Norfolk Safeguarding Adults Board

Safeguarding Adults Review:

Andrew

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Contents

1. Introduction and scope of review

1.1 Andrew[1] died, aged 56, in the autumn of 2024. A white British male who lived alone, during the year before his death he experienced five hospital admissions in succession. These were due to health difficulties relating to Type II diabetes, exacerbated by Andrew's alcohol consumption, which was recorded in medical files as up to 80 units per week. His living conditions also raised concerns about self-neglect: Andrew seems to have eaten irregularly, with food frequently left to grow mould; he reported sleeping on his sofa to keep warm; and his home environment was unsanitary. Andrew was advised in July that he should start taking injectable insulin to manage his diabetes but declined. Several agencies were involved in supporting Andrew, but there was limited joint working to coordinate their efforts. When, in September, an assistant practitioner (AP) from Adult Social Care visited his property and detected no sound or movement from inside, she requested a police welfare check, which did not happen then as the risk threshold was judged not to have been met. A week later she returned and was alarmed by a strong odour emanating through the letterbox. The police attended and entered, to find Andrew dead on the sofa.

1.2 Following Andrew's death, a referral was made to Norfolk Safeguarding Adults Board (NSAB) for a Safeguarding Adult Review (SAR) of his case. NSAB judged that the statutory criteria for a SAR were met (Care Act 2014, s. 44): there is reasonable cause for concern about how the partner organisations with relevant functions worked together to safeguard Andrew, and NSAB knows or suspects that Andrew's death resulted from self-neglect. NSAB therefore commissioned an independent reviewer to lead this SAR, with support from the SAR panel (whose members were senior representatives from the Board's partner organisations).

Terms of Reference

1.3 The purpose of a SAR is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is not done in order to re-investigate or to apportion blame, but so that lessons can be learned from the case with the intention of promoting effective learning and improvement to prevent future deaths or similar harm from occurring in the future.

1.4 NSAB specified the following key lines of enquiry, with the time period covering one year before Andrew's death (1 Sept 2023 – 11 Sept 2024):

- How might professional curiosity have made a difference?

[1] Names have been replaced with pseudonyms throughout this report to preserve the privacy of those affected.

- What efforts were made to engage and build relationships with Andrew?
- What support services are available to those who have served in the armed forces?
- Why wasn't there a coordinated multi-agency response in relation to the concerns about his environment and self-care? If there was, would he have been found and potentially offered support sooner?
- What pathways are in place in Norfolk for people with a dual diagnosis, and why were these not implemented for Andrew?
- What processes are in place in Norfolk for people who decline diabetic medication, and how are their wishes and feelings considered in decision making?
- How did Right Care, Right Person (RCRP) impact on the timeliness of the police response to Andrew?

These questions have therefore been used to structure the report.

Participating Agencies

1.4 The following agencies submitted records to the review and/or participated in the practitioner event:

- Change Grow Live (CGL)
- Department of Work and Pensions (DWP)
- East of England Ambulance Service NHS Trust
- GP surgery
- Norfolk Constabulary
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- Norfolk County Council Adult Social Services
- Norfolk Fire & Rescue Service
- Orwell Housing
- South Norfolk and Broadland District Council

Review Methods

1.5 The independent reviewer worked with the SAR Group sub-panel of NSAB to agree the review methods. The review, and practitioner event, drew on the signs of safety model in asking:

- What went well?
- What could have been better?
- What is the learning?

1.6 The review's analysis is informed by the following steps:

1. Review by the independent reviewer of the records supplied by the agencies involved, alongside strengths or concerns in multi-agency working that they identified.
2. Initial analysis of chronology and themes by the independent reviewer, drawing on previous SARs and research as appropriate.
3. The holding of a practitioner event, attended by frontline practitioners who worked with Andrew, and senior members of the partner organisations. The discussions were structured by the three questions set out above (paragraph 1.5).
4. The independent reviewer held a telephone discussion with Andrew's son, and additional online discussions with three practitioners who had not attended the learning event.
5. Further analysis by the independent reviewer of themes from the event and discussions, and production of the draft report. At this point a new SAR referral, 'Jason,' was shared with the independent reviewer, which featured some similarities with that of Andrew; NSAB decided not to proceed to a full SAR but asked the independent reviewer to explore whether it would be possible to 'read across' any themes. The reviewer agreed to look at this, while cautioning that only limited depth of analysis is possible where the referral form is the sole source of information available.
6. Review of the draft report by the SAR panel, partner agency leads, and practitioners. The independent reviewer worked with leads and SAB members on the final form the recommendations should take.

Involvement of Family in the SAR

1.7 It is good practice in Safeguarding Adult Reviews to involve family members to the extent that they wish to take part. Andrew had two adult children, and was divorced from their mother. The independent reviewer contacted Andrew's son to invite him to feed into the review and to provide a more rounded picture of Andrew's life.

1.8 At the time of Andrew's death, he was not in contact with his children and had long since divorced from their mother. His son reported that they had last spoken around 2010, when the son was 18 years old, and had been informed of Andrew's death by the latter's ex-partner who lives in Norfolk. While he and the other family members had had no contact with Andrew for several years before Andrew's death, he kindly filled in more of Andrew's history. The input was very

helpful in informing the review and learning event, and we extend our gratitude. The report was shared with him.

2. Andrew: History and Experience

2.1 Andrew was originally from a city in the North. According to his son, Andrew lost his mother early in life to health complications of some kind. Andrew had a turbulent upbringing and a difficult relationship with his own father. Andrew served in the armed forces at some point in his career, though we know little about his role and experiences. His son remembers him working for the Royal Air Force as an administrator for about two years. He later worked as a transport manager but was made redundant and had intermittent periods of unemployment, experienced financial problems and sometimes drank heavily which could cause difficulties at work.

2.2 Andrew moved away from the North to Norfolk around the year 2010. His son believes Andrew's reason for moving was to connect with a friend or possibly the woman who became his partner, though when growing up he had not been aware that Andrew or others in the family had any established links to Norfolk. Andrew had a relationship with a partner in Norfolk for some time, but the relationship had ended by the time that is the focus of this SAR. Andrew moved to his current home in 2020; the fact that this happened during the COVID-19 pandemic may have impeded him from developing social networks in the new area. Certainly, Andrew believed that the lasting effects of the COVID-19 virus had contributed to the health difficulties he was experiencing over the period within the scope of this SAR. Although the housing officers report that he spoke about wanting to go out, during the year covered by this SAR he seems to have left his flat rarely, if ever, other than when in hospital. He relied entirely on online deliveries of food or on the neighbours to do shopping for him and appears to have been socially isolated.

2.3 In the last year of his life, Andrew experienced attacks of vomiting, dizziness, falls, and weakness, and was repeatedly admitted to hospital where he was treated for alcohol-related gastritis and type 2 diabetes. Despite two deep cleans, his home environment would soon deteriorate again. Andrew spoke to professionals about not being able to afford to keep the house heated or to eat well. He accepted certain, limited help with food and practical matters. Other offers of support, such as care packages or post-discharge reablement, were declined either directly or within a few days of commencing. Comments Andrew made at times suggest that he was ambivalent about accepting help and felt embarrassment at needing it.

Chronology

2.4 The chronology below has been compiled by the independent reviewer from the reports submitted by the agencies involved with Andrew. It does not aim to be an exhaustive account of all contacts, but to capture the key information most relevant to this review.

Dates	Events	Referrals / Contacts Made
27 Aug – 19 Sept 2023	**First Hospital Admission** Found collapsed by Tesco delivery driver. Treated for alcohol-induced hyperglycaemia and ketosis. CT scan to exclude brain injury. Confusion and fluctuating capacity on admission. Seen by Mental Health Liaison Service (MHLS), but presentation assessed as alcohol related. Deep clean completed. 20+ bags of rubbish removed; access to toilet restored.	MHLS Consultant recommended CGL referral (not clear if this happened). Safeguarding alert raised. This did not progress to a safeguarding enquiry as Andrew was not considered to have care and support needs.
Oct 2023	Andrew in contact with disability employment advisor following hospital admission over Universal Credit (UC).	
29 Nov 2023 – end Jan 2024	Disability employment advisor (DEA) discovers Andrew is not registered with a GP. Andrew struggles to register, and it takes nearly two months. On 24 Jan, Andrew discloses to DEA that he is not leaving the flat. He is sleeping on the sofa as he can't afford to heat the flat.	DEA suggested referral to social prescribing to help Andrew with GP registration and UC claim. Referral to social services was declined as Andrew was not registered with a GP in the area.

7 – 12 Feb 2024	**Second Hospital Admission** Admitted following recurrent collapses, vomiting and not eating. Treated for vomiting. Advice / guidance provided by hospital substance misuse team.	Ambulance Trust raises 'Safe and Well' and Adult Social Care referrals. Andrew declines Adult Social Care referral. The referral was closed. A further social work referral on 19 Feb, requesting follow-up in the community, was also closed after Andrew declines input.
31 Mar – 8 Apr 2024	**Third Hospital Admission** Admitted following collapse, reports dizziness and vomiting. Treated for alcohol-related gastritis.	Ambulance trust makes social care referral, seeking care package and deep clean. Andrew 'states he wants assistance but at the same time is too embarrassed to accept help.' Care package initially accepted, then Andrew declined as he reported managing better. Deep clean takes place.
14 Apr 2024 Also: 2 May, 28 May, 25 June, 11 Sept.	Housing officer welfare visits taking place. Referral indicates housing are making weekly welfare visits. At some point, visits seem to have reduced, but this was not known to social care.	Housing request social care assessment – concerns over self-neglect and fluctuating capacity. Referral picked up by social services front-door team.
Apr 2024	Assessment by social services front-door team assistant practitioner (AP). Referral to Norwich Escalation Avoidance Team (NEAT) declined on the grounds that he did not meet admissions avoidance needs criteria.	AP contacts GP. AP requests assessment by NEAT / Norfolk First Support.

24 Apr 2024	Norfolk First Support (NFS) visited for three days. Andrew declined therapy, as he said he was now mobilising better with a frame and had benefited from build-up drinks and food vouchers. Discharged.	
20 – 28 May 2024	**Fourth Hospital Admission** Admitted due to vomiting. Seen by dietitian. Andrew declines CGL referral.	
May 2024	Adult Social Care transfer Andrew's case from the front-door team to the locality team, as it is felt all appropriate referrals have been made and further input is needed. Duty AP calls, Andrew tells them he has just been admitted to hospital but will be out soon.	
10 June 2024	Adult Social Care assistant practitioner (AP) allocated. Called Andrew on 10, 12 and 24 June, to arrange assessment. No reply. AP visited home on 11 June – Andrew not at home.	
9-16 July 2024	**Fifth Hospital Admission** Admitted to hospital with general weakness, possible fall, vomiting, dehydration. Blood glucose extremely high. Twice-daily insulin and diabetes education recommended. Andrew says 'he felt he would not be able to manage' the injections. He successfully injected in hospital after training. He was then discharged.	Ambulance Trust raises safeguarding alert with social care, indicating that Andrew was soiling himself, not eating, and self-neglecting: 'Due to unsanitary environment … not safe for crew to be inside home.'
10 July 2024	AP visits, but Andrew is in hospital.	AP contacts housing on 15, 22 July. Contacts 'health' on 14 Aug to ask if Andrew is in hospital.

16 – 22 July 2024	Community nurses visit and are in contact with Andrew about insulin use. Andrew agreed with GP that he would take insulin but subsequently declined. Nurses discussed risks, but Andrew 'adamant that he does not want insulin.' 'No reason to doubt patient capacity.' Andrew stated he did not want nursing visits; risks discussed. Discharged back to GP, and to diabetes specialist nurses (at NNUH) who declined referral on grounds it was unclear what support was required.	
22 Aug 2024	Andrew makes last contact with DWP.	
3-4 Sept 2024	Attempts by GP medical practice to contact Andrew by phone about fit note. Permanently engaged.	
4 Sept 2024	Adult Social Care assistant practitioner (AP) calls. No response – requests welfare check from police. The *Right Care, Right Person* policy is applied to assess if the threshold for a check is met. It is not, and the request is declined.	AP also attempts to contact housing officer. Checks with hospital and confirms Andrew has not been admitted.
11 Sept 2024	Police assist AP with forced entry. Andrew was found dead on his sofa. He is believed to have passed away some time before.	

3. Analysis

3.1 This section examines what was learnt from the records and practitioner event in relation to the events described in the chronology and applies it to the questions set in the SAR terms of reference.

3.2 *How might professional curiosity have made a difference?*

3.2.1 Professional curiosity is about enquiring beyond the surface and understanding one's responsibility to act, rather than making assumptions or taking things at face value. Professional curiosity was displayed during practitioners' involvement with Andrew. The two housing officers were aware of the circumstances in which Andrew was living and scheduled in what visits they could, to try to explore his wishes, investigate what lay behind the self-neglect, and find ways to address his needs for improved nutrition and warmth. They recognised the need for in-depth follow-up and raised safeguarding concerns due to Andrew's self-neglect. The ambulance crew also identified the concerns when attending Andrew's property as self-neglect and ensured that a safeguarding alert was raised so that these would be followed up. Assessments by hospital staff identified some of the complex emotions Andrew had about accepting help and making changes in his life.

3.2.2 However, for much of the time services were involved with Andrew, professional curiosity was inadequate to the demands of the situation. There are a number of instances where trying to dig beneath the assurances Andrew offered might have afforded useful insights, though putting these together to build a shared overall picture would nonetheless have remained a challenge.

3.2.3 For instance, District Direct provided a deep clean of Andrew's property around the time of his first admission to hospital in September 2023, supported by South Norfolk District Council. While it is positive that this intervention was offered by South Norfolk District Council, it does not appear to have been accompanied by careful inquiry as to how Andrew's domestic environment had come to be in that condition, or what might need to be put in place to prevent the situation deteriorating again. This review identified little available information about Andrew's reaction to the deep clean: was he pleased by it, or did he find it in any way intrusive, or embarrassing? Where self-neglect is a contributing factor to the need for deep cleaning, services should consider how any improvements will be sustained; the research literature demonstrates that cleaning in isolation is unlikely to lead to lasting improvements if the issues underlying the self-neglect are not addressed.[2]

3.2.4 The safeguarding alert submitted at this time meant there was awareness that Andrew might be experiencing self-neglect. However, it was rejected on the grounds that Andrew did not have care and support needs. The reasons for this judgement are unclear; the state of the property at the time was suggestive of significant difficulties, while subsequent events demonstrate that Andrew faced significant ongoing challenges in managing his personal care, taking care of his

[2] p. 79, Steils et al. (2022) *What do we know about hoarding behaviour and treatment approaches for older people? A thematic review*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-083

nutritional needs, and maintaining a habitable home environment. Whatever the reasons for the decision were, it may have encouraged the belief that it was unnecessary to explore in depth at that time how Andrew was going to maintain the improvements to the home environment.

Recommendation 1: NSAB, through the Self-Neglect and Hoarding subgroup, should promote learning from this SAR among partner agencies to encourage the sharing and escalation of concerns with appropriate agencies (potentially including Fire & Rescue, social care, GP and the housing provider), where a deep clean is proposed for an individual and there are reasons for concern that ongoing self-neglect might prevent the person from sustaining the changes, in recognition that there are frequently deeper reasons for the situation than choices actively made by the individual. The processes in place for arranging a deep clean should be explored to see if a prompt or mechanism can be put in place so that this is considered at the point that the clean takes place (for example, onward referrals for mental health, wellbeing support, psychological support or to other relevant voluntary agencies).

3.2.5 In February 2024, safeguarding alerts for Andrew were twice closed with no further action, on the grounds that he had declined assistance by telephone. The Adult Social Care report to the review notes that, had the non-engagement and self-neglect policies been followed, it should have led to further investigation before closing, including possibly a home visit.

Recommendation 2: Adult Social Care to provide assurance to NSAB that duty teams are sufficiently aware of the non-engagement and self-neglect policies, and what response they should lead to. This assurance to include a deep dive into what the barriers are for staff to access and implement the existing policies and may involve exploration in supervision and/or further audit activity.

3.2.6 On 29 November 2023, Andrew told his disability employment advisor (DEA) that he was not registered with a GP; it seems that he had taken no steps to re-register on moving to his current property. This appears not to have been picked up at his first hospital discharge. Although Andrew was highly motivated to complete this registration in order to continue receiving his disability benefits, he did not manage to complete the steps involved in registering until 29 January 2024, with considerable help from the DEA. This indicates how he struggled to organise and complete important tasks, and if it had been more widely known, might have been an early clue to the difficulty he would have in making other changes in his life.

3.2.7 In April 2024, Andrew declined the care package recommended following discharge in April 2024, as he said he was ‘managing better.’ By this stage, recurring patterns of admission, discharge and refusal of follow-up were

becoming apparent. While it did lead on to the AP being passed the case, she had not succeeded in meeting Andrew by September 2024. This was not a problem of professional curiosity being lacking as such, but of it not being accompanied by enough urgency – or to frame it perhaps more accurately (since several attempts were indeed made to contact Andrew and to follow up with other practitioners), by the sustained persistence that might have meant Andrew's holistic needs being addressed sooner and more proactively. The AP made several attempts to see and assess Andrew over the summer. She encountered challenges, however, as she repeatedly found that Andrew was either in hospital or did not answer the door. She tried to contact the GP or Orwell Housing on these occasions, to clarify the circumstances or – at one point – to try to arrange a joint visit with the housing officers. The housing officers too often did not have clear information about Andrew's hospital stays or discharges. By the summer, the list of referrals that had been made, and that Andrew had mostly refused, had become impressively long, suggesting a need to reflect together and see what other approaches might be tried. But instead of impelling a concerted plan, the outcome was that the exploration of community care input drifted for some time.

3.2.8 Why did this happen? NSAB Professional Curiosity guidance[3] notes that several barriers can hinder professional curiosity, some of which seem to have played a role in this case. One is the difficulty individual practitioners and teams can have in seeing the whole picture and its development over time; the AP mentioned that on one occasion in the summer she had found the property unlocked and looked from the doorway, the conditions were 'not the worst I'd seen.' She was unaware that there had been a deep clean in April 2024, before which conditions had been worse, and that the housing officer visits from which Andrew had been benefiting for some time were not now continuing as regularly. Sometimes the involvement of multiple services unwarrantedly reassures practitioners that the situation is being monitored; in this case, such reassurance seems to have resulted from the repeated health contacts and housing visits which were believed by social care to be weekly, though they were in fact not that frequent. This can reinforce perceptions that the situation is of lower urgency amidst the pressures of high case numbers,[4] whereas it should instead highlight the need for clear coordination and knowledge of each other's efforts. The AP lacked a clear overview of the patterns Andrew had shown over time of downplaying difficulties and declining offered input, sometimes after initially seeming to agree to it. This gap in the picture she saw contributed to proactive follow-up apparently being allowed to lapse at intervals. This theme is further developed in Section 3.5.

[3] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf

[4] Orr et al. (2025) Interprofessional collaboration to support people experiencing self-neglect: A realist review of research studies and safeguarding adult reviews. *Journal of Social Work*, advance access, p. 12. https://journals.sagepub.com/doi/pdf/10.1177/14680173251353092

3.2.9 Other barriers to professional curiosity identified by the NSAB guidance are the structural issues of caseload pressure and deficiencies in supervision. When caseload demands are high, people like Andrew can slip down the agenda as they are not seeking support – rather, they may seem to avoid it – and more immediate crises dominate. Supervision provides important opportunities to review one's caseload priorities and identify assumptions and risks that might otherwise be overlooked. The social work team were under sustained pressure and affected by significant absences, as a result of which the AP received no supervision for some months at this time. This gap has been acknowledged as a missed opportunity to recognise the need for greater coordination and for a more proactive approach to the risks of the situation. Monthly supervision audits have now been instituted in the Adult Social Care teams. This is an important step towards addressing the gap and restoring support structures so that individual practitioners are not left isolated with self-neglect work. These checks should consider not just the regularity of supervision, but also its focus. This is key to reinforcing a workplace culture where supervision is seen as an expectation by all parties and offers a space to reflect meaningfully on aspects of cases that might otherwise be passed over under relentless caseload pressures.

Recommendation 3: The monthly supervision audits instituted in Adult Social Care are a positive step and should continue. If they do not already, the audits should include steps to consider quality as well as quantity of supervision, to ensure that adequate time for reflection is incorporated. Other organisations, such as Orwell Housing and the district nursing service, should consider and confirm to NSAB what support structures are in place, should their teams need advice or opportunities to reflect on self-neglect work.

3.3 *What efforts were made to engage and build relationships with Andrew?*

3.3.1 A recent thematic SAR commissioned by Somerset SAB described a pattern with strong echoes of Andrew's story:

> Once away from acute medicine, attempts to meet ongoing needs in the community were frustrated by non-engagement, leading to repetitive cycles of poor health, neglect of personal care, or disappearance from view as the individual withdrew from contact with professionals.[5]

The SAR goes on to note the need for 'persistence and flexibility' if services are to resolve this recurring difficulty in addressing individuals' support needs in such situations.

[5] p. 36, Braye, S. (2025) *Thematic Safeguarding Adults Review – Self-Neglect*. Somerset Safeguarding Adults Board.

3.3.2 Some practitioners had a degree of success in building relationships with Andrew, relying precisely on persistence and flexibility. The disability employment advisor seems to have built some level of rapport and assisted him with registering with a new GP. She made a referral to SSAFA (Soldiers', Sailors', and Airmen's Families Association) to explore re-housing to allow Andrew to return to the North when he expressed interest in doing so, tried to connect him with an Age Concern social prescriber to help him to register with a GP, and – when Andrew did not follow this up (speculatively, it is possible that, at age 56, he did not feel Age Concern to be appropriate) – provided that assistance herself. Andrew accepted regular visits from Orwell Housing's tenancy sustainment and community management officers, who tried hard to support him with obtaining and managing food, and warm homes assistance. The research literature in self-neglect indicates that offers of practical assistance with matters valued by the individual are often a strong basis on which to seek to build a relationship of trust.[6] The Orwell officers followed up on this assistance and made regular visits to the extent they were able (while recognising that continuing these visits would not be sustainable in the long-term, in the absence of other sources of support for Andrew), consciously aiming at relationship-building.

3.3.3 The officers report that Andrew 'did not really do small talk,' and would not answer the phone or door at times when he was reluctant to engage. He discussed very little of his past with them, though he clearly missed his family. In the practitioner event, attendees noted the importance of a trauma-informed approach, running across services, that considered 'what happened to Andrew' that brought him to his current situation. Yet most of the little we know about his life story comes from his son, and we have only glimpses of his feelings about his current situation. Notably, the hospital physiotherapist's notes from 20 May 2024 record Andrew referring to alcohol and smoking as his 'only joy in life,' and stating that 'he is ex-forces and wants to keep [the property] tidy but cannot physically manage which embarrassed him.'

3.3.4 There are several factors that may have influenced Andrew to decline or avoid some of the support offered. This sense of embarrassment was perhaps one of them. An approach that placed emphasis on his goals and long-standing strengths, as well as the challenges he was currently facing, might have helped. Much of the focus in various services' work with him was clearly on his problems, as it had to be, but the cumulative effect over time on a man already embarrassed at his situation and defensive about his drinking might be one possible reason for the pattern of disengagement that he showed. A Care Act assessment may have made a start on balancing the picture with more positive aspects of his life; these are largely missing from the records shown to this SAR. We know from the DEA that Andrew was proud of his time in the armed forces,

[6] Braye, S., Orr, D. & Preston-Shoot, M. (2014) *Self-neglect policy and practice: Building an evidence base for adult social care*. London: SCIE. https://www.scie.org.uk/app/uploads/2024/06/report69.pdf

and this may have offered one route to build connection and possibly then link Andrew into support targeted at ex-servicemen. However, it was unknown to the housing officers working with him, who only learned about it when they found military paraphernalia among his possessions after his death. Because Andrew did not talk easily about his background, they did not have the possibility of exploring this route.

3.3.5 Other agencies, by contrast, were aware of this part of his background. Coordinated planning and information sharing could therefore have been valuable not just to alert each other to risks, but to build a more rounded picture of the person beyond their problems.[7] For Andrew to have the confidence, trust and willingness needed to engage with CGL or other sources of support, which would certainly have been a big step for him, this kind of encouragement was likely needed.

Recommendation 4: NSAB, through the Self-Neglect and Hoarding subgroup, should review and update the *Self-neglect and hoarding practitioner guide* to include clear, practice-focused guidance on:

- **when the complexity of a situation requires more than one agency to manage it, how to initiate core multi-agency working, and how to escalate for more senior engagement in multi-agency planning.**

The review should also incorporate clear guidance on:

- **how the language and focus of multi-agency involvement with self-neglect can compound feelings of demoralisation and disengagement; and**
- **how practitioners can counterbalance this by recognising and working with individual strengths and sources of motivation in a way that supports engagement.**

The updated guidance must make clear that, while a strengths-based approach engages with the person in ways that are not *only* problem-focused, this should not mean overlooking or downplaying the very real risks or support needs associated with self-neglect. Instead, it should support practitioners with *addressing* the risks through balanced, professionally curious approaches that encourage hope and self-worth and can lead to sustained engagement.

Assurance should be sought by NSAB through partner sign-off and dissemination activity, with consideration given to evaluating practitioner awareness via training uptake, reflective supervision prompts, or themed audit activity, and evidence that guidance has been embedded into other

[7] p. 16, Orr et al. (2025) Navigating the challenges of collaborative inter-agency practice in supporting people experiencing self-neglect in England: a multi-professional realist interview study. *British Journal of Social Work*, advance access. https://doi.org/10.1093/bjsw/bcaf239

relevant care pathways and processes so that self-neglect is not seen as standalone.

3.3.6 Coordination between agencies also sometimes offers a route to overcome some of the challenges of non-engagement. Some effort was made by the assistant practitioner to arrange a joint visit with housing, though this unfortunately seems to have been foiled by Andrew's hospital admission. This was a good initiative that may have resulted in being able to build on his connection with the housing officers to achieve engagement. Thinking even more flexibly, might it have been possible to have reached out to Andrew in hospital before he was discharged again in order to establish contact, even if he may not have been up to assessment or planning there and then? Doing so might have presented a rare opportunity to be confident about finding him. This possibility is further discussed in section 3.5.

3.3.7 Andrew seems to have been ambivalent over some of the support possibilities he was invited to consider. The involvement of advocacy might have been considered as a way to help him clarify his position and express his wishes effectively.

3.4 What support services are available to those who have served in the armed forces?

3.4.1 The Armed Forces Covenant sets out that

> Those who serve in the Armed Forces, whether regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.[8]

3.4.2 The disability employment advisor (DEA) was aware of Andrew's service, and made a SSAFA (Soldiers', Sailors', and Airmen's Families Association) referral to try to help when he expressed interest in moving back north (though because Andrew was not homeless, this referral was not prioritised). It was recorded in his hospital admission notes that Andrew was ex-forces. However, other agencies appear to have been unaware of this part of his background.

3.4.3 We cannot know if offering further support that took into account Andrew's background in the armed forces might have made a difference. Andrew's DEA notes that Andrew was clearly proud of his service, so perhaps – if more widely known – this might have helped relationship-building and been a way to

[8] https://www.armedforcescovenant.gov.uk/about-the-covenant/covenant-in-depth/

strengthen Andrew's social connections. Perhaps not; it might be that embarrassment at his predicament would have impeded him from seeking support there too. Whether or not this would have been the case, attendees at the practitioner event expressed interest in knowing more about what support might be available for veterans. Such knowledge could be useful when supporting people in the future.

3.4.4 Op COURAGE is the NHS community mental health service offering tailored support to veterans with mental health needs.[9] Some GP practices in Norwich are accredited by the 'Armed Forces veteran friendly' scheme, which recognises their knowledge of, and commitment to meeting, the specific health needs of veterans. The Matthew Project is a Norwich-based voluntary sector organisation offering specialist services 'run by veterans for veterans affected by drug and alcohol issues and living with PTSD'.[10] Further information on support services available in Norfolk can be found on the County Council website.[11] Additional national programmes designed to support ex-armed forces members with dependent drinking, including web-based programmes which may be accessible to users, are listed in a recent research report funded by Forces in Mind.[12]

3.4.5 As this makes clear, sources of support exist, but they may not always be accessed, either because practitioners are not aware of the person's ex-forces background, or because practitioners are not aware what services are available.

Recommendation 5: NSAB should liaise with Norfolk Armed Forces Covenant Board (NAFCB) to explore if they can contribute to raising awareness among partner organisations of the services and support available to ex-forces members. This potentially aligns well with the NAFCB Action Plan 2024-27, one of the three goals of which is to 'promote greater understanding of the support available to the armed forces community in relation to health and social care services in Norfolk.' NSAB may be able to reinforce the NAFCB's work in this area, most obviously when disseminating the learning from this SAR.

3.5 *Why wasn't there a coordinated multi-agency response in relation to the concerns about his environment and self-care? If there was, would he have been found and potentially offered support sooner?*

[9] https://www.eput.nhs.uk/services/op-courage-the-veterans-mental-health-and-wellbeing-service/
[10] https://www.matthewproject.org/about-us
[11] https://www.norfolk.gov.uk/article/39231/Armed-Forces-support-services
[12] Palmer et al. (2025) *Influences on alcohol and lifestyle behaviours among partners of UK (ex-)military personnel*. https://s31949.pcdn.co/wp-content/uploads/LIFE-Q-Report-2025-v6.pdf, p. 50-55, 66.

3.5.1 Several agencies were involved with Andrew over many months. As noted above, better coordination might have helped open doors to valuable information sharing and more effective relationship-building. We cannot know whether this would in the end have led to him being offered support which he might have accepted more readily, or whether it would have made a difference to when he was found or helped to make his death avoidable. Nonetheless, we can review why support for Andrew did not take a more coordinated form and consider what lessons can be drawn.

3.5.2 The AP tried to arrange a joint visit with housing. This was a good idea, and good use of joint visits was made in the 'Jason' SAR referral. However, it did not happen in the end. She noted that it took considerable time to identify the housing contacts and get in touch with them. By then Andrew was once again in hospital. The involvement of different agencies remained fragmented, with health, housing and social care working along parallel tracks. The DEA referred Andrew to Adult Social Care in December 2023, but this referral was not progressed, apparently because Andrew was not registered with a GP. Expected ongoing support from both Norfolk First Support and from the district nurses ended sooner than anticipated due to Andrew declining to continue with them. By contrast with housing, there appears to have been little exploration of the possibility of joint visits between social care and community nursing. This likely results partly from the timing of developments, but it has been noted that the management of health conditions and safeguarding – perhaps particularly in relation to self-neglect – are not always well integrated in practice.[13]

3.5.3 Services do not always seem to have had a picture of developments in the support offered by other agencies: Social care were unaware that housing welfare visits were not continuing on a weekly basis, and health may not have realised how long Andrew's social care assessment had been delayed. Other agencies were unaware of the positive relationship established between Andrew and his DEA. Both social care and housing were frequently unclear about when Andrew was and was not in hospital; housing officers found themselves having to ask his neighbours if Andrew had been admitted or discharged, and the neighbours themselves were not always able to give them correct information.

3.5.4 These are common difficulties encountered in multi-agency self-neglect working. There are close echoes of a recent Norfolk SAR, Adult R (2024), in which the practitioner event fed back that:

- it could be difficult for practitioners on the ground to contact the appropriate person in other agencies;

[13] Cohen, D. & Buckton, A. (2022) *Health and social care, integrated care and safeguarding adults*. LGA. https://www.local.gov.uk/publications/health-and-social-care-integrated-care-and-safeguarding-adults

- hospital discharge could sometimes be disjointed, with insufficiently thorough communication of information
- feedback on referrals to other agencies was sometimes lacking, and some agencies felt it was difficult to get their voices heard by – and to hear back from – other practitioners when raising safeguarding concerns.

3.5.5 In light of these recurring challenges – which are by no means specific to Norfolk but regularly feature in SARs nationally[14] – practitioners need to consider ways in which they can more effectively facilitate inter-agency communication and working.

3.5.6 Firstly, by mid-summer it should have become apparent that there was a need for one service to take on a lead coordinating role for Andrew and work towards a more proactive, less reactive, joint approach. This 'absence of a clearly identified lead agency' was also a feature of the 'Jason' SAR referral; as with Andrew, appropriate signposting was happening, but because Jason engaged only minimally, it did not lead to sustained support as agencies withdrew in response. During the months covered by the SAR, numerous referrals and offers of assessments had been made piecemeal to Andrew. Except for some of those made while he was physically in hospital, he seems to have declined all of them either immediately or within a few days of starting. He allowed only the regular visits of the housing officers to continue. As the pattern became more firmly established, a practitioner who could assume responsibility for encouraging communication and coordinating the involvement of different agencies was needed. The AP might perhaps have been in a position to do this, if not for the fact that she had not yet managed to meet Andrew. Reflecting on the work, she noted she had felt she was under an obligation to meet directly with Andrew and ascertain his wishes before trying to coordinate more detailed multi-agency work to discuss his case. Where self-neglect places the individual at significant risk, it may be justified and proportionate to proceed without delay to call a multi-disciplinary meeting (MDM) or escalate the concerns. That said, practitioners have previously reported finding it a significant challenge to bring overloaded professionals together at MDMs,[15] and those involved have highlighted the time it takes to try to contact practitioners in other agencies to find out information. It is understandable if the AP (and potentially other practitioners) found it daunting to attempt coordination work on this scale when she felt she did not yet have much

[14] Orr et al. (2025) Interprofessional collaboration to support people experiencing self-neglect: A realist review of research studies and safeguarding adult reviews. *Journal of Social Work*, advance access. https://journals.sagepub.com/doi/pdf/10.1177/14680173251353092

[15] Braye, S. & Marsh, N. (2024) Safeguarding Adults Review – Adult R. Norfolk Safeguarding Adults Board. https://www.norfolksafeguardingadultsboard.info/assets/SARs/SAR-Adult-R/SAR-R-FINAL-Rpt08-04-2024ForPublication.pdf

to ‘bring to the table’ from her own assessments, since she had not so far managed to meet with Andrew face-to-face.

3.5.7 Secondly, although it is in theory open to all practitioners to request a MDM to address concerns over individuals experiencing self-neglect, and this is often where key information is exchanged, no MDM was triggered in response to the self-neglect safeguarding concerns raised, or the cumulative picture emerging from his repeated hospital admissions and subsequent refusal of insulin. Norfolk has an alternative forum where practitioners can seek multi-agency advice on cases of concern which may not meet the safeguarding threshold but remain of concern: the Early Help Hubs (EHHs). If there were barriers to other forms of multi-agency coordination, bringing the case to the EHH may have offered a source of advice and inter-agency guidance.

3.5.8 Thirdly, Andrew’s recurrent hospital admissions seem to have placed a block on efforts by social care to engage with him while they lasted. Even if Andrew did not wish to engage with the AP while being treated in hospital, exploring the possibilities for closer communication between the discharge teams and Adult Social Care might have reduced the confusion over his whereabouts. One attendee at the practitioner event suggested that a ‘contact contract’ might have been agreed with him during his hospital stay, allowing him to clarify his preferences for when and how to be contacted once discharged. Where people are self-neglecting and difficult to engage, it may be necessary to think creatively about how to reach them.

3.5.9 Lastly, inter-agency communication is underpinned by IT systems. An issue raised at the practitioner learning event was that practitioners may not always be clear about what information other agencies can see. There have been steps forward resulting from the introduction of shared care systems that link social care and GP records. Introduction of the SystmOne electronic health record enables sharing of records when patients have open referrals to another service using the same system. However, this did not include district nursing at the time of Andrew’s case, which may have contributed to the difficulties in communication when Andrew refused insulin and was referred back to the specialist hospital team. Additionally, some GPs rely on ‘opt-out’ patient consent to inclusion within sharing, while others seek explicit consent when registering patients. Though the moves towards improved sharing of records is welcomed by practitioners, some attendees wondered if the variability across services and practices might lead practitioners to assume other services can view the records and therefore be less thorough in communicating relevant information because they are not aware it is needed.

Recommendation 6: NSAB, through the Self-Neglect and Hoarding subgroup, should reinforce expectations of early and sustained multi-agency coordination where there are several services potentially involved

and there is self-neglect with persistent non-engagement (*even if* contact is still being pursued *and especially* if it is proving elusive) and review how agencies have this embedded within their existing policies and processes.

NSAB should promote the use of Early Help Hubs (EHHs) as an appropriate forum for seeking multi-agency advice regarding difficulties encountered in attempting to engage and support, and for identifying whether other agencies are involved or share the concerns over risk.

The Self-Neglect and Hoarding subgroup will trial and publicise an online community of practice forum, encouraging practitioners to bring self-neglect / hoarding cases they are struggling with for advice and guidance.

NSAB has an expectation that each partner agency will take leadership responsibility for the embedding of these mechanisms in their relevant pathways and practice with a report back to NSAB within 12 months of publication (to include evidence of partner communications, inclusion within relevant practice guidance, and evidence from audit or case-sampling that these mechanisms are being considered and used appropriately in such cases).

Recommendation 7: When self-neglecting individuals experience repeated hospital admissions and there are ongoing challenges with engagement in the community, closer working is needed between hospitals and other agencies involved, such as social care or housing. Practitioners should consider this in their practice, and hospital leaders should facilitate discussions between safeguarding leads in the respective organisations to identify and address potential obstacles, reporting back to NSAB within six months of publication.

3.5.10 At the learning event, there were discussions about the positive relationship Andrew appears to have had with his DEA. The broader observation emerged from these discussions among practitioners and safeguarding leads that it would be valuable to increase awareness among Adult Social Care, as the lead agency for safeguarding, and relevant partner agencies of the role played in identifying safeguarding risks by DWP colleagues across all roles.

Recommendation 8: Adult Social Care and relevant partner agencies should work with the Department for Work and Pensions (DWP) to ensure that the safeguarding risks identified by DWP colleagues are recognised, understood, and embedded within local safeguarding pathways to support earlier intervention and improve protection for vulnerable adults.

3.6 *What pathways are in place in Norfolk for people with a dual diagnosis, and why were these not implemented for Andrew?*

3.6.1 Andrew was assessed for acute mental illness by the Mental Health Liaison Service on the occasion of his first hospital admission, and it was concluded that his symptoms were due to alcohol-related causes rather than a mental health difficulty. He certainly displayed low mood at times, but Andrew denied that he was depressed and was not formally diagnosed with a mental health issue. He therefore would have been unlikely to meet the criteria specifically for dual diagnosis referral. It was noted in SAR Eric[16] that pathways are under development in Norfolk & Waveney to address dual diagnosis needs, although it was reported in the practitioner event that these are yet to reach completion at the time of writing. The recent publication of the *Co-occurring mental health and substance use delivery framework*[17] should give further impetus to their development.

3.6.2 Referrals to CGL were proposed to Andrew on at least two occasions. Andrew declined the referrals. He generally denied to medical professionals that he was dependent on alcohol, either not accepting that his drinking was contributing significantly to his health difficulties and hospital admissions or feeling that this harm did not outweigh the urge to continue drinking. As pointed out by Ward and Holmes, this is not necessarily reducible to being 'in denial.' There are several factors which can hinder change, potentially including the effects of poor nutrition on energy levels, depressed states produced by the effects of alcohol, and difficulties with motivation and organisation resulting from lasting effects on the brain.[18] Alongside these physical issues, Andrew's social isolation, and reportedly feeling that his main pleasure lay in drinking and cigarettes, meant he was not readily motivated to reduce his consumption.

3.6.3 Given this, sustained engagement with Andrew to identify and build motivation would likely have been needed if he was to engage with CGL or comparable programme providers.[19] For this to be successful, it would likely have required relationship-building over time. The Orwell Housing officers attempted to engage Andrew in identifying life goals and improving his nutrition, although they felt that little lasting change was achieved. It might be that, had Andrew lived longer, this

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[16] Thompson, L. (2025) Safeguarding Adults Review – Eric. Norfolk Safeguarding Adults Board, para. 3.2.14 - 3.2.15. https://www.norfolksafeguardingadultsboard.info/document/915/SAR-Eric-FINAL-Report-v3.pdf

[17] DHSC / NHS England (2025) Co-occuring mental health and substance use delivery framework. DHSC / NHS England. https://www.gov.uk/government/publications/co-occurring-mental-health-and-substance-use-delivery-framework/co-occurring-mental-health-and-substance-use-delivery-framework#priority-area-3-workforce-and-training

[18] Ward, M. & Holmes, M. (2014) Blue Light: The Project Manual. Alcohol Concern. https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-Blue-Light-Manual.pdf

[19] Ward, M. & Holmes, M. (2014) Blue Light: The Project Manual. Alcohol Concern. https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-Blue-Light-Manual.pdf

could have been built on. Connecting Andrew to services addressing the needs of ex-armed forces members has already been discussed. Social prescribing represents another possible route worth exploring, if Andrew were to accept it.

3.6.4 Preston-Shoot and Ward further draw attention to the complexities of mental capacity assessment with individuals who have engaged in dependent drinking over long periods of time.[20] They highlight in particular the potential effects on executive functioning, that is, the cognitive abilities governing organisation and planning, working memory and impulse control, among other things. In relation to safeguarding, this is often referred to as 'executive capacity' – the ability of an individual to put into effect 'at the material time' (i.e. when real life calls for it) a decision they have previously expressed in theory (such as when discussing with a professional as part of a mental capacity assessment). As it is often described, executive incapacity in relation to a decision would arise when a disturbance of the mind or brain leaves the person able to 'talk the talk' but unable to 'walk the walk.' When not implementing the decision is judged by practitioners to be the result of a 'lifestyle choice' and therefore taken at face value, Preston-Shoot and Ward argue, it leaves people at high risk. Practitioners should therefore consider mental capacity in this group carefully.

3.6.5 Andrew's mental capacity was assessed by hospital staff on several occasions in relation to decisions about his medical treatment. He does not appear to have displayed the classic indication that executive capacity may be affected: repeatedly declaring one decision but implementing the opposite one in practice. Andrew's behaviour with regard to his medical care seems to have been largely consistent with the views he expressed to professionals. Certainly, there are instances where he expressed initial compliance when talking to doctors, but later explicitly changed his views. This in itself does not seem a reason to doubt his executive capacity to make such decisions, as there was no consistent mismatch between his words and actions. It might be more readily explained by a tendency to defer to doctors while in their presence or preferring to take the path of least resistance while in hospital but feeling more confident to express his views once at home.

3.6.6 Questions remain in other areas. Housing's request in April for a social care assessment raised concerns about Andrew's fluctuating capacity, but it is not clear that this was formally assessed in the community. Mental capacity is decision-specific, so although Andrew's expressed decisions about his medical treatment aligned with his behaviour, it cannot simply be assumed that this applies equally to other support needs. For example, although the housing officers worked with Andrew to improve his access to nutrition and food safety

[20] Preston-Shoot, M. & Ward, M. (2021) How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales. London: Alcohol Change UK. https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf

practices, this did not seem to achieve lasting change, and, if Andrew understood the risks, it is not clear that he was putting this understanding into practice. Formal mental capacity assessment would have clarified the situation, and it might have been possible to work towards risk reduction based on a firmer understanding of Andrew's cognition.

3.6.7 At the practitioners' event, attendees noted the challenges they all faced in supporting people with dependent drinking. They identified that many of them would find interprofessional training on this subject valuable, as it is a challenge that all services encounter and need to be able to address from a common understanding. The SAR panel identified that relevant local workshops had been held previously, so this request indicates a need to think through how the key learning can be cascaded beyond the workshop attendees themselves, and then sustained.

Recommendation 9: NSAB should explore whether an interprofessional training workshop, such as was requested at the practitioner event, can be offered to non-specialist practitioners. This might focus primarily on engagement, assessment, mental capacity, and how assertive approaches to dependent drinking can be implemented with self-neglecting individuals, presenting and building on the Blue Light approach.

Because such a workshop can only reach a limited number of participants, key points and practical tips emerging from it should be compiled and shared more widely across the partner organisations as a written and/or audio briefing, or potentially as e-learning. Sustaining the learning can be reinforced by putting it on supervision agendas. Consideration should also be given to identifying, and promoting awareness of, a *single point of contact* in substance use services, from whom practitioners in other services can seek advice on how to approach a case.

3.7 What processes are in place in Norfolk for people who decline diabetic medication, and how are their wishes and feelings considered in decision making?

3.7.1 Diabetes UK reports that 1 in 4 people are 'not at all willing to start using insulin.'[21] Reasons for reluctance can include concerns about the effects of the medication, anxieties about injections, lack of confidence in using insulin, its impact on one's self-perception and life, and fears about diabetes progression.[22]

[21] Diabetes UK (2025) Psychological barriers to insulin use. https://www.diabetes.org.uk/for-professionals/improving-care/good-practice/psychological-care/emotional-health-professionals-guide/chapter-5-fear-insulin

[22] p. 96, Hendrieckx et al. (2019) Diabetes and emotional health: a practical guide for healthcare professionals supporting adults with Type 1 and Type 2 diabetes. London: Diabetes UK.

Adherence to diabetes treatment varies widely, and can be influenced by multiple factors. These can include perceived support from family and/or healthcare providers; adoption of routine; knowledge about the condition; concerns about medication side-effects; and mood disorders.[23] Andrew was therefore not unusual in not following the recommended treatment regime. He was socially isolated and lacked a network to support him, and there is some evidence to suggest that he experienced low mood (during his fourth hospital admission, the physiotherapist recorded his comment that alcohol and smoking were his 'only joy in life').

3.7.2 In Andrew's fifth hospital admission in the space of a year, he presented complaining of weakness, dizziness, a possible fall, and vomiting. He was hyperglycaemic. Although Andrew knew he had type 2 diabetes, he was not picking up or taking his medications regularly and asked for sugar in his tea. The attending doctor discussed his repeat admissions and advised him to start taking injectable insulin. Although Andrew said, he felt he would not be able to manage,' the diabetes in-patient specialist nurse noted that he succeeded in the injection process after education. After being discharged, Andrew was visited by the community nursing team to support with insulin management. He declined insulin and said he preferred to continue with oral tablets. When contacted by the GP he agreed over the phone to take insulin but then continued to decline it when visited by the community nurses.

3.7.3 Andrew expressed compliance with medical advice when with the hospital doctor and GP. However, even then he seems to have shown some ambivalence. In the context of his documented self-neglect, alcohol consumption, and irregularity in eating and oral medication use, it was perhaps foreseeable that he may not follow through. Indeed, given the difficulties Andrew had with aspects of self-care such as nutrition, the fact that he was able to inject successfully under supervision, after having spent a week in hospital, does not mean his concerns that 'he would not be able to manage' once back at home were misplaced. It would have been prudent to explore alternative management plans.

3.7.4 The community nurses offered what support they could and respected Andrew's choices regarding his medication. They considered Andrew's understanding of the risks and recorded that there were 'no reasons to doubt' his mental capacity. This does not mean the same as that he was assessed to have mental capacity to make this decision, and it is not entirely clear from the information supplied

https://www.diabetes.org.uk/for-professionals/improving-care/good-practice/psychological-care/emotional-health-professionals-guide/chapter-5-fear-insulin

[23] Krass, I., Schieback, P. & Dhippayom, T. (2014) Adherence to diabetes medication: a systematic review. *Diabetic Medicine*, 32: 725-737.
Gow, K., Rashidi, A. & Whithead, L. (2024) Factors influencing medication adherence among adults living with diabetes and comorbidities: a qualitative systematic review. *Current Diabetes Reports*, 24: 19-25.

how he weighed the information. Recording clearly what was understood about Andrew's decision making would have been helpful.

3.7.5 There was an attempt by the community nurses to refer back to the diabetes specialist nurse facilitators at NNUH asking for review. The referral was rejected, apparently due to uncertainty over what was being requested of the specialist team. The community nurses then referred back to the GP and discharged Andrew due to non-engagement. It does not appear that self-neglect, and therefore safeguarding, was considered at any point by the parties involved.

3.7.6 As highlighted above (paragraph 3.7.1), insulin refusal is not rare and so in isolation it would not be standard practice to identify it as self-neglect. Given the additional factors making Andrew vulnerable, however, it would have been advisable to consider carefully the risks of ceasing involvement and to explore whether coordination could have happened to address them. In primary care, practice safeguarding leads and the named GP for safeguarding are well placed to facilitate the required inter-agency working and avoid the 'dead end' that resulted; this might have been an alternative avenue when specialist team did not accept the referral back. In secondary care, the Hospital Foundations Trust safeguarding lead might have been consulted before rejecting that referral. Either would have been in a position to consider the whole picture and how non-concordance, or potentially safeguarding, pathways might have been activated.

Recommendation 10: In cases of self-neglect where is reason to anticipate that the person may not continue with the treatment prescribed, sharing a handover or contingency plans with the community nursing team charged with following up should be considered:

- **Norfolk's acute hospitals should prepare a report to NSAB to understand the current barriers to information sharing at point of discharge.**
- **Acute and community hospitals should review current proforma for discharge letters to include any specific concerns that have been identified or remain in relation to self-neglect. Consideration should be given to use of a trigger question to consider the possibility of non-concordance, and / or flow chart setting out how to respond in '*IF x, THEN consider doing y*' format.**
- **Community health providers should review protocols for safely ceasing involvement and identify support they have available to support community nursing staff in complex and / or safeguarding cases to identify any additional needs.**

Recommendation 11: Primary care practitioners should consider the possibility that neglect of a diabetic condition may sometimes constitute self-neglect and consider escalating to safeguarding leads if needed so that the relevant needs are addressed. Practitioners' awareness of their

responsibilities should be promoted through the learning from this SAR and reinforced through training, aligned with any changes resulting from Recommendation 10.

3.8 *How did Right Care, Right Person (RCRP) impact on the timeliness of the police response to Andrew?*

3.8.1 On 4 September 2024, the assistant practitioner visited Andrew's home and became alarmed at, once again, receiving no response. She phoned the police to seek a welfare check. The receiving officer applied the RCRP criteria and assessed that the situation did not meet the threshold. Alongside limiting involvement of the police in mental health-related incidents to those situations where their presence is most appropriate, RCRP also reassessed the role they may play in undertaking welfare checks. The criteria applied are:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

3.8.2 Based on the situation described by the AP and in the police records of the call, on balance the police's application of the criteria does not appear to have been inappropriate. There were no conclusive risk indicators, the smell from the property was not significantly worse than usual, and there were no signs of inactivity such as accumulated post. It was not the first time that Andrew had not opened the door or failed to answer the phone, even at times when he was present in the flat. The AP checked and confirmed that Andrew was not in hospital but did not know at this point how long it was since he had last been seen. Though Andrew's health and living conditions meant that there were indeed risks to his wellbeing, the 'real and immediate risk' of serious harm threshold was not definitively met, such that a forced entry would have been warranted.

3.8.3 The police officer suggested contacting the ambulance trust instead. Ambulance crews – unlike the police or the fire service – do not have a statutory power of entry as such but can seek operational permission to force entry when there is an immediate risk of death or significant harm, where this would be proportionate to the urgency of the situation. Just as for the police, it is not self-evident that this was the case here. There are therefore limited options available to practitioners to address situations that fall just below the police or ambulance response thresholds but remain concerning.

3.8.4 The AP returned on 11 September 2024. She spoke to a neighbour who said they had not seen Andrew in the last month, contacted the GP who noted that he had not been seen for some weeks, and on opening the letterbox, noticed an unusual

smell and unopened mail. This time, the criteria for the police to force entry were met, and Andrew's body was discovered.

3.8.5 Andrew's continuing social isolation meant that he ran a high risk of not being discovered in timely fashion should he be incapacitated by a health crisis. As a clear care and support plan was not in place, there was little to mitigate this. It is not known precisely when he died, but his failure to respond to calls was noticed on 3-4th September, when he did not respond to the GP's attempts to make contact or to the AP's knock. It seems understandable that, although there were known risks, the police did not respond to the welfare request check on 4 September, especially as the AP had mentioned a previous visit in August when Andrew seems to have been out, suggesting that he did sometimes leave the flat.

3.8.6 It is less clear why, if there was enough concern to request a welfare check on 4 September, the next attempt to contact Andrew appears not to have taken place until 11 September. This may have resulted from an assumption that other agencies were in more regular contact than was in fact the case, but evidence that there was 'risk of serious harm' would have mounted with each day that Andrew did not respond to calls and might have led to a police response sooner than 11 September. It seems unlikely that this would have been in time to prevent Andrew's death, but it shows again how greater coordination might have streamlined the inter-agency work supporting Andrew.

4. Recommendations

4.1 The SAR's recommendations are summarised here. Each recommendation's link to one of the key thematic headings provided by NSAB is indicated in parentheses at the end of the entry.

Recommendation 1: NSAB, through the Self-Neglect and Hoarding subgroup, should promote learning from this SAR among partner agencies to encourage the sharing and escalation of concerns with appropriate agencies (potentially including Fire & Rescue, Adult Social Care, GP and the housing provider), where a deep clean is proposed for an individual and there are reasons for concern that ongoing self-neglect might prevent the person from sustaining the changes, in recognition that there are frequently deeper reasons for the situation than choices actively made by the individual. The processes in place for arranging a deep clean should be explored to see if a prompt or mechanism can be put in place so that this is considered at the point that the clean takes place (for example, onward referrals for mental health, wellbeing support, psychological support or to other relevant voluntary agencies).
(*Professional Curiosity*)

Recommendation 2: Adult Social Care to provide assurance to NSAB that duty teams are sufficiently aware of the non-engagement and self-neglect policies, and what response they should lead to. This assurance to include a deep dive into what the barriers are for staff to access and implement the existing policies and may involve exploration in supervision and/or further audit activity.
(*Managing Risk, Uncertainty & Mental Capacity*)

Recommendation 3: The monthly supervision audits instituted in Adult Social Care are a positive step and should continue. If they do not already, the audits should include steps to consider quality as well as quantity of supervision, to ensure that adequate time for reflection is incorporated. Other organisations, such as Orwell Housing and the district nursing service, should consider and confirm to NSAB what support structures are in place, should their teams need advice or opportunities to reflect on self-neglect work.
(*Ownership and Accountability: Management Grip*)

Recommendation 4: NSAB, through the Self-Neglect and Hoarding subgroup, should review and update the *Self-neglect and hoarding practitioner guide* to include clear, practice-focused guidance on:

- when the complexity of a situation requires more than one agency to manage it, how to initiate core multi agency working, and how to escalate for more senior engagement in multi-agency planning.

The review should also incorporate clear guidance on

- how the language and focus of multi-agency involvement with self-neglect can compound feelings of demoralisation and disengagement; and
- how practitioners can counterbalance this by recognising and working with individual strengths and sources of motivation in a way that supports engagement.

The updated guidance must make clear that, while a strengths-based approach engages with the person in ways that are not *only* problem-focused, this should not mean overlooking or downplaying the very real risks or support needs associated with self-neglect. Instead, it should support practitioners with *addressing* the risks through balanced, professionally curious approaches that encourage hope and self-worth and can lead to sustained engagement.

Assurance should be sought by NSAB through partner sign-off and dissemination activity, with consideration given to evaluating practitioner awareness via training uptake, reflective supervision prompts, or themed audit activity, and evidence that guidance has been embedded into other relevant care pathways and processes so that self-neglect is not seen as standalone.

(*Professional Curiosity*)

Recommendation 5: NSAB should liaise with Norfolk Armed Forces Covenant Board (NAFCB) to explore if they can contribute to raising awareness among partner organisations of the services and support available to ex-forces members. This potentially aligns well with the NAFCB Action Plan 2024-27, one of the three goals of which is to 'promote greater understanding of the support available to the armed forces community in relation to health and social care services in Norfolk.' NSAB may be able to reinforce the NAFCB's work in this area, most obviously when disseminating the learning from this SAR.
(*Fora for Discussion and Information Sharing*)

Recommendation 6: NSAB, through the Self-Neglect and Hoarding subgroup, should reinforce expectations of early and sustained multi-agency coordination where there are several services potentially involved and there is self-neglect with persistent non-engagement (*even if* contact is still being pursued *and especially* if it is proving elusive) and review how agencies have this embedded within their existing policies and processes.

NSAB should promote the use of Early Help Hubs (EHHs) as an appropriate forum for seeking multi-agency advice regarding difficulties encountered in attempting to engage and support, and for identifying whether other agencies are involved or share the concerns over risk.

The Self-Neglect and Hoarding subgroup will trial and publicise an online community of practice forum, encouraging practitioners to bring self-neglect / hoarding cases they are struggling with for advice and guidance.

NSAB has an expectation that each partner agency will take leadership responsibility for the embedding of these mechanisms in their relevant pathways and practice with a report back to NSAB within 12 months of publication (to include evidence of partner communications, inclusion within relevant practice guidance, and evidence from audit or case-sampling that these mechanisms are being considered and used appropriately in such cases).
(*Fora for Discussion and Information Sharing*)

Recommendation 7: When self-neglecting individuals experience repeated hospital admissions and there are ongoing challenges with engagement in the community, closer working is needed between hospitals and other agencies involved, such as social care or housing. Practitioners should consider this in their practice, and hospital leaders should facilitate discussions between safeguarding leads in the respective organisations to identify and address potential obstacles, reporting back to NSAB within six months of publication.
(*Collaborative Working and Decision Making*)

Recommendation 8: Adult Social Care and relevant partner agencies should work with the Department for Work and Pensions (DWP) to ensure that the safeguarding risks identified by DWP colleagues are recognised, understood, and embedded within local safeguarding pathways to support earlier intervention and improve protection for vulnerable adults.
(*Fora for Discussion and Information Sharing*)

Recommendation 9: NSAB should explore whether an interprofessional training workshop, such as was requested at the practitioner event, can be offered to non-specialist practitioners. This might focus primarily on engagement, assessment, mental capacity, and how assertive approaches to dependent drinking can be implemented with self-neglecting individuals, presenting and building on the Blue Light approach.

Because such a workshop can only reach a limited number of participants, key points and practical tips emerging from it should be compiled and shared more widely across the partner organisations as a written and/or audio briefing, or potentially as e-learning. Sustaining the learning can be reinforced by putting it on supervision agendas. Consideration should also be given to identifying, and promoting awareness of, a *single point of contact* in substance use services, from whom practitioners in other services can seek advice on how to approach a case.
(*Managing Risk, Uncertainty & Mental Capacity)*

Recommendation 10: In cases of self-neglect where is reason to anticipate that the person may not continue with the treatment prescribed, sharing a handover or contingency plans with the community nursing team charged with following up should be considered:

- Norfolk's acute hospitals should prepare a report to NSAB to understand the current barriers to information sharing at point of discharge.
- Acute and community hospitals should review current proforma for discharge letters to include any specific concerns that have been identified or remain in relation to self-neglect. Consideration should be given to use of a trigger question to consider the possibility of non-concordance, and / or flow chart setting out how to respond in '*IF x, THEN consider doing y*' format.
- Community health providers should review protocols for safely ceasing involvement and identify support they have available to support community nursing staff in complex and / or safeguarding cases to identify any additional needs.

(*Collaborative Working and Decision Making*)

Recommendation 11: Primary care practitioners should consider the possibility that neglect of a diabetic condition may sometimes constitute self-neglect and consider escalating to safeguarding leads if needed so that the relevant needs are addressed. Practitioners' awareness of their

responsibilities should be promoted through the learning from this SAR and reinforced through training, aligned with any changes resulting from Recommendation 10.
(*Collaborative Working and Decision Making*)

5. Reflections on the Process of the SAR

5.1 The author extends sincere thanks to all those who participated in the process of preparing this SAR. It was his experience that those involved contributed constructively and positively and reflected non-defensively on what for some were difficult experiences.

5.2 We acknowledge that more than a year had passed between the events described and the holding of the learning event. This interval doubtless affected practitioners' recall of some details. However, they were nonetheless able to give substantial accounts of their work with, and impressions of, Andrew.

5.3 Inevitably, not all the practitioners involved could be present at the learning event. Although this meant that the event did not fully bring together all perspectives, the author contacted absentees individually and has tried to integrate the different viewpoints into the final analysis.