SAR Rita Executive Summary



Summary

1. Background

This Safeguarding Adults Review (SAR) examines the tragic case of Rita, a young mother with complex physical and mental health needs, spanning from April 2021 to July 2024. The review highlights some systemic issues in how the whole system works together; fragmented service delivery, and missed opportunities to intervene earlier.

2. Key Findings

- The challenges of working together are systemic, that is, they are deep rooted and part of the culture of how things are done.
- The findings reveal the disconnect that still exists across organisations. This makes safeguarding the most vulnerable in our society especially challenging despite the goodwill of people working in the systems.
- Rita experienced deteriorating mental and physical health, and self-neglect.
- Her children lived in unsafe conditions, and were carers, isolated from support.
 Consent was often used as a barrier to action, limiting professional curiosity.
- Practitioners accepted Rita's self-reported health conditions without verification.
- The children's voices and daily experiences were largely invisible to services.

3. Systemic Issues

- Need for a deeper 'Think Family' approach across adult and children's services.
- Inadequate information sharing and siloed working practices. Missed indicators of perplexing and complexity.
- Inconsistent use of safeguarding referral processes and thresholds.
- Limited understanding of complex trauma and non-engagement.

4. Children's Experiences

- Children slept in unsuitable conditions and cared for their mother.
- They were not allowed to play outside and prepared their own meals.
- Despite appearing well at school, the home environment was deteriorating.
- Concerns about a partner in the home were not known to professionals.

• The children had minimal contact with their father and grandparents.

5. Recommendations

- I. Embed a 'Think Family' approach across all safeguarding processes.
- II. Improve and strengthen multi-agency collaboration and information sharing.
- III. Reform referral forms to prompt family engagement and shared decision-making.
- IV. Provide training on complex trauma and working with 'non-engaging' parents.
- V. Promote reflective supervision and defensible decision-making.
- VI. Involve families in safeguarding processes and listen to children's voices.

6. Conclusion

Rita's life reinforces the urgent need for systemic change. A trauma informed, Think Family approach must be embedded across all services to prevent future tragedies. Leadership commitment, cultural change, and continuous learning are essential to safeguarding the most vulnerable.