OPEN

Scrutiny Committee

Date: 04 September 2025

Safeguarding Adults Review - BELLA

Report of: Helen CHARLESWORTH-MAY – Executive Director Adults Health and Integration

Report Reference No: SC/07/2025-26

Ward(s) Affected: ALL

For Decision or Scrutiny: For scrutiny

Purpose of Report

1 The purpose of this Report is to inform the Scrutiny Committee about the Safeguarding Adults Review regarding "BELLA". The Safeguarding Adults Board appointed an independent author, Frances Millar, to facilitate the review and write the final report, which accompanies this briefing. It has been approved by the Safeguarding Adults Board and is ready to be published on the SAB website.

2 The Safeguarding Adults Board have a legal duty to undertake a Safeguarding Adults Review, when it suspects that an adult at risk has died due to abuse or neglect and agencies could have worked better to support the individual. Cheshire East Council is committed to creating safe communities with accessible services, where people can live free from abuse or harm, and to creating a culture of learning where lessons can be learned to prevent future harm. This Safeguarding Adults Review meets the Strategic objectives of the Council.

Executive Summary

3 A referral was made to Cheshire East Safeguarding Adults Board regarding BELLA, as she experienced life changing injuries due to being hit by a train on 27th January 2024. The Safeguarding Adults Review Panel met on 18th March 2024, and the Safeguarding Board agreed that

the criteria for a statutory Safeguarding Adults Review were met. The scope of the SAR covered the period 1/1/23 – 27/1/24. BELLA and her mum were able to contribute to this Review.

4 BELLA is a 26-year-old woman who was diagnosed with Autism in 2017. She also lives with the impact of a traumatic brain injury and non-epileptic seizures. She is creative and enjoys hobbies including arts, crafts, music, singing and climbing. These hobbies, together with her love of animals allows her to “self sooth”, regulate her emotions and reduce anxiety.

5 Professionals who have worked with Bella describe her as an articulate and self-assured individual when she is not experiencing a difficult mental health crisis. She has a strong sense of independence and knows her own mind, often making decisions with clarity and conviction. Bella is softly spoken and, at times, finds it more comfortable to communicate through text rather than verbal conversations, which helps her express herself more effectively. Overall, professionals see Bella as someone who is deeply connected to the things she values most, with her dogs being a cornerstone of her emotional support system. By recognising and respecting these protective factors, those around her can better support her journey towards stability and wellbeing.

6 BELLAs complex case included incidents of self-harm, mental health crisis and challenges associated with cross border provision. Her care and support needs meant that she was eligible for assessment and services as defined by the Care Act 2014 and the review highlighted the support being provided by her Care Team and Family.

7 Whist there had been previous safeguarding concerns, the Safeguarding Adults Review focused on the significant incidents which occurred in January 2024, the second one resulted in her being hit by a train and sustaining life changing injuries:

26th January 2024

- **1820 hours:** Ambulance service reported a call from Bella stating suicidal intent and her presence on the train tracks. British Transport Police (BTP) officers were dispatched.
- **While en route:** A train driver spotted Bella on the tracks, stopped the train, and brought her to next main station.
- **At main trainline station:** Bella engaged with officers but was timid and nervous, holding a teddy bear named Chester. She confirmed suicidal intentions and agreed to attend Hospital voluntarily.
- **Hospital interaction:** Due to sensory sensitivities, Bella waited in the police vehicle until a room became available. A senior mental health

practitioner assessed Bella and concluded this was a behavioural issue rather than a mental health crisis. Bella's support worker, agreed to supervise Bella at home.

- **Outcome:** Bella was escorted to her home address by the Police and under the supervision of her support worker.

27th January 2024

- **1016 hours:** A train driver reported seeing Bella near the train station. Bella walked onto the track and was struck by the train despite emergency braking.
- **Response:** Paramedics stabilised Bella at the scene before transferring her to Salford Royal Hospital with life-threatening injuries, including leg, pelvis, chest, and head trauma. Bella's father was informed and accompanied her to the hospital

8 As part of the Safeguarding Adults Review all Agencies within and external to Cheshire East, submitted Individual Management Reports to indicate how and why they had been in contact with BELLA. The Author collated this information and provided an analysis in line with the key lines of enquiry. A Practitioner Event provided valuable insight into the case. Within the final report the Author was able to identify key message regarding Transitions between Care Settings, Multi Agency Communication and Coordination, Mental Health and Autism Care, Safeguarding Practices and Risk Management.

9 Bella and her mum also contributed to the SAR. Prior to the incident Bella described feeling unheard and invisible with her distress being dismissed as being "behavioural", rather than a way of demonstrating her deteriorating mental health. Whilst her mum felt that the concerns she raised about Bella were often not taken seriously. They both wanted this SAR to make a difference to other families in similar circumstances.

10 The details of the SAR are not contained within this Report, as they are contained within the SAR Report itself and can be found at the end of this report.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

Scrutinise and note the learning and recommendation of the BELLA Safeguarding Adults Review.

Background and Context

11 The purpose of a Safeguarding Adults Review is to:

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard BELLA
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of BELLA are heard regarding her experience of accessing care and support in Cheshire East.

12 Prior to January 2024 the Review highlighted a 28-month period where BELLA was demonstrating episodes of risky behaviour, including multiple suicide attempts, in and outside of care settings. She had also made allegations of rape and sexual assault, with an ongoing criminal investigation.

13 At the same time, she was experiencing some relationship difficulties with her family due to disputes about religion, and challenges in relationships with specific carers, continuity of Care Coordinators/ Social Worker and consistency of staff from the same Care Agency

14 BELLA had multiple admissions between Emergency Departments, Mental Health Units, Acute Medical Wards, and private Mental Health facilities. However, the SAR found that communication was not always robust or undertaken across agencies

15 One care episode showed that BELLA was denied the opportunity of a Mental Health Assessment as she stayed in Police car due to intolerance of closed spaces and people, therefore she was discharged home – transported by British Transport Police. Conversely on the last hospital admission prior to the incident in January 2024, BELLA was discharged home following being on section 2, as her presentation was considered to be behavioural rather than a mental health crisis post attempt on life previous day. Previous assessments indicated that hospital environments were not the best place for Bella to be assessed and therefore she was sometimes not admitted to hospital or was discharged earlier than expected**.**

16 **Briefing - Key Learning**

17 **Good Practice and Protective Factors**

- Examples of compassionate, flexible, and person-centered care were evident:
- Adapted assessment environments
- Attention to Bella's relationship with her pets
- Persistent carers escalating concerns despite resistance
- Rationale: Good practice exists and must be celebrated to drive cultural and practice improvements.

Recommendation: Strengthen organizational culture through positive learning, reflective practice, and recognition of effective care.

18 **Autism-Specific Care and Trauma-Informed Practice**

- Bella's autism and trauma history were not consistently considered in care planning.
- Fluctuating capacity was present but often overlooked or poorly documented.
- Interventions often focused on 'behavioural' presentations, missing underlying mental health distress and trauma responses.
- Rationale: The Autism Act 2009, NICE guidance, and neurodiversity research all point to the need for bespoke, strengths-based, sensory-aware responses.

Recommendation: Implement a specialist autism and trauma-informed care framework, training staff across agencies

19 Communication, Risk, and Capacity Assessment Gaps

- Risk and mental capacity assessments were inconsistently applied or recorded.
- Discharge planning lacked clarity and oversight in high-risk situations.
- Example: Discharge following suicidal ideation with no community DoLS, despite intensive supervision needs.
- Rationale: Clear documentation and legal literacy are essential for defensible and person-centred care.

Recommendation: Strengthen internal governance, record-keeping, and assurance around MCA/DOLS processes.

20 Multi-Agency Communication and Discharge Coordination

- Poor coordination and lack of joint discharge planning were evident.
- Multiple agencies involved, yet no single point of oversight.
- Cross-border working introduced further fragmentation.
- Rationale: Consistent MDT involvement and joint risk planning is a national expectation under CQC standards and Care Act duties.

Recommendation: Mandate multi-agency discharge plan assessments for high-risk cases, with shared templates and expectations.

21 Exploitative Relationships and Missed Safeguarding Responses

- Bella disclosed multiple short-term relationships and allegations of sexual assault.
- No clear safeguarding pathway, risk strategy, or exploitation panel response evident.
- Rationale: Legal and statutory duties require exploitation to be proactively recognized, assessed, and managed.

Recommendation: All high-risk safeguarding referrals to include explicit consideration of sexual and criminal exploitation risks.

22 Fluctuating Capacity and Professional Assumption-Checking

- Practitioners at times viewed Bella’s risk-taking as ‘lifestyle choice’ without robust analysis of her capacity at the time.

- Carer and family concerns were often downplayed or dismissed.
- Rationale: The Mental Capacity Act 2005 and case law (e.g., GW v A Local Authority) emphasize the need for nuanced and situational assessments.

Recommendation: Embed professional curiosity and assumption-checking into safeguarding policies, supervision, and audit.

23 **Family Inclusion and the Power of Lived Experience**

- Bella and her mother described a sense of being unheard and invisible within the system.
- Their reflections were honest and brave and offer critical insights for improvement.
- "The only people who listened were the security guards."
- Rationale: Listening to families is not an optional courtesy—it is a professional and ethical duty.
- **Recommendation:** Include the voice of individuals and families in all decision-making and explicitly record how this has influenced outcomes.

Consultation and Engagement

24 No consultation is required for this Report

Reasons for Recommendations

25 This Report sets out the learning and recommendations from the Safeguarding Adults Review to ensure that service delivery is improved and to prevent further incidents of harm. The Safeguarding Adults Board will oversee the Action Plan.

Other Options Considered

26 There are no other options to consider as the Safeguarding Adults Board has met its Statutory Duty under the Care Act 2024 to undertake a Safeguarding Adults Review and to share the learning.

Option	Impact	Risk

The Care Act places a Legal Duty on Local Authorities and partner Agencies to protect Adults at Risk from Abuse, Neglect and Exploitation. AND The Care Act places a legal duty on Local Authorities to host a Safeguarding Adults Board.	The impact of this incident resulted in BELLA sustaining life changing injuries. The Safeguarding Adults Board seeks assurances from Partner Agencies about how they protect Adults at Risk from abuse and neglect.	Without Cheshire East Council having an effective Safeguarding Adults Board, there would be no other means to ensure that Partner Agencies are working to prevent Adult Abuse and to facilitate Statutory Safeguarding Adult Reviews. The aim of a SAR is to promote learning and to improve service delivery.

Implications and Comments

Monitoring Officer/Legal/Governance

27 Section 44 of the Care Act 2014 places a duty on Local Adult Safeguarding Boards to arrange Safeguarding Adult Reviews (SARS). SABs must carry out a SAR when an adult with care and support needs has died of suffered serious harm, and it is suspected of known that the cause was neglect or abuse, including self-neglect, and there is concern about how agencies worked together to protect the adults from harm. Under S44(4) of the Care Act 2014 a SAR can be undertaken in any other case concerning an adult with care and support needs.

28 The aim of a SAR is not to apportion blame but to share learning that will improve the way agencies work individually and together to minimise the possibility of it happening again.

29 The recommendation will ensure compliance with the Care Act and its statutory duties.

Section 151 Officer/Finance

30 There are no financial implications or changes required to the MTFS as a result of the recommendations in this report. Implementation of learning from this review will be carried out by the service within existing resources.

Human Resources

31 There are no Human Resource Implications from this Review. However, Staff should be able to access appropriate AUTISM training to help inform and improve knowledge and skill and communication.

Risk Management

32 There are no Risk Management Implications from this Review.

Impact on other Committees

33 This report will be presented to the Adults and Health Committee on 22 September 2025.

Policy

34 There are no Corporate Policy implications for this SAR.

35 The Adult Safeguarding Board will be monitoring the Recommendations indicated in this Safeguarding Adults Review.

36

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

37 BELLA had Autism. One of the key lines of enquiry focussed on how well Agencies respond to Safeguarding concerns for people who are Neuro Diverse. The Safeguarding Adults Board will seek assurance from Partner Agencies about how they are improving access to support, as part of the recommendations from this Review.

38

Other Implications

39 There are no implications to rural communities in this Review.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Adele Taylor	S151 Officer	Click or tap to enter a date	Click or tap to enter a date
Roisin Beressi	Principal Lawyer	18/06/25	25/06/25
Legal and Finance			
Nikki Woodhill	Finance Manager	18/06/25	24/06/25
Other Consultees: *Executive Directors/Directors*			
Helen Charlesworth May	Exec Director – Adults Health and Integration	30/04/25	Click or tap to enter a date

Access to Information	
Contact Officer:	Sandra Murphy – Head of Service - Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk
Appendices:	Appendix 1 – BELLA – Final Report Appendix 2 – Actions
Background Papers:	Bella – SAR – Easy Read Bella – 7 Minute Briefing