Nottingham City Safeguarding Adults Review for 'Lisa'

Executive Summary

Introduction

The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. Nottingham City Safeguarding Adults Board (NCSAB) commissioned an independent author to carry out this review. The author is an experienced reviewer with over twenty-five Safeguarding Adults Reviews and Domestic Homicide Reviews, as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to dependent drinkers that services find difficult to engage. The author is independent of NCSAB and its partner agencies.

The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[1]

This review considered the circumstances of 'Lisa.' Lisa was a 57-year-old white British woman who died in Hospital in February 2023. Her death was due to liver failure, alcoholic liver cirrhosis, pancreatitis and ischaemic heart disease. She had a long history of alcohol use disorders, mental health problems, self-neglect and concerns about domestic abuse.

Lisa

Lisa engaged in a cyclical pattern of poor mental health, drinking alcohol dependently, self-neglecting, falling and disengaging from services. This would then be followed by a period of abstinence, improved mental wellbeing and nutritional intake, engagement with services and improved health outcomes e.g. weight gain and mobility.

This review is mainly focused on the period after July 2020 and much about her previous history is unknown to the author. However, agencies did provide a brief picture of her life prior to July 2020.

Lisa's life and the circumstances of her death highlight several key themes which are explored in the learning points below.

[1] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*

The review specifically wanted to consider the following:

1. Were Lisa's reports of domestic abuse identified by agencies in a timely manner and reported through appropriate routes?
2. Non-recognition and escalation of self-neglect – did those involved in supporting Lisa have sufficient understanding of Safeguarding Adults policies and procedures, especially in relation to self-neglect?
3. Did agencies consider whether capacity to make decisions was impacted as a result of alcohol and was there evidence of fluctuating capacity?
4. Did agencies explore Lisa's dependence on her son as her carer, taking into consideration allegations she had made against him as a perpetrator of domestic abuse? Did agencies ever consider referrals for her son as a carer in his own right?
5. Would a stronger multiagency approach have created a clearer overall picture and provide an opportunity to a more coordinated approach?
6. Is there clear evidence of escalation utilised in a timely way?
7. Did any agency identify or explore the interplay between poor mental health, alcohol dependency, self-neglect and domestic abuse?
8. How did the Covid pandemic and the lockdown impact opportunities for agencies to become aware of Lisa and engage with her?

Summary of Learning Points

Alcohol use disorders

Lisa's care is a reminder of the importance of robust alcohol screening processes to ensure that alcohol-related risk is routinely and consistently identified at the earliest point. Without such screening it will not be possible to build an appropriate individual response; but it will also be harder to build a case for a general improvement in the approach to alcohol use disorders.

There is a question whether services other than Nottingham Recovery Network were sufficiently aware of their offer of assertive outreach for people who refuse a referral and the benefits it could provide to individuals like Lisa.

Domestic Abuse

Lisa's care highlights three main issues:

- The extent to which agencies were exploring and communicating about the role of domestic abuse. Given her reported history, this would seem to be an issue that should have been regularly explored, particularly in the context of reports of a new "partner". Practitioners need professional curiosity in such situations. The reports do not evidence such an approach.
- Were conversations about her son's role in her life taking place in his presence? If so, this could have significantly impacted on her answers. Did professionals make sure that she was seen separately from him?
- Is an approach to domestic abuse that is based on making three unanswered calls and then the Independent Domestic Violence Advocate (IDVA) referring back to the Social Worker appropriate and sufficient in a situation in which the potential victim could be subject to coercive control and, at one point, had had her phone removed by her son?

It is ultimately hard to determine the extent to which Lisa was the victim of abuse, particularly in the review period. Her son is the person that she identifies as a potential abuser, but the notes also consistently indicate that Lisa wanted to reside with her son, and he became her main carer.

Mental Health

Lisa is described at points as having problems with her mental health. However, the evidence on the nature of these problems is limited and there is no evidence that she sought or received any help for these problems. The Hospital state that there is no evidence of Lisa having a mental health diagnosis. Therefore, it has not been possible to draw any conclusions about this aspect of her care, including whether further help was required.

Individuals that services find difficult to engage

Lisa had several aspects to her presentation – a substance use disorder, possible mental health concerns, health problems and self-neglect. However, one issue underpins all these presentations – whilst the City does have an engagement procedure in place it was not successful in being adapted to support Lisa in a way which could help her consistently. Therefore, it is important to review whether this document is working for adults with these presentations and is being widely followed by practitioners. In addition, a more organised (and professionally curious) approach to the challenge of engaging Lisa could have greatly benefited her.

Multi-agency working

Inter-agency and multi-agency working is evidenced in Lisa's care. Nonetheless, agency reports suggest that Lisa's care would have benefited from escalation to a multi-agency forum involving Emergency Services, Health, Police, Mental Health, Drug & Alcohol Services, Adult Social Care and Housing Services, among others. A regular multi-agency framework would also have facilitated agencies identifying the deterioration in her well-being in the last months of her life.

Nottingham does have multi-agency groups e.g. the Complex Persons Panel or the Severe and Multiple Disadvantage meeting that focus on complex individuals. It is important to ensure that these are providing an approach that meets the needs of this client group and that practitioners are referring individuals like Lisa to them.

Safeguarding

Lisa had limited contact with Nottingham City Council ASC during the review period. Nonetheless, she was clearly, at times, an adult with care and support needs. There was one safeguarding concern that was raised about her during the review period (at the point of her death) but five prior to the review period. This limited pattern of engagement with ASC does raise the question of whether there were any missed opportunities to raise safeguarding concerns or seek other support.

More generally, there is a question about the confidence of professionals to make onward referrals to Adult Social Care when the individual has capacity and is resisting referral. Practitioners did not feel confident in relation to overriding consent and making a safeguarding referral for self-neglect concerns. It could be argued that, at the end of her life, her son was similarly deterred from seeking help for his mother by the view that she had the right to refuse care. Whether there is the need for a wider public conversation about this issue is also worth consideration.

Mental capacity

On a small number of occasions, services assessed Lisa as lacking capacity to take particular acute decisions about her care. However, her capacity was assessed on multiple other occasions regarding various decisions, which is good practice, and generally services assessed Lisa as having capacity. The report cannot re-assess any of the individual decisions made about Lisa's capacity. However, it does

raise questions about the approach to assessment. It is acknowledged that the Mental Capacity Act is a complex piece of legislation and there are differing views on its use with this client group.

In assessing capacity with vulnerable and self-neglecting individuals like Lisa it is more relevant to consider executive function / executive capacity. Repeated refusals of care, as happened with her, could raise questions about the ability to execute decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

Smoking and fire risk

Lisa was a cigarette smoker for most of her life and the risks associated with this are identified in the agency reports. These recognised the risk of house fires due to hoarding, cluttered furniture, and a pattern of dropping unextinguished cigarettes.

However, it is not just fire risk that is the concern. The health impacts of smoking are also important. Smoking increases not just the risk of lung disease; it also worsens heart disease, oral cancer, liver disease, pancreatitis and possibly even cognitive impairment – all conditions to which dependent drinkers are already prone. At one level this may be viewed as a minor issue in the SAR; but, reducing smoking among people with mental health problems is an Office for Health Improvement and Disparities (OHID) priority. There is also an OHID focus on smoking among people with substance use disorders. It is important that professionals recognise the need to address smoking with people with alcohol use disorders; particularly because 70-80% of chronic dependent drinkers also smoke.

Family involvement

Lisa's son's position is ambivalent: at times there are concerns that he is an abuser and at others he is his mother's sole carer. The reality is that for most of the last three years of her life there were no accusations of abuse, and he was her carer. As a result, he should have been considered for support as a carer. One agency acknowledged that there was no consideration of support for Lisa's son, no questioning of whether he was able to care for her and, indeed, at no point was he spoken to alone about his ability to support her. This seems to be true across other agencies.

This highlights the need for professionals to focus on engaging and supporting family members (and other unpaid carers). Without Lisa's son's input, services would have faced far greater demands from Lisa.

Covid-19

The period under review covers all but the first three months of the Covid pandemic. Many services, such as the Ambulance Service and CityCare, continued to operate throughout the period with no restrictions or limitations to the service offered. However, Lisa herself identified that she felt isolated due to Covid-19. At the time of the domestic abuse disclosure, she stated that she had agoraphobia and was not leaving the house. She also reported that she was worried about the transmission of Covid-19, which subsequently impacted negatively on her mood and mental state. It is not possible to draw a direct line between the Covid restrictions and Lisa's death. As a result, no comments have been made on Covid's impact, particularly as these were a unique set of circumstances.

Recommendations

Recommendation A

Nottingham City's Public Health Team should ensure all frontline services are aware of and offered training in robust alcohol screening tools such as the AUDIT tool to identify and record the level of alcohol related risk for clients.

Recommendation B

Nottingham City's Public Health Commissioners should ensure that as part of their training offer, all practitioners are aware of alcohol services' availability including the offer of assertive outreach and are referring appropriate dependent drinkers that services find difficult to engage.

Recommendation C

Nottingham SAB and its partners should review aspects of the response to domestic abuse:

- The need for training and support to ensure professionals are robustly exploring and communicating about the role of domestic abuse in individuals' lives.
- Reminding practitioners that conversations with individuals should be held separately from potential abusers.
- Considering whether the response to situations where a victim of domestic abuse cannot be contacted is adequate and that current polices on this are being adhered to.
- The Board needs to reassure itself that, where agencies have raised issues about the visibility of domestic abuse risk information in their client information systems, that these concerns are being addressed.

Recommendation D

Nottingham SAB should review the local procedures that guide professionals on how to respond to vulnerable or high-risk individuals whom agencies find difficult to engage to ensure that this guidance is working for this client group and is being widely followed by practitioners. The SAB should ensure that those procedures include a focus on:

- Motivational interventions
- Escalation to a multi-agency framework

Nottingham SAB should also ensure that this guidance supports professionals to consider the use of the Mental Capacity Act in the context of clients that agencies find difficult to engage generally and people with alcohol use disorders specifically. This should include reminders about the importance of considering executive capacity and helping apparently capacitous people to make decisions.

Recommendation E

Nottingham SAB should ensure that vulnerable dependent drinkers can be, and are being, escalated to a local multi-agency forum for joint management. The SAB should ensure that the importance of

escalating concerns about more vulnerable clients is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation F

Nottingham SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals who are difficult to engage in services and those with alcohol use disorders in particular. This should ensure that professionals also feel confident to raise a concern about people who are refusing consent.

Recommendation G

Nottingham SAB should initiate a discussion about whether understanding of the Mental Capacity Act is impeding care and, ultimately, determine whether these concerns need to be escalated to the Department of Health and Social Care.

Recommendation H

Nottingham SAB should use this SAR to promote. and remind all partner agencies of the importance of, family involvement in care. The SAB should ensure that, where appropriate, carers are being identified, and then positively offered, a carers' assessment under the Care Act 2014.

Recommendation I

Nottingham SAB, and its various partner agencies individually, should ensure that frontline staff are reminded of the importance of the inter-connected issues of taking action on smoking risk and fire risk with vulnerable clients.