Gloucestershire Safeguarding Adults Board (GSAB) Meeting
Tuesday 25th November 2025 at 9:30am
via MS Teams

MINUTES

Present:

David Hanley (Chair) (DH)	Independent Chair, GSAB
Marie Crofts (MC)	Chief Nursing Officer, NHS Gloucestershire ICB
Sarah Scott (SS)	Executive Director Adult Social Care and Public Health, GCC
Emily White (EW)	Director of Quality, Performance and Strategy, GCC
Helen Flitton (HF)	Head of Inclusion Health, Public Health and Communities, GCC
Sarah Jasper (SJ)	Head of Safeguarding Adults, GCC
Steve Bean (SB)	Head of Public Protection, Gloucestershire Constabulary
Jeanette Welsh (JW)	Safeguarding Adults Lead, Gloucestershire Hospitals NHSFT
Louise Duce (LD)	Associate Director of Safeguarding, Gloucestershire Hospitals NHSFT
Carolyn Bell (CB) (Minutes)	GSAB Business Manager, GCC
Mel Munday (MM)	Associate Director of Safeguarding, ICB
Sam O'Malley (SO)	Designated Safeguarding Nurse, ICB
Donna Potts (DP)	Head of Safeguarding & Prevention Manager, Gloucestershire Fire and Rescue Service
Amanda Wray (AW)	Safeguarding Lead, Cheltenham Borough Council
Hannah Locke (HL)	Strategic Housing Lead, Gloucester City Council
Sarah Hawker (SH)	Department of Work and Pensions
Vicky Livingstone-Thompson (VLT)	Chief Executive, Inclusion Gloucestershire
Jenny Cooper (JC)	Head of Commissioning for Quality, GCC
Mark Bone (MB)	Head of Service Corporate Parenting, GCC
Susan Hughes (SH)	Forest of Dean and Cotswold District Councils
Clare Lucas (CL)	Healthwatch Gloucestershire
Emma Hawkins (EH)	Safeguarding Training Lead, GCC
Jessica John (JJ)	Designated Safeguarding Lead, Young Gloucestershire
Jonathan Newman (JN)	Safeguarding Adults Lead, GHC
Karen Frayling (KF)	Julian House
Warren Lee (WL)	GARAS
Rikki Moody (RM)	Gloucestershire Care Providers Association (GCPA)
Chris Atkins (CA)	Gloucestershire Care Providers Association (GCPA)

Apologies:

Lisa Walker (LW)	Service Manager, Gloucestershire Carers Hub
Paul Gray (PG)	Head of Safeguarding, GHC
Andy Wood (AW)	Gloucester City Homes
Lerryn Udy (LU)	Head of Safeguarding, SWAST
Hannah Williams (HW)	Deputy Director of Nursing Therapy and Quality, GHC
Keith Gerrard (KGe)	Stroud District Council
Jason Poole (JP)	Trading Standards
Craig Tucker (CT)	Kingfisher Treasure Seekers
Simon Thomason (ST)	MCA Governance Manager, GCC
Nina Kane (NK)	Head of Probation
Kate Lewis (KL)	Nelson Trust
Danielle Vale (DV)	POhWER Advocacy

		Owner
1	**Declarations of Interest:** HF declared that she is the Commissioner for VIA, the drug and alcohol service.	
2	**Minutes of the Last Meeting** The minutes of the meeting held on 09/09/2025 were agreed as a true and accurate record.	
3	**Matters Arising from 09/09/2025** All matters arising are complete.	
4	**Homeless Fatality Review Arlo & Paddy – Sign Off** This review focused on the deaths of two men, Arlo and Paddy, who were rough sleepers. The purpose of the review was to identify learning opportunities, good practice, and barriers. Key findings included: • Both individuals had experienced severe childhood trauma, which contributed to their complex needs in adulthood. • Paddy was noted for his kindness and resilience, overcoming heroin addiction and supporting others in the rough sleeping community. However, he struggled with alcohol misuse and mental health issues. • Arlo, who had been in care from a young age, died from Sudden Unexpected Death in Alcohol Misuse. Good practice identified included trauma-informed approaches, multi-agency collaboration through initiatives like the Blue Light Project and Complex Homelessness Partnership Support Services (CHPSS) Team, and the support provided by Acorn House. However, barriers such as distrust of professionals, inconsistent engagement, resource limitations, and a shortage of specialist accommodation were noted. Recommendations included implementing a Multi-Agency Risk Management (MARM) Framework, introducing a Passport to share information and reduce conflicting diagnoses, and addressing staff burnout through better support mechanisms. The voluntary sector's contribution was also highlighted as invaluable. The recommendations from the review are being taken forward by the Gloucestershire Housing Partnership. MC asked if other areas had been identified as demonstrating good practice. SJ advised that Gloucestershire is now signed up to the Making Every Adult Matter (MEAM) Approach, with 50 other local authorities, so this is being explored. HL provided an update on the new Safety Assessments, which include guidance on how to talk about risk in a trauma informed way and understand an individual's needs. HF advised that Research in Practice are producing a Trauma Informed Practice Toolkit. Members agreed to sign off the Homeless Fatality Review Report.	
5	**'Marion' SAR Rapid Review Report – Sign Off** This review examined the case of Marion, a 95-year-old woman who died following concerns about neglect. Key findings included: • Marion had multiple health conditions, lived at home and was cared for by her son, she required assistance with daily living. • There was a history of domestic abuse, and her son, who was her primary carer, displayed verbal aggression towards some staff. • Despite persistent efforts by professionals, there were missed opportunities for escalation and co-ordination, including the lack of a joint	

	meeting to address safeguarding concerns. Good practice included consistent care provided by health and social care staff and the implementation of a Communication Protocol to manage interactions with Marion's son. Recommendations focused on encouraging trauma-informed practice, improving safeguarding supervision, signposting to voluntary and community groups, holding multidisciplinary team (MDT) meetings for complex cases, escalation of concerns and enhancing understanding of Mental Capacity Assessments, Executive Functioning and the Court of Protection. MC highlighted the importance of staff supervision, both safeguarding and general, as areas of concern can be discussed in these. GHC also have a Safeguarding Advice Line. EW spoke about the challenges practitioners face when dealing with domestic abuse in older adult relationships. She highlighted that it is a difficult issue because such abuse often occurs within long-standing relationships. This can lead to a different response compared to other domestic abuse cases and that training alone may not be sufficient to support professionals. The group signed off the Marion Rapid Review Report.	
6	**'Dorothy' SAR Rapid Review Report – Sign Off** This review focused on an 89-year-old woman who lived at home with her son, she was resistant to care and treatment and died in a state of severe neglect. Key findings included: • The individual was resistant to care over a long period, which predated her dementia diagnosis. • Agencies demonstrated persistent professional involvement, with regular communication and safeguarding referrals. The Fire Service was also involved to address environmental risks. Capacity assessments were completed, and her autonomy was respected. • Despite these efforts, there were concerns about family dynamics, carer support gaps, and the challenges of managing resistance to care. Recommendations included exploring more creative engagement strategies, improving family understanding of frailty and care needs, and ensuring earlier multidisciplinary team (MDT) meetings. The case will be used for teaching and incorporated into a workshop on managing resistance to care. Members agreed to sign off the Dorothy Rapid Review Report. DH discussed the use of Rapid Reviews; these have been used several times recently. Feedback on this approach has been positive, and it seems to work well. However, there will be a review of when to use these versus traditional SARs going forward. DH highlighted that recurrent themes appear across multiple SARs over the years, indicating systemic issues that have not been fully resolved. He emphasised that while individual SARs are essential and provide specific recommendations, the same issues keep arising. He proposed conducting a thematic review of SARs from the past few years, including a national perspective, to identify common themes and work collaboratively on systemic changes rather than addressing issues only at the individual SAR level. DH acknowledged the importance of SARs in identifying learning and making recommendations but stressed that more needs to be done to create long-term change by addressing the root causes of recurring issues.	

7	**Board Assurance Update** DH provided an update on the development of the new strategy, which is due to be launched in April 2026. The three areas are: Improving Practice, Increasing Awareness, and Reducing Risk. DH has received feedback from various agencies and individuals. A meeting is planned with the three main statutory partners, the Local Authority, Police, and Integrated Care Board (ICB), to ensure alignment with strategic aims. Open meetings will be held in January for Board members and other stakeholders to provide input. There will be a launch event in April. DH emphasised the importance of flexibility in the strategy, allowing for adjustments based on new insights and developments. MM asked if there was work with Gloucestershire Safeguarding Children Partnership (GSCP) when creating this, DH has met with MB to discuss transitions and it is important that both Boards are in contact, but there would be dis-benefits in joining the two plans. In parallel, work is underway to establish an Assurance Framework, this will be evidence-based and continuous, focusing on identifying gaps. Existing assurance processes will be utilised where possible to avoid duplication. The framework is expected to be operational by April 2026, with ongoing development to refine its structure and functionality. The Board expressed support for the proposed approach.	
8	**Developing the Gloucestershire Safeguarding Adults Board**  Developing%20the%20Gloucestershire' The meeting discussed proposed changes to the structure of the Board to enhance its effectiveness and ensure better alignment with strategic goals. DH outlined the rationale for the restructuring, emphasising the need for a more streamlined and focused approach to governance and decision-making. The proposed changes include the establishment of an Executive Board, which will consist of the three statutory partners: the Local Authority, Police, Integrated Care Board (ICB). The Executive Board will be a small, senior-level group tasked with taking overall oversight and responsibility for the functioning of the Board. The proposed members of this group are Sarah Scott from the Local Authority, Richard Ocone from the Police, and Marie Crofts from the ICB. This group will focus on driving forward the strategy, responding to assurance issues, and holding agencies to account for safeguarding outcomes. A Management Group will also be established to oversee the work of the sub-groups and ensure alignment with the Board's strategic objectives. This group will include the chairs of the sub-groups and potentially other key representatives. Its role will be to manage the operational work of the Board and provide a clear picture of progress and challenges to the Executive Board. To ensure the voice of individuals and communities is heard and acted upon, a Scrutiny Group will be created. This group will consist of representatives from voluntary and community sector organisations and will act as a challenge group. Its purpose will be to provide feedback on the Board's work, scrutinise its activities, and ensure that the voice of the user is central to safeguarding practice.	

	The sub-groups will be reviewed and revised to ensure they are aligned with the Board's strategy. Whilst the current sub-groups will not be immediately changed, their terms of reference and focus areas will be reassessed to ensure they contribute effectively to the Board's objectives. The sub-groups will be the primary vehicle for delivering the Board's work, with agencies contributing based on their expertise and relevance to the sub-group's focus. The proposed changes aim to ensure that all agencies can contribute fully to the Board's work, that the user voice is clearly heard, and that the Board operates in a more focused and effective manner. DH also highlighted the importance of maintaining communication across the Board system to ensure all agencies are aware of developments and can engage as needed. The timeline for implementing these changes includes establishing the Executive Board for February 2026, establishing the Scrutiny Group by April 2026 at the latest, and completing the revision of the sub-groups by April 2026. Comments included that communication needs to be both ways, both up and down, between the Executive Board and the sub-groups. Several members liked the proposed Scrutiny Group. Frequency of sub-group meetings is yet to be decided, but work will continue outside of the meetings. HF asked about the role of the Executive Board in relation to system change, DH said that would be their focus, as those decisions need to be made at a senior level. There is also wider established partnership working at a senior level. MC highlighted the changes at the ICB; the new executive structure will be in place in January, but it will be a challenge to provide the level of support needed for this. DH asked Board members to confirm their agreement for the formation of an Executive Board, Management Group, Scrutiny Group and reviewed Sub-Groups. Attendees agreed to this. DH thanked all members who have been involved in the Board and hope that they will continue to contribute in the future. If anyone has any concerns, they can contact him directly to discuss them.	
9	**Any Other Business** None raised.	