City of York Safeguarding Adults Board

Safeguarding Adults Review

Full Report

David SAR

June 2026

Independent Review by City of York Safeguarding Adults Board

Co-Authored: Catherine Law and Christine Pearson

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Executive Summary

This Safeguarding Adults Review concerns David who was a man in his sixties who died at his home in extra care housing in February 2025. The post-mortem identified alcohol toxicity as the cause of death, with ischaemic heart disease as a contributory factor. Throughout the review period (January 2024 – February 2025), David experienced significant physical health deterioration, chronic alcohol dependency, longstanding mental health difficulties, self-neglect, social isolation and repeated crises involving multiple agencies.

The review found substantial involvement from a range of statutory and non-statutory agencies including social care, housing associations, drug and alcohol services, mental health, primary care and acute hospital services. Despite frequent professional contact, cumulative risk was not effectively coordinated across the system. Repeated opportunities to develop a shared understanding of escalating risk were missed.

The central finding is that while individual services undertook activity within their own remits, no agency assumed leadership of a coordinated multi-agency response to worsening self-neglect, alcohol dependence, deteriorating physical health, repeated refusals of care and recurrent safeguarding concerns. The absence of a Section 42 safeguarding enquiry and associated multi-agency planning represented a significant missed opportunity.

Pen Portrait of David – limited interaction with family has not been successful.

David was 66 years old at the time of his death in February 2025. He lived alone in extra care housing in York and had a long history of mental and physical health difficulties, which significantly affected his daily life and wellbeing. He was known to a range of services, including Adult Social Care, mental health services, primary care, acute health services and housing providers.

David experienced enduring mental health challenges from an early age, including depression, anxiety, agoraphobia, social anxiety, self-harm and suicidal thoughts. He had extensive involvement with mental health services over many years, and frequently accessed crisis support during periods of emotional distress. He often sought help but could find it difficult to engage consistently with the support offered.

In addition to his mental health needs, David lived with several significant physical health conditions, including diabetes, heart disease, chronic pain and mobility difficulties. Following severe vascular disease, he underwent an above-knee amputation in 2024, which further impacted his independence and increased his reliance on support services.

Alcohol use was a recurring feature throughout David's life and was often linked to periods of low mood, bereavement and social isolation. There were ongoing concerns about self-neglect, poor nutrition, falls, alcohol misuse and his ability to manage daily living tasks safely. Despite these challenges, David valued his independence and regularly declined aspects of care and support, even when professionals and those close to him were concerned about his wellbeing.

David had limited family involvement, although his sibling remained known to services. A significant source of support was his friend and partner, who acted as an informal carer and frequently raised concerns about his physical and mental health.

David's circumstances were characterised by complex and interconnected needs, including mental ill health, physical disability, alcohol dependence, self-neglect and social isolation. His case highlights the challenges of supporting adults with multiple vulnerabilities who have capacity to make decisions about their own care, whilst requiring coordinated support from a range of agencies.

1. Introduction

This review was undertaken through a multi-agency rapid review process which took place in March 2026 by the City of York Safeguarding Adults Board following consideration of the circumstances surrounding David's death during February 2025.

The review period covers January 2024 to February 2025 and seeks to understand:

- Whether agencies worked effectively together.
- Whether safeguarding duties were appropriately considered.
- How services responded to self-neglect, alcohol dependency and mental health concerns.
- Whether opportunities existed to reduce risk or improve outcomes.
- What learning can improve future multi-agency practice.

2. Background

2.1 David lived alone within an extra-care housing scheme. He had extensive physical, psychological and social vulnerabilities including:

- Persistent depressive disorder and longstanding mental health difficulties.
- Recurrent suicidal ideation and self-harm concerns.
- Alcohol dependency.
- Diabetes.
- Peripheral vascular disease.
- Ischaemic heart disease.
- Above-knee amputation
- Chronic pain.
- Reduced mobility.
- Social isolation.
- Financial anxieties regarding care charges
- Historical agoraphobia
- Historic Self Neglect

2.2 Records demonstrate decades of mental health service involvement, including approximately 67 referrals since 2015 and significant reliance on crisis services after discharge from the local authority ASC Community Mental Health Team in 2021. David frequently sought support at times of distress but often declined or disengaged from intervention when offered.

3. Key Chronology and escalating risk

3.1 *March – May 2024: Physical Health Crisis and Amputation*

3.1.1 During March 2024 David attended hospital with severe vascular disease and chronic limb-threatening ischaemia. In April 2024 he was admitted with severe pain and immobility. Two days later he underwent a right above-knee amputation.

3.1.2 Following discharge in May 2024, intensive reablement support was provided with four daily visits, later reduced following reassessment. David increasingly demonstrated ambivalence toward support, refusing entry to carers and declining aspects of care provision.

3.1.3 This period represented a major life-changing event. However, evidence of formal multi-agency planning around the psychological, social and safeguarding implications of the amputation was limited.

3.2 *June – October 2024: Emerging Self-Neglect*

3.2.1 Multiple agencies identified concerns regarding:

- Alcohol misuse.
- Poor nutrition.
- Refusal of care.
- Deteriorating mood.
- Declining self-care.
- Social isolation

3.2.2 Adult Social Care (ASC) staff repeatedly attempted to engage David. Care packages were introduced, withdrawn and reinstated as DAVID alternately accepted and rejected support. Occupational therapy recommendations were declined. Financial concerns became a significant barrier to engagement.

3.2.3 At the end of October 2024 Yorkshire Ambulance Service (YAS) attended following a reported overdose. Hospital admission was refused. This should have represented a significant escalation point requiring wider multi-agency review of risk. No evidence was identified of a coordinated multi-agency response following this incident.

3.3 *November 2024 – January 2025: Increasing Complexity*

3.3.1 Throughout this period numerous professionals documented concerns about:

- Excessive alcohol consumption.
- Inability to cope.
- Poor self-care.
- Mental health deterioration.
- Repeated requests for help.

- Repeated refusal of support.

3.3.2 Primary Care described an ongoing challenge of David requesting assistance while declining interventions offered. Adult Social Care and partner agencies repeatedly revisited support options. Advocacy was offered. Referrals were made for mental health, alcohol services and practical support.

3.3.3 In December 2024 a referral was made to Older People's Mental Health Services. Assessment, which was subsequently arranged for February 2025, three days after David's death.

3.4 ***February 2025: Final Weeks***

3.4.1 The final weeks demonstrate a clear pattern of escalating vulnerability.

3.4.2 Between 4 and 10 February 2025 David was admitted to hospital with worsening foot disease and alcohol dependence. He underwent alcohol detoxification and was discharged with follow-up arrangements.

3.5 ***Between 12 and 16 February****:*

- Multiple falls occurred.
- Head injury was reported.
- David was repeatedly intoxicated.
- Housing staff made numerous welfare interventions.
- Safeguarding concerns were raised.
- Self-neglect concerns escalated.
- Mental health concerns were communicated to specialist services.
- Repeated refusals of hospital attendance occurred.

3.5.1 ***On 12–14 February 2025*** safeguarding concerns were raised to mental health services but were later identified as not having been fully explored or escalated. The Mental Health Trust's subsequent After-Action Review identified concerns regarding record management and safeguarding workflows.

3.5.2 ***On 17 February 2025*** the housing association staff conducted a welfare check and found DAVID deceased.

4. Analysis Against Key Lines of Enquiry

4.1 KLOE 1 – Risk recognition, triage and response

4.1.1 All agencies recognised elements of risk throughout the review period. Numerous referrals were made regarding self-neglect, alcohol misuse, suicidal thoughts, falls, physical deterioration and welfare concerns.

However, risks were generally managed as isolated incidents rather than as manifestations of a cumulative and escalating pattern. The chronology demonstrates repeated presentations with:

- Intoxication.
- Overdose concerns.
- Falls.
- Non-engagement.
- Physical decline.
- Mental health crises

4.1.2 The system recognised individual events but did not consistently aggregate them into a shared risk picture.

Finding: Risk recognition occurred but cumulative risk assessment was insufficiently developed.

4.2 KLOE 2 – Multi-agency coordination and information sharing

4.2.1 Multiple agencies held important information about David. The chronology and rapid review evidenced extensive contacts across housing, social care, ambulance services, primary care, hospitals, drug and alcohol services, department of work and pensions and mental health services. Yet there is little evidence of a formal multi-agency process bringing this information together.

4.2.2 The review found no clear lead professional or coordinated risk management framework. Information was shared episodically but not systematically synthesised into a joint plan.

Finding: The absence of sustained multi-agency coordination was a significant contributory factor.

4.3 KLOE 3 – Safeguarding and Section 42

4.3.1 The chronology and rapid review demonstrated repeated indicators associated with self-neglect:

- Alcohol dependence.
- Deteriorating health.

- Neglect of personal care.
- Repeated refusals of support.
- Falls.
- Inability to maintain wellbeing.
- Safeguarding referrals from multiple sources.

4.3.2 Despite this, the review identified no formal Section 42 safeguarding enquiry. Several professionals reflected that safeguarding strategy discussions may have facilitated stronger multi-agency coordination and risk planning.

Finding: Thresholds for safeguarding intervention appear not to have been consistently applied to a pattern of chronic self-neglect.

4.4 KLOE 4 – Access to mental health services

4.4.1 Mental health services were heavily involved over many years. However, DAVID experienced delays in accessing planned intervention following referral to Older People's Mental Health Services in December 2024.

4.4.2 The assessment scheduled for 20 February 2025 did not occur due to DAVIDs death. Mental Health Service's review identified learning regarding record keeping, safeguarding workflows and delays in assessment processes.

Finding: Mental health support was characterised by heavy reliance on crisis responses rather than sustained planned intervention.

4.5 KLOE 5 & 6 – Physical health and alcohol dependence

4.5.1 The chronology and rapid review demonstrate a close interaction between:

- Diabetes.
- Vascular disease.
- Chronic pain.
- Loss of mobility.
- Alcohol dependence.
- Depression.

4.5.2 Services frequently addressed these issues separately despite their interconnected nature. Following detoxification in February 2025 there is limited evidence of a coordinated relapse prevention approach involving all relevant agencies.

Finding: The interaction between physical illness, psychological distress and alcohol dependence was insufficiently addressed through integrated planning.

4.6 KLOE 7 – Housing and extra care response

4.6.1 Housing association staff demonstrated persistent efforts to support DAVID, responding to large numbers of emergency pulls, welfare concerns and crisis presentations. Multiple safeguarding referrals were submitted, welfare checks completed, and concerns escalated.

4.6.2 Staff repeatedly encountered the limits of what could be achieved without wider system intervention, particularly where David refused support.

Finding: Housing staff identified risks appropriately but lacked the authority and system support required to coordinate a wider response.

4.7 KLOE 8 – Mental capacity, executive functioning and capacitous refusal

4.7.1 **Context -** A recurring theme throughout David's involvement with services was the challenge of balancing respect for his autonomy with professional concerns regarding escalating self-neglect, alcohol dependency, deteriorating physical health and repeated refusal of support. Multiple agencies documented concerns about his welfare whilst simultaneously recognising his apparent ability to make decisions about his care and treatment.

4.7.2 Throughout the review period David demonstrated a pattern of behaviour that practitioners found difficult to manage. He repeatedly sought assistance from services, activated emergency alarms, contacted crisis support and disclosed that he was struggling to cope. However, he frequently declined interventions offered, disengaged from services after requesting help, refused hospital attendance, rejected adaptations and withdrew consent for support arrangements.

4.7.3 Primary Care and Mental Health services both identified this pattern of help-seeking alongside help-rejecting behaviours as a significant feature of Davids presentation. Professionals described the challenge of working with an individual who appeared to understand the consequences of his decisions, but whose behaviour repeatedly exposed him to escalating harm.

4.7.4 **Capacity and self-neglect -** The review found evidence that practitioners generally regarded David as having mental capacity to make decisions about his care and support. There is no evidence to suggest that professionals inappropriately assumed incapacity simply because David made decisions that others considered unwise. This reflects the principles of the Mental Capacity Act 2005.

4.7.5 However, the review identified a tendency across the system to treat the presence of capacity as the end point of professional enquiry rather than one component of a broader safeguarding analysis. Capacity assessments appear to have focused primarily on David's ability to understand and communicate decisions rather than considering the cumulative impact of repeated high-risk decisions over time

4.7.6 The chronology and rapid review demonstrate a persistent pattern of decisions that increased risk, including:

- Refusing hospital attendance after overdose concerns.
- Declining ambulance conveyance following falls and head injury.
- Refusing care and support services
- Declining adaptations to improve safety and independence.
- Continuing harmful alcohol consumption despite deteriorating health.
- Repeatedly disengaging from services after requesting assistance

4.7.7 Viewed individually, these decisions may have appeared to indicate that DAVID had Capacity. Viewed collectively, they represented an escalating pattern of self-neglect which warranted increased scrutiny and multi-agency safeguarding consideration.

4.7.8 **Capacity in the context of alcohol dependency -** Alcohol dependency was central to Davids circumstances and frequently influenced professional decision-making. Alcohol dependency was central to Davids circumstances and capacity may have fluctuated depending on his presentation. Practitioners needed to remain alert to the possibility that capacity could be rapidly impaired during periods of intoxication and may also be affected during alcohol withdrawal, when physical and psychological symptoms can impact decision-making ability. The chronology records numerous situations where David was intoxicated while refusing treatment, declining hospital admission or making decisions about his welfare. Examples include the overdose concern in October 2024, repeated falls during February 2025, refusal of medical intervention following a head injury and multiple crisis contacts in the days preceding his death.

4.7.9 The Ambulance Service identified learning regarding the assessment of capacity in the context of intoxication, particularly around:

- Decision-specific capacity assessments.
- Best-interest decision-making.
- Responses to self-neglect where consent is disputed or difficult to establish

4.7.10 The review found limited evidence that a consistent multi-agency approach existed for assessing and recording capacity where intoxication was a significant factor. While this review does not conclude that DAVID lacked capacity during these events, it highlights the importance of recognising that capacity can fluctuate and may require repeated assessment. This is particularly relevant where an individual is intoxicated, withdrawing from alcohol, or where their presentation changes over a short period. Clear documentation of decision-specific and time-specific assessments is essential.

4.7.11 **Executive Functioning -** One of the most significant areas of learning relates to executive functioning.

4.7.12 Executive functioning refers to a person's ability to initiate actions, plan, organise, maintain motivation and translate intentions into behaviour. An individual may be able to understand information and communicate choices yet struggle to implement decisions consistently because of addiction, depression, trauma, cognitive impairment or other factors.

4.7.13 Several aspects of Davids presentation suggest that executive functioning warranted greater exploration which included the following:

- He expressed a desire to reduce or stop drinking.
- He engaged intermittently with alcohol treatment services.
- He requested help repeatedly.
- He accepted referrals and appointments.
- He frequently disengaged before interventions could take effect.
- He was unable to sustain actions that aligned with his own stated goals

4.7.14 Both GP and Mental Health services records raise questions regarding the extent to which Davids apparent decision-making capacity translated into an ability to protect himself from serious harm. The review found little evidence that executive functioning was explicitly considered within safeguarding assessments, risk management discussions or multi-agency planning.

4.7.15 Whilst executive dysfunction does not imply a lack of capacity, it may indicate a need for more assertive engagement, adapted communication strategies and evidenced multi-agency oversight.

4.7.16 **Repeated Capacitous Refusal -** The review found that agencies often accepted David's refusals of support whilst continuing to record concerns about his wellbeing. These refusals related to care provision, medical treatment, adaptations, safeguarding interventions, financial assessments and community support.

4.7.17 - There was limited evidence of a coordinated multi-agency review that explored:

- Why refusals were occurring.
- Whether addiction and depression were influencing decisions.
- The impact of repeated refusals on safeguarding risk.
- Whether alternative engagement approaches could be developed.
- Whether the pattern itself should trigger escalation.

4.7.18 Consequently, refusals were often treated as isolated events rather than recognised as indicators of cumulative vulnerability.

4.7.19 **Professional Curiosity -** The review acknowledges the challenges professionals faced when working with David. However, greater professional curiosity may have assisted agencies in understanding the persistent mismatch between Davids stated wishes and his ability to act upon them.

4.7.20 Questions that may have benefited from more explicit exploration include:

a. Why was DAVID repeatedly asking for help whilst declining support?
b. To what extent was depression affecting motivation?
c. Was alcohol dependency impairing his ability to implement decisions?
d. Were repeated refusals themselves evidence of escalating self-neglect?
e. Did the pattern require escalation through safeguarding or multi-agency risk management processes?

Findings: The review concludes that professionals appropriately recognised DAVID as having decision-making capacity on many occasions. However, there was insufficient consideration across the partnership of the complex interaction between:

Mental capacity.
Alcohol dependency
Fluctuating capacity associated with both intoxication and withdrawal
Self-neglect.
Executive functioning.
Depression.
Repeated help-seeking behaviour.
Repeated refusal of support.

The key learning is not that David should have been assessed as lacking capacity. Rather, agencies should develop greater confidence in working with adults who appear capacitous, but whose behaviour demonstrates escalating vulnerability. Capacity assessments should form part of a wider safeguarding analysis that incorporates cumulative risk, executive functioning, addiction, self-neglect and the need for coordinated multi-agency intervention

5. Overall Conclusions

5.1 A significant theme emerging from this review is the challenge of working with adults who appear to have capacity whilst continuing to place themselves at serious risk. David's case demonstrates that capacity assessments should not be viewed as a substitute for safeguarding analysis. The review found opportunities for agencies to move beyond determining whether David had capacity and instead develop a shared understanding of how alcohol dependence, depression, executive functioning difficulties and self-neglect interacted to affect his ability to keep himself safe.

5.2 The evidence does not suggest that any single professional or agency failed in isolation. Rather, this review identifies a systems issue whereby cumulative risk outpaced the ability of individual organisations to respond within their existing structures.

5.3 DAVID was a highly vulnerable man whose:

- Mental health difficulties
- Alcohol dependence
- Physical deterioration
- Social isolation
- Repeated refusals of support
- Financial anxieties

created a complex and escalating risk profile.

5.4 Although many professionals recognised individual risks, the system did not develop and maintain a coordinated multi-agency safeguarding response

proportionate to the level of cumulative harm evident across the chronology and rapid review.

6. Learning and Recommendations

6.1 **Recommendation 1 -** The Safeguarding Adults Board multi-agency risk management framework developed in September 2026 should be reviewed to ensure that it includes agreed escalation triggers for cumulative risk and repeated refusals of support. Evidence of implementation should be provided through agency sign-off and dissemination across partner organisations.

6.2 **Recommendation 2 -** Partner agencies should adopt a multi-agency risk management framework by June 2027 requiring consideration of a safeguarding discussion to strengthen multi-agency communication and joint safeguarding responses where an adult presents with two or more recurring indicators, including self-neglect, alcohol dependence, frequent emergency contacts, safeguarding concerns or mental health crises. Compliance should be audited after 12 months.

6.3 **Recommendation 3 –** All\ partner agencies should review and update guidance, training and supervision arrangements by September 2027 to support decision-specific and time-specific capacity assessments, assessment of fluctuating capacity during intoxication and alcohol withdrawal, consideration of executive functioning and recording of capacitous refusals. . Agencies should provide assurance to the SAB regarding implementation with a focus on the importance of recognising that an individual's ability to understand information does not automatically indicate consent.

6.4 **Recommendation 4 -** Mental Health Services should implement the actions identified through the After-Action Review by December 2026 and provide six-monthly assurance reports to the SAB demonstrating improvements in safeguarding concern tracking, record keeping, escalation processes and timeliness of assessment.

6.5 **Recommendation 5** Following the launch and implementation of the MARM in 2026, partner agencies should ensure they've identified a lead coordinator to implement MARM or contribute to a MARM where risks span multiple organisations. Effectiveness should be reviewed through a sample audit within 12 months of implementation.

6.6 **Recommendation 6** The SAB should deliver at least one multi-agency learning event and associated learning materials by September 2027 covering self-neglect, alcohol dependence, cumulative risk, professional curiosity and balancing autonomy with protection, and evaluate learning through participant feedback and evidence of changes to practice.

6.7 **Recommendation 7** The Safeguarding Adults Board should commission and disseminate multi-agency guidance with the multi-agency risk management framework by December 2027 on working with adults who repeatedly refuse support despite apparent capacity in the context of self-neglect, addiction and complex health needs ensuring robust mental capacity assessments and use of professional curiosity an managing repeated refusal of services The SAB should seek assurance

from partner agencies within six months of publication regarding implementation and use of the guidance**.** This should include:

- Decision-specific and time-specific capacity assessments.
- Capacity assessment during intoxication.
- Understanding executive functioning.
- Professional curiosity in cases of repeated refusal.
- Escalation pathways where cumulative risk remains high despite apparent capacity.
- Recording and evidencing best-interest considerations and least-restrictive approaches

7. Conclusion

7.1 The review concludes that Davids's death occurred against a backdrop of chronic self-neglect, alcohol dependency, deteriorating physical and mental health, and repeated crises known to multiple agencies. Opportunities existed for earlier and more coordinated multi-agency safeguarding intervention. While professionals worked hard within individual services, the absence of a sustained, system-wide safeguarding response meant that cumulative risk was not effectively understood, owned or managed. The primary learning for the partnership is the need to recognise and respond to accumulated vulnerability rather than isolated incidents, particularly where self-neglect, addiction and apparent capacitous refusal coexist.

Appendix 1

David SAR Full Integrated Chronology

The integrated chronology below is drawn from information received as part of the initial scoping exercise safeguarding adults review process and the rapid review meeting.

Agencies involved included:

- Adult social care (ASC)
- Ambulance service
- Acute hospital trust
- Department of work and pensions
- Housing association
- Mental health services
- Primary care
- Commissioned drug and alcohol services

Whilst the chronology may not include every detail from every agency involved with David it provides a summary of events that took place leading up to David's death in date order.

Background Context for Chronology

	Additional Context
October /2015	First Mental Health Trust electronic referral recorded. DAVID reported previous long-standing involvement with mental health services.
2021	Discharged from Community Mental Health Team. DAVID later reported feeling abandoned and increasingly relied upon crisis line support.
Throughout review period	District Nursing Team involvement identified by GP Practice.
Throughout review period	Primary Care reported repeated requests for help alongside repeated refusal of support despite capacity being assessed.

Date	Professional/ Role	Event Description	Actions/Decisions	Agency
06/01/24	Ambulance Service crew	111 call after reported paracetamol overdose, suicidal thoughts, alcohol misuse and poor diabetic control.	Ambulance attended; hospital declined; referrals to diabetes and alcohol services.	Ambulance Service
02/02/24	111 clinicians	Pain in feet and calf swelling.	Advised local service within 1 hour.	Ambulance Service

22/02/2024 onwards	Mental Health Services	Six referrals during review period relating to low mood, self-harm, intrusive thoughts, distress and alcohol misuse.	Ongoing crisis and MH service involvement.	Mental Health Trust
26/02/24	Mental health worker/ Ambulance service	Report DAVID suicidal.	999 responses cancelled before arrival.	Ambulance Service
28/02/24	111 clinician	Low mood reported.	Referred to crisis team.	Ambulance Service
04/03/24-13/03/24	Hospital team	Admission for bilateral chronic limb threatening ischemia with tissue loss.	MH review and alcohol discussion.	Acute Hospital Trust
19/03/24	Housing Association	Raised a concern regarding self-neglect the	Did not progress to s42.	ASC
26/03/24	Ambulance service /Hospital	Chest pain and toe pain presentation.	Attended ED; left before assessment.	Acute Hospital Trust
30/03/24	111/GP	Potential blood clot concern.	Hospital attendance advised; declined.	Ambulance Service
02/04/24	Ambulance service crew	Severe leg swelling, pain and immobility.	Conveyed to ED.	Ambulance Service
02/04/24-20/05/24	Vascular team	Hospital admission after occluded SFA stent.	Above-knee amputation on 04/04/24.	Acute Hospital Trust
12/04/24	111 clinician	Inpatient call regarding pain after amputation.	Advice given.	Ambulance Service
17/05/24	Social care	Referral received and sent to reablement.	Reablement arranged.	ASC
20/05/24	Reablement	Care commenced.	4 daily calls reduced to 2 after assessment.	ASC
04/06/24	Reablement	Refused carers entry and threatened police involvement.	Care disrupted.	ASC
05/06/24	Individual Support Services	Accepted visit but refused care.	Discussed at OneTeam.	ASC

	Social Worker			
06/06/24	Individual Support Services Social Worker	Welfare follow-up.	No issues reported; review planned.	ASC
11/06/24	Friend contact	Friend advised DAVID not coping.	Face-to-face visit planned.	ASC
12/06/24	Social Worker	Agreed visit.	Assessment continued.	ASC
17/06/24	Care provider	Offer of 3 calls weekly.	Care offered.	ASC/ Housing Association
19/06/24	Social Worker	Accepted care package.	OT referral and vascular discussion.	ASC
21/06/24	Social Worker home visit	Setting himself tasks and attending community activities.	Monitoring.	ASC
24/06/24	Care provider	Care started.	Ongoing review.	ASC
28/06/24	Social Worker	Care going well.	Benefits check offered.	ASC
17/07/24	Social Worker	Vascular review, talking therapy offered, Limbless Association involved.	Transferred to Community Team.	ASC
02/08/24	Occupational Therapy ASC	OT appointment booked.	Assessment planned.	ASC
06/08/24	Occupational Therapy ASC	Assessment completed.	Recommended door opener and kitchen adaptations.	ASC
16/09/24	ASC Finance team	Refused financial assessment.	Advice provided.	ASC
20/09/24	111 clinician	Mental health difficulties reported.	Advice to contact crisis team.	Ambulance Service
23/09/24	Duty team	Discussion about refusal of financial assessment.	Explained full cost implications and PIP advice.	ASC
25/09/24	111 clinician	Leg pain reported.	No further action.	Ambulance Service

27/09/24	Housing association	Requested longer care calls.	Discussion with DAVID.	Housing Association
30/09/24	Occupational Therapy ASC	Refused all adaptations.	Case continued.	ASC
06/10/24	Housing Association	raised a safeguarding in relation to self-neglect	Progressed to Section 42	ASC
07/10/24	Social Worker/Local Area Coordinator	Cancelled care due to affordability. Safeguarding concerns about eating, alcohol and mood.	Joint visit arranged.	ASC
08/10/24	ASC staff	Allocated for visit.	Assessment planned.	ASC
14/10/24	ASC staff	Care reinstated.	Financial assessment re-referred.	ASC
16/10/24	Occupational Therapy ASC	Closed after refusal of support.	Case closed.	ASC
17/10/24	ASC staff	Discussed anxiety, alcohol use, self-neglect and impact of amputation.	Referrals for alcohol, IAPT, wheelchair and Limbless Association.	ASC
22/10/24	ASC staff	Rapid cataract progression identified.	Monitoring.	ASC
30/10/24	Ambulance service	Reported overdose.	Ambulance attended; admission refused.	Ambulance Service
01/11/24	Local Area Coordinator	Reported doing well.	PIP progressing.	ASC
01/11/2024-31/12/2024	GP	Frequent discussion due to requests for help while declining support.	Support options repeatedly explored.	Primary Care
04/11/24	Friend and social worker	Concerns about self-care, eating and continence.	Follow-up completed.	ASC
08/11/24	Emergency Duty Team ASC	Further concerns raised.	Recorded.	ASC

11/11/24	ASC staff	Large volume of messages; David objected to photos.	Crisis team referral already made by GP.	ASC
12/11/24	ASC staff	IAPT follow up, wheelchair urgency raised, home visit.	Further visit arranged.	ASC
18/11/24	ASC staff	Disclosed excessive drinking and inability to cope.	Support discussed.	ASC
19/11/2024	DWP	State Pension commenced.	Claim established.	DWP
19/11/24	ASC staff	Supported hospital attendance.	Anxious about further amputation.	ASC
20/11/24	ASC staff	Advocacy offered.	Care Act review support.	ASC
26/11/24	ASC staff	Agreed financial assessment and care.	Progressed.	ASC
27/11/24	Finance staff ASC	Care invoice paid.	Recorded.	ASC
04/12/2024	DWP	PIP commenced.	PIP established with CYC support.	DWP
04/12/24	Occupational Therapy ASC	Transfers reviewed; bed obstruction identified.	Fire safety referral.	ASC
12/12/24	CLG	Cancelled appointment	Partner cancelled appointment	Drug And Alcohol Commissio ned Service
13/12/24	ASC staff	Invoices causing distress.	Joint working with finance.	ASC
Dec 2024	Mental Health Trust	Referral to MHSOP.	Assessment planned for Feb 2025.	Mental Health Trust
10/01/25	housing association	Tenancy concerns, rent arrears and staff intimidation discussed.	Multi-agency meeting planned.	Housing Association
14/01/25	housing association staff	DAVID keen for financial assessment and care.	Information shared.	Housing Association
Jan 2025	Mental health trust	Awaiting MHSOP assessment.	Assessment remained pending.	Mental Health Trust

16/01/25	ASC staff	Refused visit and consent to share information.	Later stated he no longer wished to work with council.	ASC
22/01/25	Drug and alcohol service staff	Appointment with CGL	Last seen by CGL would have an appointment every 2 weeks- wanted abstinence from alcohol and had a care plan in place – last of two appointments attended from self-referral	Drug And Alcohol Service
27/01/25	Finance	Invoice contact.	Recorded.	ASC
31/01/25	ambulance service	Fall during transfer; alcohol use and poor daily living identified.	Falls and social care referrals made.	Ambulance Service
04/02/25-10/02/25	Hospital team	Admission for worsening left foot pain, ulceration and alcohol dependence.	Detoxification completed; foot clinic booked.	Acute Hospital Trust
08-09/02/25	Housing association staff	Repeated out-of-hours intoxicated and abusive calls.	No emergency noted.	Housing Association
Feb 2025	Mental Health Trust / Housing Association	Welfare and MH concerns raised by partner and housing staff.	Joint assessment discussions.	Mental Health Trust
10/02/25 10:00	Housing Association staff	Management meeting.	Risks and management reviewed.	Housing Association
10/02/25 11:00	Housing Association staff	Home visit.	DAVID disengaged and ended visit.	Housing Association
10/02/25	Housing Association staff	Contact with duty about care funding.	Refusal of assessment noted.	Housing Association
11/02/25	Housing Association staff	Emergency pendant call for continence support.	Support provided outside protocol; team briefed.	Housing Association
12/02/2025-14/02/2025	External Agencies/ Mental Health Trust	Safeguarding concerns raised to mental health services.	Later identified as not fully explored/escalated.	Mental Health Trust

12/02/25	Housing Association staff	Found intoxicated on floor; multiple contacts to duty, crisis team and CMHT.	999 called; treatment refused.	Housing Association
12/02/25 07:57	Ambulance Service	Fall with head injury while intoxicated.	Hospital declined despite advice.	Ambulance Service
12/02/25 evening	Housing Association staff	Multiple calls for continence support and assistance.	Ambulance and healthcare support repeatedly declined.	Housing Association
12/02/25	Emergency Duty Team ASC	Concern call from partner and DAVID sounded intoxicated.	Extra checks requested.	ASC
13/02/25 early hours	Housing Association staff	Repeated calls and self-harm comments.	111/crisis team contacted.	Housing Association
13/02/25 03:00	Housing Association staff	Reported intent to harm himself.	Welfare checks undertaken; safe.	Housing Association
13/02/25	Housing Association staff	Safeguarding referral for self-neglect.	Submitted to duty team.	Housing Association
13/02/25	ASC	Ambulance service referral requesting social care assessment.	Discussion with HOUSING ASSOCIATION about ambulance and safeguarding actions.	ASC
14/02/25	Housing Association staff	Reported fall, refused hospital.	Further safeguarding referral and Samaritans information.	Housing Association
15/02/25 01:48	Ambulance Service	Distressed and intoxicated call.	Transferred to 111; no further action.	Ambulance Service
15/02/25 13:57	Ambulance Service	Reported overdose whilst intoxicated.	Ambulance attended; later said overdose untrue; hospital declined.	Ambulance Service
15/02/25	Housing Association staff	Numerous pendant activations for continence and support.	Service limits explained; extra pendant supplied.	Housing Association
16/02/25 02:07	Housing Association staff	Emergency buzzer activation.	Responded and recorded.	Housing Association

17/02/25	Housing Association staff	Welfare check.	Found deceased; 999 called.	Housing Association
17/02/25 09:22	Ambulance Service	Attended scene after welfare check.	Life extinct confirmed 09:30; police informed.	Ambulance Service
17/02/2025	Mental Health Trust	Notification of death received.	Case closed; MHSOP assessment due 20/02/2025 not completed.	Mental Health Trust