

Northamptonshire Safeguarding Adults Board

Thematic Safeguarding Adults Review in respect of Self-neglect

Concerning Eddie and Frank

SAR References 056 & 062

Overview Report

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1. Introduction

- 1.1 This thematic Safeguarding Adults Review (SAR) was commissioned to review the circumstances surrounding the lives of two males, referred to as Eddie and Frank (not their real names), to identify key themes and areas for improvement for services supporting individuals with similar profiles.
- 1.2 A SAR referral was made to Northamptonshire Safeguarding Adults Board (NSAB) in respect of Eddie on 13th March 2024 by Northamptonshire Police following the discovery of his body at his home address. Concerns were raised that whilst known and supported by several agencies, there had not been a co-ordinated approach to that response. Northamptonshire Police also referred the case of Frank for similar consideration on 5th June 2024 when they identified that there had been many referrals made to help support him, but his living experience had not been improved. He had also been discovered deceased at his home address after not being seen for approximately three weeks.
- 1.3 NSAB considered that the circumstances of both individuals were remarkably similar and that a thematic review should be commissioned. The review was commissioned in November 2024 under Section 44(1) of the Care Act 2014.
- 1.4 Eddie and Frank were white British, middle-aged men who died in their own homes. The most striking thing in both cases was that they were not missed either by family or professionals. The last contact that Eddie had with any organisation was on 20th October 2023, and his decomposed body was only discovered on 5th March 2024 when a warrant was executed at his home address to complete gas checks. Neighbours reported that they had not seen him since October 2023. Frank wasn't missed for around three weeks and his body was only discovered when family alerted the police.
- 1.5 Both men had long-term alcohol dependency and various physical and mental health issues, including anxiety, depression and paranoia, and one of the men regularly self-harmed and often required admission to hospital. The other had mobility issues along with psoriasis and osteoarthritis.
- 1.6 There was a significant level of involvement of both statutory and non-statutory services with both men which included emergency services, police, ambulance and fire services and many health and social care professionals. However, what appears to have been lacking in responding to their complex needs was a level of co-ordination, multi-agency working and ownership, both to manage the level of complexities they presented with and a resilience in attempting to keep them engaged in the process.
- 1.7 Eddie had moved from supported accommodation into his own flat, which he found difficult, and there is evidence that he needed some support at this time of transition, not only in relation to the practical things like purchasing white goods but also with emotional support. Eddie did reach out and went to the Crisis Café on two occasions in April and July 2023 and through notes recorded by the staff, it was clear what was important to him. He wrote that he wanted "To live free from alcohol" "To set up my flat properly" and "To look at getting back to work."
- 1.8 Frank also had ambitions around where and how he wanted to live. At the time under review, he lived in a first-floor flat which was proving too difficult to access with his limited mobility, The flat was also showing signs of being neglected and his gas had been disconnected. He often slept outside in a country park and was a well-known figure there, chatting to dog walkers and other people using the park. Frank's focus was to find a one bedroomed ground floor flat which he could afford and that would be more appropriate for his mobility issues.
- 1.9 Both men had sporadic and inconsistent engagement with health and care services which often resulted in them being discharged from the service, only to then continue in a cycle of behaviour requiring emergency intervention, further medical attention and a referral back to the original service.
- 1.10 There were also practical issues for support services to navigate in attempting to contact and engage with the men due to their chaotic lifestyles.

2. Context and purpose of the thematic safeguarding review

- 2.1 This review also wanted to consider learning that has been identified through previous SARs undertaken by NSAB and the extent to which learning has influenced direct practice and organisational responses.
- 2.2 SAR 019 Jonathan was published in 2020 and reviewed the circumstances surrounding his tragic death. He died in a hotel room following being discharged from hospital, and concerns about how agencies had worked together effectively. Jonathan had multiple vulnerabilities and risks which were compounded by homelessness and rough sleeping, and frequent visits to emergency departments. The risks to Jonathan were not readily acknowledged despite him having significant physical and mental health conditions, housing issues and care and support needs.
- 2.3 There are repeated themes evident between this SAR and SAR 019 in respect of the understanding and application of MCA with regard to choice and unwise decisions, lack of holistic purposeful multi-agency working, understanding and implementing legal frameworks to safeguard vulnerable people, and developing a professionally curious approach to understanding an individual's situation.
- 2.4 The identification of risk and subsequent management are highlighted as a specific recommendation within SAR Jonathan.

NSAB to conduct a multi-agency case audit to establish how embedded in practice the ARM procedure is, with particular focus on the timeliness for carrying out an ARM and the use of lead agencies to coordinate services and risk management plans, with proposals brought forward to address the findings. The findings should consider proposals from agencies with regards to establishing more regular meetings where information can be shared and decisions made for people experiencing multiple exclusion homelessness.

- 2.5 SAR 019 identified a significant omission in relation to the lack of multi-agency meetings, and at the time of the review, the author wrote that whilst the ARM process had moved on, there was still a lack of knowledge and a reluctance to call a meeting. The process at that point was described as not embedded. The ARM process has recently been reviewed and re-launched, and whilst as already outlined, representatives at the learning together event commented that the uptake had improved, it was apparent that professionals still felt unsure about the processes and suggested that it could be easier and less bureaucratic. The author is aware that when reviewing the ARM process that a survey was carried out and a review of the existing documents led to some changes. Whilst the monitoring process was initially undertaken by the NSAB Business Office, this was taken over by WNC some years ago, but it has not been possible to establish the numbers of cases subject to the ARM process, or the number of case closures undertaken as monitoring is not proactively undertaken and is reliant on agencies submitting the monitoring form. The ARM process does not appear to be robust enough, with agencies not taking accountability and commencing the process when it would be advantageous to do so.

Agencies failing to work in a collaborative, multi-agency and holistic manner is a repeating theme within SARs 019, 026, 035 and also in this review. Practitioners, supported by line managers, should feel confident that even outside of the ARM process, that they are able to convene a meeting of relevant professionals when necessary. This way of working would help provide the best possible information on which to identify risk, hear the voice of the individual and to plan jointly for a desired outcome. Some partnerships have developed their own guidance to support practitioners.¹

- 2.6 SARs 026 and 035 is a thematic review of two people who had similar complex lives to Eddie and Frank. They were both known to multiple agencies, had complex mental and physical health needs, substance use issues and experienced homelessness. Both were frequent attenders at emergency departments, experienced criminality either as a victim or offender, and did not proactively engage with some support services.

¹ [Multi-Agency Professionals Meetings](#)

- 2.7 One of the specific barriers to supporting these individuals is identified within the SAR as being the actual agency policies and processes providing no opportunity to think “outside of the box” or take a holistic approach to the issues presenting.
- 2.8 The recommendations and findings also clearly identify that “no one agency took responsibly for the oversight of the assessment of the men’s needs and no single agency took responsibility for ensuring they accessed appropriate long-term support and treatment”.
- 2.9 The Second National SAR² analysis published in 2024 supports the evidence that the abuse type of self-neglect features in the highest number of SARs at 60% of those examined. 46% of the SARs also related to individuals with a substance dependency, 13% featured homelessness and 72% of individuals had mental ill health evident. In Northamptonshire, the Safeguarding Adults Board has received 34 SAR referrals between 1st April 2023 and 31st March 2025. 21 of these referrals (60%) related to self-neglect or had factors associated with self-neglect contained within them. This mirrors the national findings.
- 2.10 Some of the key themes identified in both direct practice and in organisational systems are relevant to this SAR and to the future practice and organisation of partners’ response to individuals with complex needs.
- 2.11 The Second National SAR analysis reflects that it is rarely one thing that goes wrong, more often there are multiple shortcomings, which when combined result in a poor outcome. The identification of risk and the management of risk feature in 82% of the SARs examined and in 56% of cases there was found to be poor recognition of the actual abuse or neglect.
- 2.12 Many of the SARs identified issues with how agencies failed to engage with individuals and in relation to practice, how professionals failed to be assertive and persistent in understanding a person’s history and overcome barriers. There was also a failure to identify repeated patterns of engagement followed by disengagement.
- 2.13 In multiple SARs, there was commentary about the lack of professional curiosity and failing to look beneath the surface of a situation. There was often a focus upon what was presented rather than what was not. Understanding why individuals make a specific decision is vital, for example why didn’t Frank want to engage with the substance use service?
- 2.14 Housing and accommodation needs interspersed with rough sleeping also featured significantly and it was identified that what was needed was a more personalised and trauma informed response to the individual’s situation.
- 2.15 The analysis also comments around substance misuse and states that attitude to alcohol use were sometimes coloured by a lack of understanding of the role alcohol in the individual’s life and an assumption that drinking was lifestyle choice.
- 2.16 In terms of safeguarding and missed opportunities the analysis also found that individuals with alcohol dependency, neglect of health care and self-harm were not often recognised as forms of self-neglect that warranted a safeguarding referral.
- 2.17 72% of the SARs examined identified that interagency case co-ordination and working together remain the greatest challenge.
- 2.18 The purpose of a SAR is neither to investigate nor to apportion blame.

² [Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association](#)
NSAB – SARs 056 & 062 – Self-neglect Thematic Review – Final – March 2026

2.19 The SAR requires outcomes that:

- a. Establish what lessons can be learnt from the circumstances of a case in which professionals and agencies work together to safeguard adults.
- b. Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
- c. Review the effectiveness of procedures both of individual organisations and multi-agency arrangements³.
- d. Improve practice by acting on the findings and developing best practice across organisations.
- e. Improve inter-agency working to better safeguard adults.
- f. Make a difference for adults at risk of abuse and neglect.

3. Terms of reference and period covered by the review

3.1 The thematic review covers the period six months prior to the men's deaths but also includes other significant and relevant incidents outside of this time.

3.2 The review covers the specific issues as set out below, and the agencies which contributed to the review have identified the key themes for further analysis.

3.3 The review aims to identify what happened, why it happened, and to establish what needs to change in terms of supporting people like Eddie and Frank in the future.

3.4 The specific themes identified for further exploration are:

- a. Demographics and relationships
- b. Vulnerabilities
- c. Opportunities to intervene
- d. Addiction
- e. Learning from previous SARs

4. Methodology for the review

4.1 The review has adopted a learning together methodology⁴ which ensures that the SAR is informed by the experiences and perspective of practitioners and managers and suggested recommendations have been developed by their input.

4.2 All agencies involved in the SAR provided a chronology of their involvement with the two men and individual meetings with key practitioners were carried out by the author.

4.3 The learning together event was held on 3rd February 2025 and focused upon the key themes and examined what worked well, identifying where there were challenges or barriers to effective support and identifying where practice and the overall system needs to improve to support people in similar situations.

5. The author

Heather Roach has been a Safeguarding Adults Board Independent Chair covering two Local Authorities over the last 8 years, an independent SAR author and the Independent Chair for a SAR Subgroup, managing the SAR process and implementing recommendations from those reviews. A former senior police officer of thirty years, she has a background in criminal investigation and safeguarding of both children and adults. She has also conducted reviews for other non-statutory organisations and facilitated safeguarding related events for other Safeguarding Adults Boards.

³ The SAR will consider any completed investigations and/or enquiries and use the information to enhance the review and avoid any unnecessary duplication.

⁴ Learning together methodology involves a facilitated event with practitioners to identify what worked well, were there concerns and what needs to change.

6. The review panel agencies

The following agencies formed the safeguarding adult's review panel:

- a. Change Grow Live - Substance to Solution
- b. Department for Work and Pensions
- c. East Midlands Ambulance Service
- d. Kettering General Hospital NHS Foundation Trust
- e. NHS Northamptonshire Integrated Care Board
- f. North Northamptonshire Council – Adult Social Care and Housing
- g. Northampton General Hospital NHS Trust
- h. Northamptonshire Fire and Rescue Service
- i. Northamptonshire Healthcare NHS Foundation Trust
- j. Northamptonshire Police
- k. Northamptonshire Probation Trust
- l. West Northamptonshire Council – Adult Social Care and Housing

7. Family involvement

The known families of both Eddie and Frank were informed of the SAR process by letter but did not accept the opportunity to be involved in the review or to meet with the author.

8. Parallel reviews and investigations

There are no other investigations or enquiries taking place in relation to either person.

9. Consideration of protected characteristics

The protected characteristics of both individuals subject of the review have been considered throughout the SAR. There is no evidence to support that agencies have been discriminatory in their actions, however as described later within the review an element of unconscious bias may have influenced the treatment of one of the males in the response to him being a victim of domestic abuse.

10. Demographic and relationships

- 10.1 The review panel wanted to understand whether there were aspects of both Eddie and Franks personal lives which were similar and what supportive and meaningful relationships were evident.
- 10.2 Both men were middle aged and had previously been married. Frank had a son but had no contact with him. There is information to suggest that Eddie had a sister living locally to him and Frank saw his mother and stepfather on a relatively frequent basis. Towards the end of his life, Eddie had a relationship with a female for a short time, but she also appeared to have similar struggles with alcohol.
- 10.3 Due to the lack of input from the men's families it has not been possible to ascertain whether they did provide a level of support but the chronology from agencies identifies what seems to be sporadic contact with family members.
- 10.4 Both men were quite sociable and friendly. In Eddie's case he responded well to the social prescriber at his GP surgery and often disclosed to other professionals that he was involved in faith related groups. He also developed an effective relationship with a housing officer who described him at the learning together event as a "really nice man." She went over and above her own role to support him. Frank was also supported extremely well by the Citizens Advice Bureau (CAB) worker who helped him complete paperwork in relation to various claims and appeals to the Department for Work and Pensions (DWP) and with applications to the local authority housing department. The CAB worker stated to the author that she could identify several men in similar situations to Frank who had all lost parents that they had previously relied upon, leading them to being unable to cope without them.

10.5 The tragedy of Eddie and Frank's bodies not being discovered for a significant amount of time is an area of concern. Research conducted in 2023 by the University of Oxford⁵ identified that the trend in people dying alone and lying undiscovered has risen significantly over the past 50 years. The research suggests that it is a problem which affects men aged over 60 at a much higher rate than similar aged women. There is no definitive evidence to support why the increases seen have occurred but theories have considered the impact of the national lockdown, digitisation replacing human interactions, changing family structures, the breakdown of formal and informal social networks and increased divorced rates. Several of these theories are applicable to the two men considered in this review.

"If someone is forgotten about in death it means these people were likely to have been forgotten about and neglected in life" Dr Theo Estrin-Serlui.

10.6 Professionals did consider the welfare of each man based on what information they knew. Social workers from West Northamptonshire Council's Adult Social Care (ASC) were concerned about Frank's welfare and following receipt of an email from Frank's GP they followed up by attending his flat on 10th May 2024 but he was not at home when they called. They informed the police on the 10th May, and later a police officer confirmed that they had seen Frank and there were no further concerns. Sadly, the following day he was once more found in a collapsed intoxicated state and taken to hospital.

10.7 A visit to Eddie's address following the final domestic abuse incident and concerns over his mental health, was also made by the substance use service on 1st November 2023, but it revealed no concerns as they observed cooking equipment and food through the window. Enquiries with a neighbour revealed that she had not seen him but wasn't concerned. No further action was therefore instigated despite him not being physically seen.

10.8 A report by Alcohol Change UK in 2017 "Learning from tragedies"⁶ examined eleven Safeguarding Adult Reviews. Four of the reviews involved men who had become unemployed, lived alone and lost contact with their families. The cause of death in these cases was related to self-neglect and a refusal of care from services, remarkably like Eddie and Frank's situation.

Analysis

10.9 It is impossible to comment upon the relationships between the two individuals and their families without direct input from them, but this point highlights the need for practitioners who are involved in supporting individuals with complex lives that developing the best understanding of them is even more important.

10.10 What gets in the way of supporting people like Eddie and Frank was discussed at the learning together event and it was identified that there are both barriers for the individuals themselves in seeking support and barriers for service providers. Recognising that individuals could have low self-esteem, feeling embarrassed about their situation and therefore not wanting to engage (or feeling able to engage) with offered support was identified. The barriers for practitioners were identified as not having sufficient time and capacity to "think outside of the box" and develop a meaningful relationship when the service user's life is chaotic and inconsistent.

10.11 From the chronology and discussions at the learning together event, it was evident that both men had a similar level of complexity, experienced similar life events and had a significant number of agencies providing varying levels of support. Whilst both appeared to lack close family support, practitioners were clear that by adopting a strengths-based, person-centred, holistic approach to supporting them, better outcomes could be achieved. Identifying the needs of individuals and being empathetic to what their perceived barriers are, were seen as important.

⁵ [A deathly silence: why has the number of people found decomposed in England and Wales been rising? - Lucinda Hiam, Theodore Estrin-Serlui, Danny Dorling, Martin McKee, Jon Minton, 2024](#)

⁶ [ACUK SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf](#)

- 10.12 The quality of the relationship between those providing a service and those seeking a service is paramount. The overall objective of adopting a strengths-based approach is to protect an individual's independence, create resilience, ensure their ability to make their own choices and to ensure their wellbeing.
- 10.13 Practitioners need time to get to know an individual and be in possession of knowledge about what support might be available. It was also discussed that it would be beneficial to identify sources of support other than from statutory partners.
- 10.14 Truly understanding an individual's situation, interests and ambitions in life is key, along with identifying whether there are other people who are already within that person's life providing emotional and/or practical support. This could be from a friend, acquaintance, neighbour, or voluntary sector agency/charity or faith sector.
- 10.15 Why neither man was missed for a significant period has a multi-faceted answer in the view of the author. Lack of curiosity, declining community spirit, family breakdown can all be considered contributory factors. A survey carried out in 2023 highlighted that about 58% of respondents had reverted to their pre-pandemic ways and went days or weeks without speaking to anyone living nearby.
- 10.16 Information provided at the learning together event also indicated that the locality of where the individuals lived was often populated by people with similar needs and dependencies. Therefore, the likelihood of noticing something was amiss, would be potentially reduced.
- 10.17 As identified earlier, there were some welfare concerns expressed by practitioners, but this did not always lead to a positive and definitive outcome. Professional curiosity and exploration of the risks presented could have led to a potentially different outcome for Eddie.

Good practice

- 10.18 There were individual professionals who featured within the lives of both men, with who they were able to engage well with. It is evident that in Eddie's case the social prescriber and the housing officer built a rapport and developed trust with him during their interactions. Similarly, in Frank's case, he was supported by the CAB worker, who clearly understood the barriers and challenges for him regarding the completion of application processes and forms for his housing applications and benefits. What each demonstrates is a basic human connection which can not only help to provide practical solutions but may also offer the emotional support that may have been lacking. Social connection to others is vital and tends to make people happier, more resilient and better able to cope with life's challenges.

11. Vulnerabilities

- 11.1 In this section the review aims to identify the vulnerabilities of Eddie and Frank, why were they particularly vulnerable, and how partner agencies can support people like them.
- 11.2 The nature of Eddie and Frank's lifestyles, physical and mental health and alcohol-addiction led them to be extremely vulnerable and exposed them to the likelihood of harm.
- 11.3 Long term dependency upon alcohol has serious implications in relation to significant health conditions, social problems such as unemployment, divorce, domestic abuse and homelessness.
- 11.4 Throughout the chronology, there were examples of both men being discovered in public places as well as in their own homes, suffering severe effects of intoxication or conversely alcohol withdrawal, physical injury, self-inflicted injuries and in general, sheer degradation. Often recovered to hospital to receive treatment, their inability to care for themselves placed them at significant risk of being exploited, assaulted or dying prematurely.

- 11.5 Eddie became a victim of domestic abuse when he developed a relationship with a woman who was also alcohol dependent. There were three specific occasions when police intervened in situations involving them. Eddie was assaulted on two of these occasions and his partner arrested. Whilst the first two incidents were appropriately and positively dealt with in line with domestic abuse policy, the same cannot be said of the final intervention. Following this incident, the follow up from police was sub-optimal and a significant period passed before attempts were made to contact him. Whilst an uncomfortable question to ask, it needs to be highlighted that Eddie might have been treated differently because he was a male victim of domestic abuse and his vulnerability was not sufficiently recognised.
- 11.6 Both men were unemployed and in Frank's case the long and often difficult process of accessing benefits, along with accruing debts caused him significant anxiety and fear. Frank told professionals that he preferred to sleep in the country park because he feared the bailiffs entering his house. Whilst this may have been Frank's preference the reality for people who sleep rough over a long period of time are, that on average, they are more likely to die than the general population.
- 11.7 Eddie and Frank led chaotic lifestyles and evidence shows there were distinct cycles. They would engage with professionals for a period and then disengage, disappear, fail to answer telephone calls and/or texts and fail to attend appointments. A crisis point would be reached, sometimes triggered by a personal issue for example the death of a family member, or the breakdown of a relationship, often resulting in a significant relapse into drinking and requiring emergency admission to hospital. When Eddie was admitted to hospital, a medical detoxification process occurred, a mental health assessment was conducted prior to discharge and he was then signposted to relevant support. Sadly, this cycle can be observed several times in Eddie's case. What is not evident is whether there were any discussions within the various agencies as to whether the risk to Eddie when he failed to engage or in fact disengaged with support services, increased. There is evidence of mental health professionals identifying a clear risk of premature mortality in relation to Eddie due to his behaviour and this is documented on two occasions.
- 11.8 Both men had problems in maintaining a habitable home. Eddie clearly struggled to manage the transition moving into his own flat from sheltered accommodation following his divorce. At one point, a safeguarding concern was raised by the housing officer following a significant deterioration in his ability to manage both himself and the property. The housing officer reported a huge deterioration in his presentation after six months of living in his own flat. This referral resulted in effective collaboration and positive engagement with Eddie by ASC, and he was referred to Support North Northants (SNN), however this was not seen as a safeguarding issue as he was described as not having care and support needs. A further complication occurred in respect of Eddie's home situation when his new partner moved into the flat and there were noise complaints from neighbours.
- 11.9 Frank also found it difficult to maintain his flat and was in debt to his gas supplier and to the local authority for council tax. His mobility was compromised and as the flat was on the first floor he wanted to move into something more appropriate and easier for him to manage. The poor state of his flat and his personal self-neglect had been known about by agencies since 2016, when a safeguarding referral was made.
- 11.10 Agencies reported that they found communication with the men difficult. There were practical issues such as having no mobile phone, or their phone wasn't charged, or that they were simply not up in a morning when professionals wanted to speak or engage with them. In Frank's case there was little point in sending him letters with important information as he had no letter box.

Analysis

- 11.11 Self-neglect was an evident factor in both cases, but it was not always identified by practitioners and the relevant action taken. Self-neglect is one of the ten abuse types defined under the Care Act 2014 and whilst the appropriate response may not be to commence an enquiry under Section 42, there is a NSAB multi-agency policy and pathway that could lead to an Adult Risk Management (ARM)⁷ process being commenced.
- 11.12 The Social Care Institute for Excellence (SCIE) describes self-neglect as “an extreme lack of self-care” and specifies “that it... may be a result of other issues such as addictions”. Practitioners did not appear to recognise the dependency upon alcohol as an act of self-neglect, and that the neglect of a person’s physical health and home environment can be as a direct result of substance addiction.
- 11.13 Representatives at the learning together event identified that there was some uncertainty and lack of confidence in their understanding of the Northamptonshire self-neglect guidance⁸ which resulted in this not being implemented.
- 11.14 Knowledge and understanding of terminology and when and how to refer a person to the Local Authority for an assessment of their care and support needs was also identified as a barrier to accessing the right support. Neither individual had a Care Act Assessment carried out despite referrals being made. The statutory guidance to the Care Act 2014 identifies when a needs assessment should be conducted. Para 6.13 states that “*Local Authorities must undertake an assessment for any adult with an appearance for care and support regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation*”⁹.
- 11.15 Resourcing issues and capacity prevented services from being able to support people like Eddie and Frank. Representatives at the learning together event identified that they struggled with waiting lists, the availability of services in terms of working hours e.g., many services provide a service only during office hours, and a lack of time and capacity to think innovatively. There was also a suggestion that staff experienced compassion fatigue as they continue to work in demanding and sometimes traumatic situations.
- 11.16 The risks facing people such as Eddie and Frank were identified by some services, particularly those who encountered them in periods of crisis and when appropriate safeguarding referrals were made. However, when there were processes that should, for example, have identified their frequent visits to accident and emergency departments, even if it had been recognised it was commented upon at the learning together event that in Eddie’s case his situation would not have been a high priority to trigger intervention.
- 11.17 From the evidence available, it is not apparent that consideration was given to the heightening of risk at the point at which individuals disengage with services.
- 11.18 Understanding why individuals do not accept help or cannot maintain a consistent relationship with services is important in developing a service that meets the needs of people such as Eddie and Frank. A study published in 2023¹⁰ in relation to identifying the barriers to seeking treatment for addiction provides six key themes that could easily be translated into interactions with all services. Without the direct input of Eddie, Frank or their families it is difficult to ascertain their reasons for not accepting some of the support offered. In the 2023 research commissioned for Leicestershire Public Health the six barriers identified are:
1. Perceptions and emotions – Fear, trust, anxiety and stigma
 2. Environment – Location, timings and other users
 3. Services – Referrals, getting appointments, ad hoc access and information

⁷ [The Northamptonshire Adult Risk Management \(ARM\) multi-agency process is an opportunity for practitioners to discuss adults at high risk of harm that fall outside the safeguarding enquiry process.](#)

⁸ [The Northamptonshire Self-neglect guidance and risk assessment tool is available here on the NSAB website.](#)

⁹ [Safeguarding-guide-final-August-2021.pdf](#)

¹⁰ [Complete-Research-Understanding-Barriers-to-seeking-treatment-for-substance-misuse.pdf](#)

4. Staff – Knowledge, shared experience and continuity
5. Pathways – Recovery pathways and access to other services
6. Previous experience

11.19 Bexley Safeguarding Adults Board published a SAR in 2023 which captures similar learning in respect of individuals struggling to engage with support services when in situations of self-neglect. *“A person struggling to self-care and to engage with others would find attending appointments and maintaining contact almost impossible. This is particularly relevant when someone lived a good life with family, friends, work, and wellbeing and then they find themselves (following trauma) unable to self-care, manage affairs and maintain relationships. They still understand the theory of addressing the individual issues affecting them but cannot find it in themselves to solve the problem that they have in managing their own problem. Something changed because of that trauma, enabling the trauma and trauma responses to consume the person and their identity. Reinstating, restoring, or exploring new ways of building self-esteem, confidence, identity, and social networks helps the trauma to integrate rather than consume. Agencies in Bexley identified that support is about fixing the barrier to the person solving their own problems, rather than taking control of the problems, or hoping that they will just go away”¹¹.*

11.20 There is a clear link between alcohol use and self-neglect and likewise a definitive link between alcohol and self-harm (Alcohol misuse in self-neglecting older adults¹²). It is therefore vitally important that all support services can clearly identify the risks associated with people such as Eddie and Frank and can appreciate their vulnerabilities. To successfully identify the risks requires professionals to take time to understand the individual’s history, what happened to them and to try to understand the reason behind their situation. This could be trauma related, loss, bereavement, or adverse childhood experience. Identifying their story and all their vulnerabilities should be a starting point for professionals and being professionally curious to help explore what the solution might be.

11.21 Practitioners need to understand their own powers and the legislation available to support people like Eddie and Frank. The Care Act 2014 does apply to alcohol dependent drinkers. Those who appear to have care and support needs have a right to be assessed under the Care Act and where appropriate, their needs should be met. Similarly, individuals who have care and support needs and who are experiencing or at risk of abuse or neglect (including self -neglect) may also require safeguarding by the local authority. Self-neglect should never be viewed as a lifestyle choice. Promotion of [Alcohol Change UK guide - How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales](#) provides a good basis for practitioners to understand their role and powers.

11.22 Northamptonshire already has a process in place for managing people who have complex needs such as Eddie and Frank. The Adult Risk Management (ARM) process provides a route for multi-agency support to people with complex needs who may not reach the threshold for a safeguarding enquiry. The guidance is clear and states that the ARM should be considered for individuals who are exposing themselves to serious risk. *Serious risks might include self-neglect, hoarding, fire risk, alcohol & substance misuse, or not engaging with services that are trying to help them to reduce their dangerous behaviours* The ARM process has been recently re-launched (January 2025) following a review and whilst take up has improved, there appears to still be a reluctance to commence the process by staff in some agencies.

11.23 At the learning together event, representatives agreed that services should consider the provision of their service from the client’s perspective and where appropriate, adopt a flexible and accessible service. The engagement with people such as Eddie and Frank should be led by the individual, not the organisation. There is a requirement to understand their wishes and develop an engagement plan that suit both, and that any discharges from a service are planned appropriately. Disengagement from a service by a vulnerable individual should be seen as a trigger to explore further rather than close the case.

¹¹ [SAR-Self-Neglect-Thematic-Review-Executive-Summary-.pdf](#)

¹² [179 - Alcohol Misuse in Self-Neglecting Older Adults | Age and Ageing | Oxford Academic](#)

Good practice

11.24 Self-neglect was identified by East Midlands Ambulance Service (EMAS) when they attended at the home addresses of both individuals. EMAS made six safeguarding referrals to the local authority in respect of Frank which were outside of the scoping period but were still relevant. They also made a safeguarding referral and a request for a care and support assessment in respect of Eddie's situation recognising that he was not coping well following his move into his own flat. Relevant information was also shared with Eddie's GP. As an emergency response, EMAS were able to see first-hand the living conditions of each man and raise concerns as appropriate about the level of self-neglect. ASC did positively engage with both men at specific periods providing some practical support, liaising with and signposting to other agencies but overall, there is still a lack of consistent multi-agency working.

12. Opportunities to intervene

12.1 The review panel wanted to consider:

1. What the touchpoints were for men like Eddie and Frank
2. The roles of statutory and non-statutory organisations
3. Where were there missed opportunities to intervene?
4. How agencies closed their cases or discharged the men for lack of engagement with their services
5. Identifying multi-agency working or silo working within and between agencies
6. How well was information shared?
7. The role of utility companies in relation to vulnerable individuals, accruing debt and being disconnected
8. Individual mental capacity and choice

12.2 The number of agencies supporting both men was significant, but despite this, throughout the period under review, a multi-agency meeting was never convened. There are also many references throughout the chronologies when both were signposted to other support services but due to their complexities it was unlikely that they would follow up with some of those actions.

12.3 Referrals were made to the local authority, often following a response from an emergency service. Some referrals were in relation to apparent self-neglect and safeguarding, whilst others were identifying that additional support was required, for example, a referral to the local authority about Eddie was made by EMAS identifying he needed some support following his move into his own property. However, this was subsequently closed due to no contact as Eddie would not respond. Some support, however, was successful through the summer of 2023 for Eddie, but it was not always consistent. What is also evident is that communication difficulties and lack of consistent engagement played a significant role in determining the outcomes for the men, with numerous attempts being made to contact them by various agencies, which often failed.

12.4 Following admissions to hospital, Eddie was the subject of medical detoxification, and whilst Frank did not want to engage with the substance use service, Eddie was already under their care for most of the period under review. However, there is an absence of proactive and assertive follow up either within the hospital when Eddie was present on a ward, or directly after discharge. He was encouraged to continue his engagement with the substance use service and signposted again to them but without optimising the opportunity whilst in hospital. At periods such as this, the desire to reduce their alcohol dependency may have been at its optimum and without a more assertive approach, the risk of relapse is highly likely.

12.5 Organisational policy around non-engagement played a part in both cases, for example, referrals were made to the Fire and Rescue Service in terms of potential fire risks through neglect of their accommodation. An initial survey was carried out for Frank by a home survey fire officer, following which, various attempts to contact him were made, but no response was received. In line with the organisational policy, a letter was sent to him regarding his non-engagement and no further action occurred. Similarly, following disengagement with a voluntary support organisation and substance use service, Eddie was discharged. A letter should have been sent to his GP in relation to the lack of engagement and subsequent discharge, but on this occasion, it was missed. This specific point was

recognised at the learning together event and the substance use provider has confirmed that checks are now in place to ensure that GPs are always updated.

- 12.6 Both men experienced issues with the appropriateness of their homes. Eddie moved into his own flat having previously been in supported living. As outlined earlier, he struggled with the move to his own flat and required some support. There does not appear to have been any consideration around planning for the transition to his own residence, and strikingly, the housing neighbourhood officer who attended the learning together event stated that she was shocked to witness Eddie's deterioration in a six-month period. This led the housing officer to raise a safeguarding concern detailing his alcohol dependence and how his mental health had deteriorated. She reported that he had facial injuries suffered during a fall, and there was a significant smell of urine in the flat. The resulting concern was assessed by ASC who recorded that "he did not have care and support needs, but when under the influence of alcohol his mental health could deteriorate and fluctuate."
- 12.7 Frank also wanted to move into accommodation that was more affordable and met his mobility needs. Having been helped by the CAB worker to complete the necessary housing applications his request went live with the local authority housing department within days. He was assigned the highest priority (Band A) as he had a critical medical condition. During the following two months he was offered at least two properties but declined both. Information provided by Frank to the local authority housing department was that he wanted to live in or around Daventry as his mother was resident there and he required a one-bedroomed flat that he could afford. He could not afford the rent on the two-bedroomed properties that were offered to him. His application was closed at the end of January 2024. In April 2024, the housing department brought in a new IT system which required all applicants to re-apply. Frank would have been sent a letter to this effect. The author is not aware of any specific support provided by the housing department to assist applicants in making their applications. In Frank's case he was well supported by the CAB worker but the housing department state that when people apply to access the housing register this process is completed online and the onus is placed upon the applicant to provide all the relevant information required.
- 12.8 There were other "touch points" that were evident for both men. Eddie had a connection with the church and visited a local café run by a charity. Frank informed people that he had a military background and contact with the British Legion.
- 12.9 There is clear evidence of compassion and acts of kindness towards both men by individuals in different organisations. Both ASC and the police had contact with Frank just before Christmas in 2023. Frank contacted ASC to ask for help and clearly articulated his fear around the potential for bailiffs entering his home and the overall unsuitability of his home due to his mobility issues. A request made by ASC for emergency accommodation at this point was declined. The rationale from the housing department was that Frank was sleeping rough by choice. They did not know that he was an alcohol dependent drinker. He also had contact with the police on Christmas Eve, and recognising his poor health and home conditions, the officers arranged for a food hamper to be delivered to him after he had missed the first delivery date.
- 12.10 In the information supplied to the author, there was evidence that mental capacity was considered by various agencies and where it is recorded, the men were deemed to have capacity. However, what is not considered is the effect that alcohol dependence had upon their mental capacity. The details of the mental capacity assessments were recorded by emergency responders as well as others involved in the social care aspect of each case.
- 12.11 Frank was in receipt of universal credit and as the chronology details, with the assistance of his CAB worker he made a claim for Personal Independence Payment which was initially refused. He appealed the process and after approximately 18 months he was finally awarded the payment. Sadly, this came too late for Frank as he had already passed away. Agencies also knew that he had no gas at his home address and therefore no hot water or heating. The Department for Work and Pensions (DWP) knew he had no gas and was in arrears to the supplier in January 2023, and the police were also aware in June 2023. He was also in debt to the local authority for his council tax payments.

12.12 DWP customers who are in receipt of certain benefits (including Universal Credit) may have deductions taken from their benefit and paid directly to a creditor or supplier under the Third-Party Deduction Scheme. However, this can only be used when all other avenues of recovery have been exhausted and application is made by the fuel supplier.

Analysis

12.13 Roles and responsibilities for statutory services are clear. The local authority provides adult care and support in line with the Care Act 2014 and statutory guidance. The Care Act promotes a concept of “meeting needs,” which is a legal entitlement establishing a consistent approach and ensuring that the principle of “wellbeing” is applied in all cases. The wellbeing principle applies equally to those who do not have eligible needs but come into contact with the system in some other way, for example, via an assessment that does not lead to ongoing care and support (Para 1.13 Statutory Guidance).

12.14 It is the view of the author that what gets in the way of applying the Care Act wellbeing concept is the application of rigid eligibility criteria, lack of understanding of when and how to refer a person for assessment, and potentially, stereo-typical views around individuals who are alcohol dependent and making assumptions about their ability to make decisions.

12.15 Understanding the effect of long-term alcohol dependency on a person’s mental capacity is complex. Mental capacity can fluctuate and they may never be in a position when alcohol does not affect their mental ability. The first principle in the assessment of a person’s mental capacity is to assume that they do have capacity to make decisions, but there is a need to also look at the supporting evidence. Each mental capacity assessment is also time and decision specific.

12.16 At the learning together event, representatives also identified that adults who are deemed to have capacity can refuse the involvement of services. However, the Mental Capacity Act (MCA) Code of Practice emphasises that “it is important to acknowledge the difference between unwise decisions, which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up information about a decision, particularly if someone makes decisions that put them at risk or result in harm to them or someone else”¹³. It is therefore important to ensure that an individual understands all of the potential risks should they decide to disengage or not accept support.

12.17 Often referred to as executive capacity, but not specifically referenced in the Mental Capacity Act, is a further consideration for professionals when undertaking an assessment is that even if a person can understand, retain, use and weigh up the information to make a decision, they may not actually be able to carry it out. Difficulties in executive functioning may lead to a person giving coherent answers to questions but, at the time they are required to use the information, they have difficulty putting that information into action. This can be referred to as ‘talking the talk, but unable to walk the walk.’

12.18 Courts have recognised this area and have referred to “executive functioning and dysfunction in relevant case law”.¹⁴

12.19 Living outdoors or in unhygienic conditions is not a “lifestyle choice” and the effects of long-term alcohol dependence making people like Eddie and Frank extremely vulnerable. No-one chooses to live in their own faeces, and both men were extremely unhappy about how they were living.

12.20 Understanding why services disengage with the individuals they are supporting is complex and based upon many things including the difficulty in consistent engagement with the client, availability of services, lack of resource, higher risk and priority cases, lack of finance and a general need to manage demand in an ever more complicated society. Many organisations have a policy about clients who do

¹³ [ACUK SafeguardingAdultReviews A4Report July2019 36pp WEB-July-2019.pdf](#)

¹⁴ [Executive functioning and the Mental Capacity Act 2005: points for practice - Community Care](#)

not attend appointments or disengage from their service. The ones seen by the author would typically direct that following several missed or failed appointments a review would take place, then letter would be sent to the individual and their case closed. At the point of closure and dependent upon the service being provided, it would seem sensible to inform other organisations that are also involved in supporting the individual to know that a service is withdrawing. Norfolk Safeguarding Adults Board have produced a short guide on “Safely ceasing involvement”¹⁵ in relation to individuals who are suspected to be self-neglecting. Of note, is that the guidance states “Before ceasing involvement, professionals must ensure that other agencies have been informed and involved as necessary. Consideration should be given to scheduling a review or follow-up by one of the partners at a later date.”

- 12.21 The disconnection of utilities to vulnerable individuals’ properties is an area of concern nationally being identified within other SARs as well as in relation to Frank’s situation. The author has attempted to contact the relevant power supplier who disconnected the gas supply to Frank’s flat but after an initial acknowledgement, no further information has been forthcoming. SAR Billy¹⁶ is a recent Nottingham City SAB publication relating to the tragic death of a single man in his fifties of Black African Caribbean heritage who lived alone and died from starvation. At the time of his death, and due to his lack of response to agencies, he had his employment and housing benefits stopped which meant he was in arrears. At the point of his death, Billy was at the point of eviction, his gas supply had been cut off and he had no heating or hot water and he had no income for essentials such as food and utilities. The SAR makes a recommendation for the local authority to strengthen the checks and balances when taking high impact actions such as cutting off gas supply without consent or seeking eviction. It suggests the development of a protocol that is compliant with the Data Protection Act to liaise with relevant Health and Social Care agencies to check any unknown mitigating circumstances or vulnerabilities and alert those services of any risk arising to the tenant from the Local Authorities intended actions. It is apparent within Northamptonshire that the local authorities are not routinely informed when a tenant is to have their gas supply cut off due to non-payment.
- 12.22 The Office of Gas and Electricity Markets (OFGEM) is the national non-ministerial government department and independent regulator for energy suppliers. It has recently published its Consumer Vulnerability Strategy¹⁷ which clearly sets out how energy companies must consider and respond appropriately to the needs and circumstances of customers in vulnerable situations. One of the specific outcomes detailed within their strategy states “Consumers in vulnerable situations who are struggling to pay their bills, or are indebted, should have proactive and consistent support, based on their ability to pay, that is delivered with compassion and understanding.” Whilst the recommendation from SAR Billy is relevant to this review, the author suggests that an approach to OFGEM would provide an opportunity to develop a nationally agreed process in all cases when there is consideration for cutting off energy supplies to a vulnerable person, this should not be commenced without liaison with the customer’s local authority. This process would allow for a review of the risk to that individual and an opportunity to provide a potential solution.
- 12.23 The statutory guidance that underpins the Care Act 2014 is clear that in relation to safeguarding, both the local authority and its partners must co-operate with each other in the exercise of their function relevant to care and support including those to protect adults. Why agencies do not adopt or feel confident in a multi-agency approach in respect of people such as Eddie and Frank again has a number reasons. Strict adherence to protocols and criteria along with a lack of “ownership” of the case was identified at the learning together event. The number of organisations supporting both men was significant, but whilst there were some good examples of agencies linking with one or two other partners, there were no purposeful multi-agency meetings to obtain the full picture, develop a plan and monitor its effectiveness. The effectiveness of multi-agency working has been examined many

¹⁵ [Norfolk Safeguarding Adults Board -Safely-Ceasing-Involvement-v3-April-2023.pdf](#)

¹⁶ [Billy-final-sar-for-publication-11th-may-2023.pdf](#)

¹⁷ [Consumer Vulnerability Strategy](#)

times and as far back as 2007 a research review¹⁸ highlighted that in terms of benefits to service users - “The main impacts on service users, where they were reported, was their improved access to services, through speedier and more appropriate referral, and a greater focus on prevention and early intervention”. Effective multi-agency working takes time, commitment and the development of a shared purpose between the agencies. The distinct lack of multi-agency meetings in relation to both Eddie and Frank led to opportunities to intervene being missed.

12.24 The drain on sparse resources was discussed at the learning together event to highlight that the circumstances apparent in Eddie and Frank’s cases meant that they repeatedly accessed services and that a more preventative approach may have reduced this demand. Between the two men they were conveyed to hospital by EMAS on twelve occasions, referred to ASC on six occasions, and had six occasions when they interacted with the police. In terms of missing appointments, Eddie failed to attend eighteen appointments with one service provider in ten months.

Good practice

12.25 In terms of information sharing and follow up, there were some examples of good practice identified in relation to both men. EMAS dealt with a significant number of calls and made referrals to other agencies as a result. The referrals were full of useful information about the concerns and identified what they might need. As a result of one safeguarding referral, Eddie was allocated a tenancy support worker who provided support around benefits, utilities, repairs and purchasing white goods. Eddie also received support from Support North Northants (SNN). Likewise, referrals from the police provided information about Frank’s living conditions and his lack of hot water and heating due to debts with the power company. This information was shared with North Northamptonshire Council’s ASC and his GP.

12.26 Within the review there are some good examples of services considering an individual’s mental capacity, in particular, EMAS always recorded their assessment and in one incident they deemed Eddie was lacking capacity to consent to medical intervention, and in his best interest, conveyed him to hospital.

12.27 Social worker engagement with Frank during the summer of 2023 was also successful. The social worker fully understood his health conditions and housing concerns and sought to refer him to various agencies to help resolve his issues. Unfortunately, this contact was then ended. Frank was also supported by the CAB in negotiating both housing and DWP processes.

12.28 Frank’s GP surgery also took a real interest in him and he had a good relationship and engagement with the social prescriber. The GP surgery also followed up after receiving an EMAS safeguarding referral which highlighted concerns around self-neglect, hoarding, fire risk and rough sleeping and met with him face to face. The GP explained to Frank about the safeguarding process and recorded a substantial amount of information about his alcohol dependency and history.

13. Addiction

13.1 The information provided by agencies to the author shows that both men had dependency on alcohol for a significant period. In Frank’s case he began drinking as a teenager and was exposed at an early age to a family who drank heavily. Information provided by him to a professional detail that both his father and ex-wife had died because of alcohol related illnesses. Eddie’s use of alcohol appears to lie more with his ability to cope with anxiety and depression. This information was available within the “system” but some partner organisations did not know that they were alcohol dependent.

13.2 In the case of Eddie and Frank there are other factors that affected their levels of drinking and alcohol dependence. Despite being sober for approximately 8 months, Frank relapsed in October 2023 following the death of his brother-in-law. Eddie also continued to rely upon alcohol and developed suicidal thoughts. The breakdown of his relationship also led him to rely upon alcohol.

¹⁸ [Multi-agency working and its implications and practice: A review of the literature](#)
NSAB – SARs 056 & 062 – Self-neglect Thematic Review – Final – March 2026

- 13.3 It is well documented that alcohol has a powerful effect on the brain, producing pleasurable feelings and blunting negative ones. There can be a significant motivation to repeatedly drink alcohol, despite the risks to health and wellbeing. It affects the brain and can lead to an inability to control its use. Becoming addicted to alcohol can be influenced by many factors including genetics and family history, childhood trauma, stress, anxiety and depression or early exposure to alcohol.
- 13.4 A 2018¹⁹ study looked at five clusters of drinkers, The “risky career drinkers” were found to be predominantly male, over 45 years old and unlikely to moderate their drinking. Reasons behind drinking were identified as requiring alcohol to cope and alleviating personal problems and worries. There was a clear association between men and their drinking, mental well-being and motivations for drinking.
- 13.5 Research also shows that there is a stigma and a more negative attitude to people with an alcohol dependent diagnosis as opposed to a mental health illness. It can often be seen as a failure, indicating moral shortcomings as opposed to an illness. There are also distinct barriers to dual diagnosis in terms of its identification, treatment and worse outcomes. As already identified, where there is a lack of a holistic approach to the circumstances, the outcome can be constant revolving doors.
- 13.6 Mental health conditions and addiction (dual diagnosis) are often treated separately. However, the author is aware that within Northamptonshire, a dual diagnosis procedure²⁰ was launched in July 2023 to ensure that substance use services and mental health services worked closely together to provide best practice in assessment and service delivery. The new procedure uses the definition of dual diagnosis as set out in Rethink and Turning Point 2004²¹, and commissioned a national substance support service to deliver its requirements. Joint assessments are described as the “gold standard” leading to the development of a joint care plan. The process highlights specifically that where there is any potential association between substance use and the risk of suicide this should be addressed with a risk management plan. As highlighted, there were some missed opportunities evident in relation to Eddie’s self-harm and suicide attempts.
- 13.7 The new process is still developing but mental health services have already provided access to their information systems for the substance use service to assist working together. Further work is underway to make sure that the pathways are clearly understood and the right clinical leads engaged across the organisations.
- 13.8 Reflecting upon the circumstances of the two men involved in this review, it would have been beneficial to have had a more assertive in-reach approach at the point of hospital admission and detoxification, although the pathway at that point was relatively new. Following Eddie’s hospital admissions he was often assessed by the Acute Liaison Mental Health Service (ALMHS) worker and signposted to the substance use service, and his GP notified. The ALMHS worker recorded twice that there was a risk to Eddie’s life through misadventure due to his alcohol dependence. There appears to be a lack of co-ordinated and proactive activity to break the cycle.
- 13.9 The substance use service is due to be re-commissioned in 2026 and whilst there have been significant improvements with the new pathway, and information sharing between the health agencies involved, a presence from the substance use service on the acute hospital wards and Emergency Departments will be included in the next specification to ensure that any detoxification starts in the hospital and then continues in the community.
- 13.10 The cost to the “system” in alcohol related hospital admissions, mortality and years of life lost is detailed in the Official Statistics Alcohol Profile commentary from February 2025.²² The analysis shows that the rate for alcohol-related admissions to hospital between 2023-2024 was the highest

¹⁹ [Understanding drinking among midlife men in the United Kingdom: A systematic review of qualitative studies - ScienceDirect](#)

²⁰ [NHFT Dual-needs-procedure-exp-may-26-clpr021.pdf](#)

²¹ [SUMH Resource Pack July 2021 \(1\).pdf](#)

²² [Alcohol profile: short statistical commentary, February 2025 - GOV.UK](#)

since the data series began in 2016. In 2023, there were 8,274 alcohol specific deaths in England which was an increase of 63.8% from 2006. Similarly, in relation to alcohol-related mortality (deaths from conditions wholly caused by alcohol), there were 22,644 deaths, an increase of 21.3% from 2006. In terms of years of life lost in 2023 in England, there were 334,421 potential years of life lost due to alcohol related conditions in males.

- 13.11 Physical access to services for people like Eddie and Frank can be problematic and processes designed by organisations to manage demand effectively can be yet another barrier to overcome. Whilst not specifically covered under the Equality Act as a disability, having a chaotic lifestyle and impaired mental health, the likelihood of either being able to complete complex forms and apply for support online, is potentially limited.

14. Conclusions and what needs to change

- 14.1 Eddie and Frank led complex lives compounded by both physical and mental health issues, substance addiction, self-neglect and an inability to navigate their daily lives. Despite a significant amount of involvement from both statutory and non-statutory agencies, both men died in their own homes and tragically were not missed. Their stories, however, are not unique.
- 14.2 There was a significant amount of support provided by individuals from the various agencies and it is clear that the relationship between the individual and the professional is key to achieving better outcomes. However, what was not apparent or considered in either of these cases, was to convene any form of multi-agency meeting or discussion, to attempt to address their circumstances in a holistic manner, and this was also the case in SAR 019 Jonathan.
- 14.3 Both men were extremely vulnerable to being exploited, assaulted or prematurely dying and these risks were not always acknowledged by practitioners and plans put in place. There were clear patterns of behaviour exhibited and opportunities to intervene, however some of these were missed. The lack of identification of self-neglect and use of appropriate pathways is concerning.
- 14.4 NSAB has already commissioned and published SARs which contain similar themes and despite these, the types of safeguarding issues remain. Recognising that partner agencies must manage significant and complex demand; the author suggests that there is a business case for adopting a more preventative approach to manage the demand created by individuals with complex needs. Northamptonshire has had the ARM process in place for several years and has recently reviewed and relaunched it at the beginning of the year. However, despite this there is no robust monitoring in place for this process so its overall effectiveness cannot be established. The author was informed that numbers had increased but it is evident that there is limited knowledge and confidence in its current operation.
- 14.5 NSAB partners should consider the following areas for improvement to develop a system that provides better outcomes for people with complex presentations and to utilise limited resources effectively.
1. Move away from an approach of strict criteria and thresholds by developing a more preventative approach. By identifying the cohort of individuals earlier who are frequent attenders, regularly using services and showing repeated patterns of need, intervene earlier to prevent them requiring the intervention of statutory and emergency services at a later stage.
 2. Ensure that multi-agency working and case co-ordination becomes 'business as usual'. Encouraging and supporting practitioners to regularly meet together to discuss cases and agree joint outcomes, less signposting and hand-offs, and making sure that individuals have the capability to access services. Any multi-agency process such as ARM should cover all complex situations including self-neglect, homelessness and addiction.
 3. Identify dedicated resources to facilitate either the current ARM process or similar process to ensure practitioners receive the support to utilise the pathway to its full capacity.

4. Develop a culture of non-discrimination and a person-centred approach that seeks to understand trauma and overcome the stigma and barriers for people to seek the support they require.
5. Support practitioners to “think outside the box,” provide effective supervision that challenges thinking, and supports continuous professional development.
6. Develop the knowledge and skills of the workforce to ensure that the application of legislation and statutory guidance is appropriate.
7. Examine current ways of providing services and shift focus to engagement rather than non-engagement, by understanding and developing policies and systems that ensure people can access services according to their needs.
8. Ensure that when any service seeks to disengage with an individual that a review is carried out and other professionals are informed.
9. Commission the right services for people with complex needs in terms of mental health and substance use which includes assertive outreach and positive reinforcement at times of opportunity. Ensuring the right clinical input at the right time and appropriate support to maximise uptake of substance use services. Adoption of out of office hours services for easier access would be invaluable.

14.6 NSAB has recognised the reoccurring themes relating to individuals who self-neglect and since commissioning this SAR, held a multi-agency Self-Neglect Summit on 11th June 2025. As a result of the Summit the board is progressing this area of safeguarding, and it is anticipated that it will form one of the boards strategic priorities for 2026.

15. Recommendations

1. Despite a previous review of the ARM process and updating the paperwork, ARM is still not working effectively. It is recommended that within six months of the publishing of the review, the four NSAB strategic partners should assess the effectiveness of the current ARM process and create a plan to improve it in line with paragraph 15.5 principles. The revised process should incorporate practitioner feedback and enable earlier intervention for individuals with complex needs. The ARM process may need dedicated resources and a central referral system to be more formal. It should be less bureaucratic and promote a collaborative culture among agencies for better outcomes.
2. Within six months of the publication of the review, NSAB should seek assurance from partners that their policies and practice for non-engagement of service users are effective. Assurance should be sought that the policies and practice are person centred, identify risk and ensure that when professionals cease involvement or close a case with a service user due to non-engagement, that a risk assessment is carried out and all other partners involved with the adult are alerted.
3. NNC and WNC should review the information they currently hold and publish so that professionals and the public can search to access support. Consideration should be given to the development of existing information or a separate repository/directory to harness the capacity of voluntary and community sector/charity, and faith organisations to provide additional support to individuals with complex needs. This has been achieved in other local authority areas and provides a “one-stop shop,” for example “Connect to Support Lincolnshire” provides an online comprehensive information and advice library and community directory for adults within the county. Please see [Connect to Support Lincolnshire | Lincolnshire](#).
4. When commissioning services for people with complex needs in terms of mental health and substance use, North and West Public Health and the local authorities should ensure that the specialist substance misuse service includes assertive in-reach whilst patients are within hospital wards to ensure continuation of service provision and that positive reinforcement at times of opportunity are maximised. The specification should also ensure that the specialist substance misuse support service is continued into the community".

5. As the guiding principles of the Dual Diagnosis Policy states, "Joint assessments between agencies are 'gold standard' and should take place where practical". Where support is needed for significant addiction, NHFT and the commissioned substance use services within Northamptonshire should deliver the Dual Diagnosis Policy as an integrated service conducting joint risk assessments and developing joint care plans for individuals who have co-occurring conditions. Compliance with the policy should be captured via audit and reported to NSAB as part of its assurance process.
5. Working together, NSAB partners should identify from this review and others, the key safeguarding areas which are continually repeated within the findings and establish a process to identify what each agency has done to embed the learning and how to evidence the impact of that learning. Areas of learning from this review will include knowledge and implementation of the Care Act 2014, the Mental Capacity Act 2005, substance use, adult risk management (ARM) process and self-neglect policy and process.
6. NSAB should escalate the learning from this review through the national network of Safeguarding Adult Board Chairs to engage with OFGEM with the aim of developing further national guidance for gas and electricity suppliers in their management of vulnerable customers. Adopting a standard approach by engaging with local authorities before cutting off utilities to vulnerable individuals.

Useful links to NSAB policies, procedures, and guidance below:

[Adult Risk Management \(ARM\) Toolkit](#)

[Bite sized learning videos – Professional curiosity and self-neglect](#)

[Professional curiosity practitioner guide](#)

[Self-neglect guidance](#)

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Acronym	Expanded form and websites
ARM	<u>Adult Risk Management</u>
ASC	Adult Social Care <u>North Northamptonshire Council</u> <u>West Northamptonshire Council</u>
CAB	<u>Citizens Advice Bureau</u>
DWP	<u>Department of Work and Pensions</u>
EMAS	<u>East Midlands Ambulance Service</u>
GP	<u>General Practitioner</u>
MCA	<u>Mental Capacity Act 2005</u>
NNC	<u>North Northamptonshire Council</u>
NSAB	<u>Northamptonshire Safeguarding Adults Board</u>
OFGEM	<u>The Office of Gas and Electricity Markets</u>
SAB	<u>Safeguarding Adults Board</u>
SAR or SARs	<u>Safeguarding Adult Review or Reviews</u>
Section 42	<u>Section 42 of the Care Act - Safeguarding Enquiry</u>
Section 44	<u>Section 44 of the Care Act – Safeguarding Adult Review</u>
SNN	<u>Support North Northants</u>
SCIE	<u>Social Care Institute for Excellence</u>
WNC	<u>West Northamptonshire Council</u>