SAR Neville

Background

Neville was an adult living alone in Somerset with a history of significant long-term health conditions, including Chronic Obstructive Pulmonary Disease (COPD) and Type 2 Diabetes. His physical health had been deteriorating over time, and he had a known pattern of disengaging from some elements of healthcare, particularly specialist services such as gastroenterology and ophthalmology. Despite this, he did attend some appointments—most notably those relating to his diabetes—when he was prompted or acutely unwell.

Historically, Neville had received a package of care between 2022 and 2023, but this was closed in mid 2023 with no ongoing support in place. He had also experienced a significant health event in 2021 and he was known to have struggled with periods of low mood. A close friend, referred to by Neville as someone he regarded like a daughter, formed an important part of his informal support network. She was the individual who first raised concerns about his deteriorating living conditions shortly before his death.

Neville's living environment had declined severely. By early January 2025, he was living in conditions described as squalid, with no food or drink available in the home. Heating appeared to be excessive, and the general condition of the flat suggested longstanding 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.

On 31 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. There is no documented evidence that hospital staff explored his home situation or undertook a mental capacity assessment before allowing him to leave. After his discharge, no agency made direct contact with him, and although concerns were raised by his friend on 1 January and again by the RSPCA on 2 January, no urgent home visit took place.

Neville died on 7 January 2025. His GP later confirmed that the recorded cause of death was an exacerbation of COPD complicated by Flu, alongside his existing long-term conditions. At the time of his death, Neville was living without adequate support, and the full extent of his vulnerability only became clear when he was seen by the RSPCA two days before he died.

Discussion of the Key Lines of Inquiry

Non Attendance and Non Engagement

Neville's pattern of non-attendance at health appointments emerged as a significant feature in the period leading up to his death. Although he was known to engage with some aspects of his healthcare—particularly diabetic reviews when prompted—he did not consistently attend outpatient appointments, including ophthalmology and gastroenterology. His repeated nonattendance in these specialist areas ultimately resulted in his removal from waiting lists, thereby reducing opportunities for early clinical intervention. It was noted during the meeting that while text messaging was recorded as his preferred method of communication, he did not

reliably respond to texts, and this lack of engagement did not appear to trigger further curiosity or alternative approaches. The decision to rely solely on text contact may have inadvertently masked a deterioration in his circumstances, as nonresponse became normalised rather than explored.

Some areas of practice demonstrated more robust responses. In particular, there were instances where the pharmacy contacted primary care when Neville failed to collect his medication, prompting follow up and communication between services. This indicated that certain processes were functioning effectively and highlighted how localised good practice can help identify emerging risk. However, this level of enquiry did not extend consistently across all service areas. There was a general recognition that people at risk of self-neglect often struggle to engage with services unless contact is assertive, persistent, and varied in method. Neville's disengagement, therefore, should have been interpreted not as a choice, but as a potential indicator of vulnerability.

The discussion also highlighted that some GP practices, such as Taunton Vale Health Centre, have established systems for reviewing repeated nonattendance. These involve regular examination of attendance patterns, escalation of concerns, and clearer oversight of people who do not respond to standard contact. In contrast, it appeared that this level of systematic follow up was not universally present across all services involved with Neville. In his case, repeated nonattendance was recorded, but not consistently acted upon. His complex presentation required a more nuanced response, recognising that nonengagement is often symptomatic of deteriorating wellbeing. The absence of a coordinated, assertive approach to reestablishing contact represented a missed opportunity to identify the severity of his circumstances.

Overall, nonattendance and nonengagement formed a critical theme in understanding Neville's decline. The meeting concluded that while some individual agencies demonstrated elements of good practice, the collective response lacked cohesion and assertiveness. Had the pattern of missed appointments, limited engagement, and inconsistent communication been viewed holistically rather than in isolation, services may have recognised earlier that Neville was at increasing risk and required proactive intervention.

Exploration of Mental Capacity

Consideration of Neville's mental capacity formed an important part of the discussion, as capacity assessments underpin safe decision making, particularly when an individual declines medical treatment or disengages from support. In reviewing the chronology, it became clear that there was no formal mental capacity assessment recorded at the point when Neville self-discharged from hospital on 31 December 2024. This absence was noted as significant, particularly given the context of his presentation and the subsequent deterioration in his living environment.

Although earlier entries within primary care records showed that Neville had been assessed as having capacity to decline hospital admission in May 2024 when he presented with haematemesis, this earlier assessment could not reasonably be relied upon in relation to decisions made several months later. Capacity is both decision specific and time specific, and any assessment must relate to the particular circumstances and risks present at the time. The hospital discharge summary contained no indication that staff had explored Neville's

understanding of the risks associated with leaving hospital, nor that they had considered whether he was able to weigh those risks meaningfully.

Ambulance documentation from the day Neville was admitted noted that he appeared oriented in time, place, and person, but orientation alone cannot be used as a proxy for decision making capacity. The paramedics had attended him at a friend's home rather than his own, meaning that they did not witness his living conditions. While they included a note that the friend had expressed concerns about the state of Neville's home, this information did not appear to prompt further exploration at hospital level about his decision-making abilities or his home circumstances.

The lack of professional curiosity at this point was highlighted as a missed opportunity. Given that Neville had chosen to leave hospital despite being unwell, had a history of disengagement with some aspects of healthcare, and was experiencing conditions that placed him at risk, the meeting agreed that further enquiry into his reasoning and understanding would have been appropriate. A more detailed exploration of his ability to make and sustain safe decisions may have led professionals to question whether he truly understood the implications of returning home without support.

It was also recognised that some services assumed capacity in the absence of clear evidence to the contrary, rather than actively assessing it where concerns were present. This assumption created gaps in the safeguarding process. For individuals experiencing self-neglect, reluctance to engage with services can sometimes be misinterpreted as autonomous choice, when in fact it may reflect an impaired ability to recognise risks or to prioritise immediate health needs. The meeting reflected that Neville's situation called for a more robust and inquisitive approach, particularly given the indicators of vulnerability that were present in the weeks and months preceding his death.

Overall, the discussion concluded that the exploration of Neville's mental capacity was insufficient at crucial points of contact, particularly around his self-discharge from hospital. A more detailed assessment, combined with greater professional curiosity, may have altered the trajectory of intervention and prompted earlier safeguarding action.

Self-Discharge from Hospital

Neville's self-discharge from hospital on 31 December 2024 was a pivotal moment in the sequence of events leading up to his death, and the meeting examined this in detail. Neville had been conveyed to hospital by ambulance following an episode of acute illness, but he had been collected from a friend's property rather than from his own home. As a result, neither paramedics nor hospital staff had direct visibility of the conditions in which he was actually living. Although ambulance notes indicated that the friend reported concerns about the state of Neville's home, this information does not appear to have prompted a fuller exploration of his living environment once he reached the hospital.

While Somerset Foundation Trust confirmed that there is an established Self-Discharge procedure for adult patients, it was unclear whether this procedure had been fully followed. The discharge documentation provided only minimal reference to the self-discharge decision and did not include any detailed account of discussions regarding risk, safety, or Neville's ability to manage at home following his discharge. There was no evidence that staff explored what

support, if any, he had available when leaving hospital, nor that they considered the potential for harm given his complex health needs, history of disengagement, and recent deterioration.

Importantly, no formal mental capacity assessment was recorded at the time of his discharge, despite the fact that he was leaving hospital against clinical advice and in a state of ill-health. Such an assessment would have helped determine whether Neville had the ability to understand and weigh the risks of declining inpatient care, particularly given the severity of his COPD and the possibility of infection. The meeting recognised that the absence of this assessment meant that his decision was accepted without adequate scrutiny, and that opportunities to intervene at this point were lost.

There was also no indication that Neville was seen by specialist inpatient teams such as occupational therapy, physiotherapy, or the respiratory service during his brief hospital attendance. These teams may have been better placed to identify the risks associated with a rapid discharge in the context of chronic ill-health and possible self-neglect. Similarly, no onward referrals appear to have been made to community-based services following his departure, leaving Neville without formal support at a time when his capacity to manage was clearly limited.

The lack of a coordinated response and the minimal documentation suggest that Neville's self-discharge was treated primarily as an expression of personal choice rather than as a decision requiring careful assessment and management. The meeting acknowledged that services were under considerable seasonal pressure at the time but nonetheless agreed that the level of risk involved in Neville returning home should have led to a more thorough and inquisitive approach. Greater attention to his vulnerability, the concerns relayed by his friend, and the potential safeguarding implications may have prompted a different outcome.

The discussion concluded that the response to Neville's self-discharge represented a missed opportunity to identify escalating risk. A more detailed assessment, supported by appropriate professional curiosity and adherence to existing hospital procedures, may have helped prevent Neville from returning to an unsafe environment without support.

Outreach Following Referral and Responsibility for Visiting

The discussion on outreach and responsibility for undertaking a welfare visit highlighted a significant breakdown in coordination between agencies in the crucial days before Neville's death. On 2 January, the RSPCA made a safeguarding referral after discovering that Neville was living in conditions of squalor without access to food and recorded that he appeared unable to care for himself. This referral was directed to Adult Social Care via the Somerset contact centre. Despite the seriousness of the concerns, Adult Social Care triage did not initiate an immediate visit. Instead, the triage worker contacted the Housing team and requested that a housing officer complete a welfare check. Housing later confirmed that no such request was received, and there was no record on their internal systems to indicate that a referral or request for action had been passed on. As a result, no agency attended Neville's property following the safeguarding referral.

The reasoning behind Adult Social Care's decision to delegate the visit to Housing was not documented, and the absence of a recorded risk assessment or rationale was identified as a serious concern. The case notes indicated telephone communication between the triage worker

and a senior practitioner, but there was no detailed account of how the risk was evaluated or why it was considered appropriate to leave the matter until after the weekend. Given the information available — including the absence of food, significant self-neglect, worsening health, and the sudden deterioration in his living conditions — the meeting agreed that a same day or next day welfare check would have been justified.

A related concern arose from the contact made by Neville's friend to the First Response mental health service on 1 January. The friend reported worries about his living conditions and wellbeing. However, rather than escalating the concern or passing it directly to Adult Social Care, First Response signposted the friend to contact Adult Social Care and the GP. This did not result in any recorded referral or action. The meeting reflected that relying on signposting, rather than accepting responsibility for escalation, created an avoidable delay that contributed to opportunities being missed. The lack of communication between services meant that the information from First Response and the RSPCA was not viewed collectively, and the emerging pattern of risk across agencies was not identified.

Housing confirmed during the meeting that they had no contemporary knowledge of Neville's circumstances. Because they were unaware of any concerns, they had no involvement in his case and no opportunity to undertake a review of his property or initiate support. They explained that annual tenancy reviews were not undertaken with regularity due to the size of the housing stock, and there had been no other triggers — such as gas safety checks or visitor reports — that would have alerted them to the deteriorating condition of Neville's home.

The discussion revealed systemic issues in interagency communication, ownership of safeguarding concerns, and responsiveness to risk. The meeting acknowledged that responsibility for visiting Neville should have remained with Adult Social Care once the safeguarding referral was received, and that triage should have led to an immediate and direct welfare check. The absence of such action resulted in no professional seeing Neville after 31 December, despite two separate concerns being raised through different routes. The failure to identify a lead agency, combined with gaps in recording and follow up, ultimately meant that the safeguarding process did not operate as intended at a time when Neville was significantly at risk.

Opportunities for Safeguarding

The review of Neville's case demonstrated that several opportunities to initiate safeguarding interventions were present in the weeks and days before his death, yet these opportunities were not fully recognised or acted upon. Each agency involved held pieces of information that, if viewed collectively, would have indicated increasing levels of risk, particularly in relation to self-neglect, physical deterioration, and an absence of meaningful support. The meeting reflected on how these missed opportunities arose and how a different sequence of actions may have led to earlier safeguarding intervention.

The first significant opportunity occurred when Neville self discharged from hospital on 31 December. Although the hospital may not have had direct visibility of his home circumstances, concerns had been relayed by the friend to the ambulance crew. These concerns were recorded, but it is unclear whether they were passed on verbally or reviewed by hospital staff. Had the hospital explored these concerns more thoroughly or questioned the wisdom of self discharge given his clear vulnerabilities, it may have prompted a safeguarding referral or, at minimum, a request for a rapid welfare check.

The second opportunity related to the contact made by Neville's friend to the First Response mental health service on 1 January. The friend reported concerns about his living conditions and his ability to cope at home. First Response did not pass this concern to Adult Social Care but instead advised the friend to make contact herself. This approach relied on a member of the public to act upon professional guidance without acknowledging that the responsibility to escalate safeguarding concerns rests with the professional receiving the information. The lack of escalation meant that Adult Social Care did not receive critical information at a point when Neville's decline was accelerating.

The safeguarding referral made by the RSPCA on 2 January represented the clearest and most comprehensive opportunity for multiagency safeguarding action. The RSPCA inspector found Neville living without food, in conditions of severe self-neglect, and in a state of poor physical health. The referral clearly communicated that Neville was unable to meet his basic needs and required urgent assistance. Despite this, Adult Social Care did not undertake an immediate visit, nor did they retain ownership of the case. Instead, a request was made to Housing to complete a welfare check. Because Housing never received this request, no visit occurred. The absence of a coordinated and timely response to a clear safeguarding concern was identified as a critical missed opportunity.

The meeting also highlighted that statutory thresholds under Section 42 of the Care Act were met at multiple points. Neville had care and support needs arising from his health conditions; he was experiencing self-neglect; and he was unable to protect himself from harm. These criteria were satisfied both at the time of his self-discharge and at the point of the RSPCA referral. However, they were not consistently recognised by professionals. Instead, some referrals were framed as care and support issues rather than safeguarding concerns, resulting in delays and misdirection of responsibility.

A further opportunity existed through the potential linking of information across agencies. Had the reports from the friend, ambulance service, hospital, and RSPCA been viewed together within a safeguarding framework, the pattern of escalating risk would likely have been more visible. Instead, each agency operated within its specific role and interpreted its own findings in isolation. The absence of cross-agency visibility was compounded by incomplete recording, meaning that decision-makers did not have a full picture of the risks involved.

The meeting concluded that safeguarding opportunities were not only missed because of isolated decisions, but also because of systemic issues relating to communication, clarity of roles, and professional assumptions about capacity and choice. These missed opportunities highlight the importance of recognising self-neglect as a safeguarding concern in its own right, requiring assertive outreach, strong interagency communication, and decisive action when individuals are unable or unwilling to engage.

Improvements Already Made

Since Neville's death, several improvements have been implemented across agencies to strengthen safeguarding practice, enhance professional curiosity, and reduce the likelihood of similar situations occurring in the future. Much of this progress reflects a recognition that safeguarding responses must be timely, well coordinated, and underpinned by clear understanding of thresholds, responsibilities, and risk indicators.

Adult Social Care has undertaken extensive work to strengthen its front door processes, particularly in relation to the screening and allocation of safeguarding concerns. The triage

pathway has been reviewed to ensure that referrals are correctly identified as safeguarding concerns where appropriate rather than being diverted into care and support processes. Updated guidance and decision-making tools have been embedded to help practitioners assess risk more accurately and to ensure that concerns meeting Section 42 criteria receive the correct response. Additional training has emphasised the importance of robust recording, the need to document the rationale for decisions, and the requirement for consistent and timely follow up.

Within Somerset Foundation Trust, focused work has taken place to develop and promote professional curiosity, particularly in situations involving self-neglect, self-discharge, and nonengagement. Teams have been provided with materials that highlight how to ask further questions, examine information from multiple sources, and avoid making assumptions about capacity or choice. A renewed emphasis has also been placed on reviewing self-discharge processes to ensure that staff follow established procedures, consider safeguarding implications, and assess capacity and risk before agreeing to discharge against medical advice.

There has also been improvement in recording standards across Adult Social Care, supported by ongoing quality audits which now specifically examine risk assessment, documentation, and follow up actions. These audits provide oversight of practice and enable managers to identify patterns, address gaps, and reinforce expectations. Over the past year, this work has contributed to clearer and more consistent recording, allowing for improved multiagency understanding of decision-making and risk.

In primary care, some practices—most notably Taunton Vale—have strengthened their systems for reviewing repeated non-attendance. Monthly reviews now take place to identify individuals whose patterns of missed appointments may indicate increased vulnerability. These reviews involve both administrative and clinical staff and have helped ensure that concerning patterns are escalated more quickly. While this good practice is not yet universal, the existence of such models offers a foundation from which wider improvements can grow.

There have also been strengthened communication pathways between Adult Social Care, the RSPCA, and Housing. The learning from Neville's case has highlighted the importance of ensuring that referrals and interagency contacts are clearly documented, followed up, and delivered to the correct recipients. These improvements are intended to reduce the risk of referrals being misdirected or overlooked and to ensure that agencies receiving information take swift responsibility for action.

Collectively, these early improvements demonstrate a shared commitment across the partnership to reflect on the learning from Neville's death and to enhance systems, communication, and responses for adults at risk of self-neglect. While further work is still required, the changes already made represent meaningful progress toward safer and more reliable safeguarding practice.

Recommendations for Consideration from the Learning Event

Agencies agreed that several areas require further focus:

1. **Strengthen the interpretation and application of safeguarding criteria**
   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.

2. **Reinforce professional curiosity across all agencies**
   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.
3. **Share and promote good practice models within primary care**
   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.
4. **Improve inter-agency communication and notification processes**
   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.
5. **Strengthen recording and documentation standards**
   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.
6. **Ensure consistent adherence to hospital self-discharge procedures**
   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.
7. **Improve oversight and supervision at points of significant safeguarding decision-making**
   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.
8. **Recognise and build on examples of good practice from nontraditional safeguarding partners**
   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.