



# Safeguarding Adults Review – Deborah

## SSCP Learning Briefing

July 2026

## BACKGROUND

The Shropshire Safeguarding Community Partnership commissioned a Safeguarding Adults Review (SAR) following the death of an adult referred to in this briefing as “Deborah” to protect her anonymity. Deborah died aged 62, four days after being admitted to hospital with severe bilateral leg cellulitis and suspected sepsis. Her recorded cause of death was cardiac arrest.

The review was undertaken in line with Section 44 of the Care Act 2014 and relevant statutory guidance. Agencies that had contact with Deborah and her family provided information to support learning and recommendations.

The review was conducted as a discretionary SAR. Although the Independent Chair concluded that the mandatory criteria were not met, it was agreed that there was significant learning for agencies and professionals.

The full review was not published. This briefing has therefore been produced to share the key findings, recommendations and practice learning to strengthen multi-agency safeguarding responses.

The review identified missed opportunities in assessment, safeguarding intervention, carer support, contingency planning, and recording Deborah’s voice, wishes and preferences.

## THE PURPOSE OF A SAR

The purpose of a Safeguarding Adults Review (SAR) is to promote learning and improvement where an adult with care and support needs has experienced abuse, neglect, or serious harm, and there is concern about how agencies worked together to safeguard them. A SAR enables agencies to understand what happened, reflect on professional practice, and identify opportunities to strengthen multi-agency working and improve outcomes for adults at risk.

The purpose of a SAR is not to apportion blame, but to understand what happened, why it happened, and what can be done differently to better support and safeguard adults with care and support needs.

## CIRCUMSTANCES

Between 2001 and 2023, Deborah had very limited contact with health, and social care services, despite having profound care and support needs arising from a traumatic brain and spinal cord injuries causing [tetraplegia \(also known as paraplegia or quadriplegia\) greatly affecting all 4 limbs](#). Care was provided almost entirely by her family mainly from Deborah’s mother who rarely sought external support despite providing considerable and constant care over many years. The review identified missed opportunities for agencies to proactively engage, assess changing needs, consider safeguarding risks, support unpaid carers and coordinate preventative actions.

Deborah’s case reinforces the importance of making every contact count, particularly when working with adults with significant care and support

needs and families who may be  
reluctant to engage.

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## TIMELINE OF EVENTS BEFORE DEBORAH'S DEATH

### 1984

- Aged 24, Deborah was involved in a serious road traffic collision which resulted in a brain injury and tetraplegia. Following rehabilitation, she returned home and was cared for by her parents.

### 2001- 2008

- Deborah and her family moved to Shropshire around 2001 and registered with a GP. Her medical records were transferred onto electronic systems in 2002. She received Disability Living Allowance from 2003. Following the death of her father in 2008, her mother Barbara continued as the main carer, supported by extended family members.

### 2013-2018

- Deborah had very limited contact with health services, mainly receiving repeat prescriptions. In 2018, Barbara contacted out-of-hours GP services on two occasions regarding her own health. Records noted her role as Deborah's primary carer.

### June 2018

- Barbara contacted out-of-hours GP services due to ill health. Records noted her caring responsibilities for Deborah. This was one of the few recorded professional contacts before 2023.

### February- July 2019:

- Feb 2019 Ambulance Service attended after Deborah slipped in her chair and the family were unable to assist her. Concerns raised regarding Deborah's presentation and mothers ability to continue caring for her. ASC completed a home visit, but no ongoing involvement ensued and the case was closed. Later that year, Deborah's was transferred to PIP following a home assessment. She also received treatment for urinary tract infections through remote GP consultations.

### 2020-April 2022:

- During the COVID-19 period, reduced contact and shielding advice may have affected help-seeking. In April 2022, a Safe and Well visit was declined, and the Fire Service was unaware Deborah lived at the address..

### 7-11 June 2023

- On 7 June 2023, Deborah was admitted to hospital where safeguarding concerns were raised by community health staff and the ambulance service. Adult Safeguarding began enquiries while Deborah remained in hospital. Deborah died on 12 June 2023 following cardiac arrest.

## KEY FINDINGS

### Missed opportunities to identify and respond to escalating risk

- Professionals encountered Deborah and her family on several occasions, most notably following the ambulance referral in 2019, yet opportunities to assess risk, explore support needs and maintain involvement were not fully utilised. Despite concerns about Deborah's presentation and the demands placed on her ageing mother, the case was closed after a single visit and no further monitoring was undertaken. Professionals focused on the family's immediate presentation rather than considering the foreseeable future risks associated with Deborah's significant disabilities and Barbara's advancing age.

### Health and Care Services

- Although Deborah had profound chronic disabilities requiring support with all aspects of daily living, she had minimal contact with statutory services for many years. The GP practice had little direct involvement, there was no community health input, no social care support, and no Continuing Healthcare assessment. Services largely relied upon Barbara requesting assistance rather than proactively identifying and responding to Deborah's complex needs.

### The Voice of Deborah

- Professionals described Deborah as able to communicate, "bright and chatty", and capable of expressing her wishes, there is little evidence that her views, wishes, feelings or experiences were captured. Records do not provide insight into what mattered to her, how she viewed her care arrangements, whether she wanted additional support, or what outcomes she wished to achieve. Professionals often spoke to Deborah in the presence of her mother, no evidence she was given an option to speak on her own.

### Consideration of mental capacity and legal duties

- Despite Deborah's acquired brain injury, professionals did not undertake or record any formal consideration of her capacity to make decisions regarding her care, support, accommodation, safeguarding or referral to Continuing Healthcare. Practitioners did not adequately consider relevant legal frameworks, including the Mental Capacity Act, Section 11 of the Care Act, safeguarding duties, or the possibility that Deborah may have required decisions to be made in her best interests.

### Recognition and support for family carer

- Barbara provided round-the-clock care for Deborah for many years and was well into her late seventies when services first became involved. Despite being an ageing carer supporting someone with extensive care needs, there is no evidence that a carers assessment was offered, that contingency planning was discussed, or that support services for carers were explored. The review identified this as a significant missed opportunity, particularly given the increasing likelihood that Barbara's ability to continue caring would decline over time.

### Professional Curiosity, Multi-Agency Working and Safeguarding

- The review identified a lack of professional curiosity across agencies. Opportunities to share information, liaise with other professionals, convene multidisciplinary discussions, make referrals and explore the reasons behind the family's reluctance to accept support were missed. Safeguarding concerns were only formally raised in June 2023 when Deborah's condition had significantly deteriorated. There were missed opportunities to consider support earlier and that professionals needed to take every opportunity to engage, challenge and coordinate support when working with highly vulnerable adults and resistant families.

## RECOMMENDATIONS OF SAR

1. In line with the All-Age Carers Strategy professionals must take steps to identify carers, offer them a referral for a carers assessment, and refer them to other forms of carer supports if they consent. This applies to all professionals working across the system. System partners should provide assurance to the SSCP that their practitioner are aware of the Carers Learning Briefing and recently published video and know how to make referrals for carers assessments when required.
2. Acute hospitals to ensure that conversations are had with adults where applicable as soon as possible so that their views and wishes are recorded on ReSPECT forms including their views on CPR. Acute Trust to consider how they collect data on the use of ReSPECT forms.
3. People with spinal cord injuries are likely to have chronic health problems and experience health inequalities. GPs should be proactive and curious, calling on other agencies to support in the absence of engagement. All agencies should be proactive in finding a way to provide person centred care and support. This should be covered in the SSCP learning briefing.
4. Local Authority to ensure that social workers are aware that 'at risk' involves consideration of future risk as well as current. Raising awareness may involve learning briefings and/or training. A thematic audit to be completed to monitor compliance
5. All staff should, as far as possible, attempt to speak to individuals alone as they are more likely to be able to speak freely. SSCP to include this in the learning briefing for all agencies
6. All professionals must make every opportunity count, especially with families where engagement is problematic. This needs to be covered in the SSCP learning briefing
7. All agencies should work with families to plan for the future and to develop contingency and emergency plans. This needs to be covered in the SSCP learning brief.
8. All agencies are to remind staff of the need to record the views of the individual, their wishes, hopes, aspirations, dreams, etc. Where possible this should be done in their words, using quotation marks. This needs to be covered in the SSCP learning brief.
9. Adult Social Care audit trail should be in place for management oversight

## LEARNING FOR ALL PROFESSIONALS:

### Make every contact count.

Professionals should maximise every interaction with adults and families, particularly where there are signs of increasing vulnerability, unmet need, or reluctance to engage. Opportunities to explore needs, offer support and build relationships should not be missed.

Where circumstances do not fully add up, practitioners should respectfully question, explore and seek a deeper understanding of lived experiences rather than accepting circumstances at face value.

Risk is not limited to what is happening today. Professionals must consider foreseeable future risks, especially where carers are ageing, support networks are reducing, or care needs are increasing.

The person's wishes, feelings, experiences, views and desired outcomes should be clearly recorded.

Professionals should seek opportunities to speak with adults privately to enable them to express their views freely and reduce the possibility that family dynamics influence what is shared.

Family carers should be recognised, offered carers' assessments and provided with information, advice and contingency planning. Carers may not identify themselves as carers, but professionals have a responsibility to recognise caring roles and associated risks.

Professionals should not work in isolation. Concerns should be shared with supervisors and partner agencies, with MDT discussions considered where risks are complex or engagement is difficult.

When families are reluctant to engage, practitioners should view assessment as an ongoing process of relationship-building, persistence and understanding rather than a one-off visit or intervention. Closing involvement too early may lead to missed safeguarding and support opportunities.

## LEARNING FOR INDIVIDUAL AGENCIES

### Adult Social Care

- Strengthen future risk assessment within Care Act and safeguarding decision-making.
- Embed professional curiosity when needs appear stable but risks may be increasing.
- Improve management oversight of case closure, safeguarding thresholds and missed opportunities for ongoing involvement.
- Improve recording of conversations, rationale, and decision-making.
- Care Act assessment, safeguarding or ongoing involvement may be required.
- Consider use of Section 11 Care Act Assessments where an adult may be at risk. Strengthen consideration of capacity assessments and best interest decision-making where there is uncertainty regarding decision making

### Health (GP's, Community and Acute Services):

- Ensure there are proactive support and review considerations for people with complex disabilities who have limited contact with services.
- Offer earlier referral, escalation and information sharing where risks or needs are increasing.
- Record wishes, preferences, and [ReSPECT](#) decisions consistently where appropriate.

### Safeguarding Partners:

- Strengthen early recognition and response to neglect and self-neglect.
- Clarify practice expectations that "at risk" includes near future risk.
- Improve timely information sharing where safeguarding concerns or escalating vulnerabilities are identified.

### All agencies:

- Seek, record, and use the adult's voice in all assessment and planning activity.
- Identify carers early and offer assessment, advice, support, and contingency planning.
- Use every contact to consider unmet needs, safeguarding risk, and opportunities for support.
- Apply respectful persistence where individuals or families are reluctant to engage.
- Plan for future deterioration, carer breakdown, and emergency situations. Strengthen multi-agency collaboration around complex, escalating, or hidden risk.

## CONCLUSION

Deborah's death shows how adults with significant care and support needs can remain unseen when contact with services is limited. Safeguarding must recognise emerging and foreseeable risks, including ageing carers, increasing dependency, isolation, deteriorating health, and reduced support networks. The adult's voice must also be actively sought, recorded, and used in decision-making.

Assessment should be viewed as an ongoing process rather than a single intervention, particularly where needs are complex, risks are escalating, or engagement is difficult. Where families are reluctant to engage, practitioners should use professional curiosity, respectful persistence and coordinated multi-agency support to build trust and reduce risk. Unpaid carers should be identified and supported early through assessment, contingency planning, and future care discussions.

Deborah's story reminds professionals to **make every contact count**. By remaining curious, listening to the adult, recognising carers, assessing future risk, and sharing information effectively, agencies can strengthen safeguarding responses and help prevent similar harm.