

Barnsley Safeguarding Adults Review Summary 2025 - 2026

Introduction

The Barnsley Safeguarding Adults Board (BSAB) has a statutory responsibility under the Care Act 2014 to review cases as potential Safeguarding Adult Reviews or non-statutory SARs when an adult with care and support needs has died or experienced serious harm, and abuse or neglect is suspected, particularly if there are concerns that partner agencies may not have worked effectively together to protect the adult.

The 2025-2026 review period reflects the continued commitment of local agencies, professionals and communities to promote a culture of safety, dignity, learning and partnership working for adults with care and support needs.

Scope and Purpose of the Review

The Safeguarding Adults Review summary for 2025-2026 covers:

- Incidents and cases referred to the Board during 2025-2026
- Cases concluded in the period that commenced in the previous year.
- Comprehensive analysis of recurring themes and areas for improvement
- Good practices and innovations adopted across the partnership.

The main purpose of the SAR is not to apportion blame but to identify what can be done differently to prevent future harm, improve service delivery, promote learning across the safeguarding workforce, and inform our communication strategy to support the public to access help and support.

Data

13 cases were considered by the SAR Panel during 2025-2026. The table below shows the type of abuse or presenting concern, and the agreed panel outcome.

Table one

Type of abuse or presenting concern	Summary of outcomes
Neglect and organisational abuse	The case progressed as a joint Safeguarding Adults Review with Wakefield Safeguarding Adults Board. The review focused on Section 117 aftercare oversight, care-provider accountability, Mental Capacity Act issues and multi-agency coordination.
Cuckooing, exploitation and physical assault	The case did not meet the criteria for a statutory Safeguarding Adults Review because there was no evidence of multi-agency failure. A non-statutory multi-agency review was agreed.
Neglect	Two cases were considered. Although one did not meet the criteria for a review as there was no evidence to suggest

	multi-agency working failed, agencies involved have been asked to provide learning and actions to prevent recurrence. The second was considered to have been appropriately managed through a Section 42 Care Act enquiry.
Self-neglect and possible exploitation	The case highlighted potential Mental Capacity Act issues. Questions were developed for assurance activity at the June 2026 Assurance Event.
Self-neglect and suicide	The case was referred following a LeDeR review and did not meet the criteria for a statutory Safeguarding Adults Review. Assurance activity is being planned with the LeDeR panel and Public Health to address identified learning.
Self-neglect, domestic abuse and health neglect	The case did not meet the statutory criteria, but a mini review was agreed.
Suicide	Two cases were considered but there was a unanimous panel decision that neither met the criteria for a Safeguarding Adults Review. In both cases, the panel found no evidence of abuse, neglect or multi-agency failure.
Substance misuse and self-neglect	The panel decided that the case did not meet the criteria for a Safeguarding Adults Review because there was no evidence of multi-agency failure. A single-agency drug and alcohol review was identified as the appropriate response.
Self-neglect	Three cases were considered. Two did not meet the criteria for a Safeguarding Adults Review because there was no evidence of multi-agency failure or neglect.

Table 2 – completed reviews.

Case	Themes	Learning	Link
'Brian'	Self-neglect, refusal of support from services, disguised compliance, unrecognised family carers, bereavement and loss.	Professional curiosity and assessment of conflict between what someone says and signs of neglect and need. Curiosity about the support from family networks and their needs for support.	Statutory Safeguarding Adult Review report. Seven minute briefing.
'Jason'	Cuckooing, not accepting or accessing services, animal welfare and mental capacity.	Curiosity for refusal of services. Curiosity about mental capacity.	Seven minute briefing.

Key Findings

The 2025-2026 cases identify recurring themes across statutory SAR consideration, non-statutory review activity, assurance activity and single-agency learning:

- Professional curiosity and persistence remain key skills and attributes required by workers when supporting people with complex needs. There is evidence within Safeguarding Adult Reviews and audit of workers doing this.
- Social isolation places people at risk of abuse and harm. This may be from exploitation and cuckooing or suicide.
- Self-neglect is a recurring feature within Safeguarding Adult Reviews, locally and nationally. This includes people who struggle with hoarding. To support people effectively requires persistence, time, sensitivity and multi-agency coordination.
- The challenges of assessing people's mental capacity and executive functioning continue to be key themes, locally and nationally. This is particularly the case when working with people who are able to articulate themselves well or have fluctuating capacity.

Best Practices and Innovations

Despite ongoing challenges, the BSAB noted several positive developments:

- Multi-agency safeguarding training events have improved consistency and raised standards across health, social care, housing, and police.
- Awareness campaigns and public events have encouraged reporting and reduced stigma around abuse, especially for marginalised groups. The Safeguarding Engagement post within Healthwatch supported a number of community champions who supported local communities.
- Policies and guidance have been updated based on lessons from reviews. These also form the basis of the training that is delivered and application has been tested through our annual assurance event.
- Development of guidance on Cuckooing.
- Themes from the Safeguarding Adult Reviews will be tested by the Safeguarding Operational Groups audit and assurance activities.

Conclusion

The Barnsley Safeguarding Adults Review Summary for 2025-2026 demonstrates the ongoing complexity of safeguarding adults with care and support needs. The SAR Panel considered cases involving abuse and neglect, exploitation, cuckooing, self-neglect, domestic abuse, mental health, substance misuse, autism, learning disability, transition between services and health-related neglect.

While not every referral met the criteria for a statutory Safeguarding Adult Review, the Panel continued to use a proportionate learning approach through joint SAR activity, non-statutory reviews, single-agency review, professional curiosity

discussion and assurance activity. This reflects BSAB's continuing commitment to partnership learning, accountability and improvement so that adults in Barnsley are better protected from harm.

Glossary

- Safeguarding Adults Review (SAR): A statutory process to review cases involving serious harm or death and opportunities for learning.
- BSAB: Barnsley Safeguarding Adults Board, a multi-agency partnership responsible for coordinating safeguarding efforts in Barnsley.
- LeDeR: (Learning from Lives and Deaths) is an NHS programme that reviews the deaths of adults with learning disabilities and autistic adults to identify learning and improve health and social care services
- Section 42 (S42) Enquiry: A statutory safeguarding enquiry under the Care Act 2014 undertaken when an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and cannot protect themselves from that risk.
- Mental Capacity Act: Legislation providing a framework for making decisions on behalf of adults who may lack capacity.