Safeguarding Adult Review "Taylor" – October 2025:

Purpose of this Briefing:

This anonymised briefing summarises key learning from a recent Safeguarding Adult Review (SAR), Taylor, conducted under Section 44 of the Care Act 2014. It is intended to support practitioners across agencies to reflect on practice, improve systems, and enhance outcomes for vulnerable adults with complex needs.

Overview:

Taylor, an adult with autism and complex health needs, experienced a significant health crisis in early 2023. Despite multiple referrals and concerns raised over a two-year period, there were delays in coordinated, multiagency intervention to support him. The SAR was commissioned to understand what happened, identify learning, and improve future practice.

Key Issues Identified:

- Lack of Multi-Disciplinary Coordination: No early MDT (Multi-Disciplinary Meetings) meetings were convened.
- Voice of the Adult Not Heard: No direct engagement with the adult to assess capacity or gain consent.

Delayed Response:

- Delays in multiagency working, collaboration and decision making to support the person to appropriate access care and treatment in a timely way.
- Poor information sharing created barriers to accessing services.
- Professionals did not consistently share information or support MDT case discussions about the adult at risk because of a lack of consent. This made

early intervention and preventative safeguarding practice more difficult to manage.

Missed Opportunities for Escalation:

- There are multiagency SAB and internal organisation pathways to escalate cases of concern using a stepped approach. The practitioner did not discuss the person in safeguarding supervision, case was not discussed in multiagency safeguarding hub (MASH). The risk to Taylor's health and welfare should have prompted consideration of a referral to the High Risk Behaviour Panel.

Good Practice Noted:

- Effective engagement by hospital-based learning disability teams.
- Positive collaboration between some agencies during the crisis.
- Recognition of the need for trusted relationships to support engagement.

Learning Themes:

- Professional Curiosity: Practitioners must explore beyond surface-level information.
- Making Safeguarding Personal: The adult's voice must be central.
- Timely Multi-Agency Working: Early MDTs (Multi-Disciplinary Meetings) can prevent the need for crisis escalation.
- System Accountability: All professionals share responsibility for initiating MDTs (Multi-Disciplinary Meetings).

Recommendations:

1. **Multi-Disciplinary Team (MDT) and Adult Risk management (ARM) Processes**: Ensure policies and procedures for MDTs and Adult Risk Management (ARM) are embedded and understood.

2. **Training**: Provide training on professional curiosity and whole family approaches.
3. **Safeguarding Supervision**: Strengthen systems for role-appropriate supervision and consistent recording.
4. **Model of Care**: Promote the "Team Around Me" model to support consistent multi-agency working.
5. **Policy Review**: Update the self-neglect policy to reflect "My Team Around Me" (MTAM).

Next Steps:

- Agencies are encouraged to review internal processes in light of this learning.
- Use the SMART goals framework to develop specific, measurable actions.
- Share this briefing in team meetings, supervision, and training sessions.

Please take some time to consider:

What are your reflections on the learning from this case, how might it change your practice and what might you do differently in the future?

Please use this space to record your thoughts:

If you would like to share your reflections please email to the SAB mailbox @ safeguardingadultsboard@cornwall.gov.uk