Safeguarding Adult Review – Alice and Peter

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1. Introduction

This is an unusual Safeguarding Adult Review because it concerns two people. Their deaths were not obviously connected.

Alice and Peter were an engaged couple who died within days of each other, both at the home they were sharing at the time in Harrogate, both of natural causes. Both deaths were unexpected, albeit both had been unwell. They had lived together for some six months prior to their deaths.

The Coroner determined the causes of death as follows:
Alice died from Ischaemic Heart Disease, Coronary Atheroma and Left Ventricular Hypertrophy. She had also lived with diabetes and a urinary tract infection.

Peter's death was recorded by the Coroner as "natural", with no further details given.

Alice was aged 77 when she died and Peter 76.

Alice had contact with statutory agencies through her mental and physical ill-health and through eviction proceedings. Peter had very little contact with agencies and little is known about him.

Agencies do not hold details of the next of kin in relation to Peter and, without this, there is an imbalance to this review that cannot be rectified. This is in no way a reflection of Peter or a lack of acknowledgment that his life was as valuable as Alice's. It is simply that this review does not have the information, or the means to gain it.

Alice was born in 1945, she had a history of mental ill-health, hoarding and self-neglect. The self-neglect was of herself and her environment. Prior to her death she had been supported by Adult Social Care's safeguarding procedures, albeit there had been no contact for some three months before her death, and Alice herself had generally declined help.

Prior to her death Alice was considered to have Care and Support Needs. She had come to the attention of agencies due to the commencement of eviction proceedings in 2018. This was due to rent arrears, hoarding and a suspicion that she was not using the flat that she rented from the Guinness Partnership as her main home.

A multi-disciplinary approach had been taken to support Alice throughout the eviction proceedings, but in agreeing to the commissioning of this SAR it was thought that relevant information with regard to Alice's history was not shared and that agencies could have worked together to support her more effectively. Alice herself had declined a Care Act Assessment (file note 24/7/22) and without her consent it would not have been possible to undertake one, assuming that she had capacity to refuse. This is explored in more detail later.

She was said by agencies to be "*evasive*", for whatever reason she seems not to have wanted helping agencies in her life, unless their presence and support was absolutely necessary. The word "*evasive*" has negative connotations, it may be that Alice could be seen as independent, living her life as she chose to. From an agency point of view this might be termed "*hard to reach*".

An event was held to facilitate this review. It was attended by people who had worked with Alice over the years and some local managers. Those who had worked directly with her spoke fondly of her and had genuinely cared about her. They described a woman who was fiercely independent and would only accept help when she really needed it. She was bright, and unconventional. Whatever the weather, she was dressed in a thick coat, hat and boots.

2. Purpose of the Safeguarding Adults Review

The purpose of Safeguarding Adult Reviews are to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning.
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- To identify good practice and to promote this.

In this review there will be a strong focus on understanding issues that informed agency/professionals' actions and what, if anything, prevented them from being able to properly help and protect Alice and Peter from harm.

The agreed timeline of this review was decided by the commissioning SAR panel as January 2022 through to the deaths of both Alice and Peter at the end of January 2023. This covers the timeline leading up to the deaths of Alice and Peter and the period where agency interventions might have been considered. Some information from before January 2022 is provided to give context to the lives of Alice and Peter and the issues that they faced.

3. Independent Review and author

This is a statutory review, the criteria for a statutory review is met in respect of Alice. The commissioning panel felt that including Peter was important. The elements that include Peter are “discretionary” but the intention is that the review is read as a whole and as one review.

The Independent Reviewer/ Author of this Safeguarding Adults Review is a safeguarding consultant. He is a qualified Social Worker and has held a number of safeguarding roles including, the Independent Chair of the Walsall Safeguarding Children and Adults Board 2015 - 2018. The Reviewer has provided the safeguarding expertise into a review of safeguarding failures at the Royal National Institute for the Blind (publ. Charity Commission 2020) and is the Independent Safeguarding Chair for Dimensions UK. Apart from authorship of Safeguarding Adult Reviews and Domestic Homicide Reviews they have no connections with any agencies in North Yorkshire and does not reside in the area. The reviewer is therefore independent of all agencies and people involved in this Safeguarding Adults Review.

4. Methodology

It is important to note that North Yorkshire SAB wanted a swift process and, therefore, it was agreed to develop the final report using the information and chronologies supplied, rather than seeking more detailed Individual Management Reports (IMRs). Given that there is little information held by agencies on both parties it is unlikely that IMRs would have helped the review in any event.
The intention was that information and chronologies supplied were augmented by a meeting with practitioners in North Yorkshire in the summer of 2025.

It was decided that the SAR author would draft a report to be shared with the Core Group consisting of the following agencies who would comment on, and contribute to, the draft review:

- Tees, Esk and Wear Valleys NHS Foundation Trust (Mental Health Trust)
- Primary Care
- North Yorkshire Police
- Harrogate and District Foundation Trust
- North Yorkshire Council (Prior to April 2023 - North Yorkshire County Council)
- North Yorkshire Police
- Housing Options – Harrogate.

The key lines of enquiry for Alice and Peter respectively were agreed by the commissioning SAR panel and are set out below. Once the review author was appointed he was asked whether he agreed with these key lines of enquiry, or whether he wanted any changes. His view was that these were the correct lines of enquiry for this review.

An extended Core Group, including some of those who had known and worked with both Alice and Peter met with the SAR author on 24th June 2025.

A meeting was held with key partners of the North Yorkshire Safeguarding Adult Board in January 2026. They welcomed and fully accepted this review and its recommendations. In the meeting some of the structural and practice changes that have occurred since the deaths of Alice and Peter were shared with the author. It was thought that the agency responses might be different today and, where appropriate, this is referred to in the review. The recommendations will test out whether the changes referred to have been embedded.

Key Lines of Enquiry: Alice

- **Was risk accurately identified and were appropriate risk assessments in place?**
- **Were opportunities to raise safeguarding concerns or share information missed?**
- **Was the safeguarding process effective in safeguarding Alice?**
- **Was Alice involved in discussions about risk?**
- **How was self-neglect and hoarding viewed when considering Alice's mental capacity? And how was executive capacity considered in decision making?**
- **Did professionals consider Alice's life circumstances when attempting to effectively build a relationship and develop an understanding of Alice and how best to work with her? (for example, when she lived in residential rehabilitation in 2001)**
- **Was hospital DNA protocol used properly and would outcomes have been different if Alice had been identified as vulnerable?**

Key Lines of Enquiry: **Peter**

- **Was safeguarding considered for Peter when concerns for self-neglect were identified?**
- **Was capacity considered when Peter choosing to decline support / visits?**
- **Did agencies work effectively together to provide appropriate accommodation and support to Peter after his release from custody?**
- **Was a telephone assessment by Health and Adult Services appropriate for the level of concern received?**

5. Family contact

An important element of any SAR process is contact with family. Safeguarding Adult Reviews are about the story of the individuals involved, their personal circumstances and the events that happened in their lives. Alice's brother has supplied some information to this review with regard to her background.

As said earlier there is no family contact available for Peter and his personal story sadly cannot be included in this review. Agencies involved in this review also hold very little information about him. Nothing about his history has been supplied to this review.

6. The circumstances leading to this review.

On January 23rd 2023 Peter went to his local GP surgery in person to report that his partner, Alice had died the evening before and that her body was in the flat they shared.

The GP went to the flat and confirmed that Alice was deceased. Due to the circumstances of the sudden death the GP called the police. The scene in the flat was described by the police as "*extremely distressing, with severe hoarding and unsanitary conditions".* Alice's body was said to be in a poor condition. This doesn't mean that she had been dead for longer than Peter had said, the pathologist was apparently unclear. It does suggest that she had been very unwell and unable to care for herself for some time prior to her death.

The tenancy of the flat that the couple lived in was held by Peter. The nature of the material hoarded suggested that Alice was the "*hoarder*" and not Peter. It follows from this that Alice's hoarding behaviour continued from her own flat to Peter's when she moved in.

7. Background and personal Information

Alice

Alice was the youngest of three siblings, herself, her brother, and an older sister. She was born in 1945.

She had a lengthy history of mental ill-health, albeit there were some times where she seemed well, or at least was not in contact with agencies. The account of contact with mental health agencies is from Alice herself and was given to the psychiatrist who interviewed her in 2018. Alice described her first contact with mental health services was when she was around the age of 15 (1960) when she displayed symptoms of OCD (https://www.nhs.uk/mental-health/conditions/obsessive-compulsive-disorder-ocd/overview/), she described herself as washing her hands repeatedly and having a persistent fear of contamination. She said that she was admitted to a psychiatric unit where she remained for six months. There is then no known history of mental ill-health until 1996 when Alice was aged 51, when she developed/was treated for depression. It was said that this followed from a relationship breakdown and the loss of her employment in a betting shop. She was admitted to hospital for some six weeks before being discharged to supported accommodation where she remained for some years.

Alice's account to the psychiatrist is incomplete. The psychiatric report details diagnoses of depression, paranoid psychosis, psychotic illness and psychotic depression. It does, however, confirm that Alice had suffered no known major psychiatric illness since her discharge from psychiatric services in 2006.

Her brother described her as having had problems since she was at secondary school, he described her as being sometimes "*alright, sometimes very depressed*".

Something of a crisis occurred in Alice's life in 2013 when her mother died. Alice, her brother and sister had been named as executors and it was their role to clear and sell their mother's property and then to distribute the funds. Alice intended that funds received from her mother's estate should be used to clear the rent arrears that she had by then accumulated on her flat. She accepted that unless these were paid, that she was at risk of eviction.

She had a tenancy with Guinness Housing in Harrogate. Proceedings began in 2018 to begin to evict her due to the state of the home, her inability to manage it and hoarding. A Care Act Assessment was requested by her solicitor but, as said earlier, Alice declined to participate in this. She did, however, accept that she was a hoarder. A visit from an environmental health worker and a HARA (Harrogate and Rural Alliance) mental health worker in 2019 showed the extent of the hoarding. They were unable to enter the property as the hoarding reached to about four feet and was "*perilously stacked*". (file note September 2019). It was said that Alice could not enter her flat due to the hoarding, nor could she use the bathroom or kitchen. Hoarding can be a particular concern in a flat as others living closely can be impacted. Hoarding is associated with other risks including fire and rodents. Alice explained that she was living with a friend at this point.

This review was supplied with a series of psychiatric reports from 2018 through to 2021, all focused on whether or not Alice had the capacity to act as an executor. The reports refer to previous episodes of psychotic illness, though by 2018 there were no signs of this. The outcome with regard to MCA is set out in the relevant section below.

The psychiatrist believed that Alice had a "*constellation of symptoms*" that suggested that she had anankastic personality disorder (https://gpnotebook.com/en-GB/pages/neurology/anankastic-personality-disorder).

The traits of an Anankastic Personality Disorder are thought to be:

- A lack of adaptability to new situations
- Lack of imagination
- Failing to take advantage of opportunities,
- Inhibiting perfectionism making ordinary work a burden
- Guilty preoccupation with wrong doing
- No sense of humour
- Ill at ease when others are enjoying themselves
- Judgemental in their attitudes
- Often very mean
- Indecisive - a fear of making mistakes
- Very sensitive to criticism
- Little outward display of emotion
- Often have unexpressed feelings of anger and resentment

A specialist mental health nurse (report for safeguarding planning meeting 30/1//2020) described Alice as having, in her professional view, *"elements of hoarding behaviours, with avoidant personality traits, which makes working with Alice exceedingly hard"*. This review has seen no direct evidence that hoarding and an Anankastic Personality disorder are linked. The specialist mental health nurse went on to say that there is no known medication that might improve the conditions.

Alice continued to largely decline visits, this included throughout the "lockdown" period. Though she did agree to the flat being cleared and cleaned in July and September, respectively, in 2021.

Given that Alice had been assessed as lacking capacity regarding her finances and the sale of her mother's house a Court of Protection order was made in March 2022 to last for one year with the specific remit of:

- supporting her in her role of executor
- Assisting in the sale of the house
- Assisting in the clearing of her flat.

In July 2022 a safeguarding referral was made for self-neglect by Guinness Housing and this was considered at the GP initiated multi-disciplinary team. The outcome was that Alice had capacity and that no more could be done until the situation changed.

Peter

Peter was born in 1946 and died just a few days after Alice in January 2023. There is no identified next of kin, so no one has been identified to supply information to this review.

Agencies hold very limited information in respect of Peter and it has proved difficult to provide any meaningful "*picture*" of him in this review.

In 2017 the police had made a safeguarding referral in respect of Peter who, at the time, was said to be suicidal. Peter, himself, reported to the police at the time that he had a "*learning difficulty*". This is not supported by any agency records or subsequent diagnosis and cannot be substantiated.

The only other relevant report is from the GP records where it was noted on three occasions in 2022 that Peter was "*slightly unkempt*" and that he may not be looking after himself well. He was asked about this and declined support. This may have reached a threshold for self-neglect but was not followed through. The GP surgery have since discussed their awareness of self-neglect.

8. Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the review.

9. Multi-agency meetings/communication

In 2018 Alice was faced with the prospect of eviction from her home, the housing provider, The Guinness Partnership, having initiated court proceedings. This was, it was said at the time, due to the state of her home (hoarding), rent arrears and an inability to manage independently. She had had the tenancy of the flat since 2005, but had not always resided there. Alice's mother had died in late 2013 and it was said that Alice was living, at least partially, in her mother's house pending its sale. That she was not living full-time in her flat provided a potential further reason for her eviction.

A psychiatric report was requested by Alice's solicitors in 2018 in relation to the eviction proceedings to assess, amongst other things, Alice's mental capacity to conduct proceedings, her mental capacity in relation to other matters, a diagnosis and prognosis and whether she had a disability as defined by the Equality Act.

In discussion with the psychiatrist, Alice accepted that she hoarded things. She also accepted that she was "*very anxious*" and she attributed this to her situation of potential eviction. She said that she was able to manage her personal care.

The view of the psychiatrist at the time was that Alice lived with paranoid psychosis, although there was little evidence of acute symptoms at the time of interview. She was also thought to have a depressive illness. The paranoid psychosis and depression were, the psychiatrist said, disabilities as defined by the 2010 Equality Act**.** The report went on to say that there were concerns about Alice's ability to live independently and a "full social needs assessment" (a Care Act Assessment), (https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs) was recommended. Adult Social Care offered this to Alice, but she declined it.

The psychiatrist concluded that Alice did not have capacity to conduct the legal proceedings. The psychiatrist thought that she might benefit from a *"multi-disciplinary biopsychosocial approach*", this would have included psychiatric assessment and monitoring, social work input and occupational therapy. It was thought that pharmacological input would have little benefit and that Alice's problems were longstanding. He did comment that Alice was vulnerable and that if she were to be evicted and become street-homeless, her vulnerability would increase.

Alice would either have had to agree to multidisciplinary intervention, or have reached a threshold for intervention via mental health legislation. Without her agreement and without reaching a threshold for intervention, there was no locus for involvement. Whilst there is no record to suggest that Alice was asked directly whether she would have agreed to intervention as suggested by the psychiatrist, it is likely that she would have refused, but in any event her ill-health did not reach a threshold for statutory intervention.

What followed was a period where there was, initially, no intervention with nothing changing. The Covid-19 pandemic from 2020 meant that the threat of eviction was temporarily lifted as no repossessions/evictions were taking place during this period.

However, support was offered to Alice from November 2020 onwards through the medium of sixteen "Safeguarding Outcomes Meetings", the last of these was held in May 2022.

These meetings focused on the threat of homelessness to Alice and included as the core members, the Guinness Partnership, the representative of the Official Solicitor whose role was to advocate for Alice, by then recognised as a "Protected Party" (https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part21), this was due to a lack of capacity to fully fulfil her role as executor and Adult Social Care. Alice herself was invited to the meetings, but she declined to attend.

The continuation of the meetings showed perseverance and a wish to support Alice. This was not reciprocated by Alice and all offers of help were declined apart a partial flat clearance in June/July 2021 and an Assessment of Needs (https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets) in January 2022. The latter was considered to be unsatisfactory because it was based solely on the information that Alice gave the social worker.

The records received by this review are not clear as to whether or not Alice's GP was invited to the Safeguarding Outcomes Meetings. In a discussion at the Practitioner event held to support this review the social worker talked of some liaison, but the GP records did not support this. Towards the end of the safeguarding meeting process the GP surgery held two multi-disciplinary team (MDT) meetings in respect of Alice. The prime purpose was to discuss concerns in relation to Alice's physical health and her acceptance, or not, of treatment. Whilst self-neglect was discussed, and followed a referral from the Guinness Trust, it was assumed that Alice did have capacity for her day to day needs. The outcome of the MDT meetings was that services should be ready to support Alice if she were to be admitted to hospital and to provide support on her discharge.

There does appear to be a lack of clarity as to whether the GP surgery was invited to take part in the safeguarding outcome meetings. There is also a potential missed opportunity in having two separate processes, the safeguarding outcomes meetings and the MDT meetings. Pooling all the information available might have led to an opportunity to use the self-neglect procedures. It was also the case, and agencies were aware, that from July 2022 Alice and Peter were living together. Both had potentially self-neglected, and a meeting could have considered, and involved, the couple together.

9 Peter's arrest in connection with Alice's death and the aftermath.

Peter reported Alice's death to his GP and was shortly afterwards arrested on suspicion of gross negligence manslaughter. (https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter). It was thought possible that Alice might have been dead for some time by the time the death was certified and that actions, or inactions, by Peter may have contributed to her death. As the property was treated as a crime scene in the immediate aftermath, the police arranged for Peter to be housed temporarily in a hotel. It was also said that the house was "*uninhabitable*", due to hoarding, hygiene and the circumstances of Alice's death.

Once the police had decided to release Peter from their custody the only option that they had was the use of a hotel. The police spent some considerable time on the phone speaking to both housing and to Adult Social Care but neither agency were prepared to accept immediate responsibility for the care and welfare of Peter. Housing because they felt that Peter's needs were too great and queried whether he had capacity. Adult Social Care undertook a telephone assessment with Peter and decided that he had no care needs identified at that point.

Reports from the police and hotel manager were that being placed in a hotel was inappropriate for Peter. The manager was not prepared to let him stay for a second night, she apparently said that he was confused, that he had poor mobility and that he may not have eaten for 24-36 hours. Hotel staff had to help him downstairs to receive his breakfast.

After one night in the hotel Peter returned to his flat as no alternative accommodation was forthcoming. The flat, previously described as "uninhabitable" was unchanged since the death of Alice, the removal of her body and Peter being taken into custody for questioning.

When the police went to see Peter on 26th January to confirm that he was no longer under investigation he was said "*to be well*". In the days afterwards, it was reported by neighbours that he had not been seen. Police used their powers of entry on the 30th January 2023 and found him dead. The ambulance crew observed that Peter was wearing a "*custody tracksuit*", presumably the one provided to him at the police station, they also noted signs of self-neglect with *"uneaten food, waste, magazines and dirt in every room".*

10 Where Alice and Peter lived.

The court proceedings that brought Alice to the attention of Adult Social Care concluded in March 2022 with an order that she would be:

- Supported in her role as executor
- Assisted in the sale of her mother's house
- Assisted in the clearance of her Guinness Partnership flat.

Alice had told those working with her that she was living in her flat throughout 2021 and, records show, that it is probable that she remained there until July 2022. She then went to live with Peter in his local authority accommodation.

11 Hoarding

The first confirmed mention that this review has received that Alice hoarded things was from October 2013 when staff from the Guinness Partnership and police officers entered Alice's flat having been informed that she was not there. Hoarding was described as being "*waist-high*" and it was questioned how she managed to get in and out of the flat.

The hoarding continued, and through the medium of the Safeguarding meetings an agreement was made that a company would assist in clearing the flat which was said

to be so cluttered that the door could not be fully opened and the social worker couldn't gain entry.

The clearing commenced in August 2021, the clearance company chosen for this removed a lot of the clutter and worked with Alice as to what she wished to keep. By the end of August 2021, the Social Worker said that the flat was less cluttered, but that a lot remained. No clutter score from "before" and "after" has been provided to this review and so descriptions are from the workers themselves. Clutter scores are helpful and provide objective accounts of a level of clutter.

Peter's flat showed signs of hoarding when Alice was found dead. This review has been given no evidence that Peter was a "*hoarder*" and the nature of the items hoarded suggested that these were Alice's rather than Peter's.

Hoarding is difficult to treat (https://www.nhs.uk/mental-health/conditions/hoarding-disorder/) and without intervention it is highly likely that Alice's hoarding behaviours would continue. Alice would have had to have wanted help, and to trust those she was working with. She would have needed to be committed to ending/reducing her hoarding behaviours. Whilst she acknowledged that she hoarded this review has seen no evidence that she had the will, ability or desire to change her behaviour.

12 Using the Mental Capacity Act

Alice's capacity was assessed in 2021 in respect of the sale of her mother's house and her ability to perform the role of executor. The assessment was mixed, she had capacity to make decisions about applying for welfare benefits. She had capacity about using any capital from the sale of her mother's house to pay off her rent arrears. However, she lacked capacity to carry out her role as executor and was not judged to be able to work collaboratively with the other executors, her brother and sister.
A GP initiated Multi-Disciplinary Team discussion on 22nd July 2022 recorded, "*Alice is **thought** to have capacity around her care needs*". A question for this review is whether capacity should have been tested at this, and other, points? In other words, was "*thought to have capacity*" good enough for an assessment? Language such as "capacity is presumed (or assumed)" is more helpful in setting out the worker's thinking.
It is important to note that capacity should be assumed unless there is good reason not to (https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance/).

The author of this review has seen no reasonable opportunity where capacity could have been formally tested. There were times where Alice was potentially making unwise decisions, hoarding, declining medical treatment, not cooperating with workers who sought to help her etc. She had been offered help through the safeguarding meetings and multi-disciplinary team meetings, but by and large she had declined.
The Social Care Institute for Excellence guidance above mentions that people will have their own beliefs, values and preferences that may not necessarily be the same as others.

Where someone is at immediate risk and can't/won't consent to a Mental Capacity Assessment a "Best Interests" decision can be made on their behalf. In some rare

circumstances a Mental Capacity Assessment can be undertaken without consent, but this will be restricted to occasions where someone is unable to contribute to an assessment, but not at immediate risk. A worker can then use relatives and other third-party reports to make an assessment on behalf of the person. Essex Chambers (https://www.39essex.com/our-thinking/mental-capacity-resource-centre/) have a helpful range of resources for those working with people where capacity is to be tested.

However, there has been no information provided to this review to suggest that Alice didn't have capacity for day to day decisions. Some of her decisions might have been considered "unwise", but she was free to make these choices.

Further, whilst Alice had behaviours and an outlook on life that was different to some other people. It is likely that her behaviours were connected to her mental ill-health and her life experiences, but they did not place her beyond a threshold where she might have been subject to mental health legislation, nor were there sufficient concerns for her to be seen as an immediate danger to herself or others.

In December 2022 Alice's GP referred her for physiotherapy, Alice has "*poor mobility, walks almost bent double and needs assistance of one (walking aid). Evidence of self-neglect"*. An initial appointment was cancelled by Alice and a further one, not attended.

Harrogate District Foundation Trust have identified that the Patient Access Policy was not followed in full in that she was not offered further appointments. In their reflection on this that followed after Alice's death they did not think that the outcome would have been any different she had been offered further appointments. From what this review has been told of Alice and the material seen, this is likely.

13 Self-Neglect

There were times when both Alice and Peter were said to self-neglect. No agency visited the flat that both lived in from July 2022 until the death of Alice in January 2023, so there were no opportunities to witness the "*self-neglect*" that was reported by the GP, police and ambulance service at the time of the two deaths.

There was a potential opportunity when the Safeguarding Outcome Meetings and GP-led Multi-Disciplinary Team (MDT) meetings were running in tandem in 2022 to consider self-neglect and, given that the couple had moved in together in July 2022, self-neglect in respect of both parties. Alice was known to self-neglect and the GP records recorded potential, at least, self-neglect by Peter.

Any agency can call a multi-agency meeting in respect of self-neglect and this is an opportunity to pool all the information available. In that way the use of the self-neglect procedures could have brought strands of the Safeguarding Outcome meetings and MDT together.

That self-neglect procedures were not used in respect of Alice and Peter is not put forward as a missed opportunity in this instance. Other procedures were being used to support Alice and she had only just moved in with Peter. Linking past knowledge of him to her situation would have been unlikely at this very early stage.

However, there is learning from this review in respect of self-neglect and a recommendation is made that can assist in other similar situations. (https://safeguardingadults.co.uk/self-neglect-practice-guidance-north-yorkshire-and-city-of-york/)

14. "Hard to reach"

Alice was described as being "*evasive*" of agencies in the SAR commissioning document. The word "evasive" has not been used in information submitted to this review and it is not clear where the word came from. "*Evasive*" is a judgemental/derogatory term, an example of "*blaming language*". It could have influenced how some of those working with Alice perceived her. It is, however, important to say, though, that there was no suggestion from the practitioner event that this was a factor with those attending who had known and worked with Alice.

The question is how to work with people who are "*hard to reach*" and how successful this might be.

This review has described how workers engaged with Alice to achieve a partial clearance of her flat. Through the Safeguarding Outcome Meeting and MDT meetings there were also consistent attempts to work with her. Her preferred method of communication was via text message and this was used.

Given the diagnosis of Anankastic Personality Disorder, and that she did not reach a threshold for statutory intervention, it may be that workers did all that they could to support Alice.

One approach that can be beneficial is Trauma Informed Practice. Bringing all aspects of Alice's past together, as this review has been able to do, does show that she suffered trauma. She was hospitalised at a young age, she suffered from mental ill-health, lost her mother and faced the prospect of losing her home due to repossession.

Recognising trauma and working with people in a trauma-informed way (https://www.communitycare.co.uk/2023/09/12/a-trauma-informed-approach-to-social-work-practice-tips/) can help to engage with those people otherwise resistant to support. Alice might still have resisted attempts to engage with her but a recommendation is made that trauma-informed practice is considered as a training opportunity by the North Yorkshire Safeguarding Adults Board.

15. Commentary on the Key Lines of Enquiry.

Key Lines of Enquiry: Alice

- **Was risk accurately identified and were appropriate risk assessments in place?**

Given that Alice had not been seen by any professional working with her between October 2022 and her death in January 2023 there is no suggestion that her death could have been anticipated.
The Safeguarding Outcomes Meetings had exhausted what they could do and effectively came to an end in March 2022 once the court order was made that support would be provided for Alice's role as executor and that her flat would be cleared. The GP led MDT meetings identified that the main risk was of Alice being hospitalised and how she might be supported on discharge. This was appropriate and, given that Alice was resistant to receiving support was probably as far as anyone could go.

An important point though, is that Alice was considered to have capacity in terms of her day to day living. Given this there was no immediate reason or authority for agencies to assess risk or plan on Alice's behalf.

Were opportunities to raise safeguarding concerns or share information missed?
As mentioned earlier, self-neglect procedures could have been used at the point of the safeguarding outcomes meetings and the MDT meetings. Whether or not it was through the use of the self-neglect procedures, there might have been benefits in joining up the two sets of procedures and pooling knowledge. This comment is reinforced by the knowledge that there was some doubt as to whether the GP was aware of the safeguarding outcome meetings.

- **Was the safeguarding process effective in safeguarding Alice?**
  Whilst Alice was ultimately not safeguarded, and she died in conditions of significant neglect it is hard to see that opportunities were missed that might have averted her death. This is particularly so given that safeguarding processes had concluded and that Alice had seen no workers in the months prior to her death. Recommendations are made from this review, but this review has not found any significant opportunities missed in safeguarding Alice.

- **Was Alice involved in discussions about risk?**
  Alice had been offered the opportunity of participating in the safeguarding outcome meetings and Care Needs Assessments. She declined these opportunities and the evidence is that she had capacity to do so. This review concludes that Alice was offered the opportunities to be involved in discussions about risk and that she participated to the extent that she was prepared to do so.

- **How was self-neglect and hoarding viewed when considering Alice's mental capacity? And how was executive capacity considered in decision making?**

The psychiatric reports referenced in this review are clear that whilst Alice did not have capacity to cooperate with others in complex situations, she did have capacity for finances in her own life. Capacity in other areas was not tested, but was presumed by those working with Alice, and there was no reason not to. As detailed earlier, whilst Alice had her own approach to her life and may well have made decisions considered to be "*unwise*"; her actions, or inactions, did not reach a threshold for intervention by further capacity assessments.

- **Did professionals consider Alice's life circumstances when attempting to effectively build a relationship and develop an understanding of Alice and how best to work with her? (for example, when she lived in residential rehabilitation in 2001)**
  Whilst significant efforts were made to support and to engage with Alice trauma-informed practice could have been tried. This is explained in more detail earlier and is a recommendation from this review.

- **Was hospital DNA protocol used properly and would outcomes have been different if Alice was identified as vulnerable?**
  If the hospital had identified Alice as being "*vulnerable*", they have accepted that they would have used a different approach in following up a missed appointment. Given that Alice was independent and was clear about making her own life choices there can be no certainty that a further appointment would have been kept, even if a different approach had been tried.

Key Lines of Enquiry: Peter

- **Was safeguarding considered for Peter when concerns for self-neglect were identified?**
  Peter was described by a health professional in 2022 as *"unkempt*" and "*slightly dirty*". With the benefit of hindsight, this may have reached a threshold for self-neglect, but it is fair to say that there were no other issues of significant concern with regard to Peter at this stage.

- **Was capacity considered when Peter choose to decline support /visits?**
  Peter's capacity was not considered to be in doubt and this review has seen no evidence from the period before Alice's death to suggest that it might have been doubted.

- **Did agencies work effectively together to provide appropriate accommodation and support to Peter after his release from custody?**
  Once it was determined that Peter would be released from custody, options were limited. His home was uninhabitable, after the trauma of finding his partner dead it was also inappropriate for him to return there without support. Placement overnight in a hotel was arranged, and funded, by the police. This was no more than a "*stop gap*" and the only option available to the police.

At the time of his release from the police station in the early hours of 24th January 2023, both Housing and Adult Social Care were aware of Peter, that he needed accommodation at that point and that he was potentially vulnerable.
Due to his apparent vulnerability the police decided to include an appropriate adult in his interview.
Although there had been no formal assessment of Peter's capacity or his Care and Support Needs he was, by the account of the police and by virtue of having found his partner dead in very difficult circumstances someone who would have had the appearance of someone with Care and Support Needs, at least at the point of release from the police station. In addition, Peter was known to be someone who had no friends or relatives to support him.
At this point the Housing Department confirmed that they would not be providing accommodation. From the information they had, they were unsure whether Peter had capacity. They believed that Social Care should be the lead agency to determine need before they considered finding accommodation.
In the absence of any other accommodation and because his flat was being treated as a potential crime scene, the police arranged for Peter to spend the night in a hotel. Albeit, they did not consider that a hotel was suitable for him. The hotel confirmed that Peter was struggling with his mobility in the hotel. That he was unkempt and potentially under nourished. Given this, they were not prepared to allow him to stay for a second night.
Later in the morning of the 24th January 2023 Social Care (EDT) interviewed Peter by phone. They offered a "needs assessment", presumably a Care Act Assessment, but he declined saying that he was happy at the hotel and that he could care for himself. EDT determined via the call that he didn't have specific needs and that they had no role in supporting him. They also determined in the telephone interview that Peter had capacity. Their view was that it was for housing to provide accommodation for him. As he already had accommodation, albeit unusable at that point, housing would be unlikely to assist.
At this stage the police were left inappropriately holding the risk for Peter, albeit they continued to believe that he was vulnerable. They attempted to telephone both Social Care and Housing on the day of the 24th but were unable to reach the contacts they thought might help. Hotel accommodation was limited to overnight on the 24th only and there was nowhere else for Peter to go on the 25th. In any event the hotel manager would not allow him to stay more than one night due to his poor mobility and what was thought to be confusion.
Throughout further discussions on the 25th Housing maintained their position that Peter's needs were too great for them.
At this stage the police could have used the "Managing Different Professional Perspectives and Mutual Challenge" policy(https://safeguardingchildren.co.uk/professionals/procedures-practice-guidance-and-one-minute-guides/professional-resolutions/). This is available

to constituent agencies of the Adult Safeguarding Board and the Children's Partnership and should be used where there is disagreement between agencies that is not immediately resolvable.
The keys to Peter's property were released back to him on 25th of January 2023 and he returned to his home. The flat was exactly as it had been left when Alice's body was found. Bearing in mind the description of the flat prior to taking Peter in for questioning, "*extremely distressing, with severe hoarding and unsanitary conditions"* it is unconscionable that Peter was returned to this situation. Regardless of how he might feel about the property given the death of his partner, it was known to be a site of significant environmental neglect and had been described as "*uninhabitable".*

Peter should have received a face to face assessment from Adult Social Care at the first possible opportunity before or after his release from the police station.

The view of the author of this review is that would have been the right and humane thing to do. By any measure Peter was vulnerable in the immediate aftermath of his discharge from custody. The police considered him to be vulnerable enough to have engaged an Appropriate Adult. In addition, he had lost his partner in most difficult of circumstances, he had then been questioned by the police. The whole experience would have been traumatic for him. He is also, as far as we know without the support of family or friend; certainly, there was no one to support him on release.

The police had worked with Peter for the previous twenty-four hours or so and recognised the level of need. The issue was less with housing who believed that Peter's needs were too great for them to support, in addition Peter already had local authority housing and it is difficult to see what more housing could have done.

Adult Social Care could, and should, have done more to support Peter. It is not for this review to say what they could have done, although a face-to-face assessment would have been a starting point. A placement in a Care Home has also been suggested. A solution should have been reached whereby Peter did not return alone to his flat where his partner had so recently died in difficult circumstances. The police should not have been left with the responsibility for Peter's welfare.

Senior managers reading this review prior to finalising it believe that the response to the police would be different now and that the police would not now be left holding the risk. Recommendation 2 follows from this. If risk is properly apportioned this will be demonstrated through the action planning.

- **Was a telephone assessment by Health and Adult Services appropriate for the level of concern received?**

Peter should have been seen, and assessed face-to-face. This is further explained in the point above.

16. Good practice

What was clear from the practitioner event was that those who worked with Alice tried hard to support her. The number of safeguarding meetings held was, in the experience of this review author, unparalleled.

There were attempts to include Alice in the safeguarding meetings, via direct invitation and the inclusion of her solicitor.

Those present described visiting Alice, communicating via her preferred method of text and "*looking out for her*" in town.

She was offered, but declined, Care Act Assessments on several occasions.

The practitioners who attended the learning event spoke fondly of Alice and their attempts to work with her and to support her. There was a comment in the meeting that, even now, some years after they had made attempts to work with Alice that they still thought about what more they might have done to engage her.

17. Recommendations

- **The North Yorkshire SAB should ensure that risk to individuals is effectively managed across the whole partnership in a way that puts the needs of the individual first.**
  Rationale: the police were left holding the risk with regard to Peter after his discharge from custody. This was not appropriate for a "Blue Light" service. The only solution available to the police was the wrong one for Peter. A partnership approach was needed to support Peter on his immediate release from custody. The wider partnership needs to assure the SAB that it can respond to individual risk and that they can provide the right care for those identified as being at immediate risk. The "Managing Different Professional Perspectives and Mutual Challenge" policy to be used as necessary. As part of the assurance for this recommendation the relevant agencies should meet to determine how Peter would be supported now and what the outcome would be now if the circumstances were the same.

- **The "Managing Different Professional Perspectives and Mutual Challenge" policy to be relaunched and promoted in each constituent agency of the North Yorkshire SAB**
  Rationale: the policy was not used by the police or housing when Peter was released from custody. In the event held to gain information for this review, managers and practitioners were largely unaware of the policy and had never used it. The policy is a helpful one that can resolve differences and get support for individuals. Each agency should assure the SAB that it has been disseminated and that employees and contractors are aware of it. A second element of this is that agencies should update the SAB six months and then one year on from the agreement of this review on the number of times the policy has been used and the outcomes from it.

- The SAB should ensure that **awareness and signs of self-neglect are promoted and that it is made clear what practitioners should do if they believe that someone is neglecting themselves.**
  Rationale- There were clear signs that Alice was self-neglecting, there was limited evidence that Peter was self-neglecting. Any agency that believes that someone is self-neglecting can call a multi-agency meeting to pool the information that all agencies have in respect of an individual so that risk can be assessed.

- **Constituent agencies of the NY SAB to consider the promotion and roll-out of Trauma- Informed practice**
  Rationale- This review has questioned what more could have been done to try to support/help Alice? She was described as "evasive" and she resisted intervention unless it were really necessary. Alice described traumatic events, hospitalisation when young, the break-up of a relationship, the death of her mother and the prospect of eviction. It is possible that taking a trauma-informed approach to working with Alice might have facilitated her engagement in a way

that other approaches hadn't. It is worth noting in this rationale that Peter had also experienced significant trauma over the death of Alice, his time in custody and his return to the home that he and Alice had shared.

- **The North Yorkshire SAB constituent agencies who work with people who hoard should ensure that they have sufficient resources and tools available to support their workers.**
  Rationale- to use the learning from this review to promote resources to work with people who hoard. To include Clutter Scores and other appropriate resources.