SAFEGUARDING ADULT REVIEW
THEMATIC REVIEW INTO THE DEATHS OF

‘James’ and ‘Simon’

‘James’ Died 27th February 2024 aged 56
‘Simon’ Died 21st March 2024 aged 48

Report author: Peter Suggett

Acknowledgements and Dedication

Members of the review panel and Telford and Wrekin Safeguarding Adult Board offer our deepest sympathy to the families and all who have been affected by the deaths of ‘Simon’ and ‘James’.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for adults with care and support needs in Telford and Wrekin.

1	**Introduction and Background**
1.1	Section 44 of the Care Act 2014 places a statutory responsibility on Safeguarding Adults Boards (SABs) to conduct a Safeguarding Adults Review (SAR) in certain circumstances. A SAB must arrange a SAR where there is reasonable cause for concern about how the SAB, its members, or another person with relevant functions worked together in a case and either: (a) the adult has died and the SAB knows or suspects that the death resulted from abuse or neglect; or (b) the adult is alive, and the SAB knows or suspects they have experienced serious abuse or neglect.
1.2	**Case summaries**
1.3	**''James''** had multiple long-term conditions (including asthma, hypertension, renal disease and hepatitis C), a long history of self-harm and illegal substance misuse and recorded mental health diagnoses (anxiety, depression and personality disorder). His behaviour towards staff was at times aggressive, necessitating security support during inpatient hospital care.
1.4	**''Simon''** had Type 1 diabetes and a history of illegal intravenous drug use. He was prescribed methadone, was recorded as being poor at managing his insulin and had a poor diet. Police records suggest that he was possibly being exploited, or was involved in the supply of controlled drugs. In the later part of his life a male known as “Matthew” was recorded as his carer, though the nature of their relationship is unclear.
1.5	Both deaths appear to have been associated with self-neglect, compounded by complex physical and mental health needs. The SAR Panel agreed the Care Act criteria were met, specifically concerns that procedures may have failed and that the cases raise serious questions about how local services worked together to safeguard adults at risk.
1.6	The Telford and Wrekin Safeguarding Adults Board commissioned a thematic SAR into the deaths of two men with comparable health and mental health presentations and the theme of self-neglect The SAR Panel therefore determined that learning would be strengthened by a single thematic review rather than two separate reports.

2	**The purpose of the review**
2.1	The purpose of the review is to identify learning that can strengthen multi-agency safeguarding practice and improve outcomes for adults who experience similar risks. It aims to provide a balanced, reflective account of what worked well, what could have been done differently, and how agencies have responded to learning since the incidents. The Board agreed that a thematic approach would provide the best insight into systemic learning about self-neglect and multi-agency safeguarding processes.
2.2	The review sought to explore the following key questions: • Establish what lessons can be learned from the circumstances of the case • Review the effectiveness of the procedures and processes of the agencies involved • Analyse how organisations work together • Analyse and expand upon the findings of the various reports • Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes or policy • Facilitate a practitioner's event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented
2.3	**Scope and key questions**
2.4	This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of both men whilst they were receiving treatment in the weeks and months prior to their deaths.
2.5	The timeframe of the review covered the final twelve months of involvement for each adult, while also considering relevant historical information outside of this timeframe to provide context. The review has been undertaken with a focus on promoting a culture of transparency and shared learning across the partnership, rather than attributing blame.
2.6	It asks: Were their human stories understood? How do services respond when people resist care and support? Did previous trauma influence the decision-making of professional?
2.7	The review also considers whether there are gaps in local service provision highlighted by these cases.

2.8	**Evidence base**
2.9	Partner reports were received from each of the organisations involved, a template was provided which included the following details: • Full chronology • A narrative of service involvement commencing 12 months prior to the deaths of both men. • A description of the specific service provided to both subjects between those dates. • Any significant factors which impacted upon the actions or decisions taken. • An evaluation of how services were delivered to both men. • Lessons learned including a judgement of the level of service received when compared against policy, procedure and practice standard. • Recommendations for action.
3	Methodology and process information
3.1	The author was appointed to undertake the SAR in August 2024.
3.2	The review adopted a blended approach involving face to face meetings with safeguarding leads and managers, individual management reports, chronologies, and a practitioner learning event hosted by the SAR author. Agencies also contributed detailed reports and shared evidence of practice and service improvements since the incidents.
3.3	The practitioner learning event provided a valuable opportunity for professionals from across health, social care, and emergency services to reflect openly on the themes emerging from both cases. The session emphasised a learning culture focused on improvement rather than criticism, and the insights gained have been incorporated into this report.
3.4	Combined chronologies were supplied to the author which had been completed by the agencies involved: • Adult Social Care (ASC) • West Midlands Ambulance Service (WMAS) • Shrewsbury and Telford Hospital NHS Trust (SaTH) • Midlands Partnership University NHS Foundation Trust (MPFT) • West Mercia Police • Shropshire Community Health NHS Trust (SCHT)

	• General Practice (GP)
3.5	**Family Involvement**
3.6	A key element of any SAR is hearing the views of the family about their perception of how their loved one was treated. As such the author sent a letter to both families asking if they wished to participate in the review. At the time of writing this report no response had been received from either family. However, should the families change their minds at any time representatives from the Safeguarding Adult Board will be pleased to meet with them.
3.7	**Thematic Focus**
3.8	Following the initial review of all the information, a number of themes were identified that the author considered were key elements of the care both men received prior to their deaths. These fell into the following categories: • Self-neglect. • Safeguarding processes. • Workload / staffing. • Partnership working
3.9	In order to better understand how the services involved were staffed and organised, the author undertook face to face meetings with managers from each of the organisations. These included the Nurse specialist, Safeguarding Adults for Shropshire Community Health Trust (SCHT), Shrewsbury and Telford Hospitals NHS Trust (SaTH) and the Safeguarding Lead for Telford and Wrekin Adult Social Care (ASC).
3.10	**Practitioner Learning Event**
3.11	A practitioner learning event was held on 17th September 2025. This event involved both front line practitioners and management staff and was facilitated by the report author. In order to allow the maximum number of staff to participate it was run via Microsoft Teams.
3.12	It was made clear at the outset of the learning event that it was to be conducted in an environment where staff would feel free to express themselves, without fear of being blamed for any apparent failings. The intention was to learn from the circumstances of the men's treatment in order to identify those elements that worked well and highlight areas that required further improvement.

3.13	The combined chronology and an explanatory letter were circulated to all participants prior to the event so that everyone was clear about the aims and objectives.
3.14	The event involved a summary of the timeline of events leading up to the deaths of both men, followed by a series of questions which the participants were asked to comment upon relating to the four themes previously identified.
3.15	Delegates were asked to consider the circumstances of the care and treatment of both men and, when thinking about a particular category, consider: • What went well? • Even better if … • How to improve learning
3.16	There was excellent participation from all partners during the session, and several key issues were highlighted and discussed. These are described in more detail within the body of this report.
4	**Short timelines and contact volumes**
4.1	**'James'**
4.2	'James' was in his fifties and had multiple long-term conditions including Type 1 Diabetes Mellitus, end-stage renal disease, chronic liver disease, and hepatitis C infection. He also had a history of self-harm, drug dependence, and diagnosed mental ill health. 'James' lifestyle, refusal of treatment, and erratic engagement with professionals contributed to deteriorating health and self-neglect. Although capacity was considered, professionals often worked around his choices rather than collectively assessing the cumulative risk.
4.3	His interactions with professionals were often challenging, as he exhibited abusive behaviour and used racist language toward staff, which was reported to the police. When admitted to the hospital, ward staff proactively addressed safety concerns by ensuring security personnel were present on the ward. Despite 'James' aggression, staff remained professional and continued to provide care.
4.4	**'James' – summary chronology**[1]

[1] The chronologies within this report details contact between both men and professionals in the 12 months immediately prior to their deaths. More detailed chronologies detailing contact for a number of years are appended at Annex A

4.5	• Feb–Mar 2023: Liaison between SCHT Diabetes Service, Renal Unit and GP about mental capacity, insulin and discharge. Refusal by 'James' of community input at points; ASC involved post-discharge; Multi-Disciplinary Team (MDT) meeting convened.
4.6	• May–Jul 2023: Repeated WMAS attendances for missed dialysis, falls and hypoglycaemia; SaTH admissions for infection, Diabetic Ketoacidosis (DKA)[2] and toe amputation; MPFT MHLT reviews noted hostility and capacity present; ASC coordinating discharge options.
4.7	• Aug–Sep 2023: Self-neglect indicators escalate. Multiple WMAS calls, Emergency Department (ED) attendances and ASC safeguarding contacts; Police logs for abusive behaviour to staff. District Nurse (DN) input disrupted due to safety concerns and access.
4.8	• Oct 2023–Jan 2024: Major admission to Intensive Care Unit (ICU) for DKA; prolonged inpatient spell until Jan. Post-discharge: DN and carers arranged; repeated WMAS call-outs; ongoing ED returns; continued safeguarding concerns and MDTs.
4.9	• Feb 2024: Further ED admissions for DKA; tissue viability service involvement (grade 3–4 wounds).
4.10	• Late Feb 2024: Refused to remain in hospital; 27/02/2024 found collapsed at home and died.
4.11	

Agency	Approx. number of contacts*
WMAS (Ambulance)	30
SCHT (Community/DN/Diabetes)	27
GP (incl. SAS/Pharmacy)	15
Adult Social Care (ASC)	15
SaTH (ED/wards/admissions)	10
Police	4
MPFT (MHLT)	4
Podiatry/Foot clinic	2

4.12	**'Simon'**
4.13	'Simon' was in his forties and lived intermittently with his mother and a friend. He had Type 1 Diabetes Mellitus, visual impairment, and a history of intravenous drug use. He was prescribed methadone and struggled with diet,

[2] Diabetic Ketoacidosis (DKA) is a serious condition that can happen to people with diabetes. A lack of insulin causes harmful substances called ketones to build up in the blood which can be life threatening and requires urgent treatment in hospital.

	medication compliance, and wound care. His self-neglect was compounded by substance misuse and potential exploitation by others. Agencies were aware of his vulnerabilities but did not always recognise his deteriorating diabetes management and disengagement as safeguarding concerns.
4.14	**'Simon' – summary chronology**
4.15	• 2022–mid-2023: ASC referral for adaptations post-amputation. MPFT STARS involvement; variable attendance.
4.16	• Aug–Oct 2023: Surgical admission (SaTH) for diabetic foot infection and toe amputation; SCHT DN engaged for ongoing dressings; multiple clinic follow-ups; several DN visits missed owing to 'Simon' not answering the door, not present at address and not responding to his phone; one ED presentation for hyperglycaemia.
4.17	• Nov–Dec 2023: GP reviews for worsening foot/mental health; urgent WMAS conveyance; further toe amputation; discharge with DN follow-up; recurrent hypoglycaemia incl. seizure at home; ED attendance; DN flag low mood/anxiety; GP adjusts medication; MPFT recovery input variable.
4.18	• Jan–Feb 2024: Ongoing DN work; missed STARS sessions; Diabetes clinic/orthotics follow-up; friction with treatment team; STARS case closure initiated.
4.19	• Mar 2024: Neighbour alerts Police to insecure address; 'Simon' found bedbound. WMAS conveyance to hospital with hypothermia and severe hyperglycaemia.
4.20	• 14/03/2024: ED to ITU with critical illness; death recorded as being 21st March 2024.
4.21	

Agency	Approx. number of contacts*
District Nursing / SCHT (incl. TVN/Diabetes community)	50
MPFT (STARS/recovery)	18
SaTH (ED/clinics/admissions)	10
GP	7
WMAS (Ambulance)	5
Police	2

	[3]

[3] Note on contacts: figures are approximate and derived from dated entries in the supplied chronologies. Multiple actions on the same dated entry are counted as one contact for that agency unless clearly stated otherwise.
More detailed chronologies can be found at appendix A.

5	**Key Themes and Analysis**
5.1	The thematic review identified four key areas of learning emerging from both 'James' and 'Simons' cases: Self-Neglect, Safeguarding Processes, Workload and Staffing, and Partnership Working. These are discussed below.
5.2	**Self-Neglect**
5.3	Both 'James' and 'Simon' experienced long-term, well - established self-neglect, closely linked to physical ill health, substance misuse, and psychological distress. In both cases, professionals recognised capacity but struggled to balance respect for autonomy with the duty to protect from serious harm.
5.4	Systems and processes were in place for supervision and clinical oversight, however if staff working with 'James' and 'Simon' did not recognise the warning signs around self-neglect, then they may not necessarily escalate concerns or recognise the need for supervision. [It is understood that since this time the service has improved handovers to allow for a better understanding and conversation around safeguarding issues.]
5.5	At what point do professionals consider if there are legal and ethical grounds apparent to over-ride a patient's refusal to be treated? This can be a difficult question to answer, which is why the system of supervision and support is so important to provide reassurance to staff and to ensure that action is taken which is in the best interest of the patient.
5.6	There are entries relating to 'James' that indicate that he had previously suffered trauma, the exact details of which are not recorded. There is no mention within the notes supplied of any professional identifying that they were taking a 'trauma informed approach' towards helping and supporting either man.
5.7	There are a number of sources of information available to professionals on the topic of trauma and the impact it has on individuals. As part of the research for this review, the author accessed online information available via E-Learning for Healthcare which is an NHS England resource.
5.8	The E Learning package states; *"Trauma-informed practice is an approach which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development, thus shaping a person's worldview and relationship development"*

5.9	Vulnerability is complex and multifaceted and can impact the individual in several ways. Some of those impacts can be: • poorer mental and physical health outcomes • isolation and loneliness • more likely not to be in education, employment or training • more likely to live in poverty and experience developmental delays • more likely to have communication difficulties • housing; poor respiratory and mental health
5.10	The guidance goes on to state that *"Trauma-informed practice aims to create safety for people accessing services by understanding the effects of trauma and its close links to health and behaviour.* *It is not about eliciting or treating people's trauma but about creating a safe space that enables people to access the services they need for their health and wellbeing.* *By adopting this approach with everyone accessing health and care services, professionals will enhance access for all and most notably for those who may find it more difficult to get the support they need."*
5.11	Easy access to information and assessment tools (self-neglect toolkit) is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them maintain their professional knowledge and understanding of complex safeguarding issues. However, the questions that arise from this are; how many of the staff involved with 'James' and 'Simon' know where to find this information? If staffing levels are very low do they have time to access and learn the information?
5.12	While the Mental Capacity Act (MCA) was referenced, there was inconsistent application across agencies. Capacity assessments tended to focus on specific decisions. However, there was no evidence of the consideration of executive capacity – the ability to give effect to decisions by taking actual steps to execute a decision in a planned way. Or put more plainly giving the appearance of being able to decide for themselves when in fact they were unable[4]. The analysis within the second national review of SARs emphasised that when considering executive capacity this may require observed decision making to establish how able the person is to apply what they have decided[5]. Both men

[4] Practical legal guidelines. https://capacityguide.org.uk/practical-legal-guidelines/. Owen and Ruck Keene et al
[5] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023. Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023

	frequently declined support or treatment, but these refusals were not always revisited in light of new evidence of deterioration.
5.13	It is worth highlighting the significant challenge presented in conducting capacity assessments with 'James', as engagement frequently occurred during crisis situations. It was observed that 'James''s behaviour was at times discriminatory and particularly challenging towards younger female staff members from diverse backgrounds within the health system. Despite these difficulties, care continued to be provided in accordance with professional standards and safeguarding principles.
5.14	In both cases, practitioners expressed uncertainty about thresholds for referral under self-neglect procedures. There was a shared perception that self-neglect was often normalised, particularly when linked to substance misuse or long-term disengagement. The absence of a clear, unified self-neglect policy contributed to variability in professional decision-making.
5.15	For 'James', repeated hospital admissions for diabetic ketoacidosis and infection provided opportunities to reappraise risk. For 'Simon', deteriorating diabetes management, repeated hypoglycaemic episodes, and poor diet were not interpreted as indicators of self-neglect.
5.16	*Learning point*: Practitioners should view self-neglect as a variety of behaviours requiring active coordination rather than something that can be managed by a series of single-agency interventions. Executive capacity should be recorded, and risk should be reviewed across time.
5.17	*Positive practice*: Both ASC and NHS partners have since strengthened training on self-neglect and capacity, embedding reflective discussion into supervision and practice forums.
5.18	**Safeguarding Processes**
5.19	Clearly both men had complex needs. In addition, there seems to be clear evidence to suggest that their physical decline was in part due to the fact that they are in the throes of prolonged substance misuse. Did this level of substance misuse result in any form of mental impairment which may have impacted upon their ability to make decisions?
5.20	There is nothing within the material supplied to the author to suggest that this was the case, but there were also occasions where both men refused treatment (admission at A&E), when clearly there was a need for treatment.
5.21	Perhaps then the issue to be addressed should be; if the system of assessment, referrals and interventions is acceptable for most patients, what

	should be done when professionals are faced with a case that is particularly challenging and falls outside the realms of what might be considered to be 'usual'?
5.22	The Mental Capacity Act (MCA) code of practice states '*it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made'*. The codes of practice go on to describe that someone's '*behaviour or circumstances may cause doubt as to whether they have the capacity to make a decision'*. A MCA assessment can therefore help to guide the professional in determining if further support is required from a mental health specialist, multidisciplinary panel or even from a family member. Even if the person is assessed to have capacity, consideration should be given regarding self-neglect and the impact to the person of not adhering to advice about care and treatment and this should be explored with the person. Again, this pattern of behaviour is highlighted and referenced within the second national SAR analysis as refusing care or treatment can lead to catastrophic outcomes.
5.23	For reference the author examined the NICE guidelines regarding mental capacity, which provide a clear pathway of assessment. In addition, there is clear guidance that this should be an on-going process. There is also additional guidance where it is recognised that a patient may be suffering from delirium.
5.24	The practitioner learning event revealed differing confidence levels in making safeguarding referrals for adults who are aggressive or resistant to care including consideration about self-neglect. Hospital staff reported that while safeguarding leads were accessible and supportive, incident reporting was not always prioritised due to workload. Practitioners recognised the importance of professional curiosity but highlighted challenges in sustaining it amid service pressures.
5.25	'James' was subject to multiple safeguarding referrals, mainly from the ambulance service, while 'Simon' had no formal referrals despite repeated crises. In both cases, staff were uncertain about thresholds for Section 42 enquiries and how to escalate chronic self-neglect in the absence of an acute incident.
5.26	Safeguarding processes functioned in principle but were inconsistently applied. While referrals were appropriately initiated, follow-up actions varied. ASC maintained oversight and coordination, yet carers' assessments were not consistently considered. Hospital teams reported time pressures and competing demands reducing safeguarding visibility. The practitioner learning event highlighted that staff confidence in managing disguised compliance and aggression differed across services.

5.27	The review found that safeguarding systems tended to respond reactively to events (such as hospital admission or aggressive behaviour) rather than proactively addressing patterns of risk. Information-sharing mechanisms were inconsistent, and feedback to referrers was often unclear.
5.28	Participants described effective internal escalation routes but limited inter-agency escalation, particularly when adults repeatedly refused support. Safeguarding was viewed as episodic rather than continuous, with lessons suggesting that cases such as 'James''s and 'Simon''s require sustained multi-agency safeguarding oversight rather than reactive intervention to isolated incidents.
5.29	In both cases, substance misuse was not consistently treated as a safeguarding concern, and the interface between adult safeguarding and drug and alcohol services lacked structure.
5.30	*Learning point*: Safeguarding procedures must explicitly include pathways for chronic self-neglect and substance misuse, ensuring proportional but assertive multi-agency action.
5.31	I*mprovement*: ASC has since introduced a duty safeguarding worker and strengthened triage arrangements to ensure consistent oversight and feedback to partner agencies.
5.32	**Workload and Staffing**
5.33	When staff are working under pressure and there is a lack of consistency due to staffing challenges, this may impact their ability to see the wider picture and identify issues such as self-neglect.
5.34	A lack of consistency will undoubtedly impact upon the quality of the outcomes. Staff who form a relationship with patients/clients over a period of time are better placed to assess their wellbeing than those who are backfilling vacancies or are agency or bank staff.
5.35	The level of supervision and support given to staff should be commensurate with the type of work being undertaken when considered against the experience and quality of the staff involved.
5.36	Both cases were managed within high-pressure operational contexts. Front-line practitioners reported large caseloads and competing priorities, limiting the time available for complex, relationship-based work. District nursing teams, in particular, experienced reduced capacity to make home visits, which affected continuity of care.

5.37	Despite these pressures, there was evidence of committed and compassionate practice. Staff from the ambulance service, GP, and hospital teams demonstrated persistence in engaging with both men and ensuring clinical needs were met.
5.38	'James' was largely dealt with by the Special Allocation Scheme. This is an NHS scheme designed to provide primary medical care services for patients who have been removed from their regular GP list due to actual or threatened physical or verbal abuse towards staff or other patients.
5.39	All patients have freedom of choice to refuse treatment or services, but there will inevitably be a point where those rights are overridden in the patient's best interest. Given their complex health needs, attitude and behaviour and documented weight loss, it seems clear that these were cases where self-neglect was evident, and professionals had a duty to intervene in the best interests of 'James' and 'Simon'.
5.40	*Learning point*: Structured reflective supervision and multi-agency case discussions are essential for practitioners managing chronic self-neglect. This supports emotional resilience and helps prevent desensitisation to risk.
5.41	*Positive practice*: Partner agencies have since introduced supervision frameworks and safeguarding link roles to promote consistency and learning.
5.42	**Partnership Working**
5.43	What became apparent during this review is the fact that there is no single department that co-ordinates this system of multi-agency working. Primary care (GP) appears to have taken the lead in coordinating this activity. The system appears to be reliant upon staff passing on referrals to the right community service, who then implement their activity. If this is not done correctly there is the risk that the community service is unaware that they need to provide care/support to a patient within their area. This can lead to vulnerable patients lacking the necessary support.
5.43	Both men were known to multiple agencies over extended periods, yet inter-agency coordination was fragmented. Communication between hospital teams, community services, and safeguarding professionals often relied on informal channels rather than structured planning. This meant opportunities for joint action were sometimes missed.
5.45	Partnership working between agencies was generally strong, underpinned by good personal relationships and information exchange through MDTs. However, the lack of shared digital systems hindered efficiency. Practitioners reported duplication of effort and delays in accessing key information. Both

	cases showed instances where goodwill and persistence compensated for systemic fragmentation.
5.46	The learning event endorsed the development of a multi-agency assertive outreach model, ensuring responsibility for engagement does not fall disproportionately on individual workers. Participants emphasised that partnership should move from ad hoc collaboration to formalised shared accountability.
5.47	In both cases, drug and alcohol misuse was acknowledged but not addressed through a coordinated care plan. Drugs and Alcohol Liaison Team (DALT) involvement was inconsistent, and there was limited liaison between hospital safeguarding teams, GPs, and community drug services.
5.48	Multi-Disciplinary Team (MDT) meetings were held, but they tended to focus on immediate discharge or crisis management rather than sustained risk planning. The absence of a clearly identified lead professional resulted in a diffusion of responsibility across agencies.
5.49	A specialist Single Point of Contact team could be created to co-ordinate this activity, however it is accepted that this would be very difficult to arrange and ultimately constrained by budgetary considerations.
5.50	*Learning point:* Partnership working must move beyond information exchange to shared ownership of risk, with one agency assuming clear coordination responsibility.
5.51	*Positive practice:* Since these incidents, local partners have enhanced cross-agency liaison arrangements and are developing a ‘lead professional’ model for complex self-neglect cases.
6	**Learning and Good Practice**
6.1	The practitioner learning event provided valuable insight to the author regarding the working practices of the teams involved in this review. Participants highlighted that while policy frameworks were sound, operational reality was shaped by workload, staff turnover, and risk tolerance. Self-neglect was frequently under-recognised until crises emerged. Staff described difficulty distinguishing between unwise decisions and neglect where capacity fluctuated, particularly with diabetes- related conditions.
6.2	Participants expressed pride in the quality of local partnership working, describing communication as generally strong despite structural barriers. However, the event also exposed a reliance on individual effort and the goodwill of practitioners. Discussion within the event reaffirmed the importance

	of professional curiosity, trauma-informed approaches, and confidence in escalation when faced with challenging patients with complex needs.
6.3	Across both cases, professionals demonstrated commitment, empathy, and a desire to engage despite challenging circumstances. Examples of good practice included: • Consistent involvement of named social workers who maintained engagement despite resistance. • Use of MCA principles in acute care, particularly during 'Simon''s hospital admissions, ensuring treatment in his best interests. • Safeguarding champions within the ambulance service promoting awareness and good-quality referrals. • Good interaction between 'James' and the Special Allocation Scheme which ensured that he remained engaged with professionals despite displaying challenging behaviour. • Multi-agency discussions that recognised the complexity of substance misuse, trauma, and self-neglect. • Improved hospital safeguarding visibility, staff training, and use of 'Think capacity' initiatives.
6.4	These examples reflect individual and organisational commitment to safeguarding adults with complex needs and should be built upon through continued system learning
7	**Conclusions**
7.1	The review concludes that 'James' and 'Simons' cases illustrate systemic challenges in recognising and responding to self-neglect where mental capacity is present, but decision-making is impaired by addiction, trauma, or deteriorating health.
7.2	Both men had extensive agency involvement, but their complex needs were managed sporadically rather than through coordinated, sustained intervention. Risk was compartmentalised, and professional focus tended to rest on physical health management rather than holistic safeguarding.
7.3	Key issues include inconsistent application of the MCA, under-recognition of self-neglect, variable safeguarding thresholds, and limited inter-agency

	coordination. These findings are consistent with national learning from other thematic reviews on self-neglect and multiple exclusion.
7.4	Both men were known, visible and supported, yet their risks remained high. Key findings include: • Self-neglect compounded by substance misuse and mental illness remains a complex, multi-dimensional risk requiring sustained coordination. • Workload and staff capacity pressures constrain proactive engagement and reflective practice. • Professionals may hesitate to intervene and instead respect the individual's right to make their own decisions, even when the situation is becoming more dangerous. • Fragmented IT systems continue to obstruct real-time inter-agency information sharing. • Safeguarding oversight tends to be episodic, limiting continuity in high-risk cases. • Emotional fatigue and risk desensitisation can reduce curiosity and persistence in long-term cases.
7.5	The review found that the deaths were due to a number of complicated factors including substance misuse, poorly managed chronic illness and self-neglect. While agencies worked diligently, the current systems make it difficult to consistently intervene when adults refuse help. To improve future outcomes, it is essential to implement reflective supervision, consistent escalation, and shared pathways for addressing self-neglect.
7.6	While agencies demonstrated compassion and engagement, responses were often fragmented and reactive. Improvements in training, safeguarding triage, and multi-agency coordination since these events provide reassurance that learning has been embedded. Ongoing focus is required to sustain reflective practice, strengthen confidence in escalation, and enhance information sharing.
8	**Recommendations**
8.1	**Theme 1 Self Neglect**
8.2	• Reinforce the consistent application of the regional self-neglect policy across all agencies as part of staff Continual Professional Development (CPD), with emphasis on coordinated planning for individuals at chronic risk.

	• Emphasise the importance of Mental Capacity Act (MCA) assessments when dealing with patients suffering from chronic self-neglect and substance misuse. Highlight the escalation policies and the availability of online toolkits (self-neglect, non-engagement) and other resources to assist the risk management process.
8.3	**Theme 2 Safeguarding Processes**
8.4	• Strengthen safeguarding referral pathways to ensure all agencies understand thresholds and that chronic self-neglect triggers proportionate multi-agency response. Emphasis should be given to the importance of accurately recording the decision-making process within records in order to better understand the risk management rational. • Implement a feedback arrangement for referrers to confirm actions and outcomes of safeguarding enquiries.
8.5	**Theme 3 Workload and Staffing**
8.6	• Ensure staff managing high-risk self-neglect cases have access to regular reflective supervision and peer support. • Monitor capacity and workload pressures within community health and social care teams to support sustained engagement. Particular attention should be given to the complexity of the professional's cases as this can impact upon working pressures. • Promote trauma-informed supervision and resilience training for practitioners working with resistant and aggressive patients.
8.7	**Theme 4 Partnership Working**
8.8	• Develop and embed a 'lead professional' model to coordinate complex self-neglect cases and ensure shared accountability. • Formalise MDT planning between relevant services for adults with chronic self-neglect. Highlight the importance of professionals attending key meetings for joint investigations when risk factors overlap. • Review information-sharing protocols to support real-time communication between safeguarding, health, and criminal justice partners. This should include a review of digital interoperability across agencies to establish if improvements can be made to enhance information sharing.