Hull Safeguarding Adults Partnership Board

7 MINUTE BRIEFING

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Care Act 2014 Safeguarding Adults Review

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The purpose of the SAR is to promote effective learning and improvement to prevent future deaths or serious harm.

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Background

Sharon had a long history of mental health challenges, including schizoaffective disorder, behavioural issues, and substance misuse. Despite her medical challenges and lifestyle choices involving alcohol and illicit drugs she was assessed as having mental capacity to make decisions regarding her care and support needs. She received support from numerous organisations and, although managed within the VARM process, remained an adult at risk.

In May 2025 Sharon' presented to HRI Emergency Department with exacerbation of COPD. She self-discharged prior to any treatment or intervention but was found later in cardiac arrest. She passed away the same evening.

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Key Risks and Concerns

- Ongoing alcohol dependency & substance misuse.
- Victim of cuckooing
- Finance: received a significant back payment of benefits in 2025 which added to her vulnerability.
- Experienced repeated physical, emotional, and financial abuse from former partners and a family member.
- Criminal Offending: long history of criminal offending between 2001 and 2025
- Found it difficult to implement boundaries and protect herself from further harm?
- Despite professionals being aware of Sharon and some of the risks she faced, they found it difficult to implement meaningful actions to reduce the risks posed.

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Links

- Multi Agency Risk Management (MARM)
- Mental Capacity and Executive Function
- Executive Function
- Hull DAP
- Professional Curiosity
- Was Not Brought
- NHS Staff mental health and wellbeing hubs
- Mind mental health helplines

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Recommendations:

1. Review the MARM process and consider;
   i. a risk escalation process to raise significant/long lasting cases to senior managers for oversight and risk management.
   ii. The need for a core membership to ensure representation of key organisations
   iii. guidance on which circumstances require a S.42 enquiry, and which require a MARM.
   iv. need for a separate template for reviews of individual MARM cases.
2. Develop training on mental capacity and executive function, particularly when linked to alcohol and substance misuse.
3. Develop a 'What If' card for supporting Dependent Drinkers and Executive Function.

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Recommendations continued:

4. Develop a toolkit for managing victims of DA with mental capacity issues.
5. Implement a similar approach to the 'Was Not Brought '(WNB) process for supporting adults who do not attend appointments.
6. Consider an 'alert' marker on organisations records and systems, advising of frequent attenders/early leavers and the risk they may leave before appointment/treatment is complete
7. Raise awareness of intrafamilial domestic abuse.
8. Create an all-age practice guidance note on professional curiosity.
9. Consider the support available and option to de-brief staff following involvement with clients, particularly if it involves potentially traumatic and emotive events.

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Good Practice

Collaboration between agencies/partners

1. Care Co-Ordinator facilitated VARM meetings for 2.5 years, establishing an excellent rapport with Sharon
2. Joint appointments facilitated to help agencies struggling to engage.
3. Flexible approach to engagement rather than set appointments with creative and flexible outreach work.
4. Effective information sharing allowing for actions to be implemented quickly to reduce risk.
5 Sharon voice is heard throughout, and her wishes and feelings always considered, despite decisions being deemed unwise.