

Ealing Safeguarding Adult Review Concerning the death of Anish

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1. Introduction

This Safeguarding Adults Review (SAR) has been commissioned by the Ealing Safeguarding Adults Board in accordance with Section 44 of the Care Act 2014.[1] The statutory duty to undertake a SAR arises where an adult with care and support needs has died and there is reasonable cause for concern about how partner agencies worked together to safeguard them.

This Review considers the circumstances surrounding the care and support provided to Anish, a 52-year-old man with a long history of severe mental illness, including paranoid schizophrenia, who was found deceased at his home in June 2025. Anish had experienced significant mental health difficulties over many years and was known to a range of health, housing and support services. Prior to moving to Ealing, he had lived within supported accommodation in Haringey, where he was known to local mental health services. In October 2024, he moved to a secure tenancy in Ealing. Following the move, concerns gradually emerged regarding reduced engagement with services, missed appointments, difficulties maintaining contact and increasing social isolation. Despite attempts by multiple agencies to re-establish contact, Anish was not seen for a prolonged period and was subsequently found deceased within his flat.

The Review focuses primarily on the period between January 2023 and June 2025, encompassing planning for the move to independent accommodation, the transfer of care and support arrangements between boroughs, and the period of increasing disengagement that followed. Earlier information has been considered where necessary to understand Anish's longer-term mental health history, patterns of engagement and previous support needs. Particular attention is given to how readiness for independent living was assessed and understood; how care, support and clinical oversight were coordinated during the transition between services; how agencies responded to signs of self-neglect, disengagement and deteriorating wellbeing; and how safeguarding, escalation and welfare processes operated when concerns increased.

Anish's case raises important questions regarding the transition from supported accommodation to independent living for adults with severe mental illness, particularly where apparent independence may continue to rely upon significant formal and informal support. It also highlights wider challenges identified within national Safeguarding Adults Reviews concerning self-neglect, social isolation, service disengagement, cumulative risk, and the difficulties practitioners face when balancing respect for autonomy with the need to respond to escalating vulnerability.

As with many Safeguarding Adults Reviews, the issues identified do not arise from a single event or isolated decision. Rather, they reflect the interaction between housing systems, mental health services, adult social care, safeguarding processes and professional decision-making over time. The purpose of this Review is therefore not to apportion blame, but to understand practice within context, identify learning, and strengthen future multi-agency safeguarding arrangements for adults with similar needs.

[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. About Anish

Anish was born in Leicester into a British Asian family of Ugandan heritage. He was the youngest of several siblings and, according to his family, grew up in a close-knit household where family relationships, culture, religion and community played a central role in daily life. His sister described him as the "baby of the family", surrounded by older sisters and a mother who cared deeply for him. The family identified the death of Anish's mother on his fourteenth birthday as a profound and life-changing event. They described this loss as a significant turning point in his life, one from which they felt he never fully recovered. The impact of this bereavement was compounded by further family changes occurring within the same year, including the marriage and departure of several siblings from the family home. From having grown up within a large and supportive family network, Anish found himself living within a much smaller household at a time when he was already vulnerable.

His family described the gradual emergence of mental health difficulties during adolescence, including increasing social withdrawal, unusual beliefs, hearing voices and episodes of challenging behaviour. Over time, these difficulties developed into a long history of severe mental illness which shaped much of his adult life. His illness affected his relationships and often left him suspicious of those closest to him. Family members explained that, despite their continued concern and efforts to remain involved, Anish's experiences of psychosis frequently led him to believe that family members were against him. This was particularly painful for his sisters, who described continuing to care about him and monitor his wellbeing even when direct contact became difficult.

Although much of Anish's adult life was affected by mental illness, his family described many positive aspects of his personality and identity. He loved music and played traditional Indian instruments, including the tabla. He enjoyed snooker, football and other sports, took pride in his appearance, and had a strong interest in fashion. Family members also recalled his sense of humour and the enjoyment he gained from spending time with his nephews, attending football matches and participating in family activities when his health allowed. Religion and culture remained important sources of identity throughout his life. Anish was a practising Hindu and maintained a strong connection with his faith. His family described how he attended temple, made offerings even when he had very little money, and valued the cultural and religious traditions that had been part of his upbringing. These connections appeared to provide a sense of continuity and belonging, particularly during periods when other aspects of his life were uncertain.

For many years, Anish lived within supported accommodation. His family consistently described this period as one of the most settled and stable times in his adult life. They recalled that he had his own accommodation but remained connected to a supportive environment where staff knew him well, understood his cultural background and provided reassurance and oversight. His sister described the secure accommodation as feeling "almost like a family" and believed that the combination of practical support, familiarity, cultural understanding and long-standing relationships played an important role in helping him maintain stability.

The family's account highlights the complexity of Anish's circumstances. He was a man who lived with severe and enduring mental illness, but he was also a brother, uncle, musician, sports enthusiast and person of strong faith. Throughout the Review, family members expressed a wish that Anish should be remembered not solely through the circumstances of his death, but through the experiences, relationships and qualities that defined his life. They were clear that their involvement in this Review is motivated by a desire to understand what happened, to identify opportunities for learning, and to help reduce the likelihood of another vulnerable adult experiencing similar circumstances in the future.

3. Methodology

3.1 Purpose

The purpose of this Safeguarding Adults Review is to understand how agencies worked together to support and safeguard Anish, and to identify learning to strengthen future practice. In line with Section 44 of the Care Act 2014, the Review focuses on:

- **Transition Planning to Independent Living:** To examine how Anish's readiness for independent living was assessed and understood, including the extent to which his mental health needs, history of self-neglect, social isolation and support requirements were considered during planning for the move from supported accommodation to a secure tenancy in Ealing.
- **Service Continuity and Oversight:** To examine how care, support and clinical oversight were maintained during the transition between Haringey and Ealing services, including arrangements for mental health care, medication management and review of changing needs.
- **Escalation and Assertive Practice:** To examine how agencies responded to increasing disengagement, unsuccessful contact attempts and emerging concerns, including the use of safeguarding procedures, welfare checks, escalation pathways and multi-agency working.
- **Housing Policy and Eligibility:** To understand the extent to which housing policy, eligibility criteria and borough responsibilities influenced decision-making regarding Anish's move, and whether there are wider partnership learning points arising from these arrangements.
- **Mental Health Care, Medication Adherence and Clinical Escalation:** To examine how Anish's mental health was monitored following the move, including arrangements for depot medication, responses to missed appointments, recognition of relapse indicators and consideration of escalation pathways.
- **Self-Neglect and Independent Living:** To examine how agencies recognised and responded to indicators of self-neglect, deteriorating wellbeing, social isolation and vulnerability whilst Anish was living independently.

The Review adopts a systems-based methodology[2]. This approach recognises that outcomes are rarely the result of a single action or decision and instead seeks to understand how professional practice, organisational arrangements, inter-agency relationships, resources and wider system factors interacted over time. The aim is to understand not only what happened, but *why* decisions and actions made sense to practitioners at the time. The focus is on learning and improvement rather than attributing blame to individuals or organisations; on understanding the conditions in which practice occurred and identifying learning that may strengthen safeguarding arrangements for adults experiencing severe mental illness, self-neglect, social isolation and disengagement from services. The Review has also been conducted in accordance with the principles of Making Safeguarding Personal,[3] seeking to place Anish's experiences and outcomes at the centre of the analysis.

[2] Munro, E., & Fish, S. (2019). *Learning together to safeguard children: Developing a multi-agency systems approach for case reviews*. Social Care Institute for Excellence.

[3] Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS). (2014). *Making Safeguarding Personal: Guide 2014.* London: LGA.

3.2 Scope of the Review

A primary focus has been placed on the period between January 2023 and June 2025. Earlier information has been considered where necessary to understand Anish's mental health history, previous support arrangements and longer-term patterns of engagement with services.

Information was provided by partner agencies involved in Anish's care and support, including:

- Individual Management Reviews (IMRs)
- Agency chronologies
- Care records and case notes
- Policies, procedures and supporting documentation
- Housing and support provider records
- Mental health and primary care records
- Police information

Information was also provided directly by Anish's family, including documentary material, photographs and contextual information regarding Anish's life, experiences and support needs. As part of this the independent reviewer met with Anish's sister, to understand the family's experiences, concerns and reflections. The family's contribution has informed the analysis throughout this report and has been particularly important in developing an understanding of Anish as a person beyond his interactions with services.

A multi-agency practitioner learning event was held on 10th June 2026. Representatives from relevant agencies participated in a structured discussion of the circumstances surrounding Anish's care and support. The event explored emerging themes, decision-making processes, organisational influences and opportunities for learning and improvement. Insights from the learning event have been incorporated into the findings and analysis contained within this report.

3.3 Analytical Lenses

The Review has been informed by four analytical lenses which have guided the interpretation of the evidence and the development of the findings. These lenses draw on national Safeguarding Adults Review learning, self-neglect research, safeguarding policy and the wider evidence base concerning severe mental illness and social exclusion.

Self-Neglect, Executive Functioning and Cumulative Harm

Research and national SAR findings consistently demonstrate that self-neglect rarely emerges as a single event. Rather, it develops through the interaction of deteriorating health, social isolation, reduced engagement with services, environmental decline and unmet support needs. Individuals experiencing severe mental illness may retain capacity for specific decisions whilst simultaneously experiencing significant difficulties in initiating, organising and sustaining actions necessary for their

wellbeing.[4] This lens explores how agencies recognised and responded to cumulative indicators of self-neglect, deterioration and escalating vulnerability over time, and whether individual concerns were understood collectively as part of a broader pattern of risk.

Severe Mental Illness, Disengagement and Assertive Practice

Evidence from mental health and safeguarding literature highlights the challenges of supporting individuals with severe and enduring mental illness who become disengaged from services. Non-engagement may itself be a manifestation of deteriorating mental health rather than simply a lifestyle choice or expression of preference.[5] This lens considers how practitioners understood and responded to Anish's disengagement, missed appointments and loss of contact, including the extent to which responses were proactive, coordinated and proportionate to the risks presented.

Transitions, Continuity and Relational Support

National reviews repeatedly identify transitions between services, locations or support arrangements as periods of heightened vulnerability. Research also emphasises the importance of relational support, continuity and trusted professional relationships in maintaining engagement and wellbeing for individuals with complex needs.[6] This lens examines the transition from supported accommodation in Haringey to independent living in Ealing, exploring how continuity of care, support and oversight were maintained and the extent to which the loss of established relationships and support structures was understood within planning and decision-making.

System Coordination, Professional Ownership and Escalation

Safeguarding Adults Reviews frequently identify situations in which multiple agencies recognise concerns, yet no single agency develops a comprehensive picture of accumulating risk.[7] This lens explores how information was shared, how responsibility and oversight were understood, and how agencies worked together when concerns increased. Particular attention is given to escalation pathways, safeguarding responses, welfare checks and the extent to which professional curiosity, challenge and coordination supported an effective response to emerging risks.

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[4] Braye, S., Orr, D. & Preston-Shoot, M. (2015). *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: SCIE; Department of Health and Social Care (2024). *Care and Support Statutory Guidance*, Chapter 14: Self-Neglect.

[5] National Institute for Health and Care Excellence (NICE) (2016). *Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services*; Preston-Shoot, M. et al. (2020). *Analysis of Safeguarding Adults Reviews: April 2017–March 2019*. London: Local Government Association.

[6] National Housing Federation. (2023). *Research into the supported housing sector's impact on homelessness prevention, health and wellbeing.*

[7] Preston-Shoot, M., Braye, S. & Martineau, S. (2020). *Analysis of Safeguarding Adults Reviews: April 2017–March 2019*. London: Local Government Association

4. Key Practice Episodes

The Review identified four key practice episodes that capture significant stages in Anish's journey and provide the framework for understanding the circumstances surrounding his death. These episodes informed the analysis and findings presented later in this report:

Table 1 Summary of Key Practice Episodes

Key Practice Episode	Timeframe	Summary
KPE 1: Supported Accommodation, Established Oversight and Assessment of Readiness for Independent Living	January 2023 – October 2024	Explores Anish's long-term support within Secure accommodation, the nature of his daily support needs, discussions regarding future housing options and planning for a move to independent accommodation.
KPE 2: Move to Ealing, Changing Support Arrangements and Early Indicators of Need	October 2024 – February 2025	Examines the move to Ealing, establishment of the tenancy, practical support provided following the move, emerging difficulties in maintaining the tenancy and the changing nature of professional oversight.
KPE 3: Deterioration, Missed Treatment and Escalating Concerns	March 2025 – April 2025	Examines emerging evidence of self-neglect, missed depot medication, deteriorating presentation, weight-loss concerns, safeguarding referrals and increasing difficulties maintaining contact with Anish.
KPE 4: Prolonged Loss of Contact, Limited Escalation and Discovery Following Death	May 2025 – June 2025	Examines the period during which Anish became increasingly absent from view, the actions taken by agencies to establish contact and welfare, and the circumstances leading to his discovery following death.

KPE 1: Supported Accommodation, Established Oversight and Assessment of Readiness for Independent Living

Before moving to Ealing, Anish had lived in secure accommodation for over twenty years. The secure accommodation's involvement began in February 2000 and ended in November 2024. Although his placement was described as floating support, the evidence indicates that Anish was living within a much more supported environment than that term might suggest. His accommodation was described as a supported living tenancy with 24-hour staff presence within the wider service, with staff routinely available on site during the week, who knew Anish well over a long period of time.

This support was not limited to formal appointments. The secure accommodation staff provided routine oversight, practical prompting and informal monitoring. Records and practitioner discussion indicate that Anish required support to maintain aspects of daily living, including personal hygiene, changing clothes, maintaining his environment, attending appointments and sustaining routines. The placement also meant that staff were able to notice changes in his appearance, behaviour, mental state and engagement. This was particularly important because Anish's schizophrenia affected his ability to engage reliably with professionals. He was known not to consistently answer or use his phone, and periods of withdrawal or avoidance could be linked to deterioration in his mental health.

By 2022 and 2023, reviews identified a longer-term aim for Anish to move towards greater independence. However, those reviews were undertaken while Anish remained within a structured and familiar setting. His apparent independence therefore needs to be understood in context. He was not living alone without oversight; he was functioning within an environment where support, prompting and professional familiarity were built into everyday life. Adult Social Care reviews undertaken prior to the move provide important context. Whilst Anish was described as making progress towards greater independence, the assessments also identified continuing support needs across multiple domains of daily living. Records indicate that he required support with official correspondence, telephone calls, maintaining appointments, meal planning, shopping, cooking, cleaning and laundry, as well as attending healthcare appointments and managing medication-related routines. Assessments also identified that Anish often required prompting to seek help when needed and benefitted from support in communicating his needs to others. Risk assessments further identified self-neglect, social isolation and withdrawal as ongoing concerns, noting that periods of isolation and reduced self-care could be indicators of deteriorating mental health.

These assessments therefore presented a more nuanced picture than one of simple independence. They described an individual who had developed skills and stability within a supported environment, whilst continuing to rely upon practical prompting, observation and support to maintain aspects of daily living. The learning event also highlighted a distinction between Anish's formally commissioned support and the practical reality of his day-to-day life. Whilst records referred to specific support hours and tasks, practitioners described an environment in which staff saw Anish regularly, had informal conversations with him and were able to identify changes in his presentation or behaviour. Participants reflected that this wider protective function may not have been fully captured within formal assessments or support plans.

During 2023, housing options were discussed. A meeting in September 2023 recorded that secure accommodation staff were willing to keep Anish in another part of the service, where he would be considered to be living more independently with a reduced support plan. Staff also noted that Anish had no friends or connections in Southgate, had limited income, few savings, and few items to take with him to independent accommodation. Anish was described as resistant to moving at that point and said he did not want to move “right now”. The later decision to move Anish to independent accommodation in Ealing therefore represented a significant change after a very long period in a supported setting. The evidence shows that the move was connected to housing pathways and the availability of a secure tenancy in Ealing.

Assessments and planning discussions took place prior to the move and that practitioners considered Anish's suitability for greater independence. The Practitioner Learning Event reflected on the complexity of balancing opportunities for autonomy and progression with the potential risks associated with long-term supported environments. Participants recognised that highly supportive settings can, in some circumstances, reduce opportunities for developing independent living skills, whilst also providing essential structure, routine and oversight for people with severe and enduring mental illness. The Review does not suggest that maintaining Anish within supported accommodation indefinitely would necessarily have been the preferred or safest option. Rather, the records provide less evidence that planning discussions systematically examined the practical and relational support functions that enabled Anish to sustain his independence within secure accommodation, or how those protective factors would be replicated following the move. Whilst formal care needs, housing aspirations and tenancy arrangements were clearly considered, there was less scrutiny around how Anish's identified support needs would be met once the relational and environmental supports available within secure accommodation were no longer present.

This KPE establishes the baseline against which the rest of the review should be understood. Anish was not moving from ordinary independent living into another independent tenancy. He was moving from a long-standing, relational and supported environment into a setting where his safety and wellbeing would depend much more heavily on his ability to initiate contact, answer the door, use a phone, attend appointments, manage his home, obtain food and respond to professionals. Importantly, several of the risks that later emerged following the move were already identified within pre-existing assessments. Isolation, self-neglect, difficulties maintaining personal care, reluctance to seek help and withdrawal from others were recognised concerns prior to transition. The significance of these risks was not that they were unknown. Rather, they provide an important benchmark against which later deterioration can be understood. Many of the indicators that became visible during 2025 had, in various forms, already been identified as potential vulnerabilities within earlier assessments and support plans.

KPE 2: Transition to Ealing and Continuity of Care and Support

Anish signed the tenancy for his new accommodation on 14 October 2024. The tenancy was a secure lifetime tenancy and was understandably viewed as a positive housing outcome. At the sign-up meeting, Anish was accompanied by secure accommodation staff and the 'Move On' worker. The tenancy terms were read to him, he collected keys and discussions took place about furniture, appliances, housing benefit and next steps. The recorded plan included liaison with secure accommodation about belongings, financial support and a reassessment of needs once Anish had moved.

Family involvement during this period requires careful consideration. Family members remained concerned about Anish's wellbeing and maintained contact with key workers over many years. However, relationships were complicated by the impact of his mental illness, including beliefs that family members wished to harm him and periods in which he distanced himself from relatives. Family members described making conscious decisions to respect his wishes whilst continuing to seek updates through professionals and offering practical and emotional support where this was welcomed. The Review therefore recognises that involvement was shaped not simply by geographical distance or service arrangements, but by the complex realities of supporting a loved one living with severe and enduring mental illness.

The chronology shows that the Move On worker undertook a considerable amount of practical work during the early months of the tenancy. This included support with welfare assistance, benefits, rent arrears, furniture, appliances, utilities, phone credit, cleaning, GP appointments, depot medication, floating support referrals and correspondence with housing and other services. This activity is important because it demonstrates that Anish continued to require substantial scaffolding to manage the practical realities of independent living. Many of the tasks being supported involved executive functioning skills, including planning, organisation, initiating action, sequencing tasks, problem-solving and responding to everyday demands. Difficulties in these areas are well recognised within severe and enduring mental illness, particularly where negative symptoms affect motivation, initiation and the ability to sustain daily routines. The support being provided was therefore not simply practical assistance but an important mechanism through which executive functioning demands were reduced, and everyday living was made manageable. By December 2024, there were already signs that Anish was struggling to manage the tenancy without close support. A home visit recorded that his flat was "a tip", with rubbish and other items littered around. Anish recognised this and said he needed bin bags and a hair clipper but had not taken steps to resolve this himself. His fridge freezer was working, but there was no food in it. He had rent arrears of over £1,200 and

needed support to understand how to begin making payments. He was also reminded about his next depot appointment and the need to attend.

Further visits in January 2025 continued to show the level of practical prompting required. On 6 January, Anish needed reminding about his floating support assessment, support to plan purchases from his welfare grant, and prompting around cleaning equipment, a bed and cooker. On 9 January, the worker recorded that Anish would benefit from an immediate cleaning schedule. A monthly cleaning arrangement was put in place. Anish was supported to top up his phone, buy a bed and mattress, purchase a calendar and record appointments. He declined to buy an electric cooker, saying he was happy with microwave meals. The records also show that phone contact was already known to be unreliable. When the cleaning schedule was arranged, the provider was told that Anish "does not normally take phone calls" and tended to switch his phone off. They were advised that he was aware of the visits and would usually respond to the communal buzzer or come down to let staff in.

The referral for floating support had been actively pursued during December 2024. Records indicate that the provider had been unable to make contact with Anish, that an assessment would therefore take place in January 2025, and that the service itself was due to end in March 2025. The provider also recognised at that stage that Anish was likely to require ongoing support beyond the lifespan of the programme. Following assessment, Anish received significant practical assistance, including support with appointments, benefits, household tasks and establishing routines within his new tenancy. The Practitioner Learning Event clarified, however, that this was commissioned as a short-term intervention rather than a longer-term support arrangement. Whilst the support undoubtedly provided important assistance during the early months following the move, it is less clear what alternative arrangements were being considered beyond March 2025, particularly as concerns regarding Anish's wellbeing, nutrition, self-care and ability to manage activities of daily living were already beginning to emerge. His need for support remained substantial and ongoing, raising important questions about how continuity of support was planned and sustained once the initial intervention came to an end.

A transfer of care review undertaken by the Haringey Wellbeing and Recovery Service on 10 February 2025 provides further insight into Anish's needs shortly after the move. Although Anish reported feeling happy and safe in his new accommodation, the review identified significant concerns regarding his physical wellbeing and ability to live independently. He had lost 6.3kg in three and a half months, was unable to cook, relied on microwave meals and convenience foods, and expressed worries about his finances and benefits. The clinician noted that Anish required support across multiple areas of daily living, including personal hygiene, nutrition, cleanliness and the safety of his accommodation. Self-neglect was explicitly identified as one of his relapse indicators, and the clinician recorded that his negative symptoms limited his ability to manage activities of daily living independently. Concerns regarding his weight loss were shared with both his GP and social worker, including consideration of whether additional support, such as meals provision, should be arranged.

There was some ambiguity regarding ongoing mental health responsibility during this period. Although practitioners from Haringey Wellbeing and Recovery Services undertook the transfer of care review in February 2025, it is less clear what ongoing role Haringey services retained following the move or precisely when responsibility formally transferred to Ealing services. The chronology suggests that the transfer process was still underway, creating a period in which support, oversight and professional relationships spanned organisational boundaries. Whilst such transitions are common, they can present additional challenges in maintaining continuity of care and ensuring clarity regarding responsibility for monitoring wellbeing and responding to emerging concerns.

This period therefore shows both significant professional effort and increasingly clear evidence of unmet need. Although Anish had secured permanent accommodation, the support structures around him had altered substantially. Tasks that had previously been observed, prompted or contained within Secure accommodation now required separate arrangements: cleaning, food, finances, medication, appointments, communication, utilities and tenancy management. The chronology, together with the February 2025 transfer review, demonstrates that Anish required continuing practical support across multiple areas of daily living and remained vulnerable to self-neglect, poor nutrition and social isolation. Whilst he could engage positively when professionals were physically present, sustaining everyday living depended upon repeated prompting, oversight and assistance. The arrangements put in place following the move did not fully replicate the routine visibility and relational support that had previously existed, and concerns about his ability to manage independently were becoming increasingly apparent before the more acute deterioration observed in March and April.

KPE 3: Deterioration, Missed Depot Medication and Early Self-Neglect Indicators

By March 2025, concerns about Anish's wellbeing had become more concrete. On 17 March, Anish did not attend a GP appointment intended to review his depot medication and address concerns regarding his recent weight loss, following a period in which practitioners had been attempting to maintain his treatment arrangements during the transfer of care process. Records state that his depot should have been administered on 17 February, that he had not attended, and that he could not be reached by phone because he had not replaced or repaired his phone as previously agreed. The same day, the Move On worker emailed Ealing Acton MINT, the GP and the allocated caseworker, noting the overdue depot, weight-loss concerns, missed GP appointment and the fact that Anish had not replaced his phone. The email explicitly asked MINT to facilitate unscheduled home visits while the review was completed.

On 18 March, a home visit took place. Anish did not respond to the buzzer or door, despite being seen lying on his bed through the kitchen window. A note was posted through the door asking him to attend the GP. The plan recorded was to make an adult safeguarding referral for overdue depot and self-neglect. A safeguarding referral was made on 18 March 2025 in response to concerns regarding Anish's wellbeing, weight loss and increasing self-neglect. However, the Review was unable to establish from the documentation provided whether this progressed to a formal Section 42 enquiry or the outcome of safeguarding screening processes. The absence of a clear audit trail limits understanding of how safeguarding thresholds were interpreted at this point and whether alternative or additional safeguarding responses were considered. A further crisis concern was sent to MINT on 21 March. This stated that Anish was likely to have relapsed, was unreachable, did not currently take phone calls, had missed depot medication, and that “considerable self-neglect” was evident. It also recorded that his last depot had been on 20 January and that his GP had raised concerns about how unstable he appeared.

On 1 April, Anish was seen and supported to attend the GP. He was described as looking very unstable, unshaven, wearing unclean clothing and physically wobbly. The GP administered the depot, checked his weight and took bloods. The case notes recorded evidence of self-neglect relating to nutrition, personal hygiene and presentation, and stated that a package of care was expected and needed “asap”. These concerns were not entirely new. Only weeks earlier, the transfer of care review had identified significant weight loss, dependence upon support for activities of daily living

and self-neglect as a recognised relapse indicator. The emerging picture in March 2025 therefore reflected an escalation of vulnerabilities that had already been identified rather than the appearance of entirely new risks. This period is therefore not simply one of “reduced engagement”. It shows that the risks anticipated in the transition planning had begun to materialise; missed depot medication, weight loss, poor nutrition, deteriorating presentation, difficulty using or maintaining phone contact, and difficulty gaining access. It also shows that some practitioners recognised this and escalated concern. The issue for later analysis is therefore not whether concerns existed, but why the accumulation of indicators including self-neglect, significant weight loss, missed depot medication, social withdrawal and increasing disengagement did not trigger a more coordinated multi-agency response. Opportunities existed to convene formal risk-management or safeguarding discussions, including a Section 42 enquiry, once it became apparent that multiple agencies held concerns about Anish's wellbeing and his ability to live safely and independently.

KPE 4: Prolonged Loss of Contact, Limited Escalation and Discovery Following Death

From the end of April 2025, Anish became increasingly absent from view. On 25 April, cleaners attended and completed the cleaning visit, but Anish did not have money to pay. This appears to be one of the last recorded occasions when anyone outside services had contact with him. On 30 April, the Move On worker emailed MINT, the GP and the caseworker because Anish’s depot was due that day, but it had not been possible to reach him by phone. The email stated that Anish needed to collect his zuclopenthixol decanoate from the pharmacy across the road from his flat.

On 2 May, the Move On worker went on annual leave until 26 May. The chronology records that a handover was sent. The next substantive entry from that worker was not until 29 May, when an email was sent to the cleaning provider, senior social worker and caseworker to check whether the scheduled cleaning visit on 30 May went ahead. The cleaning provider attended on 30 May but did not gain contact. Their report states that staff knocked, called and waited for around an hour, but Anish did not respond. The report also records that Anish was known to be reluctant to have cleaning done and that he did not receive regular activity other than monthly cleaning, meaning there had been no incidents or reports of him missing that would have triggered a missing person report.

By 13 June, DWP also could not contact Anish. A case note records that DWP had an appointment with him and could not reach him. The worker recorded that he had visited four times, including a joint visit with MINT, and that MINT also could not contact him. The plan was to bring the case to complex cases because “no one knows where he is”. On 19 June, a further home visit took place. There was no answer. The worker gained access to the communal area via the trade button, looked through the window and recorded “no signs of life in the flat”. Neighbours did not answer. On 20 June, calls were made to Anish’s former manager and his secure accommodation. His former keyworker had not had contact with him. The police were then contacted to report Anish as a missing person. Concerns were ultimately escalated to police on 20 June. Adult Social Care reported the prolonged loss of contact, repeated unsuccessful visits by services, the absence of apparent signs of life at the property and two missed depot injections, and requested that Anish be treated as a missing person and that a welfare check be undertaken. Police assessed the circumstances as a concern for welfare rather than commencing a missing-person enquiry and passed the matter to LAS, which subsequently gained entry to the property and found Anish deceased. Police then attended.

In the period preceding this final escalation, there had been repeated contact attempts using methods that were known to be unreliable for Anish: telephone calls, letters, knocking, and leaving

notes. Anish was known not to use or answer his phone consistently, and by this stage he had already missed depot medication, presented as physically unwell and self-neglecting, and become increasingly difficult to see. The chronology shows activity, but much of it did not materially increase professional knowledge of whether Anish was alive, safe, eating, taking medication or able to care for himself.

Anish was found deceased in June 2025. The post-mortem evidence indicated that he had died some weeks before being discovered. This is significant in its own right. It demonstrates that the attempts to contact him had not been sufficient to establish his welfare, despite his known vulnerability, severe mental illness, history of self-neglect and absence of reliable informal oversight. The condition of the flat after his death also reinforced concerns about whether he had been able to sustain independent living. His sister described the fridge as empty and the flat as showing no evidence that he had been cooking or managing food. She described plates still in wrapping, no food in the property, and the living conditions as profoundly distressing.

5. Good Practice Identified

Long-term relational support at the secure accommodation

For many years, Anish was supported within an environment where staff knew him well, understood his mental health needs and provided consistent practical and emotional support. There was strong evidence from both practitioners and family members regarding the positive impact of these long-standing relationships. Staff demonstrated detailed knowledge of Anish's presentation, routines, communication style and indicators of deterioration, helping to maintain stability over an extended period.

Commitment to securing stable housing

The move to Ealing was intended to provide Anish with a secure lifetime tenancy, representing a significant housing achievement. Practitioners invested considerable effort in supporting the transition, including assistance with tenancy sign-up, benefits, furniture, utilities and practical arrangements associated with establishing a new home. The Review found clear evidence that professionals were motivated by a desire to promote independence and improve Anish's long-term housing security.

Persistent practical support following the move

The Move On worker provided extensive practical support following the move, including assistance with benefits, rent arrears, furniture, household goods, GP registration, medication arrangements, cleaning support and referrals for additional services. The chronology demonstrates persistence, creativity and commitment in helping Anish establish himself within the tenancy during the early months following the move.

Recognition and escalation of emerging concerns

The Review found evidence that practitioners recognised emerging concerns and took action. This included escalating concerns regarding missed depot medication, weight loss, self-neglect and loss of

contact. Safeguarding referrals were made; crisis concerns were submitted and practitioners sought support from mental health services when they believed Anish's circumstances were deteriorating. The Review does not therefore characterise this as a case in which concerns were ignored. Rather, practitioners identified concerns and attempted to respond to them.

Professional persistence during the final weeks

During the period of increasing concern, multiple agencies continued attempting to establish contact with Anish. Home visits, telephone calls, welfare enquiries, liaison with other agencies and information-sharing all took place. Although the Review ultimately concludes that these efforts did not result in sufficient understanding of Anish's welfare, the chronology demonstrates persistence and genuine concern on the part of practitioners.

6. Findings

Finding 1: The support that sustained Anish's independence was insufficiently recognised within transition planning

The Review found that the planning and decision-making surrounding Anish's move to independent accommodation did not fully recognise the extent to which his apparent independence was supported by a highly structured environment developed over more than two decades. Whilst agencies appropriately focused on securing long-term housing and promoting independence, there was less evidence of a shared understanding of the support conditions that enabled Anish to live safely and successfully within his previous accommodation.

Research commissioned by the National Housing Federation has found that supported housing contributes positively to wellbeing, social connection and tenancy sustainment, particularly for people with multiple and complex needs.[8] The same research highlights that supported housing often acts as part of a wider network of preventative support, reducing reliance on health, social care and other public services.[9] These observations are relevant because they suggest that supported housing should be understood not simply as accommodation, but as a mechanism through which independence is enabled and sustained.

At the point of transition, Anish had lived within secure accommodation services for approximately twenty-four years. During this time, support extended beyond accommodation and formal care tasks. Records indicate that staff provided prompting and oversight in relation to personal hygiene, clothing, nutrition, appointments, medication, daily living activities and maintaining routines. Staff also possessed detailed knowledge of Anish's presentation, behaviours and mental health, enabling them to recognise subtle changes that might indicate deterioration. Family members similarly described a man whose schizophrenia affected his ability to engage consistently with others, manage day-to-day tasks and maintain routines without support.

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[8] National Housing Federation. (2023). *Research into the supported housing sector's impact on homelessness prevention, health and wellbeing.*

[9] Department for Work and Pensions & Department for Communities and Local Government. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector* (Research Report No. 927).

This distinction is important in Anish's case because the evidence suggests that the secure accommodation functioned as considerably more than a housing provider. Staff provided a combination of practical assistance, routine oversight and relational continuity that helped Anish manage the impact of his schizophrenia on everyday life. However, the Practitioner Learning Event highlighted uncertainty regarding the precise nature and intensity of support that Anish had received prior to the move. Whilst practitioners broadly agreed that the secure accommodation had provided a highly supportive environment, there was less shared understanding regarding which elements of that support were protective, which aspects of Anish's apparent independence depended upon that support, and how those functions would be replicated following transition. The Review found extensive evidence of planning in relation to accommodation, furniture, welfare benefits and tenancy arrangements. Whilst assessments did identify significant ongoing support needs, there was not a shared multi-agency understanding regarding which aspects of Anish's apparent independence depended upon routine prompting, relational support and environmental oversight, and how those protective functions would be sustained following the move. Subsequent reviews continued to identify dependence in activities of daily living, self-neglect as a relapse indicator and the need for support with nutrition, hygiene and maintaining a safe living environment, suggesting that the practical implications of these needs were not fully translated into post-transition support arrangements.

The Review does not conclude that independent living was necessarily inappropriate for Anish. Rather, it found insufficient evidence that agencies collectively identified and analysed the support ecology that had enabled Anish to function within supported accommodation and therefore insufficient assurance that those protective elements would continue following the move. For example, although he was often described as independent, the chronology demonstrates that following the move he required significant assistance with appointments, benefits, medication, household management, food, cleaning and communication. In practice, the transition appears to have been informed more by an assessment of Anish's potential for independence than by a detailed understanding of the support required to sustain it. Difficulties in these areas became increasingly visible once support was dispersed across multiple agencies and became more reliant upon Anish initiating or responding to contact himself.

Finding 2: Planned support arrangements were not fully realised following the move, resulting in a loss of continuity and a significantly reduced level of practical oversight

The Review found that Anish's move to Ealing was accompanied by an expectation that he would continue to receive a level of support broadly comparable to that available within his previous accommodation. Practitioners involved in planning the move described an intention to replicate the floating support arrangements that had been available whilst he was living at the secure accommodation. However, evidence presented during the Practitioner Learning Event indicated that these arrangements did not materialise as originally anticipated.

This finding is significant because continuity of support is widely recognised as a critical component of successful transitions for people living with severe and enduring mental illness. The Government's *Supported Housing Review* highlights that supported housing operates not simply as accommodation but as a combination of housing, care, supervision and support intended to enable individuals to

maintain independence within the community.[10] The effectiveness of such arrangements depends not only upon securing accommodation but upon ensuring that appropriate support is available and accessible following transition. Similarly, the *Supported Accommodation Review* emphasised the importance of housing-related support in helping individuals maintain daily living skills, routines and community functioning.[11]

In Anish's case, practitioners described a plan whereby ongoing floating support would continue following the move. However, Adult Social Care explained during the learning event that the commissioned provider expected to deliver this support had been decommissioned, necessitating a new Care Act assessment before replacement support could be arranged.[4] As a consequence, the support infrastructure anticipated during transition planning was not available in the form originally envisaged. The learning event also highlighted an important distinction between Anish's formally commissioned support and the practical reality of his daily life at the secure accommodation. Whilst records referred to four hours of floating support and a cleaning call, secure accommodation staff described an environment in which support workers were present on site throughout the working week and Anish was effectively seen every day. Staff provided regular prompting, informal monitoring and relationship-based support that extended beyond the formally commissioned package. Participants reflected that this level of informal oversight may not have been fully recognised within assessments of Anish's readiness for independent living.

Following the move, support became increasingly dependent upon separate agency contacts, appointments and referrals rather than routine daily visibility. Practitioners undertook considerable work to support Anish, including assistance with welfare benefits, furniture, household goods, GP registration, medication arrangements and referrals for further support. However, these interventions were delivered through multiple agencies operating within their own professional remits rather than through a single integrated support environment. The result was a model of support that relied more heavily upon Anish responding to appointments, answering his telephone and opening his door to professionals.

This shift is particularly significant given the evidence that Anish's schizophrenia affected his communication and engagement. Practitioners consistently described his tendency to switch off his phone, avoid contact and disengage from unfamiliar professionals. These were longstanding characteristics rather than new risks. Yet the support arrangements established following the move increasingly relied upon precisely those forms of engagement. As one practitioner reflected, support became difficult to deliver when contact could not be established, whilst the informal opportunities for observation and relationship-building that had existed previously were largely absent.

The Review does not suggest that practitioners were unaware of Anish's needs or that agencies failed to provide support. Indeed, the chronology demonstrates considerable commitment by individual practitioners to maintaining contact, coordinating services and responding to emerging concerns. There was a mismatch between Anish's continuing support needs and the time-limited support arrangements available following the move. Whilst practitioners worked hard to provide practical assistance, there was less evidence of a shared plan regarding how support would be sustained once the initial floating support offer ended. Whilst practitioners anticipated that a comparable level of support would be available, the practical reality was that Anish experienced substantially less oversight, monitoring and informal support than had existed previously.

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[10] Beatty, C., et al. (2024). *Supported Housing Review*.
[11] Department for Work and Pensions & Department for Communities and Local Government. (2016). *Supported Accommodation Review: The Scale, Scope and Cost of the Supported Housing Sector*.

This reduction in oversight became particularly apparent when key members of staff were absent. The chronology demonstrates periods during which practitioners who knew Anish best were on annual leave, with limited evidence of equivalent continuity arrangements or enhanced oversight despite increasing concerns regarding contact and engagement. As a result, support became vulnerable to gaps in staffing capacity and organisational resilience. Maintaining visibility of Anish increasingly depended upon individual practitioners rather than a system capable of sustaining oversight during periods of absence, transition or uncertainty.

The significance of this became evident in the weeks preceding Anish's death. Although attempts were made to contact him, these largely relied upon telephone calls, door knocks and routine welfare checks. There was limited evidence of a coordinated escalation in response to the prolonged loss of contact with a highly vulnerable adult whose history indicated that disengagement, self-neglect and deterioration were known risks. Ultimately, Anish was not found until some time after his death, despite multiple agencies holding concerns about his wellbeing. The circumstances in which he was discovered, together with evidence regarding the condition of the property and the apparent lack of day-to-day living activity, raise important questions about whether the level of oversight and professional curiosity available following the move was sufficient to recognise and respond to escalating vulnerability.

Finding 3: Recognised concerns were not brought together into a shared formulation of escalating risk

The Review found clear evidence that practitioners recognised many of the indicators associated with emerging self-neglect. The transfer of care review undertaken in February 2025 documented significant weight loss, poor nutrition, difficulties preparing food, dependence upon support for activities of daily living and self-neglect as a recognised indicator of relapse. The clinician assessed Anish as presenting a medium risk to himself and communicated concerns to both his GP and social worker. Similarly, practitioners later identified missed depot medication, deteriorating presentation and increasing disengagement from services. The issue identified is therefore not a failure to recognise individual concerns, but a difficulty in collectively interpreting their cumulative significance and responding to them as part of an escalating safeguarding trajectory.

By March and April 2025 there were clear indicators that Anish's circumstances were deteriorating. These included missed depot medication, weight loss, poor nutrition, deteriorating personal presentation, difficulty maintaining phone contact, refusal or inability to answer the door, and growing uncertainty about whether he was managing safely within his flat. These concerns were not hidden. Individual practitioners identified them, recorded them and, in some cases, escalated them through safeguarding and crisis concern routes.

This finding is important because national SAR learning repeatedly shows that self-neglect often becomes visible through cumulative indicators rather than a single decisive event. The *Care and Support Statutory Guidance* identifies self-neglect as including neglect of personal hygiene, health or surroundings, and recognises it within the adult safeguarding framework.[12] More recent SAR analysis continues to identify self-neglect, poor multi-agency coordination, insufficient escalation and

[12] Department of Health and Social Care. (2024). *Care and support statutory guidance*, Chapter 14: Safeguarding.

difficulties responding to non-engagement as recurring features in reviews involving adults with complex needs.[13]

In Anish's case, several indicators should have carried particular significance because of his severe and enduring mental illness. NICE guidance on rehabilitation for adults with complex psychosis emphasises the importance of assessment, care planning, rehabilitation pathways and attention to physical healthcare for adults with complex psychosis.[14] Anish's missed depot medication, weight loss and reduced engagement were therefore not simply practical problems. They were potential indicators of relapse, deterioration and increasing inability to sustain independent living safely. The learning event confirmed that some practitioners did recognise the seriousness of these concerns. The GP identified a 7kg weight loss between December 2024 and 1 April 2025, with no clear physical cause identified, and understood this as likely linked to poor nutrition. The GP recorded that Anish had no cooker, was using a microwave, and was living on sandwiches and Pot Noodles. Practitioners also recognised missed depot medication, lack of contact and self-neglect concerns.

The issue, therefore, was not absence of professional concern. Rather, the Review found that concerns were not sufficiently brought together into a shared multi-agency formulation of escalating vulnerability. The learning event explicitly noted that there was no structured multi-agency review at the point when weight loss, missed appointments and access difficulties were all present, and practitioners later reflected that such a discussion would have been proportionate and could have led to reconsideration of Anish's living situation.

This is a significant distinction. Agencies were responding to individual issues: a missed depot appointment, difficulty contacting Anish, weight loss, nutrition concerns, cleaning, or access to the property. However, the cumulative meaning of those issues was not sufficiently synthesised. The pattern suggested that the protective arrangements around Anish were failing and that his ability to sustain independent living was reducing. That required not only further attempts at contact, but a collective reassessment of risk, support and living arrangements. The Review therefore found that Anish's deterioration was recognised in fragments but not converted into a shared safeguarding response. This limited the system's ability to move from concern to coordinated action at the point when intervention remained possible.

Finding 4: Escalation activity increased, but did not substantially improve understanding of Anish's welfare or level of risk

The Review found that agencies did not ignore concerns regarding Anish's welfare during the final weeks of his life. The chronology demonstrates repeated attempts to establish contact through telephone calls, home visits, letters, cleaning visits, welfare enquiries and liaison between agencies. Practitioners recognised that the inability to contact Anish was concerning and undertook a range of actions in an effort to re-establish communication. The issue is therefore not whether activity occurred, but whether the nature and intensity of that activity were sufficient given the level of uncertainty regarding Anish's welfare and the risks that were already known to be present.

National learning from Safeguarding Adults Reviews consistently identifies prolonged loss of contact, social isolation and increasing invisibility as common features in cases involving self-neglect and

[13] Preston-Shoot, M., Braye, S., & Martineau, S. (2023). *Second national analysis of Safeguarding Adult Reviews: April 2019–March 2023*. Local Government Association.
[14] National Institute for Health and Care Excellence. (2020, reviewed 2024). *Rehabilitation for adults with complex psychosis* (NICE Guideline NG181). NICE.

severe mental illness. Research has highlighted that adults experiencing self-neglect often become progressively less visible to services before serious harm occurs, particularly where professional responses continue to rely upon engagement from individuals who are becoming increasingly unable or unwilling to maintain contact.[15] Recent national SAR analysis has similarly identified repeated unsuccessful attempts at contact, uncertainty regarding agency ownership and difficulties escalating concerns as recurring themes in reviews involving adults with complex needs.[16]

By May 2025, there were already substantial reasons to be concerned about Anish's wellbeing. He had missed depot medication, demonstrated significant weight loss, been the subject of safeguarding concerns, presented with evidence of poor nutrition and self-neglect, and become increasingly difficult to contact. Earlier assessments had also identified withdrawal, isolation and deterioration in self-care as potential indicators of worsening mental health. These concerns provided important context for the period that followed.

However, much of the subsequent activity relied upon communication methods that were already known to be unreliable for Anish. Practitioners were aware that he frequently switched off his telephone, did not consistently answer calls and could be reluctant to engage with unfamiliar professionals. Despite this, telephone calls, letters, routine visits and requests for contact remained the predominant mechanisms through which agencies sought reassurance regarding his wellbeing. The chronology demonstrates repeated attempts to make contact, but limited progress in establishing whether Anish was safe, eating, taking medication, managing his health needs or able to care for himself.

The Review identified a significant distinction between repeated activity intended to re-establish contact and escalation capable of establishing Anish's welfare. For much of this period, responses remained centred upon telephone calls, messages, home visits and liaison between individual services. These actions demonstrated persistence and concern, but repeatedly generated the same outcome: professionals remained unable to see Anish or establish how he was functioning within his home. The escalation to police on 20 June is therefore significant. Adult Social Care's request that Anish be treated as a missing person and that a welfare check be undertaken demonstrates recognition that the established means of trying to engage with him were no longer sufficient. Police subsequently assessed the circumstances as a concern for welfare rather than commencing a missing-person enquiry, with LAS ultimately gaining entry to the property. The learning is therefore not that practitioners failed to recognise the limitations of previous engagement attempts, but whether the cumulative concerns and repeated inability to establish Anish's welfare might reasonably have prompted this different level of response at an earlier stage.

What is also significant, is the impact of reduced continuity and organisational resilience during this period. The Move On worker who knew Anish best commenced a period of annual leave in early May, at a point when contact concerns were already increasing. Whilst handover arrangements were made, the growing uncertainty regarding Anish's welfare did not trigger enhanced oversight or a coordinated review of risk. As a result, responsibility for monitoring his wellbeing became increasingly dispersed across different agencies, none of whom had regular visibility of his day-to-day circumstances.

The significance of these issues became apparent following Anish's death. The post-mortem evidence indicated that he had died some weeks before being discovered. This is not to suggest that

[15] Department of Health and Social Care. (2024). *Care and Support Statutory Guidance*, Chapter 14: Self-Neglect.
[16] Preston-Shoot, M., Braye, S., & Martineau, S. (2023). *Second National Analysis of Safeguarding Adult Reviews: April 2019–March 2023*. Local Government Association.

any individual practitioner could have known this, but the prolonged period between death and discovery demonstrates that the escalation activity undertaken was ultimately insufficient to establish his welfare. This is particularly significant given the known concerns regarding self-neglect, missed medication, deteriorating physical health, social isolation and disengagement from services that had already been identified.

The finding here is therefore not that escalation was absent, but that the absence of reliable information regarding Anish's welfare became a risk factor in its own right before a different level of response was initiated. Whilst practitioners were active, persistent and concerned, there was limited collective reassessment of what prolonged invisibility meant for a highly vulnerable adult with severe and enduring mental illness, particularly when considered alongside the other indicators of deterioration already known to services.

Finding 5: No agency maintained overall ownership of Anish's wellbeing as risks accumulated across the system

Numerous agencies remained involved with Anish following his move to Ealing. Adult Social Care, Move On services, primary care, mental health services, housing providers, DWP and support services all had contact with him at different points. This was not a case in which Anish was unknown to services. Rather, he remained visible to multiple agencies throughout much of the period under review. However, as concerns regarding self-neglect, weight loss, disengagement, missed medication and loss of contact accumulated, there was limited evidence that any single agency assumed responsibility for bringing together the emerging picture of risk.

National learning from Safeguarding Adults Reviews consistently identifies uncertainty regarding professional ownership as a recurring feature in cases involving adults with multiple and intersecting needs. Reviews frequently describe situations in which agencies recognise concerns within their own area of involvement, but where no organisation develops a sufficiently comprehensive overview of the person's circumstances to coordinate a proportionate safeguarding response.[17] This challenge can be particularly acute during periods of transition, where responsibility becomes distributed across housing, health, social care and support services.[18]

There was evidence of considerable professional commitment from individual practitioners. The Move On worker undertook extensive practical support following Anish's move, including assistance with benefits, household goods, appointments, rent arrears, cleaning arrangements and referrals for additional support. The GP actively pursued concerns regarding weight loss and mental health stability. MINT services responded to referrals and safeguarding concerns. Adult Social Care remained involved in reviewing support needs and coordinating aspects of care planning. The issue identified by the Review is therefore not one of professional indifference or inaction.

Rather, the evidence suggests that concerns were often managed within individual service responses rather than through a shared multi-agency understanding of Anish's overall situation. Housing services understood that support was being provided by other agencies. Mental health services were aware of missed appointments and difficulties maintaining contact. Adult Social Care was involved in assessing support needs and arranging services. The GP recognised weight loss, poor nutrition and concerns regarding stability. Each agency therefore held part of the picture. However, there was less

[17] Preston-Shoot, M., Braye, S., & Martineau, S. (2023). *Second National Analysis of Safeguarding Adult Reviews: April 2019–March 2023*. Local Government Association.
[18] Department for Levelling Up, Housing and Communities. (2024). *Supported Housing Review*. London: DLUHC.

evidence that these separate concerns were routinely brought together and interpreted collectively as indicators of escalating vulnerability.

The Review identified similar uncertainty regarding responsibility for depot monitoring and escalation following Anish's move to Ealing. The WLNHT IMR highlights challenges associated with the transfer of care process and the practical arrangements for administering depot medication across organisational boundaries. Whilst practitioners recognised missed doses as a significant concern and undertook efforts to re-engage Anish, there was less clarity regarding which service held overarching responsibility for monitoring adherence, initiating escalation procedures and coordinating a multi-agency response when scheduled medication was not received. Given the importance of depot treatment in maintaining Anish's mental health stability, clearer understanding of escalation pathways and professional ownership may have strengthened the system response to emerging concerns.

The Practitioner Learning Event was particularly informative in this regard. Participants reflected that there may have been missed opportunities for a more coordinated multi-agency discussion once concerns regarding self-neglect, weight loss, missed depot medication and disengagement began to emerge simultaneously. Practitioners also reflected upon the absence of a clearly understood lead agency role once Anish's circumstances began to deteriorate. Some participants questioned whether Adult Social Care should have retained a stronger coordinating function given that the move had been social care led, concerns increasingly related to self-neglect, and multiple agencies were seeking to establish support around him.

This finding is not intended to suggest that responsibility rested solely with any individual agency. Rather, it reflects a broader systems issue concerning how agencies collectively respond when risk develops gradually across organisational boundaries. Anish's circumstances did not deteriorate within a single service. His difficulties became visible through a series of interconnected indicators: missed medication, poor nutrition, deteriorating self-care, increasing social isolation, reduced engagement and eventual loss of contact. These concerns emerged across different agencies and over time. As a result, no single service held a complete picture of his situation, yet no alternative mechanism emerged to create that picture collectively.

The significance of this became increasingly apparent during the final weeks of Anish's life. Multiple agencies were attempting to contact him, yet uncertainty regarding his welfare continued to grow. Whilst information was being shared, there was limited evidence of a coordinated process through which agencies collectively reviewed what that information meant, reassessed risk and agreed a shared response. In practice, responsibility for understanding Anish's circumstances became distributed across the system at precisely the point when a coordinated understanding was most needed.

The Review therefore found that the absence of clear multi-agency ownership contributed to a situation in which risks were recognised but not fully synthesised, concerns were escalated but not always collectively interpreted, and growing uncertainty regarding Anish's welfare did not translate into a coordinated safeguarding response. Strengthening future arrangements will require not only effective individual agency practice, but mechanisms that support shared risk ownership when adults with complex needs become increasingly difficult to engage and concerns span multiple organisations.

7. Recommendations

Recommendation 1: Understanding Support Dependency During Transitions

The Ealing Safeguarding Adults Board should seek assurance that when adults with severe mental illness, learning disabilities, autism, acquired brain injury, self-neglect or other complex support needs move from supported accommodation into more independent settings, assessments explicitly identify:

- the formal and informal supports that currently sustain independence;
- the extent to which functioning depends upon prompting, observation, relational support and routine oversight;
- how those protective factors will be replicated following transition; and
- how risks associated with reduced visibility and reduced support will be monitored.

This should include consideration of how practitioners distinguish between independence achieved through support and independence that can be sustained without it.

Recommendation 2: Continuity of Support Following Housing Transitions

The Ealing Safeguarding Adults Board should seek assurance from partner agencies that adults with complex mental health and support needs experience continuity of support during and following housing transitions, including circumstances where commissioned services are decommissioned, redesigned or transferred between providers.

This should include assurance regarding:

- contingency arrangements where planned services are unavailable;
- continuity during staff absence, annual leave and organisational change;
- clarity regarding responsibility for monitoring wellbeing during transition periods; and
- mechanisms for identifying when support arrangements are delivering substantially less oversight than originally intended.

Recommendation 3: Multi-Agency Recognition and Escalation of Self-Neglect

The Ealing Safeguarding Adults Board should review how agencies collectively recognise and respond to cumulative indicators of self-neglect and deteriorating wellbeing amongst adults living with severe mental illness.

This should include consideration of how practitioners respond when concerns emerge across multiple domains simultaneously, including:

- missed medication;

- weight loss and poor nutrition;
- social isolation;
- disengagement from services;
- repeated unsuccessful attempts at contact; and
- declining ability to manage daily living activities.

This should include consideration of the circumstances in which multi-agency discussions, safeguarding processes or reassessment of support arrangements should be triggered when multiple indicators emerge simultaneously.

Recommendation 4: Recognising and Responding to Cumulative Risk

The Ealing Safeguarding Adults Board should consider how principles of cumulative vulnerability, cumulative risk and cumulative harm can be embedded within safeguarding practice, governance and multi-agency decision-making, particularly for adults experiencing severe mental illness, self-neglect, social isolation and service disengagement.

This should include consideration of:

- how apparently separate concerns are brought together into a shared understanding of escalating vulnerability;
- mechanisms for identifying when repeated unsuccessful attempts at contact become a safeguarding concern in their own right;
- arrangements for establishing collective ownership where no single agency holds the whole picture; and
- opportunities to incorporate whole-person and whole-context approaches, including principles reflected within the LOOK Safeguarding Framework, into local learning and development activities.[19]

7. Conclusion

Anish's death occurred following a period of increasing vulnerability, deteriorating wellbeing and growing disengagement from services. Whilst the precise circumstances of his death cannot be known, the Review found evidence that concerns regarding self-neglect, social isolation, poor nutrition, missed medication and loss of contact were emerging over several months prior to his death. These concerns were recognised by practitioners across multiple agencies but were not brought together into a sufficiently coordinated understanding of the risks he was facing.

The Review does not conclude that any single decision, action or omission caused Anish's death. Rather, the evidence points to a series of interconnected system factors that developed over time. Central to these was the transition from a long-standing supported living environment into a more independent tenancy. Whilst the move was intended to promote autonomy and provide long-term

[19] Sahota, P. (2025). *Recognising Cumulative Harm in Adult Safeguarding: Executive Briefing*; *LOOK Safeguarding Framework Overview*. The framework emphasises cumulative vulnerability, cumulative risk, whole-person safeguarding and shared organisational responsibility for recognising escalating harm.

housing security, the practical and relational support structures that had sustained Anish for many years were not fully understood or replicated following the transition. As a result, vulnerabilities that had previously been mitigated within a highly supportive environment became increasingly visible.

A significant theme throughout is the distinction between independence and support. Anish had developed skills, routines and stability during more than two decades within supported accommodation. However, the evidence suggests that this stability was achieved not in the absence of support, but through a combination of practical assistance, routine oversight, professional familiarity and trusted relationships. The reduction of these protective factors exposed vulnerabilities that had always been present but had previously been managed within the supported environment.

The Review also identified challenges in how agencies collectively responded to emerging concerns. Individual practitioners demonstrated commitment, persistence and genuine concern for Anish's wellbeing. However, concerns were often managed within individual service responses rather than through a shared multi-agency understanding of escalating risk. As uncertainty regarding Anish's welfare increased, no single agency retained clear oversight of the whole picture. The circumstances of Anish's death raise important questions for safeguarding systems nationally. As increasing numbers of adults with severe mental illness and complex support needs are supported to live independently within the community, there is a need to ensure that assessments, support arrangements and risk management processes fully recognise the conditions that enable independence to be sustained.[20] Independence should not be understood solely as the absence of support, but also as the presence of the right support, at the right time, delivered in ways that reflect an individual's needs, vulnerabilities and circumstances.

Ultimately, Anish's story is one of both progress and vulnerability. He achieved a long-term ambition of securing his own tenancy and, throughout his life, was supported by practitioners and family members who cared deeply about his wellbeing. The learning identified within this Review is intended to strengthen future practice by helping agencies better understand how support, visibility, professional curiosity and shared ownership of risk can protect adults with complex needs during periods of significant change.

[20] Department for Levelling Up, Housing and Communities. (2024). *Supported Housing Review*. London: DLUHC; NHS England. (2019). *The NHS Long Term Plan*. London: NHS England.