-ordinated safeguarding response meant that no one was held accountable for the planning and execution of these assessments. GTs refusal of care and support was ultimately regarded as a capacitated decision. The trauma of his life experiences and the impact that they had on decision making went unexplored.

Assessment

Adult Social Care (ASC) Identified,

> **"*It would be a long-term piece of work to assess capacity*".**

There are repetitive patterns of service referral and refusal. It is notable when a social worker begins person centred work that GTs responds to her in a positive manner, seeking further engagement. GT can recognise the benefits.

There are some indications of risk assessment, but these do not appear to have been coordinated or led. Risk management plans were not identified and / or shared.

There are some good conversations beginning to occur in relation to GTs care and support. There appears to be a reluctance to provide a reasonable belief capacity assessment based upon information available until such time that a full and comprehensive assessment can be completed.

Multi-agency formulation (A coproduced narrative of what happened to GT, his experiences, his skills and strengths, triggers, and management) was not a consideration as part of GTs assessment. Triggers were not well understood, skills and strengths were not identified and there was little understanding of how the trauma and loss in GTs life had affected him.

Strength based assessments were not carried out. GTs former girlfriend appears to have been used as a source of support by GT, but she felt unable to manage this support. There is no clear assessment of identified needs and no care and support plan in relation to GT. The number of needs needing to be met appears to be extensive.

Planning

There were no assessments and therefore there were no care plans.

Joint visits were conducted because of safeguarding concerns, but agencies didn't use social work assessment as a tool for safeguarding.

There are no identified co-caring responsibilities, however, GTs previous girlfriend had been heavily involved and appears to have provided some care and support but there is nothing recorded about the nature of this care and support. It was clear that this support was no longer available to GT from his girlfriend.

Family and Social Context

GT didn't seem to have anyone that he could engage with.

Legal Literacy

There was a lot of discussion relating to public health and environmental health, but little to counterbalance this in relation to Human Rights, Care Act needs assessment, reasonable adjustments under the Equality Act etc.

Domain B The professionals around the adult

Counteracting silo working

There were two multi-agency meetings conducted relating to safeguarding GT. Within these meetings conflicting perspectives were not resolved. Some agencies deemed decisions that GT was making about his care, support, fire risks, and housing to be capacitated decisions relating to a lifestyle choice. Other agencies challenged this requesting further assessment, capacity assessment including the ability to put into practice what he was describing and consideration of needs. The differing perspectives were not considered in relation to Human Rights assessment and outcomes and therefore there was no collective resolution.

Information Sharing

CR MARAC meetings - Information was shared across agencies, but the responses and outcomes centred around the risks and practical solutions to the problems and difficulties presented. These practical solutions resulted in outcomes:

- To address a house considered in disrepair, cluttered and unhygienic removal of the person, repair, cleaning, and decluttering.
- To address a lack of food – by providing food
- To address a lack of money – by trying to gain access to the bank accounts.
- To address a rat infestation – by getting access to public health
- To determine a mental health condition that was not mental ill health but an impairment of the brain function because of trauma.

When GT was asked questions about how he would go about solving these issues, he was aware of and able to identify the risks and dangers and was able to describe in theory what should happen – much like MW. This led agencies to believe him to be capacitated in relation to each topic. The problem for GT, like MW, was not, not knowing what to do, it was applying the theory in practice. Doing it rather than describing it. GT like MW had problems in solving his problems and difficulties in managing his difficulties. Trauma affects a person's ability to self-care, organise, motivate themselves, make sense of things and to recall things such as appointments. It affects the way a person perceives themselves and their identity and becomes consuming.

The outcomes and solutions are not about identifying the practicalities that both MW and GT could identify themselves. It is about breaking down the barriers preventing each to address their own problems and apply their own solutions. It is healing the trauma and making the person feel safe and well, valued, and useful. Assisting the person to understand their life experiences, validate the feelings and place the traumas in the past, replaced by new experiences and identities removed from the trauma. This will mean that they will be able to once again engage with the processor of the brain (Executive function) to order and sort, self-care and live, rather than the survival mode that created the self-neglect.

Knowledge and use of safeguarding pathways

There is some evidence that policies and procedures adopted by Bexley SAB were being used and pathways to multi-agency meetings were utilised. It seemed that not all agencies were so familiar with the policies and procedures.

There were several attempts to make enquiries involving a few agencies. The enquiries focussed on things that triggered further anxiety regarding loss: The cleaning and clearing of the property, the management of finances, the removal of GT from the property. When a social worker began with trying to engage GT without so much discussion focussed upon situational matters, GT engaged better.

There was no oversight and guidance provided to ensure that needs, rights, and communication methodologies were addressed. Advice relating to models, methods, theories, and research is not recorded,

yet there is a wealth of this information relating to trauma and self-neglect available. There is little evidence-based practice and no hypothesis or formulation. Sociological and psychological methodologies of intervention that are trauma informed are beginning to emerge but are limited and specific to individual practitioners. The proposed multi-agency safeguarding panel has the potential to offer this support and guidance.

Recording

Records are well maintained and (Like Greenwich with MW) a lot of work went into engaging other agencies. There is evidence that practitioners were trying to make sense of the situation and were questioning outcomes. The problem is that the decision-making processes are flawed because the assessment of the situation is flawed. Had the assessment focussed on and recognised indicators of executive function difficulties rather than practicalities, then there might have been recognition that knowledge of what to do was not what GT (Or MWs) found difficult, it was creating a situation where he felt able to achieve this. To achieve these benefits and positive outcomes agencies must recognise the score that the body and brain have tallied in their distressed state suffering years of trauma response. Calming the mind and body is what is needed for the person to be able to sort, evaluate and self-care again. This is not a mental health response, it is a response that demonstrates care, consideration, building respect, deconstructing oppressive barriers, facilitating situations for positive feedback, and building on strengths and supporting the person to engage with likeminded people.

C. The Individuals:

- **The Family – mother, father, and son**

The Mother

The mother was born (1963) in Sidcup and said that she had lived all her life in Sidcup. Her own mother gave birth to her in the house that they lived in as a family. She always lived with her mother, even after getting married. Her sibling is a brother that she is no longer in contact with.

The mother has reported that she met her husband, known as the father, in 1987 and they got married a year later. They have 4 children (known as 1, 2, 3, and 4). 1 lives with her daughter and partner; 2 lives with his partner and her family. 3 (Son) never returned home when he went into care and his mother reported she is not in contact with him and the last time that she spoke with him was about 12 years ago. 4 (known as Son) currently lives with them.

The mother also reported that she was an escort on a school bus and her husband was the bus driver. She stopped work to look after their children and was unable to return to work due to a decline in her mental health. She explained that her first episode of 'mental health breakdown' happened when she lost her grandparents within a week of each other, at the age of 9. She had another episode when she lost her infant-child at only 8 weeks old.

Her three sons went into care in 2010, which also impacted on her mental health. She reported struggling to cope with the death of her mother in 2015, and things have not been the same since. She describes these episodes as 'mental breakdowns' that she has not been able to recover from. She is on medication to manage her anxiety and she thinks it is working. She further identified that she easily gets overwhelmed, easily gives up and is unable keep on top of things. She admitted to becoming emotionally attached to her dogs and since 2018 has suffered from agoraphobia. In May 2018 following a PIP assessment she identified that her anxieties were affecting her leaving the house.

The mother also reported that she is very religious and used to attend Baptist church every week. She stopped going to church due to issues with one of her friends at the church in June 2017. This made her feel isolated from her friends within the church. Furthermore, she thinks that it was the vicar at the church who reported her to social services when her three sons were taken into care. Following an argument with a friend in June 2017 she reported low mood and suicidal thoughts. She has been diagnosed with clinical depression and anxiety and is also thought to suffer from Asthma and Arthritis.

The mother reports a lot of loss in her life: Her grandparents, her mother, her child all died. Also, her four surviving children were removed from her care and her dogs were also removed from her care. There is no contact with her brother. She was removed from the house that she was born in, and her two youngest children do not maintain contact with her. She lost the support of her church and friends. It is thought that her own mother also hoarded and was considered to self-neglect.

In June 2017 she saw the mental health liaison team reporting that she was hearing voices and had suicidal ideation. Over the previous four weeks the voices had become more intense, telling her not to take her anti-depressant medication. She said that she was becoming paranoid, was writing poetry about bombing, and stabbing random people. In 2017, two of her children were both living at home. Her son, known as 4, returned home from care after his 18th birthday. The lack of contact from her two youngest children caused her to have a low mood and increased anxiety and stated that she had been writing satanic scripture.

A face-to-face social work assessment in February 2022 describes the mother as a short-oversized lady who appeared unkempt. She walked independently with an unsteady gait, her hair was matted and dirty, her teeth were broken, her fingernails were dirty, and her legs were blotchy. Her shoes were covered in a brown substance which the Social Worker thought to be faeces. Her main comments were that her dogs were her life and that she had suffered a lot of traumas in her life.

The mother has spent most of her time in the upstairs of the property, which was reported to be in a much worse state than the rest of the property.

She said,

'her faith, family, and dogs were the things that were the most important things to her.'

The Father

The Father is 67-year-old man with a diagnosis of diabetes and asthma. He was born in Woolwich and is the only child of his parents. The father is reported to have grown up in Bexley area and left school at the age of 15 to join Navy, Army, and Air Force Institutes (NAAFI). He worked for NAAFI for 5 years, and he did couple of odd jobs after he left NAAFI. The father also worked as a school bus driver until he retired. There was little else known about him until this review.

The Son

The son is a 25-year-old male who currently lives at home with his parents, in a home owned by his maternal grandmother. The son was born in the Bexley area, he is one of five siblings, but sadly one his brothers died at 8 weeks old.

Due to concerns around neglect and the conditions of their living environment, he and his two brothers, were taken into care when he was about 13 years old. His siblings lived with the same foster parents, while he moved between five foster families in 5 years. The son reported that the last 2 years was spent with the same foster parents and when he left care, returned home to live with his parents and grandmother. Sadly, he lost his grandmother a few days after his 18th birthday. He is in touch with one sibling regularly, but the other sibling has not been in touch with the family since their grandmother passed away in 2015.

He advised that he was happy until he went into care. He said that he had trouble controlling his anger as a young child, which became worse when he was taken into care and took part in Anger Management classes, but attended only two because he felt the facilitator was patronizing. He reported that he started going to a church nearby which helped him, and he has been managing his anger issues relatively well, with no major incidents in the last two years.

According to the son, two events contributed largely to the neglect issues in the home. The first, was following the loss of his grandmother, the family 'could not be bothered' to maintain the home; and the second, was when his sister left the house. She was moved away from the family home into temporary accommodation by Social Services. At this point, the family felt it was pointless because whatever they attempted to do in terms of looking after the home was not good enough for the professionals or Social Services.

The son stated that he loves football, he would love to be a referee in future, and presently he would like to learn how to drive, but they are both not possible due to financial constraints but does occasional work as a Deliveroo cyclist.

- **Early life of the children -** An initial child protection case conference was held on 27/01/2005. The concerns centred around the house, which was described as ***dirty, untidy, and unsafe, posing a threat to the children***. The cleanliness of the children was also of concern. It is noted that whilst Social Services intervened there were positive changes made but that this deteriorated quickly when professional involvement ceased.

- **The incident -** On the 8th of February 2023 the RSPCA made an urgent referral of the Family household comprising due to self-neglect and neglect of animals in their care.

  The report states,

  'They had 15 dogs and 2 cats. The house was in a severe state of disrepair. No hot water, no heating, broken mains pipe. Family cook food in cans on a one ring camp burner and heat up any hot water in a can over this burner. Only one working power socket which is a rigged up light socket. Ceilings all appear to be collapsing and plaster is falling off walls. The walls are damp. The family were very angry about the intrusion of the RSPCA and animals being taken. RSPCA asked if they could see the mother who was upstairs. They were told that the condition of the upstairs was even worse than downstairs, and they were not permitted by the family to go up there. They could hear her shouting at them to go away. Concerns were raised for the mother's mental health. RSPCA of view that neither the son nor his father seemed to recognise how unsafe the conditions they were living with were for their health. Questions about mental capacity of all family members living at the property. Neighbours in the street several doors up have commented about having concerns about the family / the property. RSPCA advised that they were told that one of the brothers had a very bad experience when in foster care and hence distrusts social services.

  RSPCA view: The house represents an environmental hazard and may need to be condemned. Concerns for welfare of the mother as she has not been seen and may be in very poor mental health. Decision by panel for police to visit tomorrow with Adult Social Care to carry out a welfare check'.

On the 15th of February A Social Work home visit took place. The Social Worker asked the son if he recalled the information that was discussed with him from his previous visit about moving out of the property, to allow for the property to be cleaned and repairs to be carried out. He confirmed that he recalled this, and he and his family are preparing themselves, but he wanted reassurances that the dogs will be looked after. The Social Worker informed him that he and Social Services had no control over any decisions made about the dogs.

The social worker asked the son if he and his family would prefer to be moved together or individually. He said he would like his parents to be moved together and he would like to remain at the property, as he would like to have input as to what would be disposed of. The son was reassured that he would be involved and consulted with the clean-up operation, but then confirmed that he would like to be moved with his parents.

On the 22nd of July 2022 the local authority received an email of concern from the RSPCA.

The note said,

> ***'We received a report of concerns for the dog's health and environment. We have attended the address and have great concerns for those that live at the property including that of the animals there.***
>
> ***An elderly male (father) dressed in very dirty clothes and looking extremely unkempt answered the door. When he answered the door an extremely strong smell of faeces and urine followed along with a lot of flies flying out of the door and lingering. Inside a lot of dogs were heard***

barking and howling and 2 were seen in the window beside the front door. A female (mother) was heard shouting at the dogs upstairs, this female was identified as his wife. The father stated he had 6 medium sized dogs in the property. It was identified by the father that he isn't coping very well with the dogs and the property but wouldn't sign any dogs over to us.

One of my colleagues managed to get into the property and the property was in an extremis condition and is not fit for animal and especially not human occupation. There is faeces and urine caked all over the property, the boiler was making a concerning rattling noise and the father identified that there was a leak in the house. A notice was issued to him to get the boiler checked and to clean the property thoroughly along with removing the dogs from the property. Due to the disrepair of the property, it doesn't seem possible that he could cope with the level of repair and improvement required on the property alone. Nor do I believe in his mental state he would be able to maintain it alone.

The father stated his family owns the property and he and his wife are living from their pensions and that funds are low. He stated he is not registered with any social services, but he would appreciate help as he is not coping. I have grave concerns for his health and that of his wife and of his dogs. I don't believe he fully realises how bad the condition of the property he is living in is.'

The Social Worker asked the father if he or his wife had any care and support needs, and he said no. The father said that his wife doesn't like going out as she has a bit of agoraphobia, and he is type 2 diabetic. The Social Worker asked if he walked the dogs and he said he did but couldn't manage all 6 at once. The father described the dogs as well fed and healthy and was offered information about environmental health and cleaning companies.

A follow up email was forwarded to the local authority after a second visit from the RSPCA. The email said,

'The property in my opinion is not fit for human habitation. There is no heating at all. There are no electrics downstairs. The family run an extension cable from upstairs to the kitchen to plug in a camping stove to cook on. The boiler does not work and there is severely dodgy wiring throughout the house posing a fire risk with exposed wiring so the fire officers will need informing of this if possible. There is a mains water leak in the kitchen. The property is filthy throughout, and the ceiling has fallen through in places. It needs massive amounts of remedial work and a cleaning team in to professionally clean it. It is beyond help of domestic cleaning.

The RSPCA have removed 9 dogs and a cat. We continue to work with the family to neuter the remaining animals and enforce notices to improve the conditions due to the floor being covered in faeces and urine. The ammonia smell is extremely strong throughout.

We have only been allowed access to downstairs and I attach some photos for you of the conditions. Upstairs I am informed is much worse.

The family need help and will be willing to accept any help offered to them. They are aware of my passing these details and will be welcoming for contact.'

The RSPCA Officers found that every floor area was coated with a thick layer of compacted faeces (2-3" thick in places) and the smell of ammonia was extremely strong throughout. In every room, all surfaces (walls, ceilings, furniture) were said to have a thick layer of faeces, urine, dirt and decay and the smell is described as overpowering.

On the 30th of November 2022 a triage call was made to the son. During this telephone conversation he identified that the boiler was not working so they could not use the bath. The family washed themselves with cold water. Mobility issues of both her parents meant that they had previously struggled to enter and exit the bath. The toilet cistern was not working. The oven was not working so they used a camping stove.

The living conditions had re-presented similar concerns to children's services when the children were young.

Analysis
Domain A: Practice with the individual adult in their social situation

Making Safeguarding Personal

During the early life of the Family, children's services responded to the parents in much the same manner that Adult Services responded to MW and GT. The focus of intervention was to instruct the family to clean and clear the property, to ensure that the children were clean and that they had appropriate food and equipment for school. The love between family members was noted by children's services, but the lack of care provision in the house and in ensuring baths, clean clothes and school equipment was of concern. There was no consideration of what happened to the parents and without identification of the cause of the situation no real, or long-term solutions were found. This resulted in the children being taken into care and further loss for the parents. Contemporary assessments of the family since their son's return to his family home have been different.

There is a lot of information relating to the son and his mother: Their feelings, wishes and views are well documented. Children and adult social workers have continued to work together with him. There is a clear desire to maintain continuity with the family. Concerned and authoritative curiosity along with gentle persistence, skilled questioning, conveyed empathy, and relationship building skills are evident in the work with the son. This has resulted in him engaging more and accepting support. The social worker offered to drive him to an appointment and talked about his feelings, life and what happened to him during this journey. A picture of his history and that of his mum was gathered and the links made regarding what was driving the self-neglect. ***This is excellent practice.***

Following the assessment of need for his son, the Social Worker who had develop the rapport with him stopped contact as the case was transferred to Adult Services. All good work and trust built is now lost. A new worker will have a more difficult task in achieving this as the son will be concerned that they will move on.

The needs for care and support are not well recognised for the Father. There is limited information about him although he is described as a quiet man. Services in the past had to encourage him to be involved in the children's assessments. The father's identity seems to have been consumed within the household identity.

Autonomy

The son identified his distrust of services after his experiences of being removed from his family and placed in turbulent care settings. The mother is identified as struggling with the death of family members, affecting her mental health from the age of 9 years old when her grandparents died and reaching a pinnacle when her mother died. Her identified trauma as being prevalent in her life and the losses are identified as the factors that lay behind both her and her son's self-neglect. ***This is excellent practice.***

It is not clear what lies behind the father's self-neglect, although he has suffered loss along with his other family members, these matters were not as well explored about how this affected him.

The early life of the mother and her own mother might have been helpful to explore as she also hoarded goods.

Assessment

There is evidence that the practitioner recognises and provides time to identify adverse experiences, loss and trauma affecting the son and his mother. Less is known about the father.

Repetitive patterns are identified within the narrative but not specifically sought out. The risks are well identified and documented both within the property and the risks to SJ if her dogs are removed. Less well planned is the balance of how services might support the family through this time.

None of the actions requiring consent are actions that would remove or impose something. Reasonable belief capacity assessments are alluded to but are not explored with a rationale provided. What

is clear within the assessment is that repeatedly the family have been asked to conduct clean up tasks for themselves and their children and have failed in achieving this unless there is continual scrutiny and prompting. When the family became more settled after the move, there are glimmers of positive change reported for the mother (E.g getting out to the shops), the father (E.g cooking dinner) and some very positive aspirations reported regarding the son and his wish to engage with family members and work opportunities. ***This is very good work and reflects the positive interventions of practitioners.***

The son's strengths and family assets are explored. There is some information about his ability to provide care and support, his desire and willingness to do this, but also his efforts to get his parents less dependent upon him. The son is making moves to create his life outside of his direct family although he has chosen to work alongside his sister.

There is no formal format for formulation applied. Within the narrative the assessor has identified what happened, how it impacted, the exceptions, the triggers, the strengths, and assets. ***This is exceptionally good work.*** The balance of moving house again, removal of the dogs and further loss of furniture representing history, background and connections with mother / grandmother may tip the balance the other way if not carefully planned and managed.

Needs assessments did not identify needs in relation to trauma and therefore lacked clarity about the difficulties in applying self-care and home care in practice. Important information relating to needs and capacity could not be shared with agencies involved. With so much recent additional loss and change, the family could easily revert to previous coping mechanisms. To prevent this, services will need specific planned safeguarding strategies with oversight and guidance to ensure that family members do not experience further loss and trauma.

Planning

The care and support plan for the son is thorough and was reviewed after children's services would usually have closed a case. The care and support plan embrace the importance of the transition stage which could disempower him.

The social worker is utilising their skills as a resource and the nature of intervention is trauma informed. The strengths of the family are identified, and the son and his brother discuss how they could maintain the family home in a habitable state. The son's aspirations of being a football coach are evident.

Planning to support relationship building, access to support networks and social identities such as the church are identified as a need for the family, access to community and wider networks are beginning to be formed.

Family and social context

All family that could have been involved in the assessment were involved. Advocacy hasn't been identified yet, but at the moment the family support each other. As the son grows in confidence away from family matters it may be helpful for his to have an advocate if he would accept one.

Legal literacy

There remains little reference to legal literacy within the case records. Bexley staff are expected to write in a manner that reflects rather than specifies legislation used. This has benefits and downfalls. We can see within the record keeping the positive and enabling interventions that reflect the ethos of the Care Act, Equality Act, Human Rights Act, and the Mental Capacity Act, but without summary statements specifying these forms of challenge and intervention, it is difficult for other practitioners to recognise what worked and why. These could include summaries from safeguarding meetings or transcript from reflective supervision that is shared as good practice.

Domain B: The professional team around the adult

- **Counteracting silo working -** Individual and family assessments have taken place within multi-agency forums. There is an identified worker for each family member.

Pathways and whole systems are explored but the balance of the multi-agency assessment and intervention still weighs heavily in the risk and risk management domain that results in removal, rather than the person-centred domain where the person is healed from trauma to change how they manage self and home care.

Multi-agency meetings are planned but the factors that require enquiry and planning are still not thoroughly addressed across agencies:

- Who will assess capacity and how will it be assessed?
- Who will take the lead for each person's intervention plan?
- How will each person's triggers be identified?
- How will each person's strengths and assets be used to support engagement with others, development of separate identities outside of the household and moves to have identities that are not formed from trauma?
- When the balance of risk to others, animals or public begins to tip and removal of objects of attachment from the family are being discussed what is being planned to counterbalance the negative impact of these things/
- Who has safeguarding oversight and guidance to ensure that all agencies remain focused upon trauma healing to remove risk, rather than attachment removal.
- How will evidence based and legally literate information be recorded relating to decision making for the family – clarify rationale for action (Risk to others is not sufficient as removal will increase risk to others)

The domains of good practice can be used as a check list.

Information-Sharing

The information shared at the multi-agency meeting appears to be relating to the house and the risks. The information that needs to be shared is about the people, their story, what triggers them and what helps to heal them, so that all agencies can respond in a consistent manner with a trauma informed plan.

Referrals are still being made to services in the knowledge that the service will reject that application for support from that service, or the person will not attend. Assistance from other agencies needs to be as a supportive role initially until the person feels able to engage.

Some of the common misconceptions relating to local authority eligibility, access to safeguarding and the need for a multi-agency meeting have been addressed recently because of previous SARs. The content of the meetings is what now need further consideration.

Knowledge and use of safeguarding pathways

It is evident that on most occasions the policies and procedures that are currently available are being used. SAB members recognise that these policies and procedures require updating. There is increasing evidence that the duty to enquire is being used. The enquiry process is not well understood in relation to self-neglect. The gaps in knowledge that require further enquiries include:

- Hypothesis regarding form of abuse (Is this self-neglect – a lifestyle choice, or is this neglect (An inability to meet one's own needs that requires agency support)? This can only be determined by consideration of capacity to make decisions and ability to apply in practice theories presented by the person.
- Enquiries into who has the best connection with the person.

- Identification of who can build upon trust to engage – positive regard, hold back agencies who are a threat to the person, manage the environmental risk assessment and clearance attitude, develop a contract of work that frees a person to feel safe to explore their feelings (With oversight from the safeguarding lead and multi-agency support)
- Plan sensitive response when there is genuine and significant immediate risk to the public e.g gas cannisters and the risk of fire.
- Enquiries into what happened to the person and the monitoring of when that person was not able to put into practice actions described.
- Identification of indicators of trauma through enquiries – executive function deficits check list.
- Enquiries into the co-caring responsibilities and dynamics
- Exploration of attachments – attachment theories
- Sociological and psychological hypothesis explored, and potential outcomes established.
- Enquiries into the strengths and assets of each person to utilise in helping to heal the trauma.
- Enquiries into exceptions in a person life when they have managed well or better.
- Enquiries to establish hooks that assist in understanding the person.
- Enquiries into potential social identities pathways that can be used.
- Enquiries into the risks and threats that the person experiences – what would make them decline, what can they not handle, are there agencies that pose a particular difficulty and why etc.
- Multi-agency formulation as part of the assessment process. Shared with the person in appropriately digestible chunks.
- A clear plan to assist the person to re-engage executive brain function and the begin the process of healing – thus restoring the person's ability to self-care.
- Use of the Preston Shoot check list

Recording

There is evidence that records and assessments for the son were well maintained. The rationale for decision making is set out – although not evidence based in relation to law. There is a history of attempts to get the family to clean the property and for the parents to (Historically) maintain personal hygiene and cleanliness of the children. Success was short lived and soon reverted to an unhygienic environment and dirty clothing, poor personal hygiene for the children. The same type of attempts is being offered now.

There are sporadic glimmers of trauma informed work undertaken by practitioners involved. These interventions are linked to people who really care and want to make a difference, but to create change the practitioners need to act more purposefully. The family cannot be shown, encouraged, or forced to maintain a clean home, personal hygiene, eat well and attend appointments. The only way that this will change is by actively working on engaging executive brain function, developing social identities, identifying, and managing trauma triggers and building self-confidence and self-esteem.

3. Analysis of Domains C and D of Preston Shoots SAR report into self-neglect

Domain C is described below comparing the responses of agencies to the people who are identified within this thematic review. The responses are RAG (Red, amber, and green) rated indicating the response of agencies to the person. In the full report a copy of RAG rated responses in every domain can be found. The conclusion and lessons learned that follow include recommendations and considerations under Domain D.

Domain C: Organisations around the professional team			
Provision	**MW**	**GT**	**The Family**

Commissioning provision Managers demonstrate and record case oversight, including decision-making about commissioning and the outcome of contract monitoring of service providers.	Feedback during training sessions in Bexley relating to working with people who self-neglect, indicate a discrepancy between what practitioners are being taught and the support provided by middle managers who often feel under pressure to close the case of someone considered to be self-neglecting if they are not engaging. Outcome frameworks for progress place pressure on workers to conduct short term interventions. Practitioners want to do longer term work and SAB members expect this longer-term work to take place. Middle managers need to attend training to understand these concepts and to raise concerns with the SAB if resources are restricting the ability to do this.	There are attempts made to provide oversight and guidance but the structure for this oversight and guidance needs to change focus from solving that which appears easy to solve (The practicalities) but is prevented by the person who is using these as coping and survival tools because without them their anxiety and trauma will increase. The oversight and guidance need to focus on the healing of the brains alert system, making the person feel safe and able to focus, to sort things out in their mind, to validate their experiences and recognise them not as unusual, but human responses to the experiences that they have had. Recognising and preventing triggers. Wrapping a service around the person focussed initially through someone who they can engage with that allows a person to take stock and to recognise that the trauma is behind them. This will facilitate their ability to put the self-care tasks that they know as a theory into practice.	Multi-agency responses, SAR commissioned, health contract applied for, restructure of the safeguarding response with a new panel identified to provide oversight and guidance of the commissioning of services and consideration of services required at statutory level.

Working environment. Supervision promotes reflection and critical analysis of the approach being taken to the case. Support is available for staff working with people who are hard to engage, resistant and sometimes hostile. Specialist legal, mental capacity and safeguarding advice is available, and guidance given recorded. Workforce and workplace issues are addressed, such as staffing levels, organisational cultures and thresholds. Case allocation is based on an appreciation of staff knowledge, skill sets, capability, and capacity	Middle managers need to be aware of how to provide this kind of support and guidance to those practitioners working with someone considered to be self-neglecting.	There is evidence in Bexley that supervision did try to establish critical reflection, but without the understanding of how trauma affects the person and what to look out for, hypothesis and solutions cannot be sought. Every social worker is trained in these practices and yet the skills, knowledge and abilities of social workers have been eroded into the completion of standard assessment processes. The definition of social work is desired but not available to those in practice. These cultures, barriers and threshold need to be addressed, if we are to prevent services being overwhelmed with traumatised people requiring mental health support, accessing hospitals regularly and proving difficult to discharge, causing Policing and community safety difficulties that cannot be resolved on the spot. Every agency has a vested interest in having practice in social work that matches that which is theorised. There is a need for commissioning services to have an appreciation of responses that work for those who have suffered trauma (Homeless services, substance misuse services, safeguarding responses to people considered self-neglecting, people who dramatically under / overeat in a trauma response etc)	Supervision is supportive but operational managers are not yet ofay with trauma informed interventions and the purposeful application of the assessment and care and support planning in line with complex trauma. The family have been identified as requiring a SAR and all remain alive. This demonstrates a desire for specialist legal, mental capacity and safeguarding advice with lessons to learn. The lessons will inform the changes to the systems and support required. Bexley is fighting to establish resources to facilitate the workforce requirements, culture change and change of thresholds required. Unlike GT and MW the complexity of the work involved with the family was recognised and experienced practitioners assigned to assess and care plan.
Procedural guidance Practice guidance is available and clearly embedded in case and supervision notes.	Practice guidance is available but not well embedded by all practitioners.	Practice guidance is available but is used by some practitioners, some of the time.	Practice guidance will change because of the SAR

4. Conclusions

Domain A: Practice with Individuals

Making Safeguarding Personal, Autonomy, Assessment, Planning, Family and Social Context and Legal Literacy

Using the term **self-neglect**, suggesting the possibility of lifestyle choice triggers a series of events (Reflected in SAR findings relating to domain A):

- Agencies continue to presume capacity in the absence of evidence to the contrary.
- A person is asked whether they want to be safeguarded and when they decline the case is closed.
- The local authority struggles to find needs for care and support.
- There is no link to disability to meet eligibility criteria under the Care Act
- Agencies struggle to understand the need for and solutions to be found in multi-agency enquiry.
- Any safeguarding intervention focusses on the risks to the person and the risks to others, exacerbating the guilt and inadequacy felt by the individual considered to be self-neglecting.
- Goods are removed to address the hoarding and / or squalor, re-traumatising the person who loses control of their belongings.
- Eviction, enforcement, and further loss (Children removed from care, animals removed from care and person removed from property)
- Person is held accountable for their own self-care and decisions relating to care, support, and treatment.
- Agencies struggle to differentiate between capacitated decisions that may be unwise and those decisions where a person lacks capacity.
- The person becomes more suspicious of agencies feeling the impact of rejection from those services (Not eligible for mental health services, not motivated for substance misuse services, declining health, social work, and housing services)
- The person becomes less likely to engage with agencies and support.
- No solutions can be found.

These matters were evident in the records relating to all persons whose experience of services and support were the subject of this SAR.

Using the hypothesis of **trauma,** triggers a series of significantly different events:

- It is important to understand what happened to the person, what triggers the persons anxieties and trauma responses, how trauma affected the person, what the person is good at / was good at, skills and interests the person has and use interests to re-engage the person with others who value them.
- Trauma affects executive brain function and therefore evidence of executive brain function deficits and frontal lobe concerns are explored via enquiries.
- Evidence of trauma can be identified, and the impact of that trauma directly linked to the inability to conduct self-care tasks, order, and address accumulated objects[10], feelings of guilt and lack of self-worth.
- The person has an identified need[11] as they cannot achieve self-care because of brain changes affected by trauma, rather than wont self-care because they are self-neglecting.
- The person is eligible for needs assessment as to achieve self-care / home care is either extremely difficult or would cause the person significant distress affecting each domain of the needs assessment.
- The person affected by trauma can be supported to understand what has happened to them and reassured that this is not their fault, it is a natural reaction to trauma.
- Safeguarding meetings and interventions focus upon healing trauma, building self-esteem and self-confidence, building social networks, and supporting the person to learn to self-care once more.

[10] https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted

[11] https://www.legislation.gov.uk/ukpga/2014/23/section/18/enacted

- Understanding frontal lobe deficits created by trauma, identifies why a person may be able to describe how to do something but may struggle to put it into practice. The inability to put the stated words into practice means that the person lacks capacity to make care and support decisions[12]
- Social workers are trained in communication skills and intervention methods to support a person through trauma. This healing allows the executive brain functions to re-engage meaning that the person is able to self-care once more. Lack of capacity is short term with the right interventions.
- The person requires safeguarding and (Prior to intervention for trauma) is demonstrating an inability to self-care, attend appointments and order things. The lack of capacity to enact actions of self-care and treatment means that there remains a duty placed upon the local authority to safeguard and to meet identified need, even if the person rejects services (S11 Care Act)[13]
- Meeting identified need and best interest decisions relate to the key mental capacity issue that agencies should focus upon: Supporting a person to restore capacity to make their own decision before physical and mental health deteriorate to a state where long term care and support is required (Prevention)[14].
- Wellbeing[15] and safeguarding principles apply to all intervention. Safeguarding intervention cannot be closed until the person feels safe and well. Meeting needs means maintaining safety and wellbeing.
- Interventions focus upon integrating trauma into historical context and realigning / restoring past identity or developing a new identity away from that consumed by the traumatic events.

By beginning with trauma as a hypothesis we remove blame and enhance engagement. Hypothesis means,

> ***'A supposition or proposed explanation made on the basis of limited evidence as a starting point for further investigation.'***

Trauma is not an add on perspective to self-neglect, it is the starting point for enquiries, interventions, and review processes. This makes a big difference in the responses, adjustments and support provided.

1. **LEARNING**: Trauma to be used as a starting hypothesis when there are three or more indicators of difficulties caused by a lack of engagement with executive brain function e.g. self-neglect, social isolation, and mistrust of services.

Agencies within Bexley purported to understand the correlation between trauma and self-neglect, substance misuse, and homelessness, but the reality of the recording demonstrated a focus upon the risks: Risk to others, risks in property, risks to animals, risk to person and staff and risks to health. Very little background information was collected about GT, MW, and the Father. Risk assessment is important to ensure that risks are minimised without adversely affecting the person considered to be self-neglecting. The focus of trauma informed safeguarding enquiry and intervention should be in identifying:

- What happened to the person?
- Triggers relating to the trauma[16]
- how the trauma impacts on the person[17]
- Attachment and neglect concerns[18]

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[12] https://www.researchgate.net/publication/324899681_Mental_Capacity_Act_2005_assessments_why_everyone_needs_to_know_about_the_frontal_lobe_paradox

[13] https://www.legislation.gov.uk/ukpga/2014/23/section/11/notes

[14] https://www.legislation.gov.uk/ukpga/2014/23/section/2/enacted

[15] https://www.legislation.gov.uk/ukpga/2014/23/section/1/enacted

[16] https://psychcentral.com/health/trauma-triggers#how-to-deal

[17] https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/effects-of-trauma/

[18] https://psychcentral.com/health/attachment-trauma

- What the person is interested in
- What the person is good at
- Old relationships or developing new relationships (social identity pathways)[19]
- How to heal relational trauma[20]
- Communication methodologies
- Reasonable adjustments[21] for trauma
- Community access and integration
- Things that assist in building self-confidence and self-esteem
- Mindful techniques that work for the person
- Multi-agency trauma informed approaches[22] (what they look like)
- A lead person to connect with the person considered to be self-neglecting.
- A safeguarding panel of agencies with expertise in trauma, created to support staff within each agency to recognise the appropriate course of action, providing oversight, guidance and building on evidence-based practice.
- How to prevent the removal of goods, eviction, statutory intervention until interventions to restore capacity relating to self-care / care of the home have been made.
- Relationships that are co-dependent and assessment of care providers ability to meet identified needs.
- Attachment issues and support for families with children
- Recognition of the link between trauma and the need to control one's environment to prevent trauma triggers[23]. This makes personal relationships very difficult, triggering fight, flight, freeze and flop responses in respective family members affected by trauma.
- A Human Rights based approach to assessment, safeguarding, and legislative disagreement between agencies.

All participants involved in this SAR recognised a need for a large-scale culture change across adult, domestic abuse and children's services with the exploration of 'whole family trauma' as the starting hypothesis. This involves cradle to grave recognition, identification, and exploration of indicators of trauma within family behaviours and dynamics. Collaborative work between children and adult services will prevent intergenerational trauma and secure services for the future. Pandemics, terrorist attacks and other trauma inducing events in history will require a trauma reducing plan in addition to the medical planning. The Safeguarding Adults Board are looking to create a panel of experts across different agencies to provide safeguarding advice, guidance, and support to adult services. Childrens services are considering how to change culture and work collaboratively across generations affected by trauma, using 'TRAUMA' as the starting hypothesis to rule in or out. All agencies need to recognise adult safeguarding and child safeguarding criteria and all practitioners need to be updated regarding eligibility. A joint family approach between adult and children's services that recognises and supports the impact of trauma on family members is required.

2. **LEARNING**: Safeguarding Adult Reviews, Domestic Homicide Reviews, Serious Child Case Reviews should consider trauma as a hypothesis to rule in or out. For individuals displaying signs of executive dysfunction, indicating trauma affected decision making, enquiries, assessment and safeguarding plans are to support agencies in understanding the trauma and acting in a trauma informed manner. Collaborative work with families across adult and children's services is required.

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[19] https://www.tandfonline.com/doi/full/10.1080/10463283.2020.1711628

[20] https://www.verywellhealth.com/facts-and-healing-steps-after-relational-trauma-5212446

[21] https://www.gov.uk/government/publications/reasonable-adjustments-a-legal-duty/reasonable-adjustments-a-legal-duty

[22] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

[23] https://www.psychologytoday.com/gb/blog/stress-fracture/202203/how-chronic-trauma-can-make-person-controlling#:~:text=For%20victims%20of%20ongoing%20exposure%20to%20trauma%2C%20control,safe%20space%20in%20which%20outcomes%20become%20more%20predictable.

The person affected by trauma is suspicious and believes that people will hurt them. Anything that suggests blame or anything negative will make the person feel worse. Focussing on the risks and removing things from the person exacerbates the trauma and reduces the person's ability to trust others. Work with the son and his mother demonstrated a social work desire to understand what happened to them, how it impacted on them and what coping strategies they used.

There was some evidence that triggers were sought. The children's social worker continued working with the family long after children's service intervention would ordinarily have ended. This provided consistency and the ability to build trust. During this period the son talked about his career aspirations, his plans and desire to maintain the family home in a good state of repair. The mother had previously suffered from agoraphobia but began venturing to the shops with the support of her son. This was all exceptional practice that allowed the son and mother to identify the links between the trauma and loss in their lives and their apparent self-neglect. This facilitated feelings of safety allowing for exploration of aspirations.

Contrary actions were:

- the family were removed from their home,
- the children had been removed from the care of their parents,
- the dogs were removed from the care of the parents,
- clearing the property was part of the intervention,
- the children's social worker stopped working with the family and a new adult social worker was allocated – starting all over again to build trust,
- prompts for self-care became a focus rather than the regaining of capacity to reinstate the ability to self-care, and
- there was no safeguarding oversight and guidance for practitioners and so the same responses that elicited poor safety and wellbeing results prolificated across services.

A balance sheet approach should be considered based on the years of experience agencies have of outcomes relating to 'removal' creating further trauma and increased trauma related behaviour. These behaviours present greater risk to individuals and the public. Early intervention that recognises trauma, restores a person's capacity for self-care and care of family members and works to reinstate an ability for self-care / care of others will result in positive outcomes.

3. **LEARNING:** Where-ever possible prevent further loss and trauma – use a balance sheet of decision making.

Trauma is a disconnection with a person's sense of self[24].

GT, the Mother, and the Son all had parents who were themselves affected by trauma resulting in hoarding.

Dealing with parents who have been significantly affected by trauma means that the child must make a very difficult developmental decision: Focus all their attention on the needs of the parent and sacrifice self-identity and connection with oneself, necessary to maintain the relationship with the parent; or remain true to oneself and sacrifice the connection to the parent. The mother and son describe great family attachments and significant grief following the death or loss of contact with family and friends. The attachment creates a greater sense of loss upon death and the desire to form attachments with things that are of familial significance or importance.

This is evident in the records relating to the mother who wants to maintain her family home that she has lived in all her life, where her mother lived, and her grandparents lived. She is attached to their belongings and describes the need to maintain her grandparent's furniture. Her son is also attached to caring for his parents returning to his family home as an adult following years of state foster care. The son has described his parents as ***loving and caring and his state care experience as traumatic***. The disconnection with ones-self

[24] https://www.psychologytoday.com/us/blog/the-new-normal/201807/trauma-disconnection-self

following trauma means that the person doesn't recognise the importance of self-care. The trauma identity is greater than any other self-identity and is exacerbated by the attachment issues.

4. **LEARNING:** When trauma is pervasive across generations, the attachment and lack of attachment issues must be explored and understood alongside the co-dependency issues for individuals / children. Trauma consumes a person's own identity, and it is only by integrating the trauma into a persons history and reinstating a former or new identity that a person can move on.

The hypothesis of trauma allowed exploration of how trauma affects executive brain function and recognition that physical brain changes occurred that impacted on a person's ability to self-care, organise and attend appointments (Amongst other things). The complexities of brain injury were considered and the need for multi-agency involvement to address these concerns recognised. Trauma causes a suspicion of people and their intentions, resulting in social isolation and rejection of services.

People who experience trauma and who socially isolate do so because organising appointments, planning to get to the appointment, finding suitable attire to go outside and facing strangers to tell them about things that are difficult all becomes overwhelming. Some common effects of trauma include flashbacks, panic attacks, hyperarousal, low self-esteem, dissociation, and sleep problems making it difficult for a person to engage in activities that require focus and attention, such as attending appointments. 'Mind' organisation identifies that talking of past experiences can be emotionally draining[25] and may require letting go of established coping strategies. The responses of the practitioner play an important role in making a person feel safe. All these things suggest that referral to multiple agencies is not a solution for someone who has experienced trauma leading to self-neglect.

Recognising the impact of trauma on a person's ability or inability to self-care means that every domain on the needs assessment is covered in relation to how trauma affects the person and prevents self-care.

5. **LEARNING:** Trauma affects a person's ability to function in every area of the needs assessment.

Domain B: Counteracting Silo Working, Information Sharing, Knowledge and use of Safeguarding Pathways, Recording

Needs assessment is the process by which information about the level of need and support a person requires can be shared with relevant agencies, demonstrating the extent of a person's difficulties and the solutions to help them in achieving their goals outside of the impact of trauma. By demonstrating that a person has eligible needs, how those needs affect the individual daily and identifying solutions to trauma, this informs other agencies about what is happening for the person and how to respond. The needs assessment plays a critical role in sharing information with other agencies informing them that it is a disability that is affecting the persons self-care and home care rather than a choice.

6. **LEARNING:** Accurate, trauma informed needs assessment provides clarity and guidance for other agencies and forms part of the safeguarding response.

Reasonable belief capacity assessment is an important element of the needs assessment that reinforces the struggle that a person has in achieving self-care. The Mental Capacity Act codes of practice identify,

> ***'4.68 Carers (whether family carers or other carers) and care workers do not have to be experts in assessing capacity in relation to day-to-day decisions. But to have protection from liability when providing care or treatment (see chapter 6), they must have a 'reasonable belief' that the person they care for lacks capacity to make relevant decisions about their care or treatment (section 5 (1)).***

[25] https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/effects-of-trauma/

> ***To have this reasonable belief, they must have taken 'reasonable' steps to establish that that the person lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. This includes providing support to enable the person to make their own decision. They must also establish that the act or decision is in the person's best interests.'***

Reasonable belief capacity assessments can be used in daily decision making where there are not going to be any imposed treatments or actions. It is not in the persons best interests to impose anything and therefore the best interest decision is to support them to regain capacity by working with them to achieve an identity outside of the trauma identity caused by the impact of trauma. Connecting with people, using skills and knowledge, integrating back into society, building self-confidence and self-esteem and minimising triggers are the objectives of the best interest decision.

7. **LEARNING:** Use reasonable belief capacity assessments for day-to-day decisions where there is no proposed intrusion, enforcement, or imposed action.

Agencies within Bexley were reluctant to determine that a person lacked capacity in relation to care, treatment, and tenancy issues, as they felt it a big step to remove belongings or impose treatment if the person was found to be lacking capacity. These dilemmas were evident in the records of all the individuals interfacing with agencies subject of this review. The reluctance to conduct capacity assessments was expressed through confusion relating to the outcomes and how appropriate or effective imposed outcomes might be. If we take self-neglect as the hypothesis, then it is difficult to meet the diagnostic element of the Mental Capacity Act criteria. If there are other things that might affect a person's capacity to make decisions it is difficult to relate this back to the lack of self-care.

A capacity assessment was conducted on MW but because the key focus was his disabilities and self-neglect, the impact of trauma on executive functioning was not explored. MW could describe how to manage a tenancy, but he was not capable of maintaining one; MW could not remember where he lived but he could still describe what a tenancy agreement was. Changing the hypothesis makes a huge difference as once trauma is identified as the main cause of self-neglect, imposition of self-care is not the desired outcome. Self-neglect is a biproduct of trauma, healing from trauma and re-establishing the ability to self-care becomes the goal. Agencies felt more comfortable conducting reasonable belief capacity assessments with this as an outcome.

8. **LEARNING:** Best interest decisions begin with the aim of assisting the person to feel safe and to reinstate capacity for self-care through work to engage executive functioning of the brain.

To assist agencies in understanding the needs of a person affected by trauma and the extent that the trauma has affected that person, it is helpful to have reasonable belief capacity assessments throughout the plans for care and support. This is reinforced within the Mental Capacity Codes of Practice which state,

> ***'S6.25 The preparation of a care plan should always include an assessment of the person's capacity to consent to the actions covered by the care plan and confirm that those actions are agreed to be in the person's best interests. Healthcare and social care staff may then be able to assume that any actions they take under the care plan are in the person's best interests, and therefore receive protection from liability under section 5. But a person's capacity and best interests must still be reviewed regularly'.***

There was no evidence of capacity assessment as part of daily routines identified within the care and support plans of any individual within this thematic review in Bexley.

These reasonable belief capacity assessments are important in identifying when a person cannot achieve aspects of the needs assessment and in measuring success when the person is re-engaging with executive brain functions and beginning to be able to demonstrate activities of self-care.

At this point the person may request assistance to address aspects of concern such as hoarding or squalor. Recognition that a person is demonstrating that they can put into practice actions of self-care and that they are no longer consumed by the trauma identity means also recognising that the person has regained capacity. This is an important measure in the autonomy of the person and in multi-agency empowerment for the future.

9. LEARNING: Reasonable belief capacity assessments form part of the care plan.

There was no evidence in any aspect of this thematic review of reasonable adjustments relating to trauma and access to services, care, and support. If a person cannot answer their phone and speak with agencies, then reasonable adjustments will be required. If a person has substantial difficulty addressing their post and attending appointments, then reasonable adjustments will be required. It can be anticipated that a person affected by trauma would find initial meeting difficult so reasonable adjustments are required. Motivation is affected by trauma and so a lack of motivation should not be a barrier to treatment, care, and support. These reasonable adjustments are a duty under the Equality Act 2010,

> '***Under the Equality Act 2010 public sector organisations have to make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else……..Public sector organisations shouldn't simply wait and respond to difficulties as they emerge: the duty on them is 'anticipatory', meaning they have to think out what's likely to be needed in advance'.***

Reasonable adjustments should be planned as part of safeguarding arrangements when someone is considered to be affected by trauma resulting in self-neglect. This can initially mean communication through the identified person / agency.

10. LEARNING: Reasonable adjustments under the Equality Act 2010 to be applied for those affected by trauma in order that access to services and support is on an equitable basis.

Ellie Atkins (Manchester City Council) in her internship paper relating to people who self-neglect (2023), identifies the inequality and hidden discrimination of people who are self-neglecting because of trauma and suggests that reasonable adjustments must become part of common multi-agency practice. Atkins raises the Desmond Tutu quote,

> ***"At some point we need to stop just pulling people out of the water. We need to go upstream and find out why they are falling in".***

11. LEARNING: To recognise the hidden discrimination and oppression within current systems, when faced with provision of care and support to individuals affected by trauma.

Care management remains the predominant model of social work intervention within Bexley. Agencies involved in this SAR recognised the negative impact on individuals who were repeatedly referred to multiple agencies, held accountable for not attending, not being motivated to change, or assessed as being ineligible for services. The result for the person affected by trauma is further rejection, blame and isolation, with no solution to their difficulties. It was recognised that a lead agency best placed to engage with the person should be identified and all agencies should work through the identified party until the person considered to be self-neglecting is ready and able to engage with a wider network. This means that all agencies need to provide advice and support in relation to capacity assessments, communications, and legal frameworks.

12. LEARNING: Care management will not work as a response to people affected by trauma.

Practice advice and guidance was considered, and it was determined that policies and procedures currently have a heavy focus upon the risks. These processes will be reviewed.

13. LEARNING: Self-neglect policies and procedures require a review. Multi-agency trauma informed safeguarding policies and procedures are required.

IMR discussion identified strong views about the lack of time and resources available to SAB agencies and the inability (As a result of these matters) to put in place preventative measures. Discussion about the personal and financial cost of crisis driven services identified a high level of desire to provide early intervention and preventative work, but IMR authors described themselves as exasperated and exhausted, struggling to keep up with the crisis with little leeway to be creative with solutions and responses and little to no opportunity for preventative measures. It is very distressing to services that (Using the Desmond Tutu quote)

"There is rarely the opportunity to go upstream and find the cause of the fall into the river. We just keep pulling people out of the river and hoping that they are alive and stay alive".

The strength of feeling in Bexley in relation to the current lack of resources and distressing working conditions was palpable.

14. LEARNING: Political recognition of the consequences that ignoring trauma will have on the future of services is required. Ignoring trauma means increased people within prison systems, more people hoarding, self-neglecting, homeless, misusing substances, more people who suffer mental ill health and physical ill health. Add to this national trauma such as a pandemic or significant terrorist attack, then we have a trauma pandemic that is greater than anything else ever experienced. Services and support for the future can be preserved if we act now. Funding and resources need to be removed from addressing the byproducts of trauma and to be focussed on healing the trauma itself.

***S91 Health and Care Act**.* IMR authors from hospital services identified difficulty when someone considered to be self-neglecting presents at hospital.

On one hand, it is an ideal opportunity to assess the person, gather background information and history, understand what happened to the person, conduct capacity assessments, and consider environmental risk in preparation for discharge.

On the other hand, emergency departments and ward staff do not have the time, or resources to conduct this work to the extent required to safeguard. In Bexley there are several potential support mechanisms, but these resources were not known to all IMR authors and there was no reflection of the use of these resources in practitioner records. Hospital discharges proved to be unsafe for people in a state of self-neglect as the underlying factors were not routinely considered. Pathways for admission and discharge when someone is hoarding and considered to be self-neglecting are required.

Similar difficulties were identified at the point of transition between social workers, services, and local authority areas.

15. LEARNING: Trauma needs to be identified on hospital passports and transition pathways identified. Handover between workers and services should aim to build upon the trauma informed work already achieved.

***Mental Health Act 1983**.* All subjects of this review were considered by IMR authors to have multiple and complex mental health disorders that required assessment. Occasional admission to hospital was a common occurrence for MW. Criteria for Mental Health Services exclude some forms of mental ill health affected by environmental factors such as poverty, loss, abuse, neglect, discrimination resulting in hoarding, self-neglect, homelessness, substance misuse, under / over eating etc. IMR authors felt that specific services for people who are distressed because of trauma, but who do not meet current Mental Health criteria were required. Some agencies identified feeling out of their depth when supporting or dealing with someone affected by trauma.

The British Association for Social Work (BASW) in the curriculum guide[26] identifies,

'A key element of your work is the selection of intervention methods, informed by psychological and sociological theories, and assessments. Through skills of observation and assessment, you are able to analyse and explain situations, develop hypotheses about potential outcomes, and select intervention methods to achieve desired outcomes. Implementing intervention methods requires skills in communication and knowledge in building, maintaining and sustaining relationships, as well as critical reflection and analysis in order to evaluate the intervention's effectiveness (whether through formal or informal evaluative methods)'.

The International Federation of Social Work (2014) identified the global definition of Social Work[27],

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[26] https://www.basw.co.uk/system/files/resources/basw_104913-2_0.pdf

[27] https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

"Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels."

Agencies felt that the time pressures placed upon Social Workers prevented the work described within these definitions, yet it is the gap missing for those affected by trauma. Social Workers are trained to do this type of work and then in practice (In Bexley but anecdotally nationally) conduct a very different role. The quality of assessment presented for the Father, MW and GT did not reflect the standards identified within the British or global definition of Social Work. There were no risk assessments outside of safeguarding procedures, needs were not fully explored, sociological and psychological considerations were missing, and potential hypothesis went unexplored. Needs assessment did not reflect the needs of any individual within this thematic review.

16. **LEARNING:** Agencies identify a gap in services that is the very definition of Social Work practice. Social Work intervention has been eroded in favour of care management. The discipline of Social Work intervention needs to be reinstated. Social Workers train to achieve outcomes required by traumatised people to heal but become deskilled in the workplace when the focus becomes assessment and onward referral.

For GT the potential hypothesis of cuckooing was not presented as a safeguarding concern, despite police being called to the property after people entered GTs house threatening him. Basic Human Rights were not considered; For MW as he lay in his bed, unable to mobilise with water dripping onto him, whilst covered by a plastic sheet. He had no access to the toilet and no food in his cupboards and there was limited access to the property dependent upon other residents of the House of Multiple Occupancy. It was the coldest winter on record, and he had no heating or light within his room. MW's Body Mass Index (BMI) was critically low. Why did no one consider this as inhumane, degrading, and MW to need safeguarding? The records suggest that this self-neglect was considered a lifestyle choice that no one could do anything about, an unwise decision. Hospital pressure to discharge, errant assessment of rehabilitation needs and poor needs assessment that did not collect all information available meant that this was considered a capacitated decision, rather than someone so desperately affected by trauma that they had just given up. GT died in similar conditions.

17. **LEARNING:** Human Rights should be the basis for legislative decisions, actions, and reflections

Domain D: SABs and interagency governance

The challenge is political, structural, cultural, and personal. Spending money on services that do not focus on the familial trauma, preferring hypothesis of self-neglect, substance-misuse, homelessness, domestic abuse, significant over / under eating, rather than seeing these as byproducts of the trauma response will not work. To see real change and to build stronger foundations for the future of services we need to recognise:

- That the focus is not on holding the person accountable for doing something that they can't yet achieve as they remain in a trauma state,
- That we should not be doing the self-care tasks for the person, when they can heal from trauma and reinstate their ability to do these things for themselves (The proviso being that intervention must precede the mental and physical deterioration resulting in a permanent inability rather than a temporary one).
- Blaming the person for not attending appointments when the ability to achieve this is not present, will only traumatise further.

- The person is not making an informed choice about neglecting themselves, they need to support to recognise trauma and how it affects them.
- The person can choose to self-care again but not until they have been supported to build self-esteem, heal feelings of guilt, build self-confidence, connect with skills, reduce trauma triggers, and engage with people who care about them. This connects executive brain function and therefore the ability to self-care.
- Forcing self-care will result in further loss of power and control over their own life, which is degrading and humiliating, particularly when many people who suffer significantly from trauma do so because their loss was so great. For example, a person who was a doctor before the loss of their partner, goes on to grieve so much that they lose their job and then hate themselves because of this and then neglects themselves. The loss is significant when they find themselves moving from a large house, a family, a career, being needed, to having less than nothing.
- Identities are a significant matter in the healing process. Every social worker is expected to be able to communicate effectively, understand the impact of trauma, poverty, loss, discrimination on a person and their identity, utilise hypothesis to formulate improved wellbeing and safety outcomes, create inclusive societies around a person, break down oppressive and discriminative barriers, use sociological and psychological methodology in their intervention and create plans that recognise the individuality of people and their experiences.
- Pressure on services creates arbitrary boundaries that individuals affected by trauma cannot manoeuvre.
- Public attitude towards people affected by trauma resulting in self-neglect, hoarding, substance misuse, under / overeating, homelessness is informed by propaganda rather than a firm knowledge base of evidence.

Language requires a mention in its own and is a huge challenge in this work. The challenge is that it is not the language that is different, it is the lens that we view everything through; the kaleidoscope that creates the image that we see. Our Kaleidoscope lens is tainted and everything that we say and do is tainted by that lens. It is not a self-imposed neglect of one's care, it is the unsolicited impact of trauma. Once we start to begin with complex trauma as they key matter affecting a person and the lack of self-care as a natural response, our lens clears. When we focus our attention on reinstating a person's ability to self-love and therefore self-care, then we don't need to worry about imposing things on them or doing things for them. When we realise how and why a person has been struggling to maintain safety and wellbeing, we start empathising and supporting rather than rejecting and blaming the person for their actions. The titles of our considerations remain the same, but the understanding behind the response illicit different reactions and therefore different and improved outcomes.

The findings from this review raise some significant issues for further exploration:

- What do we do if all homeless persons have identified needs?
- How do we manage the influx of persons affected by trauma at an earlier stage to prevent needs increasing and becoming complex down the line
- What was the impact of the pandemic on the trauma experiences of people and why are we now witnessing a mental health crisis?
- The impact of intergenerational trauma and the cost to society: Human and monetary
- The inhumanity of ignoring the significant and degrading effects that long term, complex trauma has on a person.

Change is required at every level of the political and systemic response to people affected by trauma.

Ignoring it will not make it go away, it will prolificate over generations.