



Safeguarding Adults Review Learning Summary

Ben

April 2025

1. What is a Safeguarding Adults Review?

Under the *Care Act 2014*, sections 44 (1-3), Safeguarding Adults Boards (SABs) must carry out a Safeguarding Adults Review (SAR) when an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse (including self-neglect) and there is concern about how agencies worked together to protect the adult(s). The SAB may also (section 44(4)) undertake a SAR in any other case concerning an adult with care and support needs. The purpose of all reviews is to identify learning that can drive change to prevent harm occurring in future similar circumstances.

2. What is the purpose of a Learning Summary?

Cheshire West and Chester Safeguarding Adults Board ask that board partners and stakeholders use learning summaries within their organisations to cascade the learning from the Safeguarding Adult Review in respect of Ben. This learning summary can be used in Team Meetings, Development Days, individual or group supervisions to share and reflect on the learning from this Safeguarding Adults Review and how the learning can translate into practice.

3. Ben's Lived Experience

Ben was aged forty-eight when he died. Ben had a formal diagnosis of anxiety and depression and was prescribed medication by his GP to help manage and stabilise his mental health. Ben was known to secondary mental health services. Ben had been employed earlier in his life and at this time had a steady

relationship which produced two children, a son, and a daughter. Ben's children were adults and lived independently. Ben's son lived in the Cheshire West and Chester area, and Ben reportedly had a good relationship with his son. Ben also had a good relationship with his mother, and they were in semi-regular contact. Ben had been living alone in a privately rented apartment although had recently moved to temporary accommodation at the time of his death. Concerns had been raised regarding the condition of Ben's apartment, some of which were attributable to hoarding and self-neglect. It was noted that the condition of Ben's accommodation constituted a fire hazard, and Ben was known to Cheshire Fire and Rescue Service as a person at heightened risk. Ben was alcohol dependent and mental health professionals felt that Ben might have a diagnosis of alcohol induced psychosis. It was noted that Ben was at greater risk of self-neglect when his alcohol intake increased. Ben had a history of suicidal ideation, and this was exacerbated when he drank to excess. Ben was resourceful and skilled in many areas of his life; he was able to maintain important links with family members and managed his finances independently.

There were missed opportunities to raise safeguarding concerns in respect of Ben.

4. Which agencies were involved in this review?

- Countess of Chester Hospital NHS Foundation Trust.
- Cheshire and Wirral Partnership NHS Trust.
- Cheshire West and Chester Council.
- NHS Cheshire and Merseyside Integrated Commissioning Board.
- Cheshire Fire and Rescue Service.
- North West Ambulance Service.
- Cheshire Police.

5. What areas for practice development were identified?

- Response to adults experiencing hoarding and/or self-neglect
- Recognition of and response to alcohol dependence.
- Working with adults who are 'seldom heard'

- Use and application of the *Mental Capacity Act 2005*, specifically in the context of alcohol dependence.
- Multi-agency information sharing.
- Professional Curiosity.

6. What is Cheshire West and Chester Safeguarding Adults Board doing to support effective practice?

- To seek assurance from partner agencies that they are aware of Cheshire West & Chester Hoarding Alliance, Cheshire West & Chester Persistent Drinkers Alliance, operational guidance to support the multi-disciplinary team approach and the LSAB self-neglect policy, procedure and toolkit.
- To seek assurance from partner agencies that they are able to demonstrate competence in working with alcohol dependence, including a robust awareness of Cheshire West & Chester Persistent Drinkers Alliance, and identifying when an individual might need to be referred to the Alliance. More information about the Alliance and how to refer is embedded at section 8 of this learning brief.
- To seek assurance from partner agencies that they are aware of Cheshire West & Chester 'seldom heard' guidance. This is embedded at section 8 of this learning brief.
- To seek assurance from partner agencies that if there are reasons to doubt capacity, then a Mental Capacity Act assessment must be completed in relation to the decision being considered. Only then can a determination be made regarding the individual's capacity.
- Consideration of the impact of alcohol dependence on executive functioning to be integral to all capacity assessments where alcohol or substance dependence has been identified or is suspected.

- Promote the use of information sharing agreements to ensure that information is shared in accordance with information governance principles and necessary legislation but to also enable those who need to know to be sighted on information, i.e. when an individual is subject to a safeguarding enquiry or there are concerns that the person may be susceptible to abuse or neglect.

7. What do partners need to do to support effective practice?

- To ensure that partner agencies demonstrate competence in utilising local guidance, policies and procedures to support people experiencing self-neglect and/or hoarding and make necessary referrals to the appropriate forums, including Cheshire West & Chester Hoarding Alliance.
- When alcohol dependence is identified or suspected it is vital to utilise the Cheshire West & Chester Persistent Drinkers Alliance,. Partner agencies can access Cheshire West & Chester Persistent Drinkers Alliance for advice. All agencies to ensure that they are aware of Cheshire West & Chester Persistent Drinkers Alliance, and how to refer to the Alliance.
- The term 'seldom heard' is used to describe under-represented people who might use services and who are less likely to be heard by professionals and decision-makers. Guidance has been produced for professionals to support them when working with people who are 'seldom heard'. This can be found at section 8: resources.
- Capacity assessments to be formally recorded.
- Capacity assessments to be decision specific.
- Concerns to be escalated, via organisational escalation procedures or under safeguarding.

- Make risk management person-centred. Ask ‘what is the person’s usual behaviour? And reflect this in the formal assessment of mental capacity.
- Consideration of the impact of alcohol, dependence on executive functioning to be integral to all capacity assessments where alcohol or substance dependence has been identified or the individual is susceptible to misusing alcohol, drugs or substances such as ‘legal highs’.
- Improve multi-agency communication and information sharing between and within agencies.
- To ensure that professionals are ‘professionally curious’.

8. Resources

Professional Curiosity: [What is professional curiosity? | Research in Practice](#)

Adult Safeguarding Procedures:



Safeguarding
Adults - Procedures.

Understanding why people are ‘seldom heard’



UNDERSTANDING
WHY PEOPLE ARE SE

Cheshire West & Chester Dependent Drinkers Alliance

The Change Resistant Drinkers Group is a multi-agency meeting where individual cases are discussed to develop safety plans, manage risk, and improve the lives of those struggling with resistance to change in their drinking behaviours.

This group is open to all professionals working with this cohort across Cheshire West and Chester, providing a collaborative space to share concerns, access support, and contribute to meaningful, community-focused outcomes.

Practitioners can use this form to request that a 'person of interest' is discussed at the Operational Group.

Referrals should be completed and sent to

jodie.rodgy@cheshirewestandchester.gov.uk . The Change Resistant Drinkers Group will consider a multi-agency approach to create an effective plan that supports both the referring professional, and the wider network of agencies involved, ensuring there is a joined-up response that benefits both the individual and the community



Cheshire West and Chester - Change re drinkers - draft refer



Change resistant

National Institute for Health and Care Excellence, Alcohol use disorders: [Alcohol use disorders – prevention \(glossary\)](#)

World Health Organisation, management of substance abuse: [Management of substance abuse – terminology and classification.](#)

Department of Health and Social care, alcohol consumption: [Alcohol consumption – advice on low-risk drinking](#)

Local Safeguarding Adults Board Training: [Training | Cheshire West and Chester Council](#)

Statutory Advocacy Service: [Voiceability | Cheshire West and Chester Council](#)

Getting support from Adult Social Care: [How to get Support | Cheshire West and Chester Council](#)

Mental Capacity Act resources: [Support for people who do not have capacity | Cheshire West and Chester Council](#)

Live Well Cheshire West and Chester:

[Home | Live Well Cheshire West](#)