Safeguarding where the referral is received after the death of the adult

1. INTRODUCTION

This local practice guidance has been developed to provide additional guidance to staff when working where an adult at risk has died and safeguarding concerns have been raised (either related or unrelated to the death). The guidance supplements the London Wide Multi-Agency Adult Safeguarding Policies & Procedures. (link to November 2025 update) also the Department of Health Care and Support Guidance (link to July 2025 update).

Templates for suggested meetings and discussions have been developed and are available here.

This guidance is specifically in relation to where an allegation of abuse or neglect is received following the death of an adult at risk **whether or not a direct link is drawn between the allegation and the death** – it does not relate to where an enquiry is on-going and the adult passes away. In those circumstances, the enquiry should continue as planned as far as possible (though with increased sensitivity and the principles of communication in Section 5 do apply here) unless there is a direct connection between the death and allegation.

It is expected that when the Local Authority becomes aware of the death of an adult at risk, and abuse or neglect is alleged or suspected to have contributed to the death, that the appropriate partners are contacted as soon as possible. Partnership working shall be at the heart of all such processes.

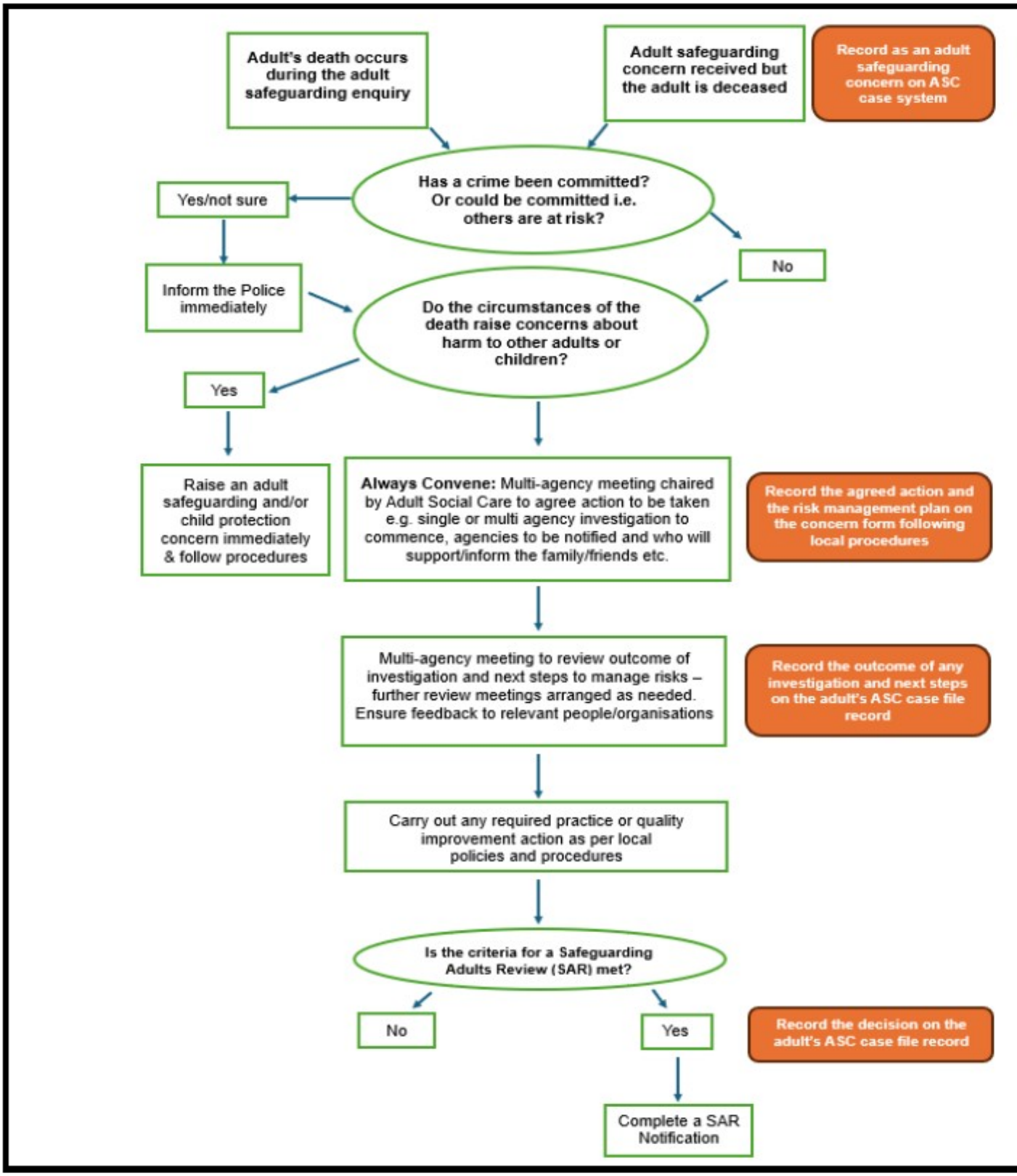
All work in dealing with risk and safeguarding should consider the six Making Safeguarding Personal principles of Prevention, Participation, Empowerment, Partnership working, Proportionality and Accountability. Decision making should be clearly recorded to reflect these principles in any form of safeguarding work.

Included in this guidance:

1. **Basic process and immediate actions following a concern received after a death.**
2. **Deaths of Care Experienced Adults under 25 years old.**
3. **Information sharing around drug related deaths.**
4. **'Other' Enquiries by the Local Authority and legal basis.**
5. **Communication with family members following a death.**
6. **LEDER reviews.**
7. **Safeguarding Adults Review referral.**
8. **Domestic Abuse Related Death Reviews.**
9. **More Detail about referrals to the Coroner.**

1. **Basic process and immediate actions following an allegation of abuse or neglect received after a death.**

Flowchart: Safeguarding Concerns When the Adult is Deceased



(Flowchart taken from London Multi-Agency Policies and Procedures for Safeguarding Adults, October 2025)

1.1 Initial points to consider.

Where the Local Authority receives a safeguarding adults concern relating to an adult who has died, they should seek to:

- Establish cause of death (if known at this stage) and Coroner involvement if any.
- Establish which other agencies are involved already and what action they have taken or are taking.
- Establish if there are needs for care and support which relate to any family members or former carers.
- Establish if there are any immediate risks to any other person in light of the allegation.
- Establish if there is a person who will be representing the deceased in terms of giving their views on any prospective enquiry and what support they may require.
- Establish if any other agency is already in contact with the representative – if so, then discuss if separate contact is appropriate; if no, then contact to be made (please see section 3).

This information will inform the Multi-disciplinary meeting around what processes should go forward.

It is also important to note that any allegation of a crime in relation to a death should be reported to Police immediately via 101 – regardless of any judgement by other agencies about the validity of this allegation. Members of the Public should also be advised of their right to report such things directly to the Police and advised that, in many cases, a direct report is most helpful to Police in making a determination. Feedback from Police on such referrals should be requested in writing.

If another authority commissioned care for the adult in question then they should be contacted as soon as possible – many of the principals in the ADASS guidance on Inter-authority Safeguarding processes will apply.

1.2 Multi-disciplinary Planning to establish what/ which processes should take place.

A multi-disciplinary meeting must be had with Police, NHS (ICB Board representative, or their delegate, and any Trusts or teams directly involved) and CQC (if a registered provider is involved) to determine what processes they may undertaking in relation to the death or allegations and what, if any information, they might hold. Adult Social Care will chair these meetings as the lead agency in safeguarding adults.

These discussions should be evidenced fully on the deceased adult's record – this may be in the form of meeting minutes or a case discussion template (specialized templates have been developed in relation to this in order to guide discussion). These discussions must take place within 5 working days of the allegation – in cases where it is alleged that the abuse or neglect caused a death then the Police must be contacted asap and at the very least within 24 hours.

Please note that providers are required to call the Police in the event of any unexpected death and they must be able to provide the CAD number upon request.

Discussion should also be had with the Community Safety Unit of the Local Authority as promptly as possible – especially, but not exclusively, where domestic abuse or anti-social behaviour is known to be a factor.

Although the Care Act 2014 says that the Local Authority is the lead agency in respect of Section 42 enquiries; Section 42 does not apply when the adult is deceased. It is not necessary for the

Local Authority to begin a Safeguarding Adults 'Other Enquiry' if another process is occurring that will establish what happened, address risks to others and offer resolution to the family.

The following are examples of outcomes of an adult safeguarding concern where the adult has died (these can run concurrently):

- A discretionary safeguarding adults enquiry takes place as the criteria in Section 42 of the Care Act are met and there are public interest concerns.

- The concern is closed, and a criminal investigation takes place

- The concern is closed and another form of investigation framework is followed. This could include a Learning Disability Mortality Review, the NHS Patient Safety Incident Response Framework, Domestic Abuse Related Death Review, MAPPA Serious Case Review, Police investigation into wilful neglect, violence or another crime, Coroner's Inquest, Mental Health Homicide Review or NHS Independent Investigation Reports (this is not an exhaustive list).

- A Safeguarding Adult Review referral is made because it is believed that there is partnership learning in this case and the criteria is met (please see section 7)

- Where the concerns relate to a provider commissioned by the Local Authority, the concern is closed, and the Local Authority Quality Assurance/ Commissioning Team leads in monitoring the quality concerns around the provider (this may include the provider completing an internal investigation).

The expectations and scope of any proposed enquiry by any agency) must be very carefully defined (to both partner agencies and the family or representative of the deceased adult) to avoid confusion or disappointment. Where multiple statutory processes are required then there should be clear discussion about how to work together to avoid duplication or delay.

There is an expectation that no matter which agency is responsible for the enquiry/ investigation process, all other Safeguarding Adults Board partners will support as necessary and be kept informed of relevant information

The limitations and scope of any form of enquiry should be clearly explained to any representative of the adult who is deceased.

It may be that, if the concerns are around a care provider, a separate Provider Support process needs to be considered to assist with protection planning and on-going improvement on behalf of current service users. However, this will be a separate and parallel process to the enquiry (as with regular Section 42 enquiries) – as enquiries look at specific past events whereas Provider Concerns looks at on-going and wide-ranging improvements to a service provider. The process would follow the already established Provider Concerns process.

Whichever agency conducts any form of review or enquiry following a death, they are expected to inform key partner agencies of the results, and any actions arising for them and consider if there is any need for a Section 44 (Safeguarding Adults Review) referral. Records of the outcomes of these investigations are to be added to the adult's Adult Social Care file.

2. Deaths of Care Experienced Adults under 25 years old.

Working Together to Safeguard Children 2023 requires that local authorities notify Ofsted of the death of any care leaver under the age of 25 (where it is aware of their care leaver status or if they are working with the Leaving Care Service). This is regardless of the circumstances of their death. The Children's Safeguarding Partnership should also consider if the criteria for a Safeguarding Adults Review are met and make a referral if so.

If you are aware of the death of a care experienced adult under 25 years old, please contact SafeguardingEnfield@enfield.gov.uk to ensure that the Partnership is aware and appropriate steps are being taken.

In addition to that, the measures above should all also be considered.

3. Information Sharing around drug related deaths.

Where deaths or hospitalizations are caused by illicit drugs then it is vital that information is shared with partners in Public Health and the Police so that they can warn potential users of potentially contamination and focus work on specific areas. Health partners should be well aware of the Local Drug Information System (LDIS) and how to complete alerts (anonymized reporting) but it is important to check that this has been completed if you become aware of such a case. Sharing information quickly in this way does save lives.

For more information then please contact the Enfield Public Health Team or email (if specially about LDIS) enfieldsldismailbox@enfield.gov.uk.

Please be aware that drug testing/ confirmation of cause of death (via the Coroner) may well take a significant amount of time and information sharing around public safety should not wait for this (though there should be clarity around what is confirmed and what is suspected).

Where there are concerns about how a setting or provider is managing drug use in their setting then advice and support should initially be given – including referring them for discussion with Enable Addiction Services and Project Adder within the Metropolitan Police. If concerns continue then a discussion under the Provider Support processes should take place.

Whilst this may not be a safeguarding enquiry or formal process, please consider if other adults in the setting, or who knew the adult who died, would benefit from a referral to Enable Addiction Services – and how they could be supported to access such services.

4. 'Other' Enquiries by the Local Authority and legal basis.

There may be multiple processes which apply where an adult has died, and an allegation of abuse and neglect, and multiple agencies are potentially responsible for those processes. Decisions about which processes should be followed should only be taken after multi-disciplinary discussion (except in the case of obvious criminal investigation requirements or where immediate action needs to take place to manage risk).

Section 42 of the Care Act (2014) refers to the circumstances where the Local Authority has the duty to cause an enquiry to be completed. This section refers to living persons so any Enquiries completed after the death of the service user are not 'Section 42 Enquiries'. It is also true that it is impossible after the death of the adult at risk to establish their views and wishes in regard to an enquiry.

However, both the London- wide Safeguarding Adults Policies and Procedures and the Framework for Making Decisions published by ADASS in 2019, give scope for the progressing of 'other safeguarding enquiries' where there is public interest (given the impossibility of identifying the adult at risk's views and wishes). This would be on the basis of ensuring that the well-being of others is not at risk so on the basis of public interest.

The Care Act (2014) gives Local Authorities a duty to promote well-being in many ways – including 'the need to protect people from abuse and neglect' – as separate from the duty to conduct Section 42 Enquiries – which means that where an adult has suffered abuse and neglect and this shows there may be a risk to others then the Local Authority has a duty to see how it may reduce those risks. An enquiry, though not under Section 42, gives us a proportionate way to do this – it may be that a Safeguarding Adults Review is also required (please see Section 4 of this guidance).

In order to determine if an 'Other Safeguarding' form of enquiry is required, staff should consider the 3-stage-test and the element of public interest. As previously mentioned, it will also be important to note if other agencies are taking action and if these actions will be sufficient to

They would also determine if the case should be referred for a Safeguarding Adults Review or other processes.

Any enquiry should seek to:

- establish the facts about an incident or allegation;
- establish if any other adults are at risk of harm and what action should be taken to protect them.
- make decisions as to what follow-up actions should be taken with regard to the person or organisation responsible for the abuse or neglect.
- If possible/ appropriate, support the adult's family or loved ones to achieve resolution and recovery.

The same paperwork and electronic recording systems can be used to record the Safeguarding process although this will be labelled 'Other Safeguarding' rather than as a Section 42 enquiry.

It should be clear to all involved that a Local Authority led enquiry does not establish whether a specific set of circumstances caused a death or not as this is for other agencies (such as Police and Coroner) to look at. The enquiry seeks to establish if the circumstances were abusive or neglectful and what protective measures for others are required.

The limitations and scope of any form of enquiry should be clearly explained to any representative of the adult who is deceased.

An example of this would be where, after a fall reported as safeguarding, an adult at risk went to hospital and then died of an infection. The enquiry will only consider if the fall reasonably could have been prevented via a risk assessment, care plan, update of risk assessment and care plan after a recent previous fall, best interest decision, etc. The enquiry will not reach a decision around the fact that the adult has died e.g. it will not consider if the fall contributed to the death. Actions from the enquiry would be focused on improvements for present or future residents.

It may be that, if the Concerns are around a care provider, a separate Provider Concerns process needs to be considered to assist with protection planning and on-going improvement on behalf of current service users. However, this will be a separate and parallel process to the enquiry as with regular Section 42 enquiries – as enquiries look at specific past events whereas Provider Concerns looks at on-going and wide-ranging improvements to a service provider.

5. Communication with family members following a death.

The below applies to any case where safeguarding processes may potentially be begun following a death but also if the adult dies during the enquiry process.

Communication with bereaved family members (or other key significant person in the deceased's life) should be respectful and consistent. The multi-disciplinary team should determine, as quickly as possible, who the key point of contact for this family will be (Contact Professional) and that person should call and/ or visit to introduce themselves and their role.

The initial conversation may be quite brief, but it should involve:

- Condolences for the death,
- An explanation of any processes begun (with an understanding that recently bereaved people may not wish to have an involved conversation at this stage and also that information gathering may still be on-going, so formal processes might not have begun as yet).
- An agreement about when and how the family would like to be contacted next (they may want very regular updates or may wish no further contact until after the funeral or other significant event).

This should then be followed up by an e-mail or letter (detailing the name, job role, contact details and manager of the professional who will be their contact) so that the bereaved have this in writing and can call the correct person if they wish an update before the next agreed contact or if they have further information that they feel professionals should be aware of.

At the Multi-disciplinary meeting following the death, the family's views and wishes should be reflected and considered. Throughout the process, communication with family members should set realistic expectations around the scope of Local Authority or other agency action, what can be achieved and what will be referred to other agencies.

Other agencies should co-ordinate sharing information through the Contact Professional where possible – this allows for the various agencies to know that information has been shared appropriately and consistently.

The appropriate professional to be the Contact Professional may well change over time – for example, if a Police investigation is begun there may be a Family Liaison Officer appointed. Where this is the case, a handover should occur both professionally and with the family members concerned.

Communication with family members should be logged carefully on the care management computer system used for the adult at risk so that other professionals can refer to a complete record if the Contact Professional is absent.

Staff should be aware that the period immediately following a death can be overwhelming both emotionally and practically (as funerals, property and finances are dealt with). Family members may delay reporting things or sharing information during this time. Their perspective on the abuse and circumstances may also change significantly as they have time to reflect also. Frontline staff and SAMs should be aware of this and allow time for discussion and reflection at each stage.

It is also important that SAMs recognize the emotional impact and complexities that such work can have on frontline staff and support them with this through reflective supervision and understanding.

If family members appear to be struggling or require further support following their loss, then they can be encouraged to speak with their GP around bereavement support (if that seems appropriate). The Enfield Carer's Centre also runs projects and gives support around bereavement.

It should also be considered that carers may also required practical as well as emotional support around their loss – for example around financial issues.

They might also look into the following sites for general advice:

https://www.ageuk.org.uk/information-advice/health-wellbeing/relationships-family/bereavement/

https://www.ageuk.org.uk/information-advice/money-legal/legal-issues/what-to-do-when-someone-dies/

https://www.nhs.uk/conditions/stress-anxiety-depression/coping-with-bereavement/

6. LEDER Reviews.

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities.

You can find more information about the LeDeR Programme (including how to report a death) here. This programme is managed by the local Integrated Care Board. An annual report is produced detailing learning from these reviews and you can find this on the ICB website.

The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes are used for this. It does not replace the need for an enquiry if the criteria described elsewhere in this guidance is met and would be a parallel process. It is important to avoid duplication. Generally, the Safeguarding Process should take the lead, with the LeDeR reviewer extracting the information they need for the LeDeR programme and supplementing it as necessary. Therefore, it is important that the responsible staff meet promptly to determine areas of responsibility and how they will ensure close co-working and communication.

7. SAFEGUARDING ADULTS REVIEW

The Safeguarding Adults Board has the lead responsibility for conducting Safeguarding Adults Reviews (previously known as serious case reviews) as determined by Section 44 of the Care Act (2014).

A Safeguarding Adults Review (SAR) must be arranged by the Safeguarding Adults Board when an adult in the area dies as a result of abuse or neglect (whether known or suspected - and including by suicide), and there is concern that partner agencies could have worked more effectively to protect the adult. The partnership element of this criteria is important – where there is believed to be learning for only a single agency then an internal process for that agency may be more appropriate.

A review must also be arranged if the SAB knows or suspects that an adult has not died but has experienced serious abuse or neglect. In such circumstances, the Safeguarding Adults Board should also conduct a review into the involvement of agencies and professionals associated with the adult at risk.

The purpose of a Safeguarding Adults Review is to identify learning for partners and apply this to prevent harm for others. It is not an enforcement process and it is important that this is made clear to family members or representatives of the adult who has died.

If a service user has died due to (or possibly due to) abuse or neglect then a Safeguarding Adults Review should always be considered. This can be discussed with member of the Strategic Safeguarding Adults team. Each service should have access to the referral form which lays out the criteria and should be sent to the Head of Service of the Safeguarding Partnership (who manages both Safeguarding Boards in Enfield). Multiple Board Partners (including the independent Chair) will then meet to consider the referral and begin to plan what, if any, form of SAR should take place.

SARs are published on the Enfield Safeguarding Adults Board website and examples can be read there. Referral documentations and protocols can be found on the Safeguarding Adults Board website here.

Safeguarding Adults Review referrals should be made within a month of the adult dying to ensure that learning is done as quickly as possible and to aid in information gathering.

8. DOMESTIC ABUSE RELATED DEATH REVIEWS.

Domestic Abuse Related Death Reviews (DARDRs) used to be referred to as Domestic Homicide Reviews but the name was changed to reflect the fact that often those who die after suicide are also victims of domestic abuse (see more information about this change here).

These reviews are carried out where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by either:

- a person to whom they were related, or with whom they were or had been in an intimate personal relationship

- a member of the same household

When a domestic homicide takes place in Enfield, the Police or Mental Health Trust will tell the Chair of the Community Safety Partnership straight away. The Community Safety Partnership will decide whether a review will take place, and if so appoint an independent chair and report writer.

As with SARs, these are public and multi-agency reports designed to help agencies learn how to prevent future tragedies.

For more information – please see here.

9. CORONER CONTACT DETAILS

Contact with the Coroner to make referrals must be done in writing but can be followed up with a telephone call as required. Here are the contact details -

The Coroner's Service

North London Coroner's Service.
For:-Barnet, Brent, Enfield, Haringey and Harrow.
Barnet Coroner's Court.
29 Wood Street, London, EN5 4BE.
E-Mail:-
enquiries.northlondon@coronerservice.haringey.gov.uk

See Appendix A for guidance for when to refer.

Appendix A: Guidance for when to refer to Coroner

Checklist		
Questions:	**Your Answer:**	**Action you need to take: (you MUST answer all questions)**
1. Is the cause of death **unknown**,	Yes (the cause of death is ***un***known)	Refer to Coroner
	Not sure what the cause is	Refer to Coroner
	My colleagues disagree	If you cannot come to a consensus as to the cause of death, **or** whether or not to refer it, you should refer it to Coroner
	No (the cause of death is known)	Check all the other questions on this checklist **If you know/are sure of the cause of death, AND you can answer NO to ALL the other questions** on this checklist, the person completing the death certificate may do so and give to the family to register the death
Even if you are sure about the cause of death, you MUST answer all of the following questions. If you answer YES to any one of the following questions you MUST refer the death to the Coroner.		
2. Is it possible that **assault or violence** caused or contributed to the death?	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
3. Could **poisoning** have contributed to the death? [whether intentional or accidental, but ***not*** food poisoning]	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
4. Did the death occur **during or immediately after an operation?** [***regardless*** of the known risks of the operation]	Yes	Refer to Coroner
	No	Go to next Question
5. Did the death occur **within 24 hours of an anaesthetic?** [but there is no need to report a death simply because it occurred within 24 hours of admission to hospital]	Yes	Refer to Coroner
	No	Go to next Question
6. Do you think that a **medical procedure or treatment** (whether invasive or not) may have caused or contributed to the death? [this *need not be a* ***recent*** medical procedure or treatment]	Yes	Refer to Coroner
	No	Go to next Question
7. Do you think that a **lack of treatment** may have caused or	Yes	Refer to Coroner

contributed to the death? [either here, or elsewhere]	No	Go to next Question
8. Do you think that **neglect** may have caused or contributed to the death?	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
9. Do you think that **non-violent trauma**, whenever it occurred, may have caused or contributed to the death? [e.g. a fall at home or school]. If you think ***violent*** trauma was involved, you should also report to the police – see Question 2	Yes	Refer to Coroner
	No	Go to next Question
10. Do you think that the **deceased's own actions** may have caused or contributed to the death? [e.g. by drug use, self-harm or self-neglect]	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
11. Did the death occur while **in custody** [police or prison or compulsory detention under section of the Mental Health Act]	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
12. Did the death occur shortly **after police contact** or Could **police action or inaction** have caused or contributed to the death?	Yes	Refer to Coroner AND Report to the police (dial 101)
	No	Go to next Question
13. Are there **any other features** of the death that concern you? Please decide what it is that is of concern to you	Yes	Refer to Coroner
	No	ONLY in the event that you have answered **NO to ALL Questions**, do you **NOT** need to Refer the death to the coroner.