North Lincolnshire Safeguarding Adults Board

Safeguarding Adult Review
Adult C

Introduction and circumstances that led to the review

Adult C was a 64 year old male who sadly passed away whilst living in temporary accommodation. He had recently moved from his home address due to concerns around his living conditions and the safety of his previous address.

The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR).

A referral for a SAR was sent to the North Lincolnshire Safeguarding Adults Board in April 2025 from Humberside Police. Due to limited information contained within the referral, further information was requested from key agencies in line with the North Lincolnshire SAR Framework[1]. Agencies were requested to consider their information/involvement from 1 October 2024 to 31 March 2025 (6 months prior to Adult C's death).

Upon receipt of the additional agency information, the SAR Executive Group met in June and July 2025 and agreed that the criteria for a Safeguarding Adults Review were met based on the following:

- Criteria 1 **(met)** – Executive Leads agreed that Adult C did appear to have care and support needs.

- Criteria 2 **(not met)** – Executive Leads did not identify any cause for concern in relation to how the SAB, its members, or organisations worked together to protect Adult C.

- Criteria 3 & 4 **(not met)** – There is no evidence or suspicion that abuse or neglect contributed to Adult C's death. The Coroner confirmed that his death was due to natural causes advised that there were no outstanding investigations taking place.

- Criteria 5 **(met)** - Whilst it was noted there was no evidence or concerns that Adult C died as a result of abuse or neglect, Executive Leads agreed there may be opportunities to identify best practice and further improvements.

The SAR Executive Group shared their decision making with the SAB Independent Chair who endorsed their decision to hold a discretionary SAR.

[1] https://www.northlincssab.co.uk/wp-content/uploads/2025/06/2.3-SAB-SAR-Framework-June-25.pdf

Multiple professionals were involved with supporting Adult C and the Executive Leads requested that the SAR explore whether partners could have done more to support him given previous concerns being raised in relation to his ability to look after himself.

Methodology and scope

In determining the methodology to be used for this Safeguarding Adults Review the SAR Executive Group considered the Care Act 2014 Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases.

The SAR Executive Group chose to undertake this SAR utilising the concise investigation and significant event methodology as set out in our SAR Framework.

This methodology brings together managers and practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.

This model includes:

- Information gathering – collation of as much factual information about the event as possible from a range of sources
- Facilitated workshop to analyse the events
- Analysis of the significant events: The key questions that require answering in a significant event analysis or audit are:
    - How could things have been different?
    - What can be learned from what happened?
    - What has been learned?
    - What has been changed or actioned?

Agencies were asked to review their own involvement and complete an Agency Author Report based on their findings and learning. Those who were involved, alongside the authors of the Agency Author Reports were then invited to engage in a multi-agency reflective workshop to review all of the material and identify key themes and learning.

The scope of the SAR covered the period of agency involvement from 1 January 2024 to 31 March 2025. Organisations were also asked to highlight those areas which they felt were pertinent to the concerns raised.

SAR author and workshop attendance

As set out in our SAR Framework, the concise investigation methodology should be led by an appropriate SAB member who is independent from the case.

Charlotte Morton, Designated Nurse and Head of Safeguarding, Humber and North Yorkshire Integrated Care Board was identified to lead the SAR, facilitate the multi-agency reflective workshop, as well as being responsible for formulating the final report.

The following agencies were identified as being involved in the case and were required to submit an Agency Author Report and attend the workshop:

- North Lincolnshire Council
  - Adult Social Care Access Team
  - Home First Community Reablement Team
  - Environmental Health
  - Housing Advice Team
- Humberside Police
- Humberside Fire and Rescue Service

East Midlands Ambulance Service submitted an agency author report as they responded to the report of Adult C's death. However, they did not attend the workshop as they had no previous contact with Adult C.

Partners who confirmed that they had no involvement included:

- Rotherham, Doncaster and South Humber NHS Foundation Trust
- GP practice (via Humber and North Yorkshire Integrated Care Board)
- Humber Health Partnership (Northern Lincolnshire and Goole Hospitals NHS Foundation Trust)
- Ongo Homes

Family involvement

A key part of undertaking a SAR is to gather the views of the adult at risk and their family members.

Upon Adult C's death, there were challenges in locating a next of kin as he had confirmed previously that he had no family or friends. Adult C led a very private life; his closest relative was his mother who had died several years previously. No agency had any contact details for any other family members or friends.

It was agreed that therefore, in line with Adult C's wishes, we would not contact anyone else to be involved with this review.

Factual summary of key events

On 1 November 2024, Adult C called the police to report a burglary at his home address. Due to the nature of the report, the police entered his property and noted that the house was in a state of disrepair and concerns were raised around Adult C's living conditions. The police officer submitted an internal vulnerable adult referral to the Humberside Police Vulnerability Unit, who triaged the concern and shared the information at the PITSTOP meeting on 5 November 2024[2]. Following the discussion at PITSTOP, a referral was made to North Lincolnshire Adult Social Care's Access Team.

[2] PITSTOP is a partnership integrated triage meeting which aims to improve early identification and understanding of need, harm and risk. PITSTOP jointly considers police information (that has already been through police decision making processes and determined that partnership triage is required) with a view to identification of potential levels of need and appropriate responses in line with the Care Act 2014.

The following day, the Access Team duty worker telephoned Adult C and offered him a care and support assessment. Adult C declined this stating he did not need any support. He was signposted to the council website so that he could get in touch in the future should he change his mind.

On 12 January 2025, a second internal vulnerable adult referral was submitted by the same police officer to Humberside Police's Vulnerability Unit after Adult C was appearing to be living in his car at a local beauty spot. A member of the public told the police that he often frequented the area and, upon being spoken to, Adult C shared that his home address had no gas, electricity or water so he spent most of his time in his car to keep warm.

On 14 January 2025, this information was shared again via PITSTOP and a second referral was made to the Access team. Multiple attempts were made to contact Adult C via telephone, email and letter between 14 January and 6 February but no contact could be made. During this time, enquiries were made with local GP practices to determine if he was registered with a GP. However, he was not registered with any of those whom they contacted. Multi-agency discussions also took place during this time between Humberside Police, Environmental Health and Humberside Fire and Rescue Service and a joint visit was agreed.

The joint visit to Adult C's home address took place on 6 February 2025. Adult C remained in his car throughout the visit and shared that he was having challenges with his mobility. He consented to a referral to the NLC Home First Community Reablement Team for support with registering with a GP, ensuring all appropriate benefits were being accessed and support with the home environment. Environmental health utilised their legal powers under the Housing Act 2004 to prohibit the property from occupation due to the condition of the property in agreement with Adult C. Temporary accommodation was sourced on the same day at a local hotel which Adult C moved into. He was again offered a care and support assessment but declined.

Between 7 February and 31 March, multiple professionals tried to contact Adult C via phone, email and in person but had challenges in locating him. Brief contact was made on the following dates:

- 11 February - Environmental Health located Adult C in his car within the community to discuss their plans to serve an Emergency Prohibition Order on his property and to help him to find somewhere else to live
- 17 February - Environmental Health found Adult C in his car within the community and shared a copy of the Emergency Prohibition Order with him
- 4 March - Humberside Police spoke to Adult C at his hotel and he agreed to attend Victor House[3] on 6 March for an assessment. However, he did not attend this appointment
- 27 March - The Home First Community Reablement Team visited Adult C at his hotel room and spoke to him through the door. He advised it was not a good time to speak and requested that they rearrange the visit for the following week

[3] Victor House is a council owned integrated hub which supports people with rehabilitation and housing needs. Staff deliver targeted support services alongside partners to support people in emergency situations

On 31 March 2025, East Midlands Ambulance Service responded to a 999 call after Adult C was sadly found deceased in his hotel room by 2 other motel residents. Subsequently, the coroner confirmed that Adult C's cause of death was not suspicious and was determined to be cardiac failure.

Analysis of agency author reports

The agency author reports were collated in a timely manner and were of a high quality with detailed analysis. The reports were shared with those invited to the multi-agency reflective workshop to allow individual members to triangulate information ahead of the event and to inform areas of discussion. This facilitated a mature reflective discussion with a high level of professional respect shown within the review for other agencies roles and responsibilities, but also recognition of some limitations.

The author welcomed the openness of practitioners and managers to reflect on where they had found challenges, and the resulting action that agencies have already implemented following single agency reviews of Adult C's journey.

During the undertaking of this review no protected characteristics as defined by the Equality Act (2010) were identified. Adult C was a white British male who was retired. Little is known about his personal relationships or significant life events, other than the loss of his mother. There is also a significant gap in GP information and health oversight over his lifetime which is interesting to note. Within the review it was noted that Adult C was visible in the community, but largely invisible in earlier years to professionals. We are left with an assumption from the information reviewed that he was a private man, and it is hard to hear his voice at times within the records.

Multi-agency reflective workshop

As dictated by the Care Act, the purpose of the SAR is not to hold organisations or persons to account for any shortcomings, that is for other processes. In order to promote learning, the multi-agency reflective workshop was carried out in an environment where practitioners were able to be open and reflective regarding their practice without fear of blame.

The key themes and learning from the workshop are detailed below.

Reflections on the use of PITSTOP

Both referrals to the Access team were made via PITSTOP in this case.

The group reflected around whether there is an over-reliance on PITSTOP and considered whether concerns should have been raised directly with the Access team or the safeguarding team if staff were concerned about a vulnerable person.

It was also highlighted that there were occasions where additional information contained within the police referral to PITSTOP was not shared and could have strengthened the response. For example, the police officer who spoke to Adult C shared within the referral that

he did not answer the phone to unknown numbers and would prefer a face to face visit. When PITSTOP agreed to make the referral to the Access team, this information was not shared with them. It was explained that because PITSTOP had received 2 referrals for Adult C within a short a space of time, the detail contained within the written referral was not discussed as part of the meeting. If this information had been directly referred to the Access team by the police instead of via PITSTOP, the duty worker would likely have undertaken a visit at an earlier stage.

Consideration was also had in terms of the feedback loop to PITSTOP where no further action was taken as a result of the first referral. It was noted that there is no formal process in place which feeds back the outcome of referrals to PITSTOP. However, it was determined to be good practice that the police officer made a second referral as it allowed the Access team to reconsider the level of vulnerability and risk. It was also noted that a referral to PITSTOP can create an over confidence that change will be achieved, and some professionals are not aware that the oversight from PITSTOP does not always generate the anticipated referral pathway for health. For example, where the required service is not represented as part of the membership of PITSTOP.

Information sharing around referrals to PITSTOP was also considered. The group questioned the ability for people to provide informed consent to share their information if the practitioner asking does not know what the offer of support is going to be. It was shared that police officers are encouraged to ask for consent to share their information with partners and PITSTOP agree whether to refer onwards.

As a result of the above considerations, there is further exploration to do around the PITSTOP process and how it is being used by partners.

Consideration 1

The SAB should ensure that a review of PITSTOP is undertaken to:

- *seek assurance that referrals being made to PITSTOP are appropriate and are not bypassing the appropriate pathways*
- *explore whether a feedback loop to PITSTOP is required to ensure that people get the correct support where no further action is required from statutory services*
- *consider whether appropriate procedures relating to information sharing and consent are in place*
- *strengthen understanding of PITSTOP across the partnership, particularly around available pathways and which agencies are represented at the meeting*

The importance of relationships in working with people who self-neglect

When working with people who self-neglect, research and evidence from national learning reviews identifies building a positive relationship with people who live in circumstances of self-neglect is critical to supporting them to achieving change, and in ensuring their safety and protection.

Adult C appeared to have a positive relationship with the police officer who managed to obtain more information from him than any other professional. There appeared to be no clear reason for this. However, the review did note that the police officer was pivotal to engaging

Adult C and recognises that such reachable moments are key with people who are reluctant to accept support from professionals.

Good practice was identified in that the Home First Community Reablement Team tried different approaches to engage with Adult C that was over and above usual practice. For example, they visited places that he often frequented when they could not make contact with him. It was also highlighted as good practice that the Home First Community Reablement Team did not close his case when he did not want to speak with them on their first visits. The team considered the level of risk and his vulnerabilities and continued to try and build a relationship with him up until his death.

The group noted that self-neglect is a challenging area of practice and practitioners are not always clear when this would escalate into a safeguarding concern. It was noted that when looking in hindsight, it is easier to identify potential self-neglect.

Since the scoping period of this review, the SAB have developed and published self-neglect policies and procedures and an accompanying toolkit which details the importance of building relationships and helps practitioners to understand how to determine when the level of risk meets the criteria for further intervention. Therefore, the below consideration has been made.

Consideration 2

Further raise awareness of and enhance practitioner understanding of working with people who self-neglect and how to determine when this meets safeguarding criteria

Use of professional curiosity

All agencies who were supporting Adult C held small pieces of information about him and his life however it was a challenge for the group to fully understand the lived experience of Adult C. Although it was acknowledged that he was a very private person and did not share information freely, professional curiosity could potentially have been strengthened in this case.

At the time Adult C was being supported, practitioners were not aware of any outstanding health needs. He was often sat in his car when spoken to and it was not until he shared that he was having challenges with his mobility that practitioners became aware of a physical health need. However, it was also not clear whether anyone asked the question.

In January, the Access team took steps to explore which GP Practice Adult C was registered with but struggled to find this information. During the review of records, it was highlighted that there was very little information recorded on Adult C's GP record. This was noted to be unusual.

The lack of health records and GP registration, in addition to the above learning around professional curiosity, may suggest that further awareness raising should be done with practitioners around the implications on long term health for someone who does not have a GP. Where it is determined that someone does not have a GP, practitioners should be

prompted to discuss this, and signpost to health services to address any immediate health needs.

Consideration 3

Continue to promote tools and resources to encourage practitioners to be professionally curious

Consideration 4

Strengthen practitioners' understanding of the implications on long term health for people who do not have a registered GP, ensuring that they discuss this with the person and signpost to address any unmet health need

Empowering the community

Communities including local businesses have a huge part to play in keeping people of all ages safe from abuse and neglect. It was noted that Adult C frequented a number of local beauty spots as well as supermarkets and shops to use their public facilities and it is likely he was known to the staff and/or security. However, no referrals were made to Adult Social Care or to the Housing Advice Team by members of the public. It was not until the police officer visited one of the areas where Adult C frequented that a member of the public informed her of their suspicions that he was living in his car.

The temporary accommodation provider would also have benefited from an enhanced understanding of how to support vulnerable people who reside in their establishments. It was felt by some professionals that staff were judgemental of Adult C and saw him residing with them as an inconvenience. It was noted that since Adult C's death, the Housing Advice Team have revisited all contracts for temporary accommodation providers to ensure that they are aware of their responsibilities to undertake welfare checks on vulnerable people residing with them.

The group reflected around how we engage with local communities and businesses to share concerns about people they come into contact with on a regular basis and how we can empower them to have a conversation with the person. In addition to creating a professionally curious workforce, there may be further work to do with local businesses and community areas to break the stigma of safeguarding and create 'curious communities. Key partners working within communities, such as those in a community policing role, could further develop conversations with businesses to enhance their awareness of safeguarding vulnerable people.

Consideration 5

Undertake further work within the local community and with businesses to empower them to have conversations with vulnerable people and to report their concerns if they may be at risk of harm

Utilising the skills and expertise of partners

Practitioners are encouraged to consider what wider legislative action can be used to assist in minimising risks where a person's home conditions impacts on the person's health and wellbeing.

It was noted as good practice in this case that environmental health used their powers under the Housing Act 2004 to seek an Emergency Prohibition Order on Adult C's property and that they did this with his consent. They made the decision to seek the Emergency Prohibition Order on the same day that the joint visit was made and his home conditions were observed.

It was also noted that despite the fact that although Adult C was a homeowner, the Housing Advice Team were able to utilise their legal powers to source emergency accommodation on the same day. The support to move him to the temporary accommodation was felt to be a step towards fuller engagement and the ability to implement a package of support in the future.

In acknowledging the success of the joint visit, the group reflected around whether there are enough mechanisms in place to have multi-agency conversations around complex cases, in particular those in which the person does not want to receive support. It was acknowledged that hoarding and self-neglect is not uncommon and due to the length of time it takes to build rapport with the person, the risk can remain high for some time with little progress being made.

It was evident from the reflective workshop that there was a genuine desire to understand and increase awareness of key issues such as self-neglect, and that attendees benefited from dedicated time to discuss learning and opportunities for future improvement. The richness of the discussion demonstrates the benefits of a peer supervision model, and the value of risk management frameworks such as the Vulnerable Adult Risk Management (VARM) process in creating a safe space for professionals to explore how to create individualised person-centred packages of care within a multidisciplinary team. Practitioners acknowledged the importance of not closing cases if vulnerabilities and poor engagement coexist but shared that they would welcome opportunities to joint work and further explore any challenges within a multi-agency forum.

It was noted that many of the available frameworks for multi-agency discussion, such as the VARM process, are for cases where there is risk of significant harm or death and there is little available for those 'stuck' cases to be discussed at a lower level. Therefore, the below consideration has been made.

Consideration 6

Consider what mechanisms and/or processes are in place for partner agencies to discuss 'stuck' cases where the person is potentially vulnerable

Trauma informed practice

The importance of trauma informed practice was a theme in this case. The impact of Adult C's bereavement was highlighted as a potential reason for him not wanting to be inside the

property and potential trigger for his self-neglect and hoarding. Without consent bereavement support could not be provided, however practitioners working with Adult C, could have utilised trauma-informed approaches to working with him.

It was acknowledged that this review was undertaken in hindsight, however there is some indication that practitioners did identify the impact of his bereavement at the time they were working with him. Therefore, the below consideration has been made.

Consideration 7

Continue to raise awareness of and promote tools and resources around trauma informed approaches in adult safeguarding

Use of language and terminology

The group reflected on the use of language in some of the case records, particularly around non-engagement and around how his living conditions were described.

There are many reasons why a person might find it difficult to access help and language can be a barrier in allowing practitioners to recognise the complex reasons behind why someone might struggle to take up services being offered. Therefore, the below consideration has been made.

Consideration 8

Strengthen understanding of the importance of the language that is used to describe the people that we support, particularly in relation to those who self-neglect and those who do not want to receive support

Understanding of executive functioning and mental capacity

When a person is presumed to have mental capacity or has been assessed as having capacity, their autonomy must be respected, and efforts should be directed to building and maintaining supportive relationships through which services can in time be negotiated if required. However, where there is self-neglect, practitioners should consider whether the presumption of capacity can stand. It is equally important to explore and ensure that there is clear evidence that the person does in fact have capacity.

In this case, it is suspected that Adult C had been living in his car for a number of years and there were concerns around self-neglect and hoarding. It was noted in records that Adult C appeared to have capacity and understood the implications of not consenting to assessment. However, it is not clear whether considerations were made around his executive functioning. It was acknowledged that given Adult C was difficult to contact, this limited practitioners' ability to have conversations with him to determine whether there were any challenges with his executive functioning. Therefore, the below consideration has been made.

Consideration 9

Undertake further training and awareness raising about the importance of executive functioning and mental capacity

Conclusion

We recognise Adult C's death was an upsetting event, which did raise some questions initially around whether partners could have done more to support him. Following robust review of the information that local agencies held in relation to Adult C, the review enabled critical analysis and reports the below findings.

The offer of temporary emergency housing did meet Adult C's needs and flexible, person centred approaches were utilised by partners.

The review did not identify significant missed opportunities. Once the multi-agency partnership became aware of Adult C's circumstances, action was taken to support him and once alternative accommodation was accepted, the offer was timely. With the benefit of hindsight, the package of support could potentially have been strengthened if his health needs had been clarified at an earlier stage. However, there is no suggestion that this impacted upon his death, or that it was a modifiable factor which could have prevented his death.

The review recognises that working with people who self-neglect is challenging for practitioners and this was evident in this case. It is recognised that working at a person's own pace where people experience hoarding and self-neglect is often a fundamental principle to continued engagement. Through this review, there is evidence to suggest that learning has been embedded from previous reviews relating to self-neglect. Practitioners and managers were able to articulate how they had utilised learning from past cases and practice wisdom to change the way in which they worked with Adult C.

Peer discussion and support was also determined to be important in working with people where there is limited engagement to identify reachable moments and to think creatively.

The report does not identify any systemic issues that require escalation to the Safeguarding Adults Board or to any wider local, regional or national forums. The learning and areas for further consideration are detailed throughout this report and are summarised below.

The reviewer would like to thank everyone involved in the review of this case for their willingness to reflect and contribute to a number of challenging discussions.

Summary of areas for consideration

Where agencies have made their own recommendations in their Agency Review Reports, and other investigations, the SAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

The following multi agency considerations are made to the SAB as a result of the learning in this case:

Consideration 1

The SAB should ensure that a review of PITSTOP is undertaken to:

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- *explore whether a feedback loop to PITSTOP is required to ensure that people get the correct support where no further action is required from statutory services*
- *consider whether appropriate procedures relating to information sharing and consent are in place*
- *strengthen understanding of PITSTOP across the partnership, particularly around available pathways and which agencies are represented at the meeting*

Consideration 2

Further raise awareness of and enhance practitioner understanding of working with people who self-neglect and how to determine when this meets safeguarding criteria

Consideration 3

Continue to promote tools and resources to encourage practitioners to be professionally curious

Consideration 4

Strengthen practitioners' understanding of the implications on long term health for people who do not have a registered GP, ensuring that they discuss this with the person so that they can be signposted to address any unmet health need

Consideration 5

Undertake further work within the local community and with businesses to empower them to have conversations with vulnerable people and to report their concerns if they may be at risk of harm

Consideration 6

Consider what mechanisms and/or processes are in place for partner agencies to discuss 'stuck' cases where the person is potentially vulnerable

Consideration 7

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Consideration 8

Strengthen understanding of the importance of the language that is used to describe the people that we support, particularly in relation to those who self-neglect and those who do not want to receive support

Consideration 9

Undertake further training and awareness raising about the importance of executive functioning and mental capacity

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