Kingston Safeguarding Adults Board

Discretionary Safeguarding Adults Review

"Paul"

Findings Report

Led by: **Eliot Smith Independent Reviewer**
Date: **April 2025**

CONTENTS

INTRODUCTION

Background

Safeguarding Adults Reviews and the case referral

One of the statutory functions of a Local Safeguarding Adults Board is to arrange Safeguarding Adults Reviews (SAR). The aim of the Safeguarding Adults Review is to learn from individual cases to produce evidence-based findings and recommendations which are applicable to the whole system. Mandatory Safeguarding Adults Reviews must take place 'when an adult in its area dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual' (DHSC, 2025). The case of Paul was highlighted by the Kingston VAMA Panel as a case that would offer learning on how the system responds to adults that self-neglect who are vulnerable but whose primary need remains unclear. Paul's case was referred to the Safeguarding Adults Board on 29 April 2024. The initial recommendation at a SAR sub-group on 19 June 2024 was that the case offered opportunities for learning, but that it did not meet criteria for a Safeguarding Adults Review. Following further discussion with the Independent Chair of the Safeguarding Adults Board and reflection on the learning opportunities in the case, the SAR sub-group in August 2024 recommended a discretionary SAR.

Information about the case

Individuals referred to in this report have been allocated a pseudonym, and where necessary identifying information has been disguised or omitted to protect confidentiality.

Paul is a man in his 60's who has been a resident of Kingston for many years. Paul presents as vulnerable and it has been suggested that he may have an underlying learning disability or autistic spectrum disorder, although he had received no formal diagnosis and had limited contact with services until 2022. Until this time Paul had lived with his father who he depended on to meet any needs he had for care and support; Paul had limited contact with the rest of his family, and few friends or other social supports. In 2022 his father was admitted to hospital and subsequently died. After the death of his father a pattern of self-neglect and rough sleeping began. Paul resisted a return to the home he had shared with his father; not accepting that he had died, Paul stating that he wished to remain outside the family home until his father was well enough to return. This triggered a pattern of rough sleeping, on the communal landing, the street, temporary accommodations, or police station. The case of Paul attracted multi-agency working and eventually, in March 2024 and through legal processes via the Court of Protection, Paul was admitted to a placement subject to a court authorised deprivation of liberty, where he still resides.

About the Reviewer

This Safeguarding Adults Review has been led by an Independent Author, Eliot Smith, who is an Independent Health and Social Care Consultant with a background in social work, mental and physical health, and safeguarding. Eliot Smith has worked for both Local Authority and NHS services and has no prior connection to the case, Safeguarding Adults Board, or partner agencies.

METHODOLOGY

Principles

Safeguarding Adults Reviews should be conducted in line with principles set out in paragraph 14.167 of the Care and Support Guidance:

- "There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively" (DHSC, 2025).

Assumptions

The Safeguarding Adults Review methodology was based upon a number of assumptions about the purpose and aims of Reviews, the evidence provided to the Review, and about learning and improvement in safeguarding systems.

- Assumptions about the case: It is assumed that the case provides a fair and representative example of practice.
- Safeguarding Adults Reviews are not a reinvestigation of incidents or performance: the purpose of a Safeguarding Adults Review (SAR) is "not to hold any organisation or individual to account" (DHSC, 2025).
- Reliability of documentary evidence: It is assumed that evidence provided to the review was contemporaneously recorded and provides a full, honest, and accurate account of events
- Practitioner's views and opinions: The views and opinions of practitioners are taken as heard, and reflect personal subjective opinions and recollections
- 'People come to work to do a good job': It is assumed that most practitioners who work with people with care and support needs are committed, compassionate, and 'come to work to do a good job'.
- Systems-focused learning: Individual practice in health, social care, and safeguarding is influenced by the system within which people work. Effective learning and improvement take place when Reviews adopt a systems focus and generate findings from individual cases that are applicable across the system.

Themes

The case of Paul is well-known to multi-agency panels in Kingston and the Safeguarding Adults Board and SAR sub-group. Local organisations have gathered initial information about his case and have held rich discussions about how the wider system responded to Paul's vulnerabilities, risk, and social circumstances. Following review and analysis of this evidence and information there are a number of themes that emerge in the case. Figure 1 provides a word cloud representation of the main themes at the early stage of analysis.

Figure 1: Emerging themes in the case of Paul at early stage of analysis

These themes reflect the learning from the SAR sub-group and unsurprisingly focus on key areas of risk and challenge – Paul's housing situation and the risk of rough sleeping and the challenge of an unclear diagnosis of underlying disability from which health, care and support needs arise. Other themes and opportunities for learning concentrate on the system response, including safeguarding (self-neglect, self-reports as a victim of crime) and the application and issues with legal frameworks, including the use of the Mental health Act 1983, Mental Capacity Act 2005 and the Court of Protection.

From themes to the practice context

The themes identified from Paul's experience of the multi-agency system in Kingston can provide valuable insights into the case context for the professionals and agencies working with him.

The practice context identifies the main factors in the case that contributed to a risk of harm, including self-neglect, or which represented challenges or barriers to good practice – factors that

made it harder for professionals to meet Paul's needs, assess risk, work together, and provide an effective multi-agency safeguarding response. This is shown in figure 2:

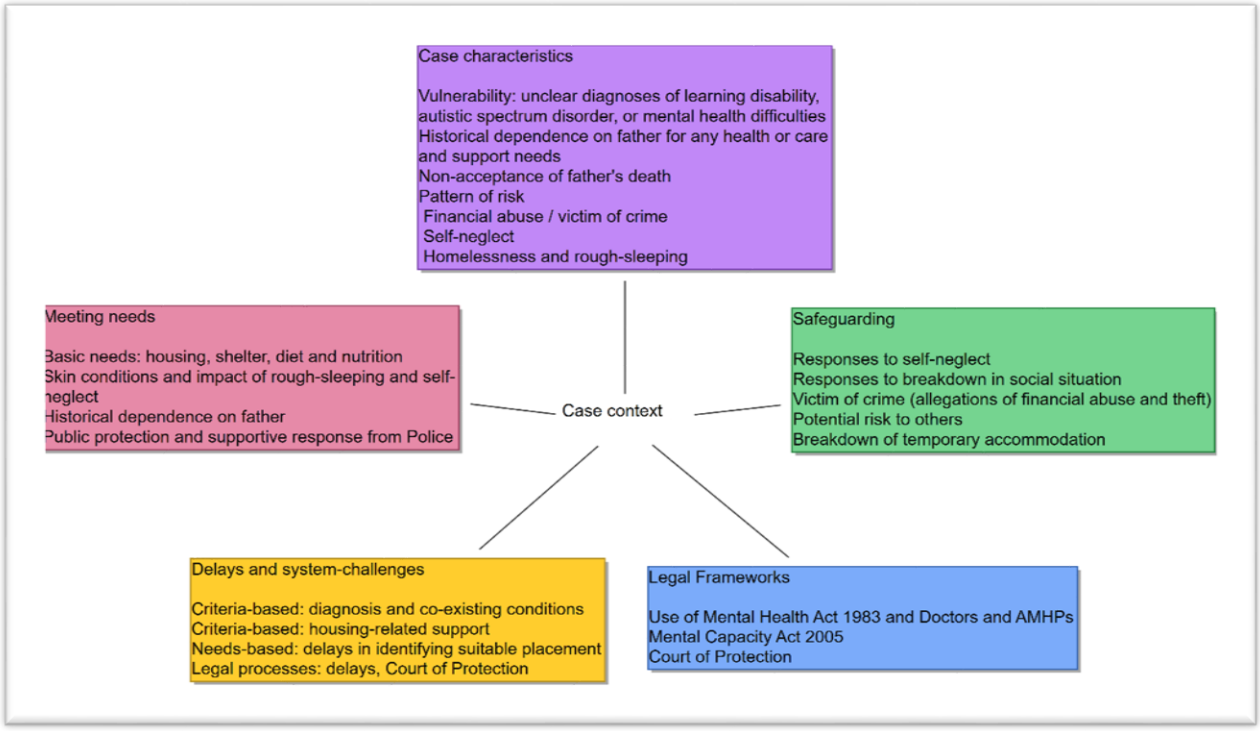

Figure 2: Practice context in the case of Paul at early stage of analysis

SAR questions

Based upon the themes and context the case of Paul offers learning in a number of areas. This Safeguarding Adults Review will address the following systems questions based upon Paul's experiences:

1. Case characteristics: What does the case of Paul tell us about how services respond to individuals who have not historically relied on services and who may present later in life with complex needs and risks of harm?
2. Safeguarding: What helped or hindered safeguarding practice in the case of Paul, in particular responses to self-neglect, allegations of financial abuse and exploitation, and the breakdown in social circumstances?
3. Meeting needs: How can the system overcome barriers to meeting the needs of individuals whose underlying impairment, condition, or vulnerability is unclear?
4. Legal Frameworks and systems frameworks: What were the enablers and barriers to effective use of legal frameworks, to support practice and empower professionals?

Methods

The Safeguarding Adults Review address the SAR questions using evidence from organisations and practitioners who worked with or had significant involvement with the case. The Review will follow a two-stage stepped analysis approach. Documentary evidence already available and a practitioner event will be used to address the SAR Questions. A draft analysis report will be considered during a learning event to consolidate findings about the system. A SAR Panel will provide expertise, advice, and quality assurance throughout the Review process.

Documentary evidence

The review will maintain a focus on the period from 2022 until the decision to undertake a Safeguarding Adults Review in August 2024. A good amount of information about the case was obtained through the initial scoping exercise. Further documentary information will be gathered only as needed for deeper analysis of specific aspects of the system response.

Practitioner Event

Practitioner events are held to listen to the expertise and experiences of practitioners who work within the system, and who can provide valuable insights into how the system works. The main focus of the practitioner event is to look for answers and explanations that are relevant to the SAR questions. Practitioner events are not held to ‘cross-examine’ or interrogate practice, rather to look behind practice to understand how the system influenced the decisions and events in the case.

Other learning and research

Learning from previous Safeguarding Adults Reviews, national learning from Reviews, and research will also be used to support analysis and to generate evidence-based findings.

Safeguarding Adults Review (SAR) Panel

A Safeguarding Adults Review Panel will be convened to oversee the review made up of individuals of an appropriate level of seniority to contribute authoritatively on behalf of each agency and the services it covers.

These will form the terms of reference for the Safeguarding Adults Review.

FINDINGS

Findings are conclusions and insights drawn from the analysis of data and evidence gathered in the course of the review. The aim of a findings in Safeguarding Adults Reviews is to enable "lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again" (DHSC, 2025).

SAR Question 1: Case Characteristics

What does the case of Paul tell us about how services respond to individuals who have not historically relied on services and who may present later in life with complex needs and risks of harm?

Crises occur when hazardous events disturb an existing steady state in which people can manage stressful events that affect them using existing coping mechanisms (Payne, 2022). In the case of Paul and his father, their steady state was characterised by the support and dependence between them. When Paul's father died, Paul entered a period of grief, trauma, and active crisis. Even without the complication of a grieving process during the impact stage of a crisis, individuals may experience fear, tension, or confusion with powerful emotions and adverse impacts on physical and mental health (Thompson, 2017). In crisis intervention theory there is a relatively short window of opportunity in which to use professional relationships to support an individual to in crisis resolution. If successful the individual may experience and increase in resilience to future crises, if unsuccessful they may become less able to function and respond to future events – maladaptive coping mechanisms may also become more entrenched making resolution more difficult.

In the case of Paul, he had been dependent on his father for many years, with very little contact with professionals or services. This meant that following the death of his father, Paul may have attempted to manage the crisis and his feelings about it using previous coping mechanisms that without his father were not sufficient to meet his needs. Examples of this may have included behaviours such as seeking out his father (despite his being deceased) or other authority figures, such as Police. Paul's vulnerability and lack of resilience were apparent to professionals only after the crisis precipitated by his father's death. The system responded using problem-solving techniques with a focus on addressing immediate concerns and practical problems. This is consistent with the task-centred practice model that commonly accompanies crisis intervention approaches. In the event Paul proved resistant to support, was unable to meet his health and social care needs through his existing coping skills, and a more interventionist approach was required, cumulating with an application to the Court of Protection and a court-authorised deprivation of liberty.

Another important element in crisis intervention is that of preparedness. Preparedness in crisis intervention can involve work to foresee and avoid, or prevent, a crisis-precipitating event from occurring, or can involve work with an individual to reduce their vulnerability or increase their resilience so that they are better prepared should a crisis occur. In cases where an individual is dependent on another, some precipitating events may be predictable – for example, that the main carer in a household may become unable to continue to provide care through age, or illness. Such events may not be preventable, but there may be steps that services can take to prepare an individual to successfully resolve a crises and resume a previous competent steady state or improve their functioning in future (Payne, 2022).

Finding 1: Legacy care planning

Context
Crises occur when hazardous events disturb an existing steady state in which people can manage stressful events that affect them using existing coping mechanisms. Where certain precipitating events can be predictable there may be steps can be taken to increase a vulnerable individuals' level of preparedness. While this would have been challenging in the case of Paul (whose family were not known to services) in the example of a vulnerable person being cared for within their family home by an elder caregiver, spouse, or parent, legacy care planning may help to prepare the family for a time when the existing caring roles may change or cease.

A legacy care plan may include specific actions to reduce vulnerability, or increase resilience, to manage the impact state or transition to a new steady state, as well as care continuity and provision for presenting needs. Legacy care plans may include or align to Mental Capacity Act provisions such as Lasting Powers of Attorney, advance decisions, and statements.

Recommendation
Creation and development of a legacy care plan model including good practice guides, exemplar legacy plans, and resources. Key partners from within the SAB and Borough may include health and social care agencies, Kingston Carers Networks, service users, and advocacy services.

SAR Question 2: Safeguarding

What helped or hindered safeguarding practice in the case of Paul, in particular responses to self-neglect, allegations of financial abuse and exploitation, and the breakdown in social circumstances?

In statutory guidance, self-neglect is defined as "a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings" (DHSC, 2025). Local safeguarding policies across England and Wales include a broader working definition of self-neglect encompassing three distinct elements of self-neglect. In the London Multi-Agency Adult Safeguarding Policy & Procedures (LSAB, 2019) these are summarised as:

- **Lack of self-care:** this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or wellbeing
- **Lack of care of one's environment:** this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g., health or fire risks caused by hoarding)
- **Refusal of assistance that might alleviate these issues**: This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment.

Research on the causes of self-neglect often focus on health conditions: mental health, mental impairments, physical health deterioration and associated loss of ability, and social determinants

including poverty, food insecurity, a lack of resources, and the undue influence of others (Abumaria, 2020; SCIE, 2018). In the case of Paul, insufficient coping mechanisms combined with a refusal of assistance may have been the combined product of his historical dependence on his father to meet his needs, and response to crisis following his father's death. Paul's risk and experience of self-neglect was apparent and well-known. Multi-agency oversight was needed, and it was forthcoming in the form of the Kingston Vulnerable Adults Multi-Agency Panel (KVAMA). The KVAMA acts as an oversight panel supporting multi-agency practice and providing input into the Multi-Disciplinary Team. The use of a multi-agency risk approach rather than a safeguarding enquiry is supported by statutory guidance. The Care and Support Guidance states that self-neglect 'may not prompt a section 42 enquiry' but that this decision 'depends on the adult's ability to protect themselves by controlling their own behaviour' (DHSC, 2025).

Based upon the definitions of self-neglect and the room for interpretation in statutory guidance, Paul's case may have met criteria for a safeguarding enquiry but in practice was equally well-suited to the KVAMA process; there was a clear commitment to partnership working, suitable processes were used, and practitioners across the system were committed to making a difference for Paul.

The key learning from this case is in making a judgement on an adult's ability to protect themselves by controlling their own behaviour' (DHSC, 2025), and in fact on what actions should be taken in the event that an adult is unable to protect themselves: what is the role of 'the state' in securing the protection of adults who cannot protect themselves, and how should they go about it? The relationship between the state's duty of care and individual freedoms and autonomy engages human rights and is considered through the lens of the legal frameworks discussion below.

Finding 2: Safeguarding and the KVAMA

Context
In cases of self-neglect, statutory guidance provides room for interpretation on when an enquiry under section 42 (Care Act 2014) should be initiated. The Care and Support Guidance states that self-neglect 'may not prompt a section 42 enquiry' (DHSC, 2025) however individuals at risk of self-neglect may still benefit from a multi-agency approach and coordination of support. In Kingston the Vulnerable Adults Multi-Agency Panel (KVAMA) offers an alternative multi-agency risk-focused approach. In the case of Paul, the KVAMA was effective at bringing agencies together and maintaining the professional commitment to Paul. The key question in this case was about what role the state should have played in protecting an individual who may have been unable to protect themselves from self-neglect.

Recommendation
In the review of self-neglect guidance, the Safeguarding Adults Board should consider the use of the KVAMA in cases of self-neglect, in light of statutory guidance.

SAR Question 3: Meeting needs

How can the system overcome barriers to meeting the needs of individuals whose underlying impairment, condition, or vulnerability is unclear?

The health and social care system is complex made up of numerous parts including a number of specialist services that focus on particular areas of need using a criteria-based approach to the allocating of scarce resources. The specialisation of services can mean that an individual may be in receipt of care, support, or treatment from a number of different agencies and sectors across the system. Effective support for individuals with multiple vulnerabilities relies on not only a combined approach, but a coordinated multi-agency response with a clear lead professional and with each agency doing its part.

As with any complex system, it can be challenging for individuals to understand how to navigate the different service offers and obtain the support they need. Before the death of his father, Paul had limited exposure to health and social care agencies, and limited experience in navigating the complexities of the health and social care system. Likewise for agencies working in the system there was limited information about Paul, his history, or his needs. During the initial stages of crisis, a range of behaviours outside of social and societal norms led to Paul becoming known to services. Paul's behaviours included potential criminal offences and risky choices that left him vulnerable to self-neglect, and exploitation by others. Paul was also a victim of harassment from others. During their early contacts with Paul services focused on the immediate and pressing needs of shelter, warmth, and other basic necessities. The eligibility criteria for social care services is set out in regulations and includes any needs arising from physical or mental impairment, or illness[1]. An adult will usually be considered eligible if they are unable to achieve two or more of the following:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Maintaining a habitable home environment
- Being able to make use of the home safely
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education, or volunteering
- Making use of necessary facilities or services in the local community including public transport and recreational facilities or services

Due to the rather sudden appearance of Paul on services' radar there was a lack of history, knowledge of impairment, and diagnosis to help guide Paul to the most appropriate service. This created multiple challenges for agencies who needed to piece together a picture of Paul's issues based on limited historical collateral and limited engagement. While eligibility criteria is based upon needs arising from an individual's physical or mental impairment, or illness, a formal diagnosis is not required, and Paul was seen as eligible for services despite a lack of clarity about exactly what impairment or illness may have been driving his needs.

[1] ("The Care and Support (Eligibility Criteria) Regulations 2015,")

The lack of a formal diagnosis did however, limit Paul's choices and options in relation to direct care provision – without a clear picture of his needs and underlying conditions a number of providers were unable to accept a referral to provide a package of care. This apparent 'gap in the market' potentially undermined the needs-based approach adopted by statutory services which meant that organisations across the system had worked together to respond to the changes and risks apparent in his social circumstances.

Paul's behaviours and presentation meant that a high degree of vulnerabilities and risk was apparent and highly visible to organisations and in his local community which led to a crisis and task-centred approach. Over time services engaged legal options and following an application to the Court of Protection his needs for care and support are being met though a residential placement subject to a court authorised deprivation of liberty.

While his practical needs may have been addressed there remains uncertainty over the underlying impairment from which his needs arise. Through the court process a tentative diagnosis of mild learning disability was made by a Court appointed doctor to support proceedings. While formal diagnoses are not always helpful or desirable, a better understanding of his longer-term needs may help services and Paul to plan for the future. There remains a need to increase resilience and coping mechanisms and protect against future crises or changes to his circumstances – for example should the authorisation of his deprivation of liberty cease and he were to leave his placement.

Finding 3: Long-term needs and resilience

Context
Paul was largely unknown to services before the death of his father and main carer, and presentation of vulnerability and risk. Organisations adopted a needs-based approach and used a crisis intervention and task-centred approach to meeting his needs for care and support, through legal processes. Following the resolution of his crisis, there is now an opportunity to work with Paul on coping mechanisms and learning from his experience of self-neglect, rough sleeping and exposure to risks of exploitation and harm. Processes such as the KVAMA worked effectively on crisis intervention, but may need to also contain an emphasis on crisis resolution and learning from crises to increase resilience and reduce vulnerability to future crisis-precipitating events.

Recommendation
To build on the KVAMA approach to include crisis resolution and resilience work for improved future functioning and ability to cope with precipitating events.

SAR Question 4: Legal Frameworks

What were the enablers and barriers to effective use of legal frameworks, to support practice and empower professionals?

One implication of a lack of clarity on whether Paul suffers from a mental impairment concerns the application of the Mental Capacity Act 2005. Again, while a formal diagnosis of a specific condition is not necessary for an individual to lack mental capacity under the Mental Capacity Act there must be evidence that their inability to make a specific decision at the material time must be *because of* an impairment or disturbance of mind or brain[2] – also known as the causative nexus. A lack of clarity on the diagnostic test for mental capacity for Paul was one of the factors that meant that a lack of mental capacity in relation to particular decisions that led to self-neglect was not always clear to professionals.

A critical issue on the case of Paul was the degree of risk of harm he faced after he entered crisis following the death of his father on whom he had previously relied. Having refused to return to his home without his father, struggling to accept that he was deceased, Paul entered a period of transient living, sleeping rough, being offered and evicted from hotel and short-term accommodation, and experiencing serious personal self-neglect. Paul's choices, decisions and behaviours led to concerns among organisations about his ability to protect himself from harm. This engages a common theme in self-neglect cases: the balance of the state's duty of care to its citizens vs. personal freedoms and individual autonomy. For example, rights to liberty and security, and to privacy and family life[3] are qualified rights – protected from interference by public authorities except in certain circumstances, where necessary and in accordance with the law. The challenges in the case of Paul that required consideration of a legal option included securing an assessment of his mental state, wellbeing, and care and treatment needs, and the protection of his health and welfare in face of risks of self-neglect – in the context of Paul's inability or unwillingness to engage or cooperate with assessment or provision of care and support. To overcome his refusal to accept services or cooperate in assessment, there a number of legal frameworks that were considered to engage his human rights in this area with a view to the protection of his health and welfare. In the context with an interference in an individual's human rights, procedures of law usually fall into two categories: statutory powers set out in Acts of Parliament, and the powers of certain Courts.

Legislation: Mental Health Act 1983

Part II of the Mental Health Act concerns the compulsory admission to hospital of individuals who are suffering from a mental disorder of a nature or degree that warrants their detention. In the case of Paul, it is unlikely that he would have benefited from a hospital environment, nor that a psychiatric hospital would have been the appropriate setting to meet his needs which were not primarily for assessment or treatment of mental disorder. The Mental Health Act also contains short-term powers to secure the assessment of an individual for admission, or alternative arrangements for their care, but these may be exercised only under specific circumstances. Section 135(1) MHA 1983 allows a justice of the peace to issue a warrant authorising a constable to enter, if need be, by force a premises to remove a person to a place of safety for assessment. It

[2] Section 2(1) ("Mental Capacity Act," 2005)
[3] Articles 5 and 8 of the European Convention on Human Rights ("Human Rights Act," 1998)

should be noted that this power is place-specific and cannot be used in a public place. In the circumstances of Paul this would not have been an appropriate means of securing his assessment. Section 136 MHA 1983 covers the removal of a person to a place of safety if they are outside a premises by a constable if it appears that they are suffering from a mental disorder and in need of immediate care and control. At times in Paul's case, it is possible that this power could have been used to secure his assessment but would have been unlikely to have led to a more lasting solution to the protection of his health or welfare. A longer-term intervention was required.

Legislation: Mental Capacity Act 2005
The Mental Capacity Act is concerned with an individual's ability to make decisions, and where they are unable to make a decision because of an impairment or disturbance in mind or brain, with how decisions can be made on their behalf. The Mental Capacity Act is intended to be an empowering and rights-driven piece of legislation, protecting the individual's right to autonomy, support to make decisions, and ensuring that decisions made on a person's behalf are in their best interests. A number of 'acts' by professionals (who have a reasonable belief in a person's lack of capacity and best interests) are covered by the Mental Capacity Act, including provision of care, treatment, and under some circumstances restraint. The Deprivation of Liberty Safeguards (DoLS) provide a legal procedure in relation to interference in an individual's Article 5 rights to liberty, but these do not include powers of conveyance to a place, rather authorising a managing authority to provide care arrangements that amount to constant supervision and control of a person resident with them. In this case the managing authority would be a residential or nursing placement, or a hospital. The limitations to the DoLS procedure as enacted also meant that this was not applicable to Paul's circumstances.

Powers of the Court: The Court of Protection
The Mental Capacity Act 2005 established the Court of Protection which has a range of powers under part I (MCA, 2005) and as a superior court of record. For individuals who lack mental capacity under the Mental Capacity Act 2005, the Court of Protection provided the only viable legal avenue for organisations in the case of Paul to intervene in his life to protect his health and welfare even subject to interference with his human rights.

A note on the timeliness and responsiveness of the Court vs. statutory powers
Professionals in the case of Paul expressed feeling frustrated with the length of time it took the Court of Protection to make declarations in his case that resulted in his move into a placement. The delays in the Court of Protection process may have been in part due to pressures on the system and listing of cases – that is in the ability of the Court to respond in a timely manner to the risks. The length of time may also have reflected difference in how legal frameworks are applied or administered. For some decisions, the court may have required further information, leading to a delay while that information was sought, or assessments were carried out. Where the court chose not to make interim declarations or orders, there may have also been differences in the degree of positive risk-taking: where the court wished to see evidence that alternative offers had not succeeded. This meant that alternative less restrictive options were trialled and 'failed' before new options were granted. For professionals in the case this represented a risk to Paul which they may not have taken if they had statutory powers been available to them.

A note on Inherent Jurisdiction

Had Paul retained mental capacity in key decisions about his care and treatment then he would have fallen outside the jurisdiction of the Court of Protection. Known as the great safety net[4], inherent jurisdiction is "the ability of the High Court to make declarations and orders to protect adults who do not fall within the scope of the Mental Capacity Act 2005, but who are in some way vulnerable and whose ability to decide is compromised… where their ability to decide is compromised by or from the actions (or sometimes inactions) of other people" (Ruck-Keene et al., 2020).

A potential gap in the statutory powers?

The availability of a legal framework to support Paul and address risks of self-neglect hinged on his inability to make decisions which engaged the protections of mental capacity frameworks. As an individual who had been assessed as lacking mental capacity to make decisions about care and treatment, and residence, his case fell under the jurisdiction of the Court of Protection. However, this was a finely balanced assessment and had he been found to have mental capacity there would have been no clear legal route to protecting him from harm.

Finding 4: A potential gap in the statutory powers

Context

Paul experienced significant risks of harm as a result of an inability or unwillingness to accept support and services that were essential for his welfare – with the outcome of serious self-neglect. Paul was assessed to lack mental capacity, however the neither the powers of the Mental Capacity Act, nor Mental Health Act, would have been sufficient to have addressed his need for assessment, care, and treatment to meet his needs and protect him from harm. The current framework of statutory powers did not allow services to intervene to ensure that his needs were met. The only viable avenue that remained was an application to the Court of Protection to secure his assessment, conveyance to a suitable placement, and keeping him there, that is a court authorisation of care arrangements amounting to a deprivation of his liberty. Had Paul had mental capacity to make decisions about his care and treatment, professionals would not have had any obvious legal route to ensure Paul's safety; this represents a gap in legal frameworks for individuals who are at risk of serious harm or death, through decisions or behaviours that result in self-neglect.

Recommendation

The potential gap in legal frameworks for individuals at risk of self-neglect should be escalated via regional and national Network of Safeguarding Adult Boards Independent Chairs as appropriate and the Safeguarding Adult Board Manager's network, for consideration and action: for example, to petition the Law Commission and HM Government for legal reform.

[4] Re DL [2012] EWCA Civ 253

SUMMARY OF RECOMMENDATIONS

No.	Learning area	Finding	Recommendation or question to the SAB
1.	Case characteristics	Legacy Care Planning	Creation and development of a legacy care plan model including good practice guides, exemplar legacy plans, and resources. Key partners from within the SAB and Borough may include health and social care agencies, Kingston Carers Networks, service users, and advocacy services.
2.	Safeguarding	Safeguarding and the KVAMA in self-neglect	In the review of self-neglect guidance, the Safeguarding Adults Board should consider the use of the KVAMA in cases of self-neglect, in light of statutory guidance.
3.	Meeting needs	Long-term needs and resilience	To build on the KVAMA approach to include crisis resolution and resilience work for improved future functioning and ability to cope with precipitating events.
4.	Legal frameworks	A potential gap in statutory powers?	The potential gap in legal frameworks for individuals at risk of self-neglect should be escalated via regional and national Network of Safeguarding Adult Boards Independent Chairs as appropriate and the Safeguarding Adult Board Manager's network, for consideration and action: for example, to petition the Law Commission and HM Government for legal reform.

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