



## Introduction

A Safeguarding Adults Review (SAR) examines how professionals and organisations worked together to safeguard an adult at risk and what can be learned to improve future practice. This briefing summarises the key findings, learning and recommendations from the SAR into the circumstances leading up to John's death in November 2024.



## Key message

Safeguarding adults at risk requires systems that can recognise change, gather information across agencies, and act decisively. The learning from John's case reinforces the importance of early escalation, shared accountability, and coordinated responses, especially where visibility into an adult's life is limited.

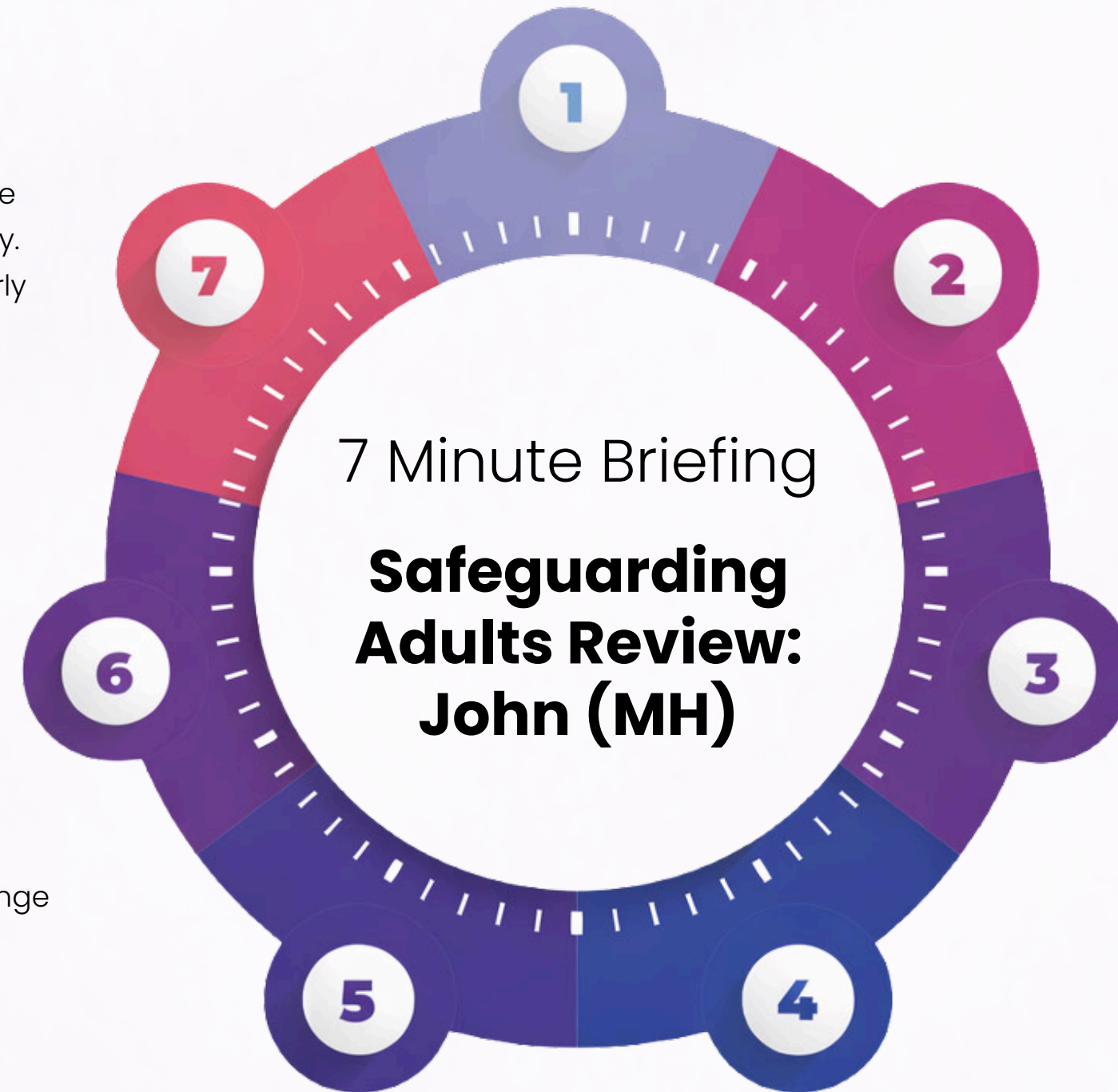
## What's changed since

Agencies have introduced a range of improvements that strengthen safeguarding processes:

- Real-time electronic referral systems
- Enhanced oversight of referral grading
- Greater welfare visibility for isolated adults
- Increased staff awareness of Mental Capacity and crisis change in circumstances
- Commitment to improving alert and information sharing mechanisms

## Recommendations (Key action areas)

- Strengthen triage and escalation pathways to ensure safeguarding concerns are acted on promptly.
- Clarify accountability and shared leadership for progressing concerns across agencies.
- Improve alert/communication systems so critical events (e.g., ambulance attendance, missed health appointments) trigger timely information sharing.
- Recognise bereavement plus vulnerability as a change in circumstances requiring proactive assessment.
- Increase routine visibility checks for adults who choose limited contact with services.
- Offer training and support for teams who regularly identify risk but are outside statutory safeguarding roles.
- Create regular multi-agency reflective spaces to embed shared learning and support staff wellbeing.



## Background

John lived privately with minimal professional contact until his sister's sudden death in September 2024. In the weeks that followed, multiple agencies became involved – including Housing, the Client Financial Affairs team, Police, London Ambulance Service and Adult Social Care. Although concerns were raised about John's wellbeing, these did not coalesce into a timely, coordinated safeguarding response before his death.

## What went well

- Practitioners across agencies showed persistence and compassion in raising concerns and maintaining visibility.
- Individual efforts to share information and escalate risk were evident even where systems constrained timely action.
- These strengths provide a basis for improvement and partnership development.

## What could have worked better

1. Recognising change in circumstances: Bereavement, when accompanied by clear indicators of vulnerability (such as confusion, isolation and self-neglect), should prompt proactive safeguarding consideration.
2. Referral triage and escalation: Delays and mis-grading of referrals limited timely action; clearer real-time triage is needed.
3. Ownership of risk: No single agency assumed responsibility for coordinating safeguarding responses as concerns accumulated.
4. Multi-agency communication: Fragmented information sharing contributed to missed opportunities to connect emerging risks.
5. Support for non-traditional safeguarding roles: Housing and financial teams acted outside usual remit without clear escalation pathways or organisational support.