Somerset Safeguarding Adults Board:
PRESS RELEASE
Review recommends national change

The recommendations are in a report published today (8th July 2025) by the Somerset Safeguarding Adult Boards (SSAB) which sets out the findings of the thematic review of self-neglect.

This holistic review of safeguarding practice was commissioned to explore self-neglect thematically and it has drawn on information provided in respect of 6 residents from across Somerset. Safeguarding Adults Review (SAR) referrals with concerns about how agencies together were received by Somerset Safeguarding Adults Board (SSAB), for five women and one man who experienced self-neglect. This was to include consideration of how the individuals involved had been supported, but also a broader scrutiny of how agencies across the partnership are working with self-neglect *currently*, to identify the features that support best practice and those that might hinder it.

A thematic review model was agreed to identify and share learning to improve future inter-agency practice and prevent deaths or serious harm in similar circumstances.

Self-neglect presents in hugely diverse ways, and this in itself represents a challenge in practice. This thematic SAR identifies individuals experiencing failing health, engaging in risky behaviour with negative impacts, neglecting their hygiene and personal care, not following a sustainable diet, living in squalid and decayed premises, hoarding and withdrawing from social contacts.

The SSAB requested the review to identify lessons that could be implemented to support those experiencing self-neglect and as well as promoting multi-agency ways of working to achieve this. Its recommendations include:

- A review of assessment tools/templates/guidance used by individual agencies to assist practitioners in assessing need.
- A review with Avon and Somerset Police, Somerset Council, Somerset Foundation Trust and South Western Ambulance Service NHS Foundation Trust of how the introduction of the Right Care Right Person approach to concerns for safety is impacting on adult safeguarding.
- Work to (a) raise awareness of safeguarding as a viable pathway for concerns relating to self-neglect, (b) ensure that the safeguarding pathway is a robust means of managing risks from self-neglect, and (c) clarify its relationship with other risk management pathways.
- Greater consistency in awareness and use of advocacy services for people in the circumstances outlined in sections 67 and 68 of the Care Act 2014.
- Development of guidance on engaging individuals who may be reluctant to maintain contact with services.

- Audit of how the Equality Act 2010 is interpreted and applied in practice across agencies.
- Assurance about practice in relation to mental capacity.
- Review by the local authority (and reported to the SSAB) of the availability of accommodation of the kind sought but not found for Mr X in 2019/2020.
- Strengthening of interagency collaborative approaches to self-neglect work, to include:
  * Audit of how the MARM pathway is being used.
  * An expectation of multi-disciplinary case discussions.
  * Review and re-launch of the SAB Resolving Professional Differences protocol.
- Guidance and standards to support home visiting for practitioners when risks to them from the conditions or circumstances in the home, whether environmental or from other sources, have been identified.
- Review of the self-neglect content within agencies' safeguarding training, followed by development of this content where required.
- Request NHS England to review the e-learning for Safeguarding Adults Levels 1 & 2 training for health staff, to ensure it adequately covers self-neglect and the interface with mental capacity, or, as an alternative, to develop an additional module on self-neglect.
- Assurance from all agencies that organisational features identified during their own internal reviews in these cases (as listed in section 7 of this report) have been implemented.
- A strategic leaders' event led by the Board with participation from partner agencies to explore what preparatory work and planning is taking place within organisations, and by the Board itself, to mitigate the impact of wider contextual pressures such as major health events on safeguarding in general and on work with self-neglect specifically.
- Consideration at strategic level of the need for local multi-agency/multi-professional teams (comparable to the children's family intervention service model), to facilitate the more longitudinal and specialised interventions needed to work with people who self-neglect in complex, high-risk circumstances.

Professor Michael Preston-Shoot, Independent Chair of the SSAB, said:

"These reviews are not about apportioning blame, they are about making sure lessons are learned and improvements made. The cause of the hoarding, self-neglect, living and personal hygiene conditions in these reviews (Like many reviews relating to self-neglect before them) went largely unexplored.

Somerset Safeguarding Adults Board sought to explore this in some detail in relation to six people considered to be self-neglecting prior to their early deaths and commissioned this review to help agencies working across Somerset to learn lessons from the circumstances surrounding the tragic deaths, who had all experienced things within their lives that lead to them neglecting to care for themselves, resulting in their deaths

We are grateful to those who knew or worked to support these individuals for their contribution towards the review, and for their insight towards what might have made a difference in these cases.

In addition to the recommendations made in by the review author the Somerset Safeguarding Adults Board has agreed that it will arrange an event, which will focus on self-neglect and how we can work together to reach those experiencing it."

The Safeguarding Somerset Adults Board is made up of all the organisations which have a role in preventing the neglect and abuse of adults, including: Somerset Council, Somerset NHS Integrated Care Board, Avon & Somerset Constabulary, National Probation Service, Somerset NHS Foundation Trust, South Western Ambulance Service NHS Foundation Trust, Registered Care Provider Association and Healthwatch Somerset.

For more information about the SSAB and a copy of the report visit www.ssab.safeguardingsomerset.org.uk

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Notes to editors