East Sussex Safeguarding Adults Board

Response to the Safeguarding Adult Review regarding Hannah

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse, or neglect is known or suspected, and an adult has died, (including death by suicide), or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult. The purpose of a SAR, as set out in the Care and Support Statutory Guidance, is to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”.

Tragically, in May 2022, Hannah died as a result of a head injury she sustained at home. The East Sussex Safeguarding Adults Board (ESSAB) extends our deepest sympathy and our sincere condolences to Hannah’s family and also to our appreciation and thanks to her family and friends for their contribution to the review which provided a rich and meaningful understanding of Hannah’s personality, life experiences and perspectives at different times.

The ESSAB commissioned this SAR to understand the circumstances leading up to Hannah’s death and to support the identification of strengths and weaknesses in how agencies worked together to safeguard Hannah.

Hannah was born abroad and had moved to England with her family in 2015 and had experienced loss of both parents in the years prior to moving. Hannah was also made redundant from her job during her pregnancy. In 2016 she was recorded by her GP to have problematic alcohol use and was seen by a private psychiatrist and found to be suffering from mixed depression and anxiety. Hannah was reportedly drinking daily from 2018 and her physical health started to deteriorate significantly in early 2020 with the first of many hospital admissions. Hannah returned to her country of birth at the start of the COVID-19 pandemic for a period of residential rehabilitation which was unsuccessful.

Hannah was dependant on alcohol at the time of her death and the physical harm caused by alcohol was significant. She had multiple inpatient hospital admissions under several medical specialities and was taking a variety of medications and treatments.

The review explored areas of learning specific to Hannah’s case:

* Self-neglect and the harm caused by alcohol.
* Multi-agency approaches to management of risk.
* Consideration of carers.
* Understanding the person.

The ESSAB has reflected on the learning from this tragic case, and fully accept the overall findings and recommendations. We remain committed to seeking assurance with regard to evidence- based improvement planning across all relevant organisations involved, with

progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

There were a number of emerging issues and learning which came out of this review. The following information represents our formal response to the findings, and learning identified in the SAR.

# **Self-neglect and the harm caused by alcohol**

Hannah was often reluctant and sometimes declined to work consistently with services that were offered. The extent of her physical health conditions linked to her alcohol dependency were significant, but this was not recognised as self-neglect and no action was taken.

The review also highlighted the importance to explore both decisional and executive capacity in the context of Hannah’s case. This could have been a line of enquiry after the occasion when Hannah had fallen down the stairs and when family shared concerns about her cognitive functioning.

**The review recommended that the ESSAB seek assurance of the progress of the implementation of** [**The East Sussex Alcohol Harm Reduction Strategy**](https://www.eastsussex.gov.uk/social-care/providers/health/research/alcohol-harm-reduction#:~:text=This%20strategy%20states%20an%20ambition,reduce%20this%20chasm%20of%20inequality.) **with particular reference to Priority 3 (Making effective treatment and recovery accessible for all who need it).**

**The review also recommended seeking assurance from commissioners, providers, and partner agencies on arrangements for ensuring that staff have the necessary knowledge, experience, and skills to recognise and act upon self-neglect with a specific focus on alcohol dependency.**

**A further recommendation included a review of the ESSAB Mental Capacity Multi Agency Policy and Procedures (2019) and consider formalising its current tools into a multi-agency MCA competency framework approach to support facilitating and standardising practice and training.**

**Board response:** The ESSAB has invited the Director of Public Health to a Board meeting to provide assurance in respect of the first recommendation.

As part of the bi-annual ESSAB safeguarding self-assessment audit 2023 we will be requesting evidence from SAB partner agencies on how they ensure their staff have the knowledge, experience, and skills to recognise and respond to self-neglect and, whether substance misuse included within any self-neglect training and awareness in order to gain assurance.

We are assured that The Alcohol Harm Reduction Strategy includes having Alcohol Care Teams (ACTs) embedded in Conquest hospital in Hastings and Eastbourne District General. ACTs provide high quality and appropriate care and liaise with the East Sussex Treatment and Recovery Service (STAR) and others, including One You East Sussex (OYES) and recovery support providers, to ensure continued alcohol treatment and recovery, where necessary, following discharge from hospital. We have also been informed that STAR workers have now been relocated in non-stigmatised settings such as GP services to allow for more flexibility in the way the service is delivered.

Reviewing the Mental Capacity Multi-Agency policy and procedures will help us identify any areas for further development. There is already significant Mental Capacity Act (MCA) training currently available to statutory agencies and providers in East Sussex.

# **Multi agency approaches to manage risk.**

The review highlighted that there were periods of time from Hannah’s admission to hospital to discharge when there were opportunities to facilitate a multiagency meeting under the self-neglect procedures to consider what support could be provided. The review found that there were three elements that may have strengthened these episodes which could also have been applied in the community:

* Recognition of self-neglect and consideration of the procedure (which may have concluded on a referral to request a safeguarding enquiry)
* Facilitation of a multi-agency meeting or discussion
* Stronger connection with and/or in- reach/ hospital alcohol services to support the discharge and help to maintain abstinence.

**The review recommended that the ESSAB review the effectiveness of the approaches and guidance available relating to multi-agency working within the workforce.**

**Board response:** The ESSAB published[The Importance of Multi-Agency Meetings Learning Briefing](https://www.eastsussexsab.org.uk/wp-content/uploads/2023/03/The-Importance-of-Multi-Agency-Meetings-Learning-Briefing-FINAL.docx) in March 2023 in recognition of the value multi-agency working provides in relation to safeguarding adults.

As part of the bi-annual ESSAB safeguarding self-assessment audit 2023 we will be requesting assurance from agencies in relation to :

* How they ensure they are part of an effective and coordinated multi-agency response to safeguarding
* What supervision and escalation arrangements they have in place when staff aren't able to effectively engage with an adult who is at severe/escalating risk and/or there are difficulties in engaging with other services to help manage the risk
* Ensuring effective multi-agency safeguarding practice, are they assured that their staff are aware of and use the Sussex Information Sharing Protocol

# **Consideration of carers**

The review identified there was opportunity to approach the situation from a whole family perspective, involving Children’s Services, and the completion of a Care Act 2014 assessment and carers assessment which may have facilitated a deeper understanding from all angles with a more coordinated approach and joint risk formulation to safeguard Hannah. Often family members can underestimate the impact that a situation is having on them, or that they may need support in their own right.

**The review recommended that we strengthen communication and seek assurance that agencies, including staff in Children’s Services, are aware of the process for carers assessments; how to identify need and how to refer.**

**Board response:** Through communications and publishing a learning briefing for this review we will promote and highlight when a carer’s assessment should be considered and promote the leaflet published by Adult Social Care and Health: [Do you look after someone?](https://www.eastsussex.gov.uk/social-care/getting-help-from-us/asc-leaflets/leaflet-do-you-look-after-someone) through our communication and media channels.

# **Understanding the person**

The reviewer reported that it had been difficult to capture a sense of Hannah’s voice from the agencies who had contact with her order to understand her daily experiences and get a sense of her perspective. There were a number of factors evident in Hannah’s case that significantly changed her role and identity, and together may have created a trauma response. These factors were known to different agencies at different times but were never considered collectively or cumulatively.

The limited amount of professional curiosity and joint response meant that the opportunity to understand the root cause of the alcohol dependency was lost.

**The review recommended that we should seek reassurance that Making Safeguarding Personal is accurately understood, and that understanding is embedded in practice across partner agencies. This could include promoting exploration of life experiences that are contributory to alcohol misuse and self-neglect and applying trauma-informed approaches by practitioners.**

**Board response:** The East Sussex SAB has produced [Making Safeguarding Personal (MSP) Guidance](https://www.eastsussexsab.org.uk/documents/msp-guidance/) which includes positive case studies and links to national resources.

Our website also has a dedicated [MSP page](https://www.eastsussexsab.org.uk/what-is-safeguarding/making-safeguarding-personal/) with further national resources and toolkits.

We will also be gathering evidence form partner agencies as part of the bi-annual safeguarding self-assessment this year on:

* How agencies gain assurance that the adult and their families/carers are central to safeguarding practice and how their views are gathered, accurately recorded, and acted upon.
* Examples of how agencies are taking a holistic approach to safeguarding with specific reference to trauma informed practice.

East Sussex Safeguarding Adults Board

November 2023