



Safeguarding Adults Review: Adult P

**Summary report for publication
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1 Introduction

Adult P was an adult with care and support needs who died in a fire at their home. The Tyne and Wear Fire and Rescue Service investigated the fire and concluded that it was most likely that it was caused by a dropped cigarette.

Adult P had a number of significant healthcare issues, some of which affected their mobility. They had extensive contact with health and care services. However, services reported that appointments were often missed and that offers of care were often declined. There were concerns about how well Adult P was able to look after themselves, and about weight loss.

The Newcastle Safeguarding Adults Board agreed that an in-depth review should be arranged to identify learning. I was commissioned to undertake the review. To do so I reviewed a detailed chronology which listed contacts with Adult P in the two years before they died. I also spoke to Adult P's family carer and to many of the agencies involved, including at a learning event in December 2025.

I would like to record my thanks to all those who were involved and, in particular, my thanks to Adult P's family carer for their engagement with the review process.

2 A brief summary of what happened

Many services were in contact with Adult P. There was ongoing contact from Adult P's GP practice and from various other community health services. In addition, there were several occasions when Adult P was taken to hospital by ambulance due to health conditions. Adult P spent two periods in hospital and two periods at a residential service for people who are not yet well enough to return home.

On 11 occasions during the last two years of Adult P's life, safeguarding concerns were raised due to what is called "self-neglect". These concerns included Adult P having lost weight, struggling to look after themselves and the condition of their house. At the same time, Adult P was missing some important healthcare appointments.

In response to these concerns, there were several occasions when Adult P was contacted by social workers who suggested the possibility of some ongoing care and support. Generally, Adult P declined these offers of support.

However, around six months before they died, Adult P agreed to a period of reablement and, about a month before they died, they agreed to a package of daily care visits. At the time of Adult P's death, this was being arranged but had not yet started.

On a number of occasions, it was noted that there were a lot of cigarette butts in the house. On one occasion, concern was expressed about fire risks and it was suggested that the Fire Service should be asked to do a "safe and well" visit. This would have led to advice about fire risks. However, Adult P did not want to have a visit and a referral to the Fire Service was not made.

Around three weeks before Adult P died, the Police went to Adult P's house on an unconnected matter. They were concerned about Adult P's health and their living conditions and called for an ambulance to assist.

Adult P was noted to appear emaciated and to be having drowsy episodes, wearing dirty clothes soaked in urine and not taking medication.

The living environment was reported to be dirty and cluttered, with evidence of mould and out of date food, and there was a high risk of fire due to the way that Adult P was smoking.

It was reported that Adult P had poor food and fluid intake and appeared to be living on fortisip supplements and Lucozade.

Adult P declined to go to hospital. The ambulance crew assessed Adult P as having capacity to make this decision and therefore accepted it. They recorded telling Adult P that if they did not go with them to hospital, there was a risk of deterioration in their health and that they may die. Adult P is recorded as saying that they felt fine.

The ambulance crew alerted Adult P's GP practice that Adult P had been found unresponsive with very low oxygen saturation. Adult P's GP practice sought to contact Adult P by phone but there was no answer.

The Police and the Ambulance Service both made safeguarding adults referrals which were reviewed by the Multi Agency Safeguarding Hub (MASH). The main concern was seen as the need to get carers in as soon as possible. However, this was taking some time to arrange.

22 days after the Police and the Ambulance Service had visited Adult P's house, Adult P died at home in a fire. The Fire Service concluded that the fire appeared to have been centred on the sofa on which Adult P had been sitting and sleeping. The most likely scenario was that a dropped cigarette had got caught in a fold in a blanket or bedding.

During the 22 days between the visit and Adult P's death, there was no recorded contact with Adult P by any service or agency. It is not known whether, during this period of time, Adult P's health improved, deteriorated or remained the same.

3 Discussion and learning

3.1 How well was Adult P's family situation understood; what impact might this have had on the provision of services and consideration of risks to Adult P?

Adult P's family carer told me that they had been caring for Adult P for some years. Initially, they would visit twice a week for around two hours but this increased in later years to three or four times a week. They would straighten things up, make them respectable and help with personal care. This included giving Adult P a sponge bath, combing their hair, cutting their nails and helping them to go to the toilet. Adult P's family carer would also do a weekly shop, prepare meals and help pay bills, and help Adult P to go to hospital appointments.

Several agencies were in contact with Adult P's family carer and knew that they provided regular support. One person told me that Adult P's family carer was devoted to Adult P. However, none of the agencies knew how much care and support Adult P's family carer was providing and they were not offered a carers assessment.

Due to safety concerns, staff visited Adult P in pairs. One person suggested to me that staff may have been intimidated by some family members and were sometimes reluctant to go to Adult P's house. However, there doesn't appear to have been any discussion between the various agencies to share their respective understandings and any concerns about Adult P's wider family situation.

3.2 Did established ways of working provide to those who were responding to adult safeguarding referrals a full enough picture of Adult P's situation and of possible risk levels? If not, what would have helped that?

Managers from the safeguarding adults service told me that each self-neglect referral had been considered under the local policy. Some progressed to Stage 2 (initial enquiry) and some to Stage 3 (strategy meeting/discussion). None progressed to Stage 4 (protection planning and review), and no formal strategy meeting was held at Stage 3 or beyond.

Discussion at the learning event identified some areas where additional information could have been helpful to those responding to referrals. Firstly, those making decisions would not have had a full understanding of Adult P's family situation. Secondly, there was no system to give an overview over a period of time. An overview could have helped patterns to be more apparent.

Managers from the safeguarding service explained that, previously, there had been regular multi agency information sharing meetings where a small number of complex

or higher risk concerns could be discussed informally. Discussion at the learning event suggested that such meetings could have been helpful in relation to Adult P.

3.3 Is there more that could have been done in response to the concerns raised shortly before Adult P died; if so, what would have helped that to happen?

As was noted in section 2 of this report, significant concerns were raised by the Police and Ambulance Service during a visit about three weeks before Adult P died.

However there was no contact with Adult P or action taken to reduce immediate risks during the 22 days between then and Adult P's death.

From the perspective of Adult Social Care, the key action needed to reduce risk was to get the planned package of care visits up and running as soon as possible. Beyond this, the concerns raised were viewed as being mainly health related, with the assumption that the situation would be followed up by Adult P's GP Practice.

There doesn't appear to have been anyone within Adult Social Care whose role would have been to check in on Adult P while they were waiting for their new service, or to have checked that the situation had indeed been followed up by Adult P's GP Practice.

Adult P's GP practice has identified that, having received the Ambulance Service's report, the question of whether Adult P had capacity to decide whether or not to go to hospital could potentially have been explored in more detail by the practice.

The practice has also identified learning points around how it reacts when patients don't respond to letters or phone calls; recognising that it may need to look at other options in future; for example, going out to knock on a patient's door, rather than just sending more letters or not pursuing the matter further.

3.4 Supporting people with self-neglect

At the learning event, I shared some recommendations from different sources about how best to support people who self-neglect. For example:

- Understand it may take time to develop rapport and trust.
- Understanding a person's journey can help them, and you, identify, how they can be best supported.
- Promote consistency where possible - time limited work and short-term interventions are proven not to work.
- Where possible, identify a professional(s) who will take the lead.

- Refusal of support - this may be for many different reasons, but if there are concerns, it is important not to walk away.
- Sustaining engagement is fundamental.

The good practice recommendations listed above did not appear to be new to those who attended the learning event. However:

- There doesn't appear to have been anyone who had known Adult P over a longer period or who engaged with Adult P beyond the end of their particular episodic engagement. The time needed to build a relationship was not present.
- There was extensive liaison between teams and agencies, but at no point did they all get together to compare notes. There was no shared understanding of why Adult P may have been reluctant to accept support. Different individuals offered different suggestions as to why this might have been the case.
- Agencies continued to seek to make contact with Adult P using their usual process via phone, text and letter, despite the fact that often this was not successful. Given the number of agencies and appointments, at times Adult P must have been receiving a large number of contacts of different kinds, mainly from people they did not know. It seems reasonable to suggest that many of us could feel a little overwhelmed in that situation.
- When Adult P declined support, referrals were closed, rather than checking back in with Adult P at a later date.
- There wasn't a lead professional or key worker who could have helped make things more manageable for both Adult P and the agencies involved.

The learning event reflected on the apparent gaps between recognised good practice and how, looking holistically rather than at individual practice, Adult P was supported.

Services are often designed and geared up to provide discreet, time limited interventions, rather than longer term support. Discussion at the learning event suggested that this does not appear to have made it easy for services or individual practitioners to support Adult P in accordance with established good practice, particularly given that resources are limited.

3.5 The perspective of Adult P's family carer

I asked Adult P's family carer about Adult P's engagement with health and care services and they mentioned several issues. They told me that, having had children in care, Adult P was cautious about contact with professionals, and that Adult P had concerns about being charged for care services that they could not afford. Adult P

wasn't sure what they were entitled to, what could be provided or what charges there would be.

Adult P's family carer also told me that there were times Adult P could not get to an appointment, due to their mobility problems, but that home visits were not offered instead.

They also commented that, given Adult P's significant mobility issues, people often did not leave their phone ringing long enough for Adult P to get to their phone and answer it.

In addition, callers often hid their identity when making a call, so that Adult P did not know who was calling. It seems reasonable to suggest that many of us would be more likely to answer a call from a known person or organisation.

I asked Adult P's family carer if it might have been helpful if there had been one person who had got to know Adult P over a longer period of time. They told me that it would have been beneficial if there had been one or two particular members of staff Adult P could have got to know. As it was, Adult P felt that they were being "passed from pillar to post." Adult P's family carer said that they themselves tried to do as much as they could because Adult P was not getting the help they needed.

3.6 Fire risks

From the records I have seen it seems reasonable to suggest that fire risks were visible to a number of the agencies.

At the learning event, the representative of the Fire Service confirmed that there was a very high risk level. Risk factors discussed included Adult P:

- Being a heavy smoker and being observed not to dispose of cigarette ends safely.
- Having limited mobility and poor general health.
- Sleeping on the sofa rather than in bed.
- Using emollient creams. (These creams can be highly flammable if they dry on bedding or clothing.)
- Being prescribed medication that can make users drowsy.

A key issue was that the agencies were operating on the assumption that a referral to the Fire Service for a Safe and Well Visit could not be made if the person did not consent. When Adult P declined, this was seen as being the end of the process, rather than being followed up in future. However, increasingly it is recognised that

there may be grounds to make a referral without consent. I understand that this has already led to a change of practice in Newcastle.

Other actions and changes already made locally were noted as follows:

- Practice has been reviewed by a focus group and advice taken from the Fire Service.
- Additional training has been arranged.
- A 7-minute briefing on Preventing Fire Deaths has been circulated.
- The multiagency form for raising adult safeguarding concerns now asks about fire risks.
- It is proposed that the format for care needs assessment should also ask about fire risks.

The learning event also identified several additional areas where more could be done. These included:

- The need for greater professional curiosity around fire risks from all agencies and staff, so that everyone shares the responsibility for the ongoing identification of risks.
- Additional training and awareness for staff from all the agencies.
- Looking at how information systems could be used to flag individuals at higher fire risk due to prescribed medications or other factors.
- Ensuring there is clarity about when and how a referral for a Safe and Well visit should be made.

3.7 The role of housing staff

The only records of contact between Adult P and staff from Housing Services relate to a routine gas safety check and to unsuccessful attempts by Housing Services to contact Adult P to discuss Adult P's rent. Housing Services were not aware of the ongoing concerns about either self-neglect or fire risks.

At the learning event, the representative of Housing and Communities spoke about the way in which housing staff can support vulnerable tenants. They may be able to maintain a longer-term relationship than is often possible in other roles, and can give practical support and encouragement around issues such as a property condition.

It seems reasonable to suggest that it could have been helpful for Adult P's situation to have been shared with Housing Services, and for housing staff to have been part of any discussions between the agencies as to how best to support Adult P.

4 Summary recommendations

While Adult P's death was a tragic accident, there is learning that should be drawn from this review of how Adult P was supported by agencies over the last two years of their life.

My recommendations, in summary, are that Newcastle Safeguarding Adults Board should:

- 4.1 Facilitate a top-level discussion about self-neglect. The discussion should be completed within six months and should consider (i) any current structural or systemic barriers to recognised good practice; and (ii) whether it would be possible to make changes to the ways in which services are organised so that self-neglect good practice flowed naturally from their day to day operation.
- 4.2 Ask relevant agencies to consider whether any actions to support self-neglect good practice can be taken forward within current arrangements; for example, considering the comments from Adult P's family carer about how professionals sought to contact Adult P. Practical steps could include:
 - A greater emphasis on in-person visits, with guidance if needed as to when an in-person visit would be appropriate.
 - Further exploration of new systems, for example the system which, shortly before a phone call is made, would send a text to say who would be calling.
 - Staff training or guidance around the use of withheld numbers and the need for a call to be allowed to ring for longer.
- 4.3 Ask relevant agencies to work together to develop a comprehensive plan to further reduce the risk of fire to adults with care and support needs.
- 4.4 Ask all relevant agencies to provide urgent assurance as to how they are working as an agency in relation to identifying and mitigating fire risks. This assurance should include actions related to staff training and awareness and the need for each agency to have a process to make direct referrals to the Fire Service for Safe and Well visits.
- 4.5 Reflect on the fact that none of the agencies appear to have had a full understanding of Adult P's family situation, and consider whether there is the need for awareness raising, training or guidance in this area.
- 4.6 Ask relevant agencies to reinstate and commit to attendance at regular meetings to share information about a small number of complex or high-risk safeguarding situations as part of the Multi-Agency Safeguarding Hub (MASH)

arrangements; with each discussion including a check that an agency has checked in on the adult since the concern was raised and that they will continue to do so.

- 4.7 Ask agencies whether it would be possible to create a system that routinely gave those considering safeguarding adults referrals a fuller overall picture of the kind offered by the timeline discussed at the learning event.
- 4.8 Ask the ICB to consider how the learning points identified by Adult P's GP practice can be shared with GPs and other general practice professionals.
- 4.9 Consider whether there is the need for further work to link staff from the City Council's Housing Services and other social landlords in to the overall multi-agency effort in support of vulnerable tenants.

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