Leicester City Council

Self-neglect and social work practice: An overview

Adult Social Care Scrutiny Commission

Date of meeting: 15 January 2026

Lead director/officer: Ruth Lake

Useful information

- Ward(s) affected: All
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- Report version number: 1

1. Summary

1.1 This report provides the ASC Scrutiny Commission with an overview of the issues relating to self-neglect, from the perspective of adult social care.

1.2 This is a highly complex area of practice, with new learning and approaches emerging from national and local reviews.

1.3 This is the first report about self-neglect to the ASC scrutiny commission: this report sets out what self-neglect is, and the law, guidance and practice frameworks in place to support our work with people who self-neglect. It also draws out some of the challenging and tragic circumstances for individuals, that have been reviewed in recent years and the learning from those reviews, together with the local plans in place to develop confident practice and support the best possible outcomes.

2. Recommendation(s) to scrutiny:

ASC Scrutiny Commission are invited to:

- Note and make any comments.

3. Main report

3.1 Self-neglect: what we understand

3.1.1 Self-neglect can be described as:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

Social Care Institute for Excellence

3.1.2 The reasons why people might self-neglect are complex. Self-neglecting circumstances generally arise over a period of time, and there is not always an identifiable root cause. Factors and causes may include mental or physical health conditions, addictions, traumatic life events or compulsive disorders including hoarding. Many people who self-neglect are judged to have 'mental capacity' – the ability to understand, retain and weigh up information in order to reach a decision, however unwise it might seem.

3.1.3 Self-neglect is most often visible to others, but not acknowledged by the individual themselves, who may not accept that there are any concerns or problems. This can result in tensions between the individual and family members or friends, leading to reduced social support networks. It is common for other people to want professionals in care and health to 'do something'. However, there are limitations on what professionals can do if a person is judged to have capacity. The complexities of assessing the capacity of people who self-neglect is covered in more detail at 3.2.4 – 3.2.7.

3.1.4 Whilst self-neglect and hoarding are not always jointly presenting issues, it is common for this to be the case, with similar underlying issues and causes. Local guidance covers both self-neglect and hoarding for this reason.

3.1.5 In statistical terms, self-neglect is the presenting harm in a modest proportion of safeguarding enquiries, typically between 4% and 6% of all enquiries per quarter (c.150 – 180 total enquiries per quarter). Referring to information at 3.3.2, the Leicester data broadly reflects the national position, and other categories of harm are more prevalent locally, namely omission / neglect by other, physical and financial abuse, in that order.

3.2 Law, guidance and practice frameworks

3.2.1 Self-neglect was included as a category of harm and abuse in the Care Act 2014 statutory guidance on safeguarding, which raised the profile of self-neglect within social work practice. However, that does not mean that everyone who self-neglects falls within this provision. Safeguarding duties will apply where the adult has care and support needs (many people who self-neglect do not), and they are at risk of self-neglect and they are unable to protect themselves because of their care and support needs.

3.2.2 Other relevant legislation includes the Mental Health Act, Mental Capacity Act, Public Health Act and the Human Rights Act. None of these provide a comprehensive legal framework for working with people who self-neglect: rather they give some duties, powers or guidance in specific areas, such as assessing capacity or detaining people who have a mental disorder and appear unable to care for themselves.

3.2.3 The local Multi-agency Policies and Procedures (MAPP) for safeguarding across Leicester, Leicestershire and Rutland includes guidance on self-neglect. Until 2024, serious self-neglect was managed differently, depending on whether an individual was judged to have capacity. Those people without capacity were supported under the principles of a s42 safeguarding enquiry, as they were judged to be unable to protect themselves from the harm caused by their self-neglect. People with capacity were considered able to protect themselves, and a separate process known as the Vulnerable Adults Risk Management framework (VARM) was in place. This had many parallels with the safeguarding process, in bringing professionals together, with the individual at the centre of the concern where possible, to identify risks and put in place plans or strategies to mitigate harm. As learning from local and national reviews emerged, this position was changed to strengthen the multi-agency working and improve outcomes. Since late 2024, all instances of serious self-neglect, that might lead to significant harm or death, are managed within the Care Act s42

safeguarding enquiry process, regardless of whether the individual is believed to have the mental capacity to make decisions about their neglectful circumstances. The local guidance on self-neglect and hoarding that forms part of the MAPP was updated and staff across the statutory safeguarding partnership were briefed on these changes. The guidance is available here should further detail be helpful. LLR-Self-Neglect-and-Hoarding-Guidance.pdf

3.2.4 Mental capacity remains a central issue, as the interventions available to staff will depend on whether a person is deemed to have capacity. The legal options for progressing a course of action that person does not agree with, are different if that person is unable to understand, retain or use the salient information relating to their self-neglecting actions / inactions.

3.2.5 A further consideration is whether the individual has impaired executive functioning. Executive function is a term used to describe a set of cognitive skills that are controlled by the frontal lobes of the brain, and which help us function in day-to-day life. This includes normally automatic abilities such as decision making, emotional control, flexibility in thinking, being able to multi-task, motivation, inhibition, self-control, planning and organisation. When executive function is impaired, it can impact on these areas. Often people with impaired executive functioning may say one thing but then find it difficult to put it into practice.

3.2.6 Impaired executive functioning does not automatically mean that a person lacks capacity. However, it may be a factor in concluding that a person cannot use or retain information, as their actions would indicate that despite appearing to understand the risks and explain how they will mitigate the harm that might arise, they have been unable to follow through on those plans. In such circumstances, practitioners may need to make applications to the Court of Protection to determine capacity or seek inherent jurisdiction.

3.2.7 As noted earlier, this is a highly complex practice issue. Unsurprisingly, Safeguarding Adult Reviews (SAR) nationally have drawn out learning where practice has been examined closely. It is challenging territory for social workers, as their decisions may be scrutinised with the benefit of hindsight.

3.3 Learning from Reviews

3.3.1 Safeguarding Adult Reviews (SARs) are an important multi-agency process for learning from situations that have resulted in serious harm or death. They are set out in s44 of the Care Act. A Safeguarding Adult Board (SAB) *must* arrange a SAR where there is reasonable cause for concerns about how people have worked together to safeguarding the individual and where the individual has died or experienced significant abuse or harm. A SAB *may* arrange a SAR in any other circumstance but is not required to do so.

3.3.2 There is a national repository for SARs, so that learning from other Local Authorities is accessible to Safeguarding Adult Boards. Two substantial reports have been published, with analysis from SARs published April 2017 – March 2019 and April 2019 – March 2023. The second national analysis found that self-neglect was the type of abuse most commonly reviewed, featuring in 60 per cent of reviews (an increase from 45 per cent in the first national analysis). It was followed by neglect/omission (46 per cent), domestic abuse (16 per cent), physical abuse (14

per cent) and financial abuse (13 per cent). This differs from the pattern of safeguarding enquiry activity under section 42 of the Care Act 2014, in which neglect/omission usually features most frequently, followed by physical abuse, financial/material abuse and psychological abuse. This suggests that whilst self-neglect may not be the most common safeguarding issue, it carries a significant risk of resulting in death or serious harm, and that agencies do not always work together well where people are self-neglecting.

3.3.3 The second National SAR analysis reflects the most common practice challenges:

"The most commonly noted practice shortcomings were poor risk assessment/risk management (in 82 per cent of cases), shortcomings in mental capacity assessments (58 per cent), and lack of recognition of abuse/neglect (56 per cent). Also frequently highlighted were shortcomings in making safeguarding personal (50 per cent), absence of professional curiosity (44 per cent) and attention to care and support, physical and mental health needs, each noted in around 40 per cent of cases. An absence of professional curiosity meant that circumstances were sometimes taken at face value rather than explored in detail. Other highlighted shortcomings included absence of legal literacy, superficial acceptance of individuals' apparent reluctance to engage, poor recognition of the impact of trauma and attention to people's living conditions."

Second national analysis of Safeguarding Adult Reviews | Local Government Association

3.3.4 Local SARs have been completed in both mandatory and discretionary situations. 'Mary and Graham' was a review completed in 2019. This was a discretionary SAR as there was no indication that either Mary or Graham died because of harm or abuse (including self-neglect). However, the circumstances of their lives included self-neglect and a reluctance to engage with professionals, and there were concerns that agencies could have worked together better to share information and find ways to engage Mary and Graham. There were also questions about the possibility of coercive behaviours and domestic abuse, although not evidenced.
Mary and Graham executive summary

3.3.5 'Rosey' was published in 2022 as a mandatory SAR. Rosey died of cancer after an extended period in her life where self-neglect was evident to people working with Rosey. The issue of capacity was central, as professionals felt Rosey understood the risks presented by her decisions and that she was able to take action to protect herself from those risks. As a result, there were missed opportunities to use safeguarding procedures to work together to protect Rosey. Detailed assessments of Rosey's capacity were not completed. The Mental Capacity Act starts with a 'presumption' of capacity in the absence of information to suggest capacity is lacking, which professionals relied on. The review stated: *"Rosey's mental capacity was assumed rather than fully assessed and Rosey's self-neglect appears to have been accepted as a capacitous decision and as a lifestyle choice. Rosey's mental capacity should have been assessed in the context of her self-neglect (as highlighted in the Mental Capacity Act code of practice). More attention should have been given to whether or not Rosey was able to understand, retain and use and weigh the information relevant in, for example, making decisions to refuse an assessment of needs after July 2016 or to not attend to her personal care. Attention could also have been given to Rosey's executive capacity and functioning, particularly about her personal care."*

3.3.6 The recommendations from these reviews included awareness raising regarding the legislation available to professionals working with people who self-neglect, improving understanding of the practical application of mental capacity assessments where people are self-neglecting, and analysing the extent to which our policies and procedures foster effective ways of working with people who self-neglect. Actions were completed in relation to the recommendations made from these two reviews, monitored by the Safeguarding Adult Review Subgroup of the SAB.

3.4 Strengthening Self-Neglect Practice

3.4.1 In light of review findings, as well as information from audits, practice forums, safeguarding self-assessments and s42 enquiries, self-neglect was a strategic priority for the Leicester SAB between 2023 and 2025. Mental capacity was another strategic priority, due to the interdependencies raised in reviews. The business plan for the SAB details the actions taken by the statutory partnership, which include monitoring performance, raising awareness, training and procedural change. Business Plan SABs 2023-2025 Final

3.4.2 The role of adult social workers and other social care staff is pivotal in assessing need and risk, assessing capacity, developing protection plans and working with other agencies to safeguard people at risk from self-neglect. The Principal Social Worker, who is a member of the SAB, has worked with other agencies to make changes to procedure, guidance and practice:

- 15-minute staff briefings were held in December 2024 to launch the new LLR self-neglect and hoarding guidance
- Learning & Development resources to support staff to embed the new guidance have been shared with all ASC staff
- Mandatory Safeguarding Adult Training has been updated to include a greater emphasis on self-neglect and the application of mental capacity considerations in safeguarding work
- Delivery of a rolling programme of mandatory mental capacity training for staff
- Monthly Legal Literacy Lunch and Learn sessions, which have included mental capacity specific topics.

3.4.2 Understanding impact from the actions taken to strengthen practice is critical. Our safeguarding data shows there has been a small increase in the abuse category of self neglect in section 42 enquiries since the new guidance was launched in December 2024. We would expect to see this increase over the year, as high-risk self-neglect situations are investigated via section 42 enquiries where our safeguarding duties apply. Safeguarding audits are a further mechanism through which to understand whether learning is being seen in practice.

3.5 Future Plans and Risks

3.5.1 Whilst not yet strongly evident in safeguarding data, the experience of social work teams is that self-neglect, hoarding and people being unable to engage with support is an increasingly common situation. Again, it is difficult to point to hard evidence, but the impact of Covid, the restrictions imposed and effects on people with underlying mental or emotional vulnerabilities, is felt to be a factor in the increasing presentation of self-neglecting individuals. Cost of living pressures may also be having an impact. Working with people who, for whatever reason, find it difficult to

engage with us, is a particular challenge for staff and for working well in partnership with other agencies.

3.5.2 A new role of Safeguarding Adult Practice Lead is being recruited to. This role will work to the Principal Social Worker, adding capacity to develop staff guidance, to complete practice audits of safeguarding work and to provide direct support to staff working with complex safeguarding risks.

3.5.3 A recent review of some individuals who were known to our First Contact service but were not engaging with us has been completed. This has identified a gap in our guidance (internal and multi-agency) about how best to work with people where they, or their family members, are not engaging, leading to unassessed or unmitigated risks. This gap has been shared with the SAB subgroup. It should be noted that an outcome may be to agree as a multi-agency partnership, that having explored all options, the individual circumstances are not within our power to change.

3.5.4 There has been a focus session at one of the six weekly Team Leader Safeguarding Adults Forum on self-neglect. Learning from Safeguarding Adult Reviews sessions have been delivered to staff this year, which included key learning on mental capacity application. These will now be held twice yearly.

3.5.5 In December 2025, the LLR Safeguarding Adult Board Audit subgroup held a multi-agency audit on self-neglect, with particular emphasis on how the new guidance and approach to practice has been embedded since December 2024. The key learning points from the audit will be used to revise any further practice or procedural changes.

4. Financial, legal, equalities, climate emergency and other implications

4.1 Financial Implications

There are no direct financial implications arising from this report, nor is any additional funding being requested. This report sets out the key areas of understanding from this complex topic of self-neglect. Where social care intervention is required, this will be funded from the adult social care budget but due to the range of other support needed, it may require contributions (funding and staffing resource) from other partners such as public health and the NHS.

Signed: Mohammed Irfan, Head of Finance

Dated: 14 November 2025

4.2 Legal Implications

This report highlights that self-neglect and hoarding has become an increasing issue for all authorities. On 22nd October 2025, the UK Parliament discussed this issue for the first time noting the urgent need for national guidelines to support.

The International Classification of Diseases defines hoarding as follows:

"*Hoarding disorder is characterised by accumulation of possessions due to excessive acquisition of* ***or difficulty discarding possessions,*** *regardless of their actual value. Excessive acquisition is characterized by repetitive urges or behaviours related to amassing or buying items.* ***Difficulty discarding possessions is characterized by a perceived need to save items and distress associated with discarding them.*** *Accumulation of possessions results in living spaces becoming cluttered to the point that their use or safety is compromised. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning'*

Alongside the various pieces of statute governing this area, as highlighted above, there is a growing body of case law around this area, focusing on both respective duties and mental capacity issues.

The legislation, case law and practice in this area highlight the significant challenges associated with co-presenting difficulties and morbidities along with complexities associated with its overlap with housing issues including possession proceedings, injunctions and/or Anti-Social Behaviour Orders. It is also highlighted, as the Serious Case Reviews set out in this report sadly evidence, that there is emotional distress and suicidal risk associated with this condition. This includes when practical support is offered such as clearance.

The report highlights that the England and Wales Court of Protection (EWCOP) is only available as an avenue where a person lacks capacity but this is not a straightforward exercise. Determining capacity in the context of entrenched self-neglect and hoarding can be challenging especially where capacity fluctuates and there is uncertainty around whether a person has capacity.

In terms of assessing capacity, there are significant difficulties presented by non-engagement and further, the Mental Capacity Assessments will need to cover a wide range of domains. For instance, alongside capacity in respect of residence/care, there may be a need to explore capacity around entering and surrendering a tenancy agreement, capacity to manage items and belongings including storage and disposal and capacity to manage finances. In respect of each of these capacity assessments, there is complex case law setting out exactly would is required of an assessor. For instance, the case of AC and GC (Capacity: Hoarding: Best Interests) [2022] EWCOP 39 sets out that capacity in respect of items and belongings would need to cover:

- Volume of belongings and impact of use of rooms
- Safe access and use
- Creation of hazards
- Safety of buildings
- Removal/disposal of hazardous levels of belongings

Where a person has capacity, intervention is limited to safeguarding duties and only then, where a person has care and support needs and they are at risk of self-neglect and unable to protect themselves because of their care and support needs. Human right considerations will be important, most particularly, a persons' right to private and family life (Article 8) and the right to liberty (article 5) so practitioners will need to evidence that any response is one which is necessary and proportionate. These considerations may limit intervention without consent, even where risks are high. It can be seen therefore, that balancing the capacity issues alongside safeguarding duties and human rights considerations whilst seeking to engage and build trust with an often reluctant individual is both challenging and complex.

Where a person is deemed to lack capacity and proceedings are advised, this is not a quick fix. Proceedings can take a long time. This was highlighted in A LA v X [2-23 EWCOP 64 where the court noted

'*Since 2017, the local authority environmental health department, working together with mental health services, have been ruing to find a solution to X's housing'. Proceedings were issued in 2021 and 'some two years on, despite strenuous and creative attempts by the local authority, X's legal team and the court to bring about any change, the position remains the same'.*

Further, as when a person has capacity, the issue of balancing a person's autonomy with safeguarding presents a difficult task for involved practitioners and the court and requires a considered and proportionate approach to any proposed restrictions sought to be imposed. Best interest decisions will need to be made on behalf of a person such as clearing and cleaning the property but this has to be balanced with considerations around the emotional distress that this can cause.

Signed: S Holmes

Dated:4 December 2025

4.3 Equalities Implications

Our Public Sector Equality Duty (PSED) requires us to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between those who share a protected characteristic as defined by the Equality Act 2010 (sex, sexual orientation, gender reassignment, disability, race, religion or belief, marriage and civil partnership, pregnancy and maternity, age) and those who do not. The Council also has an obligation to treat people in accordance with their Convention rights under The Human Rights Act, 1998.

In keeping with our PSED, we are required to pay due regard to any negative impacts on people with protected characteristics arising from our decisions (and this would include decisions on how we deliver our services) and put in place mitigating actions to reduce or remove those negative impacts.

Whilst there are no direct equality implications arising from this report as it is for noting, it provides an overview of the issues relating to self-neglect, from the perspective of adult social care and will impact on people from across a range of protected characteristics. Whilst self-neglect is a not a protected characteristic, if it is a symptom or result of an underlying condition, such as dementia, depression, then the underlying condition may qualify as a disability under the Equality Act. We need to ensure that when a safeguarding concern is raised, including for self-neglect, the person's protected characteristics are recognised in the risk assessment and responses, and these need to be included in the Team Leader Safeguarding Adults Forum on Self neglect and highlighted at the LLR Safeguarding Adult Board Audit subgroup.

Signed: Sukhi Biring, Equalities Officer

Dated: 18 November 2025

4.4 Climate Emergency Implications

Whilst the overall climate emergency implications arising from this report are minimal, service delivery generally contributes to the council's carbon footprint. Any impacts could be managed by minimising travel, encouraging the use of sustainable travel options and using buildings and materials efficiently.
Signed: Phil Ball, Sustainability Officer, Ext 2246
Dated: 30 October 2025

4.5 Other Implications None
Signed:
Dated:

5. Background information and other papers:
None

6. Summary of appendices:
Practice Examples (ppt)