

## **Somerset Safeguarding Adults Board: PRESS RELEASE**

### **Review recommends improvements following death of Somerset resident**

A series of recommendations have been made by the Somerset Safeguarding Adults Board (SSAB) following the death of a Somerset resident from COPD complicated by Flu

The recommendations are shared in a report published today (2 June 2026) which documents Neville's (pseudonym) situation; an adult living alone in Somerset with a history of significant long-term health conditions. His physical health had been deteriorating over time, and he had a known pattern of disengaging from some elements of healthcare, particularly specialist services. Despite this, he did attend some appointments, when he was prompted or acutely unwell.

Neville's living environment had declined severely. He was living in conditions described as squalid, with no food or drink available in the home and the general condition of the flat suggested long standing self-neglect. Although initially concerns had been raised about animals in the property, the RSPCA later established that Neville had voluntarily rehomed his pets due to recognising his worsening health.

In December 2024, Neville was taken to hospital by ambulance from a friend's home after becoming acutely unwell, but he self-discharged on the same day. After his discharge, no agency made direct contact with him, and although concerns were raised by his friend and again by the RSPCA, no urgent home visit took place.

Neville sadly died in January 2025.

The review made recommendations, which highlight improvements that could be made in the way agencies should work together across the health and social care system, the report makes recommendations, including:

- Agencies should ensure that concerns meeting Section 42 criteria are consistently recognised and managed as safeguarding enquiries from the outset, rather than diverted into care and support pathways.
- Practitioners should be supported to ask further questions, explore discrepancies, seek corroborating information, and avoid assumptions about capacity or choice, particularly in cases involving self-neglect or nonengagement.
- Effective approaches to reviewing patterns of non-attendance, such as those used at Taunton Vale, should be shared across Somerset practices to help identify emerging risks earlier and encourage more consistent management of DNAs.

- Agencies should adopt clearer expectations for sharing safeguarding information, ensuring that significant concerns are passed promptly and directly to appropriate services rather than relying on signposting individuals or members of the public.
- Key safeguarding decisions, rationales, and risk assessments must be clearly documented, with ownership of actions explicitly recorded to support transparency, accountability, and effective multi-agency working.
- Somerset Foundation Trust should review the application of its Self-Discharge SOP to ensure staff consistently consider capacity, risk, home circumstances, and safeguarding implications when an adult self-discharges.
- Managers should ensure appropriate reflective supervision and decision oversight where referrals involve complex risk, self-neglect, or nonengagement, to avoid assumptions and ensure a proportionate response.
- The positive and proactive actions taken by the RSPCA should be acknowledged and learning shared to strengthen understanding of how voluntary and non-statutory agencies can contribute meaningfully to safeguarding responses.

The learning from the review will be shared with the NHS Integrated Care Board (ICB), Somerset NHS Foundation Trust, housing employees within Somerset Council, Somerset Council's Adult Social Care Service and the Police.

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

“The Somerset Safeguarding Adults Board exists to protect vulnerable people, and to make sure lessons are learned so that necessary improvements can be made. I want to take this opportunity to offer Neville's friends and family my sincere condolences for their loss.

Neville's story has highlighted the need to truly understand mental capacity linked with self-neglect and how we share the information across the health and social care system to support and safeguard those in Somerset. The focus of the report surrounds how agencies need to work together in their approach to support Neville and concerns about his self-neglect. Throughout this process, all organisations have offered their contributions openly and honestly to allow us to learn from Neville's sad death. I will now work with SSAB partners to ensure that this learning becomes embedded within daily practice.”

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 Police, Somerset NHS Foundation Trust, National Probation Service, Registered Care Provider Association and Healthwatch Somerset, [Our members \(somersetsafeguardingadults.org.uk\)](https://www.somersetsafeguardingadults.org.uk)

For more information about the SSAB and a copy of the report visit [www.ssab.safeguardingsomerset.org.uk](https://www.ssab.safeguardingsomerset.org.uk)

**ENDS**

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**Notes to editors**