# THREE HUMAN STORIES

Learning for Systemic Change

DECEMBER 1, 2025

CAMBRIDGESHIRE AND PETERBOROUGH SAFEGUARDING ADULTS BOARD
Thematic review prepared by Professor Michael Preston-Shoot

## Introduction

1.1. This safeguarding adults review was originally commissioned to learn lessons from the human story of Daniel, both about positive practice and where improvements could be made to practice, the management of practice, how agencies work together, and policies or procedures. Subsequently, Cambridgeshire and Peterborough Safeguarding Adults Board (CPSAB) requested the addition of two further human stories, those of Sarah and Marcin, since there appeared to be similar as well as contrasting themes.

1.2. This report will initially present the learning from Daniel's human story before comparing and contrasting this learning with that from Sarah and Marcin's human stories. A similar process has been followed in order to identify the learning, namely the receipt of scoping documentation from the agencies/services involved following referral for a safeguarding adults review, followed by two learning events – one that considered Daniel's human story in detail and a second that focused on Sarah and Marcin. The participants in both learning events were invited to consider the parallels between all three human stories. They were also asked to reflect on what had been learned and what has yet to change following three earlier reviews completed by CPSAB, namely SAR Arthur (2018), SAR Peter (2020) and SAR Dorothy (2021), all of which have been published and which were thought to have highlighted similar themes.

1.3. The scoping documentation from agencies for Daniel covered the period January 2023 to June 2024, with references to earlier events when these were thought to be significant. The scoping documentation for Sarah mainly covered the final month of her life but some information was provided about support provided in response to her alcohol-dependence in 2019. There were also references to adverse experiences (domestic abuse) in 2011 and 2012. The scoping documentation for Marcin mainly covered the period 2023 to May 2024, with some references to his involvement with services from 2015.

1.4. Daniel's relatives were invited to contribute to this review and his step-mother has contributed to this review, supported by her husband, Daniel's father. Their contributions are embedded in this report. It has not been possible to identify any relatives and/or friends who could help our understanding of Marcin's human story. It has been possible, however, to engage with two of Sarah's relatives whose contributions are embedded in this report. Daniel's relatives and Sarah's relatives have utilised the local authority's complaints procedures and relevant information from these processes has been included in this report.

1.5. CPSAB determined that the mandatory criteria for a safeguarding adults review had been met with respect to Daniel's human story, namely that he had care and support needs, had died as a result of abuse/neglect (which includes self-neglect) and that concerns exist about how services worked together and with Daniel (Section 44(1) (2) (3), Care Act 2014). A similar decision was reached in respect of both Sarah and Marcin's human stories.

1.6. Key lines of enquiry were agreed for the review of Daniel's human story, namely:

- What can this case and past SARs tell us about barriers and enablers to managing individuals presenting with medical/mental health self-neglect?
- What can we learn from this case and past SARs about what makes it harder or easier to apply collective risk management approaches at MDT meetings, with a focus on understanding why we often work in isolation of each other?
- What can we understand from this case about individuals who have complex mental and physical health needs, are homeless and subject to frequent moves?
- What can this case and past SARs tell us about what is working well with a focus on strengths and success of implementing past SAR recommendations. What can make application of learning in practice easier?

1.7. These key lines of enquiry have also been used as a focus for learning from Sarah and Marcin's human stories. In addition, to structure the enquiry into all three human stories, a domain analysis will be used, namely direct practice, inter-agency working, organisational support for practice, governance, and the national context. This has been used previously to facilitate analysis of safeguarding adult reviews nationally[1] and of human stories featuring self-neglect and homelessness specifically[2].

1.8. Both Daniel's family and Sarah's family have asked that their given names be used in this report.

## Daniel

2.1. Daniel died, aged 29, in July 2024. He was White British. The cause of death has been certified as multi-focal brain acute infarct, with type 1 diabetes mellitus, hyperthyroidism and antiphospholipid symptoms. He had no permanent address, experiencing eight moves in the final eighteen months of his life. He was deemed to be intentionally homeless[3]. He used a wheelchair. He had care and support needs, focusing on meal preparation, shopping, personal care and maintaining and managing his home environment. He had been insulin dependent from childhood, the age of two according to his family, and was non-concordant or non-compliant, one outcome of which were amputations in 2023 and 2024[4]. The need for acute treatment for uncontrolled diabetes is one feature of his human story. He was known to use illegal drugs. His family describe Daniel as "getting in with the wrong crowd" and "not getting treatment" when there were problems with his skin integrity due to non-compliance with medications for his diabetes.

2.2. Daniel's step-mother described him as "loving, caring, funny and joking." He had initially lived with his mother but came to live with his father and step-mother full-time because of neglect, particularly of his nutrition in connection with his diabetes. Initially he had been "perfect", with

[1] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. (2024) *Second national analysis of safeguarding adult reviews: April 2019 – March 2023*. London: Local Government Association and ADASS.
[2] Preston-Shoot, M. (2019) "Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice." *Journal of Adult Protection*, 21(4), 219-234.
[3] Housing Act 1996. See also reference 10 below.
[4] Above his right knee and also two fingers.

his diabetes well controlled, but during his adolescent years he had increasingly rebelled , telling lies and misusing drugs. Although "nothing was ever diagnosed", his father and step-mother believe that he might have had a learning disability and/or a mental health condition. "He had his own rules." His family have also referred to Daniel having "three auto-immune diseases" and being "unable to look after himself."

2.3. Records reference an allegation of domestic assault in 2019 but his then partner did not pursue this with the police. It appears that he was prohibited from living with his father and step-mother who from 2021 held special guardianship for his child. This might have followed his hospital attendance for an intentional overdose, resulting in his child being seen as at risk. Suicidal ideation and mental health hospital admissions are features in his human story, with references to depression, self-harm, overdosing and feeling "*very low*."

2.4. Information gleaned from the SAR referral and from the learning event included references to Daniel experiencing a difficult childhood, with suggestions of neglect following parental separation. "*His needs were not met from a young age*." His mother died when Daniel was sixteen. He had been diagnosed as having Type 1 diabetes at the age of two. His relatives have suggested, when advocating and supporting Daniel, that it was after his mother's death that he began to self-neglect and that, when alive, she did not encourage concordance with advice and treatment regarding his diabetes. **Commentary**: the early onset of self-neglect has been identified in other human stories[5]. Information from Daniel's family has provided clarification of timelines and some correction to agency records, for example of when Daniel's mother died.

## Domain Analysis - Direct Practice

3.1. One core component in this domain is relationship-based practice that includes professional curiosity and exploration of non-engagement and non-concordance. The referral from Adult Social Care (ASC) for this safeguarding adult review includes concern that Daniel did not prioritise his health, taking risky decisions regarding his diabetes. For example, he did not respond when ASC attempted to contact him in February 2021 by text and telephone on receipt of a referral that he was not managing his diabetes correctly. **Commentary**: outreach through attempts at face-to-face contact might have been appropriate. Safeguarding adult reviews and research[6] frequently identify an assumption that individuals are unwilling, as opposed to being unable, to engage.

3.2. The chronologies within the scoping documentation provided by the services involved with Daniel frequently refer to non-engagement and to his refusal of support. For example, he declined a hospital admission in November 2023 when there were concerns about the impact on his health and wellbeing of uncontrolled diabetes. In January 2024 he declined care and support offered by ASC except for help to secure accommodation and he also declined input from a

[5] See, for example, Keith's story, available on YouTube.
[6] Braye, S., Orr, D. and Preston-Shoot, M. (2011) *Self-neglect and Adult Safeguarding: Findings from Research*. London: Social Care Institute for Excellence.

dietician and repairs to his wheelchair, the latter due to cost. In May 2024 he refused care and support when resident temporarily in a hotel. There are frequent references to non-compliance with medication, to refusal of medical treatment and to not attending outpatient appointments. In March 2024 he self-discharged against medical advice after he had been transported by ambulance to hospital following a seizure. **Commentary**: given that Daniel was known to feel lethargic in a context of his uncontrolled diabetes, this reinforces the importance of considering whether non-attendance was the result of unwillingness or inability.

3.3. The scoping documentation records that his refusals of support in January 2024 were because he was awaiting permanent accommodation, and that he was open to support with activities of daily living once he had a permanent home. Seeking to answer the question "*why?*" was one focus at the learning event. Those who knew Daniel well and who advocated for him clearly did understand his feelings and desired outcomes through the expression of professional curiosity and compassionate enquiry. Thus, it emerged that his priority was to secure permanent accommodation, to have "*somewhere stable*." Moreover, "*he did not like needl*es." He explained, when diabetic management was discussed with him, that his fingers were so tough that it was difficult to get blood, and that he felt that he had "*lived with this*" all his life. Indeed, alternatives to needles as part of diabetic care were discussed with Daniel. An insulin pump was suggested but because his concordance was so poor, this was not pursued. He explained that his refusal of insulin in hospital was because it "*stung*." Blood sugar monitoring patches have been referenced in records. It has been suggested that there were perhaps missed opportunities to discuss with Daniel why he was declining supportive options regarding diabetes management, which would not have required such an active role, despite the likely benefits.

3.4. Daniel's family have offered their perspective on diabetic management. They have stated that Daniel had become allergic to the insulin that he was being prescribed and that staff had been told this by Daniel, his family and his community psychiatric nurse. They believe that he was refused an alternative.

3.5. Again, one written contribution has observed that "*from what was recorded Daniel felt that a lot of the treatments were pointless (for example, a reference to dressings falling off within hours of district nurses changing them) and wanting to let his 'body do its own thing'*." However, the same written contribution also observes shortcomings, as follows: "*there were references to Daniel having suicidal ideation but no exploration as to whether his self-neglect was an intended plan to bring about the end of his life. Unfortunately, there does not seem to have been an engagement around alternatives (for example, going back to the nurses to report the dressing concerns and seeing if something else would work better), discussion about the benefits of changing dressings even if they didn't stay on, and what was his plan for improving his health if he wasn't going to accept what was on offer.*"

3.6. One positive feature of practice with Daniel was the consistent relationship offered in particular by a community psychiatric nurse. This relationship was mentioned positively by Daniel's step-mother and father. "They knew how to talk to Daniel to get a response" and "they were the only one who could communicate with him." They would ask him about his priorities and what he wanted them to say to his family and to other practitioners. From records and at the first

learning event, they were able to develop a relationship "*based on mutual respect and trust*" through which they could "*challenge and explore*" when "*it was the right time when things were not unstable*." **Commentary**: the continuity provided by this mental health practitioner, even when Daniel moved across service boundaries, was exemplary. As acknowledged by others who attended the learning event, they were a "fantastic advocate" for Daniel, striving for his voice to be heard. Also noteworthy was one general practice that also retained Daniel as a patient when he moved outside their catchment area, and a district council that extended his temporary accommodation on several occasions.

3.7. Daniel's family have also mentioned positively a social worker who was involved shortly before he died in sourcing a supported living placement.

3.8. Reflecting on Daniel's human story, those who attended the learning event were very conscious of the trauma and adversities that Daniel had experienced. They acknowledged that having to recount one's human story time and again can be traumatising, and believed that people do respond if services can find the right way to engage with them. Key to this was working on what people identify as their needs and priorities, and finding someone with whom they have and/or can develop a strong relationship. Also key is understanding what trauma is, which for Daniel included the loss of his mother and his child being the subject of special guardianship order. In such instances, trauma-informed practice included "*looking back at the child in the person*." Indeed, reflecting back, his family have commented that in many respects Daniel "was mentally still a child." **Commentary**: the importance of practitioners appreciating the impact of loss and bereavement has been highlighted in other safeguarding adult reviews featuring self-neglect[7].

3.9. One obstacle to relationship-based and trauma-aware practice that was identified at the learning event was the influence of prejudicial attitudes. Some of those attending the learning event expressed the concern that Daniel's human story was yet another example where professional attitudes had created barriers to engagement – they felt "*frustrated and sad*" as a result of the stigma attached to substance-dependence and homelessness, for example in assumptions about "*lifestyle choice*" and "*not wanting to change*", and the negative judgement that people feel when encountering services.

3.10. Another core component of this domain of practice is mental capacity assessment. The referral for this safeguarding adult review observes that Daniel was reported to have mental capacity for health, welfare and finances. In November 2023 he was assessed as having decisional capacity in a context of concerns about self-neglect – an infected stump resulting in hospital admission related to non-concordance with advice regarding his diabetes following amputation above the knee. In January 2024 he was also thought to have decisional capacity when he refused to return to a hotel where he had previously been accommodated and which was thought to be more suitable for meeting his needs for equipment/adaptations.

[7] For example, Northumberland Children and Adults Safeguarding Partnership (2025) Thematic Review: Self-Neglect.

3.11. From the scoping documentation it seems that there might have been missed opportunities to assess Daniel's mental capacity, for example in November 2023 after a carer had contacted NHS 111 as Daniel was feeling lethargic but declined hospital admission, and again in February 2024 when he attended an emergency department but refused medical treatments. Referring back to the discussion of professional concerned curiosity, it is unclear from the scoping documentation whether anyone on this latter occasion asked the question "*why?*"

3.12. Two further mental capacity assessments are recorded in the scoping documentation. On 26th February 2024 he was assessed as not having capacity to refuse a cannula and blood transfusion. The following day he was assessed as having capacity to refuse medical treatment. However, a repeat mental capacity assessment was requested around 14th March but there is no record of this having taken place. The contribution to the scoping documentation from a Hospital Trust acknowledges delay in completing a mental capacity assessment. By 28th March a review by liaison psychiatry found that Daniel did not lack capacity but did identify self-harming behaviours, his history of substance misuse, his poor personal care and unkempt appearance. When he discharged himself from hospital against medical advice on 31st March, he was believed to have decisional capacity. His final admission to hospital in June 2024, where he died, was arranged in his best interests.

3.13. **Commentary**: the complexities involved in mental capacity assessment are reflected in additional information provided by services involved at the request of the independent reviewer. NHS 111 records evidence how his decision-making was supported to ring for an ambulance in June 2022 and in May 2023. In November 2023, after a carer had called NHS 111 as Daniel did not know where his glucose monitor was, and was feeling lethargic, an Out of Hours GP recorded a long discussion that culminated in Daniel deciding to wait for a home visit rather than attending hospital immediately. A subsequent home visit by an Out of Hours GP identified that Daniel had not been managing his diabetes, including not testing his blood sugar owing to his dislike of needles. When he called NHS 111 in early May 2024 because he did not have any diabetic needles, options for diabetic self-management were discussed, including using a Libre sensor instead of standard glucose monitoring. "*He also was able to decide at this time that he did not want to take his current antibiotics as they interfered with his meals, so the prescription was changed by the Out of Hours GP.*"

3.14. NHS 111 have reflected that "*there could have been an indication that he may not be fully able to make an executive decision for himself due to the impact of fluctuating blood glucose levels on his health ... there were times where he was able to weigh up and make decisions, however his fluctuating blood sugars, and his admission of a dislike of needles, may have contributed to a difficulty in executive decision making which, as a result, could seriously affect his health. It is at this point that a safeguarding referral should have been made as he potentially lacked executive functioning and was making unwise decisions around his care which would have had a significant impact on his health.*"

3.15. Additional information provided by Adult Social Care acknowledges that no mental capacity assessment appears to have been completed by ASC and none referenced in their records by any other agency. "*Daniel appeared to have understood his needs and the risks (so far as they were*

*recorded as having been mentioned) but it is not clear what exploration, if any, was done into his weighing up or using of the key information in order to inform his decision-making. He was repeatedly referenced as assumed capacitated and making unwise decisions. Whilst there were references to drug use (specifically cannabis) there was no identified exploration of how his unmanaged insulin-dependent diabetes type 1 condition with high and low blood sugar levels, low body weight (he was described as very thin), insufficient dietary intake at times (several references to having not eaten for several days), a proposed mild learning disability, or his medication (including gabapentin for pain relief) might combine to affect his executive functioning*." **Commentary**: ASC's reflections here reinforce earlier discussion about professional curiosity and highlight the importance of recording and information-sharing between services to ensure a whole system, whole person approach to meeting need and mitigating risks.

3.16. Discussion at the learning event picked up the issue of fluctuating capacity and the impact of substance misuse and of uncontrolled diabetes on Daniel's decision-making. **Commentary**: a lack of appreciation of the impact of uncontrolled diabetes on mental capacity was implicit in the recognition that a student nurse, herself diabetic, had expressed concern about Daniel's fluctuating mental capacity. The need to assess his executive functioning had also been recognised but psychologists could not assess this at the time that had been arranged because of Daniel's presenting needs at the time. It was not picked up again before Daniel died.

3.17. Daniel had overlapping needs relating to accommodation, care and support, mental wellbeing and physical health. A core component of direct practice is, therefore, <u>how these needs were assessed and met</u>.

3.18. Adult Social Care have confirmed that Daniel had two social care assessments in January and May 2024, both of which concluded that he had a range of eligible social care needs, with both progressing to a care and support plan. "*Confusingly between the two assessments was a safeguarding concern in which a multi-agency risk management meeting (MARM) was requested and the MASH practitioner relayed to the discharge planning team (social care transfer of care team) 'to advise no social care needs' following a report of an improvement in his self-care ability on the hospital ward which did not fully account for changes upon discharge in a less structured, unsupported, and non-accessible home environment*." **Commentary**: this misleading statement, based on an assessment in a hospital setting, illustrates once again the importance of assessment of activities of daily living taking place in, the individual's home setting[8]. It is also probable that Daniel had care and support needs before the first formal assessment, for instance from May 2023 as a result of the impact of his uncontrolled diabetes. It has been suggested that the focus on management of his diabetes and on Daniel's need for accommodation, might have resulted in less prominence being given to his care and support needs.

3.19. Provision of care and support was complicated by Daniel's frequent refusals, his priority being permanent accommodation, and the frequency with which he moved between temporary provision, including out of county. **Commentary**: the continuity of care provisions in the Care Act 2014 were not utilised because placements out of county were only designed to be temporary.

[8] See Leeds SAB (2020) SAR Mr B.

3.20. In relation to Daniel's physical health, the scoping documentation reports that district nurses dressed Daniel' wounds weekly and that there was good contact between teams when Daniel's moved between temporary locations. A positive Continuing Health Care checklist was completed by May 2024 but he died before the implications of this assessment could be fully considered. Meeting his healthcare needs when he was transported and/or admitted to hospital, however, was complicated by his refusal to accept treatment and, occasionally, by his behaviour. Concern has also been expressed that symptoms of a stroke might have been missed on at least one occasion with assessment again being complicated by self-discharge.

3.21. His step-mother and father also referenced this episode, observing that he had a blood clotting disorder. They and the community psychiatric nurse suspected that Daniel had suffered a stroke. According to the family no tests were done. When subsequently he was readmitted to hospital with pneumonia, following deterioration noticed by the community psychiatric nurse, Daniel's family have described that he suffered a "major stroke" and that tests revealed he had experienced an earlier stroke.

3.22. Throughout the period under review Daniel received mental health support. He was also assessed on at least one occasion when in hospital by liaison psychiatry who found that he was not experiencing acute mental illness. By contrast, Daniel was not known to the substance misuse service despite references in the scoping documentation to his use of cocaine and cannabis. He does not appear to have been referred and he would have had to consent to involvement had he been referred. Additional information provided by ASC records that there is "*no identified discussion with Daniel about whether his drug use is current or if any rehabilitation support is needed*." **Commentary**: this omission represents a lack of professional curiosity and outreach about his substance misuse; whether, for instance, it was his means of coping with mental distress and the impact of trauma[9].

3.23. Throughout the main period covered by the scoping documentation, Daniel lived in temporary accommodation. His original application for accommodation because of homelessness had been in February 2021 as a result of the judicial special guardianship order decision regarding his child. However, the housing duty owed to him had been terminated when he moved to Scotland. Meeting his housing needs was complicated. He required accessible accommodation because of his physical disabilities, necessitating several moves between different hotels. On several occasions he was evicted from hotels or supported accommodation because of drug use, which resulted in a decision that he was intentionally homeless. There were also concerns about his behaviour towards staff and other residents, and his neglect of his personal care. Living with his father and step-mother was ruled out because of the special guardianship order. **Commentary**: once again, learning is apparent about information-sharing and recording. ASC have advised that the existence of a special guardianship order has not been identified in their records; "*rather there was a discussion about Daniel being discharged to his parent's home and this was discounted as an option by him due to the stairs and, being a*

[9] See Cornwall and Isles of Scilly SAB (2023) SAR Anthony and Mary.

*wheelchair user at the time, being unable to access the toilet and bathroom facilities which were upstairs.*" Similarly, ASC records do not explain what his behaviour was that caused concern.

3.24. Despite the decision in February 2024 that Daniel was intentionally homeless, he continued to be accommodated in order to prevent him having to "sleep rough" and his application for permanent housing was reinvigorated. The original decision of intentional homelessness was upheld on 25th April 2024. He continued to be accommodated until 31st May 2024. Shortly before he died the possibility of placement in supported accommodation arose.

3.25. His step-mother and father are especially critical of the response to his accommodation needs. Pointing out that he used a wheelchair, they have commented that the living accommodation that he was offered was not adapted for his use, meaning for example that he could not use a shower, and that only one placement was really appropriate for his needs. In some settings, he was at some distance from a pharmacy and/or had no cooking facilities. They have also remarked that his behaviour resulted in evictions following a limited number of warnings unlike the tolerance shown to other residents.

3.26. **Commentary**: continuing to provide temporary accommodation for Daniel pending review of the intentionality decision, and to prevent homelessness, was good practice. However, the intentionality decision itself merits scrutiny. Further information provided by one of the agencies involved questions the decision because "*his hygiene might not have been much within his own control as he was unable to access washing facilities during his tenancy after he became a wheelchair user. [The decision] does not seem to engage with an understanding of Daniel as someone with complex mental and physical health needs whose health was not stable at that time*."

3.27. **Commentary**: government guidance[10] states that a person will not be intentionally homeless if problems within their accommodation arose because of a disability, mental health or substance misuse problem. It further states that an act or omission should not be considered deliberate when it is the result of limited mental capacity or temporary aberration(s) caused by mental illness, frailty or an assessed substance misuse problem. However, the guidance does not clarify how decision-makers should respond when acts or omissions also involve anti-social behaviour and/or breaches of tenancy agreements. The intentionally homeless decision followed a conclusion that there was no evidence of temporary aberration. However, both in written answers to questions posed by the independent reviewer and at the learning event, this area of housing law was recognised as complex. At the learning event it was acknowledged that in similar situations "*decisions can go either way*." It is unclear what medical evidence was elucidated to inform the decision in this instance[11]. At the learning event, some attendees expressed doubt, in a context of Daniel's fluctuating capacity as a result of substance-dependence, about the intentionality of his decision-making.

[10] MHCLG (2024) Homelessness Code of Guidance for Local Authorities.

[11] Case law was quoted at the learning event, namely Hijazi v Royal Borough of Kensington and Chelsea [2003] EWCA Civ 692, which stated that medical evidence that an applicant is incapable of managing their affairs must relate to the relevant period.

3.28. Daniel's family have used stage 1 and stage 2 complaints procedures regarding the decision that he was homeless intentionally, and that the temporary accommodation provided was unsuitable for his needs. There is no agreement between his family and the district council regarding his mental capacity. In respect of the suitability of accommodation, the district council have relied on Daniel's acceptance of the accommodations offered and also their responsiveness when practitioners raised concerns on his behalf.

3.29. Family involvement is a final component of direct practice to be considered here. At various points in the chronology his father and step-mother advocated on his behalf, expressed concerns to different services, provided information, and collected him from hospital when he self-discharged. It is evident from the information provided by agencies that his family were a source of support. Indeed, and to add to the uncertainty about whether a special guardianship order did prevent Daniel from living with his parents, according to agency records his father and step-mother at one point offered to have Daniel to live with them if accessible accommodation could be found. The family's perspective is that they were told that, if they offered this, their request for a housing transfer would be reprioritised.

3.30. The family's use of stage 1 and stage 2 complaints procedures has not resolved a disagreement concerning whether the district council had agreed to keep the family informed. **Commentary**: some services did not have contact with Daniel's family, for example on the grounds that there was no immediate prospect of him living with them because of the inaccessibility of toilet and bathroom facilities. When services did have contact, this seems to have been prompted by his family. What does not seem to have been explored proactively is the extent of support that they could offer and whether Daniel would give consent to their involvement.

## Inter-Agency Collaboration

4.1. The referral for this safeguarding adult review expressed concern that it had taken some time for the services involved to work together and that some agencies had withdrawn once they had met their statutory obligations. However, the referral also acknowledged that between November 2023 and June 2024 regular multi-disciplinary team meetings had been convened. At the time of the referral it was suggested to the independent reviewer that these meetings might not have had a clear plan, including for contingencies, or connected the different services with a contribution to make into a connected team around the person, focused on planning for risk management.

4.2. How services work together is a core component of this domain. Endless evidence from safeguarding adult reviews[12] highlights how health, housing and social care needs overlap and interact, requiring a whole system, whole person response. The scoping documentation for this review does indeed record discussions between services at a time of hospital discharge and the

[12] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. (2024) *Second national analysis of safeguarding adult reviews: April 2019 – March 2023*. London: Local Government Association and ADASS.

convening of multi-disciplinary meetings with a focus on how to meet Daniel's needs for accessible accommodation. **Commentary**: convening multi-disciplinary meetings is positive practice, enabling information-sharing and escalation of concerns. Referrals to ASC for a multi-agency risk management meeting when Daniel was fit to be discharged from hospital (March 2024) are also recorded.

4.3. However, the scoping documentation also records occasions, for example in November 2023 and February 2024 when there could have been referrals for a multi-agency risk management meeting (MARM). Also recorded are occasions when referrals could have been considered, for example in November 2023 to psychiatric liaison.

4.4. Additional written responses from services involved highlight cross-service discussions, for example between a social worker, housing provider and district council staff. They point to the frequency of multi-disciplinary meetings as examples of positive interactions between hospital, housing and mental health services. However, the feedback also suggests that the contribution of some services "*dropped off*" and that not all meetings were well attended. The feedback also questions what the meetings actually achieved beyond the sharing of concerns. It has been suggested that there should have been a clearer focus, for example on how to respond when Daniel refused care and support, and on planning for discharge as soon as he was admitted into hospital rather than waiting until readiness for discharge was being signalled, with the consequence that the allocated temporary accommodation was unsuitable[13].

4.5. NHS 111's involvement, including that of Out of Hours GPs would have been shared with Daniel's GP. Shared care records might also be available but this is dependent on patient permissions and available records on the system. "*Information from social care, mental health and tertiary providers may not be available ... and therefore may limit collaborative assessment of need and risk*." **Commentary**: since information from NHS 111 is channelled via a person's registered GP, this highlights the importance of attendance by primary care practitioners at multi-disciplinary and multi-agency risk management meetings. Also highlighted here is the impact of separate record systems on a whole system, whole person response.

4.6. Again from additional written information, it appears that two MARM referrals were declined on the basis that the threshold was not met. **Commentary**: "*it is unclear what a MARM would have achieved beyond that by the MDT meetings held.*" This observation seems to indicate that it would be helpful to clarify the distinction between multi-disciplinary and multi-agency risk management meetings so that practitioners are clear about which pathway to use.

4.7. **Commentary**: Whether multi-disciplinary and/or multi-agency risk management meetings are convened, it is important to identify a contingency approach if the preferred agreed plan fails to materialise. Also important are mental capacity assessments and professional curiosity, as discussed above in the domain of direct practice. "*A clear determination over Daniel's mental capacity seems to have been needed early on to explore if he was weighing and using the key*

[13] For example, a hotel where he had to put his insulin in the staff fridge and had no access to shops, cooking facilities of any kind, no wet room, and could only get anywhere via a wheelchair taxi at great expense

*information effectively. There was no identified professional curiosity or respectfully challenging conversation with him about the ultimate consequences of his current actions and inactions and that these would result in serious harm or very possibly death. Whilst Daniel repeatedly indicated an accommodation change would improve his situation, he appeared to place a lot of emphasis on this and it would have been highly beneficial to explore this further in terms of a 'what if' conversation about the ways to meet his needs if his accommodation didn't change for an extended period of time*."

4.8. At the reflection event, it was also observed that attendance at multi-disciplinary meetings did not always reflect a whole system response, possibly influenced by judgemental attitudes about his behaviour and self-neglect. This meant that certain individual practitioners who were centrally involved in supporting and advocating for Daniel felt that they were left holding all the responsibility and risk. "*It kept coming back to me ... but it was way too complex just for me*."

4.9. Feedback to the independent reviewer has also included an observation that some practitioners, including social workers, did not know how to arrange multi-agency risk management meetings. At the learning event it was suggested that collaboration was rendered more difficult because of a lack of understanding of each agency's roles and responsibilities. "*We need to communicate better*."

4.10. Daniel might be termed as someone experiencing multiple exclusion homelessness[14] – not only was he homeless but he also experienced mental health and substance misuse challenges. This was discussed at the learning event with a focus on the *Making Every Adult Matter* (MEAM) approach. There are criteria for referral but it might have proved a useful approach, especially when initial plans had been frustrated. One particular component of the MEAM approach, that might have proved useful, would have been Daniel's inclusion in multi-disciplinary meetings – modelling a "*team around me*."

4.11. A further component of working collaboratively together is referrals of, and responses to safeguarding concerns. The notification for this safeguarding adult review references referrals of adult safeguarding concerns in January and October 2023 where the decisions were that the criteria for a safeguarding enquiry were not met, and in October/November 2023 when the opposite conclusion was reached. **Commentary**: the notification refers to Section 42 (1) Care Act 2014 as being a threshold. It is more accurate to regard the three sub-sections in Section 42(1) as criteria for determining whether a safeguarding enquiry should be commenced.

4.12. An adult safeguarding enquiry (Section 42(2) Care Act 2014 was commenced in November 2023, the referral having reported self-neglect in the form of uncontrolled diabetes. This decision to commence an enquiry appears to have been prompted by the repetition of concerns with no apparent improvement. The outcome was a community action plan "*where the Adult Early Help Team spoke with Daniel directly.*" ASC also liaised with Daniel's community psychiatric nurse and

[14] Fitzpatrick, S., Johnsen, S. and White, M. (2011), "Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections." *Social Policy and Society*.10(4):501-512.

ongoing concerns prompted the convening of the first multi-disciplinary meeting. Referring back to family involvement, Daniel's step-mother and father have criticised shortcomings in safeguarding him and in responding to their concerns.

4.13. However, the scoping documentation also implies that there were missed opportunities to refer safeguarding concerns, for instance for medical self-neglect when Daniel was in hospital (November 2023 and February 2024), and in May 2024 when he self-discharged against medical advice. One NHS Trust in their contribution to the scoping documentation acknowledges that the adult safeguarding team were not always informed of concerns – non-concordance and suicidal ideation. More positively, there were three safeguarding referrals in March 2024 featuring non-compliance with treatment for his diabetes. **Commentary**: in total there were seven safeguarding concerns referred. It has been suggested that it is not evident what additional safeguarding concerns might have achieved. However, what appears clear is that neither the referred safeguarding concerns nor the regular multi-disciplinary meetings managed to achieve significant mitigation of risks. A sense emerged at the learning event that Daniel's human story was an example of where greater flexibility of response was required, a willingness to go beyond normal policies and procedures. This observation led to a recognition that a complex case panel, involving senior leaders across health, housing and social care, would be useful when previous multi-agency collaboration has not been able to mitigate risk, meet needs and safeguard the individual. This might form part of the Changing Futures programme in Cambridgeshire and Peterborough.

4.14. **Commentary**: given the outcome of MARM referrals in Daniel's human story, it might be helpful to clarify how practitioners and managers across health, housing and social care see the relationship between Section 42 Care Act 2014 referrals/enquiries and MARM. In a written submission to the independent reviewer, the relationship has been described as follows. "*Primarily Section 42 is a broad pathway to share concerns about a risk of abuse or neglect, including self-neglect, for someone who has care and support needs. MARM is for where the adult is self-neglecting, has capacity to decide their care and support arrangements, and is not engaging with addressing the concerns. MARM is therefore an approach for working with the adult and multidisciplinary team in these circumstances. MARM is often seen as an alternative to a s42 enquiry rather than a multi-disciplinary approach to consider after the concerns are clarified and efforts are made to engage with the adult*."

## Organisational Support for Practice

5.1. There are two components in this domain relevant to Daniel's human story, namely the support available to practitioners and managers, and the availability of resources through the commissioning of provision.

5.2. On support for staff, what emerged clearly at the learning event was the impact on the practitioners and managers involved, both at the time and now. One participant at the learning event referred to "*moral injury*" – the emotional impact of witnessing "*a car crash waiting to happen*." It was "*very frustrating*" with ongoing feelings of "*sadness*." There were expressions of

the need for psychological support for the staff who had been involved, alongside training on trauma and risk management, especially as "*we rely on people rather than systems*." It was "*hard to keep oneself refreshed*", to remain hopeful. Whilst the learning event itself was described as "*a compassionate experience*", what was apparent was the significant impact of the outcome for Daniel - "*the frustration we all fel*t" despite efforts by community psychiatric nurses and social workers, for example, travelling to different locations, taking food parcels and vouchers, and advocating for him.

5.3. On resources, the scoping documentation foregrounds the efforts made to find accommodation that Daniel and those practitioners and family members supporting him regarded as suitable. What is implied rather than explicitly stated in the scoping documentation is the difficult in accessing accommodation that could meet all Daniel's needs. This challenge was an explicit focus for practitioners, managers and commissioners present at the learning event, with references to limited accommodation options and the shortage of supported living facilities. Long waiting times for appropriate provision for people experiencing homelessness were referenced. Also conveyed was an opinion that resources were being directed towards older people, for example experiencing dementia, rather than towards younger adults with complex comorbidities. As a result, "*it would have been challenging to find one placement that could meet all his needs*" and "*we were trying to fit him into our boxes*."

5.4. Feedback on resources expressed at the learning event did not just focus on housing. Thus, there is "*a dire lack of funding*" for mental health assessment and treatment. Not all mental health and social work teams were well resourced in terms of practitioners and managers with experience of working with people experience mental distress, substance-dependence and physical disability. Not everyone seemed to have access to supervision and safe spaces for reflection and support. **Commentary**: one hopeful development was referenced at the learning event, namely the introduction of Trauma Risk Management (TRiM). The Changing Futures programme is proposing to introduce a forum where professionals can share, discuss and reflect on complex cases.

## Key Lines of Enquiry – Summarising Learning

6.1. One key line of enquiry was to evaluate the impact of prior learning from CPSAB completed safeguarding adult reviews. Reading across the findings and recommendations from SAR Arthur (2018), SAR Peter (2020) and SAR Dorothy (2021), common themes emerge, namely:

6.1.1. How services respond when people miss appointments or do not engage, including the role of outreach.
6.1.2. How services assess mental capacity, including executive functioning, especially when there is a history of substance misuse.
6.1.3. How services work together to plan for hospital discharge in complex cases involving homelessness and repetitive patterns.
6.1.4. How services understand and work with people who experience self-neglect.

6.1.5. How services support practitioners, for example to sustain relationship-based and trauma-aware practice, and to express concerned curiosity.

6.1.6. How services work together when individuals experience overlapping needs located across mental health, physical health, substance-dependence, care and support and housing, particularly promoting the use of multi-agency risk management meetings and clarifying the interface with Section 42 Care Act 2014 referrals and enquiries.

6.2. These SARs also contain other recommendations, including for training on self-neglect and multi-agency risk management meetings, and for review of services for people who experience homelessness alongside substance-dependence, and comorbidities (mental ill-health and substance misuse). All three reviews also make recommendations about information-sharing and record systems to more effectively enable identification and assessment of, and response to risk.

6.3. There was little explicit awareness of previously completed reviews, and of subsequent service development and practice improvement during the learning event. However, there were references to training on the law relating to homelessness and positive references to the Changing Futures programme and the "*team around the person*" approach.

6.4. One written contribution suggested that the recommendations from previously completed reviews were not yet fully embedded and referred to changes in training around mental capacity to highlight executive functioning and in the approach to multi-agency risk management meetings and self-neglect. Thematic audits had also highlighted case recording requirements. **Commentary**: revisiting the recommendations from previously completed safeguarding adult reviews to identify the evidence of what has (not yet) changed would be good practice.

6.5. On collaboration with respect to meeting needs and managing risk, records show that information was shared between the practitioners working with Daniel. However, information that was shared and/or was available was not always used to inform or to challenge decision-making, for example when planning for hospital discharge or when Daniel had been deemed to be intentionally homeless. There were multiple multi-disciplinary meetings but not all services with a contribution to offer were consistently present. Daniel had multiple and overlapping needs. Individual services responded but there is little sense of a whole system approach, namely responding to mental distress, physical disability, homelessness, substance-dependence and needs for care and support collaboratively. For example, such collaboration could have begun as soon as Daniel was admitted to hospital rather than waiting until he was medically fit for discharge. The MARM procedure was not deployed and the outcomes from the multi-disciplinary meetings could have been clearer, for example in resolving how agencies would respond if the agreed plan was frustrated. There was no formal agreement as to lead agency and key worker, advisable in cases of complexity and repetitive patterns. Policies and procedures do not appear to have been used explicitly, for example the self-neglect framework, the agreed process for resolving professional disagreements, or the homeless hospital discharge protocol. Arrangements for working together have been described to the independent reviewer as "*so precarious*."

6.6. On responding to how Daniel presented, with specific reference to self-neglect, the picture with respect to compassionate enquiry or professional curiosity is mixed. There is some evidence of discussion with Daniel about management of his diabetes, of options for support and alternative ways of meeting his needs. His priority, for stable accommodation, was identified. What is less clear is the degree to which there were care-frontational challenges about the risks arising from self-discharge, non-concordance with treatment, refusals of care and support. Several practitioners offered consistent support to which Daniel responded. This level of engagement by Daniel might, however, have sometimes obscured the need to talk about the options available to respond to the impact of social isolation arising from multiple moves, sometimes at some distance from sources of support, and the meaning behind his use of alcohol and other drugs. Daniel was seen, often frequently – he was never out of sight or out of mind – but his decision-making was often, it appears, taken at face value rather than his ability to use or weigh information explored.

## Two Additional Human Stories – Sarah and Marcin

7.1. Having commissioned the safeguarding adult review with respect to Daniel, two further referrals were considered by CPSAB and assessed as meeting the mandatory criteria (Section 44 (1) (2) (3) Care Act 2014). Both human stories, of Sarah and of Marcin, were referred by local authority managers. In line with the discretion regarding methodology given to Safeguarding Adult Boards by statutory guidance[15], CPSAB resolved to include these additional human stories in this commissioned review on the grounds that the referrals appeared to raise similar concerns.

7.2. Once again, the agencies involved provided scoping documentation and a learning event was held virtually. The independent reviewer has also seen documentation relating to a complaint raised by Sarah's relatives, her sister and cousin.

7.3. Sarah, who was White British, died in November 2024 aged 47. Cause of death was intra-abdominal sepsis secondary to spontaneous bowel perforation and decompensated chronic alcohol-related liver disease. For her sister and cousin, this was "*a hard pill to swallow*." The referral identified needs relating to mental health (post-traumatic stress disorder), alcohol-dependence, physical ill-health, childhood trauma, personal care (nutritional support), maintaining her home and social support. Identified risks included non-engagement and fluctuating capacity which, according to the referral, made supporting Sarah difficult. The referral observed that family members had raised urgent concerns and had actively sought help for Sarah who was described as resilient. Her past employment skills were recorded. Also recorded was an earlier "*alcohol medical detox and further rehabilitation*" in another local authority area.

7.4. The scoping documentation has revealed more about Sarah's "*traumatic past*", including being adopted and a victim of domestic abuse. Apparently she disliked crowds. One contribution to the scoping documentation refers to the need in future to associate mental health, alcohol-use, executive functioning, suicidal ideation and self-neglect. Otherwise, it is not possible to glean

[15] DHSC (2025) Care and Support Statutory Guidance.

from the scoping documentation whether Sarah's needs, and the evident risks, were connected to adverse experiences and trauma in her human story.

7.5. The referral provided detailed information for the final month of Sarah's life, with assessment of her care and support needs and referrals for reablement, GP review of her swollen neck and dizziness, and mental health support. The referral for reablement was rejected because of Sarah's alcohol-dependence. Her relatives requested a Mental Health Act 1983 assessment, and medical and mental health support from Sarah's GP. They highlighted concerns that Sarah's executive functioning was impaired. They repeated their concerns and requests on several occasions. Sarah was not open to secondary mental health services. It was suggested that Sarah be supported to contact her GP in order to engage with a primary care mental health practitioner. It was also suggested that she be signposted to a service for ongoing alcohol misuse support. **Commentary**: signposting is rarely effective. Outreach would be more effective. There was no response to the requests from Sarah's sister and cousin.

7.6. On 22nd November 2024, following concern expressed by a family member, the police found Sarah in bed, unwell, and her home in poor condition. Paramedics were called but Sarah was not transported to hospital. Three days later she was transported to hospital "*with severe health issues, including sepsis, liver failure and potential brain damage*." **Commentary**: the decision, finally, to transport Sarah to hospital appears to have been a best interest decision, Sarah having been assessed at that point as not having decisional capacity.

7.7. The referral concluded as follows. "*Given the complexity and high-risk nature of Sarah's situation, a MARM process could have provided a more structured and coordinated approach to managing her care and support needs. It would have facilitated effective multi-agency collaboration, proactive safeguarding, and a holistic assessment of her needs, ultimately aiming to improve her outcomes and reduce the risk of harm. Additionally, a MARM may have helped ensure that the GP responded in a timely manner ... [The local authority] aimed to take a proportionate response to the initial concern, but the escalating nature of Sarah's situation could have warranted a more robust and coordinated approach through the MARM process. Sarah's primary need was her mental health, which significantly impacted her ability to manage her physical health and daily living activities. Addressing her mental health needs through a coordinated multi-agency approach could have provided the necessary support to improve her overall well-being*." **Commentary**: the concern about the absence of a whole system, whole person response clearly parallels the learning from Daniel's human story and echoes findings from CPSAB's previously completed reviews.

7.8. Sarah's relatives have offered a helpful window into Sarah as a person. "*Although a great challenge to all of us and herself at times, she was lovely and without alcohol that sadly stripped her of everything, she was a brilliant person who was kind and who cared, as well as having a great sense of humour.*" Her sister and cousin have described how Sarah had "*a zest for life*" and how she had travelled widely and could be "*hilarious*" and "*mischievous*" but on her own admission "*so awkward*." She had held "*really good jobs*", mainly in catering. She had been adopted when eleven months old. Her own son had been adopted in 2017,having been taken into care on account of Sarah's alcohol-dependence.

7.9. Marcin died in May 2024, aged 45. His nationality was Polish. The cause of his death was bronchopneumonia, with severe alcoholic liver disease also present. The referral identified needs relating to alcohol-dependence, visual impairment, very limited mobility and personal care (activities of daily living including dressing, hygiene, managing his medication, accessing a toilet and preparing meals). The following risks were also recorded – falls, home invasion (cuckooing), self-discharge and refusals of treatment and/or support.

7.10. Marcin had experienced homelessness following the breakdown of a relationship until he was offered general needs social housing in 2021 with floating tenancy support. After a period of some stability, Marcin's drinking increased. This, and risk of financial exploitation, was linked in the referral to an increase in his welfare benefits. **Commentary**: the Department for Work and Pensions does have procedures to protect claimants from financial abuse when they receive large back payments.

7.11. Marcin's care and support needs (difficulties with activities of daily living associated with alcohol-dependence) increased in late 2023 but the safeguarding adult review referral observes that the response was delayed for over a month. A care and support package followed an assessment in January 2024, that also included referrals for occupational and physiotherapy. The referral for this review observes, however, the absence of a risk assessment and safeguarding plan. **Commentary**: there is a clear parallel with Sarah's human story in that this referral observes the lack of urgency in responding to expressed concerns. There is a clear parallel also with Daniel's human story. There was particular reliance in Daniel's human story on the support from a community psychiatric nurse; in Marcin's human story, the housing and floating support providers were his main support and the safeguarding adult review referral suggests that the providers felt unsupported by other services with a potential contribution to make.

7.12. In a context of what has been described as "*extreme self-neglect*", Marcin's human story contains occasions when he self-discharged, refused personal care and declined treatment and admission to hospital. **Commentary**: similar to both Daniel's and Sarah's human stories, Marcin was not involved with substance misuse services in the final years of his life, a referral being made in the month before he died.

## Further Domain Analysis – Direct Practice

8.1. Engagement is a theme in Sarah's and in Marcin's human story as it was for Daniel. Marcin, for example following ophthalmology surgery in 2021/2022, missed several follow-up appointments. He self-discharged from hospital on two occasions although community healthcare practitioners did follow this up. He declined support when offered by a Fire and Rescue Service during a home fire safety visit. Paramedics recorded that he consistently declined hospital admission. His GP also recorded that Marcin declined admission to hospital. **Commentary**: the scoping documentation gives no indication as to how services responded when Marcin missed appointments – was Marcin unwilling or unable to attend? There is no record in the scoping documentation of what was learned from any expression of professional curiosity regarding his

refusals of support and/or treatment. At the learning event participants questioned whether anyone had ever said "*we are worried about you*" and acknowledged the importance of compassionate enquiry as an attempt to open up important strands of conversation.

8.2. Sarah's engagement with an independent domestic violence advocate from 2011 has been described as "*fluctuating*." At the learning event, it was observed that she did not seek help, for example from an independent domestic violence advocate, for three abusive relationships. The scoping documentation describes occasions when she declined transportation to hospital following seizures and/or falls, observes her "*variable engagement*" with practitioners, refusal of treatment/support and non-compliance with medications and healthcare advice, and services closing down their involvement because of her non-engagement. There were occasions when Sarah self-discharged from hospital before assessments could be completed. At the learning event it was noted that Sarah declined a home visit by a GP and cancelled follow-up appointments.

8.3. **Commentary**: again, the scoping documentation does not record what was learned from any expression of professional curiosity. Other than a substance misuse service recording occasional home visits if Sarah had not responded, and a paramedic from the GP hub also occasionally home visiting, there is no evidence of outreach, for example when "*multiple attempts to contact Sarah*" had not been successful and when she declined home visits but subsequently cancelled appointments. There is, however, recognition that the response to Sarah's alcohol-dependence and mental distress was not trauma-informed.

8.4. **Commentary**: Sarah's sister and cousin have acknowledged that one substance misuse practitioner had advocated that the service should keep her case open, despite fluctuating engagement, but that it had been decided that she was "actively *choosing*" not to attend and, moreover, had to make her own way to the service. It appears possible that assumptions about lifestyle choice influenced decisions about outreach and closure. Participants at the learning event referred to an expectation that individuals make sustained efforts to engage and that this approach needed to change. At and beyond points of transition, participants felt that individuals need visiting support. There was a suggestion of a gap in services commissioned to provide this support. The scoping documentation from the substance misuse service describes advice being given to other agencies that Sarah would be assessed with a view to a return to structured treatment, that could involve an assertive outreach approach, if she was helped to attend appointments. No such support appears to have been offered to facilitate her attendance.

8.5. In November 2024, when Sarah was in an emergency department awaiting a bed, one of her relatives had contacted the First Response Service with significant concerns that Sarah would abscond. **Commentary**: whilst it was not the remit of the First Response Service to prevent self-discharge, the significant concerns expressed by a relative, given the history of Sarah's engagement, could have prompted onward referral in an attempt to mitigate risk. Instead it appears that only suggestions and reassurances were offered to Sarah's relative.

8.6. In their letter of complaint, Sarah's relatives point out that between 2019 and 2024 she made 90 emergency calls. They also observe that, because of her mental distress and alcohol-

dependence, she often could not manage her mobile phone, for example by ensuring that it was fully charged. **Commentary**: the number of emergency calls is an indication of Sarah's distress and were opportunities to try to build on engagement. Outreach would have helped to overcome the challenges Sarah experienced with telephonic communication.

8.7. When reflecting on Sarah and Marcin's human stories, participants at the learning event concluded that there had been a lack of recognition of disguised compliance beside an over-reliance on self-report. The disjunction between their stated intentions and actual actions/behaviour should have prompted closer enquiry.

8.8. Relationship-based practice is a core component of direct work, building trust and offering continuity to establish and maintain engagement. Once accommodation had been allocated to Marcin following a period of homelessness, he received consistently intensive good floating support, alongside support from his social housing provider, and initially responded well. Indeed, the project workers supporting Marcin twice increased their hours in response to risks from exploitation and alcohol-dependence, often involving multiple visits weekly. **Commentary**: increasing the support being offered to Marcin was good practice.

8.9. In January 2024 Marcin was seen twice at home by his GP but declined admission to hospital. Elsewhere in the scoping documentation it is recorded that Marcin "*wanted to die at home*." The GP practice care coordinator offered telephone support. Occupational therapists provided equipment according to Marcin's wishes and physiotherapists advised him on how to use safely what had been provided. Community healthcare practitioners were often accompanied by a member of Marcin's floating support team since he would otherwise be reluctant to open his front door. Plans were made to cover annual leave. **Commentary**: although not specifically referenced in the scoping documentation, it is possible to discern attempts to make safeguarding personal.

8.10. Concern has also been expressed in the scoping documentation regarding delay in allocating a social worker when Marcin had been referred for a care and support assessment (November/December 2023) and subsequent delays in initiating a care package once he had returned home from hospital. A strong sense emerges from the contribution of the floating support project that there was insufficient multi-agency support and that the concerns and risks were being held by that service alone. **Commentary**: there are clear overlaps with Daniel's human story, namely reliance on one service/practitioner and shortcomings in the timeliness of response to needs and risks.

8.11. Lack of timely response has also been expressed in the scoping documentation for Sarah, for example by primary care. Contributions from an advocacy service and on behalf of community healthcare practitioners indicate that, at times, Sarah was able to engage with, and respond to the offer of supportive relationships. **Commentary**: however, unlike Daniel and Marcin's human stories, it is not possible to identify one practitioner who offered a consistent relationship and advocacy on Sarah's behalf throughout and, especially, in the final months of her life, although her sister and cousin have identified the positive support offered by a substance misuse practitioner in a different local authority area when Sarah had treatment in residential detox, and

by a social worker and social work manager who raised urgent concerns in the final month. Sarah's sister and cousin believe that these requests for urgent intervention were ignored. One contribution to the scoping documentation refers to a repetitive theme across cases of having to chase GPs for a response to concerns.

8.12. A lack of urgency also emerges, which parallels concerns identified with respect to both Daniel and Marcin. In their letter of complaint, Sarah's relatives have sought an explanation for why the GP practice did not respond to urgent concerns referred by them and by Adult Social Care. Also noteworthy is a concern expressed in one contribution to the scoping documentation for Sarah about attitudes, again mirroring comments made at the learning event that focused on Daniel's human story. "*Sometimes the tone or message from professionals involved in mental health/primary care was that all Sarah needed to do was to stop the alcohol use and she would be fine. Alcohol was a symptom for Sarah and the root problem was not identified or addressed*."

8.13. Sarah's sister and cousin have also referred to discriminatory attitudes towards Sarah. In their view, "*no-one listened or cared*." They have stressed the importance of "*treating the person, don't dismiss the addict.*"

8.14. Sarah was seen by social housing provider staff four times in May 2024 where the main focus appears to have been the condition of her property. At times she was intoxicated. She agreed to contact being made with her GP and a detox centre. There were a further two visits in September and a telephone conversation in October 2024. Once again, at times, she appeared to be intoxicated. On one occasion she referred to suicidal ideation and on another to being a recent victim of domestic abuse. She agreed to contact being made with Adult Social Care and her GP. She was given advice to contact the police regarding domestic abuse. In November social housing practitioners saw Sarah once but there were also five unsuccessful home visits. **Commentary**: perseverance of social housing staff was good practice, as was gaining consent to make contact with other services. However, there was no follow-up when Adult Social Care informed social housing staff that no referral had been received from the GP. Signposting to other services, such as the police, is likely to be less effective than seeking to directly link a person with a service. According to her family, in the final days of her life, her front door was found open and insecure by a neighbour, following an earlier police forced entry, with a delay of several days before the police secured Sarah's accommodation. There is no reference to this in the social housing provider's documentation. Apparently the neighbour found Sarah naked in freezing night temperatures and wrapped her up. This episode does not appear to have prompted referral of an adult safeguarding concern.

8.15. **Commentary**: some social housing providers have routine internal meetings or pathways for review of tenants with complex needs. This is good practice to ensure an understanding of presenting needs and risks, and to activate a multi-agency response when appropriate.

8.16. As for Daniel, loss features in Marcin's human story, namely the breakdown of a relationship that resulted in a period of homelessness. Loss and trauma also feature in Sarah's human story. Her sister was able to find Sarah's birth mother and there was some limited contact for a time before Sarah was rejected, something which understandably upset her. Although they never met,

she also had sporadic contact with two brothers in her birth family. Apparently Sarah questioned whether her mental ill-health an alcohol-dependence were genetic on the basis that her birth mother experienced similar issues. As a young adult, Sarah's social drinking escalated, something she blamed, at least partly, on having been adopted, "*given up*." Her own son was assessed as being a child at risk because of her alcohol misuse, subsequently being removed from her care and adopted. Her sister and cousin have described how she was "*broken*" when her son was removed, how she went "*off the scale*." She expressed fear that her son would "go the same way" and that he would be given a misleading picture. Annual contact letters heightened her anxiety and distress. **Commentary**: Sarah's human story highlights the importance of practitioners and services being trauma-informed and trauma-aware, and of seeking to work long-term on understanding and working through loss.

8.17. Mental capacity assessment is a further feature in the domain of direct practice. When contacting services to express their concerns about Sarah, family members referred to her compromised executive functioning with respect to decisions about health and activities of daily living. However, there is no reference to mental capacity in the information provided by NHS 111. When capacity was assessed by paramedics, the scoping documentation records that Sarah was often found to have mental capacity. By way of contrast, the submission from one NHS Trust records that there were no formal assessments of mental capacity in a context of multiple visits to an emergency department, alcohol-dependence and symptoms of alcohol withdrawal, and evidence of anxiety/depression and suicidal ideation. **Commentary**: from the scoping documentation alone, it is possible to discern missed opportunities for formal mental capacity assessments and to question the thoroughness of completed assessments in a context of alcohol-dependence, depression, anxiety and self-neglect. In its response to the letter of complaint from Sarah's sister and cousin, an NHS Hospital Trust states that Sarah "*did not appear to have capacity*" when presenting with worsening symptoms in mid-September 2024. The response does not detail, however, whether her mental capacity was formally assessed with respect to treatment decisions.

8.18. In their letter of complaint, Sarah's relatives have questioned how, in a context of "*manic episodes*", suicide attempts, over-use of emergency services and prolonged alcohol-dependence, she was deemed to have capacity, for example on several occasions by paramedics in the days before her final transportation and admission into hospital in her best interests. In relation to fluctuating capacity and executive functioning, Sarah's relatives felt that their concerns were "*pushed back*" and that practitioners across services had "*no idea*" about the interface between addiction and capacity. **Commentary**: at the learning event it was suggested that there is a "*reliance on capacity*." This theme resurfaces in Marcin's human story also.

8.19. The safeguarding adult review referral and the scoping documentation for Marcin observe that on occasions paramedics did not attend because he stated that he was "*fine*" and had the capacity to decide. The contribution from a Hospital NHS Trust states that there were "*no concerns about capacity*" when Marcin self-discharged. The primary care contribution also states that, despite his alcohol-dependence, he had "*capacity to make decisions*." There is no mention of mental capacity in the contribution from a Community NHS Trust but the Ambulance Trust has recorded that Marcin was assessed as not having capacity in February 2024, resulting in

admission to hospital in his best interests. **Commentary**: from the scoping documentation alone, it is possible to discern missed opportunities to explore Marcin's mental capacity and the thoroughness of some completed assessments in a context of the likely impact of prolonged substance misuse.

8.20. Participants at the learning event felt that undue reliance was placed on Marcin's self-report and that he had convinced workers with less frequent contact that he was independent. As a result it was suggested that some agencies had overestimated his abilities and had under-estimated the impact of alcohol abuse. Participants also acknowledged a tendency to "*hide behind capacity*" and that, with Marcin, there should have been "*legitimate doub*t" about his decisional capacity and, therefore, "*rigorous mental capacity assessments*." "*He was in a terrible state*." "*It was quite distressing.*" He was lying in excrement and could not stand.

8.21. The provision and quality of assessments, especially of mental health, substance-dependence and care and support needs, is a further core component of direct practice. Sarah's relatives requested a mental health and Mental Health Act 1983 assessment in the final month of her life but none was undertaken. "*The GP ignored everything*." Despite evidence of both depression and anxiety, and of suicidal ideation, no mental health assessment or support appears to have been offered in the months before she died[16]. On her final admission to hospital, a referral to liaison psychiatry was declined in the belief that her primary problem was alcohol misuse. Documentation from a substance misuse service refers to an expectation that Sarah would be abstinent before mental health services would engage. This was described as an "*unrealistic*" expectation, which failed to address the root cause of alcohol abuse. **Commentary**: it is best practice for mental health and substance misuse services to work together in both assessment and treatment. This avoids the well-known revolving door phenomena of whether to respond to mental discuss or substance-dependence first. Indeed, in their letter of complaint, Sarah's relatives question why mental health services did not work collaboratively with substance misuse services. They have also observed in discussion with the independent reviewer that a dual diagnosis meeting was held before her admission in 2023 to residential detox but there was no follow-on after she was discharged and returned home. **T**his was a missed opportunity to support her recovery. Finally, a substance misuse service has expressed the view that the absence of a collaborative approach with mental health services is a repetitive theme with little progress having been made in the last decade.

8.22. At the reflective learning event, it was suggested that accessing a Mental Health Act 1983 assessment did not just have to originate from a GP. Participants acknowledged the absence of a "*dual diagnosis*" response and referred to both a specialist team and a county wide forum for discussion of cases involving co-occurring conditions and the need to bring services together. **Commentary**: It seems that the forum might not be widely known or used. Similarly, pathways for initiating a Mental Health Act 1983 assessment might not be widely known.

[16] The scoping documentation does, however, refer briefly to three contacts with a primary mental health service in 2023.

8.23. In their letter of complaint, Sarah's relatives point to a mental health diagnosis in January 2014 of mixed anxiety and depressive disorder, and in February 2016 of suicidal ideation. They also believe that there had historically been consideration of whether Sarah had an emotionally unstable personality disorder but this had not been formally diagnosed. They observe that between 2019 and 2024 an Ambulance Trust wrote to Sarah's GP 18 times to request a mental health assessment. They question why no Mental Health Act 1983 assessment was undertaken in November 2024 despite their request at that time. They have also reflected that when Sarah turned down mental health support, this was because she was "*too scared*."

8.24. Judging from the scoping documentation, Marcin's mental health does not appear to have been a focus of concern. Equally, despite Marcin's alcohol-dependence and increasing use of alcohol from January 2023, with seizures and falls prompting multiple visits to an emergency department and observed liver deterioration, in the period under review the scoping documentation from a Hospital NHS Trust does not detail any direct referrals to a substance misuse service. It does appear that on one occasion he was seen by a substance misuse practitioner, on this occasion being discharged back to his GP with a request for involvement from alcohol support services. **Commentary**: at the learning event participants acknowledged that a Hospital NHS Trust employs a liaison practitioner for substance misuse and questioned whether Marcin had been screened. A repetitive pattern of alcohol-dependence had not been picked up and referral to a substance abuse service had been late (January 2024). There is, however, no mention of any referral in the scoping documentation and no evidence of a response.

8.25. The scoping documentation refers to various substance misuse treatment episodes for Sarah between 2016 and 2024, most of which were closed down because she did not engage. Prior to the final months of her life, Sarah had undergone a residential detox programme for around seven months in another local authority area, to which she responded well. This had been arranged following a multi-disciplinary meeting involving the residential provider, her GP and the substance misuse service. When she arrived, she was apparently very thin, quite incoherent and unable to stand unaided, and appeared uncertain about how to build and maintain positive relationships. Her level of drinking had taken "*nearly everything from her*." However, she "*bonded*" with staff, her anxiety reduced and she grew in strength. There was "*quite a dramatic change*." Her self-esteem grew, she engaged with counselling and she was better able to control her boundaries. Using her catering skills, she did voluntary work at the detox centre and expressed a wish to continue to work in this field once she had returned home. She demonstrated "*a passion for recovery*" and showed to staff and other service users "*a heart of gold*."

8.26. Sarah had apparently always been clear that she would want to return home despite discussion about the possible risks. To assist with that transition, she was reconnected with the local substance misuse service and a "*packed structure*" was put in place involving a course and both recovery and enjoyment—based activities. This included a practitioner from the local substance misuse service collecting her from the residential provision and introducing Sarah to the recovery hub and the timetable to support her continued recovery. Staff from the residential provision maintained weekly contact. The local substance misuse service also attempted contact

and there is a record of at least one home visit when she had not been contactable. Initially she continued to thrive. **Commentary**: candid discussion of the risks involved in returning back to her home area and the attempted approach to managed transition was good practice. However, the transition plan could have been the focus of an initial multi-agency meeting, with subsequent review meetings, involving Sarah herself, to ensure that every agency with a contribution to make had clearly assigned and agreed roles and responsibilities. When the planned timetable of activities to support her continued recovery was not achieving desired outcomes, and attempts to engage with Sarah had proved unsuccessful, that would have been one time to convene a whole system meeting with the objective of coordinating a response to the risks involved.

8.27. By the time of the final few months of her life, Sarah was not engaged in support or treatment for her alcohol-dependence. The scoping documentation describes her as "*unable to remain abstinent*." Sarah's relatives have also questioned why there was no continuity of care after completion of detox in a neighbouring local authority area, offering community support that could have included a focus on her mental health issues. "*Attitudes and practice [about addiction] have to change*." Some practitioners have also questioned the approach of the local substance misuse service that expected Sarah to make her own way in order to engage, pointing to her physical ill-health. "*She wanted support but was unable physically to get there*." Some practitioners have questioned how well addiction is understood. **Commentary**: it seems that there was an assumption that Sarah was unwilling to engage when, as is often the case in self-neglect, she was unable. Some of those who knew Sarah at this time have observed how Sarah lost control of her boundaries after a chance meeting with someone who had previously abused her, followed by men "*taking over*" and influencing or coercing her. Her sister and cousin, and some practitioners endeavouring to support her, have questioned the apparent assumption that she had capacity when she could not make decisions in her own best interests because of undue influence from others and her addiction. Some practitioners were aware that Sarah was at risk of exploitation and cuckooing, and advice was given, but this risk did not become a focus of sustained intervention despite a MASH referral in the weeks before she died.

8.28. A hospital advice and liaison practitioner from the substance misuse service did see Sarah during her final hospital admission but she was unable at that time to communicate. **Commentary**: best practice in response to alcohol-dependence includes assertive outreach. There is little reference to this in the scoping documentation. Responsibility for engagement appears to have rested with Sarah alone when "*she needed support [to get to the substance misuse service].*" The opportunities opened up by completion of a detox programme and the support provided at that time, that included a timetable of recovery activity when she returned home, were not built upon. Referencing back to the commentary on loss, there appears to have been insufficient recognition that "*old wounds*[17] *[had] opened up*."

8.29. The definition of care and support needs, which should prompt an assessment under Section 9 Care Act 2014 (and Section 11 where assessment is declined but there is evidence of abuse/neglect, including self-neglect), includes needs arising from physical disability, mental health and/or substance misuse. Sarah and Marcin's needs fell squarely within this definition.

[17] Her own adoption and that of her son.

8.30. A social care assessment for Sarah is recorded as beginning in late October 2024. This included a referral for reablement and for mental health support. The referral for reablement was rejected because of her alcohol-dependence. Support to maximise Sarah's recovery from mental distress was suggested but not provided before she died. She was referred to STARS, a service that aims to maximise people's recovery from mental health through intensive evidence-based interventions in people's homes, placements and local communities. However, Sarah's sister and cousin believe that there was no response to this referral.

8.31. **Commentary**: the focus on Sarah's urgent need for support and treatment with respect to her mental health and "*extreme intoxication*" appears to have overshadowed the need to respond to her care and support needs, essentially activities of daily living. Some practitioners who knew her at this time have questioned why those workers who saw her did not respond to the level of self-neglect that they had witnessed. Her relatives have surmised that no care package was provided because Sarah had stated that she did not need it and would refuse it. If so, did she have capacity to take this decision and what persistence was shown given the conditions in which she was living?[18] It is also unclear from the scoping documentation why a care and support assessment was not conducted earlier. Her relatives have questioned the absence of community support, including consideration of supported housing, after what appeared to have been a successful residential detox. The support that Sarah had received there did not carry over when she returned home. There was no continuity of care.

8.32. A referral to assess Marcin's need for care and support was made in late 2023 but not undertaken until January 2024. The assessment resulted in a care package and in referral to occupational and physiotherapy. The actual provision of home care was delayed by Marcin's hospital admission. There was a ten day delay after his hospital discharge. At the learning event participants questioned the approach to hospital discharge, noting the apparent absence of a whole system discharge plan and wondering whether there had been any conversations with Marcin about end of life/palliative care and the need for a support package that covered all his needs, including nutrition. **Commentary**: the provision of care and support at home was not timely because of shortcomings in coordination at the point of hospital discharge. In addition, as with Sarah's human story, it is unclear from the scoping documentation why there was not an earlier assessment of Marcin's care and support needs, especially following a deep clean of his accommodation in July 2023. The SAR consideration panel also observed that the care and support assessment found Marcin to be frail and malnourished but a risk assessment did not adequately respond to the concerns that had been recorded. At the learning event participants observed that his health deteriorated significantly and that Marcin had needed "*earlier support*."

8.33. Family involvement is the final component of the domain of direct practice. The scoping documentation for the final month of Sarah's life details consistent advocacy by her sister and cousin with a GP surgery and with Adult Social Care, with particular focus on the need to action a

[18] The independent reviewer has been shown photographs of the condition in which Sarah was living in the run-up to her final hospital admission. This evidence of self-neglect would have been seen by professionals visiting her home in the weeks before she died.

Mental Health Act 1983 assessment, a mental capacity assessment with particular focus on her executive functioning, and intervention to address her escalating alcohol-dependence. The referral for this safeguarding adult review refers to a "*lack of support or response from the GP surgery*." **Commentary**: the contribution to the scoping documentation from the GP practice acknowledges that "*urgent emails that were sent to the practice were not processed in time*" and that "*urgent issues should not be dealt with by email*." At the learning event, this acknowledgement was reiterated, namely that acute concerns should be telephoned for action by a duty doctor. It was stated that primary care records indicate that family members were contacted within two days of their expressed concerns. Referrals for Mental Health Act and mental capacity assessments were not actioned. In the final months of her life, Sarah was seen twice at home by a paramedic from the GP hub but not by a GP. On one occasion she declined a home visit when contacted by a paramedic; in another telephone conversation, she agreed to visit an A&E department but appears not to have followed up on this. A duty doctor spoke with Sarah by telephone on 22nd November (three days before she died) when she refused to attend hospital. The scoping documentation at this point refers to Sarah being "*yellow, incontinent and semi-conscious*" and to the possible need for a mental capacity assessment. There was no follow-up.

8.34. In their letter of complaint, Sarah's relatives question why, following blood tests in October 2024 that identified rapid decline in her liver function, there was no adequate follow-up. They report that the paramedic, who acted in Sarah's best interests to arrange her final hospital admission, could not understand how other professionals had not acted sooner when she was lying in faeces and vomit, and was "*confused, jaundiced and very poorly*." They believe that, if action had been taken sooner, her death could have been prevented. During her final hospital admission, her brain was found to have been affected by toxins from total liver failure. She also had sepsis from a ruptured bowel.

8.35. Sarah's sister and cousin have observed that, when police officers completed welfare checks in the final week, they did not notify family members of the outcome who, therefore, did not know whether or not Sarah was still alive and what they had observed. Whilst acknowledging the difficulty for hospital clinicians working under pressure, Sarah's sister and cousin do not believe that staff heeded their warnings about a so-called "*nephew*" who was present when Sarah was being treated and who, despite his presentation, was financially exploiting her. **Commentary**: an NHS Hospital Trust, in its response to a formal complaint from Sarah's sister and cousin have identified a need to improve the involvement of the person in informed decision-making and to lower the threshold for involving that person's support network. The complaint response letter acknowledges that the so-called "*nephew*" had not wanted Sarah to stay in hospital in September 2024 despite her worsening symptoms and medical history. It also acknowledges that communication with Sarah's relatives did occur but was delayed because of wrongly recorded next of kin details.

8.36. Sarah's relatives have stated that they "*had to be very creative when working with professionals*." What they mean by this was that Sarah did not always welcome her sister's involvement but was more accepting of advocacy by her cousin. **Commentary**: this highlights the importance of practitioners appreciating the dynamics between family carers and the cared-for

person. Furthermore, at the learning event participants questioned how well services support families who could find themselves lost within systems and uncertain about the pathways to follow.

8.37. Records from Sarah's social housing provider record one contact with her cousin in May 2024.

8.38. No family involvement has been identified for Marcin. **Commentary**: given his needs arising from visual disability, alcohol-dependence and limited mobility, referral for advocacy should have been considered both to enhance the support already being provided by staff from a floating support service and to enable Marcin to engage fully with assessments. There does not appear to have been consideration of referral for advocacy.

## Further Domain Analysis – Inter-Agency Collaboration

9.1. A core component of this domain is information-sharing and how services work together through multi-agency risk management meetings. An NHS Trust in responding to the complaint from Sarah's relatives has identified the need to ensure that "*critically important information is shared*", for example with GPs and substance misuse services. The safeguarding adult review referral for Sarah contains the reflection that no multi-agency risk management meeting was convened when this could have facilitated a coordinated response and offered structure around how agencies worked together. This omission is also noted by the police and by a substance misuse service contribution to the scoping documentation, which additionally suggests that this is a repetitive theme, possibly because there is a lack of confidence in the process for convening multi-agency risk management meetings.

9.2. A contribution from the independent domestic violence advocacy service observes that substance misuse, domestic abuse and housing services worked together in 2022 when Sarah was living in another locality but observes that, in relation to her needs, this multi-agency collaboration could have happened sooner. In their written submission, the police have commented on a referral to MARAC when Sarah was a victim of domestic abuse. However, despite the completion of a DASH risk assessment (domestic abuse, stalking and harassment), an opportunity was missed to seek an evidence-led prosecution when Sarah did not support continuation of proceedings and DVPNs (domestic violence protection notices) were not employed. The DASH risk assessment, it appears, was not shared with all partner agencies. **Commentary**: in their written submission, the police have indicated that they have reviewed their procedures and the training provided to officers.

9.3. As already noted, in the final month of Sarah's life, referrals were sent and there was communication between staff in the detox service, the substance misuse service and an IDVA, for example about the risks associated with cuckooing and exploitation, and about relapse. However, one contribution suggests that the absence of consent was a barrier as, without it, intervention would have been "*invasive*." However, as the social housing provider records evidence, at times Sarah did consent to contact being made with other services. **Commentary**: research on self-

neglect[19] has indicated that non-intervention on the grounds of autonomy misunderstands this ethical principle, and that outreach and compassionate concern and enquiry can act in support of a person's longer-term autonomy. When consent was given, follow-through was important and not always concluded.

9.4. In their letter of complaint, Sarah's relatives have stated that an Ambulance Trust notified her GP of her frequent use of emergency services and asked for a meeting to discuss an action plan. There is no evidence in the scoping documentation of a meeting or use of a protocol for "*frequent flyers*." According to Sarah's relatives, there were 21 emergency incidents between March and November 2024 but each seems to have been treated as an isolated episode rather than as a pattern that required a collaborative investigative response.

9.5. No multi-agency risk management meetings were convened in Marcin's human story. More positively, Marcin's housing provider did refer concern about cuckooing to the police and the locks on his accommodation were changed. Paramedics shared their concerns with both Marcin's GP and Adult Social Care. The social housing and floating support providers worked closely together. **Commentary**: multi-agency meetings would have been helpful to coordinate a response to Marcin's multiple needs and the escalating concerns, for example regarding financial exploitation, that floating support practitioners were having to respond to. Indeed, there appear to have been challenges in securing multi-agency collaboration, with the police apparently being reluctant to conduct welfare checks and not working with a housing provider regarding the risk of cuckooing, and Adult Social Care not responding to requests for feedback on progress with a referral for a care and support assessment. NHS 111 did not share information when Marcin was in contact in 2020 regarding eye infections. A Fire and Rescue Service did not refer concerns about Marcin's self-neglect when he declined support. When concerns were shared, this did not seem to prompt a change in the overall response to Marcin's situation.

9.6. **Commentary**: the absence of multi-agency risk management meetings is a theme across all three human stories in this safeguarding adult review. At the learning event that focused on Sarah and Marcin's human stories, participants acknowledged that further work had already begun to emphasise the importance of convening multi-agency risk management meetings. When reflecting on both human stories, participants recognised that multi-agency risk management meetings should have been convened, for example when there was no response to expressed concerns about Sarah and when Marcin's health and wellbeing were clearly deteriorating.

9.7. **Commentary**: the aforementioned learning therefore reflected on the obstacles to using multi-agency risk management meetings. It was suggested that some agencies were reluctant to attend when they were not directly involved with an individual, effectively neglecting their advisory role. It was further suggested that some agencies were reluctant to share information in the absence of consent, even though the Data Protection Act 2018 permits information-sharing without consent when necessary to safeguard an adult at risk. Some participants had experienced rejection of referrals for multi-agency risk management meetings, sometimes

[19] See note 5.

because only one agency was primarily involved, again overlooking other services' advisory roles. There also appeared to be a lack of clarity about where decision-making to convene meetings resides and how actions assigned to practitioners and agencies should be reviewed. However, despite what appeared to be "*huge barriers*", examples were also given of where multi-agency risk management meetings had been convened and successfully challenged how services were responding to human stories, for example expectations that service users/patients would get to appointments – "*they are capable of getting to us*."

9.8. Another component of multi-agency collaboration is the referral of, and response to adult safeguarding concerns. Not all the occasions when the police were responding to Sarah as a victim of domestic abuse were referred as adult safeguarding concerns, for example when the police were also aware of her suicidal ideation and alcohol misuse. NHS 111 have reported that the service did refer domestic abuse as an adult safeguarding concern but did not receive feedback as to the outcome. One NHS Trust, whose emergency department saw Sarah on multiple occasions over a period of 14 years for falls and head trauma, alcohol-dependence and symptoms of withdrawal, anxiety, depression, suicidal ideation and physical ill-health, only made one adult safeguarding referral, in 2016 for domestic abuse. Social housing staff were aware of alcohol abuse, the history of domestic abuse and at least on one occasion her suicidal ideation. Contact was made with Adult Social Care and her GP but no adult safeguarding concern appears to have been referred. **Commentary**: in this NHS Trust's response to a letter of complaint from Sarah's relatives, it has identified an action, namely to "*lower the threshold*" for referral to safeguarding. It is important to observe, however, that Section 42(1) specifies not a threshold for referral of adult safeguarding concerns but three criteria – an adult with care and support needs, experiencing abuse/neglect (including self-neglect) and unable to protect themselves because of their care and support needs. These three criteria were clearly met for Sarah.

9.9. Between September 2020 and February 2024, six adult safeguarding concerns were referred concerning Marcin in response to alcohol-dependence and self-neglect. Adult Social Care's response to the first three was a "*community action plan*."[20] The fifth prompted a social care assessment leading to a care and support plan. Only on the sixth occasion, in early February 2024, was an adult safeguarding enquiry commenced and this was still open when Marcin died on 1st May. **Commentary**: none of the adult safeguarding concerns resulted in multi-agency meetings being convened and none resulted in a coordinated approach to meeting Marcin's needs or mitigating the risks of abuse and self-neglect.

9.10. **Commentary**: as in Daniel's human story, there appear to have been missed opportunities to refer and to escalate adult safeguarding concerns. One NHS Trust did not raise safeguarding concerns despite a pattern of multiple visits to an emergency department involving alcohol misuse, seizures, falls and liver deterioration, and self-discharge. However, at the learning event it emerged that some procedures have since changed. NHS 111 now ensures that safeguarding concerns are sent initially to that service's safeguarding team. The local authority has changed its

[20] At the learning event, it was stated that a community action plan involved referral for early help. **Commentary**: if early help is the triage decision, the local authority should review whether or not early help has reduced the safeguarding risks. This does not appear to have happened.

procedure to ensure that safeguarding enquiries now conclude with an adult safeguarding action plan, which is not closed until all its components have been completed.

## Organisational Support for Practice

10.1. The relevant features in this domain are the support available for practitioners, their knowledge, and the resources available to them to meet people's needs. When reflecting on their work with Marcin, practitioners in the floating support service have stated that they felt unsupported by the multi-agency network but were able to offer him "*excellent support*." They have observed that there were limited responses from agencies over the Christmas/New Year period when Marcin was particularly at risk. They have also commented that there was no handover when an allocated social worker in the local authority went off sick, resulting in delays in providing a support package.

10.2. A Community NHS Trust have observed that their contact with Marcin was "*minimal but responsive*" in meeting his needs for occupational and physiotherapy, and that cover arrangements were "*exceptional*."

10.3. The police have reflected that their staff lacked knowledge about cuckooing and best interest powers under the Mental Capacity Act 2005, gaps in knowledge that they are taking steps to rectify.

10.4. At the learning event participants questioned the provision of supervision in a context where in all three human stories covered in this safeguarding adult review risk had appeared to sit mainly with one practitioner and/or service. The impact of stretched resources on the availability of time to respond to urgent needs and risks was also referenced, with high thresholds operating for home visits. Participants also questioned whether information about the availability of emergency lines (in GP practices), the appointment of a dedicated practitioner focusing on home invasion (cuckooing) and the existence of case discussion forums were widely known. Finally, participants recognised that there had been gaps in service provision, for example around post rehabilitation support and that more emphasis was not being placed on the recovery agenda.

10.5. It has been "*heart breaking*." "*It has impacted us as a team*." The circumstances in which Sarah lost the recovery gains she had made in a residential detox service has an emotional legacy, as is also the case for those who knew Daniel and Marcin. **Commentary**: organisational support for staff, and indeed also for families, should be a priority when human stories end, whether or not they then become the focus of reviews.

## Further Learning on the Key Lines of Enquiry

11.1. It has been possible to identify some positive practice in all three human stories, for example the relationship-based approach offered by some practitioners and the use of multi-disciplinary meetings. There have also been some recent developments. For example, multi-agency risk management meetings are now recorded within Adult Social Care IT systems. Another recent development has been the introduction of a housing support element within commissioned substance misuse services, with also a dedicated cuckooing worker. Greater emphasis is also being placed on a recovery agenda, including a new post to tackle co-occurring mental health and substance misuse concerns. Nonetheless, reading across three previously completed safeguarding adult reviews[21] alongside the findings from the human stories of Daniel, Sarah and Marcin, there are clear commonalities in how services understand and work with people who self-neglect, namely:

11.1.1. Shortcomings in outreach in response to challenges associated with engagement.
11.1.2. A lack of professional curiosity or expressed compassionate concern in response to self-neglect and a background of trauma and loss.
11.1.3. Discriminatory or negative attitudes.
11.1.4. Concerns about the completion of mental capacity assessments, including consideration of executive functioning.
11.1.5. Delays in assessment and service provision, coupled with a lack of urgency.
11.1.6. Shortcomings in how agencies work together around hospital discharge.
11.1.7. Concerns about how services engage with, and respond to concerns raised by family members.
11.1.8. A lack of a whole system response when individuals present with a combination of mental health, physical health and substance misuse concerns, and related care and support needs.
11.1.9. Absence of multi-agency risk management meetings.
11.1.10. Missed opportunities to complete adult safeguarding enquiries (Section 42(2) Care Act 2014) on receipt of adult safeguarding concerns (Section 42(1)) relating to self-neglect.

11.2. These commonalities are replicated in another recently completed CPSAB mandatory review[22]. Joe died, aged 54, of chronic alcohol-related liver disease, chronic pancreatitis and malnutrition. He lived with chronic alcohol use disorder, serious physical health issues and mental ill-health. He died at home in squalid circumstances.

11.3. Once again, this safeguarding adult review positively references joint visits and the use of multi-disciplinary meetings, an assessment by liaison psychiatry, and a care and support assessment that concluded with provision of a package of care. However, findings from the human stories of Daniel, Sarah and Marcin are echoed in Joe's human story, namely:

11.3.1. A lack of intensive assertive outreach, and a sustained relationship, in response challenges surrounding engagement associated with chronic alcohol use, mental and physical health concerns, and extreme self-neglect.

[21] Arthur (2018), Peter (2020) and Dorothy (2021).
[22] SAR Joe (2025).

11.3.2. Concerns about mental capacity assessments, including whether executive functioning was considered and how differences of opinion were discussed and resolved. Additionally, concerns that Joe "had capacity" resulted in inaction.

11.3.3. The impact of attitudes, for example demonstrated in assumptions of lifestyle choice.

11.3.4. Shortcomings in expression of professional curiosity, for example to understand what might lie behind chronic use of alcohol, and to attempt to motivate Joe to respond to the package of care.

11.3.5. Omitting to use screening tools with respect to Joe's alcohol use, and concerns about the level of understanding of addiction.

11.3.6. A lack of a multi-agency risk management meetings, for example to coordinate intervention and to discuss mental capacity questions.

11.3.7. Lack of engagement with family members when they expressed significant concerns.

11.3.8. Some referred adult safeguarding concerns not progressing to adult safeguarding enquiries.

11.4. At the learning event that focused on Sarah and Marcin's human stories, there were references to "*similar cases*." It was suggested that learning from previously completed reviews had not been implemented across all services and that there was a lack of assurance that findings and recommendations had resulted in change. **Commentary**: the challenge voiced at this learning event was one of how learning is disseminated in order to be impactful and how CPSAB seeks assurance on outcomes of its completed reviews.

## Translating Learning into Change

12.1. SAR Joe concluded with recommendations that include promotion of multi-agency risk management meetings and the development of guidance on engagement, use of screening tools in cases of alcohol-dependence, and further training and guidance on attitude change and use of mental capacity legislation. The referenced earlier completed reviews also made recommendations relating to multi-agency risk management meetings, how agencies work together when people present with multiple and overlapping issues, training on self-neglect, and how services collaborate to identify, assess and respond to risk.

12.2. This thematic review, encompassing three human stories, therefore presents CPSAB with a task to understand the outcomes of recommendations from previously completed safeguarding adult reviews, to identify the enablers of practice development and organisational change, and to pinpoint and address the obstacles or barriers to change.

12.3. SAR Joe also invites CPSAB to consider escalation of concerns about mental capacity legislation and its code of practice to the Department of Health and Social Care, specifically in relation to its application in human stories involving alcohol-dependence. Sarah's sister and cousin also believe that there needs to be change at a national level. The second national analysis of safeguarding adult reviews in England[23] also concluded with recommended

[23] See note 1.

improvement priorities for the Department of Health and Social Care on mental capacity law and guidance with respect to alcohol-dependence.

12.4. Rather than repeat recommendations from CPSAB's previously completed safeguarding adult reviews, it seems more appropriate for the Board to consider the development of a detailed programme of work that engages with senior leaders, operational managers, commissioners, providers, practitioners and people with lived experience. This programme of work should:

12.4.1. Seek evidence for changes in practice and service development as a result of learning and recommendations from CPSAB's previously completed reviews.
12.4.2. Identify ongoing obstacles or barriers to practice change and service development in response to review findings.
12.4.3. Implement an action plan to address these obstacles or barriers, integrating the findings from this thematic review of three human stories.
12.4.4. Pay particular attention to building practice that engages positively with service users/patients, expresses compassionate enquiry and seeks to understand their lived experience, thinks family, provides a whole system approach to transitions, and demonstrates comprehensive and coordinated assessments and plans with respect to mental capacity, addiction, mental health, housing and care and support.
12.4.5. Pay particular attention to reinforcing how agencies work together, with particular focus on decision-making about adult safeguarding referrals and on the use of multi-agency risk management meetings.
12.4.6. Pay particular attention to how services are designed and commissioned to promote positive engagement and practice with individuals and their families, and collaborative practice across agencies.