



Safeguarding Adults Review Learning Summary

Anita

November 2025

1. What is a Safeguarding Adults Review?

Under the *Care Act 2014*, sections 44 (1-3), Safeguarding Adults Boards (SABs) must carry out a Safeguarding Adults Review (SAR) when an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse (including self-neglect) and there is concern about how agencies worked together to protect the adult(s). The SAB may also (section 44(4)) undertake a SAR in any other case concerning an adult with care and support needs. The purpose of all reviews is to identify learning that can drive change to prevent harm occurring in future similar circumstances.

In July 2025, Cheshire West and Chester Safeguarding Adults Board received a SAR referral in respect of Anita.

Anita had a number of diagnosed physical health conditions and therefore may have had needs for care and support, although this cannot be confirmed. We do not know the circumstances leading to Anita's death.

There was concern about how agencies worked together, but this is not necessarily linked to Anita's death.

A SAR panel was convened in November 2025 and identified that the referral did not meet the criteria for a Safeguarding Adults Review.

The panel agreed that there was potential learning from this case, particularly

1. Professional curiosity
2. Working with people experiencing challenges engaging with services
3. Multi-agency decision making and making every contact count – how to feed back to referrers to ‘join the dots’

2. What is the purpose of a Learning Summary?

Cheshire West and Chester Safeguarding Adults Board ask that board partners and stakeholders use learning summaries within their organisations to cascade the learning from the Safeguarding Adult referral in respect of Anita. This learning summary can be used in Team Meetings, Development Days, individual or group supervisions to share and reflect on the learning from this Safeguarding Adults referral and how the learning can translate into practice.

3. Anita’s Lived Experience

Anita was a 54-year-old woman who was living in owner occupied accommodation prior to her death. Anita’s son, is supported by children’s social care in Cheshire West and Chester and has been known to social care services since 2017.

Her son had shared concerns regarding his mother and missing person reports were submitted by children’s social care.

Anita was reported missing to the police by children's services on 5th September 2024 and had previously been reported missing prior to this. Anita was found deceased at home on 23rd July 2025 and was in a bad state of decomposition. The cause of death was not known. Children’s social care colleagues understand there were suicide notes at the property. Anita had previously been open to adult mental health services, and it is not clear when services stopped supporting Anita.

4. Which agencies were involved with Anita’s care?

- Cheshire and Wirral Partnership NHS Trust.
- Cheshire West and Chester Council.

- Cheshire Fire and Rescue Service.
- North West Ambulance Service.
- Cheshire Police.
- NHS Primary Care (GP surgery).

5. What areas for practice development were identified?

- Working with adults who are 'seldom heard'
- Multi-agency information sharing.
- Professional Curiosity.

6. What Is Professional Curiosity?

Professional curiosity is the ability and willingness of practitioners to:

- Ask deeper questions.
- Challenge assumptions.
- Triangulate information.
- Recognise disguised compliance.
- Explore the lived experience of adults at risk.

How to Measure Professional Curiosity

While there is no single standardised tool, measurement can be approached through:

Reflective Practice and Supervision

- Use models like Gibbs' Reflective Cycle to encourage practitioners to reflect on their actions, assumptions, and decisions. [[Reflection...e Resource](#)]
- Supervisors can assess how often staff engage in reflection-in-action (during practice) and reflection-on-action (afterwards).

Case Audits and Reviews

- Safeguarding Adult Reviews (SARs) often highlight missed opportunities due to lack of curiosity.
- Auditing cases for signs of:
 - Disguised compliance not being challenged.
 - Failure to triangulate information.
 - Lack of follow-up on concerns.
 - Over-reliance on single sources. [[Strategic...n Practice](#)], [[Profession...ults Board](#)]

Observation and Feedback

- Observe interactions for:
 - Use of open-ended questions.
 - Willingness to “think the unthinkable.”
 - Ability to hold difficult conversations. [[Profession...ults Board](#)], [[NYSAB - sa...ults.co.uk](#)]
- Peer or manager feedback can assess whether practitioners demonstrate curiosity in multi-agency settings.

Training Evaluation

- Post-training assessments can measure changes in:
 - Confidence in asking challenging questions.
 - Awareness of barriers like confirmation bias or professional deference. [[NYSAB - sa...ults.co.uk](#)], [[Reflection...e Resource](#)]

Indicators in Practice

Examples of indicators include:

- Asking the “second question” (not just what is happening, but why).
- Seeking multiple perspectives.
- Not accepting things at face value.
- Recognising patterns in case histories. [[7-minute b...Curiosity](#)], [[NYSAB - sa...ults.co.uk](#)]

Barriers to Professional Curiosity

Understanding and addressing barriers is key to measurement:

- Rule of optimism – assuming things will improve without evidence.
- Confirmation bias – ignoring contradictory information.
- Professional deference – deferring to others despite concerns.
- Normalisation – accepting risky behaviours as “normal.” [[Profession...ults Board](#)], [[NYSAB - sa...ults.co.uk](#)]

7. What is Cheshire West and Chester Safeguarding Adults Board doing to support effective practice?

- To seek assurance from partner agencies that they are aware of Cheshire West & Chester ‘seldom heard’ guidance. This is embedded at section 9 of this learning brief.
- To support professionals to be ‘professionally curious’ by sharing tools such as Wonnacott’s Discrepancy Matrix and Gibbs’ Reflective Cycle. To

embed critical thinking, reflective practice and defensible decision making in organisational practice across Cheshire West and Chester. These tools and other tools to support practice and embed professional curiosity can be found at section 9 of this learning brief.

- Promote the use of information sharing agreements to ensure that information is shared in accordance with information governance principles and necessary legislation but to 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.

8. What do partners need to do to support effective practice?

- 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. Guidance has been produced for professionals to support them when working with people who are 'seldom heard'. This can be found at section 9: resources.
- Concerns to be escalated, via organisational escalation procedures or under safeguarding.
- Make risk management person-centred. Ask 'what is the person's usual behaviour?'
- Improve multi-agency communication and information sharing between and within agencies.
- If professionals are working with a child or young person and concerns are raised about an adult in the same household or an adult with caring responsibilities for the child, these concerns to be shared with Adult Social Care in a timely manner.

- Cultural competence needs to be developed among professionals. Things mean different things to different people. Representation matters.
- To ensure that professionals are 'professionally curious'. Training for professionals on how, why, where, and when to ask 'professional curious' questions, to include cultural competence. This will ensure that professional curiosity is embedded into multi-agency practice.
- Reflection on professional practice and decision making. Wonnacott's Discrepancy Matrix encourages practitioners to reflect on what is known about a case and what is unknown or not yet known – a vital aspect of working with uncertainty. It supports the practitioner to tease out the information they hold into four types: evidence, ambiguous, assumption, and missing.

9. Tools and Resources

Professional Curiosity:

[What is professional curiosity? | Research in Practice](#)

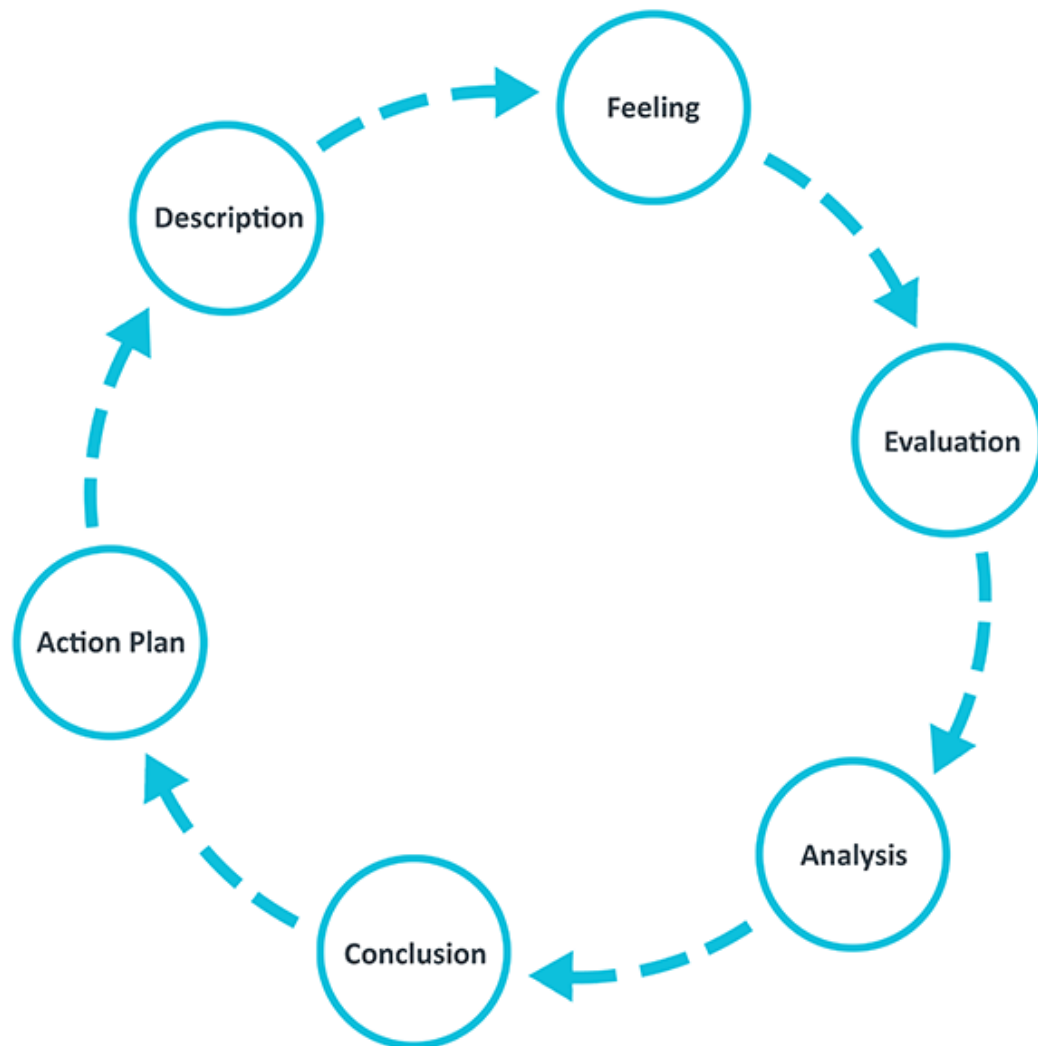
Research in Practice Strategic Briefing: Offers traits, behaviours, and organisational enablers. [\[Strategic...n Practice\]](#)

Norfolk SAB Guidance: Lists practical examples and barriers. [\[Profession...ults Board\]](#)

NYSAB Practice Guidance: Provides prompts and reflective questions. [\[NYSAB - sa...ults.co.uk\]](#)

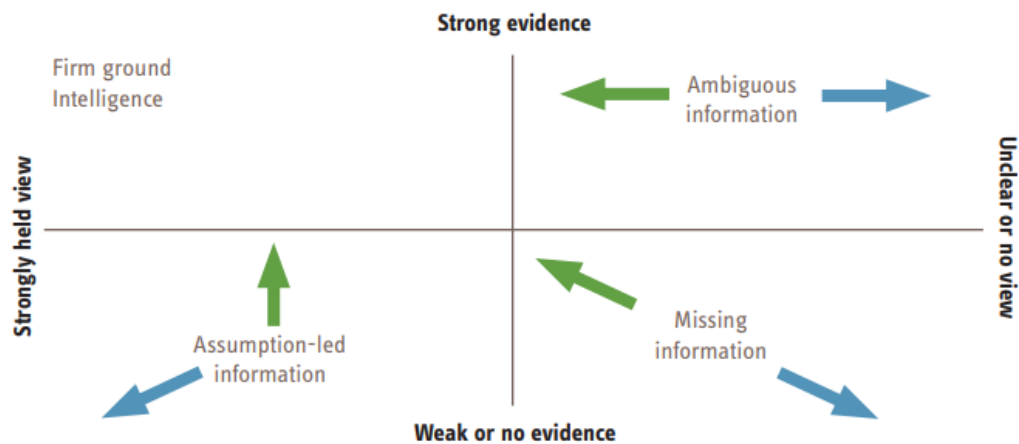
Catholic Safeguarding Resource: Links curiosity with reflection and critical thinking. [\[Reflection...e Resource\]](#)

Gibbs Reflective Cycle is a framework for reflection, commonly used in learning and professional development. It involves six stages: description, feelings, evaluation, analysis, conclusion, and action plan. By guiding individuals through these stages, the cycle helps them think critically about their experiences, learn from them, and improve future practice.



Wonnacott's Discrepancy Matrix

Discrepancy matrix



Source: Based on Morrison and Wonnacott (2009) in Wonnacott (2014)

Adult Safeguarding Procedures:



Safeguarding
Adults - Procedures.

Understanding why people are 'seldom heard'



UNDERSTANDING
WHY PEOPLE ARE SE

Local Safeguarding Adults Board Training: [Training | Cheshire West and Chester Council](#)

Getting support from Adult Social Care: [How to get Support | Cheshire West and Chester Council](#)

Live Well Cheshire West and Chester:
[Home | Live Well Cheshire West](#)