East Sussex Safeguarding Adults Board (ESSAB)

Response to the Safeguarding Adult Review regarding Donna

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

Tragically, in July 2021, Donna who was a 42-year-old white British woman and alcohol dependent, died unexpectedly shortly before her 43rd birthday. Her medical cause of death was “sudden unexplained death in alcohol misuse.”

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

Donna’s sight diminished suddenly in September 2020 possibly due to alcohol misuse and nerve damage and her condition continued to deteriorate in the period leading up to her death. Donna was known to several agencies, and agencies experienced difficulties engaging with her. There were concerns regarding the neglect of her home environment as well as the risks that excessive drinking was having on her health.

Some family members were invited to take part in the SAR and declined. However, there is a family statement which has been published on behalf of Donna’s brother. The review explored areas of learning specific to Donna’s case including:

* Was alcohol misuse recognised by agencies as self-neglect?
* Were opportunities missed to start safeguarding procedures re: self-neglect?
* Was there recognition of the need to consider undertaking a formal mental capacity assessment and consideration of advocacy for Donna.
* How was information shared and risk assessed between agencies: a multi-agency response / use of meetings.
* Highlighting good practice where agencies escalated concerns appropriately and the role the STAR drug and alcohol service volunteer played in terms of her persistent and positive support.
* What was the interface between health and alcohol related needs?

The following information represents our formal response to the key findings, and learning identified in the SAR.

**There was no co-ordinated multi-agency response to Donna’s needs.**

## Whilst there were some examples of multi-agency working and sharing of information, there was no multi-agency meeting to discuss Donna and there was no coordinated multi-agency approach which recognised the full complexity of and interrelationship between Donna’s needs, circumstances, and risks. As a result, there was a no coordinated response.

## Board Response

We will seek assurance from partner agencies that practitioners are aware of and are following the ESSAB Multi-Agency Risk Management Protocol (MARM) which was published after Donna’s death.

An evaluation of the MARM will take place in 2023/2024 and will include the consideration of the threshold of cases for individuals who have multiple and complex needs.

The importance of effective collaboration between agencies has been highlighted in [Analysis of Safeguarding Adults Reviews](https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards/practitioners) in relation to cases involving self-neglect.

[The Sussex Multi-agency Procedures to Support Adults who Self-neglect](https://sussexsafeguardingadults.procedures.org.uk/pkoox/sussex-safeguarding-adults-procedures/sussex-multi-agency-procedures-to-support-adults-who-self-neglect) assists professionals from any agency who are working with and supporting an adult who is displaying self-neglecting behaviours which was evident in Donna’s case. The reviewer identified that if the procedures had been used this may have prompted agencies to have considered Donna at high risk of self-neglect/harm through alcohol misuse.

Any professional can request and convene a multi-agency meeting under these procedures, and we will further promote the procedures in conjunction with our Safeguarding Adults Board Multi-Agency: Self Neglect training to staff working locally in substance misuse services.

**There was no mental health services input to the assessment and care of Donna.**

**There were reports of Donna’s mental health deteriorating and she may have been suffering from depression, which might have frustrated agencies’ attempts to engage with her. However, there was no referral to mental health services, whose input may have placed another jigsaw piece in Donna’s picture and may have led to a more holistic approach to identifying and meeting her complex care needs.**

## Board Response

A recommendation from this review was to improve the understanding of the full range of mental health services available for non-mental health professionals so that when working with clients in their own specialist capacity, they can recognise those with potential mental health needs and are equipped with effective strategies for motivating clients to contact and engage with mental health provision.

The ESSAB will ensure there is wide promotion of the [East Sussex Mental Health Directory](https://www.eastsussex.gov.uk/social-care/health-advice/mental-health/east-sussex-mental-health-directory) which includes local and national mental health services and support. There will be further promotion of the Adult Social Care and Health (ASCH) [Mental Health Conditions – Awareness Training Course](https://www.eastsussex.gov.uk/jobs/learning-portal/adult-social-care-training/mental-health-training#Real%20Talk%20-%20conversations%20that%20save%20lives%20(Suicide%20First%20Aid)) which is free and available to a range of agencies including the independent care sector, voluntary sector, personal assistants and unpaid carers.

**Donna’s mental capacity was assumed.**

**Donna’s mental capacity was not assessed in respect of any specific decision. It is possible that Donna had frontal lobe damage, which could have affected her executive functioning. In addition to this, the addiction itself may have impaired or overridden Donna’s capacitated decision making. Donna self-neglected and refused help such as rehabilitation and personal care. She made decisions that were unwise, yet practitioners believed Donna had capacity to make these decisions.**

## Board Response

This is a complex area for practitioners to navigate and the Safeguarding Development Team within ASCH will be developing some specific guidance on Mental Capacity Assessments in complex situations of long-term substance / alcohol dependency. A additional section is planned to be added into the [East Sussex Mental Capacity Multi Agency Policy and Procedures](https://www.eastsussexsab.org.uk/documents/east-sussex-mental-capacity-multi-agency-policy-and-procedures/) and will support practitioners to understand what the effects of alcohol and frontal lobe damage may have on capacity.

**Good practice identified.**

SARs are also about promoting good practice and in this case a number of areas were highlighted by the reviewer:

* Good practice was demonstrated by the regular input of STAR the local substance misuse service who supported Donna.
* Adult Social Care provided aids to help Donna with her diminished sight.
* East Sussex Fire and Rescue Service provided important home fire safety advice and aids.
* Sussex Police and Southeast Coast Ambulance staff recognised self-neglect and the impact Donna’s drinking was having on her family.
* Children’s Services provided counselling for Donna’s daughter and supported her beyond the age of 18 in her transition to adulthood and living in her own accommodation.

ESSAB has reflected on lessons learnt from this tragic case, and fully accept the overall findings. We remain committed to seeking assurance with regard to improvement planning across all relevant organisations involved, with progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

There were 10 recommendations that were identified from this review, and these will be developed with partners to ensure that timely learning and changes are implemented to ensure agencies learn from Donna’s sad death.

East Sussex Safeguarding Adults Board

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