



Safeguarding Adults Review for John

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Acknowledgments

At the outset, I wish to acknowledge the death of John and his sister Jane, whose lives are at the heart of this review. I offer my sincere condolences to all those who knew, cared and had contact with them. Their experiences have provided the basis for important learning across agencies.

I would like to extend my sincere thanks to everyone who contributed to this Safeguarding Adults Review. The time, honesty and thoughtful reflections offered by frontline practitioners, managers and strategic leads have been invaluable in developing a clear understanding of John and Jane's circumstances and identifying opportunities for learning and improvement.

I am grateful to colleagues from Adult Social Care, Housing, GP, London Ambulance Service, the Metropolitan Police Service, and Client Financial Affairs partners who engaged openly in practitioner discussions, shared documentary evidence, and participated in the Key Lines of Enquiry process.

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Above all, I wish to acknowledge the sensitivity with which practitioners approached this case, and their commitment to learning and improving safeguarding practice. It has been a privilege to work alongside them as the Independent Reviewer and Author of this report.

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1. Introduction

1.1 The Ealing Safeguarding Adults Board (ESAB) commissioned the Safeguarding Adults Review (SAR) Care Act 2014: Section 44, following the death of John (77) in November 2024. The statutory criteria for a SAR were met. John was an adult with care and support needs: he appeared confused and possibly cognitively impaired, was described by professionals as unable to manage his household and financial affairs and was living in poor home conditions that raised concerns about self-neglect. These needs, combined with his bereavement and isolation, meant he required coordinated support from Housing, health services, Client Financial Affairs and Adult Social Care. He was in contact with these agencies in the period before his death, and there is important learning about how they recognised and responded to his needs and risks, and how they worked together to safeguard him.

John lived with his sister Jane (83). Jane sadly died at home in late September 2024. While this review does not focus on Jane's death, it is central to understanding the circumstances that followed. Her passing left John bereaved, isolated and increasingly vulnerable. The review therefore references Jane's death and the professional responses to it, insofar as these shaped the context of John's care and safeguarding.

The purpose of this review is not to apportion blame, but to create a shared opportunity for learning and improvement. Guided by an Appreciative Inquiry approach, it seeks to understand:

- What happened in the weeks between Jane's death and John's.
- How agencies assessed and responded to the risks.
- Whether opportunities to intervene earlier were missed.
- What systemic learning can strengthen safeguarding practice across Ealing and beyond.

In doing so, the review will also acknowledge examples of persistence and good practice, valuing the dedication of professionals who raised concerns and attempted to act in John's best interests.

1.2 John and Jane's lives:

- **John:** At the time of his death aged 77, John was registered with Ealing GP Practice. He had a history of cataracts and was not known to West London NHS Trust (WLNT), which provides community health and mental health services in Ealing, nor did he have any involvement with Ealing Adult Social Care (ASC).
- **Jane:** At the time of her death aged 83, Jane was known to her GP for osteoporosis, high blood pressure and eye problems. She also had an open podiatry referral with West London NHS Trust (WLNT) and attended outpatient podiatry appointments every few months. She was not otherwise in contact with WLNT or Adult Social Care.
- **Living circumstances:** John and Jane were lifelong residents of Ealing. Following the death of their sister in 2021 and the loss of their tenancy, they moved to sheltered housing in December 2022. They opted for a "no contact" tenancy, meaning they did not receive routine wellbeing checks. Housing staff described them as polite and private people often seen when walking their dog.
- **Support network:** John and Jane were each other's next of kin, with no known wider family.

Only following Jane's death did John become visible to safeguarding systems, highlighting how private lives can remain unseen until a crisis.

2. Synopsis of Events Pertinent to the Review

2.1 As previously noted John (77) and his sister Jane (83) lived together in sheltered housing in Ealing. They were private individuals with limited engagement with services.

On 30th September 2024, Jane was found deceased at home. Her death was the first point at which agencies became alert to the potential risks faced by John, who was noted by professionals to appear confused and struggling. In the weeks that followed, concerns were raised by the Police, Housing staff, and the Client Financial Affairs (CFA) team, through October and November 2024, though the responses to these alerts varied in timing and process

Multiple alerts (highlighted in section 2.2.2) were raised through October and November, but these did not result in coordinated safeguarding action before John's death. Welfare visits by Housing staff went unanswered, and GP records show missed one appointment on the 7th November shortly before he was found deceased. This would not have necessarily alerted a concern on the GP system. On 19th November 2024, the London Ambulance Service attended following concerns and found John deceased, alongside his dog.

These events are set out in the following chronology, which provides a factual account of professional involvement with John from September to November 2024.

2.2 Timelines and Summary Chronologies

The following provides a concise, factual chronology to support the synopsis above. It summarises agency involvement before September 2024 and key events between 30th September and 19th November 2024, the agreed review period.

2.2.1 Prior agency contact

There were no recorded safeguarding concerns or Adult Social Care involvement with either John or Jane before September 2024. The only documented professional contacts were:

May 2021 – Police attendance at the sudden death of their eldest sister (aged 87). John and Jane were present; no safeguarding concerns were identified.

December 2022 – Commencement of tenancy at the sheltered accommodation. Both siblings opted for a “no contact” arrangement, which is within their right, however, limits professional oversight, especially as sheltered accommodation is typically resourced by a resource manager to support residents.

Up to early 2023 – Routine GP contact for John. After this, he did not attend further appointments, and no safeguarding concerns were identified.

2.2.2 Concise Chronology (Sept–Nov 2024)

30th September 2024 – LAS attend after health concern about Jane's non-attendance at appointments. They discover her deceased at home. John is present, appears confused, reports she is “asleep.” Police also attend. Concerns noted about out-of-date food, confusion and self-neglect.

1st October – Police referral to ARC graded Green (no timeframe for response under framework at that time)

17th – 18th October – Coroner refers Jane for a Public Health (Statutory) Funeral under the Public Health (Control of Disease) Act 1984¹. CFA note John may have dementia, police reported poor home conditions.

21st – 23rd October – CFA contacted police and Ealing housing re John. Housing confirm tenants were “no contact” but raised urgent safeguarding adult concern under Care Act 2014: Section 42² (23rd October) to ASC “for Seniors.” Housing staff noted that the sheltered accommodation was under-resourced (noting no permanent officer in post).

6th November – Referral forwarded internally but not uploaded to Mosaic³ due to Access to Resource Centre (ARC⁴) mailbox backlogs with high volumes of police referrals.

7th November – GP records noted only one missed appointment on 7th November. This would not in itself have triggered a safeguarding response within GP systems.

14th – 18th November – CFA chase housing. Housing staff visit (15 & 18 November) – no reply at the door however a neighbour reports hearing a dog. Housing emailed ASC asking if referral had been actioned.

19th November – CFA escalated the case again. On review, ARC noted that the earlier police referral had not been actioned. Police advised that welfare checks can be undertaken only where there is an immediate ‘life and limb’ risk. Although not explicitly referenced in police records, this position is broadly consistent with the principles of the national Right Care, Right Person (RCRP) model, which sets out the respective roles of police, health and social care in responding to welfare concerns. ARC contacted the GP, and Housing contacted NHS 111 and LAS. LAS attended that evening and sadly found John deceased with his dog.

3. Scope of the review

3.1 This review was commissioned to understand how agencies responded to John in the final weeks of his life and to consider what might be learned from his and Jane’s circumstances.

The scope reflects the statutory duties of the Safeguarding Adults Board under Section 44 of the Care Act 2014, which requires a focus on learning and improvement rather than apportioning blame.

3.1.1 The review therefore considered:

- John’s experiences and needs in the period following Jane’s death, with emphasis on person-centred care and the circumstances that shaped his final weeks.
- How agencies worked together, including referral handling, information sharing, and inter-agency communication at both frontline and management levels.
- The role of bereavement and isolation as significant factors, and whether these were recognised and acted upon.

¹ Public Health (Control of Disease) Act 1984 (c.22). London: HMSO

² Care Act 2014: s42

³ Mosaic is the electronic case management system used by Adult Social Care to record referrals, assessments, and casework. Failure to upload a referral onto Mosaic means the case is effectively invisible to operational staff and managers.

⁴ ARC – Access to Resources Centre (ARC) is Ealing’s adult social care front door / duty team, responsible for screening, logging, and triaging incoming safeguarding referrals and service requests.

- Strengths and areas for improvement in local safeguarding practice, highlighting where professionals showed persistence or compassion, as well as where systemic barriers limited effective response.
- System learning that can be applied to strengthen multi-agency safeguarding across Ealing and the wider region, with the intention of improving outcomes for other adults in similar circumstances.

3.1.2 Boundaries of the review:

- The SAR does not reinvestigate the causes of Jane or John’s deaths, which are matters for the coroner.
- It does not review individual professional conduct but focuses on how organisations and systems operated.
- Its emphasis is on collective learning to inform future safeguarding practice.

3.2 Appreciative Inquiry Approach

This review was facilitated using an Appreciative Inquiry (AI) approach, a strengths-based method commonly used in safeguarding reviews (Fish, Munro & Bairstow, 2008⁵; Cooperrider & Srivastva, 1987⁶). The aim was to create a safe and constructive space where practitioners could reflect on their experiences, share perspectives, and identify both strengths and areas for improvement.

AI encourages learning not only from challenges but also from examples of persistence, compassion, and professional curiosity. In this review, the approach supported agencies to acknowledge what worked well in John’s case while also considering what could have been strengthened.

By drawing out both enablers and barriers, the AI approach ensured that the learning generated was practical, relevant, and capable of being applied across the safeguarding system to inform future practice

3.3 Voice and Involvement of family and friends

During the SAR Panel discussions, consideration was given to whether any family members, friends, or wider networks could contribute to the review. Initial enquiries suggested that John and Jane were largely isolated, with no immediate relatives known to agencies.

The Panel agreed that efforts should continue to clarify whether any more distant relatives or informal connections could be identified and approached. At the time of drafting, this remains an area for further exploration, and the Board will revisit this as part of the next stage of the SAR process.

In the absence of close family involvement, the review is committed to keeping John and Jane’s voices central. Their perspectives are represented through agency observations, practitioner reflections, and contemporaneous records, ensuring that the review remains around their lived experience.

⁵ Fish, S., Munro, E. and Bairstow, J. (2008) Learning Together to Safeguard Children: Developing a Multi-Agency Systems Approach

⁶ Cooperrider, D. and Srivastva, S. (1987) ‘Appreciative Inquiry in Organizational Life’, Research in Organizational Change and Development

4. Safeguarding Adults Board SAR Referral

4.1 A Safeguarding Adults Review (SAR) is a statutory process established under Section 44 of the Care Act 2014. A Safeguarding Adults Board (SAB) must arrange a SAR when:

- An adult with care and support needs has died as a result of abuse or neglect (whether known or suspected), or has experienced serious abuse or neglect, and
- There is reasonable cause for concern about how partners and organisations worked together to safeguard that adult.

The purpose of a SAR is not to apportion blame or reinvestigate individual incidents, nor the actions of individuals or individual agencies. Instead, it is to understand how organisations and systems operated around the person, identify what worked well, what could have been improved, and what must change to better protect people in the future.

4.2 SARs are established in the principles of learning, transparency, and improvement. They focus on multi-agency working, accountability, and safeguarding responsibilities under:

- The Care Act 2014⁷ and its accompanying Care and Support Statutory Guidance (Department of Health and Social Care, 2023, updated July 2025)⁸
- The Human Rights Act 1998⁹, particularly the right to life (Article 2) and the right to be free from inhuman or degrading treatment (Article 3)
- The Mental Capacity Act 2005¹⁰, including the legal framework for decision-making, consent, and liberty

This review was initiated by the Ealing Safeguarding Adults Board following John's death, in line with its statutory duties. Board members have committed to supporting the process and using the learning to strengthen safeguarding arrangements across the partnership. This SAR will not seek to retrospectively judge decisions against information that was not known at the time.

5. Methodology

5.1 This Safeguarding Adults Review (SAR) was undertaken in line with statutory guidance and the SCIE SAR Quality Markers (2022)¹¹, ensuring that the process was transparent, proportionate, and focused on generating systemic learning.

5.2 A hybrid methodology was adopted to reflect the complexity of John's circumstances. The evidence base comprised:

- Individual Management Reviews (IMRs) and chronologies from all key agencies, including Adult Social Care (ASC), Housing, Primary Care (including the GP Practice), Metropolitan Police Service (MPS), London Ambulance Service (LAS), West London NHS Trust (WLNT), and the Client Financial Affairs (CFA) Team.
- Police reports, coronial records, and contemporaneous correspondence between CFA, Housing, and safeguarding teams.

⁷ Care Act 2014, c.23. The Stationery Office

⁸ Department of Health and Social Care (2023) Care and Support Statutory Guidance: Care Act 2014, DHSC

⁹ Human Rights Act 1998, c.42. The Stationery Office

¹⁰ Mental Capacity Act 2005, c.9. The Stationery Office

¹¹ SCIE SAR Quality Markers

These records were analysed through timeline mapping and thematic review, enabling the Panel to consider both the sequence of events and the wider systemic conditions that shaped professional responses.

5.3 Practitioner engagement was central to the process. A multi-agency learning and reflection event was convened, facilitated using an Appreciative Inquiry (AI) approach (Cooperrider & Srivastva, 1987)¹². This created a safe space for practitioners to reflect on their experiences, share what had supported or hindered their decision-making, and co-produce practical recommendations. The event also provided an opportunity to recognise the persistence and compassion shown by staff — for example, CFA officers and Housing staff who repeatedly raised concerns — while exploring the systemic pressures that made effective safeguarding more difficult to achieve.

5.4 The methodology utilised national research. The Second National Analysis of Safeguarding Adults Reviews (Preston-Shoot, 2022; Preston-Shoot, 2023)¹³ emphasises that recurring themes in SARs include failures in referral triage, the invisibility of adults living private or “hidden” lives, and the importance of considering recognising bereavement as a point of increased vulnerability. These issues resonate closely with John’s case. As national learning reminds us, these are not only technical matters but systemic conditions that have human consequences when left unaddressed.

5.5 The review also acknowledges its limitations. John and Jane lived very private lives with no known close family, which restricted opportunities to incorporate their voices directly. Their decision to opt for limited engagement with services reflects their right to a private life, protected under Article 8 of the Human Rights Act 1998 (UK Government, 1998)¹⁴. Article 8 encompasses respect for individuals’ autonomy, lifestyle choices, and family life, and this right extends to decisions about how much — or how little — individuals engage with statutory agencies.

However, Article 8 is a qualified right. Public authorities may lawfully and proportionately interfere with this right where it is necessary to protect health, safety, or the rights and freedoms of others. In safeguarding contexts, this creates a duty to balance respect for privacy with positive obligations under Articles 2 and 3 (right to life and protection from inhuman or degrading treatment), and statutory duties under Section 42 of the Care Act 2014 (UK Government, 2014) to make enquiries where adults with care and support needs may be at risk of abuse or neglect.

Case law has affirmed this balance. In *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33¹⁵, the Supreme Court held that Article 8 may be lawfully limited where proportionate to legitimate aims. In *DL v A Local Authority* [2012] EWCA Civ 253¹⁶, the Court of Appeal confirmed that Article 8 rights can be interfered with to protect vulnerable adults from harm, even where they retain capacity. Similarly, in *A Local Authority v JB* [2021] UKSC 52¹⁷, the Court reinforced the state’s positive obligations to protect individuals where risk is identified, balancing autonomy with safeguarding.

These principles are highly relevant to John and Jane’s circumstances. Their choice to live privately must be respected, but agencies also have duties to recognise when privacy intersects with potential risk — for example, through patterns of isolation, bereavement, or non-engagement — and to exercise professional curiosity and proportionate safeguarding action.

¹² Cooperrider, D. & Srivastva, S. (1987) Appreciative Inquiry in Organizational Life.

¹³ Preston-Shoot, M. (2022) Second National Analysis of Safeguarding Adults Reviews 2019–21.

¹⁴ UK Government (1998) Human Rights Act 1998: Elizabeth II. Chapter 42. London

¹⁵ *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33

¹⁶ *DL v A Local Authority* [2012] EWCA Civ 253

¹⁷ *A Local Authority v JB* [2021] UKSC 52

In the absence of family involvement, agency observations and contemporaneous records provided valuable insight into their circumstances, and the reflections of frontline practitioners ensured that both their professional perspectives and the emotional impact of this case were captured.

5.6 Ultimately, the methodology placed John at the centre of the review. By combining documentary evidence, practitioner voice, and national learning, the review sought not only to understand what happened but also to identify the conditions that enable or obstruct effective safeguarding, and to develop recommendations that are practical, compassionate, and partnership-owned.

6. Key Lines of Enquiry – in line with the SAR Terms of Reference Appendix 1.

6.1 The following Key Lines of Enquiry (KLOEs) [Figure 1] were shaped through early scoping of John’s case, which highlighted both areas of concern and opportunities for learning. Rather than focusing narrowly on whether systems “worked” or “failed,” the KLOEs were used to explore with curiosity how safeguarding responsibilities were understood, interpreted, and acted upon, and what supported or at times constrained good practice.

This approach created space not only to identify where safeguarding practice could be strengthened, but also to notice examples of persistence, compassion, and collaboration. By examining the cultural, structural, and procedural conditions that shaped professional responses, the review aims to highlight enablers as well as barriers, offering practical insights that can help the partnership build on its strengths and address vulnerabilities in future cases (SCIE, 2022)¹⁸.

Figure 1.



This review has been guided by the following KLOEs to support a structured, thematic exploration of multi-agency practice:

- **Risk Recognition and Response** – How effectively were concerns about John’s wellbeing recognised and acted upon, particularly in the context of bereavement, confusion, and self-neglect?
- **Professional Curiosity** – To what extent did practitioners explore John’s situation, test assumptions, and seek to understand his capacity and needs?

¹⁸ Social Care Institute for Excellence (SCIE) (2022) Safeguarding Adults Reviews (SARs) Quality Markers. London

- **Information Sharing** – Were concerns, referrals, and updates communicated clearly and in a timely way across agencies? Did processes or systems create delays or barriers?
- **Systems and Capacity** – How did referral handling, grading, workload, and backlog pressures affect the timeliness and quality of safeguarding responses?
- **Hidden Lives / Visibility** – How did John and Jane’s decision to opt for a “no contact” tenancy arrangement, alongside their private lifestyle, reduce their visibility to safeguarding systems? What more could have been done to make such “hidden lives” safer?
- **Person-Centred Practice** – Did agencies consider John’s lived experience, his reliance on Jane, and the impact of bereavement? Was his perspective sought or inferred?
- **Housing and Community Context** – How did sheltered housing arrangements and tenancy processes shape safeguarding responses? Were housing staff empowered and supported to escalate concerns?
- **Strengths and Good Practice** – Where did practice demonstrate persistence, compassion, or creativity (e.g., CFA escalation, housing visits)? How can such strengths be embedded across the system?
- **Governance and Accountability** – Was there clarity about roles, responsibilities, and thresholds between agencies (e.g., Police vs LAS welfare checks)? Did governance arrangements enable coordinated ownership of risk?

7. Parallel Investigations

There were no known criminal or regulatory investigations underway during the course of this SAR. An inquest is a matter for the Coroner and was pending at the time of writing.

8. Professionals Involvement

8.1 John’s life involved only limited professional engagement until the final weeks of his life. The network of agencies that became involved in the weeks following Jane’s death was therefore reactive rather than sustained [Figure 2, below]. In practice, agency involvement in referrals and care and support assessments is largely prompted by the identification of need, either through self-referral, contact by family or neighbours, or professional observation. Where adults live private lives with minimal contact, risks may remain unseen or unrecognised until a significant change in circumstances occurs. In John’s case, it was Jane’s sudden death that brought his situation to the attention of agencies for the first time. This highlights a systemic reliance on external prompts and visibility rather than proactive mechanisms to identify and respond to hidden or emerging vulnerabilities.

8.2 John attended for routine GP appointments for health matters up to early 2023 but did not engage with primary care thereafter. No safeguarding concerns were recorded until October 2024. Adult Social Care had no record of him prior to the first police referral in October 2024. West London NHS Trust confirmed that although Jane accessed outpatient podiatry services, she did not disclose caring responsibilities. Practitioners queried whether the lack of disclosure may have obscured early recognition of John’s increasing reliance on her.

8.3 Housing services became significant once John and Jane moved into sheltered accommodation in December 2022. By choosing to have a no contact tenancy, the siblings effectively opted out of regular visits or checks. Housing staff noted occasional sightings when they walked their dog, but there was no active oversight until after Jane’s death. In October 2024,

housing officers raised an urgent safeguarding referral in response to CFA concerns and subsequently carried out welfare visits.

8.4 The Client Financial Affairs (CFA) team became involved following a coroner’s referral for Jane’s statutory funeral in mid-October 2024. Through this process, CFA staff raised concerns that John appeared confused, possibly affected by dementia, and was unable to manage household affairs. They showed persistence in escalating their worries, contacting both housing and Adult Social Care repeatedly. Practitioners later reflected on the emotional impact of managing both siblings’ statutory funerals and feeling they had carried safeguarding responsibilities beyond their usual remit.

CFA Reflections

Immediate learning and reflection by CFA include that the emotional and practical burden of managing statutory funerals for both siblings was significant. The Acting Principal Social Worker and CFA representative highlighted the need for formal access to grief support and counselling for CFA staff, given the emotional impact of repeated exposure to bereavement and complex vulnerability. Although a suitable external resource had been identified, there had been no organisational follow-up at the time of the Panel meeting.

CFA also intend to update the Public Health Funeral referral form so it routinely captures contextual safeguarding information — including household composition, caring roles, and concerns about others potentially at risk following a death. They emphasised the need for a clear escalation pathway so that CFA concerns are shared with safeguarding teams and acted upon, with agreed follow-up once concerns are raised.

8.5 The Police and LAS both attended the sheltered accommodation on 30th September 2024 when Jane was found deceased. John appeared confused and the home environment raised concerns. The Police raised the safeguarding concern the following day, but LAS did not make a safeguarding or welfare referral at this point, despite the indicators of vulnerability. While raising a concern was appropriate, John’s presentation — confusion, acute bereavement, and environmental concerns — may also have warranted more assertive professional curiosity at the scene. This could have included exploring his ability to understand the situation and the risks of remaining at home and considering whether conveyance for further assessment was indicated. LAS have since acknowledged this as a missed opportunity to apply a “Think Family” approach and to consider escalation under the Care Act. On 19th November 2024, after multiple escalations by CFA and Housing, LAS attended again for a welfare check and found John deceased at home.

LAS Reflections

LAS confirmed that safeguarding should have been considered at both attendances—first when Jane was found deceased and again following the November welfare check. Both are now recognised internally as missed opportunities to apply professional curiosity and escalate under the Care Act. However, LAS practitioners reflected that single-clinician attendance limited the opportunity for on-scene reflective discussion. Where two clinicians attend, situational dialogue can support recognition of vulnerability and escalation. This was identified as a missed opportunity in John’s case.

8.6 Adult Social Care’s Access to Resources Centre (ARC) was responsible for triaging referrals. However, the 1 October police referral was mis-graded as green and was subsequently delayed, and the urgent Housing referral of 23rd October was not uploaded to Mosaic due to mailbox

backlogs. This created a gap where safeguarding responsibility was delayed until escalation on 19th November prompted joint agency checks.

8.7 This network of agencies – GP, Housing, CFA, Police, LAS and ASC – was characterised more by reactive involvement than integrated oversight. Although some reactivity is expected where adults are not engaged with services, the absence of a consolidated escalation meant that ownership of John’s cumulative risk did not occur until crisis point.

8.8 While the chronology of agency involvement highlights gaps and delays, it also shows how different professionals — often outside traditional safeguarding roles — persisted in trying to keep John visible. To explore these experiences more deeply, a Practitioner Learning and Reflection Event was held as part of the SAR process. This provided an opportunity for frontline staff to share their perspectives, reflect on what supported or constrained their practice, and identify practical recommendations for strengthening safeguarding responses in future cases

The following diagram sets out the sequence of agency contacts with John and Jane, illustrating the limited and reactive nature of professional involvement prior to John’s death.

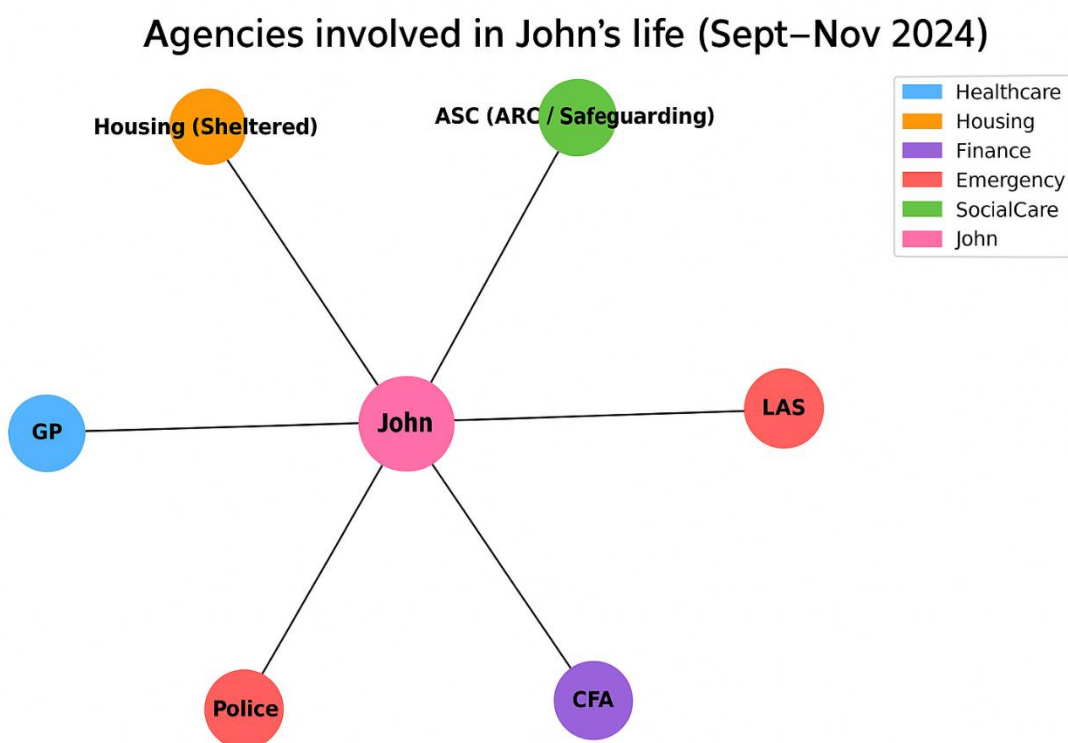


Fig 2

9. Practitioner Engagement

9.1 Following John’s death, the Safeguarding Adults Board recognised the importance of hearing directly from those practitioners who were involved. The aim was to capture not only the sequence of events, but also how professionals experienced the case, the challenges they faced, and the changes they felt could make a difference.

9.2 Practitioners from housing, Adult Social Care, Client Financial Affairs, primary care, police, and other services described the case as both complex and emotionally demanding. Several reflected on the strain of carrying safeguarding responsibilities beyond their usual remit, often without feedback or clarity on how concerns were being progressed by the receiving agency. The sense of

'missed' or delayed opportunities did not relate to individual practitioners failing to act, but to the way safeguarding alerts were triaged, escalated and coordinated once concerns had been raised. The combination of fragmented agency involvement and John's low visibility meant that no single agency brought together the cumulative concerns in a way that initiated the statutory safeguarding process under Section 42 of the Care Act.

9.3 The key themes and practitioner-led recommendations from this event are presented in Section 10. Key Messages from the Practitioner Event.

10. Practitioner Event: Thematic Learning

The Practitioner Learning and Reflection Event was facilitated using an Appreciative Inquiry (AI) approach. This created a safe and constructive space for professionals to reflect on John's case, share their lived experience of practice, and identify both the challenges and strengths within the safeguarding system. The focus was on drawing out practical learning, with practitioners co-producing the recommendations they felt would make the greatest difference.

10.1 Emerging Themes

Practitioners' reflections clustered into six thematic areas, each of which aligns with the Key Lines of Enquiry (KLOEs):

i. Isolation and Hidden Lives (KLOE: Visibility & Engagement)

In John's case, he and Jane had previously managed independently, had no identified care and support needs, and therefore had not required or sought involvement from statutory services. Their tenancy agreement further limited regular contact, meaning subtle signs of deterioration could have been missed. Practitioners reinforced the importance of persistence, visibility checks and professional curiosity where engagement is limited, while also acknowledging—as referenced in Section 5.5—an individual's right to privacy and autonomy.

ii. Bereavement as a possible Safeguarding Trigger (KLOE: Risk Assessment & Change in Circumstances)

Practitioners reflected that this was the point at which John's situation altered significantly: he was now living alone, appeared confused, and showed emerging care and support needs for the first time. Practitioners indicated that this change in circumstances should have prompted a formal response from Adult Social Care — either a Care Act needs assessment or consideration of a safeguarding enquiry under Section 42 .

iii. Communication and Information Sharing (KLOE: Multi-Agency Working)

Communication and information sharing emerged as a significant theme across agencies. Practitioners described gaps in how key information was communicated, which contributed to delays in recognising the significance of events and the emerging risks to John. Housing staff, for example, only became aware that an ambulance had attended the scheme following Jane's death when this was later mentioned by another agency. When housing officers attempted to clarify the reason for the attendance, they were not provided with information, leaving them without crucial context at a pivotal point.

While housing officers are not responsible for delivering care, practitioners emphasised that they often occupy an important position in observing day-to-day changes and raising early concerns.

In many sheltered schemes, there is now an expectation that tenants are seen at regular intervals — for example, every 10 days — which housing teams confirmed has since been introduced. In John and Jane’s case, the absence of regular visibility checks meant their lives remained largely unseen, reducing opportunities to identify deterioration or changes in circumstances following Jane’s death.

Practitioners collectively stressed the importance of coordinated alert systems that capture and share key events — such as ambulance or fire service attendance, missed appointments, or significant household risks — with clear protocols for notification and follow-up. They reflected that timely information-sharing across agencies may have strengthened joint understanding of risk by enabling a clearer picture of emerging concerns to be brought together earlier. Had Housing been informed of the ambulance attendance, they could have undertaken an earlier welfare visit, raised a safeguarding concern with fuller context, or escalated concerns to ASC more assertively. Likewise, other agencies would have been better positioned to recognise cumulative risk rather than interpreting events in isolation. In this sense, improved information-sharing may have supported earlier coordination by the statutory safeguarding lead. It is, however, important to recognise the influence of hindsight: practitioners could only act on the information available to them at the time, and the learning here relates to system processes rather than individual foresight.

iv. Referral Pathways and Triage (KLOE: Escalation & Timeliness)

The group reflected that safeguarding is “everyone’s business” and therefore every agency had a duty to raise safeguarding concerns. They stressed the importance of real-time triage supported by clear, accessible escalation pathways, to prevent concerns being delayed or lost in administrative backlogs.

v. Accountability and Shared Ownership (KLOE: Governance & Responsibilities)

Practitioners described uncertainty about who was responsible for following up alerts. They emphasised that safeguarding risk must be understood and held in partnership, rather than falling by default to housing or financial teams operating beyond their core remit. At the same time, practitioners recognised that the local authority retains the statutory duty under the Care Act 2014 to determine whether a safeguarding enquiry or Care Act assessment is required. The learning from this case relates to how that statutory responsibility is operationalised in practice — particularly how information flows, decision-making pathways, and oversight processes ensure that ASC is positioned to take timely ownership of risk when concerns are raised by partners.

vi. Learning, Reflection, and Change (KLOE: Learning & Improvement)

Practitioners valued the reflective space and hearing perspectives from other agencies. They recognised changes already made—such as housing introducing a commitment to see all tenants, including those with ‘no contact’ agreements, at least once every 10 days. They emphasised the need for ongoing reflective spaces and feedback loops to ensure change is embedded. Practitioners welcomed reflective spaces such as the AI event but noted these are not routinely available across all agencies. There is currently no multi-agency mechanism for regular cross-service reflection. Establishing a formalised reflective practice forum would support ongoing learning and system culture change.

10.2 Practitioner Recommendations

Practitioners spoke openly about the challenges they had experienced in John's case, and what, in their professional judgement, would have made the greatest difference. These challenges — outlined in Section 10.1 (Emerging Themes) — related to isolation and limited visibility, gaps in communication, delays in referral pathways, and uncertainty about who was progressing concerns. Practitioners emphasised that it was the *cumulative effect* of these factors, rather than any single issue, that shaped their experience of the case. From this honest discussion, a set of practical recommendations emerged that practitioners believed would strengthen safeguarding responses in similar situations:

- i. Strengthen referral triage and escalation** – Ensure that alerts are prioritised and acted upon in real time, with safeguards to prevent them being delayed or lost in backlogs.
- ii. Clarify accountability pathways** – Define clearly which agency or professional is responsible for holding risk at each stage, so concerns are not left without follow-up.
- iii. Improve communication and alert systems** – Develop coordinated processes for sharing critical information (e.g., ambulance attendance, fire service visits, missed appointments) with agreed feedback loops so all relevant teams are notified and follow-up is assured.
- iv. Recognise bereavement** – when combined with indicators of vulnerability or escalating risk, as a safeguarding trigger requiring proactive consideration and escalation where appropriate.
- v. Increase visibility checks for isolated adults** – Sensitively and in co-production introduce routine welfare visits or monitoring for adults known to be vulnerable, including those with “no contact” tenancy arrangements.
- vi. Support non-traditional safeguarding teams** – Provide training and clear escalation pathways for teams such as housing and Client Financial Affairs, ensuring they are not left to carry safeguarding responsibilities in isolation.
- vii. Create ongoing reflective spaces** – Offer regular opportunities for practitioners to come together across agencies to reflect, share feedback on changes, and build confidence in applying learning from cases such as John's.

10.3 Practitioners' voices captured the urgency of these recommendations:

Critical Learning

“The death of a significant person represents a critical point of vulnerability. In such circumstances, safeguarding considerations should be actively reviewed, rather than risk defaulting to housing services alone.

“Without clear escalation routes, alerts can be lost; clarity is therefore required about who holds ownership and responsibility for next steps.”

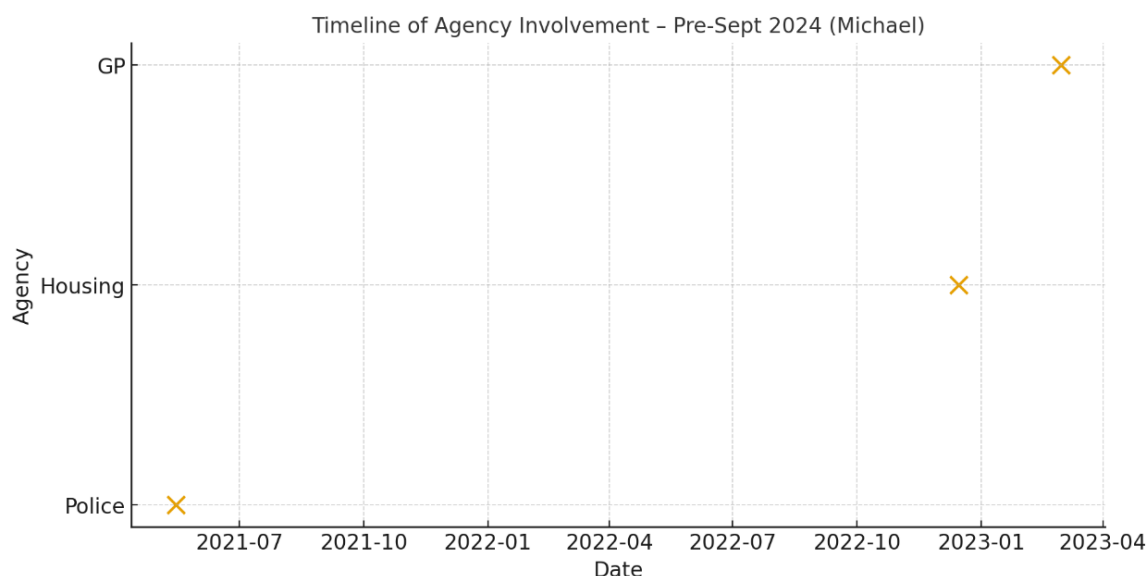
11. Analysis of practice and findings (with theoretical foundations)

The thematic analysis of practice in John’s case highlights both the limited professional contact before September 2024 and the escalation of multi-agency concern after Jane’s death, which did not translate into an effective safeguarding response. This section brings together the chronology, emerging themes, and findings, framed against the Key Lines of Enquiry (KLOEs).

11.1 Before September 2024 – sparse professional contact

John and Jane lived private and self-contained lives. Apart from occasional contact with housing and health services, they remained largely outside professional view until late 2024 [Figure 3].

Figure 3

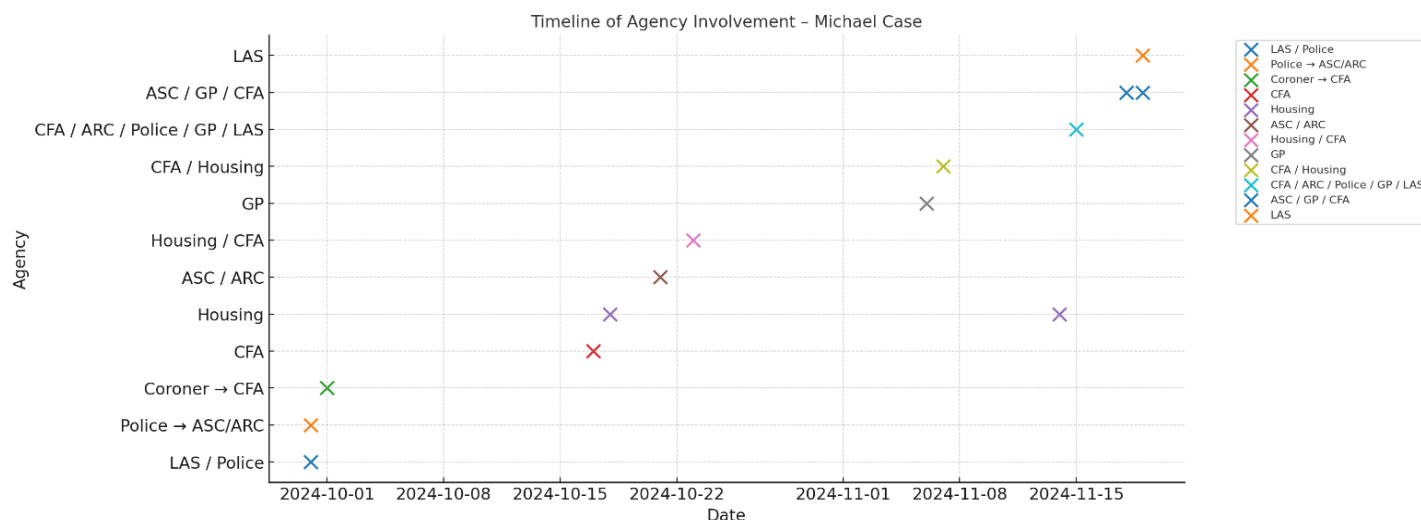


11.2 September–November 2024 – escalation and missed opportunities

Jane’s sudden death on 30th September 2024 marked a clear turning point. For the first time, agencies saw signs that John was struggling: he appeared confused, the home environment showed indicators of self-neglect — including out-of-date food, cluttered living conditions, and concerns about general household upkeep — and professionals were worried about his ability to cope. Between 1st October and 19th November 2024, multiple referrals and alerts were raised by the Police, Housing, and the CFA team.

Figures 3 & 4 illustrate this stark contrast: a long period of minimal professional contact (2021–2023), followed by a sudden surge of alerts after Jane’s death. Yet this visibility did not lead to protection. As national analyses remind us (Preston-Shoot, 2022), visibility alone is not enough — concerns must be recognised, integrated, and acted upon if risk is to be reduced.

Figure 4



11.3 Transition to thematic analysis

Taken together, the chronology shows a clear pattern: John and Jane lived largely outside professional oversight until Jane’s death, after which multiple agencies became involved.

This points to the central learning for the review: visibility does not automatically create safety. Even when John was suddenly more visible to agencies, the absence of clear triage, shared accountability, and professional curiosity meant that risks were noticed but not addressed.

To explore these issues in more depth, the following thematic analysis is structured around the KLOEs. This approach enables the review to move beyond the sequence of events and examine the cultural, structural, and procedural conditions that shaped professional responses to John.

11.4 Emerging Themes and Thematic Analysis

From the chronology, practitioner reflections, and documentary evidence, a set of interlinked themes emerged. These are explored below against the agreed Key Lines of Enquiry (KLOEs). They highlight how John’s private life, coupled with systemic weaknesses, left him at risk despite multiple alerts.

- **Hidden Lives and Visibility (KLOE: Visibility & Engagement)**

John and Jane lived privately, opting for a “no contact” tenancy and engaging minimally with health services. This limited their visibility until crisis. Jane’s death in September 2024 brought John into view, but not into safety. This reflects national SAR findings that “hidden lives” are a recurring risk factor (Preston-Shoot et al., 2020; Preston-Shoot, 2023).

- **Referral Grading and Triage (KLOE: Escalation & Timeliness)**

The police referral of 1st October described confusion, indicators of self-neglect and concerns about John’s ability to cope, yet it was graded Green, which at the time carried no timeframe for action. Housing’s urgent referral of 23rd October was not uploaded to Mosaic due to backlogs, resulting in significant drift before concerns were reviewed. Academic research on multi-agency safeguarding highlights how weaknesses in referral triage, variable thresholds, and gaps in information-sharing can delay recognition of cumulative risk and the escalation of appropriate responses. Practitioners working across agencies must make difficult judgments

about when a threshold for action has been crossed, and inconsistent information flows can compound this challenge.

These patterns resonate with national SAR analysis and CQC reviews of local authority ‘front doors’, which identify delays in triage and escalation as recurring systemic themes rather than isolated practitioner errors, reinforcing the need for consistent triage frameworks and a shared understanding of risk across partners (CQC, 2022; Preston-Shoot et al., 2020; Preston-Shoot, 2023)

- **System Capacity and Drift (KLOE: Systems & Capacity)**

At the time of the referrals concerning John, ARC was experiencing significant operational pressure. High volumes of incoming referrals — particularly police CJSM notifications — created overloaded mailboxes and workflow delays. These system conditions contributed to the delays described in the referral triage section above, where concerns did not enter the Mosaic workflow as intended.

Ealing Adult Social Care later clarified that the issue was not a shortage of core staffing, but the concentration and volume of referrals at specific points in time, which created temporary bottlenecks in handling and processing alerts. Following this surge, additional staff were deployed to stabilise the system and clear a backlog of more than 1,800 police referrals. These improvements occurred after the period relevant to this SAR.

National analyses of safeguarding systems (Preston-Shoot et al., 2020; 2023) highlight that such pressures routinely create “blind spots” in “front door” arrangements, where referrals may be delayed, overlooked, or not triaged with the expected level of scrutiny. John’s case reflects these wider systemic patterns.

Post-Review Improvements to Front Door/ARC Processes

Since John’s death, Ealing’s Adult Social Care “front door” (Access to Resources Centre – ARC) has undergone significant targeted improvements, overseen by the Ealing Safeguarding Adults Board (ESAB). These changes were part of a broader service improvement programme and were not a direct response to John’s death, but they address several of the systemic weaknesses highlighted by this review.

ASC clarified there was no shortage of staff overall; rather, the additional staffing resource was specifically targeted to manage the surge in police referrals (CJSMs). This focus has produced tangible results:

- **Police referral backlog cleared** – from a peak of over 1,800 cases last year to just 34, effectively eliminating delays.
- **Quicker outcomes** – a 300% increase in people receiving an initial outcome within 10 days, achieved through surge teams, improved triage and targeted backlog reduction.
- **Improved accessibility** – reduced call waiting times and improved answer rates.
- **Clearer safeguarding pathways** – unnecessary steps have been removed, advocacy services embedded, and practice made more consistent.

These changes have also positively impacted ARC’s ability to focus on more complex cases. For example, in January 2025, 241 referrals were processed without delay. Together, these improvements represent a significant shift towards a proactive, data-informed, person-centred front door, underpinned by ESAB’s strategic oversight.

- **Shared Ownership of Risk (KLOE: Governance & Responsibilities)**

Responsibility for safeguarding remained fragmented. MPS Police, Housing, CFA and Adult Social Care each held pieces of information, but no single agency coordinated risk or took clear ownership. Although the police did submit a safeguarding referral following their attendance on 30th September, thresholds for subsequent welfare checks between MPS and LAS were misaligned, creating uncertainty about who should take the lead when new concerns emerged.

These challenges were compounded by the introduction of the Right Care, Right Person (RCRP) model, which has significantly raised the threshold at which police respond to welfare concerns. Practitioners reported that requests for police welfare checks are now frequently declined unless there is clear evidence of immediate risk to life or limb. As a result, partners described a hesitation or uncertainty when escalating concerns, anticipating that police may not attend. This represents a substantial shift in professional practice: where police welfare checks were previously a routine component of joint risk management, RCRP now requires agencies to have clear alternative pathways and confidence in their own safeguarding responsibilities.

LAS did not submit a safeguarding referral following their attendance on 30th September, despite observable indicators of vulnerability. Practitioners reflected this as a missed opportunity to apply a “Think Family” approach and consider their duty to make a safeguarding referral in line with the Care Act 2014 and associated statutory guidance.

This constellation of issues echoes national findings, including the LGA (2019) Making Safeguarding Personal analysis, which emphasises that safeguarding responsibilities must be clearly defined, collectively understood, and jointly held. Without shared ownership of risk — particularly during periods of policy transition such as RCRP — there is a heightened risk that no agency acts decisively, even when multiple agencies hold fragments of concern

- **Professional Curiosity and Mental Capacity (KLOE: Person-Centred Practice)**

John’s presentation on the 30th September 2024, when Police and LAS attended following Jane’s death, raised concerns about his ability to manage specific decisions. He appeared confused, the home environment indicated possible self-neglect, and he had difficulties managing essential tasks. Under the Mental Capacity Act 2005, capacity must always be assessed in relation to a specific decision at a specific time. Where there is reasonable cause to doubt a person’s ability to understand, retain, use or weigh information relevant to a decision, the duty is to consider an assessment rather than assume capacity. This principle is reinforced in national guidance (ADASS, 2022)¹⁹ and in case law (A Local Authority v JB [2021] UKSC 52)²⁰.

In John’s case, the decisions potentially requiring consideration included his ability to manage his personal safety and self-care, organise urgent practical matters following Jane’s death (such as funeral arrangements), and engage with support offered by agencies. The step of considering whether an MCA assessment was required was missed here, meaning that the emerging concerns were not explored through an MCA lens. This was not aligned with MCA principles, which permit presumption of capacity only where there is no reasonable cause for doubt, and require a structured assessment where doubt is present

¹⁹ (ADASS, 2022)

²⁰ (A Local Authority v JB [2021] UKSC 52).

- **Support for Non-Traditional Safeguarding Teams (KLOE: Learning & Improvement)**
CFA officers persistently escalated concerns, keeping John visible when referrals stalled. They also carried the emotional impact of managing statutory funerals for both siblings. This highlights the importance of supporting staff who are not traditional safeguarding leads but often act as critical safety nets. Trauma-informed frameworks (Herman, 2015; Bloom, 2017) underline the need for organisational support in such cases.

CFA highlighted gaps in training for non-safeguarding frontline staff. They recommended formal training on recognising safeguarding concerns, escalation pathways, and cross-agency understanding of roles — so that concerns raised by teams outside statutory safeguarding aren't left unsupported.

11.5 Findings

The analysis of practice in John's case highlights a number of cross-cutting findings. These draw together the themes explored above (**Section 11.4**) and provide a bridge into the recommendations.

Headline Findings:

- Referral triage errors meant urgent concerns (confusion, bereavement, unsanitary conditions) were mis-graded by the police and left without timely follow-up (KLOE: Thresholds and Risk Grading).
- Systemic backlogs and administrative drift (e.g., unallocated referrals, failure to upload to Mosaic) created blind spots where risk was effectively invisible (KLOE: Systems and Capacity).
- Hidden lives and tenancy invisibility reduced oversight, with bereavement not treated as a potential risk (KLOEs: Hidden Lives, Bereavement, Person-Centred Practice).
- Fragmented accountability meant no single agency assumed ownership of safeguarding risk, with responsibilities blurred between Police, LAS, Housing, and ASC (KLOE: Governance and Shared Ownership).
- Missed opportunities for professional curiosity and MCA assessment left questions of cognition and capacity untested at a critical time (KLOE: Professional Curiosity and Capacity).
- Non-traditional safeguarding teams (e.g., CFA, Housing) carried risk beyond their remit, showing persistence but experiencing emotional strain without adequate systemic support (KLOEs: Strengths and Good Practice; Staff Wellbeing).

These findings reflect not only the practice gaps in John's case, but also wider systemic conditions identified in national SAR analyses (Preston-Shoot et al., 2020; 2022; 2023).

Table 1. Cross-Reference of KLOEs, Findings and Evidence Base

No	KLOE (from TOR)	Relevant Findings (from Section 11.5)	Supporting Evidence / Research
i.	Thresholds and Risk Grading To reflect on how safeguarding thresholds were applied and understood in practice, particularly in relation to known indicators of self-neglect, isolation, and cumulative risk following bereavement, and to explore	Threshold decisions highlighted both strengths and challenges: practitioners identified risk factors (confusion, bereavement, unsanitary conditions) but thresholds for response were not consistently applied, leaving some concerns without timely follow-up. This creates an	Preston-Shoot et al. (2020); Preston-Shoot (2023)

	how threshold decision-making might be strengthened in future cases.	opportunity to strengthen confidence and consistency in grading decisions.	CQC (2022)
ii.	Referral Handling and Systems Delay To examine the systemic and operational factors that contributed to delays in responding to safeguarding concerns, and to identify what changes in referral pathways, triage, or escalation mechanisms are needed to enable timely intervention in similar circumstances.	Referral pathways showed persistence by staff (Housing, CFA) but were hindered by system pressures, mailbox backlogs, and unclear processes. This highlights the resilience of practitioners and the need to better align operational systems so their efforts translate into timely safeguarding action.	Reason (1997); Dekker (2011); Preston-Shoot et al. (2020); Preston-Shoot (2023)
iii.	Professional Curiosity and Escalation To explore how professionals responded to emerging concerns, including whether missed opportunities for assertive practice and escalation could be addressed through strengthened training, supervision, and cross-agency clarity on roles.	Professionals noticed John's confusion and difficulties, and some persisted in escalating their worries (notably CFA). However, opportunities for capacity assessment and safeguarding enquiry were not taken forward. This suggests that strengthening confidence in escalation and embedding professional curiosity could help practitioners act on such early signs more decisively.	Munro (1999); ADASS (2022)
iv.	Multi-Agency Communication and Coordination To understand the points at which multi-agency information-sharing and coordination were fragmented or ineffective, and to consider how structures, protocols, or relationships could be improved to enable earlier and more joined-up action.	Each agency contributed valuable insights, but these remained fragmented without a clear coordinating lead. CFA's persistence kept risk visible, but without multi-agency alignment, no single agency took ownership. This shows the importance of building structures that encourage shared responsibility and collaborative ownership of risk.	Braye & Preston-Shoot (2017); LGA (2019)
v.	Recognition and Response to Self-Neglect To consider the extent to which John's situation was understood as involving self-neglect under Section 42 of the Care Act 2014, and how professional and organisational understanding of self-neglect could be enhanced across the partnership.	Indicators of possible self-neglect were noticed but not consistently framed as safeguarding triggers. This offers learning about strengthening shared understanding of self-neglect and ensuring Section 42 duties are clearly embedded across agencies.	Preston-Shoot et al. (2020); SCIE (2018)
vi.	Organisational Oversight and Risk Management To explore whether organisational governance and oversight arrangements were sufficiently robust to detect and respond to operational risks such as unallocated referrals, triage delays, and mailbox backlogs, and to consider how systems of assurance can be strengthened to safeguard individuals in similar contexts.	The case highlights how committed staff escalated concerns, but governance gaps (e.g., mailbox blind spots, backlog) meant these did not always reach decision-makers. This underlines the need for organisational assurance systems that can translate frontline persistence into effective action.	Reason (1997); Dekker (2011); Braye & Preston-Shoot (2017); Preston-Shoot (2023)

vii.	<p>Recognition of Bereavement and Welfare Risk</p> <p>To identify missed opportunities for timely recognition of bereavement as a possible significant trigger for risk, and to consider how housing, safeguarding, and health professionals can more proactively respond to vulnerable adults following the loss of family or carer.</p>	<p>Bereavement was recognised by practitioners as a change in circumstance, but not consistently acted upon as a safeguarding trigger. This case shows the value of embedding bereavement protocols in safeguarding pathways to ensure timely support when adults lose a carer or co-resident.</p>	<p>SCIE (2018); LGA (2019); Herman (2015)</p>
viii	<p>The Role of Housing Providers in Safeguarding</p> <p>To examine how the housing provider’s responsibilities for tenancy management, resident welfare, and safeguarding intersected, and to identify how housing teams can be better supported to recognise and act upon risk within non-regulated settings.</p>	<p>Housing staff recognised risk and raised urgent referrals despite resource pressures. Their role demonstrates the importance of supporting housing providers with training, clear escalation routes, and recognition of their safeguarding responsibilities.</p>	<p>Braye & Preston-Shoot (2017); SCIE (2018)</p>
ix.	<p>Learning and Preventative Action</p> <p>What has been learned from this case so far, and how can that learning be translated into preventative action to reduce the risk of similar failures in the immediacy during the review process and in future cases?</p>	<p>Across agencies, staff persistence and concern were evident, but systemic issues limited the impact of their actions. The learning is to build on that professional commitment by aligning systems, thresholds, and governance, while embedding trauma-informed support for staff. This creates a foundation for preventative action in future.</p>	<p>Preston-Shoot et al. (2020); Bloom (2017)</p>

11.6 Theoretical Foundations

The themes in John’s case reflect a wider body of safeguarding research and theory. National analyses of Safeguarding Adults Reviews emphasise that safeguarding failures rarely stem from isolated practitioner error, but from systemic misalignments — in thresholds, communication, and accountability (Preston-Shoot et al., 2020; 2023). John’s story illustrates these dynamics in practice.

Several conceptual frameworks are particularly relevant:

- **Respectful uncertainty** (Munro, 1999)²¹ reminds practitioners to remain curious and test assumptions. In John’s case, signs of confusion and self-neglect were noticed but not pursued.
- **Systems theory** (Reason, 1997²²; Dekker, 2011²³) explains how structural weaknesses — such as overloaded mailboxes or unclear referral timescales — create “latent conditions” where human error becomes more likely to result in harm.
- **Making Safeguarding Personal** (LGA & ADASS, 2019²⁴) highlights the importance of shared ownership and person-centred practice. In John’s case, accountability was fragmented and his perspective absent, leaving him without coordinated support at a critical point.

²¹ Munro, E. (1999). ‘Common errors of reasoning in child protection work

²² Reason, J. (1997). *Managing the Risks of Organisational Accidents*. Ashgate.

²³ Dekker, S. (2011). *Drift into Failure: From Hunting Broken Components to Understanding Complex Systems*. Ashgate.

²⁴ Local Government Association (LGA) & ADASS (2019). *Making Safeguarding Personal: Supporting Practice Development*. London

- **Trauma-informed practice** (Herman, 2015²⁵; Bloom, 2017²⁶) underlines the need to support staff exposed to distressing circumstances. CFA and Housing staff demonstrated persistence, but at personal cost, underscoring the importance of organisational cultures that sustain wellbeing.

Taken together, these frameworks reinforce the central message of this review: effective safeguarding requires systems that are curious, resilient, person-centred, and supportive of practitioners. John's case demonstrates the consequences when these conditions are absent and the opportunities for learning when theory is applied to practice.

12. Summary of learning

This review identifies six cross-cutting lessons that connect John's case with national safeguarding learning. They highlight where local systems can strengthen practice and ensure adults in similar circumstances are better protected.

- **Bereavement considered as a safeguarding trigger**
Practitioners agreed that this assessment should have been initiated and that bereavement should be recognised as a potential safeguarding trigger when it coincides with indicators of vulnerability, prompting timely assessment and coordinated response.
- **Thresholds and referral handling**
Referral grading and triage processes must deliver timely action. Incorrect grading or delays in processing referrals can result in urgent risks not being identified or acted upon promptly, leading to drift at critical points
- **Professional curiosity and capacity assessment**
Practitioners need to remain curious, test assumptions, and use the Mental Capacity Act where confusion or self-neglect is observed.
- **Hidden lives and visibility**
Adults with care and support needs who choose limited contact with services may be at greater risk. Housing and community services must have clear approaches to maintain visibility and follow-up.
- **Shared ownership of risk**
Safeguarding requires coordinated action and clear accountability. Although the local authority holds the statutory safeguarding responsibility, no single agency should be left carrying responsibility in isolation
- **Support for non-traditional safeguarding teams**
Teams such as Housing and Client Financial Affairs play a vital role in raising concerns but require training, escalation routes, and emotional support to sustain this work safely.
- **Targeted system improvement and governance**
ASC's targeted response to police referral surges and triage delays demonstrates how focused operational change, supported by Board oversight, can address systemic safeguarding risks.

LAS Update - Improvements undertaken to date.

Since the events reviewed, LAS has introduced a new electronic safeguarding referral system (October 2024), enabling attending crews to submit referrals in real time directly to the local

²⁵ Herman, J. L. (2015). Trauma and Recovery

²⁶ Bloom, S. L. (2017). Creating Sanctuary: Toward the Evolution of Sane Societies

authority duty team. A dedicated team of referral administrators provides oversight to ensure referrals are complete and followed up appropriately.

Level 3 safeguarding training has also been strengthened to emphasise bereavement, when combined with indicators of vulnerability, as a potential safeguarding trigger, alongside Think Family approaches. Structured feedback loops have been established, and learning from John's case has been recorded within LAS's safeguarding learning database and is monitored through internal governance arrangements

Police Update (January 2026)

At present, no formal senior officer checking system is in place for RADAR grading. However, enhanced oversight measures are operating. The MASH team sergeant is undertaking increased dip sampling to monitor grading accuracy, and an additional civilian supervisor has been appointed to strengthen oversight and quality assurance.

Where concerns regarding grading are identified, these are addressed through regular meetings between the local authority and the police MASH team, providing a forum for issues to be discussed and resolved collaboratively.

Housing Update

Housing has implemented a range of practice improvements following reflective learning, although these were not introduced solely in response to this SAR. These include strengthened vulnerability assessment for all tenants; removal of "no contact" arrangements; increased visibility through welfare checks at least every 10 days; enhanced MCA awareness training for staff; regular tenancy checks; clearer staff presence during periods of absence; and the introduction of updated support plans and risk assessments.

Agencies have also committed to improving alert and information-sharing systems so that significant events (such as ambulance attendance, missed health appointments, or fire service visits) are automatically shared with safeguarding teams.

Practitioners emphasised the value of reflective spaces and recommended these continue to support cross-agency learning and embed change.

Where this review references grading, recording, or referral handling across agencies, these are considered as system-level issues rather than individual or agency fault. Any service improvements described later in this report reflect wider organisational learning and development and were not reported as changes implemented specifically in response to John's death.

12.1 Strengths and Good Practice

While this Safeguarding Adults Review focuses on identifying where safeguarding systems did not respond as effectively as they might, it is also important to recognise the professional commitment and persistence demonstrated across agencies in John's case. In line with an Appreciative Inquiry approach, the review acknowledges that learning also arises from practitioners' efforts to raise concerns, maintain visibility, and act in John's best interests, even where system constraints limited the impact of those actions.

These strengths provide an important foundation for the recommendations set out in Section 13, enabling the partnership to build on what worked while addressing the systemic gaps identified through this review.

Emerging examples of good practice include:

- Persistence despite barriers
- Escalation beyond role remit
- Compassionate engagement
- Multi-agency awareness

13. System Learning and Recommendations: (CLEAR Framework)

The CLEAR framework, as defined in the Second National Analysis of Safeguarding Adults Reviews (SARs) (2022), is a tool further developed by the National Network for Chairs of Safeguarding Adults Boards (NNCSAB) to support the formulation of impactful, actionable recommendations.

No	Recommendation	C – Case for Change Clear / Clarity	L – Learning /Leadership / Logical	E – Evidence-Based / Escalation	A – Actionable / Accountability	R – Relevant / Review
1	Strengthen referral grading and triage systems	Referrals must clearly state risk factors (e.g., confusion, bereavement, self-neglect). Timescales must be unambiguous.	Leadership in ASC must ensure thresholds are applied consistently with clear decision-making logs.	CQC (2022) and Preston-Shoot (2023) highlight drift in safeguarding 'front doors.'	Implement automatic escalation if referrals are unallocated beyond a set period. Assign a duty senior to oversee triage daily.	Directly addresses delay in John's case and national learning on thresholds.
2	Embed bereavement as a risk of safeguarding concern	Embed bereavement as a red flag requiring proactive welfare checks in sheltered housing and health settings.	Housing and ASC leaders must ensure bereavement triggers safeguarding review.	SCIE (2018) and DHSC Guidance (2023) stress contextual safeguarding risks.	Develop a bereavement pathway shared with GPs, housing, and ASC.	Relevant to adults like John left suddenly isolated after loss.
3	Strengthen housing visibility in safeguarding systems	Sheltered housing providers must have clear escalation pathways for welfare concerns. These need to have clear routes to ASC	Leadership to empower housing staff with safeguarding training and clear lines into ASC.	Braye & Preston-Shoot (2017) identify housing as an under-used safeguarding partner.	Create joint housing/ASC protocols for welfare checks in 'no contact' tenancies.	Ensures housing can escalate effectively, reducing invisibility risk.
4	Enhance professional curiosity and MCA to become part of daily practice	Confusion, missed GP appointments, or inability to manage household tasks should prompt consideration of an MCA assessment in relation to the specific decisions in question.	Leaders in health, social care and police must reinforce MCA practice through training and supervision.	ADASS (2022) and Munro (1999) highlight importance of curiosity and testing assumptions.	Incorporate case-based reflection in supervision; mandate MCA where cognition is questioned.	Responds directly to John's untested confusion/self-neglect.
5	Build trauma-informed support for non-traditional safeguarding teams	Acknowledge the emotional toll for teams like CFA managing statutory funerals and safeguarding risk.	Organisational leadership to provide debriefs and psychological support.	Herman (2015) and Bloom (2017) emphasise trauma-informed systems.	SAB to adopt guidance and include debriefs and psychological support and/or safeguarding supervision to ensure wellbeing for staff carrying safeguarding beyond remit.	Relevant to CFA's role in John's case and nationally.

14. Conclusion

This Safeguarding Adults Review has sought not only to understand the circumstances surrounding John's death, but also to uncover the lessons about how systems, practitioners, and communities can work together to better protect adults whose lives are lived quietly and often out of sight.

John's life reminds us that vulnerability is not always visible until a point of crisis. His story, shaped by love and loyalty to his sister Jane, illustrates how sudden change — such as bereavement — can transform independence into risk. The agencies who became involved in the final weeks did so with persistence and concern, yet systemic barriers, capacity pressures, and fragmented accountability meant opportunities to safeguard were not realised.

Through the lens of Appreciative Inquiry, the review recognises the dedication and compassion shown by those who raised concerns and escalated worries, even when they worked outside traditional safeguarding roles. Their persistence kept John visible and demonstrates the strengths within our system that can be built upon.

The learning from this review is therefore twofold:

- It highlights where processes, thresholds, and communication need strengthening.
- It also affirms that safeguarding is everyone's responsibility and that partnership working, professional curiosity, and trauma-informed support for staff can make the difference between drift and decisive action.

The purpose of this SAR is not to place blame, but to inspire improvement. John's story offers the Ealing Safeguarding Adults Board and its partners an opportunity to reaffirm their shared commitment: to notice sooner, act with clarity and compassion, and ensure that adults living private or "hidden" lives are not left unseen.

The recommendations set out in this report aim to embed that learning into daily practice. If acted upon with consistency and courage, they can contribute to a stronger, more responsive safeguarding system — one that honours John's memory by reducing the likelihood of similar tragedies in the future.

Appendix 1 - Terms of Reference

Terms of Reference for Safeguarding Adults Review (SAR) -

Name	
Address	
Date of Birth	
Date Deceased	19/11/2024
Inquest	TBC

1. Introduction:

This Safeguarding Adults Review (SAR) has been commissioned by Ealing Safeguarding Adults Board (ESAB) following the sad death of John in November 2024. The SAR will focus on the events leading up to these incident, interagency collaboration, decision-making processes, safeguarding practices, and any opportunities for learning and improving safeguarding systems.

2. Purpose of a SAR:

The Care and Support Statutory Guidance under the Care Act 2014²⁷ makes it clear that the purpose of a Safeguarding Adults Review (SAR) is not to hold any individual or organisation personally accountable. Separate processes exist for that, such as criminal prosecutions, disciplinary procedures, employment law, and professional regulatory bodies like the Care Quality Commission²⁸ (CQC), the Nursing and Midwifery Council²⁹, the Health and Care Professions Council³⁰, and the General Medical Council³¹ (14.139). In contrast, the role of Safeguarding Adults Boards is to hold local organisations to account for how they protect adults with care and support needs.

The distinction is vital: for SARs to be effective learning tools, they must be seen as safe, constructive experiences that adopt honesty, transparency, and openness. If SARs are approached with fear of blame or punishment, individuals and organisations are likely to become defensive, resulting in limited and guarded engagement, which undermines the whole purpose of learning from past incidents.

3. Scope

3.1 The Scope of this SAR is to:

- Complete Individual Management Reviews / Chronologies covering the period of 12 months up to and including the 19th November 2024.
- Review the circumstances leading to the confirmed passing of John on 19th November 2024
- Examine the roles and actions of agencies involved in John's care and safeguarding.
- Identify any gaps in interagency communication, safeguarding procedures, and risk management.

²⁷ The requirement to conduct a Safeguarding Adults Review is set out under Section 44 of the Care Act 2014.

²⁸ The independent regulator of health and adult social care in England

²⁹ The Nursing and Midwifery Council regulates nurses and midwives in the UK

³⁰ A statutory regulator for 15 health and care professions in the UK

³¹ The General Medical Council regulates doctors in the UK

- Understand the decision-making processes concerning housing, safeguarding, and health interventions
- Provide learning opportunities to improve the safeguarding of adults at risk, particularly those with complex needs, across Ealing and beyond.

3.2 Methodology

The SAR will use a blended methodology combining a structured multi-agency chronology with thematic analysis and Appreciative Inquiry (AI)³². This approach will enable exploration of key systemic themes—such as risk grading, referral delays, self-neglect, and inter-agency communication—while encouraging forward-focused, no-blame learning. The methodology aligns with SCIE guidance³³ and is proportionate to the complexity of the case, facilitating reflection across both statutory and non-statutory agencies. Final recommendations will be shaped using the CLEAR³⁴ framework to ensure they are actionable and reviewable.

3.3 Commitment to a Respectful and Inclusive SAR

The Review will be undertaken with a commitment to openness, fairness, and impartiality. It will consciously avoid attributing blame, applying hindsight bias, or favouring any particular agency or individual. The process will prioritise compassionate and sensitive engagement with the family, ensuring they are meaningfully involved. Where needed, advocacy support will be offered to family members or representatives to facilitate their participation.

The Review will be conducted in accordance with the Equality Act 2010³⁵, ensuring due regard is given to all protected characteristics throughout the process.

4. Key Areas to further learn from

4.1. Agency Roles and Responsibilities:

Examination of the roles of key agencies involved in John’s care. These agencies involved include

- Adult Social Care,
- London Ambulance Service
- General Practitioner
- Metropolitan Police Service
- Housing Management
- Client Financial Affairs
- Voluntary and Community Sector if applicable

4.2. Key Lines of Enquiries

These Key Lines of Enquiry are shaped by known areas of concern and missed opportunity identified through initial scoping. Rather than seeking to confirm whether systems functioned appropriately, the

³² Cooperrider, D.L. and Whitney, D., 2005. *Appreciative Inquiry: A Positive Revolution in Change*. San Francisco: Berrett-Koehler.

³³ Learning Together to Safeguard Adults: An Appreciative Inquiry Approach.

³⁴ The CLEAR model (Case for change, Learning-oriented, Evidence-based, Actionable, Reviewable) is highlighted in the 2023 National SAR Analysis as an emerging standard for structuring effective recommendations

³⁵ Equality Act 2010. An Act of Parliament that legally protects individuals from discrimination

SAR will focus on how and why safeguarding responsibilities were not effectively discharged, and what this reveals about underlying cultural, structural, or procedural barriers to effective safeguarding practice. This review will be guided by the following key lines of enquiry to support a structured, thematic exploration of multi-agency practice:

- i. Thresholds and Risk Grading**
To reflect on how safeguarding thresholds were applied and understood in practice, particularly in relation to known indicators of self-neglect, isolation, and cumulative risk following bereavement, and to explore how threshold decision-making might be strengthened in future cases.
- ii. Referral Handling and Systems Delay**
To examine the systemic and operational factors that contributed to delays in responding to safeguarding concerns, and to identify what changes in referral pathways, triage, or escalation mechanisms are needed to enable timely intervention in similar circumstances
- iii. Professional Curiosity and Escalation**
To explore how professionals responded to emerging concerns, including whether missed opportunities for assertive practice and escalation could be addressed through strengthened training, supervision, and cross-agency clarity on roles.
- iv. Multi-Agency Communication and Coordination**
To understand the points at which multi-agency information-sharing and coordination were fragmented or ineffective, and to consider how structures, protocols, or relationships could be improved to enable earlier and more joined-up action.
- v. Recognition and Response to Self-Neglect**
To consider the extent to which John's situation was understood as involving self-neglect under Section 42 of the Care Act 2014, and how professional and organisational understanding of self-neglect could be enhanced across the partnership.
- vi. Organisational Oversight and Risk Management**
To explore whether organisational governance and oversight arrangements were sufficiently robust to detect and respond to operational risks such as unallocated referrals, triage delays, and mailbox backlogs, and to consider how systems of assurance can be strengthened to safeguard individuals in similar contexts.
- vii. Recognition of Bereavement and Welfare Risk**
To identify missed opportunities for timely recognition of bereavement as a significant trigger for risk, and to consider how housing, safeguarding, and health professionals can more proactively respond to vulnerable adults following the loss of a co-resident or carer.
- viii. The Role of Housing Providers in Safeguarding**
To examine how the housing provider's responsibilities for tenancy management, resident welfare, and safeguarding intersected, and to identify how housing teams can be better supported to recognise and act upon risk within non-regulated settings.
- ix. Learning and Preventative Action**
What has been learned from this case so far, and how can that learning be translated into preventative action to reduce the risk of similar failures in the immediacy during the review process and in future cases?

5. Individual Management Reports

The following agencies are invited and politely requested to contribute to the SAR by submitting Individual Management Reports (IMRs):

- Adult Social Care
- Sheltered Housing
- GP
- Ambulance Service
- Police
- NHS Trust
- Financial Services

- 5.1** The IMRs should be carried out by someone who was not directly concerned with MH or family, or the immediate line manager of the practitioner/s involved and are not Panel members of this SAR.
- 5.2** IMRs should be completed in the format provided.
- 5.3** All IMRs must include a full chronology of significant events in the format provided.
- 5.4** It is important that all IMRs also capture good practice to enable sharing for the purpose of learning and implementing evidenced based practice.

6. Timetable

- 6.1** The main timeline for this SAR will cover the 12-month period up to and including the 19th November 2024 when John was discovered.
- 6.2** All IMRs and chronologies must be submitted to Ealing Safeguarding Adults Business Team electronically by:
- 6.3** Information will be collated from the Individual Management Reports (IMRs) from the agencies listed in point 5 where they will be analysed by the Panel and Overview Report Author.
- 6.4** All agencies submitting an IMR and chronology will have the opportunity to present their findings to The Panel on **19th September 2025**.
- 6.5** The Panel will, having considered the IMR's and chronologies and taking account of the agencies presentations, agree the SAR outcomes and final publication issues at a meeting on **3rd July 2025**.
- 6.6** The Draft Report will be available for all agencies to comment on inaccuracies week commencing **15th September 2025**. All agencies will have 7 working days to notify of any inaccuracies or concerns. The independent chair/author may amend the report or will detail the concerns raised and reasons why the report has not been amended.
- 6.7** The Panel will meet on **19th September** to agree the final Overview Report and Executive Summary.
- 6.8** The Final Overview Report will be circulated to an Extraordinary Ealing Safeguarding Adults Board Members before week commencing **16th March 2026**. Individual and where appropriate and applicable family will also be notified of the key findings.
- 6.9** The Independent Chair of the Safeguarding Adults Board will identify a SAB meeting to receive and discuss the Overview Report and Executive Summary, which will be presented by the independent chair/author, and the agreed recommendations. This may be an extraordinary meeting. This should be no later than **March 2026**
- 6.10** Practitioner Learning Event: **15th September 2025**

Once the report has been presented to Ealing Safeguarding Adults Board:

All agencies involved with the SAR will take the Overview Report and Executive Summary through their own governance and accountability routes.

- All agencies involved with the SAR will debrief their staff.
- The Communication plan will be initiated.
- The action plan will be monitored by the Safeguarding Adults Board until it is completed.

7. Cross Border Collaboration- At the time of agreeing these Terms of Reference there are no other Safeguarding Adults Boards with an interest in the case that this SAR is based on.

8. Independent Chair and Panel Membership

The Safeguarding Adults Review will be independently chaired and authored by Frances Millar, who has been commissioned by Ealing Safeguarding Adults Board (ESAB). Frances Millar confirms that she is independent of ESAB and of all agencies involved in this case. Her role is to provide independent oversight of the review process, facilitate reflective discussion, and produce the final Overview Report and Executive Summary.

The SAR Panel will be made up of senior representatives from agencies with organisational involvement in the case. Panel members will provide professional insight, contribute to analysis and challenge, and ensure the review process is informed by multi-agency expertise. The Panel will also support the development and quality assurance of the report, and the identification of meaningful learning and recommendations.

The Panel membership will include:

- Frances Millar, Independent SAR Chair and Author
- Head of Adult Social Care
- Finance Department Lead
- London Ambulance Safeguarding Lead
- Designated Safeguarding Nurse Integrated Care Board
- General Practitioner
- Housing Lead
- Adult Mental Health NHS Trust
- Metropolitan Police – West Borough Command

9. Communications plan

- All public or media enquiries will be managed by ESAB or Ealing Local Authority Communications team. All agencies, statutory, voluntary and independent, should re-direct any enquiries to the above Communications Team.
- The action plan will identify how all agencies should report the SAR through their respective governance routes.

10. Additional Areas

10.1 Legal Advice

Ealing Safeguarding Adults Board and The Panel will take legal advice where it is required.

10.2 General Advice

General advice on Ealing Safeguarding Adults Review procedure will be available from the SAB Business Manager. The SAR Panel will review and amend these Terms of Reference as required during the SAR. ESAB will be informed of any changes to the Terms of Reference.

11. Confidentiality:

All information shared as part of the SAR will be treated confidentially and used only for the purposes of the review. Agencies are expected to cooperate fully and transparently, sharing all relevant data and documentation.

12. Conclusion:

This SAR aims to provide a thorough review of the events leading to the incidents involving John, to ensure that all agencies involved in his care can learn from this case and improve their safeguarding practices for those adults who are at risk by definition of The Care Act 2014 in the future.

References

- The Care Act 2014
- The Care and Support Statutory Guidance issued under the Care Act 2014
- Ealing Safeguarding Adults Review Policy and Procedures
- SCIE – Safeguarding Adult Reviews under the Care Act: implementation support.

These terms of reference have been agreed by Ealing Safeguarding Adult Review Panel and the Independent Safeguarding Adult Board Chair.

Appendix 2 – References and Bibliography

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Appendix 3 - Glossary of Terms

Term	Definition
ADASS	Association of Directors of Adult Social Services. National leadership body for directors of adult social care in England.
Adult Safeguarding	Protecting an adult's right to live in safety, free from abuse and neglect.
Appreciative Inquiry (AI)	A strengths-based approach to learning and improvement, focusing on what works well and how positive practice can be amplified.
ARC (Access to Resources Centre)	The local authority service is responsible for managing incoming safeguarding referrals and allocating resources.
Bereavement Protocol	A structured response that ensures adults are proactively supported and reviewed following the death of a co-resident, carer, or close family member.
Care Act 2014	The primary legislation setting out duties for local authorities in England to assess needs, provide care and support, and safeguard adults at risk.
CFA (Client Financial Affairs Team)	Local authority team manages the financial affairs of people unable to do so themselves, including statutory funerals.
CLEAR Framework	A framework for structuring safeguarding recommendations, ensuring they are: Clear, Leadership-focused, Evidence-based, Actionable, and Relevant.
CQC	Care Quality Commission, the independent regulator of health and social care in England.
DNAs (Did Not Attend)	A term used in healthcare when patients miss scheduled appointments without notice.
DHSC	Department of Health and Social Care, government department responsible for

	health and adult social care policy in England.
IMR (Individual Management Review)	An agency's internal review of its involvement in a case, is often submitted to SARs or Domestic Homicide Reviews.
KLOE (Key Lines of Enquiry)	Agreed areas of focus within a review, used to guide thematic analysis and ensure consistent exploration of key issues.
LAS (London Ambulance Service)	NHS ambulance trust serving London.
LGA	Local Government Association, the membership body representing local authorities in England and Wales.
Making Safeguarding Personal (MSP)	A national initiative promoting person-centred safeguarding practice that focuses on outcomes defined by the adult themselves.
MCA (Mental Capacity Act 2005)	Legislation provides the framework for decision-making on behalf of adults who may lack capacity to make specific decisions.
Mosaic	Local authority electronic case management system used to record social care contacts and safeguarding referrals.
No Contact Tenancy	A housing agreement where tenants opt out of routine welfare visits by housing staff.
Practitioner Learning Event	A reflective workshop bringing together professionals involved in a case to identify learning strengths and opportunities for improvement.
Preston-Shoot National SAR Analyses	Independent national studies of Safeguarding Adults Reviews identifying recurring themes, strengths, and system challenges across England.
Professional Curiosity	An approach to practice that involves probing, questioning, and exploring concerns rather than accepting things at

	face value, especially where risk may be hidden.
Respectful Uncertainty	A term introduced by Munro (1999) to describe the professional stance of questioning assumptions and remaining alert to potential risks, even when an adult appears quiet or compliant.
SAR (Safeguarding Adults Review)	A statutory review under Section 44 of the Care Act 2014, undertaken when an adult with care and support needs dies or experiences serious harm and there are concerns about how agencies worked together.
SCIE	Social Care Institute for Excellence, a national body promoting good practice and producing evidence-based safeguarding resources.
Section 42 Enquiry	A safeguarding enquiry duty under the Care Act 2014, requiring local authorities to make enquiries if an adult is at risk of abuse or neglect and unable to protect themselves.
Statutory Funeral	Funeral arrangements are undertaken by the local authority when no other arrangements are made.
System Drift / Normalisation of Deviance	Terms from systems theory (Reason, 1997; Dekker, 2011) describing how, under pressure, organisations gradually come to accept unsafe delays or errors as normal practice.
Trauma-Informed Practice	An approach recognising the impact of trauma on individuals (including staff), and embedding practices that promote safety, choice, and support.