



Cumbria Safeguarding Adults Board

Safeguarding Adults Review **‘Stephen’** **Overview Report**

Independent Author: Suzy Braye

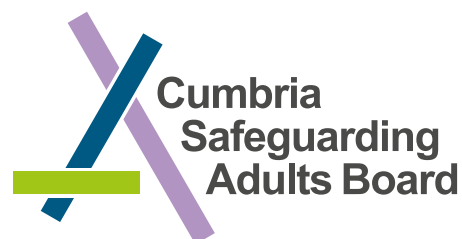
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Safeguarding Adults Review

'Stephen'

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1. Introduction

- 1.1. In June 2024, Cumbria Safeguarding Adults Board (CSAB) received a referral from North Cumbria Integrated Care NHS Foundation Trust, requesting review of the circumstances surrounding the death of Stephen, who died in hospital in February 2024. He had been neglectful of his personal care, his health and his home environment, and had experienced an acute health crisis. He had been admitted in a critical condition after he declined earlier urgent hospitalisation.
- 1.2. The Board considered that Stephen's case met the mandatory criteria for a Safeguarding Adult Review (SAR) and commissioned an independent reviewer¹ to carry out the SAR, working with a SAR Panel of senior leaders from the agencies involved.
- 1.3. The Board specified that the review should build on earlier learning from a CSAB thematic review featuring six individuals who had died in circumstances of self-neglect². The thematic review had been completed and published in 2025, with improvement actions already underway. Any additional learning from Stephen's case would be addressed alongside these.

2. The Thematic Safeguarding Adult Review Process

- 2.1. The Care Act 2014 gives Safeguarding Adults Boards a statutory mandate to arrange a Safeguarding Adults Review in certain circumstances. Under section 44 (1-3), a review **must** take place where:
 - An adult with care and support needs³ has died and the Board knows or suspects that the death resulted from abuse or neglect⁴, or an adult is still alive and the Board knows or suspects that they have experienced serious abuse or neglect, and
 - There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

The Board has discretion (section 44 (4)) to undertake a review in any other case involving an adult with care and support needs.
- 2.2. The Care Act requires SAB partners to co-operate with and contribute to the review, with a view to identifying the lessons to be learnt and applying those lessons in the future⁵. The purpose is not to allocate blame for the events but to identify how agencies can work together to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.
- 2.3. The key lines of enquiry for the review were:
 - 2.3.1. What learning has already been identified in recent SARs or internal learning that is relevant to Stephen's experience?

¹ Suzy Braye (Emerita Professor of Social Work, University of Sussex) is an independent adult safeguarding consultant with specialist expertise in self-neglect and in learning from safeguarding adult reviews.

² <https://cumbriasab.org.uk/sites/default/files/10694942/2025-10/CSAB%20thematic%20selfneglect%20Safeguarding%20Adult%20Review%20SAR%20REPORT.pdf>

³ Whether or not the local authority has been meeting any of those needs

⁴ 'Abuse and neglect' includes self-neglect (Care Act 2014 Statutory Guidance)

⁵ Section 44(5), Care Act 2014

- 2.3.2. How were the risks in Stephen's situation addressed and how well was he safeguarded?
- 2.3.3. How effective was multiagency working in respect of Stephen's circumstances?
- 2.3.4. What organisational features impacted upon the work that took place with him?
- 2.3.5. What changes or developments have taken place since his death that could prevent future similar circumstances for adults experiencing self-neglect?
- 2.4. The period under review was between June 2023, when Stephen's GP referred him to the local authority for assessment under the Care Act 2014, and February 2024, when Stephen died. Focus has been placed on both good practice and practice shortcomings.
- 2.5. The key steps for the review were:

Agency information submitted by the following agencies:

- Cumberland Council Adult Social Care (ASC) and Housing
- Cumbria Police
- Department for Work and Pensions (DWP)
- Eden Medical Group
- Cumbria Fire and Rescue Service
- North Cumbria Integrated Care NHS Foundation Trust
- North West Ambulance Service
- Riverside Housing Association

An in-person learning event bringing together front-line practitioners, operational managers and safeguarding specialists to explore experiences of working with Stephen, to ensure that learning from the review was informed by those most directly involved with him. The event was attended by 18 people from a wide range of occupational roles and agencies. Discussions were supported by members of the SAR panel.

Meetings with family members⁶: The Board advised Stephen's sister, brother and sister-in-law that the review was taking place, his brother and sister-in-law met with the independent reviewer. Their involvement has helped to give a more rounded picture of Stephen as a person and has provided additional perspectives on the work of the agencies involved with him. CSAB and the independent reviewer recognise that participating in a SAR is not an easy process for family members and are very grateful for their willingness to contribute to the learning that can arise from Stephen's story.

Thematic analysis: The independent reviewer has carried out thematic analysis of the learning, drawing also on previous learning from the thematic SAR on self-neglect.

⁶ Statutory guidance on SARs requires family members to be invited to contribute to reviews.

3. Parallel Processes

3.1. Individual agency reviews

The GP practice initiated a formal after-action review, which was submitted to the SAR. This identified learning related to the management of self-neglect, which is reported at relevant points in this report. No other agency reported that an internal review had taken place.

3.2. Coroner's office

An inquest hearing took place on 28th November 2024. The Coroner concluded that Stephen had developed infected leg ulcers, which led to septic shock and multi organ failure. He had declined urgent admission to hospital and died following an emergency admission. The Coroner also noted that self-neglect had contributed to his death.

4. Stephen's Story

- 4.1.** Stephen lived alone and had been a tenant of his housing provider Riverside since 2000. His flat was a general needs property, accessed via a flight of stairs. He was not in good health and had poor mobility, with diagnoses that included osteoarthritis, hypertension and type 2 diabetes. He was a heavy smoker and had been a long-term and regular user of alcohol, drinking to excess, although it is understood that when he died he had been sober for 3 years. Throughout his life he had had no notable relationships with partners. At home he lived in squalid and unhygienic conditions, with animal faeces from his pet cat and infestation. His property was severely hoarded and his personal hygiene was compromised by his mobility difficulties and the neglected condition of his bathroom.
- 4.2.** Stephen was the middle child of three, having an older sister and a younger brother. The three siblings were close as children. Stephen was a talented artist and musician, in his youth playing guitar in a group that toured Europe. But he began to drink heavily in his teens, and his behaviour when intoxicated would become challenging and unpleasant. He also experienced two traumatic losses through the deaths of close friends, which hit him very hard, and he came to rely on alcohol. His relationships were affected by his drinking and he also later lost his driving licence through drink-related offences, compromising his job as a lorry driver. His brother and sister-in-law have described how when sober, he was 'a gentle soul, a placid, pleasant and respectful man' but intoxicated he treated people very badly. He was, in effect, a man of two halves. He remained close to his mother, but gradually his brother and sister distanced themselves from him due to his behaviour and he became quite isolated. When their mother, who was very fond of Stephen, was admitted to a care home in 2022, the family were concerned to ensure that she and Stephen did not become estranged through lack of contact. Stephen's brother's wife, therefore, reached out to Stephen as a gobetween to represent the family, to share news with him and bring his news to their mother. In that role, she became increasingly involved in supporting him as his health deteriorated.
- 4.3.** In 2018 Riverside raised concerns with Adult Social Care about the conditions in his home. Initially the referral was closed after Stephen, when contacted by Adult Social Care, indicated that he did not need any help. Riverside then sent photographs taken on a joint visit with the Fire and Rescue Service, and the assessment was re-opened. But Adult Social Care's attempts to proceed with assessment faltered due to lack of contact and response from Stephen.

- 4.4.** A further referral from Riverside in May 2019, detailing Stephen's struggles with depression and alcohol, resulted in Adult Social Care advising him to seek support from his GP to address his alcohol dependency, as it was believed this needed to happen before he could be referred to the mental health team. They also provided details of potential financial support to clean and tidy his property and subsequently closed the referral.
- 4.5.** Late in 2019 Riverside referred him to Adult Social Care again for OT assessment for the installation of a shower. This resulted in a plan for a wet room with level access shower. The bathroom adaptations were not carried out, however, as the building contractors required the property to be cleaned before they did the work. Stephen declined to do this and was rude and abusive to them. He also declined support from a Health and Wellbeing Coach to assist with managing his hoarding.
- 4.6.** In December 2020 the Police investigated concerns from Stephen that he had fallen into financial difficulties due to the behaviour of a friend who was taking advantage of him. The police advised him on how to deal with this and shared information about his vulnerability with Adult Social Care.
- 4.7.** By April 2022 the bathroom adaptation had not been resolved and Riverside asked Adult Social Care whether local authority contractors could be used. This was not possible, however. ASC do not have contractors for anything other than minor works and the scale of this adaptation fell outside that contractual arrangement. Similarly, the local authority's housing department work to a framework agreement within the Disabled Facilities Grant process, with Stephen's bathroom again falling outside of those arrangements. Adult Social Care advised Riverside to discuss with Stephen a move to a more suitable property. This advice was repeated in August 2022, when Stephen's sister-in-law raised the question of adaptations to assist him in carrying out personal care.
- 4.8.** Stephen's sister-in-law by this time had become involved in supporting him on behalf of the family. She discovered he had debts and insufficient income, so ensured he received debt advice and supported him in applying to DWP for Personal Independence Payment (PIP). She offered to help with his cleaning, which he refused, but he did accept her shopping for him, so he always had food. By this time he was sober and receiving support from AA. His sister-in-law has described this as a time when Stephen could begin to enjoy a better quality of life and it was possible to anticipate better outcomes for him.
- 4.9.** In January 2023, however, Stephen's GP on a home visit noted concerns about the state of his property, describing it as in complete disarray. Stephen reassured the GP that this was being dealt with by his social worker and the housing association (although there is no evidence of any actions taken since the previous April).
- 4.10.** In June 2023 Riverside again raised the bathroom adaptation with Adult Social Care and at the same time the GP practice asked Adult Social Care to provide a Care Act assessment for Stephen. This was allocated to an Occupational Therapist (OT), who in September 2023 did a joint home visit with the housing officer and found his home situation unchanged - Stephen still needed the bathroom adaptation but would not allow any cleaning to enable contractors to carry out the work. Nor would he allow Riverside to clean the bathroom for him so that the work could take place. He did not want to consider moving, as this was his home. Adult Social Care did request a fire safety visit, which the Fire and Rescue Service carried out in November 2023. Riverside made further requests for assistance in finding a contractor,

but Adult Social Care did not progress this, continuing to see the bathroom as a matter between landlord and tenant. They wrote to Stephen explaining that they were closing their own involvement and that the bathroom plans remained available should he change his mind. Stephen rang to protest at the closure but remained adamant that he would not allow the cleaning.

- 4.11.** At the end of January 2024, following a GP home visit, the surgery referred Stephen to district nursing for assistance with hygiene and application of emollients, and to monitor skin breakdown. After their first home visit on 31st January, district nursing made a safeguarding referral to Adult Social Care, raising concerns about Stephen's living conditions, which they described as horrendous: the property was fly-infested with evidence of hoarding, his bathroom and bedroom were not usable, the bathroom had no running water and he slept on a tiny couch.
- 4.12.** After a phone conversation with Stephen, Adult Social Care did not progress the safeguarding referral to a s.42 pathway because he had indicated his willingness to accept help. His sister-in-law was shopping for him. He was listed for support from Homelife and a Care Act assessment with a standard priority rating. In the days that followed, district nursing continued to request a safeguarding response and remained in contact with Adult Social Care, providing photographs and updates on his condition – they were visiting daily to attend to his legs. They were alert to the risk of sepsis and discussed this with Stephen. Adult Social Care reviewed the decision on the safeguarding referral but confirmed that he remained listed for Care Act assessment rather than s.42 enquiry.
- 4.13.** On 6th February 2024 Stephen asked Adult Social Care for support with shopping as his sister-in-law was unwell with Covid and a food delivery by Age UK was arranged. The following day, his case was discussed at an Integrated Care Community Frailty Team meeting but was not taken on by the Frailty Team. District nursing liaised further with Adult Social Care, who advised referral to Environmental Health for treatment of infestation, which would be required before any deep clean. Given Stephen's difficulty tolerating compression bandages due to pain, the district nurses sought assistance from the GP practice nurse and a community hospital day unit, but no additional support was available. District nurses were now visiting daily and continued to raise concerns with Adult Social Care.
- 4.14.** By Wednesday 14th February 2024, Stephen's health was declining rapidly. District nurses found him shaking, grey and tired, with blood in his stools and losing the ability to stand or use the toilet unaided. He was in acute pain and could not tolerate the compression bandages. An ambulance was requested to convey Stephen to hospital but shortly afterwards Stephen cancelled the ambulance, saying his sister-in-law would take him to hospital two days later.
- 4.15.** The following day, 15th February, the social care worker visited Stephen at home to carry out a Care Act assessment, with Stephen's sister-in-law also present. Multiple care and support needs were identified but also the risk of infection for care workers due to the home conditions. A plan was made that Stephen would go to hospital the following day and that while he was in hospital a deep clean of his property would prepare it for his return, with a care package on discharge. Stephen undertook to consider a move to a ground-floor

property in the longer term.

- 4.16.** That evening, the GP visited Stephen at home and assessed his condition, strongly advising him that urgent hospital admission was necessary. Stephen was adamant that he did not want emergency admission that day. The GP gave worsening advice with a view to district nurses reviewing him the following day.
- 4.17.** On Friday 16th February, the social care worker who had visited Stephen the previous day raised a safeguarding referral. The referral noted that the property was in an extremely poor and unsanitary condition. Stephen had open leg wounds that were weeping fluid. District nurses were visiting to dress his legs but he was removing the bandages. He also had pressure sores on his upper leg and bottom but had declined district nursing assessment of these. The district nurse and GP believed he was at serious risk of contracting sepsis and, because of this, was at risk of death. His breathing was very poor and he became breathless even when merely talking. He had COPD and still smoked 40/50 cigarettes a day. He was unable to mobilise around the property due to his legs and his breathing. He was at serious fire risk due to smoking, being unable to self-evacuate and having no working smoke alarms in the property. This safeguarding referral was classed as medium priority and flagged for allocation the following week⁷.
- 4.18.** Also on 16th February, the GP and district nursing planned a joint visit. The GP rang Stephen, who refused to be seen before 6pm, saying he was too tired, and that he would only go to hospital when he himself decided. The GP gave safety netting advice. The district nurse and Stephen's sister-in-law attempted throughout the day to remain in contact with him and continued to liaise with each other. The district nurse arranged a visit for the later time and in the meantime sought advice from the hospital trust's Safeguarding Team Advice and Support Line, who advised that if Stephen remained out of contact later then a police welfare visit should be requested.
- 4.19.** When Stephen's sister-in-law attended Stephen's home in the early evening, she found it in darkness and could not gain access. She liaised with the district nurse and the police were called. On arrival, they found Stephen collapsed and extremely unwell, with difficulty breathing and sharp chest pain. The police were equipped to administer oxygen, which they did while also requesting ambulance attendance. Stephen was conveyed to hospital by ambulance but deteriorated further, and on admission was in a critical condition. He subsequently experienced two cardiac arrests and died in the early hours of the following morning.

5. Thematic Analysis

This analysis focuses on the four key lines of enquiry for this SAR: how the risks in Stephen's situation were addressed; how his decisions about his living situation were understood; how well agencies worked together; what organisational factors may have impacted upon practice. The analysis draws the written information submitted by agencies, the perspectives of attendees at the learning event and family perspectives. It also references the learning from the thematic

⁷ Adult Social Care have clarified that under their standard operating model a safeguarding enquiry in respect of someone who already has an allocated practitioner would be undertaken by that practitioner. It appears likely that the priority was seen as Medium because an interim risk management plan was in place – namely that Stephen had agreed to go hospital later on the Friday. The following Monday the enquiry was allocated to Stephen's practitioner, alongside their team manager.

SAR on self-neglect and identifies any additional learning from Stephen's circumstances.

5.1. Risk management

5.1.1. The risks in Stephen's situation were well recognised: environment, hygiene, health and fire risks were all observed. Some action was taken: referrals to adult social care for care and support, offers of support from a health and wellbeing coach, home fire safety visits, safeguarding referrals and proactive attempts to secure a safe outcome in health crisis.

5.1.2. But Stephen was not always an easy person to work with. Participants at the learning event described their interactions with him as a challenge at times; he trusted some staff more than others and he could be impatient, rude and abrupt, making it clear when he wanted practitioners to leave. Riverside had worked over the years to support him to keep his flat clean and uncluttered, but it had always slipped back. More recently, they had been unable to understand why he refused their hands-on involvement to clean the bathroom, finding him fixed in resentment at the belief that the builders were calling him dirty.

5.1.3. The failure to secure a satisfactory outcome on his bathroom adaptation was a key omission in terms of management of risk. This left him without adequate facilities to keep himself clean and as his health declined the implications of this became increasingly serious. While Stephen's own refusal to allow cleaning was clearly a barrier, and the practitioners involved did not find any cause to question his mental capacity to make that decision, it should not have remained an insurmountable barrier for so long. In such circumstances, persistence in building a relationship of trust can be a powerful intervention that enables eventual agreement on difficult issues to be reached⁸.

5.1.4. At the learning event, district nurses described how challenging it was to provide care for his leg ulcers. In practical terms, his home conditions were far from suitable. The nurses had to wear Personal Protective Equipment (PPE) for their own health and safety and found it hard to keep clear a sanitised area in which to work without causing embarrassment to Stephen. In addition, he was often in pain when having his legs dressed and would become irritable. He refused certain elements of wound care such as compression bandages as he could not tolerate them and would run out of patience, making it difficult to complete planned interventions. District nurses responded to the challenges by making longer visits so they could spend time talking with Stephen, persuading him to change his views and fixed ideas. They tried to keep consistent personnel on visits. Recognising the extreme risks to his health they raised a safeguarding referral and persisted in communications with Adult Social Care. They commented that although they were only involved for two weeks, it felt like a lifetime.

5.1.5. The GP practice's after-action review identifies the need for a structured approach to risk management and a safeguarding mindset in high-risk self-neglect cases, even where the individual has mental capacity. Clear, structured documentation of decisions is seen as essential for legal and regulatory compliance.

⁸ Research on positive outcomes in self-neglect provides evidence that trusting relationships, built over time, can be effective in enabling individuals to overcome the barriers to accepting help (Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: SCIE; Steils, N., Woolham, J., Manthorpe, J., Owen, J., Martineau, S., Stevens, M., Tinelli, M. & Tynan, S. (2025) *Social care responses to self-neglect and hoarding among older people: what works in practice?* York: NIHR School for Social Care Research).

- 5.1.6.** Participants at the event made the point that risks such as those Stephen faced in his final days escalate quickly. Discussion took place on whether outcomes would have differed had Stephen been placed on a safeguarding pathway when referred initially by district nursing two weeks earlier. The view was expressed that his deterioration was so fast that the pathway was not significant - what was needed was action that recognised the need for a rapid response. It does seem possible, however, that a safeguarding pathway at that point would have enabled a strategy meeting to be convened and more urgent action to take place. In the event, on the basis of the information provided he was placed on the waiting list for care and support assessment, with a normal, nonurgent priority weighting. Adult Social Care have pointed out that any agency could have convened a multidisciplinary meeting; such meetings are not confined to the safeguarding pathway. A key question to consider, however, is why this did not happen. Previous SAR findings in fact indicate that the arrangements for multidisciplinary meetings outside of safeguarding are complex and at times unclear to practitioners. In the present review, Riverside, as Stephen's landlord, have indicated that they were not aware they could convene a meeting, and indeed that they were not aware of the range of practitioners involved with Stephen. This review understands that new guidance is being developed. An important consideration going forward will be to ensure the widest possible dissemination and ongoing monitoring of its impact.
- 5.1.7.** Participants at the learning event expressed concerns at the different interpretations of what 'rapid response' or 'urgent' means. For district nurses, rapid response means 2 hours, whereas for Adult Social Care urgent response means 24 hours and a normal response is 1-2 weeks. Participants called for a common understanding and set of standards.
- 5.1.8.** Stephen's family recognise the very real efforts that health personnel made to respond to Stephen's needs and manage the risks he faced. They have nothing but praise for the district nurse most involved with Stephen, noting her professionalism, empathy, compassion, kindness and teamwork, all of which they feel went above and beyond expectations. They also commend the Police, for the speed of their response on Friday 16th February and the immediate assistance they gave Stephen to ease his distress. They are grateful to the hospital for the support provided to them at the time of Stephen's death, and to Riverside for their support with Stephen's property after his death.
- 5.1.9.** In contrast, they are concerned at the impasse that occurred over several years, which resulted in no action being taken on Stephen's bathroom. And in his final days they are critical of what they see as an absence of timely action by Adult Social Care in the light of what was known about the conditions in his home and the risks to his health. Equally, they find it regrettable that on Friday 16th February, the GP rang Stephen before pursuing the plan for a home visit and accepted his refusal to receive a visit before 6pm. While acknowledging that respecting a patient's wishes is often good practice, they feel that a duty of care should have overridden Stephen's wish at this point, given what was already known about the risk of death. There is also sadness that family dynamics prevented him having the full support of his family. They would have wished Stephen to have a more dignified, less painful exit to the world. They recognise that earlier hospital admission may not have prevented his death, but it would have meant they could have been with him.
- 5.1.10.** In summary, it seems recognition of risk did not always lead to a risk management response. The Fire and Rescue Service have acknowledged that although aware of the risks from the conditions in which Stephen was living, they did not refer these into safeguarding.

The Police have reflected that a safeguarding report could have been submitted in regard to Stephen's vulnerabilities. The GP has noted that they did not make a safeguarding referral about his home conditions as they believed Adult Social Care were already aware of these. The district nursing service did make a safeguarding referral immediately after their first visit to Stephen. However, this did not result in a timely risk management response. It is questionable whether care and support assessment, with a medium response time, was an effective pathway for Stephen at this point. District nurses did challenge this but the outcome remained the same and district nursing did not use the CSAB formal escalation policy to pursue the challenge. Adult Social Care have commented that a safeguarding pathway would not have changed things, but the core concern here is less the pathway than the lack of urgency attached to the management of risk; safeguarding may have triggered a speedier response. It is important to acknowledge, nonetheless, that effective risk management relies upon accurate and detailed information about both the level and the urgency of the risk (see section 5.3.3).

5.1.11. A key finding from CSAB's earlier thematic self-neglect SAR was that agencies did not worry enough about the risks arising from an individual's self-neglect. There too, self-neglect was triaged out of safeguarding and risk was assumed to be managed within case management. Stephen's situation reflects this but also gives some additional learning about the importance of finding a common language about level of risk and how to ensure that responses are matched to that level. Detailed and accurate information about an individual's circumstances, conveyed at the referral stage, is vital to securing a safeguarding response that matches the level of risk.

5.2. Stephen's decision-making

5.2.1. Stephen's refusal to allow cleaning to take place so that his bathroom adaptations could proceed impacted negatively on his personal hygiene and, later, on the course and speed of his health decline. Participants at the learning event reflected on how resolution of this issue might have led to a very different, and much more positive, outcome. Despite attempts by Riverside to reassure him that the builders were not saying he himself was dirty, he remained wedded to refusal. Stephen's brother and sister-in-law believe that it was pride, shame and embarrassment that lay behind his refusal to acknowledge the level of squalor in his home and to agree to the cleaning.

5.2.2. In such circumstances, research evidence on self-neglect indicates that building a relationship of trust can pave the way for an individual's thinking to shift. But Stephen did not have such a relationship; agency involvement had been episodic, with the bathroom issue going round in circles – more of the same rather than a different approach being tried. And later involvement by district nursing and Adult Social Care took place over a short time only and was focused on the rapid decline of his health.

5.2.3. His refusal to attend hospital in the days before his death was also hard to understand. At the learning event, practitioners reported two possible influences:

- He was expecting an Adult Social Care visit the day after hospital admission was first proposed, which he may have believed would lead to his bathroom adaptation being progressed;
- He was fearful because he had the memory of his father dying in hospital. His family too recognised the impact of the memory of his father's death in hospital and added that he was worried about who would look after his beloved cat if he was away.

5.2.4. A key question to be addressed is whether Stephen's decisions, with their high-risk consequences, were made with mental capacity. It seems there was consensus that he did have capacity to decide about his health and safety but there is no evidence that any formal assessments under the Mental Capacity Act took place. This was despite the sequence of increasingly unwise decisions that he made and despite the likely impact of his rapidly deteriorating health. It can be argued that on the basis of his clinical signs alone a Mental Capacity Act assessment was warranted when he declined hospitalisation.

5.2.5. The GP practice after-action review notes a potential over-reliance on historical determinations of capacity without sufficient reassessment during Stephen's deterioration. They also note limited documentation of how his understanding of the risks he faced was explored in discussion with him. The review makes the important point that capacitous refusal does not remove the need for risk management and safeguarding.

5.2.6. Reasons for the absence of assessment were also discussed at the learning event:

- District nurses stated that they had no reason to doubt his capacity and that they would not undertake a formal assessment unless they did.
- They also felt that if they broached the question of capacity assessment with Stephen he would have declined and withdrawn and feared that this would have damaged their relationship with him.
- Stephen consistently stated his views very firmly, which may have contributed to the assumption that he had capacity.

5.2.7. Some practitioners, however, questioned whether he really did understand the risks to his life during the few days before he died, whether he understood the consequences of not receiving treatment and whether he would really have been able to carry out the worsening advice the GP had given. Stephen's brother and sister have observed that although he knew he wasn't well, he didn't seem to retain information about his health and medication. In particular they consider he may not have appreciated the severity of the risks of pulling off his leg dressings to ease his pain, and that the severity of his condition during his last days may have escaped him.

5.2.8. Without a Mental Capacity Act assessment having been carried out at the time, it is not possible to be wholly confident in his capacity. Added to this is the question of his long-term alcohol use and whether alcohol-related brain damage was interfering with his ability to use and weigh the relevant information about risks and likely outcomes. Again this aspect of capacity was not considered. Practitioners at the learning event, acknowledging the importance of executive function, were unsure where they might go for advice on this aspect of capacity (although it is hoped that action on the recommendations from the thematic self-neglect SAR, as this matter was raised there).

5.2.9. CSAB's earlier thematic self-neglect SAR similarly found that Mental Capacity Act assessment was often absent in circumstances that warranted it taking place. Instead practitioners relied on an assumption of capacity, even in the face of persistent and high-risk unwise decisions and did not consider the significance of executive brain function. Stephen's case does not provide new learning here, but it reinforces the importance of the improvement actions recommended in the thematic SAR.

5.3. Interagency working

- 5.3.1.** There was some proactive information-sharing between agencies - notably district nursing, GP, Adult Social Care and Riverside – and district nursing kept in close liaison with Stephen's sister-in-law.
- 5.3.2.** Not all communications ran smoothly, however. The GP practice after-action review also notes fragmented communication between GPs in respect of handover of his situation, and between the GP practice and community services. Nursing staff at the learning event stated they had to spend precious time following up referrals to Adult Social Care and chasing outcomes, seeking the feedback that was crucial to ensuring effective responses to high-risk circumstances and pushing for a coordinated strategy. They suggested that shared mailboxes should be used for communications so that staff absence does not cause delay in the flow of information.
- 5.3.3.** Questions were raised about whether accurate and sufficiently detailed information about Stephen had been shared when district nursing made their initial safeguarding referral and in subsequent communications. Were the severe risks to his health and later the imminent risk of death sufficiently spelled out? Participants believed this may not have been made sufficiently clear and emphasised that a shared understanding of the level of risk is essential if appropriately urgent action is to be taken.
- 5.3.4.** One way to achieve this would have been to convene a multi-agency risk management process. The concerns raised by district nursing were not being taken forward under safeguarding, so a safeguarding strategy meeting was not available. District nursing sought support via the Frailty Team MDT but felt let down that this process did not result in any enhanced support for their work with Stephen. The GP practice notes limited use of multidisciplinary forums and missed opportunities to achieve a coordinated response.
- 5.3.5.** A number of learning event participants observed a disconnect between district nursing and Adult Social Care during the final two weeks of Stephen's life. This did change once a social care worker was allocated to Stephen's case in the days prior to his death, when there is clear evidence of multi-agency working between that practitioner and the district nurse. Prior to that, district nursing felt they were the one agency holding the risk, when a multi-agency team response was needed. There was discussion at the learning event about the role that a central hub might play in facilitating such conversations in urgent circumstances – akin to the Multi Agency Safeguarding Hub (MASH) that is established in Children's Services.
- 5.3.6.** It is important to note that once Adult Social Care visited Stephen to undertake a Care Act Assessment on Thursday 15th February, a shared plan, agreed between Adult Social Care and district nursing, did evolve. Stephen would go to hospital the following day - Friday 16th. While he was in hospital his flat would be deep-cleaned and he would receive care and support on discharge home. The contingency plan was that if he did not go to hospital on the Friday, then a multidisciplinary team discussion would take place the following Monday. The problem here, as noted in the earlier section relating to risk, was that the plan did not match the urgency of his circumstances. He had already been recognised as being at risk of death. A delay of four days before discussing what should be done next was not reasonable.
- 5.3.7.** The findings here echo the earlier CSAB thematic SAR on self-neglect, which similarly found an absence of inter-agency risk management meetings outside of safeguarding pathways.

Stephen's SAR adds even further weight to the need, identified in the thematic SAR, for a clear process for convening agencies in situations of high and urgent risk.

5.4. Organisational features

- 5.4.1.** From agencies' responses there emerged evidence of challenges within the organisational context. High on the agenda was insufficient staffing capacity, which was leading to longer waiting times and difficulty maintaining consistent personnel to work with individuals.
- 5.4.2.** There were also concerns about whether current procedures are 'fit for purpose', particularly in the context of risk to life where speed of response is critical. One agency felt that the need for an individual's consent to intervention could pose a barrier to effective use of risk management procedures. Another questioned the robustness of safeguarding decisions made on the basis of phone / text messages, in which high-risk factors can be missed, either because they are not fully conveyed by the referrer or because they are not fully recorded by the recipient. They called for communications to be in writing to ensure that detail can be accurately conveyed and verified. Learning event participants similarly raised this issue.
- 5.4.3.** Nursing staff felt there was a risk they were not believed when referring into Adult Social Care, and it is notable the once a social care practitioner had visited Stephen at home to undertake a Care Act Assessment, they raised their own safeguarding referral. Prior to this, contacts with Stephen had taken place by phone. While recognising that phone contacts are embedded in agency custom and practice for responding to referrals, participants were of the view that in cases of extreme self-neglect face-to-face contact was essential in order to assess and understand levels of need and risk.
- 5.4.4.** Further concerns about the organisational context included the observation that ICC step-up beds in community hospitals are often used for hospital step-down, blocking access for step-up. Such a facility would have been highly appropriate for Stephen, enabling him to receive healthcare interventions while his property was cleaned.
- 5.4.5.** More broadly, system pressures generally make it hard to intervene early enough in a situation to prevent crises escalating. It was believed that more persistent, earlier involvement with Stephen could have prevented his subsequent decline.
- 5.4.6.** There was much discussion at the learning event about the organisational work environment. Participants described a feeling that they, and their agencies, were merely fire-fighting – struggling to deal with the volume of referrals, with practitioners set up to fail because of the level of pressure in the system. Added to this in Stephen's case were the very real frustrations and distress of trying to support him, which arose from witnessing the decline of his health, from his reluctance to follow vital health advice and from the physical conditions in which the work with him took place: "The builders won't go in, but we do". The experience of the organisational context for professional practice was, for some, one of acute burnout and doubts were expressed about whether any improvement priorities arising from SAR learning could really make any difference.
- 5.4.7.** Learning event participants made suggestions for actions that would support practitioners in achieving best practice in cases of self-neglect. All of these pertain to the organisational context:

- Emphasis was placed on the need to ensure that levels of risk are fully understood and shared between agencies, and how shared risk management can be achieved. As part of this they called for:
 - A clear and accessible MDT pathway for individuals where risk to life is present and urgent action is required;
 - A review of rapid response timescales for each agency so that expectations are clear and understood.
- In terms of community resources they called for more reliable access to step-up beds to support middle-ground healthcare for those who do not need to full hospital care but cannot have their medical needs met at home.
- Finally they drew comparison with children's safeguarding, where co-located practitioners in a multi-agency safeguarding hub work closely together to close the gaps between services, support information-sharing and promote shared safeguarding strategy.

5.4.8. The organisational pressures evident in Stephen's SAR do in part reflect those encountered in the earlier CSAB thematic SAR. In Stephen's case, however, there was less evidence of change or flux within agencies and perhaps more evidence of how the pressures of working with self-neglect take their toll on staff. This requires attention to how staff can be supported. Working with self-neglect is in itself hugely demanding and distressing for practitioners. Added to this is the challenges of securing a shared perspective and approach with other agencies. It is clear that to provide a supportive organisational context requires measures both to address the personal impact of the work and to secure multi-agency engagement with common goals in extreme cases of risk to life.

6. Additional learning from the present SAR

6.1. There is nothing in the learning from this SAR relating to Stephen that contradicts the conclusions of the 2025 thematic SAR on self-neglect. Many of the themes evident in the six cases featured in the thematic SAR are apparent here also, particularly those relating to risk management and use of safeguarding, mental capacity, interagency working and organisational pressures. For that reason the learning from Stephen's case is largely addressed by actions already under way in response to the thematic SAR recommendations.

6.2. However, Stephen's circumstances do raise important additional questions.

6.2.1. In relation to practice with individuals whose self-neglect places them at extreme risk:

- How do we manage persistent reluctance of the kind that Stephen showed?
- Are we clear about how to respond to persistent and repeated unwise decisions and when capacity should be formally assessed under the Mental Capacity Act?

6.2.2. In relation to interagency working on self-neglect:

- Can we be confident in our risk assessments?
- Are we equipped to identify extreme, urgent risk involving risk to life, communicate it between agencies and secure an effective risk management response?

6.2.3. In relation to the organisational context:

- Do the short timescales for our involvement allow the kind of approaches that will be effective with individuals who are self-neglectful? These need to be persistent, professionally curious and relationship-based and they take time.
- How can we best support practitioners with the personal experience of the work and with the escalation of concerns across agency boundaries?

These matters, along with those discussed by practitioners at the learning event, give rise to a small number of important recommendations.

7. Recommendations

7.1. It is recommended that as part of work in hand on recommendations from the thematic self-neglect SAR, CSAB includes action on the following priorities:

7.1.1. To consider how risk to life should be managed. This will require work on:

- A common, cross-agency language about level of risk,
- Clarity about the interagency decision-making pathway to be followed for management of risk to life,
- Shared understanding of indicators for a risk to life response,
- Discussion of what a risk to life response might entail, including relevant powers and duties in the context of an individual's refusal of treatment.

7.1.2. To further strengthen communications and shared decision-making about safeguarding referrals and other high-risk circumstances⁹ through:

- Arrangements for electronic referral to ensure a written record;
- Clear expectations on detail and accuracy shared about levels of risk;
- Review of the newly updated CSAB guidance on multi-disciplinary team meetings to ensure it is informed by the learning from this present SAR;
- Re-launch of the CSAB escalation policy and monitoring of its use going forward.

7.1.3. Allied to this, to seek assurance on:

- How agencies, within their internal case management systems, flag cases of high risk, including self-neglect, in such a way that the level of concern can be understood by anyone consulting the record;
- What arrangements are in place within agencies to ensure that the flow of information between agencies in relation to volatile, high-risk situations remains fluid even in circumstances of key staff absence.

⁹ While a multiagency safeguarding hub for adults, as put forward by learning event participants, is not seen as a possible development at the present time, the suggested measures are intended to strengthen the accuracy and effectiveness of communications about risk.

- 7.2.** To lead discussions with partners about enhanced staff supervision and support, with five areas of focus:
- Ensuring that frontline staff are receiving good quality, regular safeguarding supervision that includes support to manage both the professional challenges and the personal impact of self-neglect work,
 - Providing guidance and support on managing reluctance to engage by individuals with complex needs that present a risk to life,
 - Ensuring flexibility on workflow timescales to allow practitioners time and space to persist with building relationships of trust with people who self-neglect,
 - Engaging with and addressing the frustration and despair experienced by some practitioners about the current organisational context for their professional practice,
 - Re-building confidence in the improvement priorities that emerge from SAR learning.
- 7.3.** To consider using the escalation pathway to the national network of SAB chairs and thereafter the Department of Health and Social Care to escalate the concerns identified in this review about the impact of burnout and demoralisation on safeguarding practice and staff welfare.