Safeguarding Adult Review – Thematic Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

1. Background – 'James' (56) and 'Simon' (48) died in early 2024 following long-term self-neglect, complex health problems and substance misuse.

'James' was described by practitioners as someone who had experienced significant adversity throughout his life. He often presented as guarded, frustrated and mistrustful of services, yet there were periods where he engaged well with staff who took a calm, consistent and trauma-informed approach. Despite his challenges—including chronic illness, substance misuse and mental health difficulties—James also showed moments of humour and determination, expressing a strong desire for independence even when his health was deteriorating.

'Simon' was known as a quiet, polite and at times vulnerable individual who struggled with anxiety, low mood and the long-term impact of diabetes. He often relied on others for practical and emotional support and could be easily influenced by people around him. Staff who worked closely with 'Simon' noted that he could be warm, appreciative and cooperative when he felt safe, but his own feelings of shame about his health and substance use sometimes led him to withdraw or miss appointments.

2. Process - Following receipt of the referrals in quick succession in Spring 2024 scoping information was requested which informed the decision to progress to a Safeguarding Adult Review (SAR) in Spring 2024. Immediate safeguarding actions were implemented, and an independent author was sourced in mid summer 2024. The review panel was made up of practitioners involved with the case alongside managers from across the partnership and met formally three times throughout the process, with additional theme specific meetings taking place in between. Contact was maintained with the respective families throughout to offer them the opportunity to contribute to the review, however this offer was not taken up.

Shared Themes: - Chronic illness (Type 1 Diabetes, renal/liver disease) - Substance misuse - Missed appointments/poor engagement - Indicators of trauma and fluctuating mental health - Risks not always identified as safeguarding concerns

3. Recommendations and Learning

- **Self-Neglect** - Treat chronic self-neglect as a safeguarding issue requiring coordinated multi-agency oversight. - Improve use of self-neglect tools and trauma-informed approaches. - Strengthen assessment of *executive capacity*.
- **Safeguarding Processes** - Chronic self-neglect should trigger safeguarding action—not only acute events. - Improve feedback to referrers and clarity around thresholds. - Staff need confidence to escalate when people refuse care.
- **Workforce & Staffing** - High caseloads impacted engagement and recognition of risk. - Ensure reflective supervision for complex, challenging cases. - Promote resilience and trauma-informed supervision.
- **Partnership Working** - Strengthen coordinated planning and shared ownership of risk. - Develop a lead professional model. - Improve real-time information sharing and MDT consistency.

4. Positive and proactive steps taken to address the recommendations so far

- Stronger safeguarding triage and oversight in ASC
- Improved cross-agency liaison and early development of lead professional model
- Enhanced NHS training on MCA, self-neglect and professional curiosity
- High level of visibility of hospital safeguarding teams
- Continued high-quality safeguarding referrals from ambulance service

'James' and 'Simons' cases highlight the need for proactive, coordinated, multi-agency responses to chronic self-neglect. Strengthened supervision, shared responsibility, trauma-informed practice and improved safeguarding pathways are essential to reducing future risk.