Briefing Note

SAR Hannah

The Liverpool Safeguarding Adults Board is today (03.03.2026) publishing the Executive Summary of Safeguarding Adults Review (SAR) Hannah.

Hannah sadly died following a fall from height at a car park shortly after being discharged from hospital, where she had been detained under section 136 of the Mental Health Act. Following the incident, Hannah was taken to the Emergency Department but was sadly declared deceased soon afterwards.

Hannah's death was referred to HM Coroner. Following an investigation, a Coroner's Inquest was opened and concluded that Hannah's medical cause of death was multiple injuries. The Independent Office for Police Conduct investigation concluded that the cause of death was misadventure.

The SAR panel identified the following focused learning themes for analysis:

- Who was Hannah, and what were her care and support needs?
- What pathways did professionals follow to support Hannah?
- What pathways and existing safeguarding practices were available to professionals?
- How will the action plans from previously completed Safeguarding Adults Reviews support the learning identified in relation to Hannah?
- What barriers do professionals face in achieving engagement, good practice, and effective use of all relevant pathways?

A key focus of the review was to identify areas for improved practice, including any obstacles or barriers to achieving this, and to highlight areas of good practice.

The Board wishes to record its condolences to Hannah's family.

The Liverpool Safeguarding Adults Board and its partners fully accept the report, including its learning and the questions directed to the Board as an outcome of the SAR. The Board has developed a multi-agency improvement plan to address the recommendations within the SAR report. The purpose of this plan is to strengthen practice, particularly in relation to alcohol and substance dependency, mental health, homelessness, and maintaining positive engagement in complex and challenging circumstances.

The Board will be convening a post-Safeguarding Adults Review learning event with professionals in Liverpool to explore the key learning from this review on 5 March 2026.

Duncan Robinson

Independent Chair
Liverpool Safeguarding Adults Board

Please note a pseudonym name has been selected to help to protect the identity of both the individual and their family.