

East Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of Hannah

Author: Anna Berry

**Date: June 2023**

(Published December 2023)

|  |  |
| --- | --- |
|  |  |
| 1. Introduction …………………………………………………………………………... | 4 |
| 1. Overview of case and circumstances ……………………………………………. | 5 |
| 1. Key Themes …………………………………………………………………………. | 5 |
| 1. About Hannah ………………………………………………………………………. | 6 |
| 1. Engagement with family ……………………………………………………………. | 8 |
| 1. Parallel processes …………………………………………………………………. | 8 |
| 1. Key Learning Episodes ……………………………………………………………. | 9 |
| 1. Initial summary of findings …………………………………………………………. | 14 |
| 1. Overarching learning ………………………………………………………………. | 14 |
| 1. Analysis of findings: …………………………………………………………………  * Self-Neglect and the harm caused by alcohol. * Multiagency approaches. * Consideration of carers. * Understanding the person. | 14 |
| 1. Key findings …………………………………………………………………………. | 29 |
| 1. Improvements made ………………………………………………………………. | 31 |
| 1. Summary ……………………………………………………………………………. | 31 |
| 1. Conclusion …………………………………………………………………………... | 32 |
| 1. Recommendations …………………………………………………………………. | 33 |
| References ……………………………………………………………………………… | 35 |

**Glossary:**

|  |  |
| --- | --- |
| **Abbreviation** | **Definition** |
| SAB | Safeguarding Adult Board |
| SAR | Safeguarding Adult Review |
| GP | General Practitioner |
| ADP | Adult Death Protocol |
| CGL | Change, Grow, Live |
| MARM | Multi Agency Risk Management |
| ED | Emergency Department |
| HSCC | Health and Social Care Connect |
| ESFRS | East Sussex Fire and Rescue Service |
| PLE | Practitioner Learning Event |
| S42 | Section 42 (of The Care Act) |
| MCA | Mental Capacity Act |
| MHA | Mental Health Act |
| SWIFT | Safeguarding with Intensive Family Treatment |
| ICB | Integrated care Board |

## Introduction

### Under section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to 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 together more effectively to protect the adult. If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

### The purpose of conducting a review is to enable members of the SAB to:

* Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
* Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
* Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
* Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

### Further information on the local SAR process can be found in the [Sussex SAR Protocol](https://www.eastsussexsab.org.uk/documents/sussex-sar-protocol/)[[1]](#endnote-1).

### Safeguarding Adults Reviews are required to reflect the six safeguarding adults’ principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

### The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

### There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

### The review process to meet these aims and objectives has followed a clear path. The methodology chosen for this review is a Learning Together approach. This included a panel to agree terms of reference and a focus on themes, patterns, and factors together with family and practitioner discussions. The Independent Reviewer has conducted research by analysing the information provided culminating in an overview report for the East Sussex Safeguarding Adults Board.

### The review will cover the period of 2019 to 2022:

### Contributing agencies:

* Primary care -GP
* Sussex Police
* Adult Social Care & Health, ESCC
* Children’s Social Care, ESCC
* East Sussex Safeguarding Children’s Partnership (ESSCP)
* Sussex Partnership NHS Foundation Trust (SPFT)
* Change Grow Live (CGL)- STAR
* University Hospitals Sussex
* South East Coast Ambulance Service (SECamb)
* East Sussex Fire and Rescue Service (ESFRS)
* East Sussex Healthcare NHS Trust (ESHT)
* UK Addiction Treatment Centres (UKAT)

## Overview of the case and circumstances leading to the review

### The SAR referral was received on 21st October 2022 from Adult Social Care Mental Health and Substance Misuse Team.

### This review is about a 48-year-old woman Hannah[[2]](#endnote-2), who died in May 2022 as a result of a head injury. Prior to her death Hannah had severe alcohol misuse issues resulting in significant physical health problems. Initially the Adult Death Protocol (ADP) was followed[[3]](#endnote-3), however it was determined that the injury was sustained due to a fall whilst intoxicated. Hannah lived with her husband and young boys at the time of her death. The children were being supported by the Local Authority Early help team within Children’s Services.

### There were a number of professionals involved throughout the timeframe of this review, largely the GP and several hospital Trusts encompassing various clinical specialities, as well as Change, Grow, Live (CGL) who were working with Hannah in 2019/2020. There was also contact with emergency services on some occasions.

### A post-mortem took place providing a cause a death, and a coronial inquest is pending at the time of writing this review.

### The SAR Subgroup reached a recommendation that the mandatory requirement to undertake a SAR was met and this decision was endorsed by the SAB Independent Chair on 30th November 2022.

### The SAR Subgroup acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care.

## Key Themes identified for this review:

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

* How support services and statutory services manage alcohol related complexity.
* Legal literacy.
* Consideration of the self-neglect pathway and thresholds.
* Commissioning of services for alcohol treatment .

### Multi-agency approaches to management of risk.

* Professional curiosity and unconscious bias.
* How services work together
* Interface between services working with adults and children- “Think Family.”
* Consideration of the Multi Agency Risk Management (MARM) protocol.

### Consideration of “carers”

* How was the family supported?

### Understanding the person.

* Background.
* Daily lived experience.
* Social circle of support.
* To what level was Hannah’s voice heard?
* Impact of the COVID-19 pandemic.

## About Hannah

### Hannah was 48 years old when she died in May 2022 as a result of a head injury. 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.

### Hannah’s GP identified a medical history to include:

* Mixed anxiety and depression
* Severe alcohol dependence
* Gastritis (inflammation of the stomach)
* Hiatus Hernia (where the upper part of the stomach comes up into the chest and can cause heartburn symptoms)
* Alcoholic hepatitis and cirrhosis (liver inflammation and scarring caused by alcohol)
* Portal hypertension (raised pressure in the vein going to the liver due to liver disease)
* Oesophageal varices (dilated veins in the oesophagus due to portal hypertension – as above)
* Recurrent pancreatitis (inflammation of the pancreas caused by alcohol in this case)
* Hepatic encephalopathy (a build-up of toxins in the blood due to the liver being unable to remove them which affects brain function and causes confusion)
* Branch retinal vein occlusion (blockage of a vein in the back of the eye causing sudden visual loss)
* Low platelet count
* Uterine Fibroid (benign growth in the uterus which can cause heavy bleeding)

### It is important that this review explores the agreed terms of reference with Hannah at the centre and in order to do this, it is essential to get a sense of Hannah as a person so that the events leading up to her death do not define her. This will also allow episodes of care and action to be seen through the lens of Hannah’s own experiences.

### Hannah was born abroad and was part of large family consisting of mother, father, and several much older siblings (from both parents’ previous marriages), and several younger nieces and nephews. She worked as a Video Photojournalist and lived abroad which is where she first met her husband Matthew in 2001[[4]](#endnote-4).

### Hannah and Matthew both worked in the field of journalism and enjoyed successful jobs with their professions. They married in 2005 and had two young boys, Luca, and Theo[[5]](#endnote-5). In 2015 the family moved to the UK to be near Matthew’s parents.

### There are several relevant events in Hannah’s history before she moved to the UK; both of her parents died in the few years leading up to the move to the UK, her father in 2008 and her mother in 2012 which was shortly before she became pregnant. Additionally, Hannah was made redundant during her pregnancy which was a great disappointment to her.

### Initially the family resided with Matthew’s parents until they found the right house of which Hannah took great pride in designing the interior. This is described as beautiful, tasteful, and colourful.

### Hannah and Matthew were very sociable people and had many friends both abroad and in the UK. They enjoyed many interests together including music, travelling and photography. Hannah is described as having an “amazing creative eye for clothes and design.”

### A close family friend whom Hannah met abroad and who lives close by in Sussex was a great source of support and help during the timeframe of this review. She describes Hannah as a “force of nature” and said that she was energetic, always wore vibrant clothes and was kind and generous with time and had “always been there when needed.” She believes that due to various factors, Hannah slowly lost a part of herself over the years leading up to her death.

### Matthew describes the early years of their relationship and initially following the move to the UK as being very happy with Hannah being a “spectacular mother,” very functional and active. This is reinforced by Matthew’s father who describes Hannah as an excellent mother and as a “bright, bubbly engaged person who was often late!”

### It is helpful to note that as early as 2016 she was recorded by the GP to have problematic alcohol use, to have been seen by a private psychiatrist and to be suffering from mixed depression and anxiety. Matthew has reflected on this time period and notes that she did seem to be displaying some “OCD type” behaviour at this time, in particular to be very preoccupied about American politics and Donald Trump. Matthew notes that Hannah saw mental health as a stigma and felt ashamed of that and her subsequent alcohol dependency.

### In the couple of years leading up to the COVID-19 pandemic there was a disconnect in the marriage with some particular difficulties with communication; Matthew believes that Hannah’s depression had worsened but she was reluctant to seek or receive any help.

### It is difficult for Matthew to pinpoint at what stage the alcohol use exacerbated, as Hannah was very careful to remain “functional” and in control. Matthew recalls that Hannah was drinking daily from at least 2018 and the GP records reflect problematic alcohol use as early as 2016.

### Matthew’s father observes that Hannah struggled to adjust to life in the UK and he felt she had underlying mental health problems. Hannah had informed him when asked, that she “could not stop drinking.” He also had an impression that there had been some familial problematic alcohol use when Hannah was growing up.

### Reflected in some of the agency records and mentioned by all of the family members and friends was the matter of how deeply Hannah had been affected by bereavement, specifically the loss of her mother shortly before she became a parent herself. A family friend noted that Hannah was often particularly focused on the death of her mother during times when she was intoxicated and felt that the impact of her death was significant.

### Hannah’s physical health started to deteriorate significantly in early 2020 with the first of many hospital admissions, on this occasion for pancreatitis. Hannah returned to her home country at the start of the COVID-19 pandemic for a period of residential rehabilitation which was unsuccessful and, according to a close friend the cause of much shame and anxiety. Subsequently she had multiple alcohol related medical problems, several hospital admissions and 2 private residential detox periods in the UK. These episodes will be explored further in the review.

### It is difficult to get a sense of Hannah’s ongoing relationship with her family abroad. According to Matthew and her friend, it was the source of sadness that contact with them was fairly minimal and when she returned from abroad after the failed detox, she was deeply ashamed and felt a sense of disappointment from them. However, her friend notes that one niece in particular did persistently try to help.

### Matthew reflects on a period when Hannah was abstinent in early 2022, she was extremely medically unwell at this time, and he notes that “she had suffered a significant change in personality and cognitive function and remained distant from the children and family life”. This will be explored further in this review.

## Engagement with Family

### Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported on a daily basis and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

### The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[[6]](#endnote-6).

### Hannah’s family and friends contributed significantly to the review, providing multiple examples, anecdotes, and information. This provided a much wider context to the information that was available. Their contribution provided a rich and meaningful understanding of Hannah’s personality, life experiences and perspectives at different times.

### In particular Hannah’s husband Matthew, provided significant insight into Hannah’s life and her experiences which have helped to identify the learning for future practice.

### The family believe that there is meaningful learning that can be gained from reviewing Hannah’s case. This learning includes multidisciplinary coordination and delivery of care alongside alcohol pathways. They hope that agencies will use this learning to improve practice.

### It is the wishes of the family that this review is anonymised, and thus different names have been identified and used throughout.

## Parallel processes

### For reference, background, and context it is helpful to consider the relevant statutory process and their conclusions.

### The cause of death on the death certificate is:

1a) Raised intercranial pressure.

1b) Acute left sided subdural haematoma

2) Cirrhosis of the liver

### There is an inquest pending which will be held in 2023, SAR progress and the final report will be provided to the Coroner.

## Key learning episodes:

### Within the information provided for this review there is evidence of at least 70 episodes of contact with services between January 2019 and July 2022 including and not exhaustive:

* Children’s Social Care Early Help services.
* School
* Hospital Trusts (in and outpatient services)
* Privately funded alcohol services (UKAT)
* GP
* Adult Social Care
* CGL
* Police
* Ambulance Service
* Fire and Rescue Service

An overarching chronology of events includes the key points of contact with these services.

To note, her full contact with services was more extensive:

|  |  |
| --- | --- |
| DATE | EPISODE |
| 2015 | Moved to the UK |
| 2016 | Noted by the GP to have been seen by a psychiatrist and to have accessed counselling related to problematic alcohol use. She had abnormal liver tests at this time. She was prescribed anti-depressants |
| 2017 | Diagnosis of gastritis |
| 2019 | Referred to Colorectal team due to rectal bleeding, investigations showed an enlarged liver and ascites. Colonoscopy arranged but several appointments postponed by Hannah |
| 13/09/2019 | GP raised concerns with children’s social care about the impact of maternal alcohol use on the children |
| 23/10/2019 | CGL- STAR personalised assessment |
| 06/11/2019 | 1:1 appointment with STAR, engaged well with the service, reported stresses at home and said she was having couples counselling. |
| 20/11/2019 | STAR appointment, reported that alcohol intake had increased, nurse led assessment to be booked to discuss detox options |
| 06/12/2019 | STAR nurse led alcohol assessment completed, Hannah reported feeling very isolated since moving to the UK, she described significant withdrawal symptoms when she tried to be abstinent and said she felt physically unwell as well as depressed and anxious |
| December 2019 | STAR team working with Hannah and liaising with GP for physical health investigation and monitoring e.g., blood tests |
| 18/12/2019 | STAR telephone consultation, isolation, depression, and anxiety self-reported at this consultation. |
| 2019 | Referral to gynaecology due to bleeding, fibroid found in uterus |
| February 2020 | Referred to ophthalmology from opticians- branch retinal occlusion |
| 13/02/2020 | STAR telephone consultation, reported that she had been drinking increased amounts, but she still wanted support |
| 12/03/2020 | STAR telephone call attempted but noted Hannah was in hospital |
| March 2020 | Admitted via Emergency Department (ED) to Eastbourne District General Hospital (EDGH) with alcoholic pancreatitis. Alcohol detoxification done during admission |
| 18/03/2020 | STAR appointment cancelled by Hannah |
| 15th April 2020 | Police called by husband due to a domestic incident, Matthew had allegedly made a recording of Hannah with the purpose of demonstrating how she behaved when intoxicated. Hannah became very upset and grabbed a knife, threatening Matthew and then saying she was going to self-harm. Police attended this incident and Hannah was taken to the police station. A referral was made to children’s social care as children were present – closed to children’s social care and it was noted that Hannah was travelling abroad to stay with family to attempt detox |
| 17/04/2020 | STAR- attempted call, no response |
| 24/04/2020 | STAR- Hannah contacted the service to report she was abroad |
| April 2020 | Returned to her home Country to stay with family for a period of detox which failed, returned back to the UK shortly after |
| Throughout  lockdown | Children were allocated school places during lockdown on the basis of vulnerability after Matthew had discussed the home situation with the Head Teacher |

**Points**

* Escalating alcohol issues at the later stage of 2019, good engagement with CGL where Hannah self-reported increasing alcohol use, depression, anxiety, marital difficulties. She wanted to be abstinent but wanted an “easy option.”
* Domestic incident prompting a children’s social care referral. This may have been an opportunity to consider adult safeguarding referral, mental health assessment and/ or liaison with CGL.
* Absence of professional contact during the first period of national COVID-19 restrictions.

|  |  |
| --- | --- |
| October 2020 | Missed gynaecological appointments, subsequently seen by GP who referred her for admission under gynaecology for heavy bleeding due to fibroid |
| 02/12/2020 | Attended the ED at Princess Royal Hospital and admitted to the Royal Sussex Hospital with acute pancreatitis |
| 07/12/2020 | Attended Sussex Eye Hospital due to loss of vision |
| January 2021 | 28-day period of residential rehabilitation/ detox at a private provider |
| 16/03/2021 | Referral made to children’s social care in view of Hannah’s residential detox- closed |
| 05/01/2021 | Attended ED from Lighthouse due to abdominal pain and hallucinations, discharged back to Lighthouse. |
| 15/02/2021 | Missed gynaecological appointment |
| February 2021 | Discharged from Lighthouse and started drinking alcohol again |

**Points:**

* Hannah was discharged from residential detox and signposted to Alcoholics Anonymous (AA) and CGL to support her continuing abstinence once discharged. As per organisation policy, the discharge summary for the GP was given to Hannah.

|  |  |
| --- | --- |
| 19/02/2021 | 111 call made by Hannah to request help with alcohol abstinence. Advised to go to the GP |
| March 2021 | 28-day period of residential rehabilitation/ detox at a private provider (Banbury Lodge- UKAT) |

**Points:**

* Hannah was discharged from residential detox and signposted to Alcoholics Anonymous (AA) to support her continuing abstinence once discharged. As per organisation policy, the discharge summary for the GP was given to Hannah.

|  |  |
| --- | --- |
| March 2021 | Admitted to John Radcliffe Hospital with abdominal pain. Safeguarding referral made in respect of the impact of maternal alcohol use on the children |
| March/ April 2021 | Multiple contacts attempted by GP to monitor Hannah and check blood tests, noted significant alcohol use at this time |
| 22/04/2021 | 999 call as Hannah could not walk, noted to be falling over, facial spasms but refused to attend ED |
| 23/04/2021 | Admitted to EDGH, underwent alcohol detox, significant medical issues noted due to alcohol use |
| April/ May 2021 | Missing appointments for blood tests |
| May 2021 | Seeing a private counsellor regarding alcohol |
| 07/06/2021 | Missed ophthalmology appointment |
| 9th June 2021 | Attended ED and admitted to EDGH due to alcoholic hepatitis |

**Points:**

* There was a brief period of abstinence from the beginning of May and therefore this may have been an opportune time to think about muti-agency opportunities to consider services, encourage engagement to prevent relapse.
* There was no referral to CGL STAR during this time period.
* During this period of abstinence, it was made very clear to Hannah that the harm caused to her physical health was significant, she reported increased anxiety and depression and mental health input may have been timely

|  |  |
| --- | --- |
| 02/07/2021 | Fell down the stairs and admitted to ICU, reported during this admission that she had been abstinent since 1st May 2021. Tests and observations reinforced this as she was not found to be withdrawing. The seriousness of the harm caused by alcohol was reinforced again during this admission. Safeguarding referral made in respect of Hannah due to concerns about family dynamics, concerns about the children, reported verbal abuse from Matthew and levels of support at home. On receipt of the safeguarding referral, “Health and Social Care Connect” (the East Sussex adult social care portal- HSCC) reviewed the concern and passed this to the relevant “Out of County Hospitals team” to address through case management. A social worker in adult social care then contacted ICU and requested they refer to them to be part of the discharge planning process, as they were informed by the hospital that Hannah would be in hospital for several days due to needing organ support. There is no evidence and recording of whether this occurred or any follow-up. The hospital discharge summary to the GP reflected that safeguarding concerns had been investigated. |
| August 2021 | Missed appointments for “First Fit” clinic, chest X-Ray, blood tests, gastroenterology appointments |
| September 2021 | Missed blood test appointment |
| 21/09/2021 | Attended ED and admitted to EDGH with jaundice, shortness of breath and was noted to be withdrawing. The harm caused to her liver by alcohol use was reinforced and “ceilings of care” discussed with Hannah and her husband. Maximum interventions agreed. |
| 11/10/2021 | Children’s social care contacted by husband for advice |
| 01/11/2021 | Consultation with Advanced nurse Practitioner (ANP) at the GP practice due to increased anxiety and Hannah expressed a wish to access STAR again and wanted a consultation with her GP. Details provided for the STAR and Health in Mind services and Hannah was encouraged to access them. |
| 08/11/2021 | GP consultation where Hannah reported increased anxiety, said that she had been attending Alcoholics Anonymous (AA) and has been abstinent since her latest hospital admission. GP reinforced ANP advice to access services. Noted that she had started to take Fluoxetine again (a type of anti-depressant). Hannah reported that she was having weekly private counselling. |
| 25/11/2021 | Consultation with GP where fluoxetine dose was discussed. Also discussed various hospital appointments that Hannah was not aware of, but she declined the offer of the GP to contact her husband to assist with coordination of appointments. Hannah reported that she remained abstinent, and the GP noted that she appeared calmer and brighter. |

**Points:**

* A safeguarding referral was made in respect of Hannah, this was an opportunity to conduct a safeguarding enquiry under The Care Act
* Content of the referral did not specifically identify self-neglect as the primary concern
* There was concern about support at home, there was opportunity for a Carers assessment to be conducted under The Care Act to ascertain what support Matthew was providing and what support may be needed.
* There was a significant deterioration after this period of abstinence where Hannah was asking for help (albeit she did not carry through self-referral to services who may help her). Self-referral may not have been a realistic method for Hannah and there was no professional referral to CGL STAR during this time period.
* In July 2021 she had fallen down the stairs and had a subsequent seizure- was this considered in the context of head injury and capacity.
* Given the clear consequences and harm caused by alcohol use, there were multiple touch points with services but little evidence that self-neglect was considered or defined.
* There may have been an opportunity to consider access to mental health services during the period of abstinence.
* There were opportunities for multi-agency discussions during this period of time.
* Discharge from hospital after the fall down the stairs may have been an ideal time to capture all the above points.

|  |  |
| --- | --- |
| 21/12/2021 | Attended ED following 999 call and admitted to the Royal Sussex Hospital as she was vomiting blood due to Oesophageal variceal bleeding, she was jaundiced and had severe anaemia and a scan showed liver cirrhosis. |
| 21/12/2021 | Children’s Safeguarding referral was made by East Sussex Fire and Rescue (ESFRS) service who had attended the family home to assist with getting Hannah to hospital- this resulted in a family assessment and the offer of Early help Service which commenced in January 2022. ESFRS also made an adult social care referral to HSCC who attemptedcontact with Hannah by telephone calls (leaving voicemails) to offer a social care assessment but received no response and thus was closed with no further action. Contact was attempted between the 22nd and 24th December and a letter was sent to Hannah. The GP was not aware of the safeguarding referrals. |
| 19/01/2022 | Children’s Social Care family assessment facilitated Early help service |
| 21/01/2022 | Attended Royal Sussex hospital for endoscopy but admitted due to chest and breathing difficulties, treated for pleural effusion. Noted to be abstinent of alcohol |
| 21/02/2022 | Admitted from ED to EDGH due to bleeding from mouth, feeling lightheaded and generally unwell. Noted that she has started drinking alcohol again. The bleeding was secondary to pancytopenia (low blood counts), portal hypertension (high pressure in the portal vein to the liver caused by liver disease). She was discharged with gastroenterology follow up arranged |
| 10/03/2022 | Outpatient gastroenterology appointment carried out followed by telephone consultation where the harm caused by alcohol was noted to be significant, the consequences of continued alcohol use was reinforced, and Hannah informed that it would take up to 6 months of cessation for the liver to recompensate. Hannah was abstinent at this time and engaging with a private counsellor. |
| 07/04/2022 | Hannah attended ED due to neck and back pain. On this day, her husband wrote to the GP to inform them that Hannah was significantly drinking again, alternating between drinking, and sleeping. Early help worker informed GP that Hannah had given consent for a referral to be made. |
| 12/04/2022 | Referral to STAR asking for support |
| 13/04/2022 | STAR attempted call, no answer |
| 14/04/2022 | STAR attempted call, no answer |
| 22/04/2022 | Closed to STAR due to failed calls |
| 27/04/2022 | STAR received referral from Early help service |
| 28/04/2022 | GP telephone consultation where Hannah reported that she had relapsed, GP chased up referral/ appointment with STAR |
| 28/04/2022 | STAR attempted call with Hannah, no answer |
| 02/05/2022 | STAR attempted call with Hannah, no answer, email was sent to Hannah and to the Early help service as they had made the referral |
| 03/05/2022 | STAR received referral from GP |
| 03/05/2022 | STAR attempted call with Hannah, no answer |
| 04/05/2022 | STAR attempted call with Hannah, no answer, this was followed by a text message |
| 05/05/2022 | Telephone call between GP and Early help worker, GP face to face appointment was arranged that the Early help worker planned to attend with Hannah to support her in accessing services that she needed. |
| 12/05/2022 | Hannah was not able to attend the face-to-face GP appointment due to being intoxicated. Early Help worker planned to do an adult safeguarding referral following this visit. GP spoke to husband and the face-to-face appointment was rearranged. It was reported that Hannah had fallen earlier in the day into the slats of the bed but had not sustained any injuries and was asleep in bed. Appointment was rearranged. |
| 13th May 2022 | This was the day that Hannah was found deceased, referral to Adult Social Care made and S42 initiated |

**Points:**

* Escalating issues and concerns when Hannah was attempting to access services but could/ would not follow through calls with STAR.
* Threshold reached in Children’s Social Care for targeted Early help services to be offered.
* Apart from the referral made by ESFRS which was closed when there was no response received ,following the attempts to contact that were made, there was no evidence of Adult Safeguarding Referrals/ consideration despite increasing self-neglect.
* Matthew was trying to reach out to services on her behalf and had noticed a particular change of cognitive functioning- there were opportunities to explore this via the Care Act in terms of Hannah and Matthews needs.
* Opportunity to consider capacity in view of previous head trauma and seizure (fall downstairs).

## Initial summary of findings:

### Analysis of the following points will be completed in section 11.

* Lack of evidence of legal literacy/ professional curiosity
* Insufficient analysis of presentation in terms of safeguarding- self neglect presentation
* Absence of multi-agency meeting or discussion to consider the presenting issues.
* Person centred care planning was not evident- management of Hannah was largely responsive to the presenting issue on the day rather than a proactive and preventative approach, there is little evidence of Hannah as a person.
* There was emphasis placed on responding to the effects of harm caused by alcohol, but this was not balanced with emphasis on the root cause of alcohol dependency.
* There was insufficient evidence of the time taken to explore Hannah’s or Matthew’s daily lived experience using the legal tools available.
* The COVID-19 lockdown measures contributed to Hannah’s increasing sense of isolation and her alcohol intake significantly increased at this time.
* There could have been a better alignment between Children’s Social Care and Adult Social Care- why was vulnerability recognised at different times by both but not together (with recognition that both work to different legislation).

## Overarching Learning

### The review has identified learning following consideration of the following areas of practice that were identified during review process, highlighted within the agency reports, and discussed at panel, practitioner event and with family members.

|  |
| --- |
| **Areas of learning:** |
| Self-Neglect and the harm caused by alcohol. |
| Multi-agency approaches to management of risk. |
| Consideration of carers |
| Understanding the person (including impact of COVID-19) |

## Analysis of findings

### Self-Neglect and the harm caused by alcohol:

### The Care Act 2014 recognises self-neglect as a category of**abuse and neglect.** It is helpful to consider what we mean by self-neglect and how this relates to alcohol use.

### Self-neglect is an extreme lack of self-care; it is sometimes associated with hoarding and may be a result of other issues such as substance misuse. The Care Act 2014 clarified the position of self-neglect and safeguarding. Under the Act, self-neglect now falls under the definition of causes to make safeguarding enquiries. To note, Care and Support Statutory Guidance (2016) clarified that self-neglect may not necessarily prompt an enquiry under section 42 of the Care Act (often referred to as a ‘Section 42 enquiry’).

### An assessment should be made on a case-by-case basis, and a decision on whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. However, there may come a point when they are no longer able to do this without external support. Section 42 of the Care Act states:

*‘Enquiry by local authority*

* *This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) – (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*
* *The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.’*
  1. The most common type of abuse identified in the National SAR analysis was self-neglect.
  2. The Alcohol Change UK report, learning from tragedies analysed 10 safeguarding adult reviews (SARs) and one independent safeguarding review published in 2017 where alcohol was relevant to the death of the individual, whether as a result of health problems, killing or suicide. In all cases, there was little or no engagement in services, while self-neglect was explicitly linked to alcohol use in nine cases; in six cases, self-neglect and refusal of services was the main factor leading to death.
  3. The study also identified a lack of understanding of self-neglect. This was perceived as a ‘lifestyle choice’ by practitioners in three cases, which “*prevented a deeper analysis of the underlying causes and precluded attempts to address them.”* The study also said that, among *“even among those with knowledge of self-neglect, alcohol misuse is less readily perceived as [such] compared to other behaviours such as hoarding or lack of personal hygiene.”* This was supported by the panel and the Practitioner Learning Event with the view that there is often a different response to concerns/ referrals made that relate to self-neglect and substance/ alcohol misuse and this will be explored later in the review.

### In applying Hannah’s presenting issues alongside the definition of self-neglect, we know that she was often reluctant and sometimes declined to work consistently with services that were offered. We also know that the extent of her physical health conditions led to a consultant on more than one occasion to tell Hannah in “no uncertain terms” that she would die if she continued to drink. Despite the level of seriousness of this message, it was not recognised as self-neglect and no action was taken. We also know that Hannah did not adhere with advice, treatment and frequently did not turn up to crucial health appointments. The panel, practitioners and family are all in agreement that Hannah was significantly self-neglecting.

### Having considered the timeline and chronology, a coherent view of the escalating nature and pattern of Hannah’s alcohol use from at least 2019 onwards was required however each agency only ever had their own snapshot of information and at no point came together to share what they knew. It is therefore noted by panel members and practitioners that there was a lack of definite recognition of self-neglect in respect of Hannah.

### To support this view, we can see that there was an absence of more safeguarding referrals, lack of multi-agency discussion, lack of personal history and exploration of significant events, lived experience and caring and carers responsibilities. Refusal of services was not fully explored or understood and there was an assumption of capacity which will be fully explored later.

### It should be noted that East Sussex has self-neglect procedures that are readily available on the Safeguarding Adult Board website . The procedures were updated in 2019 and are thorough, easy to follow and inclusive of substance misuse and the challenge of non-engagement.

### The Practitioner Learning Event explored the reasons for the absence of identification of self-neglect and considered the self-neglect procedures which highlight the “Lead Agency” and explicitly says “any professional can request and convene a multi-agency meeting under these procedures” and where a safeguarding enquiry is being undertaken, the Local Authority will be the lead agency under the procedures. In other cases, discussions will be held by the agency involved who is best placed to coordinate and convene a multi-agency response. This theme will be captured as a key finding.

* 1. It is noted that self-neglect can be a difficult area for intervention as issues of mental capacity and lifestyle choice are often involved, which includes individual judgments about what is an acceptable way of living and degree of risks to self. To expand, if the person is assumed to have capacity, then the way they life their life is “choice.” Even in cases where it appears the risk to the individual may be significant, there may be no clear legal grounds to intervene. However, it is important to not treat a person as lacking the capacity to make a decision just because they make an unwise decision. In Hannah’s case, her perceived “non-engagement” was often viewed negatively as a bad choice, rather than explored in the context of safeguarding/ self-neglect and without exploring capacity. Legal literacy will be considered with this review.
  2. There were three occasions when Adult Social Care received referrals throughout the timeframe of this review. Firstly, from a hospital in July 2021, Hannah was abstinent at this time and the referral was made largely due to self-reports that she had a lack of support and disclosing that Matthew had been verbally abusive, the referral did mention self-neglect but despite being passed from HSCC to the relevant team, and their request to be part of discharge process, there is no record of any further follow-up or action from any agency. Secondly the ESFRS made a referral in December 2021 when they were called to assist Hannah downstairs when she required hospitalisation, Hannah was drinking again at this time, the referral did not explicitly include self-neglect and was closed as Hannah did not respond to several communications from Adult Social Care. Lastly in May 2022 which was due to Hannah’s death.
  3. For clarity, the above points mean that:
* The self-neglect procedure was not instigated by any agency (within the community or hospital).
* There were only 2 safeguarding referrals made during Hannah’s life which closed with limited feedback to agencies, and there was no recorded follow up from any agency.
* A S42 Safeguarding enquiry was not carried out until after Hannah’s death.
  1. The use of The Care Act will be further considered; however, it can be seen that there was little evidence of recognition of the indicators and causes of self-neglect in this case. Discussion at the practitioner learning event facilitated a common view that the self-neglect procedures are rarely applied when Adult Social Care are not directly involved. Thus, there was a catch 22 situation here in that agencies did not recognise or act upon self-neglect by following the procedure themselves, and on the occasions where referrals were made to Adult Social Care, they were closed with no further action and this was never challenged or followed up, thus self-neglect through a safeguarding lens was never fully investigated.
  2. The review would specifically like to draw out the point of awareness, ownership, and application of procedures. In this instance self-neglect was not thoroughly explored and had there been a more strengthened multi-agency approach to Hannah’s situation this may have been considered further. Furthermore, the self-neglect procedure does not need to depend on the local authority being involved and discussions at the practitioner learning event (PLE) indicated that this may not be commonly understood across the agencies.
  3. It is helpful to consider the provision for alcohol misuse services. The East Sussex STAR service is provided by CGL which is a national Health and Social Care Charity. In East Sussex CGL provide substance misuse services and domestic abuse support. The STAR service provides specialist community treatment and support for adults affected by substance misuse who live in East Sussex. CGL receive both self and agency/ professional referrals, and for both routes’ treatment is consent based.
  4. Alcohol and Drug services are commissioned by the Substance Misuse Team within the East Sussex Safer Communities Partnership with the aim to prevent and reduce harm caused by alcohol. The way services are commissioned reflects evidence-based guidelines such as NICE guidelines.
  5. As part of the Joint Strategic Needs Assessment (JSNA) for East Sussex, an assessment of need for Substance Misuse in East Sussex was published in 2022 following the publication of the national Drug Strategy “From Harm to Hope” in 2022 . The national strategy stipulates the requirement for strong multi agency partnership and a local strategy and action plan. It should be noted that there is no national strategy for alcohol, but in East Sussex, these requirements are reflected in the local Alcohol Harm Reduction Strategy
  6. The way services are commissioned is comprehensively covered in the East Sussex Alcohol Harm reduction strategy 2021/2026 . The strategy began its implementation in 2021 with the aim to reduce alcohol harm in East Sussex by 2026. Priority 3 articulates the commissioned offer from identification to recovery and describes the need to upskill the whole multi-agency workforce so that they are trained and able to provide advice. Additionally, it highlights a seamless pathway from acute services to community. It is noted that this strategy was launched in the middle of the timeframe for this review and therefore some of its ambitions were not a reality of the offer at that time. Certainly, the PLE identified that there was a need to strengthen hospital to community alcohol services. This theme will be captured as a key finding.
  7. With reference to Priority 3, it is relevant to consider the 2 residential detox periods that Hannah self-funded, and the review notes that these significant episodes of care would have also benefited from a seamless pathway in the same way as “acute to community”.
  8. In terms of Hannah’s contact with commissioned services, she had two specific periods of involvement with STAR- firstly in late 2019/ early 2020 and secondly shortly before her death in 2022. On the first occasion Hannah engaged well and there was a robust exploration of some of the difficulties Hannah was experiencing generally- for example, she shared that she felt isolated in the UK and that she was worrying about her physical health, her marriage and felt depressed and anxious. These occasions were via self-referral and there are multiple times in between where services encouraged and promoted the service to Hannah, but she could/did not facilitate this herself.
  9. We have found that there was a lack of recognition or exploration of self-neglect however considering the findings so far, we can put this into the context of the legal powers available.
  10. Hannah’s alcohol use could be described as chronic, the evidence for this is the level of harm caused from a physical/ medical perspective. Preston-Shoot & Ward describes a smaller subgroup of people who are particularly vulnerable and face significant safeguarding risks to themselves and others . This group are captured in the following way “without action, these people and those around them can experience serious dangers, including neglect, abuse and untimely deaths.”
  11. We know that Hannah comes under this category by virtue of this SAR and because she had an untimely death related to her alcohol use. We also know that irrespective of the event leading to her death, that she was chronically unwell and highly likely to die as a result of the harm already caused by alcohol. Therefore, the question is related to the “action” part of the above statement and how that could or should have been better facilitated by those services involved. It is helpful to consider the legal powers that may be applied.
  12. The review carefully considered the discussion of the PLE with recognition that certain legal frameworks such as how The Care Act (2014), The Mental Capacity Act (2005) and the Mental Health Act (2007) could be used to help people but there was uncertainty about how, and a general consensus that The Care Act should have been better used but that the other legal powers almost certainly couldn’t.
  13. As a point of clarification, none of the legal powers that could have been considered were ever applied successfully in Hannah’s case, therefore exploration of these powers is a reflective view of how they could have been considered. This theme will be captured as a key finding. Let us take each framework in turn and explore how Hannah’s circumstances apply to each:

### 

* **The Care Act** does apply to people with alcohol problems and in particular the inclusion of self-neglect as a form of neglect will encompass many in this group.
* **The Mental Capacity Act** can be used with people impaired by the effects of alcohol. There are challenges to applying this Act to chronic dependent drinkers because of a lack of specific guidance. However, the concept of executive capacity can be useful.
* **The Mental Health Act** should be used as a last resort. It specifically excludes people who are solely dependent on alcohol, but there are circumstances in which the Act may be used with people who have other mental or behavioural disorders arising from alcohol dependency.

### We have found that there was not enough weight given to considering Hannah’s situation from a safeguarding perspective and therefore the self-neglect procedure was not applied. The review has considered the reasons for this and did not find evidence of robust professional curiosity. Professional curiosity is a recurring theme in Safeguarding Adult Reviews (SARs), Local Child Safeguarding Practice Reviews (LCSPRs - children) and Domestic Homicide Reviews (DHRs) nationally. Broadly it describes the capacity and communication skills to explore and understand what is happening with an individual or family.

### Enhancing professional curiosity in practice encourages practitioners to challenge the assumption that people “choose” or “like” an abusive or self-neglecting lifestyle; and outlines alternative ways of thinking about these people and the reasons for the challenges they face.

* 1. Assessment under the Care Act may have yielded additional social care support or safeguarding action. It would be impossible in retrospect to guess at what a care package or action may have looked like for Hannah, but the response would be built on a multi-agency foundation with a view to support the longer-term management and support recovery.

### Dependent drinkers will frequently deny they have a problem and reject help, this was a pattern seen in Hannah’s case. However, if someone is self-neglecting, then consent is not required to raise an adult safeguarding concern. We know that on 2 occasions a safeguarding concern was raised, it was closed, and this was accepted and unchallenged by all agencies involved and therefore the legal powers and actions under The Care Act were never applied. A Care Act Assessment could and should have been facilitated and this may have been done in conjunction with a carers assessment for Mathew (which we will explore further on). This theme will be captured as a key finding.

### There is often a perception that a person cannot be vulnerable or self-neglect if they have capacity, for example they can choose their lifestyle and thus make a conscious choice to self- neglect. In the context of alcohol use, there is a lack of understanding of the relationship between alcohol misuse and self-neglect. Under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making ‘free’ choices that lead to self-neglect, it is still self-neglect and action is required.

### There was a particular confusion about application of the Mental Capacity Act in so much as when Hannah was abstinent/sober she did not appear to lack capacity or to have care and support needs because she was functional. Alcohol dependency is, by definition, a chronic relapsing condition and Hannah was at times abstinent. To rely on assessments taken only at those moments, rather than over the whole trajectory of their condition, is unlikely to help the person and may even perpetuate or worsen their problem. A long-term, evidence-based view is required in any assessment process.

### Assessing that someone has capacity does not automatically mean there is no longer a case for taking action to safeguard them, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what can be done to support them in caring for themselves.

### In respect of mental capacity, a study found that a lack of understanding by individuals and services was also a factor in people not getting the support they needed; eight of the reviews considered highlighted a lack of understanding of mental capacity among frontline practitioners. In all but three cases, the person’s capacity was not assessed despite indications that an assessment was needed. For example, in three cases where the person’s capacity was not assessed, practitioners were unsure whether the adult understood the consequences of their choices. The reviews also identified challenges in dealing with fluctuating capacity, where a person would have the ability to make decisions when lucid, but not when intoxicated. One review questioned whether a chronic alcohol user could be sober and pointed out that their ability to make decisions about alcohol intake was undermined by the addictive nature of the substance.

* 1. These issues were linked to the quality of guidance on the MCA available to practitioners. Specifically, t[he MCA code of practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf), the statutory guidance on applying the act, does not address alcohol use other than to point out that a temporary lack of capacity may be caused by the effects of alcohol. The study says *“the guidance suggests that if it is thought a person will be able to regain capacity at a later point, and if it is practical, then the assessor should wait to assess capacity, however, this is challenging if an individual continually moves in and out of capacity due to intoxication or spends the majority of their waking hours intoxicated with some moments of lucidity. It is this dynamic that limits the application of the Act to people with alcohol problems.”*
  2. The panel considered the issue of assumption of capacity. The first principle of the MCA is to assume the adult has capacity unless proven otherwise[[7]](#footnote-1). The correct application of the presumption of capacity in s.1(2) MCA[[8]](#endnote-7) is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm.
  3. With reference to principle 3 of the MCA, the Code of Practice[[9]](#endnote-8) highlights *“the difference between unwise decisions, which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up information about a decision, particularly if someone makes decisions that put them at risk or result in harm to them or someone else”.* It is likely that different factors including Hannah’s age, background, and general presentation during periods of abstinence led people to assume mental capacity rather than to consider assessing it.
  4. The current Mental Capacity Act Code of Practice highlights that it is important not to judge mental capacity based solely on behaviour, appearance or “assumptions about [someone’s] condition” (Department for Constitutional Affairs, 2007). However, neither should it be assumed that they have capacity because of “good social or language skills, polite behaviour or good manners.” Hannah was an articulate, intelligent, and likeable person who often appeared to have very good insight into her own behaviour and the consequences of it. The PLE demonstrated a clear assumption that Hannah was not lacking in capacity however perhaps assumptions should not be made from face value conversations and could have been better explored in a multi-agency way with full view of the situation.
  5. It is also important to explore both decisional and executive capacity in the context of Hannah’s case. Alcohol Change UK (2019) consider this and clarify that “decisional capacity, covered by the Mental Capacity Act, is where a person can show that they can understand, retain, use, and weigh up the information needed to make a decision. In contrast, executive capacity is the ability for a person to actually carry out that decision. Both of these can be impaired by alcohol misuse. Executive capacity can be impaired, such that someone can be in no fit state to make it to an appointment that they had previously decided to attend. A person’s decisional capacity may be impaired due to them understanding, but not being able to use, the information to make a decision.” This is a particularly relevant and helpful consideration when applying self-neglect processes, thus a person would be assessed to articulate their decision and demonstrate how they would carry it out.
  6. In particular the review considers that it could and should have been a line of enquiry after the occasion when Hannah had fallen down the stairs in July 2021. We know that Hannah was abstinent at this time and that she remained so until approximately February 2022. From thereon she began drinking again and this pattern escalated significantly until her death. For clarity, this incident resulted in a period of time in the Intensive Care Unit and resulted in a seizure. Further to this, exploration with Matthew would also have yielded important information that he was concerned about her “cognitive functioning,” and this gives extra weight to the relevance of the Mental Capacity Act.
  7. The observations of the Early Help team in February 2022 support Matthew’s views and they describe Hannah as “ambivalent” about engaging with services relating to her own health. This supports the picture of significant deterioration of self-neglect from late 2021 to early 2022. Additionally, the Early Help team had considered that Hannah may have lacked executive capacity and had helped to facilitate a GP appointment and made the decision to make a safeguarding adult referral, albeit this was shortly before her death.
  8. It is very difficult to conclude in retrospect what the outcome of a Mental Capacity Act assessment may have been in Hannah’s case given the changing nature of her pattern with alcohol at different times. However, there is no evidence within the agency records or discussions that it had ever been considered. It is perhaps more realistic to conclude that agencies were aware of indicators of concern that could have prompted more professional curiosity to think about capacity.
  9. Moving on to the Mental Health Act, there is a common perception that alcohol dependency is not covered by the Act however it does not allow detention “solely” on the grounds of alcohol dependency. However, action is possible for people with mental disorders which arise from psychoactive substances. If someone has a disorder of the mind related to alcohol use, for example alcohol-related brain damage, acute confusion, severe depression, and even psychosis, then it is absolutely possible to build a case for action under the Act. It will generally require considerable multi-agency discussion to demonstrate the need for this route. The review finds that it is unlikely that the Mental Health Act could or should have been applied in Hannah’s case.

**Multi agency approaches**

* 1. It is unclear even with the benefit of the review process, how Hannah’s health needs were being coordinated or addressed due to the sporadic nature of her issues and her inconsistent engagement with many specialties and professionals. However, it can be observed that more professional curiosity could have led to a more coherent approach. This meant that on the occasions where she was in hospital, the GP was not always consulted in real time in their capacity as her primary health care provider and thus a rich knowledge of her alcohol dependency patterns, private provision of care and patterns of non-engagement was not always fully understood. The discharges from hospital may have provided an opportunity for a multi-agency discharge meeting, particularly after her fall downstairs when she was actually abstinent- this may have offered a good opportunity to get services together with Hannah at the centre. This will be captured as a key finding.
  2. The periods of time from admission to hospital to discharge have been highlighted as opportunities to facilitate a multiagency meeting under the self-neglect procedures to consider what support could be provided. The review finds that there were three elements that may have strengthened these episodes, these could also have been applied in the community.
  3. The periods of time from admission to hospital to discharge have been highlighted as opportunities to facilitate a multiagency meeting under the self-neglect procedures to consider what support could be provided. The review finds that there were three elements that may have strengthened these episodes, these 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.
  1. Family members did describe the challenges from hospital to home, they felt she had received robust medical treatment in hospital but then returned home unsupported and reliant on self-referral and willpower. This was the source of great anxiety and frustration as they did not know how to support Hannah.
  2. This raises the several questions of ownership, for example who is the lead agency or professional? Who is the point of contact for the family? Who is coordinating the healthcare requirements? The GP has an obvious central role to play, and the Practice contributed significantly to the review and described a sense of challenge in understanding their role in coordinating the safeguarding aspects of this case. Gallagher (2019) highlights that there is little provision of training to GPs on alcohol management, despite it being the most prolific alcohol dependency that GPs will interact with.
  3. The GPs within the practice also highlighted the challenge of balancing information from private providers, coordinating NHS providers information and trying to persuade Hannah to engage with the speciality leads who she was under. They also recognised her underlying mental health issues (depression and anxiety) and signposted to relevant services, but Hannah did not consistently access services.
  4. In terms of a coordinating or lead agency role, this does not need to be prescriptive and could have been established within a robust multi agency meeting. Generally, a lead professional role would be someone who is integral to the majority of the care provision and less often a speciality clinical team. In Hannah’s case that could have been the GP or, at times of engagement CGL STAR. To note, CGL STAR would only have been the lead agency if Hannah has been in structured treatment. Additionally had Hannah been in receipt of adult social care or mental health services this could also have been a social worker, nurse, or support worker. Explored within the PLE was the restraints that many services, particularly GPs have in terms of time and capacity.
  5. Alongside the self-neglect procedures there are also several other local processes that could have been utilised or considered (acknowledging that thresholds for services apply) including:
* Co-existing conditions steering group
* Multiagency Risk Management Protocol (MARM)
* The Multiple Complex needs community link workers.
* SWIFT service
  1. Each of these services have a different focus and criteria. In terms of practical application, it was clear from the PLE that there was a lack of awareness or confusion about what these services and processes are and when they should be used. This is not a criticism of the services, simply an observation that if the frontline workforce do not know or understand them, then they cannot be used to their full effect.
  2. As a point of clarity, the panel, the PLE and the independent reviewer all unequivocally agree that the MARM protocol could not have been applied in this case as criteria would not have been met. It is interesting to note that the safeguarding procedures including self-neglect are pan-Sussex (East Sussex and West Sussex) however the MARM protocols differ in these areas in terms of criteria. It is noted that the MARM protocol in East Sussex is under review in 2023/2024.
  3. Each individual component within the wider multi agency team has their own service specification and responsibilities, however there is always strength in coming together for the benefit of the service user. This would have formed part of following the self-neglect procedure or even as a standalone discharge planning meeting in the first instance. This opportunity allows for any difficulties or challenges in care delivery to be understood and a joint solution reached with the person at the centre. Discharge from hospital on a few occasions offered a captive opportunity.
  4. Already discussed is the limited amount of professional curiosity, as episodes of care and conversations with Hannah were viewed through a very narrow lens, relied heavily on self-report, and did not explore the full, realistic, and unfolding picture.
  5. There is little evidence of risk assessment and on the basis of this it can be observed at times, there may not have been assurance that agencies were able to recognise and understand the risks related to self-neglect, the legislative frameworks available to use including a duty to report concerns to the local authority under the provisions of the Care Act 2014.
  6. There were local self-neglect policies and procedures available at that time, but they were not effectively applied in Hannah’s case, this could be because professionals were not aware of them, or they did not recognise that they needed to use them. That meant that self-neglect was not referred as a safeguarding concern (out of the two referrals that were made in Hannah’s life, only one mentioned self-neglect and that was not the primary reason for referral).
  7. Therefore, there was escalating risk without risk-aware responses from agencies. Examples include the risk implications of not attending health appointments, escalating frequency of hospital admission, deterioration in physical and (reported) mental health, and continuing alcohol use.

### Consideration of carers and whole family approaches.

### It is helpful to consider what a carers assessment is. The Care Act 2014 (section 9 and 10)[[10]](#endnote-9) uses the term 'assessment’ to refer to either a Care Act assessment of an individual's needs for care and support (in this case Hannah) and/or a carer's needs for support and determination of eligibility (in this case Matthew). In this case there is the added perspective that Children’s Social Care were also involved as there were two children in the household. In consideration of Hannah and Matthew, it may have been good practice to carry out a Care Act assessment and a carers assessment simultaneously. This theme will be captured as a key finding.

## In terms of the ‘carers assessment; when a carer is found to have support needs following assessment under section 10 of The Care Act 2014, the local authority must determine whether those needs are at a level sufficient to meet the “eligibility criteria” under section 13 of the Act. It is noted that Mathew had not asked for help and was, understandingly preoccupied with ensuring that help was directed toward their children as he wanted their lives to be as “normal” as possible. However, he possibly underestimated the impact that the situation was having on him, or that he needed support in his own right. It is difficult to conclude without hindsight bias whether he would have been assessed to have eligible needs however the PLE felt it likely that he would.

### Considering the matter through the lens of the whole family, they found it difficult to support Hannah at home. When considering the brief chronology above, there are many different clinical specialities in place, multiple appointments, not to mention the multiple occasions when Hannah was encouraged to “self-refer” to CGL STAR but did not, the private provider and the needs of the children. Mathew was also working and helping to care for his mother who had dementia, and he did not know where to turn or what to do to change the situation. Professionals at the PLE acknowledged that the health and social care system is not easy to understand and thus the expectation of a relative to know how to navigate through the system was unrealistic and unfair.

### It was noted in the hospital records in October 2021 that a friend had asked questions about the discharge to ensure that support would be in place and said that Matthew was “on the edge”. Towards the latter stage of the timeframe of the review, Matthew was asked if he needed support on a few occasions however there is no evidence that this translated into a formal consideration of carers assessment. This suggests that there was a lack of insight and understanding of the term “carer,” the impact that the situation was having on the “whole” household, or of the steps and processes to ensure that appropriate assessments were undertaken.

### There is a service in East Sussex tailored to work with whole families that is helpful to consider, the Safeguarding with Intensive Family Treatment (SWIFT)[[11]](#endnote-10). This service employs a specialist substance misuse team that can provide a dual response to safeguarding concerns and parental alcohol or drug treatment needs. It is a jointly commissioned, multi-disciplinary provider of specialist assessment and intervention.

### The SWIFT service can be accessed only when there is existing children’s services involvement (which there was in Hannah’s case from February 2022). Ordinarily the service works well when concerns reach the “child protection” threshold and was unlikely to have been considered in this case due to the presence of a protective parent (Matthew). However, it is an excellent example of a “whole family” approach and thus children’s services are developing a new way of working under a Family Safeguarding model that reflects the principles of the service in its more generic offer. Children’s services have and are continuing to recruit specialist adult practitioners to work alongside the children’s teams to address parental issues such as mental health, substance and alcohol abuse and domestic violence.

### The review has already found that there was an absence of safeguarding activity in terms of applying the legal frameworks, there was also insufficient professional curiosity and a lack of multi-agency working. A carers assessment had not been facilitated but we can see that the impact on the children had been considered several times leading to the offer of targeted Early Help from February 2022. We also know that the children were offered a school place during COVID-19 due to their vulnerability at home and this was instigated largely by the temerity of Matthew and the discretion of the Head Teacher. To note, Hannah was extremely upset that personal details of her alcohol dependency has been shared with school at this time.

### As part of the Children’s Services Early Help assessment, the issues that had been raised during a hospital admission about Mathew being verbally abusive were explored and considered in the context of domestic abuse, the assessment did not yield any evidence of this however did identify that there was parental conflict. Parental conflict was recognised by both Hannah and Matthew and in the best interests of the children, they did commence some work with the Early Help team. There was an opportunity as part of this assessment to further consider the role of adult social care and to facilitate a referral for assessment.

### The Reducing Parental Conflict Programme (RPCP)[[12]](#endnote-11) outlines that some level of arguing and conflict between parents is often a normal part of everyday life. However, there is strong evidence to show how inter-parental conflict that is frequent, intense, and poorly resolved can have a significant negative impact on children’s mental health and long-term life chances. The programme therefore aims to work with parents to reduce conflict.

### It is essential to make the clear distinction between Domestic Abuse and parental conflict. Thus, practitioners should continue to be vigilant and confident there are no indicators of domestic abuse, including fear, imbalance of power and controlling behaviour. If there are signs of controlling behaviour that adversely affects one person in a relationship, this can be an indicator of an abusive relationship. In this case local policies and procedures would be followed to manage any potential risk of harm.

### The review found that there was often uncertainly about application of thresholds and perceptions from front line staff about the point that issues would meet criteria for certain services. This point was raised several times at the PLE with Early help services saying that they were about to make an adult safeguarding referral on behalf of Hannah as they thought it had at that point reached a threshold for a safeguarding enquiry. The review finds overall that there were many opportunities much earlier on where this could and should have been facilitated.

### The services of Early help were well received and spoken very highly of by the family members in terms of the level of support they provided. However, triangulated with appropriate carers support and correctly applied safeguarding for Hannah, a whole family approach may have strengthened the family offer significantly and without the whole view, they were a sticking plaster holding together only one aspect of the family. It should be noted that Early Help were involved for a relatively short period of time, and the assessments and interventions that had commenced may have naturally led to consideration of carers assessment.

### There was opportunity to approach the situation from a whole family perspective, children’s services, care act assessment and carers assessment which may have facilitated a deeper understanding from all angles with a more coordinated approach and joint risk formulation.

### Understanding the person

### It was difficult to capture a sense of Hannah’s voice from the agencies who had contact with her and thus in order to understand her daily experiences and get a sense of her perspective, the review has drawn on conversations with family and friends, exploration of practitioner views and some of the significant factors that may have strongly contributed to her alcohol dependency.

### 10.76 Services that Hannah needed to address her alcohol use were offered to her on a self-referral basis at times when she could or would not access them. It can be evidenced that the GP made multiple and persistent efforts to stay in contact with Hannah and to encourage her to access services, on these occasions Hannah often expressed a preference to access private services rather than the referral pathways available. On many occasions Hannah did not access or engage with services which was her choice, but at what point does that become self-neglect? Unequivocally services and family articulate that Hannah’s refusal and reluctance to access or accept services was an ongoing issue, with the exception of those services that she chose herself (private services). There is an absence of professional curiosity and application of legal powers and local processes that we have explored above.

### The two episodes of residential detox were significant because Hannah chose to engage on these occasions thus demonstrating her want, need and commitment to become abstinent. It is noted that there was also a high level of encouragement from family. These episodes were both 28 days in length of stay and the provider identified that this may have been difficult for Hannah because of the length of time she was away from her children. The care provided on these occasions was twofold, firstly the medically monitored assisted withdrawal and secondly a period of therapeutic treatment and Hannah is noted to have been very engaged in both of these processes. The period of time that followed these stays must have been highly distressing to Hannah as she was unable to remain abstinent once she returned home.

### For clarity, for admission to the alcohol treatment centres a GP summary is required which was received on both occasions. On discharge Hannah was signposted to AA and CGL STAR and a discharge summary provided for the GP. There is no formal agreement or arrangement between UKAT centres and CGL in the geographical footprint and this likely to be the case for other private providers of alcohol treatment and recovery. UKAT as the private provider in this case reflected and considered there to be great value in fostering better relationships and connectivity with the CGL offer, particularly at a highly opportunistic and crucial time when a person is discharged from their service. This point was raised in section 11.1 and will form part of the findings.

### Hannah’s friend referred to the issues considered in this review as a “destructive journey.” It can be seen that there are 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.

### Considering these factors may provide some insight into Hannah’s experiences, perspectives, and turmoil:

* Previous physically abusive relationship, disclosed to Matthew and within private therapy
* Her preoccupation with politics and the election of Donald Trump had a significant effect on her mental health, this was a significant concern expressed by Matthew
* Loss of parents (2008 & 2011)
* Becoming a parent (2012)
* Losing her job (2012)
* Moving to the UK (2015)
* Marriage difficulties
* Menopause
* Depression and anxiety
* COVID-19
* Multiple chronic health problems

### Trauma is defined as “an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being”[[13]](#endnote-12).

### With reference to addiction, Mate (2021) “Trauma is not what happens to us but what happens inside of us as a result of what happens to us, and that trauma is manifested in a disconnection from self, all of which represent as a disconnection from yourself. Addiction is a response to trauma, and it is an attempt to solve a life problem.” This explanation resonates with Hannah’s circumstances.

### Hannah’s friend said that there was a “WhatsApp” group of family and friend who maintained contact to try and support Hannah to stop drinking, they tried different approaches and strategies. Unfortunately, their frustration was often with the lack of services and/or Hannah’s poor engagement with them. Again, to reiterate a point made above, it should not be for loved ones to have to navigate a complicated system of processes and services and they simply did not know which way to turn. This does however demonstrate how highly thought of and loved Hannah was.

### Family and friends mentioned frequently that she had lost a part of herself, and although they were not able to pinpoint the specific reason for that, that did articulate multiple issues that may be described as “loss.” In particular, bereavement appeared to be a significant factor with reference to the loss of her mother.

### The limited amount of professional curiosity and joint response meant that the opportunity to understand the root cause of the alcohol dependency was lost. To avoid hindsight bias, it would be conjecture to reach a conclusion but we do know that there were multiple factors that may have elicited a trauma response and contributed to the extent of alcohol use. It is important to consider these factors to understand the difficult journey that Hannah experienced.

### We know that Hannah was often resistant or reluctant to input from agencies and her family and friends all expressed that she felt a sense of shame and stigma however there was opportunity to explore more of the background issues. It can be seen that CGL STAR has started to uncover some of those deep-rooted issues in 2019.

### It is helpful to try to view the scenario through Hannah’s own eyes, how fearful, ashamed, and desperate she must have felt. Hannah was an intelligent and articulate person and the severe impact that alcohol use had on her physical health will have been clearly understood at different times. On one occasion in hospital when “ceilings of care” were discussed, she expressed clearly that she wanted to be alive and to be part of her children’s future. This prompts one to think about how different conversations, better professional curiosity and a strengthened multi-agency response may have made a difference. This is supported by Braye, Orr and Preston-Shoot (2014) who state that “at the heart of self-neglect practice is a complex balance of knowing, being and doing”[[14]](#endnote-13), they go on to define this as:

* **Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.
* **Being**, in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company.
* **Doing**, in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for bigger things, and deciding with others when the risks are so great that some intervention must take place.

### Consideration has been given to the impact of the Covid-19 pandemic in terms of delivery of care. This is because the care delivery models of crucial teams changed during this time thus impacting on how people received care.

### Sinclair (2020), from the Royal College of Psychiatrists describes COVID-19 as an “addiction crisis” and describes how the pandemic changed and escalated drinking behaviours in the UK. She starts by saying that “Addiction is a complex and life-threatening health condition, one that effects both physical and mental health” and highlights the merits of teams of staff consisting of “addiction psychiatrists” to bridge the gap between physical and mental health.

### Sinclair also observed that nine months of drinking in 2020 was enough to “push many people over the edge”. She makes several key points:

* Survey data demonstrates that people were drinking at significantly higher levels at the latter stage of 2021 than they were in 2019.
* Social isolation is a fertile place for addiction to prevail.
* There is a barrier in how mental health services can support people with addictions.

### The review heard from family members how Hannah’s drinking significantly escalated during the COVID-19 period however in terms of timeline it is important to note the dangerous levels that she was drinking before this. She did indeed reach out to her family abroad at the very beginning of the national lockdown and after a failed detox returned home where she was not seen by services for a period of time from April 2020 to October 2020. This is not because services failed to see Hannah, more that she had not “opted in” to be in receipt of services during this time period.

### The Royal College of Psychiatrists considered how the pandemic affected their ability to provide face to face interactions. It should be noted that Hannah was not under any mental health services and thus was not affected by this. However, the College predicted a tsunami of mental health problems caused by the impact of COVID-19 which is borne out in subsequent data with a significant increase in presentations of “mental distress” and increased anxiety.

### Therefore, the review has not necessarily found that the offer of services for Hannah differed in the period of time but observes that the pandemic measures themselves significantly contributed to Hannah’s decline.

### Therefore, whilst recognising that there was certainly a detrimental consequence of the lockdown measures in respect of increasing alcohol levels, there is no direct evidence that Covid-19 was a causal or contributory factor to the way services worked together in this case.

### The series of events, the failed detox’s and the continued drinking paints a picture of a desperately unhappy person who felt out of control of her life as a person in her own right, and as a wife and mother, and despite attempts to be abstinent she simply could not successfully stop drinking.

### Overall, there was an absence of Hannah’s voice in part due to the lack of safeguarding activity. The panel and practitioners agree that there was sufficient cause for the self-neglect procedures to have been followed, a safeguarding enquiry was indicated and a coordinated plan that kept Hannah at the centre of it. This theme will be captured as a key finding.

## Key Findings

|  |  |
| --- | --- |
| **Key Finding:** | **Key points:** |
| 1. **Recognition** | There was insufficient recognition of Hannah’s presentation as a safeguarding concern resulting in a lack of action.  There was limited awareness of self-neglect compounded by poor awareness of the East Sussex self-neglect procedure. Panel members observe that the multi-agency neglect training does not specifically focus on alcohol use as a form of self-neglect.  There was an absence of robust safeguarding referrals and although contact was attempted, it was not proactively followed up. Communication of referrals and their outcome did not effectively take place. |
| 1. **Multi-agency coordination** | There were multiple practice episodes between 2019 to 2022 that could have prompted multi agency coordination. In particular these opportunities presented themselves throughout 2021 and could have facilitated self-neglect meetings, the identification of a lead professional and collective consideration of risk, capacity, and safeguarding concerns.  The Panel and PLE shared details of various multiagency meetings, forums, posts, and steering groups in East Sussex designed to address different aspects of “complex” safeguarding but there was an absence of awareness of them, and they were not utilised in Hannah’s case.  A multi-agency approach, including strong connectivity between children’s and adults social care teams would have provided the platform for Hannah’s voice to be clearly heard and the 6 principles of adult safeguarding to be enacted. |
| 1. **Professional Curiosity** | Professional curiosity is the capacity and communication skill to explore and understand what is happening within a person’s situation rather than making assumptions or accepting things at face value.  Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns, and make connections to enable a greater understanding of a person’s situation[[15]](#endnote-14).  This review found that there was limited professional curiosity that resulted in inaction rather than action. |
| 1. **Legal Literacy** | This finding relates to key findings 2 & 3, there was an absence of collective risk assessment and in turn a lack of consideration of when to apply the different legal frameworks- in this case The Care Act and Mental Capacity Act.  In terms of application of the Care Act and the Mental Capacity Act, the author recognises the mandatory learning, training and resources that have been put into practice but notes that further work may be needed to be assured that the collective workforce is consistently competent, particularly when applying them to alcohol related self-neglect. |
| 1. **Carers assessment** | This case highlighted a complex situation of a family unit who needed different services and support in a more coordinated way. It is noted that “carers assessments” under Section 10 of the Care Act 2014 was not considered or instigated completed in respect of Matthew. This could have been facilitated on different occasions by any of the agencies involved.  Furthermore, it would be good practice to consider a way of aligning the Care Act assessments and outcomes, with the children’s services offer as a whole family approach |
| 1. **Commissioning of alcohol pathways** | The way services are commissioned is comprehensively covered in the East Sussex Alcohol Harm reduction strategy 2021/2026, however the review found that there was an absence of a bridge between acute and community services at the key points of discharge. This finding may also be applied to discharge from private providers of care. This may have offered a timely opportunity to engage meaningfully with Hannah without relying on self-referral once she was at home. |
| 1. **Person Centred Care** | The review finds that safeguarding processes were never effectively applied to Hannah, this includes The Care Act, the Mental Capacity Act and the local processes that have been developed including the self-neglect procedure. Therefore, Hannah did not remain central to planning and her voice and lived experience was not consistently considered. |

## Improvements made:

### The panel discussions and PLE demonstrated areas of improvement where learning has already been taken forward and implemented. These developments are all relevant and ongoing assurance of effectiveness should be sought on a continual basic.

### Progress to note is as follows:

* Implementation of the East Sussex Alcohol Harm reduction strategy 2021/2026
* Implementation of the Alcohol Harm Reduction Strategy include 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 [STAR Drug and Alcohol Service](https://www.changegrowlive.org/star-drug-alcohol-service-east-sussex/drugs) and others, including [One You East Sussex](https://oneyoueastsussex.org.uk/services/drink-less/) (OYES) and recovery support providers, to ensure continued alcohol treatment and recovery, where necessary, following discharge from hospital
* CGL 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.
* A new service to provide alcohol brief intervention and advice to those over 50 will begin delivery in May.
* Commissioning and delivery of a training session via the ICB; Alcohol Concern’s Blue Light project; “Working with Change Resistant Drinkers.”
* Development of the co-existing Conditions Steering Group
* Implementation of the pan- Sussex Self Neglect procedure
* A Pan-Sussex Thematic Review around working with people who self-neglect is scheduled in 2023 to consider the learning from SARs and a wide focus on the complexity of the self-neglect process within Sussex, considering practical change in relation to support for cases who self-neglect.
* A review of the Multi Agency Risk Management protocol (MARM) in East Sussex will be carried out in 2023/24.
* Commissioning and implementation of the multiple complex needs workers
* Development of the SWIFT service, and subsequently the Family Safeguarding model.
* West Sussex SAB is considering the application of learning events to assist children’s services to better understand adult safeguarding principles, processes, and lawful differences.
* Roll out of Self- Neglect workshops for Primary care in 2023.
* Circulation of a learning briefing entitled the ‘*Importance of Multi-Agency Meetings Learning Briefing.’* This was developed in response to a recent SAR, and it outlines the different type of multi-agency meetings in East Sussex and the importance of Making Safeguarding personal[[16]](#endnote-15).
* As a result of learning from SARs, there has been a focus on professional curiosity on the joint intranet of Surrey and Sussex Police Force. This includes “*recognising/ acting on self-neglect”* and a 6-minute podcast entitled “*exercising your professional curiosity*”.

## Summary

### Alcohol use almost always occurs in the context of other factors. It is rarely the case that alcohol is the sole, or even the defining factor in cases such as Hannah’s. It usually emerges as part of a complicated set of causal factors, but a factor that exacerbates every other factor e.g., depression, anxiety, ill health. Often frontline workers are so busy addressing the crises as they occur that they are unable to consistently work on the underlying alcohol use, despite the fact that improving the alcohol issue is likely to reduce the full range of problems. This was found to be the case in Hannah’s situation.

### There were multiple opportunities throughout the timeline that the provisions of The Care Act could and should have been used to consider self-neglect, and towards the latter stage of the timeline the Mental Capacity Act could have been considered.

### There was an absence of multi-agency working and with better professional curiosity, services could have applied a whole family approach to consider Hannah’s needs and the impact on the family to better equip them to support her.

### In view of the above findings, Hannah’s voice, views and lived experience was difficult to find.

## Conclusion

### This SAR Overview Report is the East Sussex Safeguarding Adults Board’s response to the death of Hannah to share learning that will improve the way agencies work individually and together.

### Without hindsight bias it is difficult to conclude whether interventions may have resulted in a different outcome for Hannah. However, the life she lived for the last 4 years of her life leading to her death may have been avoided and is a tragedy to her family. Her vulnerability stemmed from a range of issues which cannot be definitively concluded on but were never fully explored.

### The review has found gaps in knowledge related to self-neglect where alcohol is a feature. It is important that assurance and oversight of this is robust to evidence effectiveness of future care delivery.

### Hannah’s alcohol use and behaviour was consistently viewed as a personal choice and there was insufficient attention given to self-neglect. There was a lack of multi-agency working despite the various forums and pathways in East Sussex. The review finds that there is insufficient understanding in the workforce about these tools and how to apply them.

### Without a thorough understanding of how to work with this client group, professionals will not be able to respond effectively to their needs and protect them from harm. This review also reaffirms that much work remains to be done to improve adult safeguarding in this area. At the most general level, non-alcohol specialist workers need to better understand and respond to alcohol misuse and know how to work with people with alcohol problems who are not in contact with services. It is noted that this is an integral part of the East Sussex Alcohol Strategy.

### There is also a specific gap in frontline workers’ knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to this group, this is not unique to East Sussex.

### Hannah may have experienced an improved approach if the following areas had been strengthened.

* Recognition of self-neglect and application of legal frameworks.
* Listening and hearing her voice and daily lived experience.
* A strong multi-disciplinary approach with Hannah at the centre, and an identified lead professional.
* Considering the support of her family as a strength and supporting them in a “whole family” way.
* Confidence in the skills, knowledge, and experience of the workforce to consider Hannah’s circumstances.

### The review has considered the degree to which this case highlights systemic issues in how the multi-disciplinary team approach complex areas of safeguarding and the need to align pathways and processes and promote awareness of them across the workforce. The review recognised the collective strength of the East Sussex Alcohol Reduction Strategy but notes the wider challenges regarding system working and the knowledge and experience of staff responsible for meeting people’s needs.

### The case also raises the question of who we mean when we refer to a “multi-agency” team, and the challenge of coordinating such a response especially when the Local Authority are not (yet) involved remains an issue in terms of expertise and capacity.

### It is hopeful that the outcomes from this review will recognise thematic areas of learning from previous reviews. The findings and recommendations should be monitored for compliance, implementation, and assurance by the East Sussex SAB.

## Recommendations

### It is noted that progress has been made in East Sussex against the areas of findings. However, the recommendations made in this review should be applied as learning for the system where deeper and continual assurance is required and an action plan developed against them.

### Arising from the analysis in this review the following recommendations are made to the East Sussex Safeguarding Adult Board.

|  |  |
| --- | --- |
| 1. **East Sussex Alcohol Harm Reduction Strategy** | The East Sussex Safeguarding Adult Board are asked to seek assurance of the progress of its implementation with particular reference to Priority 3 (Making effective treatment and recovery accessible for all who need it).  * Additionally with reference to Priority 3, to ask for clarity about how delivery models align and connect with private providers of substance and alcohol misuse in the geographical footprint. |
| 1. **Multi-agency working** | * The East Sussex Safeguarding Adult Board are asked to review the effectiveness of the approaches and guidance available relating to multi-agency working within the workforce: * Assurance of its effectiveness * Alignment of the various pathways, groups, procedures, and protocols * Evidence of impact across the partnership * Oversight in managerial and professional supervision * Coordination and decision making |
| 1. **Workforce Knowledge and Skills** | * The East Sussex Safeguarding Adult Board are asked to seek 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 (linked to Priority 3 of the Alcohol Harm Reduction Strategy).   With reference to the specific findings of this review this should include:   * Relevant training for all staff who work with chronic, highly vulnerable, dependent drinkers (whether in a specialist or generic setting) on the use of legal frameworks with this group of people. * When staff should escalate to someone who has expert knowledge and understanding of this area. * Ongoing assurance should be sought to ensure that good quality training happens regularly and is included in the professional development programmes of all relevant agencies. This is in accordance with the general guidelines in NICE Guidance[[17]](#endnote-16) |
| 1. **Mental Capacity Act** | It is r   * It is recommended that the East Sussex Safeguarding Adult Board review its Mental Capacity Multi Agency Policy and Procedures (2019)[[18]](#endnote-17) and consider formalising its current tools into a multi-agency MCA competency framework approach. This will facilitate standardised practice and training and allow different professionals working at different levels in agencies to consistently apply the statutory requirements of the MCA in practice. In addition: * It should address and include the issue of executive capacity. * Its effectiveness should be regularly reviewed to provide an oversight of whether practice is working. |
| 1. **Making Safeguarding Personal** | * The East Sussex Safeguarding Adult Board are asked to seek reassurance that Making Safeguarding Personal is accurately understood, and that understanding is embedded in practice across partner agencies[[19]](#endnote-18).   Additionally, the Board should continue to promote professional curiosity in practice and:   * Consider its effectiveness measures to continually seek assurance that professionals are routinely applying professional curiosity in their practice and that this is proactively informing decision making. * Strengthen single and multi-agency supervision models and reflective practice opportunities. * Promote exploration of life experiences that are contributory to alcohol misuse and self-neglect, and thus apply trauma-informed approaches by practitioners. |
| 1. **Carers assessments** | * The East Sussex Safeguarding Adult Board should 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. The process for carers assessment should include a clear timescale for completion and a method of feedback to the wider agencies.   When there are whole family factors, this should be aligned with the wider “family” approach. |

1. [Sussex SAR Protocol - East Sussex SAB](https://www.eastsussexsab.org.uk/documents/sussex-sar-protocol/) [↑](#endnote-ref-1)
2. Hannah is a name chosen by the SAR panel and the family to maintain anonymity. [↑](#endnote-ref-2)
3. [Sussex Adult Death Protocol - ESSCP](https://www.esscp.org.uk/sussex-adult-death-protocol/) [↑](#endnote-ref-3)
4. Matthew is a name chosen by the SAR panel and the family to maintain anonymity. [↑](#endnote-ref-4)
5. Luca and Theo are names chosen by the SAR panel and the family to maintain anonymity. [↑](#endnote-ref-5)
6. Department of Health and Social Care (2020) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office (section 14.165) [↑](#endnote-ref-6)
7. [Mental Capacity Act 2005 at a glance | SCIE](https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance) [↑](#footnote-ref-1)
8. MCA (2005) [↑](#endnote-ref-7)
9. [Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf) [↑](#endnote-ref-8)
10. The Care Act (2014) sections 9 &10 [↑](#endnote-ref-9)
11. [SWIFT (nuffieldfjo.org.uk)](https://www.nuffieldfjo.org.uk/wp-content/uploads/2021/05/SWIFT_-A-multidisciplinary-approach-to-pre-proceedings-work.pdf) [↑](#endnote-ref-10)
12. [Reducing Parental Conflict: what is parental conflict? - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/reducing-parental-conflict-what-is-parental-conflict) [↑](#endnote-ref-11)
13. [Working definition of trauma-informed practice - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice#trauma) [↑](#endnote-ref-12)
14. Braye, Orr and Preston-Shoot (2014), Self Neglect Policy and Practice: Key Research Messages [↑](#endnote-ref-13)
15. [Professional curiosity in safeguarding adults: Strategic Briefing (2020) (researchinpractice.org.uk)](https://www.researchinpractice.org.uk/adults/publications/2020/december/professional-curiosity-in-safeguarding-adults-strategic-briefing-2020/) [↑](#endnote-ref-14)
16. [The Importance of Multi-Agency Meetings Learning Briefing - East Sussex SAB](https://www.eastsussexsab.org.uk/documents/the-importance-of-multi-agency-meetings-learning-briefing-2/) [↑](#endnote-ref-15)
17. [Recommendations | Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE](https://www.nice.org.uk/guidance/cg115/chapter/Recommendations) [↑](#endnote-ref-16)
18. [East Sussex Mental Capacity Multi-Agency Policy and Procedures (eastsussexsab.org.uk)](https://www.eastsussexsab.org.uk/wp-content/uploads/2020/07/East-Sussex-Mental-Capacity-Multi-Agency-Policy-and.pdf) [↑](#endnote-ref-17)
19. [https://www.eastsussexsab.org.uk/wp-content/uploads/2020/10/SAB-MSP-Guidance-V1-final-Accessible PDF.pdf](https://www.eastsussexsab.org.uk/wp-content/uploads/2020/10/SAB-MSP-Guidance-V1-final-Accessible%20PDF.pdf) [↑](#endnote-ref-18)