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Welcome to our August 2025 Newsletter

In this newsletter, we bring together information which we hope you will find useful and we highlight how the Partnership continues to communicate and keep in touch with all our agencies and provide guidance to support you in your role working with children and adults. In this edition, we bring you information in the spotlight about Self-Neglect, updates and also information about Partnership work, important safeguarding updates and new training dates.

Me Learning

Don't forget to log in to your Me Learning account and see our new e-learning courses on a range of safeguarding topics

A wide, sandy beach with the word 'SUMMER' written in the sand. The ocean and sky are visible in the background.

SUMMER

In the Spotlight..... Self-Neglect



What is self-neglect?

- 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

What causes self-neglect?

- It is not always possible to establish a root cause for self-neglecting behaviours. Self-neglect can be a result of:
 - a person's brain injury, dementia or other mental disorder
 - obsessive compulsive disorder or hoarding disorder
 - physical illness which has an effect on abilities, energy levels, attention span, organisational skills or motivation
 - reduced motivation as a side effect of medication
 - addictions
 - traumatic life change.

The inclusion of self-neglect in chapter 14 of the Care Act 2014 statutory guidance means that safeguarding duties apply where the adult has care and support needs and is at risk of self-neglect which they are unable to protect themselves from (due to their care and support needs). The nature of the potential harm is often a chronic risk that originates in quite deep rooted psychological issues (e.g. unresolved grief).

The adult often struggles to recognise the risks they are living with. They may lack mental capacity in relation to the care needs, but often very fine judgements are required to determine whether the adult has capacity but is making a choice about how they are living. Assessment of the adult's 'executive functioning' (the ability to set goals and carry them out) is a key component in the assessment of their mental capacity in relation to specific decisions.

The most effective approaches are ones which allow a worker to get alongside the adult and work with their wishes as far as possible to build a relationship of trust. It is important for local partners to have a clear unified policy and process for when to raise a safeguarding referral in a situation of self-neglect, and when other approaches of support are more appropriate. A multi-agency approach to risk assessment and risk management in partnership with the adult is likely to be most effective, where it is possible.

In some more complex and high risk circumstances it may be necessary to consider using the Mental Capacity Act 2005 and Best Interests frameworks to provide vital care or support.

World Suicide Prevention Day 10th September

World Suicide Prevention Day is Wednesday 10 September. It is a global movement focusing on raising awareness of suicide, reducing stigma, and encouraging strategies and actions to prevent suicide. Every 90 minutes, someone in the UK or Ireland dies by suicide and 1 in 4 of us has had suicidal thoughts.

This year's theme of 'Changing the narrative on suicide', highlights the importance of starting a conversation about suicide. Research shows that only 10% of employees would know that the best way to save the life of someone thinking of suicide is to ask them directly whether they have a plan to end their life.

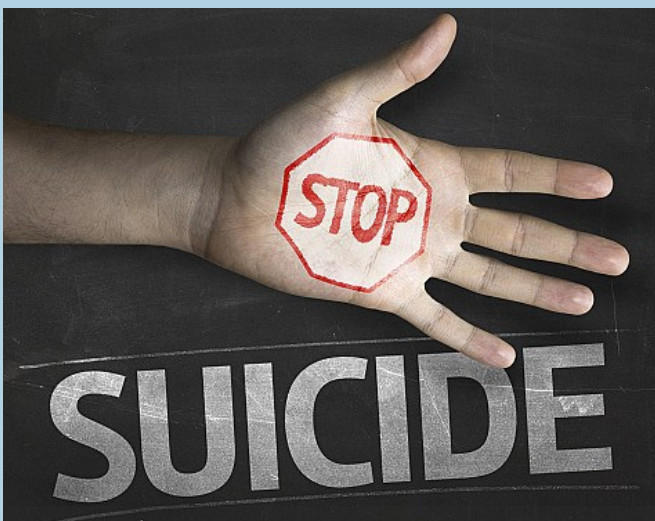
Everyone needs to come together to reduce suicide. We're calling on workplaces to embed suicide awareness, prevention, and support into their mental health and wellbeing strategies. Over 75% of employees do not know if suicide prevention is currently part of their organisation's wellbeing strategy. This must change. Suicide can be prevented through education and intervention.

Resources

Samaritans— [Suicidal thoughts can be interrupted](#)

Mental Health Learning— [poster](#)

MHFA England— [Five Pillars of Suicide Prevention in the Workplace](#)



Domestic Homicide Reviews in England and Wales will be renamed Domestic Abuse Related Death Reviews to better recognise suicides linked to domestic abuse (2024). The reviews are a multi-agency effort which seeks to identify and implement lessons learnt from deaths which have, or appear to have, resulted from domestic abuse. The aim is to better protect potential victims and prevent further tragedies.

Following public consultation, it was recognised more focus needed to be placed on hidden victims who die from domestic abuse-related suicide. The new wider definition recognises the often hidden victims of domestic abuse who die after suicide, coercive and controlling behaviour, and economic abuse.

A Domestic Homicide Review (a 'DHR') under section 9(1) of the Domestic Violence, Crime and Victims Act 2004 ('the 2004 Act') is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were in an intimate personal relationship, or by a member of the same household.

This month, Darlington Community Safety Partnership has published the findings of a Domestic Homicide Review. In 2022, the Partnership were made aware of the death of 'Grace'. It was established that the death met the criteria for a Domestic Homicide Review under Section 9 of the Domestic Violence Crime and Victims Act.

The purpose of a Domestic Homicide Review is to establish what lessons can be learnt from the domestic homicide and how local professionals and organisations work individually and together to safeguard victims. The Community Safety Partnership has a statutory duty to carry out Domestic Homicide Reviews.

Read the Executive Summary [here](#)



OUR PLEDGE

To have open, honest, bold conversations with each other as multi-agency partners in order to do the very best we can for adults and children in Darlington.

For many families across Darlington, multi-agency working is vital to maintain a focus on children and adults while also keeping them at the heart of all decisions.

Our Pledge is an opportunity to:

- Seek out professional conversations with each other at the earliest opportunity
- Have a shared understanding of the strengths and risks within a family
- Actively listen to each other and share important information
- Respect each other's expertise
- Be open and empathetic to the professional views of others
- Be professionally curious and evidence what we say
- Use common language that everyone understands



Concerned about a child?

Contact the Children's Initial
Advice Team
Professionals on **01325 406252**
Public on **01325 406222**

**Concerned about an
adult?**

Contact the Adult
Contact Team
on **01325 406111**



PARTNER SHIPS

Statutory Safeguarding Partners

James Stroyan, Executive Director of People

Nicola Lawrence, Detective Chief Superintendent

Hilary Lloyd, Chief Nurse