Peter & Ahir - Thematic Safeguarding Adult Review

6 Step Briefing

The Review

Southampton Safeguarding Adults Board (SSAB) Case Review Group (CRG) received separate referrals for two men, Ahir and Peter. Although not statutorily being provided with care and support as defined under the Care Act 2014, it was recognised that both men required care and support, that their deaths had occurred from abuse or neglect (including self-neglect) and there was reasonable cause for concern about how agencies worked together. CRG determined that there were several similarities in the lives and experiences of both men and clear learning was identified. A discretionary Thematic Safeguarding Adult Review was commissioned by SSAB on 11th January 2024.

The Background

Ahir was a 54-year-old man of Asian heritage who lived alone in private housing. He had three adult children and was described by his family as intelligent and sociable. Ahir had poor eyesight, partial deafness, poor mobility, depression and alcohol dependency. He also disclosed infrequent cannabis use and had a diagnosis of bipolar disorder. Family members suspected he may have been neurodivergent. Ahir had multiple interactions with various agencies, including Change Grow Live (CGL), Adult Social Care (ASC), the Community Mental Health Team (CMHT), his GP and the police, regarding his mental and physical health, over many years.

Peter was a 64-year-old man with type 2 diabetes, poor mobility, and a history of drug and alcohol use. He became reclusive in his later years and had limited contact with his family. Peter too had multiple interactions with healthcare services, including his GP and Podiatry, but faced challenges in accessing support due to his living conditions (Peter repeatedly presented at appointments with bedbugs falling off his person) and mental health conditions.

Key Lines of Enquiry

- How did professionals engage with Ahir and Peter?
- Were the risks of harm to Ahir and Peter fully recognised by professionals and appropriate action taken to manage these?
- Was the individual's voice heard by professionals and their views and wishes taken into account?
- How was the Mental Capacity Act applied?
- How does stigmatisation attached to individuals who use substances and/or self-neglect have an impact on their access to services?
- How effective is multi-agency communication and working when individuals are perceived as not engaging?
- Was there effective challenge and escalation when support services were closed?
- How can agencies engage with individuals where high risk self-neglect is evident?

As part of the review process, Ahir's family and Peter's niece met with the author and provided valuable insight into their loved one's lives.

The Incident

Sadly, Ahir was discovered deceased by his landlord at his home address. Police officers observed poor living conditions in his property and that Ahir did not appear to have changed his clothes for some time. There were empty bottles of vodka and mould throughout the flat.

Tragically, Peter was also found deceased at his home address. Concerns were raised after it was established that he had not collected his diabetic medication for over 12 months. Police officers attended and found the front door shut but unlocked. On entry, letters had to be pushed back to open the door, and a heater was found running. The living room was in a poor condition with rubbish bags around the room. The kitchen was empty and had no oven, fridge, freezer or microwave and no evidence of any food present. Based on the last agency contact and post at the address, it is believed that Peter had passed away 16 months prior to being found.

Peter's death was subject to a Coroner's Inquest which was held on the 23rd October 2024 and concluded that cause of death could not be ascertained due to his body's severe state of decomposition.

Ahir's death was not subject to a Coroner's Inquest as it was determined that he passed away from natural causes, specifically alcohol related liver disease.

Findings

Multiple presenting needs

Ahir and Peter presented with multiple ongoing physical health needs, both men expressed they hoped they would die and that they struggled to leave their homes. Agencies reflected on having little knowledge of who else was involved with either Ahir or Peter. There was a lack of ownership and coordination in both Ahir and Peter's care, with the responsibility of onward signposting often falling on Ahir or Peter's GP. Agencies reflected that Ahir and Peter may have benefitted from application of the Multi-Agency Risk Management (MARM) framework.

Review consideration 1: Are agencies giving equal consideration to raising a Multi-Agency Risk Management (MARM) framework?

Fluctuating or perceived non-engagement

There were times when Ahir and Peter disengaged from services but the reasons for the perceived disengagement were not explored. Given the complexity of needs, both men may have benefited from services offering support in different, flexible and more assertive ways.

Review consideration 2: Create multi-agency guidance for working with adults who may not be engaged with offered support.

The review highlighted potential stigma associated with individuals who use substances or experience self-neglect. If individuals were deemed to be making a 'lifestyle choice' this may impact on a professional's persistence to engage the adult. Agencies considered unconscious bias and that this bias may have reduced professional curiosity.

Review consideration 3: Produce a public communication campaign, similar to the NHS 'Stigma Kills' campaign, that focuses on how perceptions, actions and words can reduce vulnerable adults' accessibility to services.

Safeguarding

It was not always explicitly identified that Ahir and Peter were experiencing long term self-neglect. There was good evidence of agencies raising safeguarding concerns for both Ahir and Peter, but agencies were rarely working together.

The review identified an ongoing lack of confidence amongst professionals in understanding and applying the Mental Capacity Act (MCA), with misunderstanding around both decisional and executive capacity and that mental capacity is both decision and time specific.

Review consideration 4: Is the SSAB self-neglect guidance suitably robust enough to support practitioners to respond to high-risk self-neglect when services have difficulty achieving engagement with the adult?

Review consideration 5: What measures can be put in place to support practitioners in working with executive capacity? Should partners commission additional training and guidance for frontline staff on this issue?

Ahir and Peter's voices and wishes

There was some evidence of Ahir and Peter's voice and wishes being captured, but this was not analysed to understand why they felt that way or pursued in an attempt to resolve what Ahir and Peter perceived they needed.

Review consideration 6: Are agencies aware of the different types of advocacy and that practitioners feel confident in raising the need for statutory advocacy in cases where it may otherwise be overlooked?

Useful links for Best Practice

- 4LSAB MARM framework
- 4LSAB Safeguarding Adults Escalation Protocol
- Guidance for Working with Non-Engaged Adults (Calderdale Safeguarding Adults Board)
- Self-neglect Guidance
- MCA Toolkit
- 4LSCB and 4LSAB Family Approach toolkit.
- 4LSAB Adult Safeguarding Policy, Process and Guidance