This is a Rapid Time methodology review of serious harm concerning Bernard. The focus of this review is to highlight the key systems findings that have been identified through the review of events surrounding Bernard.

Safeguarding Adult Review Bernard

Rapid Time Methodology

Swindon Safeguarding Partnership

Introduction:

This SAR was commissioned by the Swindon Safeguarding Partnership (SSP), which fulfils the statutory functions of a Safeguarding Adults Board (SAB). The decision was taken to undertake a discretionary SAR under s44(4) of the Care Act 2014, on the basis that the case offered important opportunities for learning around how transitional planning was approached, alongside the Mental Capacity Act 2005 (MCA), in relation to Bernard who was at risk of, and experienced, self-neglect.

The SAR was conducted using the Safeguarding Adults Review in Rapid Time (SARiRT) methodology. This approach was selected as it enables learning to be identified and disseminated at pace, whilst maintaining a robust systems-based analysis. The focus is on social and organisational factors that will make harder or easier to help someone facing self-neglect, like Bernard, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning, the detailed case-specific analysis is not included within this systems findings report. Similarly, a full overview of the methodology and review process is available separately. Instead, each systems finding is presented in turn, followed by a short set of reflective questions to support the Swindon Safeguarding Partnership (SSP) and partner agencies in considering how learning can be translated into practical improvement.

Brief Overview of Bernard:

Bernard is a man in his 60s with a long-standing history of paranoid schizophrenia spanning over two decades, during which he has required inpatient treatment under the Mental Health Act and received Section 117 aftercare. Prior to his step down, Bernard also had a range of complex physical health issues, including coeliac disease, a history of deep vein thrombosis, and periods of double incontinence. Bernard had also experienced significant weight loss, leading to a change in treatment from depot antipsychotic injections to oral medication.

Prior to his move, Bernard had been living in supported accommodation for adults with mental health needs. His previous supported accommodation was staffed 24/7. Bernard would receive support with medical appointments and day to day living. This included welfare checks throughout the day and support with prompting to eat regularly. A short-term support plan was also put in place prior to his move, as Bernard's needs were increasing beyond what the provider was able to meet. This included two 30-minute care calls each day, focused on prompting and supporting him with personal care, maintaining his living environment, changing clothes, toileting, and meal preparation.

By early 2024, however, his needs had increased beyond what the service could safely provide, particularly in relation to managing incontinence. A needs assessment in June 2024 confirmed that symptoms associated with his schizophrenia were affecting his motivation, energy, and self-awareness, limiting his ability to manage daily living tasks independently. It was concluded that Bernard required regular prompting with personal hygiene, nutrition, maintaining his living environment, and medication management, without which he was at risk of self-neglect, deteriorating health, and hospital admission. It was concluded that his needs could be met in a more independent setting with a 'minimal support package' of four 30-minute care visits per week, in line with his wish for greater independence.

Bernard's move was delayed after multiple unexplained collapses and hospital admissions. During this period, his support provider raised increasing concerns about his escalating needs, and their capacity to manage his needs safely.

Bernard moved in December 2024 to a flat in sheltered housing accommodation. The package of formal care provided to Bernard was based on what had been agreed in the plan from June 2024 – four 30-minute care visits per week. The support focused upon prompting Bernard with daily living tasks, including personal care, medication, and nutrition. They also provided assistance with some tidying and laundry support.

A service review in January 2025 initially identified no concerns, but within weeks the care agency raised safeguarding issues relating to self-neglect, including poor nutrition, hygiene, and medication management, prompting a further review. Despite these interventions, concerns persisted, alongside instances of declining care and refusing GP involvement.

On 28 March 2025, Bernard collapsed in public and was admitted to hospital with significant physical health concerns, including acute kidney injury, infection, urinary retention, a femur fracture, and the need for a long-term catheter. During his admission, professionals raised concerns that his existing care package was no longer sufficient given his deteriorating health and increased risks of self-neglect, prompting requests for an urgent reassessment of his needs and mental capacity before discharge, alongside consideration of enhanced support on return home. However, this could not be completed before Bernard's self-discharge from hospital on 10 April 2025.

Following his self-discharge, concerns were raised about Bernard's safety, including poor nutrition, pain management, and his ability to manage a newly inserted long-term catheter; although a mental capacity assessment was reportedly completed at the time, it was not formally recorded. While referred to community nursing for catheter support, Bernard struggled to manage this independently, with multiple incidents including suspected infection, poor drainage, self-removal of the catheter causing injury, and refusal of further treatment or assessment.

During this period, Bernard increasingly disengaged from services, cancelling care visits, declining support, and demonstrating unsafe medication practices, leading to a safeguarding referral that was not progressed. A MDT meeting was eventually conducted in May 2025, although without the inclusion of the community nursing team. This identified serious concerns about his mental capacity and ability to manage his needs, resulting in a temporary increase in care provision (one visit of 30-minutes daily) and agreement for reassessment; however, his physical health continued to deteriorate rapidly, with significant weight loss indicating severe malnutrition.

On 22 May 2025, Bernard was admitted to hospital with acute kidney injury, severe dehydration, infection, anaemia, and ongoing delusions, prompting an urgent DoLS authorisation and safeguarding referral. Bernard absconded while still requiring treatment. By this time, the initial urgent DoLS authorisation had lapsed after seven days and had not been extended at that time. The police were contacted to assist with locating Bernard, but they did not attend under the Right Care, Right Person policy. Bernard was later found at home by the mental health recovery team and persuaded to return to hospital.

During his hospital admission, concerns were raised that Bernard's self-neglect was linked to his mental health, with referral to the mental health liaison team. It was reported that he was experiencing distressing auditory hallucinations. He expressed both doubts about coping at home and resistance to further care; he was subsequently assessed as lacking capacity with respect to care and support needs, and it was agreed in his best interests to increase support

to two daily care visits, with discharge on 13 June 2025. A referral was also made to the community nursing team by the hospital, noting self-neglect as a key concern but capacity was not assessed for catheter care.

Following his second discharge, Bernard consistently reported persistent and distressing auditory hallucinations that disrupted his sleep. His presentation raised ongoing concerns about self-neglect, including poor hygiene, an unkempt living environment, inconsistent medication adherence, and avoidance of care visits.

At the same time, Bernard's physical health needs deteriorated. A referral was made due to concerns about ongoing weight loss. A joint home visit involving social work and community dietetics services found Bernard minimally communicative, responding mainly with brief or closed answers; concerns about inadequate nutritional intake were explained, alongside advice on maintaining a gluten-free diet and increasing calorie consumption. While options such as oral nutritional supplements were discussed, Bernard declined supplements and some interventions but accepted general dietary advice. Guidance was provided on the risks of non-adherence to a gluten-free diet in coeliac disease, though subsequent follow-up attempts achieved limited engagement.

Community nursing continued to provide catheter care to Bernard through both planned and urgent contacts, with multiple reports of catheter-related issues including leaking bags, bypassing, and concerns raised by carers. Clinicians at times noted poor hygiene and compromised skin integrity, including soreness and a strong smell of urine. Bernard's engagement was inconsistent, sometimes accepting interventions such as catheter changes and equipment provision, but at other times declining support, including refusal of a home visit.

In early September, ambulance services attended on a couple of occasions due to concerns including diarrhoea, abdominal pain, vomiting, low mood and suicidal ideation. He refused to go to hospital on the first occasion and denied entry for assessment on the second. On 11th September 2025, Bernard was taken to hospital due to severe infection, acute and rare medical emergency, requiring surgery. Bernard underwent multiple procedures and a prolonged inpatient stay during which his condition briefly deteriorated to the point of being placed on a palliative care pathway, before stabilising and gradually improving. He remained subject to DoLS and ongoing multi-agency planning due to fluctuating capacity, complex physical health needs, and risks associated with self-neglect. In November 2025, Bernard was discharged to a nursing home, where he continued to require support with wound care, catheter management, nutrition, and personal care, although he remained ambivalent about accepting assistance and expressed a strong desire to return to independent living.

During his placement, capacity assessments and best interest decisions concluded he lacked capacity regarding accommodation and care needs, and plans were made for longer-term nursing care while continuing to review his independence. He required further hospital treatment in December 2025, with ongoing risks identified around engagement, insight, and self-management, but remained in nursing care with continued multi-agency oversight.

Bernard's Voice and Engagement with the Review

In line with the principles of SARs, it was important to seek to involve Bernard in a way which enabled his lived experience and views to inform the review, while also respecting his wishes, autonomy, and what felt manageable to him.

Bernard was provided with information about the SAR and understood that the review would proceed irrespective of whether he chose to participate. He was clear at an earlier stage that he

did not feel the review was necessary and did not wish to be actively involved in the process at that time. This position was respected, noting that there is no requirement to compel participation and that his involvement should remain proportionate to what he considered appropriate.

Consistent with this approach, a form of involvement with Bernard was identified that he felt comfortable with. This included reviewing and commenting on the draft report with the support of his Independent Mental Capacity Advocate. This was considered an appropriate and proportionate means of enabling his voice to inform the SAR.

Bernard's responses to the draft findings provide insight into how he understands his experiences and the events considered within the SAR.

A consistent theme in his feedback was a clear distinction between past events and his present situation. He expressed the view that the report focused on historical experiences which no longer reflected who he is now, stating that it was "going over what has happened in the past" and emphasising that he was "different then" and "better now". Bernard did not necessarily attribute his deterioration or his subsequent improvement to insufficient support at the time. He referred to being "supported enough" and that people were "doing their best".

Bernard placed a significant emphasis on his preference to be left alone and to keep to himself. He recognised that in his previous supported accommodation it was "non-stop-do this, do that". In contrast, the move to sheltered accommodation offered an opportunity to be independent. He noted that he did not see the "point of people coming in asking if [he'd] eaten or washed". Bernard rejected the notion of self-neglect. However, this is consistent with the recognition that Bernard can lack insight or awareness into his needs.

Whilst Bernard emphasised the importance of independence, he did recognise that the placement itself had not been suitable, describing it as "never right for me" and stating that he could "never go back there". He also reflected more broadly on the perceived reduction in availability of specialist accommodation for people with mental health needs, suggesting that he might have benefited form an alternative arrangement.

Terms of Reference:

The SSP agreed that the SAR should focus on identifying learning for agencies in relation to transitional planning when individuals move into step-down accommodation, particularly where there are concerns regarding self-neglect and mental capacity. The review seeks to explore how effectively systems respond to complexity and risk during such transitions. The specific lines of enquiry are:

- How does the system support step-up and step-down care provision through transitional planning that is robust and ensures an MDT approach, including consideration of risk assessment, advocacy and lead professionals?
- How is the MCA 2005 understood by agencies, when there are changes in presenting need, particularly when there is a noticeable deterioration?
- How are agencies understanding and responding to health needs, when there is evidence they are deteriorating, including management of nutrition and catheter care needs?

The review period was initially set as April 2025 to December 2025, based on information indicating that key events, including the move to step-down accommodation, had taken place in June 2025. However, it was subsequently established that these events occurred in December 2024. In light of this, the review period was extended to cover February 2024 to December 2025, ensuring that the relevant circumstances and issues identified within the Terms of Reference could be effectively examined.

Findings:

Finding 1: Existing service models do not adequately support individuals whose severe mental illness and complex physical health needs were closely interconnected.

System findings:

Bernard's circumstances highlight the challenges that can arise when an individual's chronic mental illness are intertwined with complex physical health and care needs. The review identified evidence that existing service models were not well configured to respond to needs that cut across traditional mental health, physical health and social care boundaries.

Prior to his move, Bernard was living in specialist supported accommodation for adults with mental health needs. Although concerns had emerged regarding increasing physical health needs, particularly continence management and personal care, the placement provided specialist mental health support, established therapeutic relationships and staff with detailed knowledge of Bernard's presentation, risks, behaviours and long-term support needs. The provider ultimately concluded that his growing physical health needs could no longer be safely managed within the service.

As a result, Bernard moved to a more independent setting with a package of care focused primarily on prompting and practical assistance with activities of daily living. Whilst this arrangement was intended to better meet his physical care needs and support his wish for greater independence, it also resulted in the loss of a specialist mental health environment. The support available following the move was not designed to provide the same level of therapeutic engagement, mental health monitoring or specialist understanding of the impact of chronic psychotic illness on day-to-day functioning.

This was particularly significant given Bernard's longstanding presentation. Bernard was consistently described as guarded and often reluctant to discuss his mental health symptoms or engage fully with professionals. There was evidence that he would minimise difficulties, provide limited information and, at times, avoid conversations about his health and wellbeing. However, there was also evidence that meaningful engagement could be achieved through the development of trusted and enduring therapeutic relationships. Staff who had supported Bernard over time were familiar with his presentation and more able to elicit information about his needs and experiences. The move therefore resulted not only in a change of accommodation, but also the loss of the established relationships that had enabled professionals to engage Bernard.

An integrated approach was especially important because Bernard's mental and physical health needs could not easily be separated; deterioration in one domain had the potential to adversely affect the other. His initial needs assessment in June 2024 clearly identified that during periods of mental health deterioration, Bernard experienced reduced motivation, low mood, and diminished self-awareness, which significantly impaired his ability to initiate and sustain essential daily living tasks. Without supervision and prompting, this placed Bernard at risk of self-neglect and deteriorating physical health, which could in turn further adversely affect his mental health and increase the likelihood of hospital readmission. This

cyclical pattern was recognised across most areas of need, including nutrition, personal hygiene, toileting, and maintaining a habitable home environment.

The interaction between mental and physical health was particularly evident in relation to medication and treatment. Bernard was no longer able to receive depot antipsychotic medication because of significant loss of muscle mass associated with poor nutritional intake. At the same time, there were concerns regarding his adherence to prescribed antipsychotic medication, with evidence that he was instead relying on over-the-counter sleep remedies. This occurred against a background of reports that distressing auditory hallucinations were disrupting his sleep. In this context, mental health symptoms were contributing to physical deterioration, while physical deterioration was limiting treatment options that may have supported his mental health. Taken together, these factors illustrate how Bernard's mental and physical health difficulties were part of an interconnected pattern of risk, rather than separate areas of concern.

There were also indicators within contemporaneous professional records that Bernard's presentation and behaviours were being influenced by his mental health. For example, in relation to malnutrition, it was recorded by a safeguarding manager that Bernard's "not eating [was] being driven by voices", demonstrating a potential link between his mental health symptoms and his physical deterioration. Bernard, however, disputed this account during his feedback on the draft report. Nonetheless, the fact it was reported at the time highlighted the need for more in-depth exploration of the relationship between reported symptoms, behaviour, and physical health outcomes. This is evident from other reports, including Bernard describing avoiding going to the shops due to fear associated with distressing auditory hallucinations, further suggesting his mental health condition may have been shaping his ability to meet basic needs.

Despite these indicators, there were occasions when his presentation was understood predominantly as a physical health or social care issue, which risked obscuring the contribution of mental illness to the difficulties being observed. The review found a tension between service perspectives. For example, one agency reported a 'noted decline in Bernard's physical and mental health, the two being intertwined'. However, the agency responsible for providing ongoing mental health support in the community had considered discharging Bernard from their service on the basis that his mental health was stable, and his needs were primarily physical and related to care and support. This appears to have contributed to a situation where responsibility for understanding and managing the interaction between his physical deterioration and mental health became less clear.

There is evidence that concerns were repeatedly raised that existing support arrangements were not meeting Bernard's needs. However, despite ongoing deterioration in both his physical and mental health, the fundamental model of care remained largely unchanged. The primary response was to increase the frequency of prompting support, despite this model continuing to rely upon Bernard engaging with services, being present for visits, accepting support and acting upon prompts. This raises questions about whether sufficient consideration was given to whether a different model of care was required; one capable of providing both the intensity of specialist mental health support that Bernard had previously benefited from, alongside the enhanced personal care support required by his increasingly complex needs. However, the review also highlights a broader systemic challenge, namely whether such integrated models of care were available within local service provision, or whether professionals were required to work within service arrangements that separated mental health and physical care needs in ways that made it difficult to respond effectively to individuals whose needs spanned both domains.

Questions for SSP:

1. SSP should consider how the Local Authority, Integrated Care Board, mental health providers, acute and community health services, housing providers and wider system partners can strengthen collaborative commissioning and service design to develop integrated models of support for adults with complex intersecting needs. This includes considering models involving in-reach physical healthcare support within specialist mental health accommodation.

Finding 2: **Transitional care planning did not sufficiently provide for a gradual step down, flexible support for fluctuating needs, or contingency arrangements for proactive risk management.**

Step-down planning should be approached as a gradual process in which support is reduced only as risks stabilise and the person is shown to be managing safely in the new setting. Where needs are known to fluctuate, the care plan should also allow support to increase quickly during periods of deterioration, rather than depending on a fresh review after concerns have escalated. This should be underpinned by clear contingency planning, so that identified foreseeable risks may trigger timely escalation and coordinated multi-agency action.

System findings:

Bernard's move was precipitated by concerns that his physical health and care needs had increased beyond what his mental health supported accommodation provider was able to safely meet. This escalation in need was explicitly recognised within the assessment conducted in June 2024. However, despite the assessment identifying increasing complexity, it is not clear that these concerns were fully reflected in the support plan that accompanied the move. This raises questions about whether the envisaged level, intensity and flexibility of support provided were proportionate to the risks that had been identified.

As outlined in Finding 1, the June 2024 assessment recognised that Bernard's mental health and physical health were closely interconnected and that deterioration in one area had the potential to adversely affect the others. The assessment also identified a foreseeable risk of self-neglect and hospital admission without ongoing supervision and prompting. It also recognised that Bernard's needs were liable to fluctuate, particularly during periods of mental health deterioration when his ability to initiate and sustain essential daily living tasks reduced.

Against this backdrop, there was a clear need for any step-down arrangement to be carefully managed and responsive to changing levels of need. The assessment itself appeared to acknowledge this when it recorded that it had been "agreed" that Bernard would benefit from "30-minute care calls four times a day" for "a couple of months after moving to ensure [he] settle[d] in safely". This suggests an intention for a period of enhanced transitional support, enabling close monitoring of risk and adjustment of support as required, with greater independence introduced only once it had been demonstrated that the arrangement was both safe and sustainable.

However, the same assessment contained a material inconsistency. Despite recording that Bernard would benefit from a higher level of transitional support, it also concluded that his needs could be met through a "minimal package of care" consisting of "four weekly 30-minute calls", in line with his "desired outcome of independence". This represented a substantially lower level of provision and was difficult to reconcile with the recognition that Bernard's needs were increasing rather than reducing. The proposed package was also significantly less intensive than the level of support Bernard had received towards the end

of his time within supported accommodation, which was twice daily. The assessment did not provide a clear rationale explaining how four weekly care calls would safely address the risks that had been identified, nor how the frequency, duration and timing of those calls would adequately respond to Bernard's pattern of need.

It was suggested during learning events that this discrepancy arose from an error, with four weekly calls representing the intended plan. However, the presence of two materially different levels of provision nonetheless raises questions about the robustness of quality assurance and sign-off arrangements in the care planning process. Several systemic improvements and learning opportunities were discussed with safeguarding managers. They reflected on the importance of ensuring that, for adults with complex and intersecting needs, that responsibility for care planning is allocated to someone with substantial experience and necessary training. It was indicated that changes in allocation practices had been implemented.

Alongside a more gradual step-down, the care plan needed to take account of Bernard's fluctuating needs. The assessment accurately recognised that Bernard's need for prompting and supervision could increase during periods of mental health deterioration. However, this was not translated into a dynamic plan that provided flexibility in response to changes in presentation. Instead, the plan was based on a fixed minimal package of care, consisting of four calls per week.

It is important that care planning processes are aligned with the Care Act 2014 statutory guidance, which makes clear that care and support planning should make "comprehensive provision" for people with fluctuating needs and should not be "something determined only once the person reaches crisis point".[1] In Bernard's case, this could have included a personal budget that would have enabled the frequency or duration of care calls to be increased during periods where Bernard showed reduced motivation. This would have supported a more proactive response, rather than depending on a review only after risks had escalated, which, in this case, contributed to delay.

Linked to this, the statutory guidance also emphasises the importance of contingency planning. The transitional plan might therefore have specified what would happen if the identified risks around self-neglect, contained in the assessment, did arise. This might have included identifying escalation routes, relevant triggers or thresholds, Multi-Disciplinary Team (MDT) involvement, safeguarding referral, advocacy, mental capacity assessment (MCA) and consideration of whether the accommodation remained appropriate.

The discussion with managers identified that, in some cases, contingency planning for fluctuating needs, including the use of flexible support hours, was already part of care planning practice. However, it was acknowledged that this was not consistently applied. A clearer policy or practice expectation would help ensure that, where fluctuating need and foreseeable self-neglect risks are identified, care plans routinely include support.

Questions for SSP:

1. SSP should consider developing a clear practice expectation for step-down planning where adults have complex intersecting needs and are at foreseeable risk of self-neglect. This could make clear that transitional support should usually be reduced gradually, and only where there is evidence that risks have stabilised and the person is managing safely in the new setting.

[1] Department of Health, 'Care and Support Statutory Guidance' (10.44)

2. SSP should consider introducing a clear practice expectation that care plans for adults with fluctuating needs include flexible support arrangements. This could allow the frequency or duration of care calls to increase quickly during periods of deterioration, rather than relying on a further review only after risks have escalated.

3. SSP should make contingency planning a routine part of care planning where there is a clear recognised risk of deterioration and self-neglect.

4. SSP should consider strengthening quality assurance and sign-off arrangements for care plans. This should help ensure that inconsistencies in assessments and care plans are identified before implementation, and that the level, frequency and timing of support are clearly aligned with assessed needs.

Finding 3: Indicators of impaired decision-making, including possible executive dysfunction, were not acted upon promptly or consistently.

System findings:

Prior to his step-down, there were indicators in Bernard's care assessment of potential impaired capacity. In particular, it was recorded that symptoms associated with schizophrenia that Bernard was experiencing would impact on his motivation, mood, and self-awareness, meaning that he would be unable to initiate or sustain different daily living tasks. This was understood primarily as a practical care-need for prompting, but it might also have indicated issues around decision-making capacity. The Court of Protection has recently found that schizophrenia-related avolition could prevent a person from initiating and sustaining the goal-directed behaviours required for safe diabetes management, with prompting operating as a compensating factor relevant to the promotion of their best interests.[2] This is not to suggest that Bernard would necessarily have been found to lack capacity prior to step-down. Rather, the issues around Bernard's ability to initiate and sustain activities may have warranted closer consideration of whether his need for prompting reflected only a support need, or also an impairment in his ability to make and act on relevant decisions.

This is important because, in an assessment of care needs, a person may be able to give superficially coherent answers. They may, for example, appear to understand the importance of maintaining a strict diet, taking medication, or attending to personal care. However, the assessment should not be confined to what the person can say in response to questioning. It should also take account of what they are able to do in practice, and whether there is a significant gap between their stated understanding and their ability to use that information in the real world. Where such a gap exists, it may call for a deeper enquiry into whether the person can make decisions at the point when they have to be implemented, rather than merely in the abstract setting of a needs assessment.

Linked to this, it is also important to consider the appropriate response to potential fluctuations in capacity. As noted earlier, during particular periods, Bernard's mental health could deteriorate, leading to low mood, reduced motivation and impaired ability to initiate and sustain activities of daily living. In turn, the failure to perform those activities could have a further negative effect on his mental health. This is especially the case in relation to taking medications, although it was also a recognised risk across other domains. In such

[2] *SJ v Cardiff & Vale University Health Board & Anor* [2025] EWCOP 54 (T2)

circumstances, capacity may need to be considered longitudinally.[3] The issue is not only whether the person appears able to make a decision at a particular point in time, but whether they are able to make and act on the relevant decisions across the period in which those decisions need to be implemented.

Following the step-down, it was reported on 5th March 2025 that social care had agreed to conduct a capacity assessment, due to concerns around self-neglect. However, no assessment for care and support needs was formally recorded until 11th June 2025, which took place during Bernard's second hospital admission. It was recorded that a mental capacity assessment had been planned at an earlier point, but this was not carried out as, when Bernard was visited, he had accepted some support, appeared well-dressed, although there were some issues with soiled bedding. As a result, it was felt that the presentation was health-related, rather than linked to mental capacity concerns, and so an assessment was not conducted.

This approach further highlights the importance of a longitudinal assessment where capacity may fluctuate. Intermittent engagement or appearing superficially well at a particular point in time, may obscure ongoing concerns about a person's ability to make and act on decisions about their care consistently over time. Rather than relying on a single presentation, practice should place greater weight on patterns of behaviour, particularly where there is evidence of fluctuating need, repeated disengagement, self-neglect, and difficulty translating decisions into action.

In relation to timescales for assessments, it was recognised during the learning events that assessments should be conducted "as soon as practically possible". The timing would depend on factors such as urgency, the person's circumstances, their ability to engage, workforce capacity and competing pressures. However, there appeared to be less clarity about what would count as "urgent" in the context of self-neglect. It was reported that this would usually be determined through discussion between the social worker and their supervisor or manager.

While professional judgement is important, this creates a risk of delay and variation in practice, particularly where risks escalate gradually rather than through a single acute incident. Self-neglect may therefore require clearer direction around what counts as urgent. Managers reported that quality assurance processes have since been strengthened to ensure that identified assessments are completed and recorded more promptly, providing greater oversight and reducing the risk of similar delays in future.

Prior to, and following the assessment, there were a number of occasions on which professionals engaging with Bernard did not consider whether he lacked capacity with respect to particular decisions in the moment. For example, there were occasions where he refused on visits to consent to a referral to a GP or Recovery Doctor or was declining visits. However, there were indicators of lack of capacity at these times, which might have prompted consideration of whether Bernard was able to make a decision.

Where there is a reasonable doubt as to a person's capacity to make a specific decision, professionals are required to actively assess capacity at the material time. As to what constitutes such doubt, the learning events indicated that clearer direction in guidance may be helpful. In relation to the SSP Multi Agency Policy and Guidance on Responding to Self-Neglect, for example, there is reference to 'reason to doubt this capacity'. However, the policy could more clearly articulate what factors or indicators should trigger such doubt.

[3] *Cheshire West And Chester Council v PWK* [2019] EWCOP 57; *Royal Borough of Greenwich v CDM* [2019] EWCOP 32; *Calderdale Metropolitan Borough Council v LS & Anor* [2025] EWCOP 10 (T3).

Questions for SSP:

1. SSP should update its training on capacity to recognise that, for adults with avolition linked to a cognitive impairment, prompting may not only be a support need but may also operate as evidence of potential incapacity. In particular, training should address when prompting may compensate for an inability to initiate or sustain the behaviours required to give effect to a decision.

2. The SSP should emphasise that capacity and risk in self-neglect cases should not be assessed solely on the basis of a single visit or presentation. Guidance and training should encourage practitioners to look at patterns over time. This is particularly important where mental health conditions impact practical decision-making.

3. The SSP should reinforce that professionals should actively consider whether there is reasonable doubt about capacity at that moment. This should apply across agencies, including social care, health professionals and emergency responders. Guidance and training should make clear the reasons to doubt capacity, which require an assessment.

Finding 4: Multi-agency coordination was predominantly reactive and did not consistently involve the right partners at the right time to anticipate and mitigate emerging risks.

Where an adult has intersecting mental health, physical health, social care, and housing needs, there should be clear criteria for convening an MDT meeting at an early stage. MDT arrangements should include all key agencies involved in care and support, agree a shared formulation of risk, clarify the lead professional or coordinating role, record contingency plans, and ensure that relevant information about capacity, safeguarding and deterioration is available to all involved in the adult's care.

System findings:

Bernard has a range of complex mental and physical health needs, which could interact and compounded one another (see Finding 1). Given the number of agencies involved in his care, particularly following the step-down to more independent living, with additional input from community nursing services for nutrition and catheter care, there was a clear need for a coordinated multidisciplinary approach to planning and managing his support.

The review identified evidence of positive practice, including bilateral communication and information-sharing between individual agencies in response to emerging concerns. However, this communication was largely reactive and episodic, rather than part of a structured, planned and ongoing multi-agency response. The agencies involved often responded to specific presenting issues within their own service remit, rather than working from a shared formulation of Bernard's needs.

Discussions with managers recognised that earlier and more frequent MDT meetings could have supported improved coordination, shared risk understanding and more effective

planning of care. The first recorded MDT discussion took place on 2nd May 2025, by which point concerns had already significantly escalated. However, not all key agencies involved in Bernard's care were included. In particular, community nursing services, who were responsible for important aspects of Bernard's physical health support, including catheter care, were not part of the discussion. This was a missed opportunity to share concerns about Bernard's capacity and ability to manage catheter care independently.

The impact of the lack of a coordinated approach was evident in the different understanding's agencies held about the level of care and support in place. For several weeks after Bernard's discharge following his first hospital admission, some agencies were working on the assumption that his care package had been increased to twice daily. In fact, it remained at four 30-minute calls per week and was not increased until later. There was similar uncertainty in the records available to the GP practice about whether Bernard was receiving two or four visits per day for support with prompting. It was recognised that clear and accurate information on these matters was essential to ensuring that medication in the dosette box was rationalised in line with the care calls.

Multi-agency working could also have been strengthened during the hospital admission, particularly in relation to ensuring that Bernard could safely manage his catheter care on discharge. Prior to Bernard's first hospital admission, it had been agreed on 5 March that SBC would undertake a mental capacity assessment. When mental health services visited Bernard at NHS Hospital Trust in April, they reiterated this request, specifically in relation to his support needs. This indicates that concerns about Bernard's capacity were already present within the wider network and had been identified before and during admission.

However, it was reported by the hospital team that these concerns were not communicated in a way that informed discharge planning. It reported that concerns had not been raised by social care or community mental health teams regarding Bernard's mental capacity, and that it had no reason itself to doubt a lack of capacity. This was significant because Bernard was being discharged with a catheter, and his ability to understand, manage and seek support with catheter care was directly relevant to whether discharge home was safe. This was particularly important because a hospital assessment can provide only a partial picture of capacity. Staff in hospital are usually assessing the person in the circumstances immediately before them: whether they appear to understand information at that time, can communicate a choice, and can engage with decisions about treatment or discharge in the clinical setting. However, that perspective may not capture how the person operates over time in the community, particularly where the concern relates to fluctuating mental health or reduced executive functioning.

A more coordinated MDT discharge process would therefore have strengthened capacity decision-making. It would have enabled the hospital team's immediate clinical assessment to be considered alongside community evidence about Bernard's functioning over time, including his ability to manage catheter care in practice. Without that shared understanding, support appears to have proceeded on an incomplete assessment of what Bernard could safely manage independently. Although his care plan was updated to recognise that he had a catheter in place and would benefit from prompts to empty his leg bag at regular intervals, there was also clear evidence that he was struggling with catheter management, including several reported problems. It is therefore notable that, when Bernard or others contacted community nursing services about catheter-related issues, he was advised that changing catheter bags was not their responsibility and that he would need to do this himself. Yet there is no indication that his ability or capacity to manage this aspect of his care independently was actually assessed.

Questions for SSP:

1. SSP should consider updating existing guidance on MDT meetings to more clearly specify at what point in the process they should be initiated and how frequently they should be convened.

2. SSP should consider how processes may be improved to ensure that MDT meetings include all key agencies involved in the adult's care.

3. SSP should consider how concerns about mental capacity, executive functioning and self-neglect can be more effectively shared across agencies, particularly where these concerns are relevant to safe discharge and post-discharge care.

Finding 5: When capacity was assessed, it was understood in a fragmented way, focusing on separate domains of "social care" and "physical health" when they were closely interlinked.

System findings:

Capacity was assessed in June 2025 in relation to care and support needs under the Care Act. However, it was not assessed in relation to catheter care or dietetic input. This distinction appears to have been made on the basis that these were the preserve of "physical health". As a result, as mentioned above (see Finding 4), the capacity of Bernard to manage his catheter independently was never assessed and it was assumed that, for example, he understood how to change bags and what the risks were around pulling out the catheter.

This risked creating an artificial separation between areas of decision-making that are, in practice, closely interconnected. As noted above (see Finding 4), more coordinated multi-disciplinary working would support better information-sharing and continuity of assessment. In particular, where there is clear overlap between different domains, capacity assessments should not be undertaken in isolation but rather considered in an integrated manner.

This is especially important given the clear practical overlap in this case. In the context of social care, the relevant question concerned Bernard's capacity in relation to managing continence and nutrition with appropriate prompting. In the context of physical health, the issue would have been whether he had capacity to manage catheter care and adhere to medical dietary guidance.

The issue of a need for capacity assessment in relation to organising and managing catheter care was raised but not acted upon. The social work team informed the GP that Bernard had been assessed to lack capacity around care and support and suggested that there was evidence that this extended to medication and catheter care and requested to GP for MCAs to be completed. However, this was not progressed.

Although the Mental Capacity Act requires capacity to be assessed on a decision-specific basis, it is nonetheless somewhat artificial to consider these decisions in isolation. Where a person lacks capacity to manage aspects of continence through prompted care, it is highly probable that they will lack capacity with the more complex and riskier task of catheter management.

A more integrated approach to capacity assessment would therefore better reflect the reality of how these needs overlap. In this case, the separation between care and support assessments and decision-making about physical health may have contributed to missed opportunities to explore the full extent of Bernard's decision-making capacity.

It was also identified that there were concerns regarding Bernard's ability to independently manage medical correspondence, attend appointments, and obtain or manage medication. Evidence indicates that Bernard frequently failed to engage with correspondence and repeatedly did not attend scheduled appointments. Despite these ongoing issues, there was no clear or consistent assessment of Bernard's capacity in relation to managing these aspects of his health nor a consideration of the level of support required to meet these needs.

Support was offered to enable Bernard to attend appointments when these were known; however, he often declined such assistance. Efforts were also made to arrange home visits as an alternative means of engagement. However, a more formal and coordinated approach to addressing these issues may have provided a more consistent and effective response to his ongoing challenges in engaging with healthcare.

During the learning events, it was suggested that joint capacity assessments and best interest decision-making would be particularly helpful in addressing these complexities. However, participants also identified barriers to undertaking such assessments, particularly in relation to responsibility for assessing capacity concerning physical health decisions. Concerns were raised regarding the practical challenges of engaging GPs in this process, including time constraints and uncertainty about the extent of their role within multi-agency capacity assessment and decision-making.

Questions for SSP:

1. SSP should develop multi-agency guidance making clear that, although capacity must be assessed on a decision-specific basis under the Mental Capacity Act 2005, assessments and best interest decision-making should not be undertaken in artificial isolation where the relevant matters are practically interconnected. The guidance should emphasise that where a person's ability to manage care and support needs overlaps with physical health needs, agencies should consider whether a coordinated or joint capacity assessment is required.

2. SSP should work with agencies to clarify who is responsible for, or should be involved in, assessing capacity and making best interest decisions in relation to physical health decisions. This should include clear expectations about when particular professions, such as GPs, should be expected to contribute.

3. SSP should develop clear guidance for cases where an adult repeatedly misses appointments, fails to respond to correspondence, does not obtain medication, or declines support to engage with healthcare. It should explore whether, for example, it might adapt existing guidance on missed appointments that have been formulated in response to SARs findings.[4]

Finding 6: Screening processes for safeguarding referrals did not sufficiently take account of cumulative risk and limited the potential for coordinated action.

System findings:

Bernard was the subject of repeated safeguarding referrals. However, these did not progress to a section 42 enquiry, as they were 'screened out'. The indication given, in the

[4] guidance-for-missed-appointments-of-adults-with-care-and-support-needs-accessing-health-and-social-care-services

learning events, was that when such referrals arrived, they may not be progressed if they were “being dealt with by [a]…care manager”.

It was also noted that, if a person was screened out, there would be no flag on the system. This had a potential bearing on addressing cumulative risk. Each referral or concern may not, when viewed in isolation, have appeared to require formal enquiry. However, taken together, they indicated a sustained pattern of serious self-neglect. Where repeated safeguarding concerns are screened out or closed without enquiry, there is a risk that professional attention remains focused on whether the latest incident meets the threshold, rather than on whether the overall pattern shows that existing arrangements are no longer sufficient.

The absence of progression to enquiry also reduced opportunities for a structured multi-agency safeguarding response. A safeguarding enquiry could have provided a framework for bringing agencies together, clarifying risks, reviewing the adequacy of the care package, considering mental capacity, exploring whether legal frameworks were needed, and agreeing contingency and escalation arrangements. Without that framework, responses were more likely to remain fragmented and reactive.

It was reported that there have been some welcome improvements to practice. These include ensuring that cases are examined by the safeguarding team before they are screened out. There is also now a mechanism on the system to record previous safeguarding referrals, which support a more longitudinal assessment of risk.

Building on these improvements, local arrangements may benefit from clearer guidance on when self-neglect referrals might progress to a section 42 safeguarding enquiry. Existing guidance recognises that self-neglect will not always require an enquiry and that decisions should be made on a case-by-case basis. While this reflects the statutory guidance, it would be helpful to clarify what criteria or threshold are being used in practice.

Questions for SSP:

1. SSP should review and update local safeguarding guidance to include clearer practice indicators for when self-neglect concerns should progress to a section 42 enquiry or equivalent coordinated safeguarding response.