



Somerset Safeguarding Adults Board: PRESS RELEASE

Review recommends stronger action to protect adults at risk from self-neglect

The recommendations are contained in a report published today (28 October 2026) by the Somerset Safeguarding Adults Board (SSAB), setting out the findings of a Safeguarding Adult Review into the deaths of three men, known in the report by the pseudonyms Keith, Norman and Roland.

The review was commissioned after deaths involving severe self-neglect were referred to the Board while its earlier thematic review of self-neglect was under way. It examined how needs and risks were addressed, how agencies responded to the men's decisions and reluctance to accept support, how effectively agencies worked together, and what organisational factors affected practice.

Keith, Norman and Roland lived with serious health problems and in highly unsafe home conditions. All three were reluctant to accept some offers of help. The review identified examples of committed and persistent practice but also found missed opportunities to assess and manage risk, resolve uncertainty about mental capacity, share information promptly and establish coordinated multi-agency plans.

The review confirms much of the learning from the Board's 2025 thematic review of self-neglect and highlights four areas requiring renewed or additional attention:

- clearer shared expectations for timely, urgent and emergency responses where self-neglect creates an extreme risk, including risk to life;
- more effective escalation when risk continues to increase despite attempts to manage it;
- persistent and relationship-based approaches when a person is reluctant to engage; and
- stronger use of professional challenge and escalation routes when agencies disagree.

Its recommendations include:

- reviewing and updating the existing thematic self-neglect action plan, including work on mental capacity, risk and equalities;
- developing a common cross-agency language for levels of risk and an escalated inter-agency pathway for risk-to-life situations;
- renewing the focus on non-engagement, persistent outreach, supervision and practitioner guidance;
- improving the use of escalation and professional challenge routes, including Multi-Agency Risk Management meetings and the Resolving Professional Differences guidance; and
- monitoring the effect of organisational pressures on self-neglect practice while also sharing positive outcomes.

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

“Safeguarding Adult Reviews are not about apportioning blame. They help us understand what happened, identify learning and strengthen how organisations work together to protect adults at risk.

“This review recognises examples of determined and compassionate practice, while also showing that people experiencing severe self-neglect can fall between services when risks escalate, engagement is difficult or professional views differ. We must make it easier for practitioners to act together with urgency, persistence and professional curiosity.

“The Board will oversee the recommendations and ensure the learning from Keith, Norman and Roland informs continued improvement across the safeguarding partnership. We are grateful to everyone who contributed to the review.”

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

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

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