Safeguarding Adult Review in respect of Family B

July 2025

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1. BACKGROUND

Cheshire West and Chester Local Safeguarding Adults Board (The LSAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:

- In line with the Care Act 2014, a Safeguarding Adults Review (SAR) is required when an adult with care and support needs has experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies worked together to safeguard the adult. In this case, the SAR focuses on understanding the circumstances that led to the B family experiencing serious self-neglect, with the aim of identifying learning to strengthen future safeguarding practice, and

- There is reasonable cause for concern about how the LSAB, its members, or others worked together to safeguard the adult.

1.1 A Safeguarding Adults Board (SAB), in this instance Cheshire West and Chester Local Safeguarding Adults Board, has the authority to commission reviews in circumstances where there is potential learning to be derived from how agencies worked together, even if it is inconclusive as to whether, in the case of the B Family, significant harm was the result of abuse or neglect. Abuse and neglect also include self-neglect.

1.2 LSAB members are invited to actively participate in and support the review process, with a focus on uncovering valuable insights and opportunities to enhance future safeguarding practices. The Safeguarding Adults Review (SAR) is not about apportioning any blame nor responsibility but about promoting a culture of learning and collaboration. Its aim is to identify areas of strength, good practice that can be shared and/or improvement in how agencies, both individually and collectively, safeguard and support adults with care and support needs who are at risk of abuse and/or neglect, including self-neglect, and who may be unable to protect themselves.

1.3 On 27th August 2024, Cheshire West and Chester Local Authority Adult Social Care submitted a referral for consideration of a Safeguarding Adults Review (SAR) regarding the B family. The referral highlighted a series of concerns regarding how services worked together to support the B family to live safely in the community. The main concerns highlighted within the initial referral include the way in which services respond to adults experiencing hoarding, the response to potential coercive and controlling behaviour, how services work with people who are seldom heard, and how professionals work with the Mental Capacity Act and take account of executive functioning.

2. UNDERSTANDING WHY PEOPLE ARE SELDOM HEARD

Seldom Heard has previously been referred to as non-engagement, which encompasses 'disguised compliance'. Disguised compliance does not take account of a person's history, which may include a history of, and/or responses to trauma; nor does it encompass a strengths-based approach.

When services experience difficulty engaging with a person, this might mean that the person is under-represented, and as a result, they might be under-served and seldom heard.

The term 'seldom-heard groups' refers to under-represented people who use or might potentially use health or social care services and who are less likely to be heard by professionals and decision-makers from these services.

These groups used to be described as hard to reach – suggesting that there is something that prevents the person's engagement with services. Seldom heard emphasises the responsibility of agencies to reach out to excluded people, as opposed to the onus being on the person to engage with the agency, ensuring that people have access to health and social care services and that their voices can be heard. The term seldom heard is preferred for those reasons.

Examples of seldom heard groups might include:

- Specific ethnic minority groups
- Carers
- People with disabilities
- Lesbian, Gay, Bisexual, Transgender, Queer and Questioning people (LGBTQI+)
- Refugees and asylum seekers
- People who are homeless
- Younger people
- Older people
- People with language barriers, for example, those for whom English is not their first language or those with low levels of literacy.

When people experience difficulty accepting or engaging with support, their behaviour may give the appearance of co-operating with professionals. This might be because the person wishes to avoid confrontation or because this is what they think the professional wants to see or hear. Some people may be fearful of professionals and as a result do not engage completely with support.

Learning from Safeguarding Adults Reviews evidence that professionals might delay or avoid interventions due to the person giving the appearance of engaging with services. Professionals should use professional curiosity and be prepared to think the unthinkable. Findings from recent studies of Safeguarding Adults Reviews indicate that a greater degree of curiosity may have led to information or action that could have prevented harm (Braye et al., 2014; Preston-Shoot, 2017).

Professionally curious practitioners are tenacious and determined. They are open to new ideas, challenges and ways of doing things (Oshikanlu, 2014). They are interested to learn the person's story and hear the voice of lived experience (Preston-Shoot, 2020) and want to use strengths-based approaches to both empower and protect (Pattoni, 2012).

The professionally curious practitioner will ask questions to fill gaps in information and gain a holistic perspective on a situation from the person and others (Oshikanlu, 2014). They will be alerted by tension, uncertainty or repeating patterns in people's situations, recognising this as a signal to push for further information (Burton and Revell, 2018) and will have the skills and courage to hold difficult conversations and promote challenge.

Practitioners need to understand what has led to the person's situation. Regarding behaviour through a trauma-informed lens empowers practitioners to understand potential links between current difficulties and past experiences. Re-traumatisation can occur when a current experience triggers the same, or similar, emotional, psychological and/or physiological response as an original, traumatic experience. Re-traumatisation may occur when professionals make decisions on a person's behalf. Trauma responses may be triggered when practitioners do not understand how their interactions and imbalances of power remind a person of a past trauma. Being curious by asking sensitive and respectful questions will allow important information to be discovered and enable appropriate support to be provided.

When professionals are concerned that a person is experiencing difficulty accepting or engaging with support, they should be asking:

- Why does the person behave in this way?
- Does the current situation have a link with a previous traumatic experience?
- What skills can I use to make a connection with the person?
- How can I make the person feel safer?
- How can I give the person choice and control?
- How can I empower the person to engage with me?
- Am I the right professional to engage with this person?
- What are the triggers in the person's life that led to them experiencing difficulty engaging with or accepting support?
- How can I create a relationship with the person based on trust?

What are the risks when people experience difficulty accepting or engaging with support?

- Professionals fail to recognise the origins of the behaviour.
- The relationship between the professional and the person may break down.
- Professionals may perceive the risk to be low level.
- It removes focus from the person.
- Professionals can become over optimistic about progress being achieved, leading to cases being stepped down and delaying timely interventions.
- Professionals may close the case because of lack of engagement or lack of progress.

Top Tips to achieve change:

- Focus on the person. Ensure you speak with them about their wishes and feelings in line with **Making Safeguarding Personal**.
- Consider if the views of family and carers are consistent with the those of the person. Do their accounts of the situation match?
- Practitioners need to ensure that they are professionally curious about the person, their life experiences, and the impact it has on them.
- Effective multi-agency work needs to be coordinated, so that all agencies have the necessary information regarding the lived experience of the person.
- Family or carers can easily prevent practitioners from seeing and listening to an adult with care and support needs. Ensure that you speak with the person and involve an advocate if required.
- Practitioners might miss opportunities to identify risk because of stories that we want to believe are true.
- Practitioners need to build cooperative relationships with people based on the **5 trauma informed principles: Safety, Collaboration, Trust, Empowerment and Choice.**
- Use regular supervision to help understand and demonstrate defensible decision making.
- **Incorporate the 6 principles of the Care Act: Empowerment; Prevention; Proportionality; Protection; Partnership; and Accountability.**

3. METHODOLOGY

This Safeguarding Adults Review (SAR) has been undertaken using a hybrid methodology, chosen to suit the specific circumstances of the B family's case. The process will include an analysis of agency chronologies, with an emphasis on critical reflection and a chronological analysis of events. This personalised approach ensures that all relevant information is captured from the professionals directly involved in the B family's care while creating space for collaborative reflection and development.

By incorporating these elements, the SAR process not only aims to provide answers and understanding for The B family and those close to them but also seeks to identify systemic barriers and enablers that affect best practice. As highlighted in the first and second national analyses of SARs (Preston-Shoot et al, 2020; 2024), it is crucial to adopt a whole-system understanding when conducting reviews of this nature. The findings from that analysis demonstrates how factors that enable or obstruct good practice often reside within interconnected domains of the system. This means the focus must extend beyond individual actions to consider how organisational structures, policies, and inter-agency collaboration either align to support best practice or, in some cases, create misalignments that weaken it.

In this case, The B family is placed at the heart of the SAR process. The aim is not only to understand the circumstances leading up to and following key incidents but also to explore how the systems designed to support the family have interacted and, at times, failed to do so effectively. This includes the involvement of seven agencies including statutory partners of Cheshire West and Chester LSAB. Each of these agencies has played a role in The B family's life, and the SAR will explore how well their efforts have been coordinated and aligned with The B family's needs.

The SAR process will focus on identifying the enablers of and barriers to good practice, with the aim of making recommendations for improvement across the wider

Cheshire West and Chester safeguarding partnership. By placing the B family at the centre and utilising observations from evidence-based research, this review seeks to provide understanding and action in addition to a plan for system-wide improvements to better support individuals and families in similar circumstances.

4. KEY THEMES

4.1 RESPONSE TO ADULTS EXPERIENCING HOARDING

Cheshire West and Chester Adult Social Care expressed concerns regarding how services respond to hoarding behaviour including diagnosis, support, therapeutic and legal interventions. This was highlighted in the referral for consideration of a SAR. These concerns were mirrored by North West Ambulance Service who attended the B family home on several occasions throughout the period covered by this review. On 5th August 2024, Samuel B was admitted to hospital. The ambulance crew recorded that the B family's home address was cluttered to the extent that it scored a rating of 9 on the Clutter Image Rating Scale. Cheshire West and Chester Adult Social Care staff recorded that Hilary B was at risk of a deterioration in her mental and physical health as a result of the hoarded environment. Furthermore, Adult Social Care considered the environment within the family home to pose a fire risk but noted that Cheshire Fire and Rescue Service had assessed the level of risk as 'low'.

Samuel B's GP discussed hoarding with a paramedic from North West Ambulance Service who initially raised concerns following ambulance attendance when Samuel fell at home on 6th October 2022. The fall was attributed to the hoarded home environment. Good practice was noted by North West Ambulance Service who completed an adult safeguarding referral to the local authority. The referral noted that at this time, the home address scored 7-8 on the Clutter Image Rating Scale. North West Ambulance Service received feedback from Adult Social Care that the safeguarding was open to a worker and that the case was going to be subject to longer-term case management. Later that month, on 13th October 2022, Samuel's GP visited Samuel at home and raised concerns regarding the home environment. The GP recorded that the hoard reached the ceiling in some places. No Clutter Image Rating Scale was completed by the GP. Samuel and Jay told the GP that

Hilary was responsible for the hoarded items. No onward referrals were made or safeguarding instigated. This was a potential missed opportunity to consider other adults residing at the address, and a lack of a 'Think Family' approach. It was noted that Cheshire Fire and Rescue Service updated their records to reflect that the environment was hoarded. Two safe and well visits were undertaken by Cheshire Fire and Rescue Service and six alarms were installed; these were in all the rooms that were accessible.

Cheshire West and Chester Adult Social Care undertook one decision-specific capacity assessment in respect of Hilary on 9th November 2022 which confirm that at that time, Hilary had the mental capacity to make decisions about her care and accommodation, specifically exploring the subjects of hoarding and self-neglect. The outcome of this assessment was that further assessment was required, and a strengths-based social care assessment was completed on 11th November 2022. No Clutter Image Rating Scale was completed by Adult Social Care at this time. One further mental capacity assessment is recorded on Liquid Logic, dated 14th November 2023, with an outcome of no further action as support was declined. Adult Social Care noted a gap in services for people who hoard and reflected that this was a national issue. On 26th January 2023, Hilary was seen at the GP surgery for a face-to-face review. No formal mental capacity assessment was recorded by the GP. There was no evidence of considering a safeguarding referral in respect of Hilary nor a whole family approach given the risks posed in the property due to hoarding. There was no evidence of multi-agency discussion or onward referrals following this consultation which was arguably a missed opportunity to safeguard Hilary. There was no evidence of exploring psychological wellbeing with Hilary, nor the reasons behind self-neglect, demonstrating a lack of professional curiosity. On 16th February 2023, Hilary was referred to Cheshire West and Chester high-risk panel which was the appropriate forum to discuss the circumstances and demonstrated that Adult Social Care were following local policy and procedure.

On 21st April 2023 Hilary was assessed at home by a district nurse who referred to self-neglect and hoarding within the notes. These concerns were appropriately

shared with Hilary's social worker. On 2nd May 2023, Hilary was admitted to hospital. Adult Social Care contacted the complex care team and Countess of Chester hospital. Safeguarding was instigated due to hoarding, which coupled with health concerns was recorded as 'life threatening'. The Countess of Chester hospital chronology made reference to hoarding and noted that 'the social worker may want to deal with hoarding and its associated risks'. Cheshire and Wirral Partnership NHS Trust also noted that 'a social worker was reported to be involved, and it was advised they were best placed to support with hoarding'. Adult Social Care noted that the hospital and community interface needs to be clearer. The Hoarding Rating Scale was completed by Adult Social Care, but no rating recorded. 12 weeks of support from mental health reablement was arranged, to support with hoarding. At a multi-disciplinary team meeting on 11th September, Adult Social Care social worker requested a psychiatrist report to support Hilary with her issues around hoarding. There was no health service commissioned to work with hoarding and therefore this was not actioned. There are two references to Adult Social Care providing support with hoarding recorded in GP notes in September 2023 and November 2023, with reference to 'the whole family having hoarding issues'.

GOOD PRACTICE

- Use of Clutter Rating Scale by North West Ambulance Service and Adult Social Care.
- Recognition of safeguarding and onward referrals by North West Ambulance Service and Adult Social Care.
- Safe and well checks completed by Cheshire Fire and Rescue Service and installation of alarms.

AREAS REQUIRING IMPROVEMENT

- Assumption that support with hoarding is solely the remit of Adult Social Care.
- Lack of professional curiosity from GPs.
- Clutter Rating Scale not always completed.
- Lack of onward referrals by GPs and hospital staff.

- Multi-agency communication needs to improve at the point of hospital admission and discharge.
- Lack of specialist services for hoarding and self-neglect.
- Lack of formal Mental Capacity Act assessment by GP.
- Short-term support with hoarding and self-neglect has been proven to be ineffective, but the service was only available for 12 weeks.
- Cheshire Fire and Rescue Service had assessed the level of risk as 'low'.
- Lack of consideration of the whole family and their needs which are intrinsically linked.

4.2 RECOGNITION OF AND RESPONSE TO COERCIVE AND CONTROLLING BEHAVIOUR

In October 2022, Hilary made a disclosure of domestic violence against her brother, Stephen. In addition, Adult Social Care noted potential controlling behaviour from Hilary towards her father, Samuel, resulting in him not accessing social support and physiotherapy. Cheshire Police noted practice shortcomings as neither Police nor Adult Social Care pursued or recorded domestic violence offences. Furthermore, Police noted a lack of professional curiosity and challenge. The Police chronology refers to Hilary being left in a high-risk environment and noted that other adults within the household were adults at risk in their own right. From an Adult Social Care perspective, there is consideration of a referral to Independent Domestic Violence Advocate service in respect of Hilary, and appropriate discussion of domestic abuse but there is no evidence of DASH/RIC (Domestic Abuse Stalking and Harassment Risk Indicator Checklist) being completed.

In April 2023, a district nurse assessed Hilary as being at high risk of being a victim of domestic abuse. The district nurse advised Cheshire and Wirral Partnership NHS Trust that she would be completing a DASH/RIC (Domestic Abuse Stalking and Harassment Risk Indicator Checklist), although there is no evidence within the chronology that this had been completed. There was also a missed opportunity in the same month where Adult Social Care could have completed a DASH/RIC

(Domestic Abuse Stalking and Harassment Risk Indicator Checklist) when Hilary was seen away from the family home.

Hilary was admitted to Countess of Chester hospital in May 2023 and on admission it was noted that there was an open safeguarding enquiry which included disclosure of domestic abuse from her brother. Countess of Chester hospital safeguarding team recorded that the hospital-based Independent Domestic Violence Advocate liaised with the complex case manager requesting that the ward explore Hilary's home situation and family dynamics and to ascertain if she would consent to a referral to the Independent Domestic Violence Advocate while she is in hospital. Notes from Countess of Chester hospital stated that Hilary declined any further support and stated that the assault from her brother was an isolated incident. This was not explored further, demonstrating a lack of professional curiosity which mirrors the findings from Cheshire police. There was also an assumption that Hilary had capacity to make this decision with no consideration of the impact of coercion and control on Hilary's executive functioning. It was noted that the IDVA at the Countess of Chester hospital did visit Hilary on a second occasion in an attempt to discuss potential domestic abuse, however, she was too unwell to participate in discussion

Chronologies from health and Adult Social Care state that Hilary refused to complete a DASH/RIC (Domestic Abuse Stalking and Harassment Risk Indicator Checklist). Notwithstanding, guidance from SafeLives, the UK-wide domestic abuse charity clearly states that the results from a checklist are not a definitive assessment of risk, and that risk must be assessed using the practitioner's professional judgement. SafeLives guidance is easily accessible via a public-facing website. The SafeLives website states that risk is dynamic and can change very quickly. There is no evidence that the potential risks to Hilary were reviewed at each contact, or that there was any joined up, multi-agency approach to risk identification and management. Information contained within the chronologies indicates an assumption that Adult Social Care would deal with domestic abuse risks with no further exploration. There were missed opportunities to liaise with the local authority domestic abuse intervention and prevention service for advice and guidance. While

the Adult Social Care chronology states that there was consideration of a referral to the Independent Domestic Violence Advocate service, the information provided in the multi-agency chronologies evidences a single contact from the hospital-based Independent Domestic Violence Advocate shortly before Hilary's death. There was also no exploration from any agency of potential controlling behaviour from Hilary towards her father, Samuel which had been identified by Adult Social Care in the referral for this SAR.

GOOD PRACTICE

- An Independent Domestic Violence Advocate visited Hilary in hospital.
- Domestic abuse was recorded as a category of abuse at closure of the s.42 safeguarding enquiry.
- Decision-specific Mental Capacity Act assessments completed by Adult Social Care.

AREAS REQUIRING IMPROVEMENT

- Domestic Violence offences were not recorded or pursued.
- Lack of professional curiosity.
- No exploration from any agency of potential controlling behaviour from Hilary towards her father.
- Missed opportunities to undertake further assessment of risk in relation to domestic abuse. No consideration of alternative to DASH/RIC (Domestic Abuse Stalking and Harassment Risk Indicator Checklist).
- Lack of liaison with the domestic abuse intervention and prevention service for advice and guidance.
- Not able to evidence that practitioners considered other reasons such as undue influence, coercion and control and executive functioning when assessing mental capacity or Hilary's decision-making.

4.3 WORKING WITH ADULTS WHO ARE 'SELDOM HEARD'

The SAR referral highlighted risks to Hilary should she not engage with services and concerns about how services work together with people and families who are hard to engage. Seldom Heard has previously been referred to as non-engagement, which encompasses 'disguised compliance'. Disguised compliance does not take account of a person's history, which may include a history of, and/or responses to trauma; nor does it encompass a strengths-based approach.

When services experience difficulty engaging with a person, this might mean that the person is under-represented, and as a result, they might be under-served and seldom heard.

The term 'seldom-heard groups' refers to under-represented people who use or might potentially use health or social care services and who are less likely to be heard by professionals and decision-makers from these services.

These groups used to be described as hard to reach – suggesting that there is something that prevents the person's engagement with services. Seldom heard emphasises the responsibility of agencies to reach out to excluded people, as opposed to the onus being on the person to engage with the agency, ensuring that people have access to health and social care services and that their voices can be heard. The term seldom heard is preferred for those reasons.

Hilary had a disability and therefore is an example of a cohort with a protected characteristic under the *Equality Act* 2010 which makes her more susceptible to being seldom heard.

Top tips to achieve change are included within section 2 and referenced in section 5: learning and recommendations.

4.4 USE AND APPLICATION OF THE MENTAL CAPACITY ACT 2005

Within the SAR referral, Adult Social Care expressed a wish for this review to provide learning to explore executive functioning and the influence of compulsion on mental capacity.

From an analysis of the agency chronologies, there is no clear evidence that practitioners consider other reasons such as undue influence, coercion and control, or any concerns regarding executive function when considering an individual's capacity to make decisions.

On 7th November 2022, the wellbeing coordinator asked Hilary's GP to undertake a Mental Capacity Act assessment to determine Hilary's capacity to consent to medical treatment. The GP did not undertake an assessment and stated that Hilary had capacity, but it was unclear on what basis this assessment of capacity was made. The wellbeing coordinator had asked for an assessment of capacity as Hilary was refusing medical treatment and refusing to take medication. This would suggest that there were reasons such as undue influence, coercion and control or concerns in respect of executive functioning impacting on Hilary's decision making. It was noted that Hilary was described as cachectic which is more severe than being malnourished and can affect decision-making ability

On 26th January 2023, Hilary was seen at the GP surgery for a face-to-face review. No formal mental capacity assessment was recorded by the GP. There was no evidence of considering a safeguarding referral in respect of Hilary nor a whole family approach given the risks identified, representing a missed opportunity to safeguard Hilary.

On 19th April 2023, Hilary attended a telephone consultation with her GP. The chronology refers to 'hints at a mental capacity assessment but no recording of a thorough assessment' representing a further missed opportunity to undertake a formal assessment of Hilary's mental capacity. Later in the same month, Hilary's father, Samuel attended a telephone consultation with his GP. The GP had recorded

that '[Samuel] has mental capacity to make decisions for himself. No concerns regarding disorder of the mind/brain currently'. It is not clear what has prompted the comment regarding Samuel's mental capacity. There is no record of a capacity assessment being undertaken.

GOOD PRACTICE

- Formal capacity assessments recorded by Adult Social Care.
- Familiar staff consulted with Hilary, evidencing practical steps to support individual decision making.
- Hilary was consistently communicated with.

AREAS REQUIRING IMPROVEMENT

- Capacity assessments not always undertaken or formally recorded.
- Capacity assessments were not always decision-specific with reference to 'has capacity' or 'lacks capacity' but not clear what this was in relation to.
- Not always able to evidence that concerns were escalated.
- Professionals making opinions about the outcome of an individual's decision-making ability without a formal capacity assessment.
- Improvements in case recording to ensure that the purpose of meetings and actions are clear, with timescales for completion of actions and action owners assigned and recorded.

LEARNING AND RECOMMENDATIONS

The following table sets out the key recommendations arising from this Safeguarding Adults Review (SAR). These recommendations are designed to address the systemic issues and practice gaps identified, while also building on the examples of positive practice evidenced throughout the care of the B family. Each recommendation is formulated to promote improvement through an emphasis on practical actions, measurable outcomes, and clear lines of accountability across the multi-agency safeguarding partnership in Cheshire West and Chester. The recommendations align with statutory responsibilities, evidence-based practice, and learning from national SAR findings.

Number	Theme	Recommendation	Action	Measure	Timeframe	Lead Agency
1	**Theme 1 Response to adults experiencing hoarding**	Hoarding disorder is recognised by the NHS as a mental health condition. Hoarding is considered a significant problem if the amount of clutter interferes with everyday living and/or if the hoarded items negatively affect the quality of life of the person or their family, both of which apply in this case. This review has highlighted the importance of the Cheshire West & Chester Hoarding Alliance. Outcomes of the Hoarding Alliance include: -Early intervention, which is responsive, personalised and respective of the individual. -Building a community of	All agencies to ensure that they are aware of Cheshire West & Chester Hoarding Alliance, operational guidance to support the multi-disciplinary team approach and the LSAB self-neglect policy, procedure and toolkit. All agencies to demonstrate competence in utilising local guidance, policies and procedures to support people experiencing hoarding and make necessary referrals to the appropriate forums.	Case audits to evidence referral to Cheshire West & Chester Hoarding Alliance and use of local guidance, policies and procedures to support and evidence defensible professional decision-making. As the Hoarding Alliance has only recently been set up (end of 2024), it would be most beneficial to undertake the case file audits once the Hoarding Alliance has been established over a longer period.	Audit of hoarding cases to be considered by LSAB QA & Performance subgroup. To be added to audit schedule and prioritised in accordance with recommendations from other reviews. It would be most useful to review the impact of the Hoarding Alliance once it has become more established. Suggested timescale to begin audit in the first quarter of 2026-27.	All agencies, report to LSAB to monitor. Audit to be led by LSAB QA & Performance subgroup.

		practice to support professionals working with people experiencing hoarding.		Target: 90% of case file audits.		
2	**Theme 2 Recognition of and response to coercive and controlling behaviour**	The review highlighted missed opportunities to undertake further assessment of risk in relation to domestic abuse. When domestic abuse is identified or suspected it is vital to utilise the Cheshire West & Chester domestic abuse intervention & prevention service (DAIPS). Partner agencies can access DAIPS for advice even in cases where consent is not given. There was a lack of consideration of the impact of coercion and control on Hilary's executive functioning	All agencies to ensure that they are aware of DAIPS, how to make contact and how to refer to the service. All agencies to demonstrate competence in working with domestic abuse, including a robust awareness of coercion and control, and identifying when an individual might be at risk.	Evidence that partner agencies have an up-to-date organisational policy around undue influence, coercion and control (including as part of safeguarding procedures). Evidence of staff training within the last two years, to cover domestic abuse and coercion and control. This can be incorporated into the multi-agency skills audit (outlined below).	To be confirmed, to align with the case file audits as part of one overarching piece of work in order to realise efficiencies and to ensure coordinated focus.	All agencies, report to LSAB to monitor. Practice leads to work with LSAB QA & Performance subgroup on skills audit. LSAB to coordinate evidence of partner organisations' policies.

3	**Theme 3 Working with adults who are 'seldom heard'**	The term 'seldom heard' is used to describe under-represented people who might use services and who are less likely to be heard by professionals and decision-makers.	Produce guidance for professionals to support them when working with people who are 'seldom heard'.	To raise awareness of the guidance across all agencies. For this to form part of a multi-agency skills audit to Adult Social to ascertain professionals' confidence in using the 'seldom heard' guidance and knowledge of how and when to use.	To be confirmed, to align with the case file audits as part of one overarching piece of work in order to realise efficiencies and to ensure coordinated focus.	All agencies, report to LSAB to monitor. Practice leads to work with LSAB QA & Performance subgroup on skills audit.
4	**Theme 4 Use and application of the Mental Capacity Act**	This review highlighted inconsistent use and application of the *Mental Capacity Act* 2005. If there are reasons to doubt capacity, then a Mental Capacity Act assessment must be completed in relation to the	Capacity assessments to be formally recorded. Capacity assessments to be decision specific. Concerns to be escalated, via organisational escalation	As part of the Mental Capacity Act audits that are being completed at the time that this review took place, the LSAB is considering implementing	To align with recommendations from the Mental Capacity Act audit.	Cheshire West & Chester and Cheshire East LSABs to coordinate and involve key partners from both boards.

		decision being considered. Only then can a determination be made regarding the individual's capacity.	procedures or under safeguarding. Make risk management person-centred. Ask 'what is the person's usual behaviour? And reflect this in the formal assessment of mental capacity. Consideration of the impact of coercion and control on executive functioning to be integral to all capacity assessments where coercion, control or domestic abuse have been identified.	a dedicated Mental Capacity Act subgroup which will operate across Cheshire West & Chester and Cheshire East borough areas, as it was acknowledged that there are commonalities in the findings from SARs across both local authority areas. Furthermore, a significant number of SAB partners sit on both Cheshire West & Chester and Cheshire East safeguarding adults' boards.		

5	**Overarching theme: Hospital discharge**	This review has identified that multi-agency communication needs to improve at the point of hospital admission and discharge. Hospital discharge processes are in the 'top three' themes from SARs undertaken in Cheshire West & Chester.	It would be beneficial to understand if there wider issues in relation to hospital discharge processes that require deeper analysis. The Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (published April 2024) found that improvements in direct practice featured in 93% of the 229 SARs analysed, and cited hospital discharge as an example of a priority area identified through the review.	Audit of hospital discharges within hospitals in Cheshire West & Chester.	Audit of hospital discharges to be considered by LSAB QA & Performance subgroup. To be added to audit schedule and prioritised in accordance with recommendations from other reviews	Audit to be led by LSAB QA & Performance subgroup.
6	**Overarching theme: Professional curiosity**	Professional curiosity, escalation and challenge needs to be embedded into the	This has been addressed through recommendations	The SAB seek assurance from partner agencies that	Aligned with recommendations from the Mary SAR.	Reviewed March 2025. Progress to be

		frontline and managerial practice of all agencies working with adults at risk in Cheshire West & Chester.	from the Mary SAR, although remains outstanding at the time of writing.	they have reviewed and revised as appropriate their supervision procedures and monitoring systems to reduce the likelihood of future failures to initiate relevant internal and multi -agency procedures as identified in the Mary SAR.		monitored by LSAB.
7	**Overarching theme: effective multi-agency communication**	Multi-agency collaboration is key in adult safeguarding but is often impacted by system and communication barriers. Hierarchy of decision makers mean that	Use of information sharing agreements to ensure that information is shared in accordance with information governance principles and necessary legislation but to	Contact lists to be kept up to date and shared across the adult safeguarding partnership. LSAB inbox to be central point for coordination and distribution.	Within the next 6 months.	All agencies. Coordinated by LSAB.

		responsibilities can be 'passed on' and nobody takes ownership.	also enable those who need to know to be sighted on information, i.e. when an individual is subject to a safeguarding enquiry or there are concerns that the person may be susceptible to abuse or neglect.	Partners to send contact lists to the LSAB inbox in the first week of every month. Information sharing to include distribution of meeting minutes to partners as appropriate. Exploration of the shared care record (CAM system) which could be used to share information on a multi-agency basis.		