‘Dhiren and Paul’ SAR Statement

Sola Afuape, Independent Chair of Newham Safeguarding Adults Board

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The Newham Safeguarding Adults Board acknowledges the delay in publishing the Dhiren and Paul Safeguarding Adult Reviews. This delay has been due to the complexity of the cases and the need to ensure that all legal and confidentiality considerations were fully addressed before publication. We remain committed to transparency and learning, and the reports will be published on ***17th December 2025*** *to share findings and recommendations that will strengthen safeguarding practice across our partnership.*

Newham Safeguarding Adults Board (NSAB) considered two cases of young men, ‘Dhiren’ and ‘Paul’ who both sadly died in their early thirties. At the time of the commissioning of the Safeguarding Adults Review (SAR) it was thought that the circumstances of both men met the **Care Act Section 44 criteria for a mandatory Safeguarding Adults Review**. (These are not their real names. Pseudonyms are used to provide the families’ privacy.)

‘Dhiren’ was of South Asian heritage and Hindu and had learning difficulties and several health issues including diabetes. In 2021 the sodium levels in Dhiren’s blood became abnormally low and he suffered a cardiac arrest, dying a month later at age 35.

‘Paul’ was Black African and Christian with severe learning disabilities and other health conditions. In 2019, at age 33 ‘Paul’ died tragically after an accident at home, the precise cause of his death remains unclear but was inferred that it may have been linked to his epilepsy.

The SAR highlights several areas for learning including a lack of engagement from agencies and professionals with both Dhiren and Paul and their families, with several missed opportunities to ensure there were robust safeguards in their care.

I extend my sincere condolences to ‘Dhiren’ and’ Paul’s families for their loss. It is the SAB’s role to take time to really reflect on the sequence of events leading up to their death and critically examine actions taken by all involved agencies to ensure that meaningful learning is identified and tangible improvements are made in how we safeguard our residents.

There are several themes considered including - cultural competent practice & appropriate understanding and responsiveness to residents’ needs that intersection across ethnicity and disability; adequate support to families & advocacy; understanding the needs of residents with learning disabilities; professional curiosity and transitional support from children’s social care to adults’ social care.

This review was presented to the SAR panel and appropriate decisions made on behalf of NSAB. Some of the panel’s reflections and agreed areas for learning centred on how well we truly know and respond to the diverse needs of our residents, the impact this has on the disparities in support and care they receive and how much attention is paid to marginalised residents within our systems. There was acknowledgement of the work each partner is already doing to address some of the issues raised however my reflection, as Chair, is a greater emphasis from all partners is required to illicit the improvements that need to happen. Equity in safeguarding will, here-on-in, be a foundational theme of NSAB’s work.

A multi-agency action plan is in place which is the SAB partners’ response to the specific findings and recommendations in the review. NSAB will be seeking assurance, through a **multi-agency audit,** that these actions are realised, learning from this review is embedded into practice and there is evidence of continuous improvement.

Work is underway to identify, understand and address disparities within safeguarding and there will be a long-term commitment with greater input from residents to making safeguarding personal ensuring the fullness of their lived experiences informs and shapes our work.