Safeguarding Adults Review for John

Author and Independent Reviewer: Frances Millar

EXECUTIVE SUMMARY

1. Introduction and Purpose

This Executive Summary sets out the key findings, learning and recommendations arising from the Safeguarding Adults Review (SAR) commissioned by the Ealing Safeguarding Adults Board (ESAB) following the death of John in November 2024.

The SAR was undertaken under Section 44 of the Care Act 2014, as John was an adult who appeared to have care and support needs, and there was reasonable cause for concern about how organisations worked together to safeguard him in the weeks preceding his death.

The purpose of this review is not to apportion blame to individuals or agencies. Instead, it seeks to understand how safeguarding systems operated around John, to identify learning, and to strengthen multi-agency practice so that adults in similar circumstances are better protected in the future.

The review has been conducted using an Appreciative Inquiry approach, recognising both strengths in practice and areas where systemic barriers limited effective safeguarding responses.

2. Who was John?

John was 77 years old at the time of his death. He lived a private life with very limited engagement with statutory services. He was registered with a GP and had a small number of historical health issues, but he was not known to Adult Social Care, mental health services, or community health services prior to late 2024.

John lived with his sister, Jane, aged 83. The siblings were each other's primary support and next of kin. There was no known wider family network.

Following the death of another sister in 2021 and the loss of their previous tenancy, John and Jane moved into sheltered accommodation in Ealing in December 2022. They opted for a "no contact" tenancy arrangement, meaning they did not receive routine wellbeing checks. This decision was within their rights but significantly reduced professional visibility.

Only after Jane's sudden death did John become visible to safeguarding systems, highlighting how adults living private or "hidden" lives may remain unseen until a crisis occurs.

3. Summary of Events

On 30th September 2024, London Ambulance Service (LAS) attended the sheltered accommodation following concerns about Jane's non-attendance at health appointments. Jane was found deceased at home. Police also attended. John was present and appeared confused. Concerns were noted about the home environment, including out-of-date food and indicators of possible self-neglect.

In the weeks following Jane's death, multiple agencies raised concerns about John's wellbeing, including the Police, Housing, and the Client Financial Affairs (CFA) team. These concerns related to confusion, isolation, ability to manage household affairs, and John's capacity to cope alone following bereavement.

Despite multiple alerts and escalations between October and November 2024, these concerns did not result in a coordinated safeguarding response before John's death. Welfare visits by Housing went unanswered, and internal delays in referral handling meant that some concerns were not actioned in a timely way.

On 19th November 2024, following further escalation, LAS attended again and sadly found John deceased at home.

4. Scope and Methodology

The review focused on the period following Jane's death, examining how agencies recognised and responded to John's needs and risks, how information was shared, and how safeguarding responsibilities were understood and discharged.

The SAR drew on:

- Individual Management Reviews and chronologies from relevant agencies
- Documentary evidence
- Practitioner reflections gathered through a multi-agency learning and reflection event
- National safeguarding research and statutory guidance

The review explicitly avoided retrospective judgement based on information not available at the time and focused on systemic learning rather than individual accountability.

5. Key Findings

5.1 Reactive rather than coordinated safeguarding responses

Agency involvement increased following Jane's death, but this involvement was largely reactive and fragmented. Although multiple agencies identified concerns, these were not consistently drawn together to assess cumulative risk or to prompt coordinated safeguarding action.

The review highlights that visibility alone did not translate into protection. John became visible to services only after crisis events, and the safeguarding system did not respond with sufficient coordination or clarity.

5.2 Bereavement as a significant change in circumstances

Bereavement alone does not constitute a safeguarding concern. However, in John's case, bereavement occurred alongside clear indicators of vulnerability, including confusion, isolation, and possible self-neglect.

Practitioners later reflected that this combination should have prompted proactive consideration of a Care Act assessment and/or safeguarding enquiry. This represents a key learning point about considering and recognising bereavement as a trigger when combined with indicators of vulnerability.

5.3 System barriers to timely action

The review identified system-level issues that delayed safeguarding responses, including:

- Referral mis-grading
- Administrative backlogs
- Delays in uploading referrals to case management systems

These issues created blind spots where risk was not acted upon promptly. Importantly, these were systemic conditions, not individual failures.

5.4 Unclear ownership of safeguarding risk

Multiple agencies held pieces of information about John's situation, but no single agency took timely ownership of coordinating safeguarding responses as risk escalated.

Practitioners described uncertainty about who was responsible for progressing concerns once referrals had been made. This lack of consolidated escalation contributed to drift at a critical point.

5.5 Pressure on non-traditional safeguarding teams

Housing and CFA staff demonstrated persistence in raising concerns and attempting to keep John visible, often beyond their usual remit.

CFA staff, in particular, experienced the emotional burden of managing statutory funerals for both siblings while carrying safeguarding concerns without clear escalation routes or organisational support.

This highlights the importance of recognising and supporting non-traditional safeguarding roles within the system.

6. What Worked Well

Despite the challenges identified, the review also found examples of good practice, including:

- Persistence by practitioners in raising and re-raising concerns
- Compassionate engagement with John during a period of acute bereavement
- Attempts to maintain visibility despite limited access
- Commitment across agencies to learning and improvement

These strengths provide a foundation on which future safeguarding practice can build.

7. Service Improvements Since the Events Reviewed

Agencies have reported a range of service improvements aimed at strengthening safeguarding systems. These include:

- Real-time electronic safeguarding referrals within LAS
- Strengthened safeguarding training emphasising bereavement and vulnerability
- Enhanced oversight of referral grading within policing
- Increased welfare visibility and routine checks within housing
- Commitments to improved alert and information-sharing systems
- Targeted improvements to Adult Social Care "front door" processes

Where this review references grading, recording, or referral handling, these are considered system-level issues rather than individual or agency fault. Service improvements reflect wider organisational learning and were not reported as changes implemented solely in response to John's death.

8. Key Learning

The review identified six cross-cutting learning points:

1. Bereavement, when combined with indicators of vulnerability, should prompt proactive safeguarding consideration.
2. Referral triage and escalation pathways must ensure concerns are acted upon in real time.
3. Clear accountability and shared ownership of safeguarding risk are essential.
4. Communication and alert systems must support multi-agency visibility of risk.
5. Adults living private or "hidden" lives require proportionate mechanisms to maintain visibility.
6. Non-traditional safeguarding teams need training, clear pathways, and emotional support.

9. Recommendations

The recommendations arising from this review are framed using the CLEAR framework to ensure they are clear with case for change, evidence-based, actionable, and reviewable. They focus on:

1. Strengthening referral triage and escalation
2. Embedding recognition of bereavement-related vulnerability
3. Enhancing housing visibility and escalation pathways
4. Embedding professional curiosity and MCA practice
5. Providing trauma-informed support for staff

10. Conclusion

John's case illustrates how adults who live largely private lives can remain unseen by services until a moment of crisis. It shows that effective safeguarding relies not only on the actions of individual professionals, but on systems that are able to recognise significant change, draw information together across agencies, and respond decisively as risk begins to build.

The learning identified through this review reflects well-established themes in national safeguarding research and Safeguarding Adults Review analysis. Across the country, reviews consistently highlight bereavement and loss as pivotal moments at which previously hidden vulnerability can surface, particularly where adults have relied on informal care or close family support. Research and practice evidence demonstrate that bereavement can disrupt coping strategies, expose unmet care and support needs, and increase the risks associated with isolation, self-neglect, and difficulties managing everyday life. While bereavement in itself does not constitute a safeguarding concern, it is widely recognised as a significant change in circumstances which, when combined with indicators of vulnerability, should prompt proactive consideration of assessment, support, and coordinated response.

Seen in this context, John's experience is not exceptional, but reflective of wider national challenges in safeguarding adults whose needs only become visible following sudden loss. The case underlines the importance of systems that are able to respond to cumulative patterns of

risk rather than isolated events, and that provide clarity around escalation, accountability, and shared ownership when concerns begin to emerge.

The learning from this review offers the partnership a clear opportunity to strengthen safeguarding responses, better support practitioners, and improve coordination at critical points of change, including bereavement. If implemented consistently, the recommendations arising from this SAR have the potential to contribute to a more responsive, compassionate, and effective safeguarding system — one that reduces the likelihood of similar tragedies and honours John's life through meaningful and sustained system improvement.