SAFEGUARDING ADULTS REVIEW: JESSICA

Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

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Contents

1 Introduction and Background

1.1 Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions, worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.2 The Cambridge & Peterborough Safeguarding Adult Board (CPSAB) has accepted the request for a Safeguarding Adult Review (SAR) to be conducted into the circumstances surrounding the death on the 13th of August 2023 of Jessica who was 88 years of age. The referral was made by the Cambridgeshire and Peterborough Coroner's Office. During the period of the SAR production there were no parallel reviews.

1.3 The SAR panel agreed that the situation met the Care Act Safeguarding criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk.

1.4 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity. The principles apply to the Review as follows:

Empowerment:	The Review will seek to understand how the agencies listened to/heard and engaged with Jessica and applied Making Safeguarding Personal. Involving Jessica's family in the Review.
Prevention:	The learning will be used to consider actions for prevention of future harm to others, particularly in relation to holistic, person-centred planning.

Protection:	The learning will be used to inform ways of working, actions and professional curiosity to protect others from harm.
Partnership:	Partners will seek to understand, looking through the lens of person-centred working, how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process.

Glossary

Name	Abbreviation
Continuing Health Care	CHC
Chronic Obstructive Pulmonary Disease	COPD
District Nurses	DN
Electronic Patient Records	EPR
Emergency Department	ED
End of life medication	EOL
Making Safeguarding Personal	MSP
Medical Research Council	MRC
Mental Capacity Assessment	MCA
Next Of Kin	NOK
Occupational Therapy	OT
Package of Care	POC
Shortness of Breath	SOB
Tissue Viability Nurse	TVN

2 The Purpose of the Review

2.1
- Establish what lessons can be learned from Jessica's story.
- Analyse how organisations work together.
- Analyse and expand upon the findings of the various reports.
- Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes, or policy.
- Facilitate a practitioner's event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented.

2.2 This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of Jessica in the weeks and months prior to her death on the 13th of August 2023. The

time period of the review was from the 1st of August 2021 until Jessica's death.

3 What do we know about Jessica.

3.1 Jessica was born in July 1935 she was of White-British ethnicity.

3.2 Jessica had health challenges which included:

1. Type two diabetic[1]
2. Diverticulitis disease[2]
3. Chronic Obstructive Pulmonary Disease (COPD)[3]
4. Chronic leg ulcers.

3.3 Jessica was frail, slight, stooped and needed mobility aids to walk. Jessica was started on supportive care in the community during June 2023 for increasing breathlessness and fatigue.

3.4 District Nursing records report she was covered in faeces when they visited and on more than one occasion she had faeces on her face with faecal covered tissues on the floor, hands and nails.

3.5 Jessica was developing pressure areas and losing weight. District Nurses also reported more than once that there were insufficient clean clothes for her in the house to change in to, absence of clean sheets and wash products.

3.6 Jessica felt she needed more support than her son could provide but declined moving to a Hospice or Nursing Home.

3.7 Jessica lived with two of her sons who we will call son A & son B, (at different intervals) during this review period. Jessica previously lived in Norfolk with another son who we will call (Son C), before moving to Cambridgeshire. Jessica lived with her son (son A) and his wife who was Jessica's daughter in law, and we will call DIL, between August 2022 & March 2023 and then (son B) and her granddaughter, (son B's daughter) between March 2023 and her death.

4 Methodology and Process Information

4.1 The author was appointed to undertake the SAR in October 2024.

Organisations Involved

4.2 Combined chronologies were supplied to the author completed by a safeguarding adult lead from the organisations involved. The agencies involved included:

[1] Type 2 diabetes – a condition that causes a person's blood sugar level to become too high
[2] Diverticulitis – common condition affecting the large intestine
[3] COPD – a group of lung conditions that cause breathing difficulties.

- Cambridgeshire County Council [CCC]:
- Cambridgeshire and Peterborough Foundation Trust [CPFT]:
- GP Practice
- Hospice at Home – Arthur Rank Hospice (HAH)
- NHS Cambridgeshire & Peterborough Integrated Care Board (ICB)
- Herts Urgent Care (HUC)
- Department for Works and Pensions (DWP)
- North West Anglia NHS Foundation Trust (NWAFT)

4.3 Following the initial review of all the information, a number of key lines of enquiry (KLE) were identified.

1. What was the involvement of Adult Social Care and if none why not, what was the threshold applied and was this correct?
2. Did Jessica have mental capacity to make decisions? What was the assessment process (if any) undertaken?
3. Should residential care have been arranged when concerns about neglect continued?
4. What consideration was given to concerns that one of Jessica's sons had access to all Jessica's finances, and the impact on Jessica?
5. Were agencies coordinated in their approach and was information shared to allow agencies to risk assess appropriately?
6. There was a referral for an ultrasound of her abdomen, which may have had significance, but as she did not attend, the request was cancelled. Was the impact of not attending this appointment considered by agencies? Did any agency have a plan around following up this non-attendance?
7. Was the carers assessment process effective and applied correctly?

5. Analysis and Learning

5.1 Practitioners Event

5.1.1 A practitioner learning event was held on the 11th of March 2025. This event involved front line staff and was facilitated by the report author. The purpose of the practitioner event was to provide professionals who had worked with Jessica and knew her in that context, to share their insights and identify key areas for learning. The author would like to thank all members that participated for their open and honest approach to learning and understanding that, though distressing, this event was key to shaping learning and not blaming any individual or agency.

5.1.2 Participants/professionals were asked to consider the circumstances of Jessica's death with reference to:

- What went well?
- What could have been done differently?

- How to improve learning?

5.1.3 It was acknowledged by all attendees, that this was a really difficult situation. Jessica had on multiple occasions expressed her wish to die at home. The participants all agreed this is a hugely important principle and should be respected. On balance despite concerns which were raised and escalated, it was felt that the wishes of Jessica where correctly followed.

5.1.4 One concern discussed by the practitioners was perhaps an over reliance on SystmOne (S1) to report safeguarding concerns. The panel noted this however S1 is used by many different agencies and is a great tool for the sharing of information between agencies that have access, which were many with Jessica. It is a system where information can be shared and is used to document care and treatment. There is no expectation for a GP to read daily entries. Safeguarding concerns might have been documented within S1 which is correct, and any subsequent discussions/supervisions and actions should be recorded. Escalations for safeguarding referrals should be made by all agencies when appropriate utilising their own referral mechanism.

Recommendation 1: All participating agencies to ensure staff are clear on the reporting processes in their agencies and to remind staff they have a responsibility to report any safeguarding concerns identified, irrelevant of if they believe another agency has reported.

5.2 Having reviewed the chronologies and agency IMR's and listened to the practitioners involved in caring for Jessica, there is evidence to support that there was areas of expected practice and some areas for development.

5.3 An analysis for each of the key lines of enquiry identified is outlined below.

5.4 What was the involvement of Adult Social Care and if there was none, why? What was the threshold applied and was this correct?

5.4.1 The initial contact with ASC was for a referral for Occupational Therapy (OT) which was triaged according to OT thresholds. As part of this the details on how to refer to ASC for care and support was provided.

5.4.2 ASC received referrals relating to financial abuse. Several times referrals relating to the same concern were made and explored fully on each occasion. The records indicate that staff adhered to expected practice standards relating to adult safeguarding and the principles of the Care Act. ASC identified an unpaid carer and referred them on for support in the unpaid carer role.

5.4.3 The GP reported that Jessica's care needs were being addressed through CHC funding and Hospice at Home team. However, the panel have identified if there was concern about needs not being met this should have gone to CHC.

5.4.4 From the **HAH** review the evidence suggests that a referral to adult social care was not completed for support, but consideration was given to raising a

safeguarding referral (neglect) on 16/6/2023, however an incident report was not completed. In a discussion with the Safeguarding Lead on 21/6/2023 the information provided was that Jessica had capacity to make decisions, including those that may be considered unwise; however, the capacity of Jessica was not verified at this stage. Support was increased, for example, increasing care calls, ensuring son B knew how to contact Hospice at Home team between care calls and the Palliative Hub line. However, there was a missed opportunity to refer to adult social services for a carer's review assessment to support son B. The team did not revisit the safeguarding discussion and decision when the situation deteriorated, and Jessica's condition changed in July.

Recommendation 2: HAH - Ensure HAH team are aware of how and when to escalate concerns regarding complex patients.

Recommendation 3: HAH Ensure the team are aware of internal and external sources of support regarding social care advice.

5.5 Did Jessica have Mental capacity to make decisions? What was the assessment process (if any) undertaken.

5.5.1 Making Safeguarding Personal (MSP)[4] recognises individuals' rights to self-determination on the understanding they have capacity to make key and critical decisions. Safeguarding interventions need to be person centred and involve the adult, working towards agreed outcomes. Safeguarding individuals can be challenging where agencies have struggled to effectively engage with the adult. Duty of care means taking all reasonable and proportionate steps to manage presenting risks, including non-engagement. This is reiterated in policy: 'Making Safeguarding Personal'. It does not mean 'walking away' if a person declines safeguarding support and/or a S42 enquiry. That is not the end of the matter. Autonomy and self-directed support must be balanced with risk, the duties under the Care Act and the principles of the Human Rights Act.

5.5.2 At no point throughout the interactions with Jessica did anyone have reason to doubt her ability to engage in the process or identify that she lacked the mental capacity to make decisions regarding the safeguarding concerns or to receive care and support. There was no need for assessment under the Mental Capacity Act (MCA) for a specific decision identified in CCC's involvement.

5.5.3 During interactions with CPFT Jessica was asked at every visit for consent to undertake wound dressings, and pad checks and Jessica always responded appropriately e.g. her pad did not need checking as the carers had recently left or were due. She knew who her visitors were and was able to name them.

[4] Making Safeguarding Personal | Local Government Association

5.5.4 Jessica had a period of being confused according to Son A. This was identified as an infection and antibiotics were prescribed, although there was a delay in Son A collecting the prescription. Jessica's mental capacity was not evidenced/documented as requiring formal assessment.

5.5.5 The GP recorded that when Jessica deteriorated and became housebound, she was assessed to have capacity to decide about her management and place of death. Her wish was to remain at home, and this was challenged on more than one occasion by different clinicians and care teams. There is good documentation of Jessca's capacity to retain and weigh up information by different GPs in May and July 2023. As Jessica's condition deteriorated her capacity may have wavered, but her wishes when she had the capacity to understand were clearly expressed. At no time did Jessica express a desire to be admitted to hospital, hospice, or a care home.

5.5.6 HUC NHS 111 had one contact with Jessica within the time frame of the IMR in April 2023, where son B called HUC due to his mother presenting with a blood blister.

5.5.6 After consulting with a clinical floor walker for advice on which pathway was required, the disposition of a category 2 ambulance was organised due to the concern that Jessica had septicaemia. The voice of Jessica was heard, and Jessica was deemed to have capacity.

5.5.7 Jessica was assessed by Community Sisters on 12/6/2023, 14/6/2023 and 21/6/2023 and made it clear that her wishes were to remain at home with son B and "under no circumstances" wants to go into hospice or hospital.

5.5.8 There was also a further assessment by a nurse on 9/7/2023. Following this, there is continued evidence of neglect, for example hygiene needs not being met between care calls and continuously covered in faeces between care calls. This coupled with the multiple entries of lack of clean clothes/bedding, no milk (or milk gone off), dirty home, son B was not giving medication, son B shouting at Jessica, raises the question; were there missed opportunities to discuss safeguarding again with the safeguarding lead as things had clearly changed since 21/6/2023. It was considered whether Jessica was asked if she was happy to be living in these conditions. The reasonable assumption would be no, and thus a safeguarding referral should have been discussed.

Recommendation 4: HAH Ensure the team are aware that they can review and revisit safeguarding concerns even if they have been previously raised with safeguarding lead and did not meet safeguarding criteria. Ensure that when discussing safeguarding concerns, safeguarding leads and senior clinicians are provided with evidence confirming that mental capacity and the need for a MCA had been considered.

Recommendation 5: HAH Ensure the band 7 have regular weekly time (or sooner) with band 8 matron to discuss complex cases and safeguarding.

5.5.9 NWAFT only had two interactions during the scoping period and no safeguarding concerns were identified during these. The cause of blood blister on the leg was unknown, Jessica did deny any trauma and so it could be attributed to several medical reasons or may even be age related. There is no evidence to raise any concern that Jessica did not have capacity. There was an opportunity whilst in hospital for staff to have to have spoken to her alone to check that she felt safe and that no harm had come to her. It may have been beneficial for staff to ask a few further questions around home environment for her son and if he needs any support.

5.6 Should residential care have been arranged when concerns about neglect continued?

5.6.1 At the time of contact with CCC, there were no concerns that indicated that Jessica may have required residential care or that she was subject to neglect.

5.6.2 It was not identified in the main by CPFT staff. There was a discussion with CPFT safeguarding as Jessica had been found lying on a settee within the home, she had been incontinent as she was unable to get to the toilet, and as she had curvature of the spine was in a poor position lying on a settee.

5.6.3 The GP reported Jessica expressed her wish to be cared for at home. Her care team visits were intensive, and she had three, sometimes four, visits daily to support that wish. It was felt moving Jessica to an unfamiliar environment away from her family against her repeatedly expressed wishes could have been traumatic and potentially a source of harm. However, the review considered that given Jessica had 3 or 4 care visits a day, and her son was a carer, why was she soiled so often. Also, if the sons were informal carers had what this meant in the way of caring responsibilities outside of the visits been discussed and agreed with them. Also, what was the escalation plan if the number of visits were not working.

5.6.4 Jessica made her wishes clear she *“under no circumstances”* wanted to go into care home. She had moments of being lucid and the notes show she was in a good mood in July. Forcibly removing her would have been extremely distressing for her and her family.

5.6.5 Hindsight might suggest that had all agencies collectively discussed their individual findings would any intervention have occurred in relation to residential care? The panel have discussed this and as Jessica had expressed, she wanted to die at home, she had just in case medications, four double up visits from HAH, night cover when available and requested. She lived with family, and her wishes were adhered to.

5.6.6 The panel considered could additional resources have been put in place to help Son B cope more effectively in supporting Jessica. An assessment to identify if he required support as an unpaid carer could have been offered. A discussion with carers and sons on the practicality of the care being given and if they all understood their roles and to have an open and honest discussion when it was not working.

Recommendation 6: All agencies to ensure the consideration of planned reviews of the care plan (as well as keeping it under review generally) and to be reminded that when it is suspected a care plan is not working to open up discussions to ensure the plan is reviewed again and escalated accordingly.

5.7 What consideration was given to concerns that one of Jessica's sons had access to all Jessica's finances and the impact on Jessica.

5.7.1 This was referred to Adult Social Care and managed as a safeguarding concern. At each referral the concern was considered following the ASC safeguarding process with the practitioner undertaking an appropriate and proportionate investigation into the concern raised, including speaking directly with Jessica as the adult at risk to establish what outcomes she wanted as per the Making Safeguarding personal principles. MOSAIC shows that this work was completed in a timely manner and that advice and information was provided.

5.8 Were agencies coordinated in their approach and was information shared to allow agencies to risk assess appropriately.

5.8.1 Adult Social Care spoke to P3 Housing who made a safeguarding referral regarding alleged financial abuse. There is no evidence of other agencies contacting ASC for information or raising any concerns outside of the concern about alleged financial abuse.

5.8.2 Within CPFT records exchanges did occur but more by coincidence than design. Agencies did talk to each other, one to one, if they crossed at visits but no joined up approach is evidenced. Tasks were used on SystmOne to make requests – e.g. cream for Jessica on prescription, or an urgent community nursing visit by primary care.

5.8.3 The GP expressed that there was good communication regarding medical needs and medication between the District Nursing team and GCS. The GP did not receive any safeguarding concerns from the community teams. The daughter-in-law concerns expressed to GCS were not relayed to the care teams. It was felt that there appears to be confusion regarding CHC funding, and where raised safeguarding concerns go. It is clear they need to go to ASC and there appears to be a lack of clarity on this point. It is felt communications to spread the message would be beneficial.

5.8.4 The HAH team had shared information to other agencies and documentation was available to GP, district nurses within SystmOne of the concerns raised, however no formal MDT meetings took place with other agencies to discuss the concerns. Also, it was discussed that HAH were left in isolation and only really received support from district nurses.

5.8.5 The panel believe that in this case it would have been beneficial for a MDT meeting to have taken place. This would have ensured that the information known by all agencies and concerns raised by HAH including a wider consideration of mental capacity of Jessica. The panel discussed that prior to Covid, there were MDT meetings which were more frequent and now don't happen quite as often. Whilst it is accepted some practices established during COVID have improved service and efficiency the panel agree that in the case of MDT meetings these need to return to their previous frequency.

Recommendation 7: All agencies to understand the importance and benefits of MDT meetings taking place and to recognise a continuous multi-agency approach and not leave any agency in isolation.

5.8.6 The panel also noted the work that HAH undertook in this case and their commitment to this review process.

5.9 There was a referral for an ultrasound of her abdomen, which may have had significance but, as she did not attend, the request was cancelled. Was the impact of not attending this appointment considered by agencies? Did any agency have a plan around following up this non-attendance?

5.9.1 The GP surgery was aware that Jessica had not attended for chest x-ray and ultrasound however these were no longer felt to be clinically appropriate as would not have added anything to her plan of management. There was a statement by Jessica supported by son B that she did not want any further intervention. The panel were not clear from the review that at this stage when end of life or palliative care was agreed how was this agreed and discussed. Where all involved clear on their expectations of their service roles. Again, an MDT approach would be the preferred option.

5.10 Was the carers assessment process effective and applied correctly?

5.10.1 The Carers' process was applied correctly and was effective. The MASH duty worker identified that DIL was an unpaid carer and that as such would be eligible for an assessment in her own right. The worker made a timely referral running alongside their work in adult safeguarding to minimise any delay in support for the DIL. The Carer received a carer conversation within a week of referral and subsequently a carers assessment took place. The process was applied correctly, and support and advice were provided to the unpaid carer.

Freedom of Choice

5.11.1 All patients have freedom of choice to refuse treatment or services, but there will sometimes be a point where those rights are overridden in the patient's best interest.

5.11.2 At what point do we over-ride a patient's refusal to be treated? This can be a difficult question for a professional to answer, which is why the system of supervision and support is so important to provide reassurance to staff and to ensure that action is taken which is in the best interest of the patient.

5.11.3 The panel have considered all the information and within discussions have concluded that Jessica's decisions did not meet the threshold to be overridden. However basic care could have been better provided and a MDT approach to palliative or EOL care could have been in place

6 Good Practice Identified & Conclusions

6.1 At each referral the staff within the MASH spoke directly to Jessica to establish their outcome under MSP. They worked using the principles of the Care Act and the work undertaken was appropriate and proportionate.

6.2 As soon as there was an unpaid carer identified they were offered support with a referral made to the Carer Support Team. The unpaid carer was contacted promptly, and the carer process followed. The unpaid carer was seen away from the cared for person to enable them to speak freely and talk about their experience.

6.3 Within CPFT records, on many occasions who was present was documented, to include, son, daughter in law, granddaughter, adopted son and stepson, although other than the sons' names and the daughters-in-law name being consistently recorded, it was rare to see a name for the other family members being recorded on more than one occasion and stepson did not have a name at all. Son A and B names were consistently used by all and recognised as her son, her adopted son, had a name documented and recorded and Jessica had referred to him by name and how he was related to her. This is good practice but not widely, consistently used. The Community Team's documentation was always very thorough, and referrals received were registered and triaged within 24hours of receipt. Documentation from Teams was outstanding.

Recommendation 8: CPFT To consistently include the name of the person present as well as their relationship to the client.

6.4 The GP practice arranged regular reviews of Jessica. Initial investigations into her weight loss and referrals were appropriate and there was evidence of good communication and discussion between colleagues. When Jessica became too frail to attend the surgery Practice Nurses ensured that continuity of care was maintained by a referral to the District Nursing team.

6.5 The need for carer support was recognised and initial referral to social prescribing team made. Jessica was involved in the decisions about her care and her wish to remain at home was supported. There was timely recognition that end-of-life care was appropriate, care arranged, and medication issued. Staff correctly signposted family to social services when concerns were raised about her care and documented those concerns well.

6.6 The panel were reassured that the GP practice held a Significant Events Meeting with the Surgery team. They discussed concern about possible neglect then they should consider assessing the patient themselves or if there is already sufficient evidence in the records from other agencies/assessments then they could consider making a referral to Adult Safeguarding after speaking with the patient and potentially their relatives.

6.7 It was also discussed that there were many entries in the records about Jessica being covered in faeces and potential neglect and that this would have been enough evidence to ensure an Adult Safeguarding referral was discussed with Jessica and her son and other immediate family.

6.8 It was discussed within the practice that in future, if concerns such as those in this case are raised, then a clinician should make contact quickly with the patient concerned to assess them and discuss those concerns with them. It was discussed that in future they would ensure that the concerns with those involved in caring for that patient to ensure a complete picture of the situation was gained when making a decision to make an Adult Safeguarding referral and also to ensure that others were aware and to be vigilant about the concerns. The panel considered at this point an MDT would have been appropriate and a package of EOL care agreed with very clear roles understood by all involved.

6.9 From the review of this case, a safeguarding referral was not submitted by HUC for Jessica, however due to Jessica losing a considerable amount of weight, being informed by the son that she “bruises easily” and not reporting the blood blisters sooner, in line with best practice, this information could have been shared with the HUC Safeguarding team who would have contacted social services to see if Jessica was known and to share the information with the GP for joint working purposes.

6.10 The call that was taken by a Health Advisor, was audited internally by the HUC Quality and Improvement team using the NHS Pathways Call Audit tool for Health Advisors. Learning identified in relation to NHS Pathways questions and probing was fed back to the health advisor for learning and improvement.

6.11 HUC has recently changed the internal referral process to make it easier for all safeguarding concerns to be submitted to the HUC safeguarding team to be triaged prior to making a safeguarding referral. This enables each concern to be assessed for the level of risk, needs, safety, and priority and ensure the correct information is included in the safeguarding referral or shared with partner agencies for information sharing purposes as required. With the new

system, which started in September 2024, the safeguarding team would have liaised with the GP and social services for any appropriate information about the contact and concerns identified for joint working purposes.

Recommendation 9: HUC safeguarding team to complete a professional curiosity flow chart and disseminate widely to encourage all teams to adopt.

Recommendation 10: HUC safeguarding team to encourage the use of the Safeguarding Concerns Form (SCF) through meetings, training and supervision.

6.12 The team at HAH were responsive in visiting and reviewing Jessica regularly, they also went over and above to care for Jessica, often cleaning the house, buying sheets/clothes for Jessica and washing laundry (the panel recognise the commitment of the team at HAH). The team correctly recognised the signs of neglect/abuse; however, they did not consistently escalate their concerns to the appropriate senior staff and Safeguarding Lead within the hospice. HAH demonstrated compassion and sensitivity to the situation.

6.13 There were instances in which the team did not escalate concerns appropriately, to ensure they were supported with key decision making. There were missed opportunities to source additional social support for Jessica and her son to ensure he was supported socially in meeting his mother's needs.

6.14 The team needed support and assurance to review safeguarding concerns and raise them again with the safeguarding lead, even if they believed the situation was unchanged. Band 7 team leads could benefit from regular complex case review meetings with band 8 matron to review complex cases and gain additional support advice.

7. Recommendations

RECOMMENDATION 1: ALL PARTICIPATING AGENCIES TO ENSURE STAFF ARE CLEAR ON THE REPORTING PROCESSES IN THEIR AGENCIES AND TO REMIND STAFF THEY HAVE A RESPONSIBILITY TO REPORT ANY SAFEGUARDING CONCERNS IDENTIFIED, IRRELEVANT OF IF THEY BELIEVE ANOTHER AGENCY HAS REPORTED.

RECOMMENDATION 2: HAH - ENSURE HAH TEAM ARE AWARE OF HOW AND WHEN TO ESCALATE CONCERNS REGARDING COMPLEX PATIENTS.

RECOMMENDATION 3: HAH ENSURE THE TEAM ARE AWARE OF INTERNAL AND EXTERNAL SOURCES OF SUPPORT REGARDING SOCIAL CARE ADVICE.

RECOMMENDATION 4: HAH ENSURE THE TEAM ARE AWARE THAT THEY CAN REVIEW AND REVISIT SAFEGUARDING CONCERNS EVEN IF THEY HAVE BEEN PREVIOUSLY RAISED WITH SAFEGUARDING LEAD AND DID NOT MEET SAFEGUARDING CRITERIA. ENSURE THAT WHEN DISCUSSING SAFEGUARDING CONCERNS, SAFEGUARDING LEADS AND SENIOR CLINICIANS

ARE PROVIDED WITH EVIDENCE CONFIRMING THAT MENTAL CAPACITY AND THE NEED FOR AN MCA HAD BEEN CONSIDERED.

RECOMMENDATION 5: HAH ENSURE THE BAND 7 HAVE REGULAR WEEKLY TIME WITH BAND 8 MATRON TO DISCUSS COMPLEX CASES AND SAFEGUARDING.

RECOMMENDATION 6: ALL AGENCIES TO ENSURE THE CONSIDERATION OF PLANNED REVIEWS OF THE CARE PLAN (AS WELL AS KEEPING IT UNDER REVIEW GENERALLY) AND TO BE REMINDED THAT WHEN IT IS SUSPECTED A CARE PLAN IS NOT WORKING TO OPEN UP DISCUSSIONS TO ENSURE THE PLAN IS REVIEWED AGAIN AND ESCALATED ACCORDINGLY.

RECOMMENDATION 7: ALL AGENCIES TO UNDERSTAND THE IMPORTANCE AND BENEFITS OF MDT MEETINGS TAKING PLACE AND TO RECOGNISE A CONTINUOUS MULTI-AGENCY APPROACH AND NOT LEAVE ANY AGENCY IN ISOLATION.

RECOMMENDATION 8: CPFT TO INCLUDE THE NAME OF THE PERSON PRESENT AS WELL AS THEIR RELATIONSHIP TO THE CLIENT.

RECOMMENDATION 9: HUC SAFEGUARDING TEAM TO COMPLETE A PROFESSIONAL CURIOSITY FLOW CHART AND DISSEMINATE WIDELY TO ENCOURAGE ALL TEAMS TO ADOPT.

RECOMMENDATION 10: HUC SAFEGUARDING TEAM TO ENCOURAGE THE USE OF THE SAFEGUARDING CONCERNS FORM (SCF) THROUGH MEETINGS, TRAINING AND SUPERVISION.