Southampton Safeguarding Adult Board

Safeguarding Adult Review

SSAB

SOUTHAMPTON SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW – 'NICOLA'[1]

EXECUTIVE SUMMARY
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1. INTRODUCTION

1.1. Nicola was a young woman with three young children. She had experienced domestic abuse in London and was rehoused in Southampton, but maintained contact with the father of two of her children. Concerns arose about her alcohol dependency and self-neglect, and the impact of these on her own and her children's wellbeing. As a result of these concerns all three children returned to live with their fathers, and following their departure Nicola's self-neglect and alcohol use escalated. She died aged 28 in hospital of pneumonia and alcohol-related liver disease, having experienced cardiac arrest in the context of severe damage to her body due to alcohol dependency and self-neglect.

2. THE SAFEGUARDING ADULT REVIEW PROCESS

2.1. Southampton Safeguarding Adults Board SAB concluded that the circumstances of her death met the criteria[2] for carrying out a mandatory safeguarding adult review (SAR) under section 44 of the Care Act 2014. An independent lead reviewer was commissioned to work with a panel of senior leaders from the agencies involved.

2.2. The period under review was the three-year period when Nicola lived in Southampton prior to her death The key lines of enquiry were to explore:

a) Whether interagency working was effective in Nicola's case;
b) Whether appropriate action was taken in the context of her self-neglect and alcohol use;
c) Whether her dual diagnosis (mental health/substance dependency) was addressed;
d) Whether children's and adults' services together addressed the family's needs;
e) What support was offered in relation to Nicola's experience of domestic abuse;
f) Whether her history was understood and a trauma-informed approach taken;
g) How she was supported through the children's return to their fathers;
h) What were the impacts of Covid-19 restrictions?

2.3. All Southampton agencies involved with Nicola submitted information to the review and a learning event offered practitioners and managers with direct experience of working with Nicola to share their perspectives. The review team also received information from the Metropolitan Police and from three London boroughs including those in which Nicola lived prior to her move to Southampton and those to which her former partners had taken their

[1] A pseudonym

[2] A SAR must take place when an adult with care and support needs (whether or not receiving services) has died as a result of abuse or neglect (which includes self-neglect) and there is reasonable cause for concern about how the Board, its members or others worked together to safeguard them.

respective children in early 2020. The fathers of her children and her sister were all informed about the review and invited to participate. The father of the two younger children responded and had a telephone discussion with the independent reviewer to share his views.

3. LEARNING THEMES EMERGING FROM THE REVIEW

3.1. Responses to domestic abuse

3.1.1. Domestic abuse, involving not just physical abuse but also controlling behaviour, was an ongoing feature in Nicola's life, to a degree that was not recognized and there were a number of shortcomings in agencies' responses to her experience.

- There was an absence of proactive response by the Police when she reported that she was being intimidated, disagreement between two Police forces resulting in no investigation taking place and no further contact with Nicola about her fears.

- When she was referred the High-Risk Domestic Abuse Panel, subsequent support was short-lived. An absence of professional curiosity by both the Independent Domestic Abuse Advocacy Service and Solent NHS Trust Health Visiting Service about Nicola's experience of contact with the younger children's father resulted in their support being withdrawn, when follow up monitoring should have taken place.

- When Nicola reported a further assault by the younger children's father, the Police did not persist in their attempts to contact her.

- At an initial child protection conference convened due to concerns about Nicola's care of her children, there was no reference to the impact of domestic abuse on her mental health or consideration of this being a contributory factor to her alcohol misuse and no plan to address these impacts.

3.1.2. It is also of concern that when the younger children's father twice reported his concerns about Nicola's alcohol use and neglect of the children, Children's Services concluded that no action was necessary because he was understood to be a perpetrator of domestic abuse and there was no evidence his allegations were anything other than vexatious and malicious. This led to missed opportunities to provide parenting support to Nicola at a time when her alcohol use had not escalated to the point of severely damaging her health, as it subsequently did, and when she might have been more receptive to support.

3.2. Trauma-informed practice

3.2.1. Nicola's alcohol use, mental health needs and self-neglect can be seen as rooted in the multiple layers of trauma in her life from both historical events and recent life experience.

- The loss of her mother died when she was 13;
- Becoming pregnant at 16 and being barred from the family home;
- Becoming mother to three children over a short number of years, a difficult role transition in the light of her own maternal loss;
- A difficult relationship with her eldest child's father and an episode of homelessness;
- Incidents of sexual assault and rape, which were investigated but not prosecuted;

- Evacuation from home following a fire with her children placed in foster care under police protection for a week due to concerns about the squalid conditions;
- A tense relationship with the father of her two youngest children, in which she experienced physical abuse and intimidation, remaining in contact with him due to commitment that her children should have a relationship with him;
- The loss of her children to their fathers' care, about which she was deeply distressed to the point of contemplating suicide, with a rapid escalation of her drinking and self-neglect.

3.2.2. Such experiences can result in an individual being overwhelmed by feelings of being physically or emotionally unsafe and turning to coping mechanisms that can be detrimental or even destructive. Trauma-informed approaches, which work from a strengths-based perspective aiming to help trauma survivors regain a sense of control, are now well established as an important framework for agencies' work.

3.2.3. Yet little use appears to have been made of such approaches by the agencies involved with Nicola. Child-oriented services such as Children's Services and health visiting did not readily engage with Nicola's own history. Services providing healthcare to Nicola did not explore either historical or current adverse experiences and consideration of safeguarding focused solely on present risks and behaviours. Mental health services, knowing some detail of her history, merely signposted her to other support, despite her known reluctance to engage making it unlikely she would follow signposts.

3.3. Engagement with services

3.3.1. Nicola experienced difficulty accepting anything more than crisis involvement with services and a consistent pattern of crisis-led engagement followed by withdrawal is evident.

3.3.2. Some degree of persistence by agencies can be noted, although for the most part Nicola's reluctance was seen as a choice on her part and was respected. This was exacerbated by barriers arising from systems and agency practices. Hospital-based services, for example, secured better engagement when she was in crisis, but were unable to continue their involvement post-discharge. Some agencies have noted an over-reliance on contacts by phone or text rather than in-person. Even where attempts by community-based agencies to engage her were successful, a lack of follow-up failed to capitalise on what had been achieved. The evidence base on the achievement of positive outcomes in self-neglect work[3], in contrast, shows the value of careful and persistent engagement strategies to create rapport, seeking to understand what lies behind the person's reluctance, as a pathway to a trust relationship that can lead to the possibility of support being accepted.

3.4. Dual diagnosis

3.4.1. Nicola's alcohol use was long-term and impacted adversely upon her daily living, her relationships and her parenting. She had not had any involvement with mental health services prior to arriving in Southampton, but clearly experienced distress related to the domestic abuse she had experienced and to the emotional and psychological pressures

[3] Braye, S., Orr, D. and Preston-Shoot, M. (2014) Self-Neglect: Building an Evidence Base for Adult Social Care. London: Social Care Institute for Excellence. https://www.scie.org.uk/files/self-neglect/policy-practice/report69.pdf

of her ongoing contact with her youngest children's father. As events unfolded, her mental health deteriorated, her reliance on alcohol increased, her health declined and her self-neglect escalated. The added distress of losing her children was an additional factor in the final months of her life. Even with warnings from medical and nursing staff about the likely fatal outcome should she continue to drink, she remained unable to overcome her reliance on alcohol.

3.4.2. Despite her needs, Nicola had relatively little exposure to either mental health or substance misuse services. The approaches taken by agencies made little headway into the complex and inter-related features of alcohol dependency and mental ill-health in her life, to which her experience of domestic abuse and her role as a parent to three young children added further complexity. Earlier opportunities to offer support with alcohol dependency were missed and it was not until a few months before she died that such support was offered. While her mental health needs were also latterly recognised, the challenges of securing her engagement with services could not be resolved through the established pathways that existed within and between services. That individuals with dual diagnosis will need more active support to engage with services is now well understood, with research by Alcohol Change UK[4] indicating that services themselves need to provide more assertive outreach to assist in generating positive engagement. The approach here was insufficiently proactive; Nicola's needs therefore remained un-met and her health continued to spiral out of control. The failure to consider the Mental Health Act as a means of securing attention to her mental health needs was a significant omission. And when mental health services were unsuccessful in making contact with her, escalation would have been more appropriate than case closure and return to a primary care service, her GP, that did not subsequently seek contact with her or monitor her needs.

3.4.3. A final concern is that Children's Services, although actively involved in the period that led to the children's removal by their fathers, did not recognise the re-traumatising impact on Nicola of this loss, or consider her vulnerability going forward, indicating that recognition of the needs of vulnerable parents needs to be better embedded in their practice.

3.5. Mental capacity

3.5.1. Nicola's decisions on use of alcohol, self-care and care of her home, as well as her difficulties accepting support, placed her at serious risk. And these were not one-off, isolated decisions; they were consistent and repeated. In these circumstances, questioning her capacity to make those decisions would have been warranted. While her capacity was recognised as likely to fluctuate due to her alcohol use, no reason was found to question her capacity when sober. There were no formal capacity assessments, even during the rapid escalation of her self-neglect in the months before she died, and equally no consideration of how her alcohol dependency, and later her physical deterioration, affected her ability to make decisions. This amounts to a significant missed opportunity to explore potential alternative avenues for support and it is of concern that such a key element of her decision-making was overlooked. The absence

[4] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017.* London: Alcohol Change UK. https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

of a robust approach to mental capacity indicates a need for practice improvement in complex cases involving alcohol use, self-neglect, mental health and physical health.

3.6. Think family

3.6.1. While one agency - the IDVA service - had a whole family focus inherent to its role, other agencies focused either upon Nicola's health needs or upon the safety of her children. A holistic, 'Think Family' approach was not evident. Throughout the child protection process, no attention was given to potential adult safeguarding responsibilities with respect to Nicola herself. Children's Services, knowing Nicola was in hospital in the period following the children's return to their fathers' care, believed that her health, mental health and alcohol use would be coordinated by health. But this was an assumption rather than the result of any active liaison or discussion. There is no mention, in Children's Services assessments, of liaison with adult-facing professionals or of Nicola's own needs, nor were any adult-facing professionals invited to the child protection case conferences. The focus of all safeguarding was the children's experience, with limited understanding of Nicola's self-neglect.

3.6.2. At the same time, the adult-facing services involved with Nicola did not undertake any proactive liaison with Children's Services. Despite the well-embedded notion of whole family approaches, there is no evidence of a holistic approach to the needs of the family as a unit, or how support for Nicola *as a parent* could be built into adult services actions. Thus there was no *shared* plan to promote and safeguard the welfare of all family members.

3.7. Safeguarding

3.7.1. The safety of Nicola's children was a key concern for a number of agencies involved with the family. Appropriate referrals were made by the Police, and by both the nursery and the school, with both establishments continuing to monitor the children's attendance and needs while they remained with them. Hospital staff were attentive to the safety of the children and appropriate information-sharing took place.

3.7.2. While Children's Services initially did not see cause for concern about Nicola's care of her children (due to misplaced assumptions about reports from the younger children's father being malicious), they did subsequently become involved when the conditions in Nicola's home became apparent. When the youngest children's father removed them, Children's Services undertook appropriate follow up through the London Borough in which they were living and later initiated a child safeguarding assessment in respect of the eldest child, who remained with her. The child protection plan was overtaken when the child's father removed him from her care, but Children's Services did then follow up, including making an in-person visit to assure themselves of his wellbeing. Thus it seems that once thresholds were reached, Children's Services involvement was effective in promoting and safeguarding the children's welfare, with the follow-up process to the eldest son's relocation notable as good practice.

3.7.3. In respect of Nicola, the local authority received 14 adult safeguarding referrals (variously from the Ambulance Service, the hospital, the Police, a community mutual aid group and psychiatric liaison). Thus practice was robust in terms of agencies' recognition of her self-neglect. But all were triaged out of safeguarding by the Hospital Discharge Team, who either closed them as not meeting the criteria set out in section 42 of the

Care Act 2014, or re-directed them elsewhere for other forms of support. These decisions - made for a variety of reasons including Nicola having no care and support needs, having mental capacity and making a lifestyle choice, and having been referred to other services - are difficult to justify, and raise serious questions about decision-making and adherence to legal requirements. The local authority has acknowledged that safeguarding practice within the Hospital Discharge Team was not robust, and changes have been implemented.

3.7.4. It appears also that adult safeguarding referrals that should have been made were not made, indicating a need for greater adult safeguarding awareness in some agencies, particularly to raise the profile of self-neglect and promote better understanding of avenues for addressing it.

3.7.5. Thus it seems that while Nicola's children were appropriately safeguarded in the months before she died, the risks to Nicola herself did not enter the safeguarding arena, despite multiple opportunities for them to do so. Each crisis point in her life received a 'more of the same' response – emergency services involvement, acute medical care, warnings on the consequences for her health, signposting to support services, subsequent withdrawal by her – rather than recognition of the need for escalation. The repetitive nature of this pattern also raises the question of why none of the referring agencies challenged the triage decisions made or considered alternative action to bring agencies together. It was not until the final hospital admission just before her death that a Multi-Agency Risk Management process was activated.

3.8. Interagency working

3.8.1. There are numerous examples of information-sharing and liaison between agencies during their work with Nicola, primarily by email but also some phone calls. The nursery, MASH, PIPPA, Children's Services, the Police, the hospital Alcohol Care Team, Vulnerable Adult Support Team, Psychiatric Liaison Team and Hospital Discharge Team, Adult Social Care Connect, Change Grow Live, the Acute Mental Health Team and Covid-19 Support Group were also involved in communications with each other at various points. The HRDA process was appropriate convened and resulted in some initial (though short-lived) support for Nicola

3.8.2. Despite the positive examples of information-sharing and collaboration, there were nonetheless numerous gaps of communication between the agencies and in the information held by different agencies. Examples include incomplete, unclear or absent communications about Nicola's experience of domestic abuse, lack of information-sharing between hospital medical and psychiatric teams, liaison between the IDVA service and other agencies, communication from the Acute Mental Health Team to Adult Social Care about their closure of her case, communication and liaison between Children's Services and adult-facing services during the child protection processes, communications with health visiting services from agencies in direct contact with Nicola as her health declined.

3.8.3. Of key concern also is the significant delay in bringing agencies together to consider a shared strategy to manage the risks of Nicola's situation. Mechanisms for bringing agencies together were located in both safeguarding adult procedures and in a Multi-Agency Risk Management Framework (MARM), available for use even where safeguarding procedures were not in process. The failure to use either avenue was a

significant missed opportunity, and even when the MARM meeting was arranged just before Nicola died, not all agencies were invited.

3.9. Covid and other constraints

3.9.1. The final months of Nicola's life coincided with the early stages of the Covid-19 pandemic, a period when pressures on agencies escalated rapidly and lockdown regulations necessitated dramatic changes to working practices. Challenges to NHS provision were extreme, with significant impacts on primary care, outpatient appointments and inpatient provision. Local authorities focused on meeting the most pressing care and support needs of those in the community, using easements applied to Care Act 2014 duties[5], although it is important to note that safeguarding duties were unchanged by the easements. Pressures on other agencies meant the withdrawal of many support services and the interruption of intervention plans. Emergency services were often at the front-line and were sometimes the only agencies having in-person contacts with those most at risk in the community.

3.9.2. Agencies have identified some Covid-19 impacts on their services to Nicola, although some were minimal. It seems clear that Covid constraints did not adversely affect responses to Nicola's acute healthcare needs. She had access to hospital care when she was acutely unwell and at the end of her life she received intensive care that was, in the short term, effective in managing the extreme compromise to her health caused by her alcohol use and self-neglect. But impacts in some other agencies were more significant, including a greater reluctance to visit Nicola in-person, particularly in relation to safeguarding referrals and in relation to the conditions in her home, the use of virtual rather than in-person meetings, less access to hospital patients, the removal of teams from working on site, cancellation of community support meetings, restrictions on assertive outreach, difficulty securing GP appointments. Despite these challenges, efforts were made to minimise the impacts, for example Nicola's eldest child was prioritised for school attendance, and he was later seen in-person by his social worker at his new home with his father.

4. CHANGES SINCE THE CIRCUMSTANCES OF NICOLA'S DEATH

4.1. A number of agencies have made changes to their practices in the intervening time since Nicola's death. These include:

4.1.1. The city council restructuring the management of safeguarding concerns and providing further staff training;
4.1.2. The hospital making more proactive use of MARM meetings and raising awareness on self-neglect and alcohol dependency;
4.1.3. The IDVA service have re-stated to agency partners the nature of their service and emphasised the importance of supporting parents whose children are being removed;
4.1.4. Southern Health Foundation Trust developing a training package on neglect and self-neglect, and strengthening communications with referring agencies;
4.1.5. Hampshire Police introducing a policy of seeing victims of domestic abuse in-person, and undertaking work with Hampshire refuges on information-sharing in high-risk situations;

[5] Permitted through the Coronavirus Act 2020, which received Royal Assent on 25th March 2020 and was implemented the following day.

4.1.6. Solent NHS Trust updating its policies to ensure consideration of mental capacity and to incorporate trauma-informed language, and reviewing its training offer to include the impact of alcohol dependency on self-neglect;

4.1.7. Children's Services developing its approach to working with families to incorporate support for staff in cases where alcohol dependency and mental health concerns are present, developing understanding of self-neglect and of trigger points for referral to adult services, investigating concerns raised perpetrators of domestic abuse, engaging with victims of domestic abuse where their relationship with the abuser is resumed, considering how to support parents with mental health and substance misuse needs who are not engaged with services.

5. CONCLUSION

5.1. Most of the agencies involved with Nicola at various points after her arrival in Southampton provided a service that was in line with standard practices at the time. She received support from the refuge, she was re-housed, her fears of intimidation led to a response under HRDA, support from the IDVA and follow up from the health visiting service, the nursery was alert to her mental health needs. Later there were proactive attempts to contact her following her report of a further assault, her children's safety and wellbeing received attention, her medical needs were recognised, understood and treated at points of crisis.

5.2. There were, however, significant gaps and shortcomings in the support she received. As set out in the thematic analysis, these related to the following:

- the flow of information between agencies, particularly relating to domestic abuse;
- failure proactively to engage with her over her fears of intimidation;
- acceptance at face value of her assurances that all was well;
- absence of professional curiosity and therefore poor understanding of the experiences that contributed to her self-neglect;
- shortcomings in the extent to which agencies' approaches taken were trauma-informed;
- lack of persistence in engaging her in intervention to address her mental health and alcohol use;
- absence of attention to her mental capacity;
- failure to recognise the impact on her of her children's departure to live with their fathers;
- failure to recognise her self-neglect as a safeguarding issue.

5.3. The pattern was one of sporadic contact with services, prompted either by Nicola herself seeking help or by agencies noting her vulnerability, followed by rapid withdrawal. It is likely that Nicola was ashamed of her home conditions and fearful about what would happen to her children if they were known. In the period following the children's departure from her care she spoke of how adversely this had affected her, triggering the intensification of her distress. At the same time her physical health was also in severe decline and even with stark warnings about the likely fatal outcome she continued to drink. From her actions in crisis it is clear that she recognised the need for change but the combined effects of trauma, alcohol addiction and mental ill-health made her increasingly unable to act on what needed to be done. Agencies collectively failed to initiate action that could have opened up pathways to intervention.

5.4. Pathways that could have brought agencies together to engage in shared discussion and strategy were not used. One such pathway was safeguarding, yet multiple referrals of

concern were, incomprehensibly, triaged out of safeguarding without effective alternative pathways being identified. Equally, it was not until just before she died that use of the Multiagency Risk Management process was considered. Whether agencies were simply not worried enough to act or whether, although worried, they simply did not act is not clear, but the pattern of 'too little too late' is evident.

5.5. Finally, during the final few months of Nicola's life the Covid pandemic was placing severe pressures across all agencies and, in some cases, changes to working practices. In Nicola's case, services continued to be provided or offered, although sometimes in a different form – a greater reliance on telephone or online provision and restrictions on in-person meetings. This would have limited awareness of the scale and impact of her self-neglect, although it is clear that emergency services were providing information on this from their own involvement with her at home.

6. RECOMMENDATIONS

The review concludes with a number of recommendations, grouped together under the thematic findings.

Actions relating to domestic abuse: these include recommendations for review of domestic abuse structures with particular reference to information sharing and cross-border cooperation, as well as training on the impact of the experience of abuse.

Actions relating to self-neglect and safeguarding: these include recommendations on self-neglect training, policies on non-attendance/non-response and the use of assertive outreach, use of holistic, Think Family approaches, improvements at the interface between Children's and Adults' Services, improvements to safeguarding triage and practice, guidance on professional curiosity, and the development of trauma-informed practice.

Actions relating to dual diagnosis: these include implementation of Alcohol Change UK recommendations, a commissioner/provider summit to consider strengths and pressure points in dual diagnosis services, action to improve practice relating to mental capacity, review of cases featuring dual diagnosis associated with self-neglect.

Actions relating to interagency working: these include review of self-neglect, safeguarding and MARM procedure guidance to ensure they provide seamless pathways to multiagency working, review of self-neglect guidance to emphasise pointers drawn from the best practice evidence base, and review of the MARM process and audit of the new policy once re-launched.

Actions relating to learning: these include a detailed action plan arising from these recommendations and active dissemination of the findings and action plan across the safeguarding partnership, with feedback to the Board on how agencies have used the learning.