Safeguarding Adults Review "Brian"

Overview Report 29/09/2025

Contents

1 Introduction

1.1 This Safeguarding Adults Review ("SAR") concerns a man, Brian who died in May 2024, aged 84.

1.2 Brian was known to refuse support from services and not attend appointments that had been arranged for him. This had been a feature of Brian's behaviour for a number of years, and was significant as his health began to deteriorate in the last two years of his life.

1.3 The week before Brian was found dead an ambulance from Yorkshire Ambulance Service ("YAS") visited Brian. This was dispatched because of concerns raised by his sister as she was worried about Brian following multiple calls that Brian had made to his sister-in-law asking for help. The ambulance was accompanied by South Yorkshire Fire and Rescue ("SYFR"), to support the ambulance crew to get access to Brian's flat. Brian was found alive, but concerns were raised by the Watch Manager at SYFR. This was because:

1.3.1 Brian looked severely thin (his weight was estimated to be 5 stone 6 pounds which is around 40 kgs).
1.3.2 He had no working lights in his home.
1.3.3 He had no food in his fridge.
1.3.4 He was smoking, but leaving the cigarettes he had smoked in a drawer by the sofa.
1.3.5 He was lying on the sofa and didn't appear to be able to move off it, despite saying that he could.
1.3.6 He was refusing help and support from the ambulance crew.

1.4 A safeguarding concern was raised with Adult Social Care ("ASC") by SYFR as a result of the visit. They also notified the social housing provider, Berneslai Homes ("BH"). BH made contact with Brian and raised their own safeguarding concern with ASC on the 15 May 2024.

1.5 YAS made contact with the out of hours GP service and requested a visit for Brian and medication to help him.

1.6 Brian refused support from BH, his own GP and ASC; however, despite this ASC and BH organised a joint visit to Brian because of concerns about his wellbeing and possible self-neglect.

1.7 Unfortunately, Brian was found dead by a neighbour and his sister-in-law on the same day a joint visit from his housing association and adult social care was due to take place on the 22 May 2024.

1.8 Brian's cause of death is noted as being from pneumonia, metastatic small cell lung carcinoma and chronic obstructive pulmonary disease, smoking and ischaemic heart disease.

2 Acknowledgement

2.1 The reviewer and Barnsley Safeguarding Adults Board ("BSAB") would like to acknowledge the support of Brian's sister in contributing to this review. The information provided has helped the reviewer to know more about Brian and understand the challenges and concerns faced by Brian's family and friends.

3 Context of Safeguarding Adults Reviews

3.1 Section 44 of the Care Act states that a *"SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –*

a. *there is a reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult"* and "*the adult has died,*
and
b. *the SAB knows or suspects that the death resulted from the abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)."*

3.2 The purpose of this review is not to hold individual workers or agencies to account, but to highlight learning that needs to be adopted.

4 Terms of Reference and Methodology

4.1 The review focused understanding the impact that Barnsley Safeguarding Adult Board's Self-Neglect and Hoarding Policy and Procedures and the Was not Brought guidance had on practice with Brian. This includes:

4.1.1 Evaluate if the learning from previous SARS/lessons learnt has been embedded in practice and how this has been evaluated.

4.1.2 Evaluate the compliance with agreed Self Neglect and Hoarding Policy, including risk assessments, and any other tools, policies or guidance published by BSAB.

4.1.3 Examine the effectiveness of multi-agency information sharing and joint working.

4.1.4 Identify any missed opportunities to offer appropriate support to Brian, and anyone caring for him.

4.1.5 Identify appropriate lessons to prevent similar missed opportunities.

4.1.6 Identify any good practice.

4.1.7 Consider the effectiveness of supervision and support of people working with Brian, and mechanisms to escalate concerns?

4.1.8 Identify mechanisms, if needed, to embed learning from future SAR's and lessons learnt

Methodology

	Process	Dates
1	Agree Terms of Reference	October 2024
2	Engagement with Brian's sister	This continued throughout the review process. The author also contacted Brian's sister-in-law and neighbour by letter but did not receive a response. From speaking with Brian's sister, the author understands that they did not want to be involved in the review.
3	Individual Management Review ("IMR")	December 2024 and January 2025
4	Collate Information	January 2025
5	Host a Practitioners' Learning Event	12 February 2025
6	Host a Managers' Learning Event	19 March 2025
7	Draft Report	v1 - 13 May 2025 v2 - 28 May 2025 v3 – 24 June 2025 v4 – 30 July 2025 v5 – 16 September 2025 v6 – 25 September 2025 v7 – 29 September 2025
8	Report approval	

5 About Brian and the views of his family

5.1 The information about Brian was gathered from agencies that had contact with Brian and from his sister, Marilyn, who kindly contributed to this review.

5.2 Brian lived alone in a in a Berneslai Homes ("BH") flat. He was one of three siblings. His brother Don died in 2019. He is survived by his sister, Marilyn who is about 15 years younger than Brian.

5.3 Marilyn felt that Brian was a difficult character to understand. She explained that even though she lived with Brian on three occasions when growing up, she couldn't say that she really felt that she *"knew him"*. This was even though she would try to speak to Brian each day and considered Brian's ex-wife, who was 10 years older than Marilyn, like a big sister. Marilyn also said that she was not sure that everything that Brian would tell her would be completely true and "*you had to take a lot of what he said with a pinch of salt".*

5.4 Brian was a music and film lover. He would frequently ask Marilyn to order him music that he wanted to listen to, or he would ring her or her children on the phone to tell them to watch particular films that he thought they would enjoy.

5.5 When Brian was young he was involved in a car accident, which caused an injury to his ear and some deafness in that ear. However, Brian was still able to speak on the telephone and remained a music lover throughout his life. So it is not believed the injury had a significant impact on his life.

5.6 Brian's mother also told Marilyn that Brian had spent time in a *"psychiatric hospital"*. However, Brian told Marilyn that this wasn't true.

5.7 When Brian was a young man he was married. He also spent some time in prison for stealing from a former employer. During his time in prison his wife had a child with another man. Brian brought up this child as his own son. Unfortunately, Brian did not have any contact with his son in the last 15 years of his life. Marilyn tried to help Brian to reestablish contact with his son in the last 12 to 18 months of Brian's life. However, Brian's son did not want this to happen.

5.8 Brian moved to Barnsley to be close to his brother Don. Don had encouraged Brian to move to Barnsley about 20 years ago from East London. Don made a number of practical arrangements and helped to get Brian a flat. This was following a difficult period for Brian where his best friend had died.

5.9 After Brian moved to Barnsley, he would visit Don nearly every day. Brian would spend most of his day at Don's house. Don would become concerned about Brian and would call him on the telephone on days when Brian didn't visit Don.

5.10 Don died in May 2019. Don had a life-limiting condition. Whilst his death was not a surprise, it still had a significant impact on Brian.

5.11 There were signs that Brian may have had a condition that was gradually getting worse from January 2021. However, Brian appeared to live independently for some of the following period. Brian appears to have been very dependent on a small network of family and friends by March 2023.

5.12 While Brian had some independence he would do some of his own shopping at his local Coop and would go out for a haircut frequently. However, in the last couple of years the Coop would have a chair by the till for Brian so that he could sit on it and catch his breath when he went to do some shopping.

5.13 It is believed that Brian had not left his flat in the 12 months before he died. He had very long hair and so had not been for a haircut in sometime.

5.14 Marilyn lives in the South West. Marilyn last visited Brian around 2022; although, they spoke nearly every day. Marilyn was part of a support network that helped Brian on a day to day basis. Marilyn has her own health issues which made travel to visit Brian very difficult.

5.15 Brian was also supported by one of his neighbours, Richard (a pseudonym) and his sister-in-law, Mary (a pseudonym), who was Don's wife.

5.16 Mary would bring fresh food for Brian, which she would put in his fridge. She would also make him multiple cups of tea at the start of the day and would leave them for Brian by his sofa so that he could microwave them to warm them and drink them through the day. Brian would keep a microwave on a table by the sofa so that he was able to do this. He would also use this to cook frozen meals.

5.17 Brian smoked throughout his life. He kept his ash and smoked cigarettes in a draw by the sofa, which was a fire risk.

5.18 Mary would also try to help Brian with some cleaning from time to time. However, it was difficult for Mary to do these things for Brian, particularly as she developed her own health needs. At one point, Mary had a double mastectomy but was still supporting Brian. Mary didn't actually tell anyone about her mastectomy until about seven months after the surgery.

5.19 Brian placed some pressure on Mary to keep supporting him, even when she needed rest herself. Brian did tell Mary that he would arrange a cleaner for himself; however, he did not do this. On at least one occasion Brian was contacting Mary on the telephone at around 10 pm, and after Mary had been at work all day and had already visited Brian to support him. Brian was placing so much pressure on Mary to visit him that Mary was in tears. This led to Richard being asked to knock on Brian's door and check on him. When Richard did this Brian told him he just wanted a cup of tea.

5.20 Mary did have some periods abroad visiting family members. When she was abroad she would ask other members of her community to support Brian in her place.

5.21 Marilyn would order any items that Brian needed. These included frozen meals, razors, tobacco and music. When there was a delivery, Brian would be unable to get down the stairs of his block of flats to pick it up. Richard would then bring the package to his flats.

5.22 Richard also began to develop his own health needs and began to find it increasingly difficult to get up the stairs. When he did drop parcels off for Brian he would leave them just inside Brian's door. Richard also helped Brian attend some appointments. Brian informed Marilyn that Richard drove him to try to help Brian get to an x-ray appointment, although even with this support Brian was unable to make it to the appointment.

5.23 Brian and Richard appeared to have a good relationship. They had been on holiday with each other in the previous couple of years and Brian gave Richard his car when Brian stopped driving. Despite this, Brian would not want Richard to come into his flat, even when carrying Brian's parcels up the stairs and to Brian's flat. Richard would have to leave them just inside Brian's flat door.

5.24 Brian did not appear to like people coming into his flat. Even when Marilyn travelled a long distance to visit Brian, Brian would not let her stay over and so she had to travel a long-distance home again. Also, just prior to Marilyn contacting the ambulance service for Brian in May 2025, Brian had not allowed Mary or Richard into his flat for about 2 months and he had only just started to allow Mary into his flat to do some cleaning on the day that Marilyn had to call an ambulance for him. Marilyn is not aware of any events that triggered Brian to stop Mary and Richard from coming into his flat.

5.25 Over the last few years Mary, Marilyn and Richard tried to support Brian to use an Ipad, a laptop and a phone. This was so that he could order his own items and undertake some the tasks that they did for him. However, he did not want to use them and gave them away.

5.26 Brian may not have wanted the people supporting him to have contact with each other without his own involvement. As an example, he did not want to share Richard's contact details with Marilyn, so that Marilyn could contact Richard independently. He was then upset when Mary gave Marilyn these details.

5.27 Marilyn also felt apprehension when contacting services without Brian's consent or direction. In December 2021 Mary's son contacted South Yorkshire Police (SYP) to ask to do a welfare check on Brian as they were concerned about him. He had been unwell and the family had been unable to contact him. SYP conducted the welfare check and found Brian to be well and watching TV without any concerns. Brian was very angry that the family had contacted the Police. He shouted at them and broke off contact for a period.

5.28 This created circumstances when Brian's family felt caught between being concerned about Brian and trying to get him help (which he may likely refuse) and being at risk of him not speaking to them again; versus, watching him get sicker without the support he needed, and feeling pressure to try to meet these needs. This was particularly challenging for Brian's family.

5.29 Brian did not appear to have difficulties with money. He would pay Marilyn back for the items that she would order on his behalf and would give Mary any money that

she gave him so that he had cash available. When he died, he had about £3,000 in his bank account. When cash had built up in Brian's bank account, from his pension, Brian would also give cheques with some money to Marilyn and Mary.

5.30 Towards the end of Brian's life, it was clear to Marilyn that Brian was struggling to breathe. She would speak to Brian on most days and she could tell that Brian was finding it hard to talk, because he was breathless. She asked Brian if she could call him every day, even if he didn't have to speak because he was breathless.

5.31 Marilyn was concerned that Brian may require oxygen to be able to breathe. Brian told Marilyn that his GP required him to go to the surgery to complete a form, but he couldn't travel to them. However, Brian's GP had offered to refer Brian to the respiratory service to be assessed for oxygen. Brian declined this. This may be because he would not have been able to have oxygen in his own home whilst he was smoking.

5.32 Marilyn has explained that Brian was a lifelong smoker and this was a habit that he enjoyed. Marilyn bought the tobacco herself. It may have been that Brian did not want Marilyn to know his smoking was the reason why he couldn't get oxygen in case it risked the arrangement.

5.33 Marilyn reflected some frustration that she had trying to get support from services without Brian's consent and a frustration that she would be told that Brian could decide to refuse help if he *"had mental capacity"* decide.

5.34 Marilyn said that she could recall contacting ASC around six months before Brian died to try to find out if there was any support that they could offer. Marilyn said that she recalls speaking to someone and being told that if Brian wouldn't consent to support and he had the mental capacity to make that decision, they would not be able to provide him with anything. There is no record of this conversation within ASC, and so it is possible that it was an anonymous query.

5.35 Marilyn also had a number of conversations with Brian's GP surgery about her concerns about his need for help. His mental capacity to refuse this support was discussed by the GP. She recalls being told that Brian had the mental capacity to refuse support and this had to be respected, even if it appeared unwise.

5.36 Marilyn organised for Brian to have prescriptions delivered to him, and even sent Brian some of her own prescribed laxatives when Brian wouldn't contact his GP about being constipated. Marilyn did also make some attempts to get oxygen delivered to Brian and paid for privately; however, she had to abandon this as she found it too complex.

6 Chronology

Date	Event

2005 – 2018	Brian became a BH tenant and moved into his flat. Brian Registered for GP Services.
2018	BH made attempts to contact Brian and make offers of help around fraud, if needed. This was good practice to recognise Brian as a potentially vulnerable tenant and to offer him support with local priorities, such as action around fraud.
31/05/2019	Brian's brother, Don, passes away.
2020	BH also made attempts to contact Brian at the start of the Covid-19 pandemic to offer support. Gas service conducted by BH. This was good practice to recognise the impact that the Covid-19 pandemic and lockdown might have on vulnerable tenants and to offer them support.
26/4/2021	Referral for Brian to be seen in Ophthalmology regarding Glaucoma from his GP. There were no vulnerabilities identified on the referral regarding Brian.
23/6/2021	Brian did not attend ("DNA") his outpatient appointment at Ophthalmology. The DNA review form was completed correctly. Another appointment was to be arranged. It is positive that another appointment was made for Brian when he did not attend. It is also often helpful to understand and record why someone may not have attended so that any issues and needs for support can be identified and addressed.
25/6/2021	Gas service carried out at Brian's home by BH.
19/7/2021	Brian had an appointment with the practice nurse for a blood pressure check. It was noted that he didn't come to the surgery very often so they conducted blood tests and made GP appointment. It is positive that Brian's inconsistency with attendance was identified and the opportunity to conduct some blood tests was taken rather than trying to organise a later appointment.
August 2021	Brian's GP was concerned about Brian having lung cancer. He was referred for a chest x-ray and prescribed a Trelegy inhaler. It was also noted that he had *"raised PSA"* from blood tests conducted by the Practice Nurse in July 2021 and he was referred to Urology on the two weeks wait pathway. The record of the appointment also noted that Brian had a previous episode of depression. Although, Brian did not seek any support of treatment for this during his time registered with the GP practice.

	Brian attended the chest x-ray appointment, and the result *"seemed to refute"* the lung cancer suspicion. Brian did not attend the urology appointment.
3/12/2021	Brian's nephew contacted the Police after concerns that the family had not been able to get in touch with Brian. Brian's nephew stated "*this was out of the ordinary for Brian and he had recently been ill."* Brian was triaged as vulnerable because of his age and a recent period of illness. A welfare check was conducted by the Police. The Police Officers who attended noted that Brian was safe, well and watching TV. Brian told them that he was feeling better. Brian's family were informed. It should be noted that Brian was very angry that his family had contacted the Police to raise concerns about his wellbeing. He cut off contact with them for a short period after this. It is good practice that Brian's vulnerability was recognised when the concern was raised and triaged and that a welfare check was conducted.
11/1/2022	Brian did not attend another outpatient appointment at Ophthalmology. The DNA review form was completed correctly. Another appointment was arranged.
25/1/2022	Brian did not attend an outpatient appointment at Ophthalmology. A letter was populated to arrange a follow-up appointment.
27/6/2022	Gas service carried out by BH at Brian's home. No concerns raised by workers.
11/1/2023	Electrical survey carried out at Brian's home by BH. No concerns raised by workers.
24/1/2023	This was an appointment between Brian's GP and Brian at his home. This led to a further chest-x-ray and a spirometry test being arranged. The appointment took place at Brian's home based on a request from himself. During the appointment a *"social history"* was taken by the GP to identify the support available for Brian. Based on this a decision was made that *"no referral to social [care services] was required"*. Brian did not attend the chest x-ray or spirometry assessment. Brian's GP contacted him to discuss this. Brian's GP offered to rearrange the missed appointments, but Brian declined this.
2/2/2023	A Community Phlebotomist from South West Yorkshire NHS Foundation Trust ("SWYFT") visited Brian to collect blood for blood tests. They were able to collect the blood sample. There was nothing of concern noted about Brian or the environment by the worker.
16/3/2023	Whilst visiting the flats a neighbour (we believe to be Richard) stated that he was concerned about Brian, *"as he is no longer good on his legs"*.

	The neighbour said that Brian had put a note on his door asking for deliveries to be brought up the stairs. Brian would also leave the door open so that Richard was able to do this.
21/3/2023	Brian was contacted by the Housing Officer from BH on the telephone. Brian told them that he can get downstairs and only leaves his door unlocked when expecting a delivery. Brian refused support offered by the Housing Officer.
22/6/2023	Gas service carried out at Brian's home by BH. No concerns raised by workers.
Late 2023/Early 2024	Brian's sister, Marilyn, believes she contacted Barnsley Metropolitan Borough Council ("BMBC") ASC for advice and support for Brian. Marilyn recalls being told that support couldn't be offered without Brian consenting to it. Marilyn didn't believe that Brian would do this. It should be noted that ASC do not have a record of his conversation. However, it is possible that it was a conversation where Brian's personal details and name were not given as Marilyn was just asking for general advice and may have been mindful about Brian being very angry with his family in December 2021 when they requested a welfare check for him.
14/5/2024 (notes for YAS ambulance crew)	At 22:43 Marilyn called 999. Because of the location of the caller, this was with South-West Ambulance Service. This was then transferred to YAS, who contacted Brian at 22:48. The YAS call hander recognised that Brian was breathless. Brian told them he had emphysema. Brian told the call handler that he was *"okay"* and they should call him the following day. He told them a number of times to cancel the ambulance. Because of concerns about Brian's welfare, the YAS call handler didn't cancel the ambulance. The call handler did end the call as Brian was getting breathless when talking and they didn't want to make the situation worse. This was good practice. The call handler was conscious of the risks if Brian was to require medical support, even if he was resistant to it at that moment, and that the ongoing call might exacerbate those risks. Therefore, they responded in a way to try to manage those risks. The YAS Ambulance crew arrived at Brian's flat, but couldn't get access. At 22:55 they requested help from SYFR to get into the flat. SYFR arrived at 23:03 and supported entry. Brian informed the crew that his breathing was normal for him and refused to be taken to hospital. YAS crew documented that, following an assessment of Brian's mental capacity to decide to go to hospital, they believed that Brian had the mental capacity to refuse this support. YAS crew contacted the out of hours GP who spoke with Brian and gave a prescription to try to help some of the symptoms Brian was experiencing.

	Richard, Brian's neighbour, said that he would pick up the prescription the following day. Brian refused a referral to ASC. A worker from BMBC then arrived to secure the door and gave new keys to Brian and Richard. The YAS crew left after two hours. The YAS crew displayed good practice by trying to find support that Brian would accept and making contact with the out of hours GP.
14/5/2024 (Notes for SYFR crew)	SYFR received a call from from YAS at 22:52 – support to gain entry to a property. The SYFR crew attended for 55 minutes. It was noted that the *"occupant was severely underweight and unable to move from sofa. High risk of fire because of smoking and lack of mobility. Used cigarettes were put in draw next to the sofa.* *Upon inspection of the rest of the property, it was noticed that none of the lights worked in the property, there was no food in the fridge, the general cleanliness was poor with a strong odour throughout the property and carpets extremely dirty."* The crew was concerned that Brian was at high risk of *"self-neglect & fire".* Brian was refusing help from paramedics and to go to hospital. SYFR records noted that the Watch Manager was concerned that Brian *"was lacking capacity"*. The Watch Manager and Crew conducted a home safety check, which included checking the fridge for food as Brian appeared underweight. It was noted that Brian didn't have much fresh food, but his freezer was full of frozen meals that had iced over and probably hadn't been eaten for some time. An out of hours safeguarding concern was submitted to the SYFR Group Manager, but was not sent through to ASC until the following day. The SYFR Watch Manager showed excellent practice and professional curiosity. They were curious about the difference between Brian saying that he was able to look after himself versus their observations that he had little food, was underweight and didn't have working lights at the property. Their concerns about his mental capacity came from this discrepancy, how underweight he was and how he seemed to have not left his sofa from some time. The Watch Manager recognised the potential urgency for his and raised his concerns that night following SYFR's pathways.
15/5/2024	The SYFR Safeguarding Officer read the concern submitted by the Watch Manager the previous night and submitted safeguarding concern to ASC.

	This was good practice that the concern was reviewed by the Safeguarding Officer referred to ASC, even though the Group Manager had not considered it to meet the threshold for Safeguarding Adults.
15/5/2024	The SYFR High Risk Coordinator at SYFR raised concerns with BH. This was good practice. SYFR began to identify agencies that might offer support to Brian with some of the risks that they could identify and share information with them that was necessary to identify the risks that required addressing.
15/5/2024	On receipt of the concern the Housing Officer contacted Richard and agreed to visit Brian on that day. The Housing Officer visited Brian; however, Brian declined any support. Brian told the Housing Officer that he is usually supported by his sister-in-law, but she was in Thailand at that time. The Housing Officer also submitted their own Safeguarding Adults Concern to ASC. This was good practice to both visit Brian and offer support, and to raise their own independent safeguarding adults concern based on the information that had been shared with them and Brian's refusal of support.
15/5/2024	Four contacts with Marilyn by GP surgery. Marilyn informed the surgery about Brian's out of hours contact and contact with ambulance service from 14/5/2024. Marilyn was concerned about Brian's wellbeing. Marilyn was signposted to ASC.
17/5/2024	Brian's GP received an *"out of hours letter"* from the out of hours GP about their conversations with Brian on the 14/5/2024. This was sent following a request by the GP service. Brian's GP contacted Brian, who declined a medical assessment. *"Suitable safety advice"* was given to Brian. Brian's GP appears to have a clear and direct conversation with Brian that not engaging with assessments and support from them means that they won't be able to support him well, diagnose any conditions and treat them. Brian's GP contacted Marilyn, as she had made a number of calls to the GP Surgery. It is noted that Marilyn was given *"safety netting advice"*. This included advising Brian's sister to seek help from ASC if she remained concerned about Brian. There was good practice from the GP in contacting Brian and having a direct conversation with him about their concerns.
20/21 May 2024	There were a number of discussions between SYFR and ASC about the safeguarding concern that had been raised. This was to support ASC to triage the concern and recognise the risks.

	ASC did make contact with Brian on the telephone on the 20/5/2024. It is noted that Brian *"did not engage in conversation stating he did not want support and felt he was managing at the time. When attempts were made to ask* Brian *further questions he ended the call."* On the 21/5/2024 ASC made the decision that the concern would progress to a s.42 (Care Act) enquiry. The concern was allocated to the locality safeguarding team. The Social Worker made arrangements with the Housing Officer from BH to visit Brian on the following day. This shows a number of points of good practice: • There were conversations between SYFR and ASC following the safeguarding concern as they tried to reach a consensus on risk and agree the best way forward. • It is positive that SYFR continued to follow up the concern until they were satisfied that the severity of risks were recognised. • It is positive that ASC remained curious about Brian's needs and progressing the concern to a s.42 enquiry, despite Brian stating he didn't want any support. It is good practice that Brian's wishes were being balanced with the risks. • It is good practice that the Social Worker made contact with the Housing Officer to arrange a joint visit and so they could consider what multi-agency support could be offered to Brian.
22/5/2024	Brian was found deceased by neighbour and sister-in-law. The Housing Officer was informed by them and they contacted 999. Social Worker arrived from ASC following Brian's discovery.
11/6/2024	A Safeguarding Adult Review request was submitted by SYFR.

7 Summary of what we found

Brian's behaviour making it difficult to support him

7.1 Brian wasn't always honest with workers, his family or his friends. There were a number of ways that Brian would make it difficult to support him:

7.1.1 There were occasions when he would decline support that was offered to him, and tell workers he did not require it or his needs were being met by others. E.g. he declined a second referral for a chest x-ray, when he didn't go to his appointment for the first.

7.1.2 When asked by the BH Housing Officer about who was supporting him at home, he told them that Mary was abroad visiting family. This was not true and may have been said so that the agencies did not try to contact her.

7.1.3 There were occasions where he would not tell the truth when asked by his relatives about the support, treatment or assessments that had been offered to him e.g. he told his sister that he couldn't get access to oxygen at home because he had to go to the GP surgery to complete a form. However, Brian

was offered a referral to the respiratory service, but would have had to have stopped smoking before being allowed oxygen. Brian declined the referral.

7.1.4 He was initially resistant to the people providing support to him having each other's contact details so that they could speak to each other directly.

7.2 It is not clear what the motivations were behind these actions, and whether there was anything in Brian's history that may have influenced his behaviour. It is possible he tried to stop family and friends from worrying about him, but another possibility was that he didn't want to lose control of the support that was being offered to him. He may not have wanted to make compromises in some areas of his life that he enjoyed, such as his smoking.

7.3 It did present challenges to his friends, family and workers who made offers to support him. It was not possible to make a diagnosis of his health conditions. It also means that agencies didn't know about his history and the motivations for his refusals of support.

7.4 These issues prevent Brian from being supported well at home by health, social care and housing providers. This may have made his life more comfortable and increased his choices at the end of his life.

7.5 This may have also relieved some of the pressure on his family and friends that were supporting him. Although, more could have been done to directly offer support to his family and friends and this is discussed more in paragraphs 7.25 to 7.32 below.

Self-Neglect vs Self-Care

7.6 Brian's behaviour showed a number of possible signs of self-neglect, some of which appear to have been missed. These included:

7.6.1 Inconsistent attendance at appointments with his GP and Barnsley Hospital.

7.6.2 Refusing further referrals for chest x-ray and breathing assessment.

7.6.3 Refusal of help and support, even when his health was very poor and he was dependent on being supported by others.

7.6.4 Attempts to mislead his sister about the extent of his ill-health or his pursuit of a diagnosis and medical support.

7.6.5 Living in his flat when he didn't have working lights (this was recognised by SYFR).

7.6.6 Freezer that was full or meals, but had iced over as they had been infrequently used (this was recognised by SYFR).

7.7 Whilst these are signs of self-neglect, they don't automatically mean that Brian was self-neglecting. He may have been trying to self-care in a way that made sense to him or met his wishes. At both the practitioner and manager's workshops attendees discussed the possibility that Brian may have been happy at home and he may not have wanted intervention or treatment. He may have had concerns that this would

have meant that he would have lost control of decisions about his life, or that he died in hospital or somewhere else he didn't want to be.

7.8 Whether Brian was neglecting himself or making decisions that made sense to him to be able to best look after himself, there were signs of self-neglect that were missed and BSAB's Self-Neglect & Hoarding Policy and Guidance was not followed. This meant that there were missed opportunities for multi-agency working and to try to form a relationship with Brian, to understand his concerns and to find a way to address these.

Professional Curiosity and Missed Signs

7.9 Workers could have been more professionally curious.

7.10 There were missed opportunities to be curious about discrepancies between what Brian would say and what he would do in real life. Brian missed a number of health related appointments (Ophthalmology, chest x-ray and Urology). These were sometimes re-referred and rebooked and sometimes Brian would decline this. However, more could have been done to recognise how the pattern of his attendance could have indicated someone who was self-neglecting. Particularly when these assessments may have led to a diagnosis of a serious or terminal condition that could have been more effectively treated or managed, or Brian and his supporters could have been offered help.

7.11 Brian's situation also highlights the importance of seeing people in person.

7.12 There was at least one missed opportunity to visit Brian and see him in person in the 12 to 15 months before he died. This was when Richard told Brian's Housing Officer that Brian was not managing. As Brian was just contacted on the telephone he was able to decline support, and it may not have been apparent to the worker that there was a difference between Brian's description of his abilities and what he could do in real life.

7.13 However, it could have been that Brian's difficulties may not have been visibly apparent in March 2023, and certainly not to the extent that they were in May 2024. Brian had had fairly recent visits from his GP and a Phlebotomist in January and February 2023 respectively. Neither of whom recognised anything of concern in Brian's appearance or the environment. Therefore, it is possible that he appeared to be coping at those times with the support that he had. This may have even appeared to have been the case in March 2023, as there was a gas safety visit in June 2023 that didn't highlight any concerns. As his condition continued to decline and he was able to do less and less, this would have changed.

7.14 Whilst a visit by a Housing Officer in March or April 2023 would have been helpful, Brian is likely to have refused support at this time. In such circumstances, good practice would have been to conduct some follow up visits in the following weeks and months to try to build a relationship with Brian and monitor the situation looking for evidence that Brian was able to meet his needs and that his situation at home was stable and not declining.

Mental Capacity, Executive Functioning and Mental Health

7.15 The majority of workers and organisations that met with Brian felt that he had the mental capacity to make decisions about his care. This was reflected in Individual Management Review ("IMR") questionnaires that Brian had the mental capacity to make decisions about his care. However, only YAS state that their workers conducted a mental capacity assessment. Other workers and agencies worked on the *"presumption"* that Brian had the mental capacity, and there was no reason to suspect otherwise based on their interactions with them.

7.16 Had agencies conducted an assessment of Brian's mental capacity, it is likely that Brian would have been able to articulate what he wanted. For the assessment to have been effective it is likely to have required the assessor to challenge Brian about the elements of his care that he was not managing. The assessments would have also required consideration of his executive functioning to carry out the decision that he had made.

7.17 As an example, when SYFR met Brian he was asked how he was looking after himself and whether he was able to get to the toilet. Brian said he was. However, at this time Brian had no fresh food in his fridge and his freezer had iced over. He had no working lights in is flat and appeared to have lying on his sofa for some time. Brian was so frail he may not have had the strength to do many of the daily tasks required and get up to go to the toilet unaided. The discrepancy between what Brian may have said versus what could be observed in his home should have featured as part of the assessment and records[1]. It is important that workers remain curious about such differences and try to gather information or ask questions to try to make sense of them.

7.18 Whilst this situation may have been the result of genuine choice, good practice would have been to try to understand why someone wanted to live in such a manner and ensure that they were aware what support was available to help them to live more comfortably.

7.19 Brian was known to make decisions that could be characterised as *"unwise"* when considering his care and support. It is possible that if he had been visited at home in the ten months prior to May 2024 workers may have seen a difference between what he was telling people about the support he required, versus what he was actually able to do for himself. This may have led to more curiosity about his mental capacity or executive functioning. Assessing his mental capacity would have been justified by the inconsistency between what he said and what he did, and the risks associated with his *"unwise"* decisions.

7.20 Recognising issues at an earlier stage would have allowed for more assertive offers of support. This may have also given more time for relationship building and trying to explore some of Brian's resistance to help and support. This might have included whether there was any impact from the trauma of losing his brother, being unable to repair his relationship with his son or reoccurrence of any mental health issues[2]. It is likely that Brian would have been resistant to this and escalation may

[1] (PDF) Mental Capacity Act (2005) assessments: Why everyone needs to know about the frontal lobe paradox – whilst this paper is written considering the care of people with an injury to their frontal lobe, it highlights how people's struggles with executive functioning can be masked by their use of language, and even reasoning skills.

[2] salford-sar-eric-v6.pdf – this review highlighted some of the challenges of trying to support someone refusing any help. The review was focused on a man in his 70s refusing support, medical intervention and neglecting their nutrition and hydration. It follows attempts by their GP and services trying to engage with the man in the last months of his life,

have been required within agencies because of the ongoing risks of his refusal of support.

7.21 It would have also allowed for a consideration whether any of the support offered by his family and friends made them carers, and offers to assess any of their needs as a result of those caring responsibilities.

7.22 It should be noted that Brian would have still had the right to choose his support whilst he retained his mental capacity to do so, and executive functioning to act upon his decisions. However, good practice would have been to specifically assess these based on the risks associated with the decisions he was making.

Risk Management

7.23 There are a small number of occasions when agencies tried to manage the risks of Brian's decision making. These included:

7.23.1 the YAS call taker making the decision to terminate the call to Brian and send an ambulance crew, despite his refusal, because of the risks of Brian's breathing.

7.23.2 The visit by YAS and SYFR as a result of Marilyn calling 999.

7.23.3 Brian's GP made some attempts to offer Brian and his sister information about managing some of the risks of Brian's decisions, which included referral to ASC and direct conversations with Brian that it would not be possible to meet his needs if he doesn't engage with medical assessments.

7.23.4 SYFR shared information about their concerns and risk with ASC and BH. They followed up these concerns with ASC to ensure that concerns were followed up.

7.24 No agencies considered what support Brian may require if his support network was unable to meet his needs.

Support for Carers and Engagement with people that knew Brian

7.25 There were missed opportunities to recognise his family and friends, particularly Mary, as carers and ensure that they had the support required in those roles.

7.26 Although a social history was taken by Brian's GP in January 2023 and it was identified that he had family and friends that were caring for him, Brian's friends and family were not contacted or offered support.

after his family had been raising concerns about his wellbeing. It highlighted the need for specialist mental health assessment where someone has historic mental health needs, good quality mental capacity assessment, consideration of their executive functioning and a need to obtain early legal advice. There are similarities between Eric and Brian, although, less is known about Brian's last 11 months and any historic mental health issues.

7.27 Richard informed Brian's Housing Officer that Brian was unable to meet his own needs and was being looked after by a network of family and friends. However, this did not lead to contact being made with Brian's family.

7.28 Brian's sister, Marilyn, was known as a contact for Brian by Brian's GP. Brian's sister also appears to have contacted ASC for advice about support for Brian. Whilst this appears to have been an *"anonymous"* enquiry with no details about Brian given, it does not appear that there were questions about Brian's family and friends meeting his needs, or whether any of them should be assessed as his carers and consider what support they can be offered.

7.29 When Brian was visited by a Housing Officer on the 15 May 2024, he told the Housing Officer that he was supported by a family member who was abroad in Thailand. This was not true.

7.30 There was at least one occasion when Brian's sister-in-law was supporting Brian to buy fresh food and clean, but was struggling with their own physical health needs. Mary provided support for Brian even when recovering from a mastectomy and trying to work.

7.31 Brian may not have recognised that his family network was struggling, as his needs were being met. However, had they been contacted by workers they may have expressed some concerns about the unsustainability of the current arrangements.

7.32 Previous Safeguarding Adult Reviews[3] highlighted learning where there had not been consideration of the needs or experience of other carers, including where family members that might be in a position to offer support. This also includes whether or not they have been listened to when raising concerns about their loved ones. We have been unable to identify situations where Brian's family and friends were engaged and offered support.

Speed of visit following the Safeguarding concern being raised

7.33 It is good practice that a safeguarding concern was raised and that Adult Social Care triaged this. It is also good practice that SYFR remained in contact with ASC after the referral was made, and a joint visit was arranged with Berneslai Homes.

7.34 Brian's Housing Officer visited him in person on the 15 May 2024, the day BH were contacted by SYFR about their concerns and the day after SYFR and YAS visited Brian. Brian told the Housing Officer that he did not require support and the Housing Officer was able to resolve the issue with Brian's lighting (a tripped switch).

7.35 Brian also had a history of refusing support from organisations. He was contacted by his GP on the 17 May 2024, by telephone, and refused their help and support. He was also was contacted by ASC on the 20 May 2024. Brian refused support again. Therefore, in these specific circumstances, even if there had been a faster triage and visit by ASC, it may not have led to Brian being provided with more support before he passed away.

7.36 However, there may be circumstances where a delay of seven days may change the outcome. Further, it may be that people may be less likely to engage and

[3] Clive, Jack and Harry.

accept offers for help over the telephone, but could be encouraged more in person. Therefore, in different circumstances it may be good practice for a face to face visit to be conducted sooner.

Use of BSAB Self-Neglect & Hoarding Guidance and Policies and Use of BSAB Was Not Brought Guidance

7.37 The Self-Neglect & Hoarding Policy and the Was Not Brought Guidance were not followed. Not all agencies were aware of them and YAS work across a large number of local authority areas. In their response to the Individual Management Review YAS have stated that they follow the Joint Royal Colleges Ambulance Liaison Committee guidelines ("JRCALC Guidance") and YAS own Safeguarding Adults Policy and Guidance.

7.38 As discussed above, there was some good practice such as Brian's GP contacting him following missed appointments, having a direct conversation with Brian about difficulties treating and supporting him because of his refusals and a social history being taken. However, there was no collaborative work between agencies.

7.39 Following concerns being raised by SYFR there appeared to be the start of a new approach that showed signs of good practice and that some lessons may have been embedded. SYFR raised concerns with BMBC ASC and remained in conversation with ASC to ensure that the concerns led to an enquiry under s.42 of the Care Act.

7.40 SYFR also raised concerns with BH who quickly visited Brian.

7.41 BH and ASC then organised a joint visit to Brian. Despite Brian refusing support from ASC on the telephone.

7.42 Had Brian's behaviour been recognised as self-neglect earlier, earlier referrals then being made to Adult Social Care and more time invested in relationship building and understanding the root cause of Brian's refusals; it is unlikely to have affected Brian's underlying health conditions and prevented his death. However, it may have given him more options around his care and environment at the end of his life. It may have also meant more support for his carers.

7.43 It should also be noted that BSAB's Guidance on Was Not Brought was not published until October 2022, and so didn't apply to the entire period of this review. Some missed appointments were prior to this time.

7.44 Further, whilst the current drafting of the WNB/DNA policy does discuss an adult's *"disengagement"*, which is how Brian's behaviour might be characterised. The guidance is primarily focused on the actions to be taken when adults who are dependent on other adults bringing them to appointments as their carers. The labelling of the guidance as Was Not Brought, but not including "Did Not Attend" may also lead some people to think that it would not apply to someone like Brian who, prior to a significant decline in his health, would have been able to attend appointments independently.

Record Keeping and Sharing of Information

7.45 Until YAS contacted SYFR and concerns were raised by SYFR with ASC and BH, there was no multi-agency work to consider and manage risk. The only sharing of information before this date was Barnsley Hospital notifying Brian's GP of missed appointments.

7.46 A number of IMRs also highlighted the importance of good person centred recording that identified risks and considered the environment that people may be living in. This is vital as unless situations are recognised, the right information won't be recorded and it is unlikely that it will be shared. This will have a profound impact on agencies' abilities to manage risks and ensure people receive the correct support.

Training, Support and Supervision

7.47 Supervision and training are important in embedding learning from safeguarding adult reviews and the effective use of guidance. Not all agencies shared information about supervision and support following contact with Brian, this was often because contact was so brief it didn't feature as part of ongoing work.

7.48 However, agencies that did reflected the need for workers to attend further training on self-neglect, mental capacity (including executive functioning) and case recording.

7.49 Further, that an open culture around safeguarding was important so that workers can approach managers and colleagues with appropriate experience and skills for advice, and for such conversations to be a feature of supervision.

7.50 This is particularly important to ensure that there is professional curiosity, support to balance the decisions made by people against identifiable risks and prioritising work based on risk. It will also help to identify any unmet training needs.

8 Identify appropriate lessons to prevent similar missed Opportunities

8.1 The review has highlighted a number of lessons and recommendations. These include:

8.1.1 Workers should visit people and see them in person. More than once. Particularly where there are concerns about the person making decisions that could lead to them experiencing harm.

8.1.2 Workers should observe, compare and record what someone is saying against what workers can actually see over a period of time.

8.1.3 Workers should share information with agencies that might be able to support someone at risk of self-neglect at an early stage.

8.1.4 Information can be shared where this is required to try to manage the risks. This may even be against the person's wishes.

8.1.5 Workers should keep good records that are based on the individual and their own circumstances. These should include observations of the person's environment.

8.1.6 Workers should engage with family and friends that know the person well and are supporting them in some way. This is both to try to develop relationships and understand the person at risk, but also to ensure that those helping are well supported.

8.1.7 Workers should try to understand the person's history. This is both in terms of their distant past, such as a history of mental ill-health, and more recent events, such as the loss of a loved one. This also requires consideration of how this history may impact the person's behaviour.

8.1.8 Workers should understand the difference between a *"presumption"* of someone's mental capacity and an *"assessment"* of someone's mental capacity. It is legitimate to formally assess an individual's mental capacity based on their *"unwise"* decisions that are carrying a great deal of risk.

8.1.9 Sometimes issues with mental capacity can be disguised by an individual's ability to articulate themselves well and their resistance to talk about the support they may need from services. This is why a formal assessment of capacity may be important.

8.1.10 Any assessment of mental capacity should also consider possible issues around executive functioning. This would require a direct comparison between what the person says versus the evidence that we can see that contradicts this e.g. someone asserting that they don't need any help despite living in a flat with no lights, no fresh food in the cupboards and in a very frail state that could indicate they didn't have the physical strength to carry about basic hygiene tasks for themselves.

8.2 These are all lessons highlighted in previous SARs. They are also considered in BSAB's Self-Neglect & Hoarding Guidance and Tools.

9 Recommendations

9.1 The author would recommend that there is a review of BSAB's Was Not Brought Policy for adults to be clearer about actions where the person doesn't attend themselves, and has some vulnerabilities but has not previously been dependent on other people. This may also require the policy to be relabelled to include "*Did not attend"*, as well as *"Was not brought"*. This is just to make it clear that it applies to both situations.

9.2 Training being delivered to GP's around Was Not Brought/Did Not Attend and self-neglect.

9.3 With the exception of GP practices, conduct a random audit of cases across BSAB partner agencies to identify the proportion of people that had:

9.3.1 physical visits where they were seen and spoken too,

9.3.2 and where there were multiple visits trying to build relationships and identify any changes in circumstances.

9.4 The cases should be focused on those where:

9.4.1 Concerns have been raised about an individual, either by workers or family and friends, and

9.4.2 The person is refusing help, and

9.4.3 There maybe concerns about risks.

9.5 The audit referred to in paragraphs 9.3 and 9.4 above should also consider whether any action was taken to identify if:

9.5.1 There are family and friends supporting the person, and

9.5.2 Are there any risks that may stop or reduce this support, and

9.5.3 Was contact made with those family and friends to offer an assessment of their needs and further support, and

9.5.4 What further support was provided.

9.6 Request data from primary care on the number of patients who may be recorded on SystemOne as:

9.6.1 having a vulnerability and received a home visit within the last 12 months, or

9.6.2 the proportion of patients with a vulnerability and that had a home visit in the last 12 months compared to the proportion of patients with a vulnerability who did not receive a home visit.

9.7 Conduct a *"check and challenge learning event"* within six months of the publishing of this review. The purpose of the event will be to discuss case studies across multiple agencies examining good practice in scenarios such as Brian's.

9.8 Agencies should consider available training that will support their workers to work alongside family members in trying to support someone who may be refusing help, such as the *"Group around the Person"* training.

9.9 Appendix 4 and Appendix 5 of the Self-Neglect & Hoarding Guidance offer helpful practical guidance to workers on practically checking an individual's executive functioning, when assessing their mental capacity, and a checklist for workers to consider when someone is potentially self-neglecting and refusing necessary support. These appendices could be created into individual checklists for workers. A communications exercise can then be delivered to promote the individual checklists into areas and agencies that would benefit.

9.10 Where agencies, such as YAS, work across many local authority areas and follow guidance that is not BSAB's guidance and polices, we would recommend that copies of those policies and documents are reviewed by BSAB partners to understand any significant variations and differences in practice which may need to be managed.

9.11 Some agencies reflected the need for further Mental Capacity Act training within their Individual Management Reviews. Those agencies can access the BSAB training programme, which is free to access, and offers courses on the key lessons around Mental Capacity identified in Safeguarding Adult Reviews. The training calendar can be accessed here.

9.12 Some agencies reflected the need to support non-clinical staff to develop their skills around recording contacts and concerns with patients and their family and friends. Agencies should consider the needs of their workforce, whether there are similar unmet needs and how they can be addressed.

9.13 The recommendations to share the learning from this review are:

9.13.1 A *"7 Minute Briefing"* will be prepared from this review to summarise the key findings and lessons. This will be published on the BSAB webpage. The full review report will be published on the BSAB webpage and shared with the Social Care Institute for Excellence to go to the SAR library.

9.13.2 Lessons from this review will be added to the BSAB training programme.

9.13.3 Where agencies have their own training teams, or workers within the Safeguarding Teams that may also deliver training, BSAB will offer materials and case studies, with guidance, based on the key lessons from this Safeguarding Adults Review. This is so that they can be delivered by those trainers within their own organisations, whilst still reflecting the key messages.