Hammersmith & Fulham Safeguarding Adults Board Safeguarding Adult Report Concerning the Death of Alistair & Simon

Date of completion: December 2025

'Alistair' and 'Simon' are pseudonyms which is used to protect the identity of the subject of the review.

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1. Introduction

The Hammersmith and Fulham Safeguarding Adults Board (H&F SAB) commissioned this Safeguarding Adults Review (SAR) under Section 44 of the Care Act 2014[1] following the deaths of two adults with complex and overlapping needs: Alistair, a 54-year-old man with significant physical health problems, chronic pain and long-standing trauma; and Simon, a 45-year-old man with severe mental-health difficulties, substance use and chronic self-neglect.

Alistair was found collapsed on 11 November 2024 and died the following day. Simon was found deceased at his home on 20 February 2025, after concerns were raised when he had not been seen.

The criteria for a statutory SAR were met because:

1. there was reasonable cause for concern about how organisations worked together to safeguard both men in the months preceding their deaths; and
2. there is clear potential for learning that can strengthen multi-agency responses for adults with complex, chronic and intersecting needs.

Both men had long histories of adversity, trauma, homelessness, fluctuating capacity, self-neglect and health deterioration. Their circumstances reflect wider national patterns seen in SARs involving adults whose needs do not sit neatly within single service pathways and who require sustained, coordinated and relationship-based support.

The purpose of this review is to understand what influenced multi-agency decision-making and responses; to identify what helped and what created barriers; and to consider what changes might reduce the risk of similar outcomes in future. The review adopts a systems-focused, learning-oriented approach, with an emphasis on psychological safety, reflection and Making Safeguarding Personal[2]. This means recognising Alistair and Simon as individuals with rights, preferences and histories, and considering how their wishes, feelings and experiences were understood and responded to within professional decision making. The review has sought to present their circumstances sensitively and without stigma, with attention to how choice, autonomy and dignity were supported or constrained by the safeguarding system.

Background and Context

Alistair and Simon lived with complex, long-standing vulnerabilities that shaped their interactions with services and their ability to sustain engagement. Both had experienced trauma, instability and chronic health difficulties, and had extensive contact with health, social care, housing and voluntary-sector services in the years preceding their deaths. Their circumstances reflect a wider national pattern in which adults experience overlapping risks related to self-neglect, substance use, mental ill-health and social exclusion, often requiring sustained, coordinated and relationship-based support.[3]

Alistair lived with severe and deteriorating physical health needs, including renal disease, chronic infection and significant functional decline. These difficulties were compounded by self-neglect,

[1] Care Act 2014, s.44 (Safeguarding Adults Reviews). Statutory duty/criteria for SABs to commission SARs. Home: legislation.gov.uk. Care Act 2014

[2] Local Government Association & Association of Directors of Adult Social Services. (2014, updated 2020). *Making Safeguarding Personal: A Toolkit for Responses*. London: LGA/ADASS.

[3] Braye, S., Preston-Shoot, M., & Orr, D. (2017). *Self-Neglect and Adult Safeguarding: Findings from Research*. London: Social Care Institute for Excellence (SCIE).

inconsistent engagement and fluctuating ability to make or act on decisions. Earlier life experiences contributed to mistrust of services, and his interactions with agencies frequently occurred during periods of acute crisis, fragile discharge or rapid deterioration. His most stable and continuous relationships were with voluntary-sector practitioners, who were often the first to notice changes in his presentation.

Simon experienced enduring mental-health problems, including psychosis and emotional instability, alongside substance use and executive functioning difficulties. He lived with periods of isolation, environmental neglect and fluctuating capacity to engage. Although he had contact with primary care, mental health and substance-misuse services, his participation was often affected by distress, fear, and ambivalence about statutory involvement. As with Alistair, his most trusted and consistent relationships were with third-sector navigators, who played a crucial role in maintaining contact and identifying risk.

The experiences of both men sit within a broader context of increasing complexity in adult safeguarding, where practitioners must balance autonomy, capacity, risk and protection in situations shaped by trauma, addiction and chronic decline.[4] Recent Hammersmith & Fulham SARs, including SAR Brian (2023),[5] have highlighted recurring themes of self-neglect, homelessness, dual diagnosis and fragmented coordination. This review therefore provides an opportunity to understand how far that learning has been embedded and where systemic barriers remain.

Alistair and Simon's cases offer important insight into the functioning of the safeguarding system, the pressures on frontline practitioners, the challenges of unclear risk ownership and escalation, and the central significance of relational practice. Understanding these dynamics is essential for strengthening responses to adults whose lives are shaped by cumulative harm and complex vulnerability.

2. Methodology

2.1 Purpose and Approach

This review was completed in line with the Care Act 2014, the London Multi-Agency Adult Safeguarding Policy and Procedures, and the SCIE Safeguarding Adults Review Quality Markers.[6] It adopted a systems-learning methodology, drawing on the principles of the Learning Together model[7] to understand the organisational conditions that shaped practice rather than attributing individual blame.

The review drew on a wide range of evidence, including agency chronologies, internal records, assessments, safeguarding referrals, hospital documentation and written submissions from key services. The reviewer met with practitioners from health, adult social care, housing, mental health, substance-misuse services and the voluntary sector, and facilitated a multi-agency learning event to test emerging findings and explore areas of challenge.

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[4] Preston-Shoot, M. (2020). *Safeguarding Adults Reviews: Analysis Study of 231 SARs (April 2017 – March 2019)*. London: Local Government Association & ADASS.

[5] Hammersmith and Fulham Safeguarding Adults Board. (2023). *Safeguarding Adults Review: Brian*. London: Hammersmith and Fulham Safeguarding Adults Board.

[6] Social Care Institute for Excellence. (2022). *SAR Quality Markers: Supporting SARs to Drive Improvement*. London: SCIE.

[7] Fish, S., Munro, E., & Bairstow, S. (2008). *Learning Together to Safeguard Children: Developing a Multi-Agency Systems Approach for Case Reviews*. London: SCIE.

The analysis examined the timeline of events, decision-making processes and multi-agency coordination, with particular attention to cumulative risk, trauma, mental capacity, engagement and escalation pathways. Pseudonyms are used throughout and identifying details have been removed.

2.2 Evidence Base

The review draws on documentary evidence provided by partner agencies, including chronologies, internal case records, assessments, safeguarding referrals, risk management plans, multi-disciplinary meeting notes, clinical correspondence and housing records. Internal management reviews and incident reports were reviewed where available. Together, these documents provide a detailed record of agency involvement, presenting needs, decision points and the pattern of risk over time.

Agencies contributing evidence included:

'Alistair'	**'Simon'**
• Groundswell (*referrers*) • Adult Social Care • Central London Community Healthcare NHS Trust • Chelsea and Westminster NHS Trust • Sage Care • The Dr Hickey Surgery • Metropolitan Police Service	• Public Health - Hammersmith & Fulham Suicide Prevention Case Review and Learning Panel (*referrers*) • Adult Social Care • Imperial College Healthcare NHS Trust • Metropolitan Police Service • West London NHS Trust Ashchurch Medical Centre • Turning Point – Drug and Alcohol Services • St Mungo's • Groundswell

Relevant local policy frameworks were also reviewed, including the London Multi-Agency Adult Safeguarding Policy,[8] Mental Capacity Act 2005[9] and its Code of Practice[10], High Risk Panel procedures, and local self-neglect guidance.

The practitioner learning event provided essential context, offering insight into workload pressures, threshold considerations, fluctuating engagement, service constraints and interagency communication. These reflections informed the review's understanding of how information was interpreted and how decisions were made in real time. The reviewer is grateful to all who contributed openly and constructively.

The review was conducted independently and in line with the SAB's SAR protocol, ensuring transparency and fairness. Records were handled in accordance with information governance requirements, and agencies were invited to check factual accuracy and provide additional context.

As with all retrospective reviews, there were limitations. Some records were incomplete or unavailable, and some practitioners were not able to participate due to operational pressures, changes in employment or ill health. Reflective accounts may be shaped by recall. Nevertheless, the

[8] London Safeguarding Adults Board. (2023). *London Multi-Agency Adult Safeguarding Policy and Procedures.* London: LSAB.
[9] Mental Capacity Act 2005. London: The Stationery Office.
[10] Department of Health. (2007). *Mental Capacity Act 2005: Code of Practice.* London: The Stationery Office.

evidence base was sufficient to identify key themes, systemic influences and opportunities for learning across the partnership.

2.3 Scope of the Review

The Safeguarding Adults Review focuses on the period in which multi-agency activity was most concentrated and when risks relating to Alistair and Simon escalated in the months before their deaths. The scope reflects the complexity of each man's circumstances, the pattern of their engagement with services, and the points at which professional decisions were most likely to influence outcomes.

For Alistair, the review examines the period from **1 November 2023 to 12 November 2024**, capturing the final year of his life. This timeframe includes deteriorating physical health, repeated admissions, refusals of treatment, fluctuating capacity, environmental risks and challenges in coordinating complex care across health and social systems. Earlier history is drawn upon selectively where it assists in understanding long-standing mistrust of services, chronic self-neglect and episodes of rough sleeping.

For Simon, the review covers **January 2023 to 20 February 2025**, encompassing the final two years of his life. This includes escalating mental-health distress, substance use, environmental decline, suicidal ideation, and inconsistent engagement with mental-health and substance-misuse services. Earlier context is used where it illuminates the cumulative impact of trauma, isolation, executive impairment and housing instability.

The scope does not treat the men's lives as a series of isolated incidents but recognises the long-term adversity and intersecting needs that shaped their experiences. Relevant earlier history is therefore included where it helps to explain patterns of risk, professional assumptions and decision making.

The review also considers learning from recent local SARs, particularly SAR Brian (2023), to assess whether previous recommendations relating to self-neglect, dual diagnosis, trauma-informed practice and multi-agency risk coordination have been embedded in practice, and whether systemic barriers identified previously may have influenced responses in these cases.

Family involvement in the review was limited. In Simon's case, contact had not been possible at the time of writing, and Alistair had no known relatives available to contribute. Lived-experience perspectives were instead drawn from voluntary-sector practitioners who knew both men well and provided consistent support.

The scope reflects the SAB's commitment to understanding the complexity of these cases, the pressures faced by practitioners, and the systemic factors influencing multi-agency responses. It aims to support learning that strengthens safeguarding arrangements for adults experiencing cumulative risk, chronic vulnerability and fluctuating engagement.

2.4 Analytical Framework

The analysis in this review is guided by a set of interrelated perspectives that reflect both the Terms of Reference and the complexity of Alistair and Simon's circumstances. These perspectives move the review beyond a chronological account of events and support an examination of how practitioners understood risk, what shaped their decisions, and how the multi-agency system responded over time.

Self-neglect and cumulative risk
The review draws on research showing that risks linked to chronic ill health, trauma, environmental neglect and fluctuating engagement evolve over extended periods and rarely occur in isolation[11]. This perspective supports an understanding of both men's long-standing vulnerabilities and the need for coordinated, proactive responses.

Trauma-informed practice
A trauma-informed lens[12] is applied to explore how fear, mistrust, shame and emotional overwhelm influenced each man's engagement with services. This helps interpret behaviours such as withdrawal or refusal as potential expressions of distress rather than straightforward non-compliance.

Mental capacity and executive functioning
The review considers how cognitive and emotional factors affected Alistair and Simon's ability to process information, plan, prioritise and act on decisions, and how the Mental Capacity Act 2005 was applied in practice. This framework supports analysis of how practitioners interpreted autonomy, risk and fluctuating ability.

Multi-agency coordination and responsibility-holding
This perspective examines how agencies shared risk, escalated concerns and collaborated across organisational boundaries. It includes scrutiny of safeguarding pathways, communication practices, discharge arrangements and the operation of the High-Risk Panel.

Systems perspective
A systems approach is used to understand how organisational factors; such as workload pressures, service thresholds, continuity of care, access to specialist input and differences in agency expectations, shaped professional responses. This aligns with national SAR guidance emphasising learning about systems rather than attributing individual fault.

Together, these analytical perspectives provide the structure for interpreting events in the review and for identifying the systemic factors that enabled or constrained effective safeguarding practice.

3. Who Alistair Was

Alistair was a man of complexity, intelligence and quiet strength. Born at King's College Hospital in Camberwell, he carried a deep pride in his Scottish heritage, reflected in the Celtic cross tattoo bearing his mother's name. His early life was marked by instability, and he experienced periods of rough sleeping from a young age. Despite this, those who knew him well described a man of sharp insight, calm humour and a strong sense of fairness.

Alistair engaged with Groundswell over many years, where workers came to know him not through his difficulties but through his character. He was thoughtful, articulate and often acted as a steadying presence during tense situations. He could be firm in his views yet was usually guided by a wish to resolve conflict rather than inflame it. Although he was sometimes misjudged or scapegoated, Alistair carried himself with dignity and a quiet determination to be recognised as more than his circumstances.

[11] Hughes, K., Bellis, M., Hardcastle, K., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health, 2*(8), e356–e366.

[12] NHS England. (2022). *Trauma-Informed Approaches in Health and Care: NHS England Guidance.*

He took pride in his appearance, favouring carefully chosen clothes and moving with intention despite mobility challenges. He had a deep bond with his dog, Caira, his companion for nearly two decades, whose loss affected him profoundly. Alistair had a personal spirituality, believing in God in a way that was private and sincere rather than rooted in formal worship.

Curious and knowledgeable, he enjoyed reading, Radio 4, museums and learning new things. He had a wide range of interests, from architecture to cars to film, and delighted in sharing what he knew. He also had simple preferences that grounded him — no pickles on his Burger King, no carrots or chilli on his kebab, and a fondness for Jaffa Cakes and baked cheese and onion crisps.

Alistair attended hundreds of medical appointments in his final years and worked closely with those he trusted, including Groundswell workers and staff at Dr Hickey's surgery, who treated him with respect. He valued relationships built on patience, honesty and genuine listening. Those who knew him remember him as thoughtful, resilient and perceptive, someone who challenged assumptions and encouraged others even during his own difficult times.

4. Who Simon Was

Simon was a man shaped by early adversity, long-standing mental health difficulties and periods of significant isolation. Those who knew him described someone with insight, sensitivity and a desire for stability, even when his circumstances felt overwhelming. He engaged most meaningfully with practitioners he trusted, responding to calm and consistent support, and often showed warmth and dry humour when he felt safe.

His life was marked by fluctuating mental health, alcohol use and difficulties managing daily routines. Although his home environment reflected these struggles, he took pride in certain possessions and routines that mattered to him. Workers noted that his withdrawal or avoidance of services was often rooted in anxiety or fear rather than a lack of interest in help.

Simon valued honesty and reliability in relationships, and he was deeply affected when support changed around him. Despite the challenges he faced, he made repeated attempts to seek assistance and expressed a wish for things to improve. Practitioners remember him as more than the risks he presented: a thoughtful and often gentle man doing his best to navigate experiences that were frightening and difficult to manage alone.

5. Summary of Key Practice Episodes

Table 1 Summary of Key Practice Episodes

Key Practice Episode (KPE)	Alistair	Simon
1. Escalating health and self-neglect concerns	Increasing physical deterioration, repeated hospital attendances, difficulty managing self-care and the home environment. Concerns raised across ASC, Groundswell, primary care and community health.	Increasing mental health distress, alcohol use, suicidal ideation and deteriorating home conditions. Escalating risk recognised by voluntary sector workers and primary care.

2. Attempts to engage and assess (including capacity)	Multiple attempts to assess needs, support engagement with treatment and explore mental capacity regarding refusals. Engagement inconsistent and influenced by mistrust and pain.	Repeated attempts by voluntary sector, primary care and mental health services to assess risk, support engagement and complete MH assessments. Engagement fluctuated due to anxiety, paranoia and distress.
3. Coordination of multi-agency risk management	Informal multi-agency discussions occurred but without consistent coordination or clear ownership. High Risk Panel thresholds seen as difficult to meet, limiting escalation.	Ongoing attempts to coordinate care through mental health pathways, substance misuse services and voluntary sector navigation. Difficulties sustaining joint working and consistent oversight of risk.
4. Safeguarding activity and decision-making	Multiple safeguarding concerns raised relating to health deterioration, environment and self-neglect. Outcomes varied; questions emerged about proportionality, capacity assessments and responsibility-holding.	Safeguarding enquiries considered but not always progressed. Concerns about how mental health, addiction and self-neglect interacted were not consistently held within safeguarding processes.
5. Discharge planning and continuity of care	Recurrent discharge from hospital with fragile community arrangements. Challenges in coordinating follow-up, ensuring engagement and maintaining oversight of health risks.	No acute discharges, but transitions between mental health, primary care, substance misuse and voluntary sector support were fragmented, with gaps in sustained clinical oversight.
6. Critical final period	Rapid deterioration in physical health. Increasing concerns from Groundswell and ASC. Collapsed on 11 November 2024 and died the next day.	Heightened distress, increased alcohol use, significant home environment concerns. Not reachable on 19 February 2025; found deceased at home on 20 February 2025.

6. Systems Findings

Finding 1: Cumulative and Compounding Risk Was Not Fully Recognised or Coordinated

Alistair and Simon lived with long-standing, intersecting risks that compounded over time; including deteriorating physical and mental health, trauma histories, self-neglect, substance use, environmental hazards, social isolation and fluctuating capacity. Although individual agencies recognised aspects of this complexity, the overall cumulative pattern was not consistently brought together into a shared, multi-agency understanding of escalating harm.

Practitioners demonstrated strong, person-centred practice at multiple points. Groundswell and St Mungo's staff identified early changes in presentation, provided relational continuity, and repeatedly alerted other agencies when either man appeared distressed, deteriorating or disengaged. Health practitioners; including GPs, community nurses and hospital staff, also raised concerns in good time and documented significant risk indicators. These contributions were crucial but remained dispersed across services rather than combined to drive coordinated planning. Alongside the voluntary-sector practitioners referenced here (e.g. Groundswell, St Mungo's), commissioned substance-misuse treatment services such as DAWS were also involved and contributed to the multi-agency support provided.

National evidence shows that cumulative risk in adults with complex needs is frequently under-recognised, particularly where trauma, chronic deterioration and fluctuating engagement mask underlying decline.[13] Similarly, local learning from SAR Brian (2023) highlights the need for systems that support practitioners to integrate concerns across agencies and avoid viewing each episode as isolated.

In both cases, the absence of a shared, proactive overview meant deterioration was often seen as episodic rather than part of a long-term trajectory. Opportunities for joint planning, anticipatory intervention and coordinated risk-holding were therefore missed, despite strong individual efforts and significant good practice across the workforce.

Finding 2: Safeguarding Pathways and Threshold Decision-Making Were Inconsistent

Safeguarding pathways were not used consistently or confidently to respond to the escalating risks experienced by Alistair and Simon. Although several practitioners; including housing coordinators, GPs and voluntary-sector workers, raised concerns appropriately, decision-making across agencies varied, and referrals did not always lead to coordinated safeguarding responses. Some concerns were treated as isolated incidents rather than indicators of cumulative harm, chronic deterioration or distress-based behaviours.

Practitioners demonstrated good professional judgement in recognising risk and attempting to escalate concerns. Housing officers documented clear safeguarding indicators; community nurses highlighted repeated refusals of care; and voluntary-sector practitioners persistently sought support when either man's presentation shifted. These actions showed strong awareness of vulnerability. However, thresholds for Section 42 enquiry were interpreted differently across services, and safeguarding processes were not always used as mechanisms for shared risk-holding.

National SAR evidence indicates that safeguarding pathways for adults with complex needs are often inconsistently applied, especially where risks relate to self-neglect, fluctuating capacity, trauma and co-existing mental and physical health conditions.[14] Concerns can be reframed as lifestyle choice or non-engagement rather than indicators of escalating harm, leading to uncertainty about when safeguarding is the appropriate route. Local learning from SAR Brian (2023) identified similar issues, including variability in threshold decisions and reliance on practitioners to "hold" risk in isolation.

[13] Braye, S., Preston-Shoot, M., & Orr, D. (2017). *Self-Neglect and Adult Safeguarding: Findings from Research*. London: SCIE.

[14] Preston-Shoot, M. (2020). *Analysis of Safeguarding Adult Reviews: April 2017–March 2019*. London: LGA/ADASS.

In these cases, ambiguity around thresholds limited opportunities for multi-agency planning, collective decision-making and coordinated intervention, despite the strong efforts of individual practitioners who repeatedly attempted to escalate concerns.

Finding 3: Mental Capacity and Executive Functioning Were Not Consistently Considered Together

Both Alistair and Simon experienced fluctuating mental capacity and significant executive functioning difficulties that affected their ability to process information, plan, prioritise, and follow through on decisions about treatment, self-care and engagement. While individual practitioners undertook decision-specific assessments and recorded concerns appropriately, mental capacity and executive functioning were not consistently considered together, and assessments were not always revisited in response to deteriorating health or escalating distress.

There was notable good practice: GPs, community nurses and some hospital staff recognised fluctuating capacity, documented clear concerns, and adapted their communication accordingly. Voluntary-sector practitioners also played a key role in explaining information, supporting decision-making and recognising the impact of trauma, fear and overwhelm on both men's choices. Their sustained relational contact provided critical insight into how Alistair and Simon understood and experienced professional involvement.

However, decision-making across agencies often relied on isolated assessments rather than longitudinal understanding. Difficulties with memory, organisation, executive processing and emotional regulation were sometimes interpreted as "refusal" or "non-engagement" rather than potential indicators of impaired ability to use or weigh information. National SAR evidence highlights that adults with complex needs frequently demonstrate decision-making that appears capacitated in one moment but is significantly compromised by trauma, substance use, psychosis, pain, or cognitive overload in others.[15] The Mental Capacity Act (2005) requires assessments to be time- and decision-specific, but also proportionate, iterative and responsive to change.

In these cases, inconsistent integration of executive functioning into capacity assessments reduced opportunities for coordinated planning and contributed to differing professional interpretations of autonomy, risk and the thresholds for intervention, despite strong efforts from individual practitioners to support both men's decision-making in a respectful and person-centred way.

Finding 4: Multi-Agency Coordination, Continuity and Escalation Processes Were Not Reliable

Although individual agencies worked hard to support Alistair and Simon, multi-agency coordination and continuity of care were inconsistent. Risk information was dispersed across services, escalation routes were used inconsistently, and no single agency or forum maintained a sustained, proactive oversight of the cumulative risks. This meant that deterioration was often responded to episodically rather than as part of an escalating trajectory requiring coordinated action.

There was substantial good practice across the system. Groundswell and St Mungo's provided exceptional relational continuity, maintained contact during periods of withdrawal, and repeatedly raised concerns when they noticed subtle but significant changes in either man's presentation.

[15] ibid

Housing staff, community nurses and primary-care practitioners also demonstrated strong professional curiosity, seeking collateral information, coordinating around hospital discharges, and attempting to bring agencies together when risks increased. These efforts were notable and often went beyond expected roles.

Despite this, the wider system struggled to create a shared, continuous plan. Transitions between services; particularly hospital to community, mental health to primary care, and housing to health, were vulnerable to gaps in information-sharing, unclear expectations and limited follow-up. Case closure in one service did not reliably trigger review or escalation in another, and there was uncertainty about where chronic, cumulative or mixed-need risk should sit. National SAR analysis highlight that adults with co-existing physical health problems, substance use, mental ill-health and self-neglect are particularly affected when systems rely on linear referrals rather than coordinated partnership working.

The High-Risk Panel had the potential to support shared risk-holding but was used inconsistently. Thresholds, expectations and referral confidence varied, and its role in managing long-term or complex risk was not always clear. Local learning from SAR Brian (2023) similarly identified the need for clearer escalation routes, sustained oversight, and structured mechanisms for joint planning. No referrals were made to the High-Risk Panel in either case; the Panel was therefore not asked to consider, advise on, or decline involvement in relation to Alistair or Simon. Panel discussion highlighted that the High-Risk Panel is intended to function as an escalation mechanism when local multi-agency working has not been able to achieve shared risk ownership or coordinated action. In this model, agencies are expected to first attempt to convene proportionate local MDT discussions to respond to escalating concerns, drawing together relevant services involved at that point in time. Escalation to the High-Risk Panel should occur where local arrangements are unable to resolve disagreement, secure engagement from key agencies, or sustain coordinated oversight of risk.

Locally, the High-Risk Panel had limited impact during the review period. Practitioners reported that the High-Risk Panel did not meet as frequently as it used to. Meetings were frequently cancelled due to a perceived lack of suitable referrals, and thresholds had become increasingly restrictive. This followed an earlier period in which referrals were made too early, leading to a swing towards higher thresholds that may have inadvertently created barriers to escalation. Recent changes in Panel Chairs have led to renewed consideration of relaxing thresholds to restore balance, but confidence and awareness across the workforce had already diminished, contributing to reduced referral levels. Practitioners in the voluntary sector also reported that they were not made aware of ability to refer to the High-Risk Panel and felt these escalation routes are only advertised to statutory services. These dynamics meant the Panel did not function as a reliable mechanism for shared risk-holding in either case.

Overall, practitioners often worked with dedication and insight, but the absence of a coherent system for coordination and escalation meant that responsibility for holding risk frequently fell to individual workers or agencies, particularly those in the voluntary sector.

Finding 5: Trauma-Informed Practice Was Evident, but Not Consistently Embedded Across the System

Both Alistair and Simon had long histories of trauma, adversity, fear of services and experiences of loss and shame that shaped their engagement with professionals. Practitioners across voluntary and statutory services frequently demonstrated skilled, compassionate and relational approaches — yet

trauma-informed practice was not embedded consistently across the system, contributing to differing interpretations of behaviour, capacity and risk.

There was exceptional good practice from Groundswell and St Mungo's practitioners, who used consistent, calm communication; slowed the pace of conversations; offered choices rather than demands; and persisted gently during episodes of withdrawal or distress. These approaches aligned strongly with trauma-informed principles of safety, trust, choice, collaboration and empowerment,[16] and were central to maintaining contact with both men. Several health practitioners similarly showed sensitivity to trauma, taking time to build rapport, recognising distress during clinical interactions and adjusting their communication to reduce fear and overwhelm.

However, these strengths were not consistently supported by the wider system. Episodes of avoidance, non-attendance or refusal were sometimes interpreted as disengagement or "lifestyle choice" rather than as trauma-related responses, emotional overload or indicators of escalating vulnerability. National SAR evidence shows that trauma can significantly affect capacity, executive functioning, motivation and trust, and that without a shared trauma-informed framework, agencies may unintentionally default to risk-averse or compliance-driven responses.[17] The absence of consistent trauma-informed supervision, reflective spaces and multi-agency training limited opportunities to understand behaviour in context and to coordinate relational approaches across organisations.

Despite notable individual strengths, the wider system lacked the structures needed to sustain trauma-informed practice, meaning the responsibility for recognising and responding to trauma fell heavily on individual practitioners, particularly within the voluntary sector.

Finding 6: Suicide Risk, Deterioration and End-of-Life Concerns Were Not Viewed Through a Safeguarding Lens

Both Alistair and Simon showed indicators of significant deterioration in the months before their deaths. Simon expressed distress, hopelessness and suicidal thoughts; Alistair experienced rapid physical decline, repeated infections, functional collapse and increasing pain. Practitioners recognised many of these concerns and documented them well, but the system did not consistently interpret either man's presentation as requiring coordinated safeguarding intervention.

There was strong, compassionate and skilled practice across several agencies. Voluntary-sector workers maintained close relational contact, recognised changes in mood, behaviour and affect, and escalated concerns when Simon appeared distressed or withdrawn. Primary-care and community-health practitioners identified key risk indicators in Alistair's physical deterioration and sought to engage him in treatment despite repeated refusals. Mental-health and substance-misuse workers also made sustained efforts to maintain engagement in challenging circumstances. These contributions show significant professional commitment and emotional labour. In Simon's case, MDT discussions did take place in the period prior to his death, involving mental health, substance-misuse and other relevant services. However, the review found limited evidence that MDT discussions

[16] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* Rockville, MD: SAMHSA.
[17] Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). *A paradigm shift: Relationships in trauma-informed mental health services.* BJPsych Advances, 24(5), 319–333.

consistently translated into sustained, coordinated action or a shared multi-agency plan for managing escalating risk.

Evidence from practitioners indicates that Simon expressed ongoing concerns about the effectiveness of his medication and felt that his mental-health needs were not being adequately addressed. These disclosures formed part of a broader picture of distress, uncertainty and fluctuating engagement, and should be understood within the wider context of cumulative vulnerability rather than as standalone explanations for risk.

The system did not consistently integrate these warning signs into a shared understanding of escalating harm. Simon's suicidal ideation was not always linked to his social isolation, environmental decline, executive dysfunction and substance use. Alistair's refusal of treatment was sometimes interpreted as choice rather than a potential marker of impaired capacity, emotional overwhelm or end-of-life need. National evidence shows that adults experiencing chronic self-neglect, substance use and deteriorating mental or physical health often express distress in ways that mask underlying risk, and that suicide risk should be interpreted in the context of cumulative vulnerability rather than as a discrete event. NICE guidance also emphasises the importance of coordinated multi-agency responses to escalating risk.[18]

In these cases, opportunities for joint safety-planning, end-of-life support, or integrated responses across mental and physical health services were missed. Despite strong individual efforts, the system did not consistently frame either man's deterioration as a safeguarding concern requiring sustained and coordinated intervention.

Recommendations

The following recommendations arise directly from the systems findings in this review. They are intended to strengthen the response to adults with complex, long-term and intersecting needs, and to support practitioners who are already delivering strong, relational practice under significant pressure. Each recommendation reflects the evidence from this review, national SAR learning and local priorities within Hammersmith & Fulham. These recommendations are intended to be sufficiently specific to support accountability and action, while recognising that detailed operational design, sequencing and resourcing should be developed and agreed through the Safeguarding Adults Board and relevant quality and practice governance arrangements.

Recommendation 1: Strengthen Recognition of Cumulative and Compounding Risk

Develop a shared multi-agency approach for identifying and responding to cumulative and compounding risk in adults with complex needs, including where mental ill-health, substance use, physical health deterioration and self-neglect co-occur. This should include agreed expectations for joint chronologies, shared risk analysis over time, and clear mechanisms for bringing together fragmented information across mental health, substance-misuse, primary care, housing, adult social care and voluntary-sector services. Consideration should be given to the use of a shared or

[18] National Institute for Health and Care Excellence (NICE). (2022). *Suicide Prevention: Quality Standard (QS189).* London: NICE.

'universal' multi-agency care plan in cases where risk is chronic, escalating or not contained within a single service pathway.

Recommendation 2: Improve Consistency in Safeguarding Threshold Decision-Making

Review and clarify local Section 42 safeguarding guidance to ensure consistent application in cases involving self-neglect, chronic deterioration, fluctuating capacity and dual diagnosis. This should include clear practice prompts on when cumulative risk, repeated concern-raising or deterioration should trigger safeguarding processes, even where engagement is inconsistent. The revised guidance should be supported by multi-agency training, reflective case discussions and routine audit to strengthen confidence and consistency in threshold decision-making.

Recommendation 3: Strengthen Practice in Mental Capacity and Executive Functioning

Strengthen multi-agency practice in mental capacity assessment by explicitly incorporating consideration of executive functioning, trauma, emotional regulation and fluctuating cognition. This should include guidance and training on recognising when repeated 'unwise' decisions, non-engagement or refusal may indicate impaired ability to use or weigh information over time, and on the need for capacity assessments to be iterative, revisited and responsive to deterioration rather than treated as one-off events.

Recommendation 4: Re-Launch and Clarify the Role of the High-Risk Panel

Re-launch the High-Risk Panel with a clearly articulated remit, proportionate thresholds and consistent operating arrangements, so it functions as a reliable escalation forum for shared risk-holding where local multi-agency working has not achieved coordinated action. This should include clear guidance on when escalation is appropriate, expectations for follow-up and review, and explicit inclusion of voluntary-sector practitioners within referral and decision-making pathways. Partnership-wide communication and awareness-raising should support renewed confidence in the Panel's role.

Recommendation 5: Improve Multi-Agency Coordination, Risk Ownership and Continuity

Introduce clearer arrangements for coordinating complex cases involving cumulative risk, including agreement on lead professional or lead-agency responsibility and expectations for shared planning. This should include defined points at which multi-agency review is required (e.g. hospital discharge, service withdrawal, escalation of self-neglect or deterioration), and mechanisms to ensure that risk ownership is not left with individual practitioners or single services in isolation.

Recommendation 6: Embed Trauma-Informed Practice Across the Partnership

Embed a shared trauma-informed practice framework across the partnership, supported by multi-agency training, reflective supervision and opportunities for joint learning. This should promote a consistent understanding of trauma-related behaviours, ensuring that avoidance, refusal or withdrawal are interpreted in context and do not default to assumptions of disengagement or lifestyle choice. Organisational arrangements should support practitioners to sustain relational, psychologically informed practice in complex cases.

Recommendation 7: Strengthen Continuity and Information-Sharing During Transitions

Review and strengthen arrangements for continuity and information-sharing at key transition points, including hospital discharge, mental-health step-down, service closure and changes in housing provision. This should include agreed expectations that transitions involving adults with cumulative risk prompt proactive multi-agency review, rather than isolated decision-making or parallel case closure.

Recommendation 8: Formalise the Role of Voluntary-Sector Practitioners in Complex Case Responses

Formalise the role of voluntary-sector practitioners within safeguarding, MDT and escalation processes, recognising their relational continuity and detailed knowledge of individuals' lived experience. This should include systematic inclusion in information-sharing, planning and decision-making forums, rather than reliance on informal advocacy or persistence to ensure concerns are heard.

Table 2 Table of Recommendations

No.	Recommendation	Rationale / Link to Findings	Intended Outcome
1	**Strengthen recognition of cumulative and compounding risk, including dual diagnosis. Develop a shared multi-agency approach to identifying cumulative risk where mental ill-health, substance use, physical deterioration and self-neglect co-occur, supported by joint chronologies, shared risk analysis and consideration of a universal multi-agency care plan in complex cases.**	**Finding 1: Risk was recognised by individual services but not consistently brought together; co-occurring needs were not held as a single risk picture.**	**Earlier identification of escalating harm; improved shared understanding and coordinated responses to chronic, intersecting risk.**

2	**Improve consistency in safeguarding threshold decision-making. Clarify Section 42 guidance for cases involving self-neglect, chronic deterioration, fluctuating capacity and dual diagnosis, supported by training, reflective discussion and audit.**	**Finding 2: Thresholds were applied inconsistently, with repeated concerns not always leading to safeguarding processes.**	**Increased confidence and consistency in safeguarding decisions; clearer and timelier escalation.**
3	**Strengthen practice in mental capacity and executive functioning. Embed consideration of executive functioning, trauma and fluctuating cognition into capacity assessments, ensuring they are iterative and responsive to deterioration rather than one-off events.**	**Finding 3: Capacity assessments did not consistently reflect executive impairment or changing presentation.**	**More accurate, proportionate and trauma-informed decision-making; reduced misinterpretation of 'refusal' or non-engagement.**
4	**Re-launch and clarify the role of the High-Risk Panel. Refresh remit, thresholds and operating arrangements so it functions as a reliable escalation forum where local MDT working has not achieved shared risk ownership, including clear expectations and voluntary-sector inclusion.**	**Finding 4: Escalation routes were unclear; the Panel was not used and confidence in its role had diminished.**	**A trusted, accessible mechanism for shared risk-holding in complex cases.**
5	**Improve multi-agency coordination, risk ownership and continuity. Establish clearer expectations for lead professional/agency responsibility and defined points for multi-agency review, particularly at discharge, service withdrawal and escalation.**	**Finding 4: Risk ownership was often fragmented, falling to individual practitioners or services.**	**Sustained oversight of risk; clearer accountability and coordinated planning.**
6	**Embed trauma-informed practice across the partnership. Adopt a shared trauma-informed framework supported by training, reflective supervision and joint learning, to promote consistent interpretation of distress, avoidance and withdrawal.**	**Finding 5: Trauma-informed practice was evident but not consistently embedded system-wide.**	**More consistent, relational and psychologically informed responses across agencies.**
7	**Strengthen continuity and information-sharing during transitions. Ensure transitions (e.g. hospital discharge, mental-health step-down, housing change, service closure) prompt**	**Finding 6: Deterioration and suicide risk were not consistently held across transitions.**	**Safer transitions; reduced risk of escalation being missed at points of change.**

	proactive multi-agency review rather than isolated decision-making.		
8	**Formalise the role of voluntary-sector practitioners in complex case responses. Systematically include voluntary-sector practitioners in safeguarding, MDT and escalation processes, recognising their relational continuity and insight.**	**Findings 4 & 5: Voluntary-sector staff held significant risk informally without consistent inclusion in formal processes.**	**Better use of relational knowledge; reduced isolation of practitioners holding risk.**

Conclusion

Alistair and Simon were two men living with long-standing and complex needs arising from trauma, chronic health conditions, mental ill-health, substance use and self-neglect. Their lives were shaped by adversity, loss and fear, but also by moments of trust, connection and the sustained commitment of the practitioners who supported them.

Throughout this review, practitioners from across the voluntary and statutory sectors demonstrated exceptionally high-quality practice. Groundswell and St Mungo's staff in particular provided consistent, trauma-informed, relationship-based support that enabled both men to remain connected to services when engagement was fragile. They recognised subtle changes, persisted when contact was difficult, and repeatedly escalated concerns when they believed risk was increasing. Their insight formed a crucial part of the multi-agency understanding of both men's needs and circumstances.

Community nurses, GPs, housing officers, rough-sleeping coordinators and substance-misuse practitioners also showed considerable skill, empathy and professional curiosity. Many went well beyond the expectations of their roles, holding deep contextual knowledge and advocating tirelessly for further intervention. Their records and contributions to the learning event reflect genuine concern, emotional labour and a strong desire to protect both men from harm. The quality of frontline practice in these cases was consistently thoughtful, caring and attuned.

The challenges identified in this review stem not from individual practice but from wider systemic conditions; fragmented coordination, inconsistent thresholds, limited escalation pathways and gaps in sustained risk-holding. These structural issues constrained the ability of practitioners to act collectively on the concerns they identified and meant that responsibility for complex, cumulative risk often fell on individual workers or agencies.

The learning from this review is therefore twofold: it recognises and honours the dedication, skill and persistence of those who worked closely with Alistair and Simon, and it highlights the need for organisational structures that better support and integrate this relational work. Strengthening coordination, clarifying pathways and ensuring consistent trauma-informed responses will enable practitioners to build on the strong foundations that already exist.

Both men's deaths were deeply felt by those who knew them. The openness, reflection and commitment shown by practitioners during this review demonstrate a shared determination to improve. This conclusion acknowledges their contribution, affirms the value of their work, and sets a

clear direction for strengthening a safeguarding system capable of holding the complexity of adults with long-term and intersecting needs.

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