

SOMERSET SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW: SELF-NEGLECT KEITH, NORMAN AND ROLAND¹

FINAL REPORT : 10th July 2026

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1. INTRODUCTION

- 1.1. In March 2025, Somerset Safeguarding Adults Board (SSAB) completed a thematic Safeguarding Adult Review (SAR) evaluating learning from six cases involving individuals who had died between 2020 and 2023 in circumstances of self-neglect. The SAR report, which was published in July 2025², made recommendations for improvement priorities designed to strengthen responses to self-neglect across the safeguarding partnership. Improvement actions are currently progressing under SSAB's leadership.
- 1.2. While the thematic SAR was in progress, further self-neglect deaths were referred to the SSAB and considered for safeguarding adult review. The Board concluded that a further thematic review of three cases should take place to identify what additional learning could be derived. The Board commissioned the independent reviewer who had carried out the earlier thematic review to undertake this further review³ and established a SAR panel comprising senior leaders from the agencies involved.
- 1.3. The individuals involved are:

Name	Sex	Date of death	Age	Circumstances	SAR status	Review period
Keith	Male	11/11/24	66	Died in hospital following admission in a critical state from squalid home conditions	Discretionary	2 years
Norman	Male	10/1/24	67	Died in hospital from sepsis and community acquired pneumonia following earlier discharge to unsafe home conditions	Discretionary	2 years
Roland	Male	3/1/24	75	Died at home from cardiac arrest during admission to hospital from squalid home conditions	Mandatory	1 year

2. THE THEMATIC SAFEGUARDING ADULT REVIEW PROCESS

- 2.1. The Care Act 2014 gives Safeguarding Adults Boards a statutory mandate to arrange a SAR in certain circumstances. Under section 44 (1-3), a review must take place where:

¹ Keith, Norman and Roland and pseudonyms.

² <https://somersetsafeguardingadults.org.uk/wp-content/uploads/2025/07/Self-Neglect-Thematic-Review.pdf>

³ Suzy Braye (Emerita Professor of Social Work, University of Sussex) is an independent adult safeguarding consultant with specialist expertise in self-neglect and in learning from safeguarding adult reviews.

- An adult with care and support needs⁴ has died and the Board knows or suspects that the death resulted from abuse or neglect⁵, or an adult is still alive and the Board knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

The Board has discretion (section 44 (4)) to undertake a review in any other case involving an adult with care and support needs.

2.2. The Care Act requires SAB partners to co-operate with and contribute to the review, with a view to identifying the lessons to be learnt and applying those lessons in the future⁶. The purpose is not to allocate blame for the events but to identify how agencies can work together to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.3. The overall aim of the present SAR has been to identify how learning from the circumstances of Keith, Norman and Roland reflects or add to the learning from the earlier thematic self-neglect review.

- What similar themes emerge?
- Are these themes being addressed by actions already under way?
- Is there new learning that requires additional improvement action?

2.4. Key lines of enquiry have been:

- 2.4..1. Needs and risk: How well were these addressed?
- 2.4..2. How well were the three individuals safeguarded?
- 2.4..3. How well did practitioners understand the individuals' own decisions about their situations, including their mental capacity for those decisions?
- 2.4..4. How effectively did agencies work together?
- 2.4..5. What organisational features impacted on practice?

2.5. The key steps for the review were:

Agency information submitted by:

- Avon and Somerset Police
- NHS Somerset Integrated Care Board
- Somerset Council Adult Social Care
- Somerset NHS Foundation Trust
- Village Agents with the Community Council for Somerset, operating as Thrive
- South West Advocacy Network
- South Western Ambulance Service NHS Foundation Trust

An online learning event bringing together front-line practitioners, operational managers and safeguarding specialists to explore experiences of working with self-neglect. The event was attended by people from a wide range of occupational roles and agencies. The key aims in discussions, which were supported by members of the SAR panel, were:

- To share early learning themes from the SAR, mapping these to the findings from the 2025 thematic SAR;

⁴ Whether or not the local authority has been meeting any of those needs

⁵ 'Abuse and neglect' includes self-neglect (Care Act 2014 Statutory Guidance)

⁶ Section 44(5), Care Act 2014

- To seek participants' experiences of some key challenges arising in the present SAR:
 - How non-engagement by individuals with measures designed to support and protect them is addressed in practice,
 - How practitioners broach difficult conversations about risk to life,
 - How the differences between timely, urgent and emergency intervention are managed,
 - How differences of opinion between agencies are managed.
- To give participants an overview of actions already being implemented by the SAB in response to the recommendations from the thematic review.

Meetings with family members⁷: The Board advised known relatives of the three individuals that the SAR was taking place and invited their participation. No response was received and the SAR therefore proceeded without family involvement. Repeated further contacts were attempted as the SAR proceeded, with the same outcome. A final contact will be made to advise relatives of the SAB's decision on publication of the report, once that decision has been made.

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

3. PARALLEL PROCESSES

3.1. Individual agency reviews

- The GP surgery in Roland's case held a significant event meeting after his death, following which additional training was delivered at the practice to clarify escalation processes.
- A supervisory review by the Avon and Somerset Police after Roland's death questioned whether additional medical or social intervention might have been appropriate during officers' attendance at his home on 24th December 2023. This resulted in referral to the Police Professional Standards Department, who then referred the matter to the Independent Office for Police Conduct (IOPC). The IOPC found no evidence that police actions caused or contributed to Roland's death. A single learning outcome related to the timeliness of information about the officers' concerns reaching Adult Social Care. Although the officers had completed their risk assessment on the day of their visit, there was a delay of 5 days before the Police Safeguarding Unit notified the safeguarding concerns to Adult Social Care⁸. The IOPC highlighted the importance of officers being aware of the Police Safeguarding Unit's availability and of alternative safeguarding routes that can be used when the Unit is not accessible.

3.2. Coroner's office

The inquest relating to Keith has been concluded. No inquest was held in relation to Norman. For Roland an inquest took place in April 2026, the outcome of which is awaited.

⁷ Statutory guidance on SARs requires family members to be invited to contribute to reviews.

⁸ The BRAG was completed on 24th December 2023; the Lighthouse Safeguarding Unit notified the safeguarding concern to Adult Social Care on 29th December 2023.

4. PEN PICTURES

Keith

- 4.1. Keith had chronic obstructive pulmonary disease and poor mobility. He was alcohol dependent and neglected his self-care. His home surroundings were squalid. He had been rehoused in February 2024 and lived alone. During 2024 there were further mounting concerns about his home conditions and their impact on his health. He underwent hospital admissions and there was police involvement when, intoxicated, he alleged his money had been stolen. Safeguarding referrals were made but did not result in s.42 enquiry. In June 2024 Adult Social Care undertook a Care Act assessment but did not find him eligible for care and support. He was referred to community connectors for support to manage his home conditions and to community rehabilitation for his mobility. He was provided with advocacy to assist with his financial management. Village agent involvement led to further significant concerns being raised about his living conditions.
- 4.2. In November 2024 his neighbour found him barely conscious and called emergency services, who found him unresponsive and close to death. His property was described as being in 'an advanced state of decay'. A safeguarding referral was made and he was taken to hospital, where he subsequently died.

Norman

- 4.3. Multiple agencies were involved with Norman over many years. He had multiple physical health comorbidities, including chronic obstructive pulmonary disease, and mental health difficulties: schizophrenia and agoraphobia. He neglected both his personal care and care of his home; his diet was poor and he had continence problems. His self-neglect was recognised and he had received direct payments with which he engaged multiple micro-providers to assist him. He persistently declined deep cleaning. District nursing services made safeguarding referrals.
- 4.4. Both his health and his home conditions deteriorated further during the autumn of 2023 and the Council considered repossession proceedings. Adult Social Care were undecided whether support should be provided by the community social care team or the mental health social care team, but it was thought that his self-neglect did not arise because of his mental ill-health, which was seen as stable. A Multiagency Risk Management (MARM) meeting took place in November 2023, revealing mixed views on whether he had mental capacity regarding health and care decisions. He was assessed as lacking capacity to make decisions on care and support, and a referral was made for advocacy. In late November he spent three weeks in hospital and was discharged on 20th December with a D2A care package comprising 4 visits a day for personal care, continence management, nutrition and maintaining his home. He refused to engage with care workers, however, and was believed to have capacity to make this decision. He declined attempts to readmit him to hospital. Uncertainty about his mental capacity for these decisions remained unresolved. He finally became very unwell and was readmitted to hospital, where he died on 10th January 2024.

Roland

- 4.5. Roland lived with his sister and until late 2023 had no contact with agencies other than his GP, who monitored his multiple health concerns, including hypertension, respiratory and memory concerns, which had been referred for investigation. In October 2023 his sister was hospitalised and later discharged to a friend's house due to concerns about the conditions in her home, which was in poor structural condition with evidence of hoarding. She

subsequently died, and the GP surgery attempted follow up with Roland, contacting also his nephew, the sister's son. Neighbours' concerns about Roland resulted in health connector referral, multidisciplinary team discussion, a safeguarding referral and s.42 enquiry visits. Adult Social Care had contact with Roland's nephew but no protection plan was concluded. He was seen as having no evident care and support needs but was listed for Care Act assessment.

- 4.6. In December 2023 the GP flagged concerns with Adult Social Care and requested Roland receive urgent respite care due to the state of the property. This was declined. The GP visited Roland at home on 22nd December and made a call to the Adult Social Care Emergency line raising concern that Roland was at risk of death. On 24th December a friend of Roland called the First Response Service raising serious concerns about Roland's health and welfare. A Police welfare visit took place that evening, officers finding him living in very squalid conditions, with no heating and no evidence of fresh food. Their concerns were submitted to the Police Lighthouse Safeguarding Unit but the Unit did not review this and make a safeguarding referral to Adult Social Care until 29th December. At that point, the practitioner working with Roland was on leave, and the safeguarding was merely logged for action by that practitioner on their return on 12th January. On 2nd January a neighbour visited Roland to assist him with a hospital appointment and found him in a critical condition. He was admitted to hospital and died shortly after admission

5. THEMATIC ANALYSIS

This analysis focuses on how needs and risks were addressed, how the men's decisions about their health, living situation and support were responded to, how well agencies worked together and what organizational factors may have impacted upon practice. The analysis draws on the written information submitted by agencies and on the perspectives of attendees at the learning event. It also references the learning from the earlier 2025 thematic SAR on self-neglect and identifies the additional learning evident from this review.

Managing needs and risk

- 5.1. Some good practice was evident in how needs were met and risk managed. Keith received proactive health screening and medical assessments when he presented at hospital. Village agents showed sustained persistence in attempting to engage him, despite his repeated avoidance and non-attendance. Village Agents were also in regular contact with Norman attending to practical matters such as deep cleaning, replacement bedding, support with direct payments and liaison with micro providers. For both men Village Agents identified and recorded the risks they faced, escalating these to Adult Social Care, albeit outside of formal safeguarding.
- 5.2. Both Norman's and Roland's GP surgeries identified the risks the men faced and escalated these to multidisciplinary teams and sometimes to safeguarding. District nurses recognised the risks from Norman's poor living conditions, sharing concerns and undertaking joint visits with Village Agents. In respect of Roland they were proactive in seeking a welfare check from the Police.
- 5.3. Adult Social Care took a lead role in coordinating multiagency risk management initiatives for Norman, convening MARMs to coordinate responses to the emerging risk. They also took rapid action in respect of Roland, allocating a practitioner to pursue a s.42 enquiry the day the safeguarding referral was received, with a visit being made the following day and proactive liaison with Roland's nephew.

- 5.4. Police officers gave timely and proportionate responses, identifying significant risk, recognising that safeguarding action would be necessary and escalating concerns. The delay in those concerns reaching Adult Social Care was subject to appropriate scrutiny. Ambulance service personnel recognised risks from Keith's and Norman's self-neglect and submitted appropriate referrals. The Ambulance Trust notes good practices shown in the attending clinician's records: the consistent recognition of safeguarding, the negotiation of protection plans with community colleagues, and observance of the principle of making safeguarding personal. In some instances, ambulance staff went 'above and beyond' providing personal care in the absence of other support.
- 5.5. But there were shortcomings in all three cases in how need and risk were addressed. Although Keith's Care Act assessment recognised the impact of his home environment on his health and wellbeing, Adult Social Care declined care and support as they believed him to be more capable of self-care than he claimed. On his discharge from hospital the GP surgery made multiple attempts to contact him but did not escalate concerns when they were unsuccessful. Village Agents consider that many risks remained unmanaged due to Keith's reluctance to engage with support and Adult Social Care's belief that he had mental capacity to make this decision. Somerset Foundation Trust reflect that either his self-neglect was not considered as a risk factor or too much reliance was placed on Village Agents supporting him. When community rehabilitation practitioners visited him and found him in squalid conditions, had they contacted the Trust's safeguarding advisory service they would have been advised to raise a safeguarding referral.
- 5.6. Norman also experienced long periods without face-to-face contact from his GP, resulting in the surgery having limited understanding of his circumstances and needs. During much of this period he was not flagged as an adult at risk on surgery records and staff were not aware of his safeguarding history. District nursing were quick to discharge him without exploration of why he was struggling to manage continence equipment and later declined to visit due to the state of his property. Adult Social Care allowed a delay of four months before Care Act assessment was undertaken but district nurses did not use the Resolving Professional Differences pathway, despite their awareness of increasing risk. Again advice from the Trust's safeguarding advisory service was not sought. Village agents consider that instead of managing each referral about Norman episodically, they could have argued more strongly for more formal multiagency oversight, given the ongoing complexity of his situation and the deterioration of his environment. In respect of both Keith and Norman they reflect that they could have more explicitly linked their observations to specific safeguarding criteria, formalising their concern as safeguarding referrals and strengthening the case for more assertive multiagency involvement.
- 5.7. In Roland's case, the GP surgery has reflected that some GP actions were not sufficiently timely or thorough. Aspects of Roland's situation, such as the level of reliance on his sister and the impact of his cognitive impairment on his decision-making, were not well enough understood. His sister's death could have triggered a home visit but contact continued to be by text despite Roland having asked for contact by letter and evidently not responding to texts. Concerns could have been escalated to the ICB but were not.
- 5.8. Adult Social Care did not undertake formal risk assessments in respect of any of the men and recognise that risk management was not effective. Triaging of referrals did not meet required timeframes, particularly in respect of Norman, and s.42 processes for both Norman and Roland were still ongoing at the time of their deaths without protection plans having been concluded.
- 5.9. A s.42 enquiry for Roland had been open since 22/11/23 and two visits made, with the practitioner making a referral for care and support needs assessment. At the family's

request, the GP surgery on 8/12/23 requested urgent respite for him so that work on his property could take place. Adult Social Care declined to provide this until a care and support needs assessment had been carried out and a plan made for property repairs. The GP carried out a home visit on 22/12/23 and informed the Adult Social Care emergency line that Roland was at risk of death. On 24/12/23, an alert by a family friend to the Somerset Foundation Trust First Response Service resulted in a police welfare visit to Roland. Although the officers completed a BRAG assessment and submitted a safeguarding referral, this was not reviewed by the Police Safeguarding Unit and sent to Adult Social Care until 5 days later. Because the previous safeguarding referral was still open, the police referral was logged for response by the social worker involved, who was on leave until 11/1/24.

- 5.10. One further aspect of meeting needs and managing risk relates to protected characteristics under the Equality Act 2010. Equalities were not a specific focus of enquiry in this second thematic self-neglect SAR. Here the review was primarily concerned with highlighting new learning that emerged beyond the themes apparent in the first thematic self-neglect SAR. In the report from that earlier SAR, there is a significant focus on equalities, summarised here.

While no evidence of discrimination was identified by agencies, it is clear that the attention paid to protected characteristics in work carried out with the six individuals featured was limited, with the exception of disability (including mental illness). But even where disability was recognised as a source of inequality, there was mixed evidence on whether explicit reasonable adjustments were made. The requirements of the Equality Act 2010 appear to have remained largely under the radar and unrecognised in daily practice. The review recommended that the Board should undertake an audit of how the Equality Act 2010 is interpreted and applied in practice across agencies, to move beyond simple assurances and to involve:

- a) Audit of whether protected characteristics are routinely recorded in agency records;*
- b) Audit of what measures are used to ensure that protected characteristics are taken into account in interventions;*
- c) Based on the outcomes of the audit, consideration of whether further guidance (backed by briefings and training) is necessary.*

The present SAR does not provide any evidence to suggest changes in agencies' approach have taken place in the intervening period. Equalities and protected characteristics remain under the radar in the information submitted. The SSAB will therefore need to seek assurance on the completion and impact of the actions detailed in the earlier recommendation. In addition, it is apparent that SAR referrals to the SSAB do not request information on ethnicity, resulting in an additional recommendation arising from the present review.

- 5.11. Judging when a situation requires a standard, urgent or emergency response is a constant challenge in safeguarding, and discussions at the SAR learning event highlighted widespread frustration with the inability of systems to respond flexibly when risk escalates. Participants described bureaucratic barriers, lengthy referral processes and rigid pathways that can delay action in situations perceived as urgent. There was seen to be a lack of shared understanding across agencies about what constitutes a timely response, an urgent response and an emergency response. Participants repeatedly emphasised the value of direct professional-to-professional discussion, noting that reliance on electronic referrals alone can result in loss of nuance and delay. Difficulties navigating front-door processes and lack of feedback following referrals were identified as undermining confidence and potentially leaving risk unmanaged.

The individuals' decision-making

- 5.12. All three men were reluctant to accept help and support, in relation both to their health and to their personal and household care. This is not an unfamiliar picture in self-neglect, and achieving some understanding of what lies behind such reluctance is an important foundation for intervention.
- 5.13. The Village Agents' response to this review sets out some clear understanding of the factors that can underpin self-neglect and responses to offers of support, including shame, embarrassment, mistrust, exhaustion, apathy, denial and concern for privacy, as well as cognitive decline. What is less clear is whether these factors were recognised and explored at the time intervention was taking place and, if so, how they influenced actions and/or communications with other agencies.
- 5.14. Elsewhere, there is little evidence that the reasons for the men's self-neglect, or for their refusal to engage with support, were explored. Time-limited contacts leave little leeway for relationships to be built, particularly when there is plenty of immediate practical concern to focus upon. Yet without such understandings, intervention in self-neglect may lack a firm foundation.
- 5.15. In the face of extreme risks, discussion with the individual about the serious nature of those risks, and the likelihood that they will occur, is a key element of practice. There is some evidence that candid discussions took place with NO. The GP, Adult Social Care, the Village Agents and Somerset Foundation Trust all consider that they informed him of the serious consequences of his decisions and their potential impact on his health and survival. On a joint visit to Keith, the village agent and occupational therapist gave him a detailed account of how his living conditions were seriously detrimental to his health (although no safeguarding referral resulted from this visit).
- 5.16. Village Agents, however, comment that records of these candid conversations are lacking in detail, potentially compromising the evidence for escalation. Similarly, Adult Social Care found little explicit evidence of exactly what was discussed with Norman, and no evidence that risks were discussed with Keith.
- 5.17. At the SAR learning event, participants discussed the challenges and importance of being explicit with individuals about the risk of serious harm or death arising from self-neglect. Honesty, clarity and transparency were viewed as essential, particularly where risk information is material to an individual's decision-making. Participants emphasised the value of explaining risk in accessible language, allowing time for reflection, and returning to conversations rather than expecting immediate responses. There are barriers, however. These include uncertainty about role boundaries, assumptions that someone else will have already discussed risk and difficulty being confident that the individual understands, particularly where unidentified learning needs or cognitive impairment might be present. Some practitioners reflected too that using the word 'death' in discussion with an individual can feel very uncomfortable, even though it was acknowledged as necessary. But there may also be reluctance to embark on a difficult conversation in the time-limited context in which the contact takes place, as well as a wish to avoid raising matters that can prompt distress or hostility.
- 5.18. Agencies responded to non-engagement in a variety of ways. Village Agents in particular were persistent, making multiple attempts to visit. They nonetheless reflect that use of a structured non-engagement escalation pathway may have ensured a more robust response. Others too see room for improvement. Keith's GP reflects that they had many 'did not attend' and 'no response' contacts. While they made appropriate referrals,

subsequent follow-up to these and proactive liaison with Adult Social Care could have strengthened how this was addressed. Similarly, Norman's GP could have been more proactive in the face of his non-engagement. The practice finds that it over-relied on telephone consultations and Norman went long periods without any face-to-face contact or home visits. This limited practitioners' ability to identify the extent of his self-neglect and to understand the reasons behind it. Adult Social Care too consider that Norman's refusal of support that was so evidently needed should have raised questions about his executive brain function.

- 5.19. Reluctance to engage was a focus of discussion with the SAR learning event. Participants clearly recognised the importance of continued attempts to engage even where individuals repeatedly decline support. They emphasised the value of finding some small problem-solving contribution on a matter of concern to the individual, even if not central to the self-neglect, as a means of building trust. They also emphasised the need to understand reluctance through the lens of trauma, loss and previous experiences. In this context, professional curiosity was seen as essential in order to gently uncover what may lie behind an individual's behaviour. But there were seen to be significant barriers to working in this way, including practitioner burnout and emotional fatigue arising from repeated non-engagement and perceived lack of progress. A clear distinction was drawn between statutory and voluntary sector capacity, with voluntary sector practitioners able to spend more time with individuals, offering continuity and flexibility that supported relationship-building and trust, while statutory services described operating within tightly constrained time and substantial workload pressures.
- 5.20. A further question relating to the individual's decision-making is how mental capacity was addressed. The Ambulance Service did carry out a capacity assessment for Keith when attending him in February 2024, concluding that he lacked capacity in relation to hospital admission at that point; he was conveyed in his best interests. Other than this there is no evidence that mental capacity assessments were carried out by any agency for either Keith or Roland. It appears that in Keith's case, no reason was found to doubt his capacity and his apparent decisions about living conditions were seen as a choice – something that he could change if he decided to. In relation to Roland, Adult Social Care have ascertained that at the time the safeguarding practitioner had face-to-face contact with him in November 2023, they found no reason to doubt his mental capacity. There is, though, acknowledgement that in the time intervening between this point and his death in January 2024, the decline in his physical condition could have impacted on his capacity. District nurses in fact did recognise that his capacity to manage his health-related needs should be assessed and the GP recognised the need for assessment also. None took place, however, and the GP comments that this was because the decisions in question related to his care and support rather than to his health. The GP raises the point also that complex executive functioning assessments require skills and confidence beyond those currently experienced within surgery practice.
- 5.21. At the SAR learning event, a recurring theme raised by participants was the challenge they experience determining whether and how far unwise decisions should be respected and what they might recognise as triggers for scrutiny of mental capacity through Mental Capacity Act assessment. Executive dysfunction was an aspect of capacity about which some lacked knowledge and confidence.
- 5.22. Mental capacity assessments did take place for Norman, but his capacity was contested. Assessments by Adult Social Care in November 2023 (relating to care and support needs, fire risk and tenancy breach) concluded that he lacked mental capacity for decisions on those matters. The need for best interests decisions was identified and an advocate was sought to support him, but events were overtaken by his admission to

hospital due to a decline in his health. As part of discharge planning, his home was cleaned and his capacity to decide to return there was assessed several times by different practitioners in hospital with different outcomes. This discrepancy was not resolved, but he was discharged in line with his wishes, with immediate concerns arising about his ability to live safely there. He declined a return to hospital and was considered by his GP to have capacity to make this decision. His GP reflects that the need for formal MCA assessment was not recognised, despite indicators that his executive brain function was impaired, and considers that the impact of executive dysfunction on decision-making was not well understood. It appears that a further capacity assessment relating to risk from self-neglect was planned but not undertaken. Norman continued to decline hospital admissions, even after falls, but was eventually admitted by ambulance and died shortly afterwards.

- 5.23. Village agents consider that mental capacity assessment is outside their remit. With Keith, they worked to the guidance from Adult Social Care that he had capacity in the matters over which they were engaging with him (although this had not been established through MCA assessment). They reflect, however, that the pattern of his decisions — avoidance, inability to follow through on tasks, and contradictory explanations — may have indicated impaired executive functioning and that they should have made an explicit request to Adult Social Care to explore this further. For Norman, they did request further assessment but consider they could have provided improved evidence to justify their view that this was necessary.

Interagency working

- 5.24. A key foundation for robust interagency practice is the timely and accurate sharing of information, both bi-laterally between specific agencies and across a collective network, without which agencies can easily be left out of the loop.
- 5.25. There is some good practice to note in these three cases. Within health services, information-sharing between GP practice, district nursing teams and secondary care / hospital teams was generally sound. GP practices also initiated communications with Adult Social Care. In respect of Keith and Norman, Village Agents shared information promptly and consistently with Adult Social Care, providing updates after each attempted or completed visit and sharing significant observations about escalating risks. They also liaised with occupational therapy, housing, advocacy, financial support organisations, hospitals and micro providers. In relation to Keith, the Police shared information with Adult Social Care and community rehabilitation practitioners worked closely with Village Agents. In respect of Norman, communications between Adult Social Care, the D2A service, district nursing services and housing took place. The ambulance service routinely shared information with referrers, with others present and with primary care services, both face-to-face on scene, over the phone and virtually post visit.
- 5.26. There were, however, gaps in information-sharing. At times the outcomes of referrals made to other agencies were not known. In respect of Keith, his discharge summary to the GP practice was delayed, and the practice itself reflects that they did not sufficiently communicate his social care and safeguarding needs to Adult Social Care. Village Agents too found the information flow from others inconsistent. With respect to Norman, although information was shared between health providers, communications both to and from the wider multiagency network were lacking. His GP surgery reflects that this lack of reciprocal information flow reduced the ability to form a shared understanding of Norman's needs and risks. In Roland's case, there was a notable 5-day delay in information being passed from the police Lighthouse Safeguarding Unit to Adult Social Care, with review by the IOPC recommending that greater awareness was needed about alternative routes for notifying safeguarding concerns when the Unit was not accessible.

- 5.27. But even good information sharing, in and of itself, is insufficient. A key question is how agencies then come together to develop and pursue shared strategies for intervention. Again, there is evidence of some good practice. In respect of Norman, multidisciplinary network meetings took place, involving primary care, district nursing and the proactive care team. This had positive outcomes such as identification and escalation of risks, requests for capacity and mental health assessments and referrals to community support services. When Norman was admitted to hospital in November 2023, key personnel including the hospital social work team, the discharge liaison nurse, housing, the primary link team and the hospital MCA lead came together to plan a coordinated approach to his discharge.
- 5.28. There were nonetheless multiple missed opportunities to bring agencies together in shared discussion. As a result, shared risk management strategies were lacking. Even where health-led MDTs took place, participation was not system-wide. In Keith's case, Adult Social Care received information at various times from single agencies but there is little evidence of a multidisciplinary approach involving multiple agencies and no MARM took place. Although joint visits were made by Village Agents, Adult Social Care and occupational therapy, a more formalised interagency structure for discussion and planning would have strengthened planning, ownership and follow-through of actions.
- 5.29. In respect of Roland, a multidisciplinary meeting took place in early December 2023 but no minutes are available. Adult Social Care records do not clarify who attended or what was discussed. Later in December, the GP surgery nurse practitioner requested urgent respite care for Roland (following liaison with Roland's nephew about necessary repairs to Roland's home). Adult Social Care declined this request on the grounds that Roland's needs were primarily health related. Yet health professionals felt the needs and concerns arose due to unmet social care needs. Adult Social Care have reflected that terminologies used can impact on how discussions between agencies unfold. Although a request was made for respite, they believe it is likely that it was temporary accommodation that was required. Use of the term respite caused a barrier to identifying and considering the broader range of services Adult Social Care could offer. Because at this time a safeguarding enquiry was open, an Adult At Risk meeting should have taken place to discuss concerns and agree on a course of action, but this did not happen.
- 5.30. In relation to Norman, Adult Social Care did attend health-led meetings but reflect that the records of those meetings do not specify who attended, what information was shared and what plans were made. While concerns and information were shared through these MDT channels, it was not until November 2023 that a MARM meeting was convened. Again, it is unclear whether a record of this meeting was circulated to participating agencies. Thus the utility of meetings that did take place was compromised by poor recording lacking in detail, making it difficult to share with those not present, to work within an agreed strategy and to hold agencies accountable for actions taken.
- 5.31. Even the strong multidisciplinary commitment to discharge planning at the outset of Norman's hospital admission in November 2023 did not result in a safe discharge. There were differences in opinion with respect to his mental capacity for decisions about his discharge destination and a failure to act to resolve these, resulting in a failed discharge that was then not acted upon due to debates about whether his needs were medical or social, and therefore how they should be addressed. The discussions that took place did not form a sustained multidisciplinary plan, and implementation was fragmented. While some actions (such as safeguarding referrals, assessment requests, a deep clean and bed replacement) were followed through, others, such as securing appropriate accommodation on discharge, were not achieved. The discharge did not reflect the known risks in his living situation and no formal mechanism was used to challenge this decision.

- 5.32. This places the spotlight on an important aspect of interagency practice – how differences of opinion are aired and resolved. Differences of professional judgement were evident in all three cases. In respect of Keith, differences between Village Agents and Adult Social Care centred on thresholds for statutory involvement, interpretations of risk and mental capacity, and decisions about whether a visit for further assessment was necessary. In Norman’s case, disagreements within the network of those involved included his eligibility for replacement furniture, responsibility for funding, statutory action on environmental risks and safeguarding action on his home conditions. In both cases, differences were resolved through informal communication, Village Agents usually deferring to the statutory agency’s perspective. They consider that use of a formal resolution pathway would have enabled them to offer a more robust challenge and that without stronger alignment between statutory and non-statutory agencies’ perspectives, the non-statutory role has limited impact.
- 5.33. Somerset SAB’s Resolving Professional Differences pathway was not used either to resolve the differences in Norman’s mental capacity assessment or concerns about the safety of his hospital discharge. The conflicting capacity assessments were referred to the Council’s DoLS and Mental Capacity Act lead, who advised that a coordinated approach involving the hospital social worker and the neighbourhood team should be adopted to facilitate discharge. However, the difference in professional opinion regarding the MCA assessment was not formally resolved.
- 5.34. Professional differences were a discussion focus at the SAR learning event. They were described as most commonly occurring in relation to mental capacity, safeguarding thresholds and responsibility for leading complex cases. Participants noted that agencies are not always aware of each other’s statutory duties, pressures or decision-making frameworks, leading to mismatched expectations. Effective strategies discussed for resolving differences included joint visits, shared reassessment of capacity and early dialogue between practitioners or escalation to managers. However, participants reported uncertainty about escalation routes and under-use of the Resolving Professional Differences protocol. Multi-Agency Risk Management meetings were viewed as valuable in securing a shared perspective but were seen as under-utilised.
- 5.35. One further interagency theme to emerge is the presence of debate on whether needs are health-related or represent a social issue. In both Norman’s and Roland’s cases, the medical vs social dichotomy surfaced, resulting in debates about which agency was responsible for responding. In fact such differentiation is usually impossible in cases of chronic, severe self-neglect such as are seen here, where the circular pattern of causality between decline of physical health and impact of self-neglect was very apparent. Mental health can be an underlying, influential factor, yet here was discounted as significant, with self-neglect seen purely as a social issue. And in Roland’s case there appears to have been no consideration of whether the loss of his sister had impacted upon his mental health and his ability to care for himself.

Organisational features

- 5.36. Challenges within the organisational context can affect practice at the front line. Several agencies did not report any such pressures, but from those that did a picture emerges of a system under strain.
- 5.37. Adult Social Care raise a number of matters that they believe in all likelihood contributed to challenges in effective risk management and safeguarding, emphasising that some of these are challenges that extend nationally, well beyond Somerset:

- There were missed opportunities for early intervention in some situations, notably for Norman, which suggests that the identification and escalation of safeguarding concerns require attention.
- Compliance with established risk management processes was a barrier to effective risk management.
- Delays in intervention could be attributed to resource limitations and staffing capacity constraints, leading to longer waiting times and difficulty maintaining consistent personnel to work with an individual.
- Over the last 10 years there has been a notable increase in less experienced and newly qualified staff and a significant reduction in experienced practitioners, resulting in a changed skill mix among Adult Social Care professionals.
- Between 2022 and 2024, Adult Social Care experienced significant organisational restructuring to expand frontline management through an increase in advanced practitioners and to introduce changes in its team model.
- Post COVID-19 demand and resource constraints, alongside cultural shifts within the workplace have resulted in reduced staff presence in offices, which has limited opportunities for nuanced, reflective in-person discussions.

5.38. Norman's GP practice notes that until late 2023, when an adult at risk code became available on electronic patient record system, clinicians were not consistently working with the full safeguarding context – a systemic issue that impacted on the availability of information about a patient's vulnerability. Roland's GP reflects that use could have been made of the ICB's safeguarding team to escalate the challenges being faced.

5.39. After Roland's death, the IOPC considered the question of whether police actions on the visit of 24th December caused or contributed to his death. The single learning outcome to emerge related to safeguarding notification routes, highlighting that officers need to understand the operational pattern of the police Lighthouse Safeguarding Unit and to consider other available routes for raising concerns when the unit is not immediately accessible.

5.40. Somerset Foundation Trust draw attention to the presence of winter pressures and all-round increasing demands on health services in a post-covid era. Again these reflect national issues. In addition, they highlight organisational flux during the time these three men were receiving services: in April 2023 Somerset NHS Foundation Trust merged with Yeovil District Hospital Foundation Trust, a merger followed by a substantial period of service, policy and process alignment.

5.41. They also highlight that the Trust's Safeguarding Advisory Service is not sufficiently seen as a reference point by practitioners working in challenging situations. There were missed opportunities for practitioners to take advice from the service, as when community rehabilitation practitioners found Keith's living conditions in such a poor state but did not see his self-neglect as a matter for escalation. This was despite it being at a level that the Trust considers should have triggered a safeguarding adult referral, or at least a multiagency / professionals meeting. When he was discharged from hospital in February 2024 there is no evidence that home conditions were explored, despite the fact that he had been admitted from home conditions that had warranted a safeguarding referral by the ambulance service. The Trust reflects that in the current climate across health and social care with resource constraints, time constraints and service demands, it can sometimes be difficult for practitioners to work outside of their key objective of delivering their treatment or care plan. Putting 3-4 hours into following up self-neglect concerns means 3-4 patients or service users not being seen, or the practitioner undertaking 3-4 hours of unpaid work. This is the reality.

- 5.42. Village Agents make an observation that is related to this focus on the pressures on staff. They consider that the systemic barriers that exist can leave frontline staff feeling isolated and stuck when they are grappling with the emotional and ethical complexity of the work. They argue it is vital that the existence of such barriers is escalated upwards, not simply carried at practitioner level.

6. LEARNING FROM THE PRESENT SAR

- 6.1. The circumstances in which these three men lived and died are not unusual within safeguarding. Nationally there is ample evidence of the circular causality between self-neglect and ill-health. Within Somerset, the thematic self-neglect review in 2025 showed similar patterns and many of the learning themes evident in the thematic SAR are apparent in the present SAR also. These include the need for holistic understanding of the individual, risk management and use of safeguarding, attention to mental capacity including executive function, interagency working and organisational pressures. There is nothing here that contradicts the conclusions of the thematic SAR. For that reason the learning from the three cases in the present SAR is to a large extent addressed by actions already under way in response to the thematic SAR recommendations.
- 6.2. It is evident also, from information gathered during the present SAR process, that some agencies have made some significant changes in their practice, some of which arise from SAR or internal review learning and some from wider considerations that will nonetheless impact on self-neglect practice. These changes are set out for information in Appendix 1.
- 6.3. However, the circumstances of the three men in the present SAR do raise some points of new or more strongly emphasised learning. These are similar to those found within a recent standalone Somerset SAR, 'Nigel'. They include:
- the need for clearer, shared understanding across agencies of what constitutes timely, urgent and emergency responses;
 - more effective escalation when risk increases despite attempts to manage it;
 - renewed emphasis on how persistent reluctance to engage can be addressed;
 - improved use of professional challenge and escalation routes where there is disagreement.
- 6.4. At the SAR learning event participants highlighted also the absence of a coordinated, system-wide response for individuals with complex, high-risk self-neglect. Individuals who self-neglect were seen often to fall between services due to the complexity of their needs. Concerns were expressed about safeguarding referrals being screened out at an early stage without sufficient professional dialogue. There was strong agreement on the need for direct discussion, clearer feedback loops and better visibility of decision-making. There was strong consensus that current pathways do not consistently provide the intensity, continuity or authority required to manage escalating risk and the need for a strategic complex care or complex case panel was repeatedly identified.
- 6.5. These matters give rise to a small number of important additional recommendations from the present SAR.

7. RECOMMENDATIONS

- 7.1. On learning themes that are likely to be already in hand through the thematic review action plan, it will be necessary for the SAB to review that plan, to assure itself that the learning from the present SAR can be addressed therein. Recommendation 1 addresses this. Recommendations 2, 3 and 4 address learning from the present SAR that was not as overtly encountered in the thematic review and from which new actions therefore become necessary. Recommendation 5 addresses the overarching theme of organisational pressure.

Recommendation 1

SSAB to review the action plan already in progress from the thematic self-neglect SAR to establish whether the actions specified can be expanded to encompass the learning from the present SAR where it has raised learning on common themes. This would require assurance that the following are already in hand through thematic SAR actions:

- a) Mental capacity: when assessment must be undertaken and by whom, addressing an individual's executive function, recording of decisions on capacity (whether or not assessment has taken place);
- b) Risk: recognition of self-neglect as a risk factor and safeguarding issue, seeking a holistic understanding of risk by undertaking risk assessment and consulting other agencies, monitoring and promoting the use of MARM, stronger recording of attendance, discussion and action plans from MARM and other complex care meetings.
- c) Equalities: assurance on the completion and impact of the actions detailed in the earlier thematic SAR recommendation relating to equalities and protected characteristics. In addition, SSAB should revise its SAR referral form to ensure that information on ethnicity and other protected characteristics is requested.

Following review, SSAB to amend / update the thematic SAR action plan to encompass any additional actions necessary on mental capacity, risk or equalities.

Recommendation 2

SSAB to lead development work to establish expectations on how extreme risk from self-neglect, including risk to life, should be managed. This will involve:

- a) Development of a common, cross-agency language about level of risk to clearly differentiate between the need for timely, urgent and emergency action;
- b) Guidance for practitioners on raising risk to life concerns with individuals;
- c) Development of an escalated interagency decision-making pathway for management of risk to life, and indicators of the threshold that will trigger its use;
- d) Clarification of what a risk to life response can entail, including relevant powers and duties in the context of an individual's refusal of treatment.

Recommendation 3

SSAB to renew a focus on how persistent reluctance to engage can be addressed. This will involve:

- a) Assurance to the SAB by all agencies that
 - They have policies in place to address non-engagement and non-attendance;
 - Persistent outreach forms part of strategies for addressing non-engagement in situations where risk is known;

- Policies contain appropriate and accurate reference to escalation pathways should non-engagement persist in situations where risk remains high;
- b) Assurance that discussion of reluctance to engage and assertive outreach strategies is embedded within supervision on self-neglect cases, along with support to address the emotional fatigue and burnout practitioners can experience when working with complex and chronic self-neglect;
- c) Review of the SSAB's practitioner guidance Working with People who are not Engaging with Services to ensure it covers the barriers experienced in work with complex self-neglect and that it includes reference to (i) the importance of consulting agency non-engagement policies and (ii) the role of supervision. This review to be followed by relaunch and promotion of the revised guidance.

Recommendation 4

SSAB to lead measures to improve use of escalation and professional challenge routes where risk is extreme or professional differences of opinion are evident. This will involve:

- a) A mapping exercise to determine the escalation pathways available for use (for example advisory services or leads within agencies, senior management consultation, MARM and other forums to which complex cases can be referred, safeguarding referrals, Resolving Professional Differences guidance) with a view to ensuring that the circumstances in which each should be used are clearly specified; followed by launch of a document of guidance applicable across the partnership;
- b) Assurance from Avon and Somerset Police that the learning from the IOPC review of officers' contact with Roland has led to appropriate action. The IOPC recommended that greater awareness was needed by officers about when the Police Safeguarding Unit is and is not available, and what alternative routes should be used for notifying safeguarding concerns when it is not;
- c) Review of the SSAB's Resolving Professional Differences guidance to ensure that it adequately recognises the barriers to resolving professional differences and proactively supports practitioners to overcome them; followed (as noted above in recommendation 3c) by re-launch of the guidance.

7.2. The actions set out in recommendations 1-4 above are designed to strengthen the organisational and interagency systems that impact on self-neglect practice. They aim to help those systems run effectively and to ensure checks and balances are in place. They do not remove the immense organisational pressures under which agencies across Somerset, as nationally, are operating, which can act as barriers to practitioners being able to work on best practice lines. This gives rise to one further recommendation:

Recommendation 5

SSAB to consider and take appropriate action on:

- a) How it monitors and collates evidence of the impact on self-neglect practice of the ongoing, extreme organisational pressures and constraints experienced within agencies, and what action is being, and can further be, taken to mitigate impacts;
- b) How it gathers and showcases positive outcomes that are being achieved in work with people who self-neglect. Placing these positive human stories alongside the tragic ones found in SARs can make an important contribution to maintaining energy and optimism for change.

APPENDIX 1: CHANGES ALREADY MADE BY AGENCIES

1. Adult Social Care

- 1.1. The Council has introduced a Practice Quality Framework and established a Practice Quality Board, providing enhanced governance for practice and learning. It includes an audit system that encompasses practitioners at all levels. The Board serves as a key mechanism for monitoring, tracking, and fostering improvements in learning and practice, and has led to the implementation of the internal serious incident review policy. The Board is now working to integrate Housing following its inclusion into Adult Social Care in the 2025 council-wide restructure.
- 1.2. Work has taken place to embed risk management practices and assessments throughout the workforce. Updated guidance has been issued on the management of waiting lists, including the “Waiting Well, Waiting Informed” initiative. Additional guidance has been disseminated on the safeguarding pathways available in Somerset, which address the escalation of concerns for individuals who self-neglect.
- 1.3. Work has taken place on MARM guidance and processes, with a focus on differentiating between MARM meetings and Adult at Risk meetings. A practice development lead delivered a targeted workshop for all practitioners on this subject; a recorded webinar of which is available to all staff.
- 1.4. Since December 2025 the Customer Contact Centre must now notify the Safeguarding Team when three or more safeguarding concerns have been raised within 12 months, or where multiple contacts have been made to localities teams without subsequent action.
- 1.5. Managers and advanced practitioners have been trained to facilitate internal reviews, and these are shared through learning briefs, webinars, and team meetings.
- 1.6. A Serious Incident Practice Forum is held monthly, providing insights and recommendations that are subsequently presented to the Practice Quality Board, which also convenes monthly. This process ensures the identification and implementation of learning opportunities, modifications to procedures, and the detection of potential service gaps.
- 1.7. A new programme, ‘Understanding Hoarding Behaviour’, has been introduced. Workshops focusing on self-neglect have been made available to safeguarding team members, with plans to broaden access. Training sessions on self-neglect (tier 2) are mandatory for Adult Social Care (ASC) staff who have already completed Tier 1 mandatory training, inclusive of safeguarding and mental capacity modules. Future plans include joint training initiatives for ASC staff and relevant housing colleagues.
- 1.8. A comprehensive audit of MCA practice took place in 2024, resulting in enhancements to the guidance available within the Eclipse MCA and Best Interests (BI) forms. A MCA toolkit was launched offering staff improved access to supplementary guidance and direct links to external resources. The Council has also embedded the MCA competency framework within the MCA toolkit, enabling staff to identify personal development objectives and determine how these can be achieved.
- 1.9. Formal Tier 1 and Tier 2 MCA training is accessible via the Council’s ‘The Learning Centre’. Annual MCA refresher training now addresses executive functioning and fluctuating capacity, and emphasises a longitudinal approach when assessing mental capacity in complex cases. Training content will be updated to address the risks associated with an over-reliance on the presumption of capacity and failure to undertake MCA assessments, particularly for individuals who self-neglect and are disengaged from services. Trainers are to place greater emphasis on lessons learned from SARs and internal reviews within all relevant training sessions.
- 1.10. Housing services are now incorporated within Adult Social Care and are co-located in shared workspaces. This is intended to encourage stronger collaboration and facilitate more effective communication between teams. Two new social work appointments support individuals experiencing homelessness.

- 1.11. The Principal Social Worker is leading an initiative to improve how learning is effectively integrated into practice, focusing on ensuring it becomes embedded and has a meaningful impact on practice.

2. Avon and Somerset Police

Organisational work is underway to strengthen the force's response to safeguarding and vulnerability, including adults who self-neglect. This includes ongoing reinforcement of the BRAG process, improvements in recording, data capture and information-sharing, developed through the Constabulary's "Programme Two". These are intended to support more robust identification, monitoring and assurance in safeguarding cases, including those involving self-neglect.

3. General practice

3.1. Keith's practice

- Practitioners are more aware of the MARM process and feel more confident to call meetings when necessary. MARMS but always a challenge on who should lead on these, for people like Norman, we would now also put a flag on their EMIS record Eg f2f/home visits only

3.2. Norman's practice

- The practice now has a formal safeguarding process and weekly discussions where concerns/reports are raised, documented and followed up.
- A mental capacity toolkit and training, including on executive function, are available on the safeguarding website.
- Patients' records are flagged for face-to-face/home visits only where identified as necessary.

3.3. Roland's practice

- The practice has undergone additional training to clarify escalation processes. Similar cases are now taken to MARM meetings and where outcomes are not adequate the safeguarding lead escalates concerns to the ICB. In addition, monthly MDT meetings with CAMHS have been established, alongside ongoing complex care MDT meetings.
- The safeguarding lead has delivered Specific training on supporting patients with self-neglect with a focus on early identification, risk assessment, and appropriate escalation. Health Connections are undertaking regular welfare checks for identified patients. Patients are contacted by telephone rather than text to ensure meaningful engagement, and home visits are arranged where appropriate, including joint visits with mental health teams and social services. In addition, individualised care plans are developed for patients who self-neglect, with clear documentation of risks, protective factors, and agreed actions. Patients are discussed in MDT meetings to ensure a coordinated multi-agency approach, and concerns are escalated promptly when risks increase. Ongoing monitoring and regular review are in place to ensure support remains responsive to patients' changing needs.
- Escalation triggers for capacity are clearly defined and shared with all staff. Where these are present, mental capacity assessments are reviewed, cases are escalated to MDT and MARM meetings and where required the safeguarding lead escalates concerns to the ICB and external agencies.
- More home visits are being carried out even if patient not technically housebound but are identified as vulnerable.

4. Somerset Foundation Trust

- 4.1. Musgrove Park Hospital has established an alcohol / substance misuse team that can provide specialist advice and assessment and liaise with external drug and alcohol services.
- 4.2. A CPD workshop focused on self-neglect has been introduced and self-neglect is included in mandatory adult safeguarding level 3 training, which has been re-mapped to include band 6 nurses and allied health professionals.
- 4.3. Quarterly safeguarding supervision is delivered to district nursing services.
- 4.4. Further MCA CPD sessions, in addition to MCA L2 training, are provided and bespoke work is undertaken with teams where necessary. Mental capacity assessment is kept high on the agenda through training, support and advice.

5. South West Advocacy Network

The network has developed greater awareness regarding executive functioning and mental capacity.

6. South Western Ambulance Service NHS Foundation Trust

- 6.1. SWAST safeguarding team have undertaken a 2-year improvement process focused on 5 key deliverables: Governance/ Assurance; Capacity/Recruitment; Referral processes; Information Sharing; Safeguarding training
- 6.2. The improvement plan is concluding and from April 2026 the safeguarding team is moving into 'business as usual'. The team is at full capacity, with a safeguarding specialist in each county and a safeguarding educator. Quarterly reports are provided to safeguarding committee with escalation to quality committee and an annual board report is presented. A revised referral process went live in January 2026 and will be automated in March 2026. Safeguarding training is entering its 3rd year of rolling training and is fully aligned to the intercollegiate documents.
- 6.3. Processes and policies on application of the Mental Capacity Act are under review, with a view to the development and delivery of MCA training for the workforce.

7. Village Agents

- 7.1. Entrenched self-neglect is now treated as a safeguarding issue from the outset, not solely as a support need. Cumulative patterns are identified and more consistent use is made of safeguarding frameworks. Earlier multiagency communication, partnership working, enhanced documentation standards and clear escalation expectations are established.
- 7.2. The agency has strengthened its recognition, recording and escalation of concerns about capacity, with clear observations documented where capacity may be compromised and concerns shared with statutory agencies.
- 7.3. An updated safeguarding policy has been introduced and six Level 5 qualified Designated Safeguarding Leads identified. Guidance has been developed emphasising professional curiosity, executive functioning considerations, and the use of resolution pathways to challenge threshold decisions when risk persists. There is increased use of reflective supervision, risk focused discussions and more consistent documentation standards.
- 7.4. Safeguarding is regularly reported to the agency's Board and a designated safeguarding trustee, ensuring oversight at senior level.
- 7.5. The agency recognises that these improvements are still emerging, and that the organisation is at the early stages of transitioning from a primarily supportive approach to a more assertive safeguarding approach in chronic self-neglect. Our aspiration is for self-neglect cases to be managed with more consistent oversight, earlier escalation, and more structured multiagency collaboration.