

Andrew SAR – Norfolk

Spotlight on...

Learning from the Andrew Safeguarding Adults Review

A recently published SAR from Norfolk explored the circumstances surrounding the death of "Andrew", a 56-year-old man experiencing self-neglect, alcohol dependency, deteriorating physical health and social isolation. Despite involvement from a wide range of agencies, opportunities to coordinate support and develop a shared understanding of risk were missed.

The review identified several important themes with relevance for practitioners across Richmond and Wandsworth.

Whilst individual agencies recognised concerns, including poor living conditions, repeated hospital admissions, declining health and refusal of services, professionals often worked in parallel rather than through a coordinated multi-agency response. This meant that no single agency held the full picture of Andrew's circumstances and no lead practitioner was clearly identified.

The review highlights the importance of:

- ❖ **Maintaining professional curiosity when adults repeatedly decline support.**
- ❖ **Looking beyond immediate presenting issues to understand underlying causes.**
- ❖ **Using safeguarding processes to coordinate responses to self-neglect.**
- ❖ **Sharing information effectively between organisations.**
- ❖ **Making use of multi-agency forums where risk is escalating.**
- ❖ **Considering how trauma, shame and previous life experiences may affect engagement with services.**

The review also reminds practitioners to recognise strengths, identity and life history when building relationships. Information about Andrew's military background was known to some practitioners but not others, representing a missed opportunity to engage him through veteran-focused support services.

For Richmond and Wandsworth partners, the review reinforces existing learning from local SARs relating to self-neglect, professional curiosity, substance misuse, homelessness and coordinated partnership responses.

In this issue:

- **Spotlight on: Andrew SAR Norfolk**
- **Learning and Practice**
 - ❖ *Looking Beyond Behaviour: Learning from a Dementia SAR*
 - ❖ *Domestic Abuse: Partnership Working Saves Lives*
 - ❖ *Out-of-Borough Safeguarding: Five Key Messages*
- **Policy, Legal and National Updates**
 - ❖ *Crime and Policing Act 2026: New Powers to Tackle Anti-Social Behaviour and Cuckooing:*
 - ❖ *Councils Cannot Outsource Their Safeguarding Duty*
- **Updates from SAB Executive and Sub-groups**

Learning and Practice

Looking Beyond Behaviour: Learning from a Dementia SAR

A Safeguarding Adults Review commissioned by Bedford Borough and Central Bedfordshire SAB examined the tragic circumstances in which one resident living with advanced dementia fatally assaulted another resident in a care home. The review focuses on wider systems learning rather than individual blame.

Key learning includes:

- The importance of robust risk assessments within dementia care settings.
- The need for effective oversight of dementia care provision.
- Improved support and information for self-funding residents and families.
- Careful consideration of environmental risks and night-time supervision arrangements.
- Multi-agency responses when needs and risks escalate.

The review serves as a reminder that safeguarding within residential care requires continuous attention to changing risks, personalised care planning and collaborative decision-making.

Domestic Abuse: Partnership Working Saves Lives

A recent safeguarding case study demonstrates how rapid information sharing and coordinated intervention can protect adults experiencing domestic abuse. The case involved concerns raised by a GP regarding potential coercive and controlling behaviour and risk of serious harm.

A swift response involving Adult Social Care, health services, police, housing and specialist domestic abuse services led to immediate protection measures, safe accommodation and a coordinated safeguarding plan.

Key messages for practitioners:

- Listen carefully when people disclose concerns.
- Remain professionally curious.
- Share information promptly and lawfully.
- Work collaboratively across agencies.
- Act early to prevent escalation.

The case also highlights the important role of MARAC in managing high-risk domestic abuse cases.

Out-of-Borough Safeguarding: Five Key Messages

Many adults receive care and support outside their home borough.

Recent practice guidance highlights five key principles:

- The host authority leads the safeguarding enquiry.
- Agencies should agree roles and responsibilities early.
- Safeguarding should remain person-centred.
- Immediate safety should not be delayed by funding disputes.
- Effective communication is critical throughout the process.

These principles help ensure adults receive consistent safeguarding support regardless of where concerns arise.

Policy, Legal and National Updates

Crime and Policing Act 2026: New Powers to Tackle Anti-Social Behaviour and Cuckooing

The Crime and Policing Act 2026 introduces significant reforms designed to strengthen the response to anti-social behaviour, exploitation and community safety concerns. Several provisions will be particularly relevant to safeguarding practitioners, housing providers, local authorities and police partners.

Stronger Housing and Community Safety Powers

The Act introduces new Respect Orders, Housing Injunctions and Youth Injunctions, giving courts additional powers to place restrictions and requirements on individuals whose behaviour causes harassment, alarm, distress, nuisance or anti-social behaviour connected to housing and local communities. These measures are intended to provide a quicker and more effective response to persistent anti-social behaviour and community harm.

For housing providers and local authorities, these powers may support earlier intervention where anti-social behaviour is creating safeguarding concerns or increasing risks for vulnerable adults. Housing providers, local authorities and the police can apply for certain orders where behaviour affects housing management functions or community safety.

New Criminal Offence of Cuckooing

One of the most significant developments for safeguarding adults is the creation of a specific criminal offence of cuckooing (home takeover). The legislation recognises cuckooing as a distinct form of exploitation, where criminals take control of another person's home and use it for criminal purposes. Victims are often people experiencing mental ill-health, substance misuse, disability, social isolation, homelessness or other vulnerabilities.

The new offence is intended to strengthen the response to exploitation by recognising the harm caused when vulnerable people lose control of their homes and are subjected to intimidation, coercion or criminal activity. The specified criminal activity can include offences associated with drug supply, weapons, sexual exploitation and other serious crime.

What This Means for Practitioners

The changes reinforce the importance of:

- Identifying possible indicators of cuckooing and exploitation early.
- Sharing information between housing, police, adult social care and community safety partners.
- Using safeguarding processes alongside community safety and criminal justice powers.
- Considering whether anti-social behaviour may be masking exploitation of a vulnerable adult.
- Working collaboratively to protect adults whose homes are being targeted by criminal networks.

As implementation guidance continues to emerge, partners are encouraged to familiarise themselves with the new powers and consider how they can support coordinated safeguarding and community safety responses across Richmond and Wandsworth.



Councils Cannot Outsource Their Safeguarding Duty

The Local Government and Social Care Ombudsman has reminded councils that they remain ultimately responsible for safeguarding adults, even where care and support services are commissioned from external providers. The finding arose following an investigation into care failings in Portsmouth, where concerns were raised about the way safeguarding responsibilities had been exercised and overseen.

The Ombudsman was clear that whilst councils may commission services from independent, voluntary or private sector providers, statutory safeguarding duties under the Care Act cannot be delegated. Local authorities remain accountable for ensuring that adults at risk are protected from abuse and neglect and that safeguarding concerns are responded to appropriately.

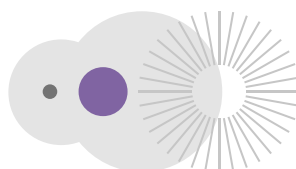
For safeguarding partners, the case highlights several important lessons:

- **Accountability remains with the local authority.** Commissioning or contracting arrangements do not remove statutory responsibilities.
- **Effective oversight and assurance are essential.** Councils must have confidence that commissioned services are identifying, escalating and responding to safeguarding concerns appropriately.
- **Safeguarding is everyone's responsibility.** Providers, commissioners, safeguarding teams and partner agencies all have a role in recognising risk and taking action.
- **Robust information sharing and escalation processes matter.** Concerns should not be allowed to drift between organisations because of uncertainty about ownership or responsibility.
- **Quality assurance should extend beyond contract compliance.** Organisations should seek assurance about safeguarding culture, practice, decision-making and outcomes for adults receiving support.

The ruling serves as a timely reminder that safeguarding arrangements are only effective when clear lines of accountability, oversight and partnership working are maintained. As services become increasingly integrated and delivered through a range of organisations, it is critical that safeguarding duties remain visible, understood and actively monitored across the whole system.

For Richmond and Wandsworth partners, the findings reinforce the importance of strong governance, effective provider assurance, escalation pathways and multi-agency oversight to ensure adults with care and support needs receive safe, effective and person-centred support.

Further reading: [Local Government and Social Care Ombudsman](#)



Update from SAB Executive

In July, the SAB Executive approved the RWSAB Annual Report 2025/26 and reviewed the AGNI judgment, progress on the Hope and Aubrey SAR improvement plans, and work to strengthen community engagement. Priorities include self-neglect, homelessness, substance misuse, prevention, professional curiosity and embedding learning in practice. At its October meeting, the Executive reviewed emerging partnership risks, including workforce pressures, mental health and safeguarding capacity. Members also received an update on the refreshed Suicide and Self-Harm Prevention Strategies and heard updates from each of the three statutory agencies..

Quality and Improvement Sub-group



The Quality & Improvement Sub-group reviewed rising safeguarding demand across both boroughs, while noting that risk management and outcomes remain strong. Members also considered emerging patterns linked to deprivation, including self-neglect and financial abuse, and agreed to continue monitoring these trends. The Sub-group also continues to oversee workforce development across the partnership.

Safeguarding Adult Review (SAR) Sub-group



The SAR Sub-group continues to monitor local learning and improvement plans and review national SARs and identify opportunities for local improvement. Recent learning has focused on Self-neglect, Homelessness, Substance use, Dementia care, Professional curiosity and Partnership working.

National SAR learning is being shared through practitioner forums and newsletters to support continuous improvement across the partnership.

You can access via the website the [Published reports](#) and [7-minute briefings](#) for all SARs.

Richmond and Wandsworth Community Forums



The Richmond and Wandsworth Community Forums continue to provide an important space for partners to share safeguarding issues and strengthen community engagement. The latest discussions focussed on preparations for Safeguarding Adults Week, scam awareness, safeguarding performance and improving feedback to organisations making safeguarding referrals. Partners also contributed to the development of practical tools to support better safeguarding referrals and signposting.

