

**East Sussex Safeguarding Adults Board**

**SAFEGUARDING ADULT REVIEW**

**Donna**

**Executive Summary**

October 2023

**SAR Report by Patrick Hopkinson**

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# Donna’s Story

* Donna was a 42-year-old white British woman and the mother of three children. Donna was proud of her job as a manager of care services. Donna liked cooking, floristry and reading.
* Donna was alcohol dependent, her sight diminished suddenly in September 2020 (possibly due to alcohol misuse and nerve damage) and her mobility deteriorated meaning she was less able to do the things that she enjoyed.
* Donna’s condition continued to deteriorate in the period leading up to her unexpected death shortly before her 43rd birthday in July 2021.
* Donna was known to several agencies, and agencies were not always able to engage effectively 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. Donna’s mobility and ability to manage transfers, for example, from sitting to standing, had deteriorated over the last year of her life.
* Donna’s partner told the family’s social worker that Donna had misused alcohol throughout their relationship together, and that it had gradually become worse over time. Practitioners believed that the breakdown of Donna’s family together with the loss of her job were triggers for her deteriorating mental health and possibly increased alcohol consumption.

# Thematic review

1. ‘Alcohol Change UK,’ (July 2019) published a report[[1]](#footnote-1), “*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*”, analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, a further SAR (Andrew, Staffordshire and Stoke, 2022) identified eleven themes. These eleven themes were explored in context of Donna’s case as follows:

***Theme 1: Agencies’ engagement with Donna***

Agencies were not always able to engage or secure Donna’s engagement at times. There were instances of Donna not attending medical appointments and she regularly refused personal care. She would allow some carers to help her but not others.

CGL STAR (the local alcohol and drug treatment and recovery service) consistently tried to help Donna, and although CGL STAR did have some success in engaging with Donna, it was sporadic. A practitioner from CGL STAR who had worked with Donna since September 2020 had adopted a “flexible” approach with Donna but was unable to fully to secure her engagement.

Donna was involved with the SWIFT Specialist Family drug and alcohol service as well as CGL STAR According to practitioners it is usual for there to be such a level of support in place when there is a high level of clinical risk. However, on reflection practitioners felt that having all these services involved at the same time could have been overwhelming for Donna.

SWIFT discharged Donna on 27/1/21 as they were not able to engage with Donna in any interventions however brief and SWIFT considered that its involvement was not making the situation any safer. SWIFT identified that Donna was underreporting her alcohol consumption and detected higher levels of drinking through breathalysing.

On reflection practitioners noted that Donna may have been reluctant to reveal her true level of drinking because she feared that it would be reported back to a social worker and subsequently affect access to her children or that she may be penalised in some other way.

***Theme 2: Self-neglect***

There is evidence that Donna self-neglected, heavy alcohol use and the clinical risks associated with this are an example of this. It appears that there was no conclusive evidence that Donna’s alcohol misuse caused her optic nerve damage and diminished sight, but it is known that heavy drinking is a possible cause of [optic neuropathy](https://media.nhsbsa.nhs.uk/blogs/dry-january-alcohol-and-eye-health) and [other conditions](https://www.nhs.uk/conditions/alcohol-misuse/risks/).

Donna was not eating well and on 29/3/21 CGL STAR noted that Donna was underweight. Adult Social Care (ASC) also noted that she was throwing most of her food away in the last weeks of her life. A poor and meagre diet might be an example of a dependent drinker prioritising alcohol intake overeating. Other examples of self-neglect are that Donna found it difficult to follow medical advice, for instance she declined to attend hospital when her GP called an ambulance for her concerned about Guillain-Barre Syndrome (a form of neuropathy) and Donna did not attend ophthalmic and blood test appointments.

Two of the safeguarding concerns sent to ASC and Children’s Services, by the police on 16/2/21 and by South East Coast Ambulance on 14/3/21, listed “self-neglect” as one of the reasons for concern. ASC rated Donna’s risk of self-neglect as low. It is not clear that services recognised that alcohol misuse can be a form of self-neglect. There should not be a need for evidence of the consequences of alcohol misuse (such as losing weight, physical harm) for agencies to intervene.

***Theme 3: Exploitation***

There is no evidence put to the SAR reviewer that Donna was exploited.

***Theme 4: Domestic and child abuse***

There is no evidence provided to the SAR reviewer that Donna was a victim of abuse as a child. However, it is not clear whether this was ever explored with Donna. There may have been instances where Donna was the victim of domestic abuse. For example, it is alleged that Donna’s historical ex-partner who had come to stay with her, threw a bottle at her.

***Theme 5: Chronic health problems***

Donna had optic nerve damage which is irreversible, and she may have had Wernicke-Korsakoff syndrome.

***Theme 6: Mental health problems***

In August 2020 CGL STAR noted that Donna’s mental health was deteriorating, and her alcohol intake was increasing. Practitioners believed that the loss of her job, the breakup with her partner and separation from her family caused Donna’s mental health to deteriorate substantially.

***Theme 7: Traumatic events triggering alcohol intake.***

Practitioners believed that the traumatic events of job loss, relationship breakdown and family separation were triggers for Donna’s increased alcohol intake. However, it was clear that alcohol had been a factor for the duration of Donna’s relationship with her most recent partner. Traumatic events prior to their relationship commencing may have triggered high levels of drinking.

***Theme 8: Variable family involvement***

Donna’s daughter was Donna’s carer for the last six months of her life.

After Donna’s partner had moved out, he offered to return to support Donna to detoxify at home. Once the original plan to detoxify at home was not thought appropriate, it is not clear whether agencies engaged with Donna’s ex-partner to explore how his offer of support could have been utilised in a different way.

Donna’s mother was also identified as a source of support. Donna went to stay with her out of the area at the end of April 2021. There is, however, no evidence that Donna’s mother was contacted as part of Donna’s care and support needs assessment. It is possible that Donna specifically refused to allow ASC to contact her mother. There was also a report that Donna may have had an argument with her mother, following which she returned home.

In summary, there was frequent family involvement with services, especially by Children’s Services. However, Donna’s relationship with her family was breaking down and, and it seems this, together with the loss of her job, this led to a deterioration of Donna’s mental health and an increase in alcohol intake.

***Theme 9: High levels of alcohol intake and over-reliance on alcohol use to explain Donna’s presentation.***

All the evidence from agencies suggested that Donna was drinking high levels of alcohol and that she may have under-reported her consumption. On the day of her death the ambulance crew noted evidence of haematemesis/melaena (gastrointestinal bleeding) on Donna’s body and the coroner determined an unexplained death from alcohol misuse.

There does not appear to be any evidence that there was an over-reliance by practitioners on alcohol to explain Donna’s presentation, but there was no mental health assessment, or referral to mental health services, and this may have been a missed opportunity to identify and meet Donna’s complex care needs.

***Theme 10: Regular contact with ambulance services***

During the last 12 months of Donna’s life the ambulance service was called six times (excluding the day she died), mainly by Donna’s family and once by Donna’s GP. On the five occasions that calls were made by a member of Donna’s family, SECamb made safeguarding referrals to ASC, concerned for Donna and/or for the effect of Donna’s behaviour on her family.

***Theme 11: Unpopularity with the local community or concerned neighbours.***

There is no evidence to suggest that Donna’s behaviour was affecting the local population or attracting bad comment from neighbours.

In summary, of the eleven factors listed above at least nine applied to Donna. This pattern of circumstances might be predictive of poor outcomes unless different approaches are taken. In consequence, services should consider how the presence of this pattern of characteristics might be identified in the future and how this might lead to interventions that result in better outcomes.

# Emerging Issues and Learning

***Mental Capacity***

Donna was assumed to have mental capacity. It appears her mental capacity was never formally assessed.

Donna may have sustained frontal lobe damage, and it was highly likely that alcohol addiction was having a coercive and controlling effect on her decision making. Donna self-neglected and declined help such as rehabilitation and personal care. She made decisions that were irrational. One of the practitioners involved in supporting Donna described Donna as “extremely unwell” by the time she went into the detox centre and that the situation was akin to a “medical emergency” in that she would likely pass away if she did not detox. Detoxing only deals with the physical dependency. It does not deal with the emotional dependency and additional support is required in the form of rehabilitation services for sustained abstinence to be possible. When Donna declined rehabilitation, it would have been appropriate to have considered and assessed Donna’s mental capacity to make decisions about her alcohol use and about to treatment and support options including whether to decline them. If Donna had been found to lack the mental capacity to make these decisions, then decisions could have been made in her best interests on her behalf.

***Best Interests***

A best interests meeting may be needed where someone aged at least 16 years old lacks the mental capacity to make significant decisions for themselves and requires others to make those decisions on their behalf.

Had Donna’s capacity been assessed, and had she been found to lack the capacity to make decisions about self-care, alcohol use or treatment options, a best interest’s decision could have been made on her behalf. Because it was never considered whether the presumption of capacity had been rebutted, Donna’s mental capacity was never assessed and making decisions on her behalf in her best interests, which may have changed outcomes for Donna, was not possible.

If Donna had been found to have the mental capacity to make the relevant decisions, then consideration should have been given to whether or not there was a duty to act to promote her wellbeing (section 1, Care Act 2014) or her rights under, for example, articles 2 and 8 of the Human Rights Act.

***Meeting Donna’s care and support needs***

The processes for identifying and meeting Donna’s care and support needs were not executed in a timely manner. There were delays in assessing Donna’s needs and this resulted in considerable time elapsing before a care package was put in place.

***Safeguarding***

Between August 2020 and June 2021 there were six safeguarding referrals made relating to Donna and/or her children. Of the six, one was handled by Children’s Services and action was taken, but ASC were not invited to take part, nor were they updated on the actions taken. Five of the referrals were made by SECamb, four of which were reported to ASC.

Donna was judged not to have met the criteria set out in Section 42 of the Care Act, but the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (also known as “other” enquiries) and interventions where the criteria are not met, but where there is sufficient concern that someone may come to harm. It is likely that Donna met at least the criteria for a non-statutory adult safeguarding enquiry and that either this or a Section 42 enquiry might have been an opportunity to reconsider the extent to which the current interventions and approaches were proving effective.

***Multi-Agency Working***

Whilst there was a Strategy meeting led by Children’s Services which included a number of different agencies, this was focused on Donna’s children. There was no multi-agency meeting to discuss Donna. There was no coordinated multi-agency approach which recognised the full complexity of and interrelationship between Donna’s needs and circumstances.

There was no shared approach to risk management. At the time of Donna’s death the [East Sussex Safeguarding Adults Board Multi-Agency Risk Management (MARM) Protocol](https://www.eastsussexsab.org.uk/wp-content/uploads/2021/12/Multi-Agency-Risk-Management-Protocol-SAB-Final-Version-Dec-2021-.pdf) was not in place. However the [Sussex Multi-Agency Procedures to Support Adults who Self-Neglect](https://www.sussexsafeguardingadults.org/), published in May 2019, were in place during the SAR review period for Donna (August 2020 to August 2021) and, had the procedures been followed in Donna’s case, it is likely that a multi-agency planning meeting would have been held and a comprehensive assessment of risk would have been completed.

***Mental Health***

Some mental health input may have enabled a more holistic approach to understanding and meeting Donna’s complex needs. It may also have considered Donna to be at high-risk level.

***Self-Neglect***

Some of the good practice guidelines for working with people who self-neglect was in evidence in the way agencies worked with Donna. However, for the future more attention needs to be given to seeking to understand the significance of self-neglect, capitalising on moments of motivation, a sound understanding of legal powers and duties, mental capacity, thinking flexibly about how family members and community resources can contribute to interventions, and working proactively to engage and co-ordinate agencies with specialist expertise to contribute to shared goals.

# *Good Practice*

CGL STAR were heavily involved in supporting Donna. CGL STAR offer a “non-judgemental” and “friendly” service. These elements are important requirements in seeking to secure engagement and are good practice. They gave Donna advice about detoxing safely; secured a bed in a London detox centre and provided additional funding to support Donna with her mobility needs during her stay at the centre.

Donna was provided with a number of aids to support her with mobility and her diminished sight.

Sussex Police dealt with a number of incidents and although these were reported as individual events, there was ‘joined up’ thinking and a recognition in police contacts with Donna that her drinking was increasing and having a significant impact on her family. There was also an understanding by police and by SECamb that self-neglect was increasingly evident as a result of Donna’s alcohol misuse.

Children’s Services took appropriate action in response to safeguarding concerns and worked closely with ASC.

# Conclusions

* ***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.
* **Opportunities to initiate safeguarding enquiries were not taken*:***Safeguarding enquiries under S42 of the Care Act 2014, or non-statutory enquiries, could have been initiated at various points between March and July 2021 in response to Donna’s deteriorating situation and self-neglect. Multi-agency planning meetings could have helped to co-ordinate support, information sharing and to explore other strategies to try and effect change.
* ***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.
* ***Donna’s mental capacity was not explored :*** Donna’s mental capacity was not assessed. It is possible that Donna had frontal lobe damage, which could have affected her executive functioning.
* ***Working with people who self-neglect:*** Some of the good practice guidelines for working with people who self-neglect was in evidence in the way agencies worked with Donna. However, for the future more attention should be given to seeking to understand the significance of self-neglect, to capitalise on moments of motivation, to understand legal powers and duties and mental capacity, to think flexibly about how family members and community resources can contribute to interventions, and to work proactively to engage and co-ordinate agencies with specialist expertise to contribute to shared goals.
* ***Self-neglect and risk assessment:*** There was no multi-agency approach to risk assessment. The Sussex Multi-Agency Procedures to Support Adults who Self-Neglect were not instigated, possibly because Donna’s risk of self-neglect was rated as low in care and support needs assessments. Analysis of Donna’s circumstances compared to the eleven factors listed in the Alcohol Change Report and the Andrew SAR [[2]](#footnote-2)(Staffordshire and Stoke, 2022) would have shown that Donna met at least nine of the factors. This may have prompted agencies to have considered Donna as at high risk of self-neglect/harm through alcohol misuse.
* ***Involvement of Donna’s family:*** There was frequent involvement of family members by services and there was a focus on Donna’s children. ASC could have been more creative in seeking support from family members to help with Donna’s own needs.
* ***Traumatic events triggering alcohol intake:*** There was no exploration of the extent to which Donna’s earlier life had exposed her to traumatic events which may have affected Donna or her family.
* ***Under reporting of alcohol consumption: It*** is possible that Donna under-reported her alcohol consumption for a number of reasons including fear that there might be negative consequences for her, for example, in access to her children. This was not explored with Donna.
* ***Processes for referrals and identifying Donna’s care and support needs were not executed in a timely manner:*** There were delays in assessing Donna’s needs and this resulted in considerable time lapsing before a care package was put in place. Further support to Donna’s carer may have been available had other agencies been informed of the safeguarding concerns raised.

# Recommendations

# Recommendation 1: *Partner agencies should review the application of multi-agency safeguarding and risk management processes to ensure that individuals who are at risk and have complex needs are recognised and considered at a multi-agency level.*

# Recommendation 2: *Partner agencies should promote an understanding amongst practitioners of the relationship and interplay between alcohol misuse and self-neglect and when and how safeguarding referrals and enquiries related to alcohol use and self-neglect should be instigated*.

# Recommendation 3: *Partner agencies should ensure that non-mental health professionals have a broad understanding of the full range of mental health services available, so that when working with clients in their own specialist capacity, non-mental health professionals 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.*

# Recommendation 4: *Partner agencies should improve legal literacy amongst practitioners, including knowledge of the role of the Court of Protection, the inherent jurisdiction the Human Rights Act, and the Mental Capacity Act with particular reference to the effects of alcohol and frontal lobe damage may have on capacity.*

# Recommendation 5: *Partner agencies should use the characteristics associated with alcohol dependency outlined in section 5 of this report when formulating risk assessments.*

# Recommendation 6: *Partner agencies should identify how a ‘Think Family’ approach could be used to involve family members in supporting people who are substance dependent.*

# Recommendation 7: *Partner agencies should promote history taking and the exploration of life experiences that may have triggered self-neglect and alcohol misuse (and substance abuse) and encourage the use of trauma-informed approaches by practitioners.*

# Recommendation 8: *Partner agencies should consider the relationship and interplay between the self-reporting of alcohol intake (and substance misuse) and consequences for individuals in other aspects of their lives (for example, family life) and consider how individuals may be engaged with and reassured about accurate self-reporting.*

# *Recommendation 9: Children’s Services should identify how it can share information about safeguarding concerns with appropriate specialist agencies, which could then offer support to children and young carers including those whose caring roles will extend into adulthood, in addition to the support offered by Children’s Services themselves.*

# Recommendation 10: *The ESSAB should request an update on the Local Alcohol Reduction Strategy from the Director of Public Health, East Sussex.*

1. https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017 [↑](#footnote-ref-1)
2. https://nationalnetwork.org.uk/2022/Andrew-SAR-Report-Final.pdf [↑](#footnote-ref-2)