SAR Nicola - 6 Step Briefing

The Background

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 around 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.

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.

The Review

Southampton Safeguarding Adults Board concluded that the circumstances of Nicola's death met the criteria for carrying out a mandatory safeguarding adult review 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 to review the three-year period when Nicola lived in Southampton prior to her death. The following key lines of enquiry were explored:

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

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 an opportunity 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 respective children in early 2020.

Findings

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 was provided from an Independent Domestic Violence Advisor (IDVA) with follow up from the health visiting service, whilst 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. There were gaps and shortcomings in the support she received relating 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.

Learning Themes

Responses to domestic abuse – there is a need for a greater proactive response by agencies following reports of domestic abuse. Consideration should be given to the potential impact of domestic abuse as part of multi-agency meetings such as the Initial Child Protection Conference.

Trauma-informed practice – Nicola experienced multiple layers of trauma in her life from both historical and recent life experience. 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, need to be embedded in practice.

Engagement with services – consideration should be given to increasing support available prior to crisis management stage.

Dual diagnosis – consideration should be given to earlier and more timely access to mental health or substance misuse services.

Mental capacity – professionals should undertake formal capacity assessments when an individual's decision making places themselves at serious risk over a sustained period of time.

Think Family – the need for a holistic 'Think Family' approach – appropriate reflection of the impact of the situation on both adults and children within the family environment. When acting to safeguard children, there is a need for Children's Services to give greater recognition to parents' own needs and work closely with Adult Social Care to ensure that these are met.

Safeguarding – promotion of the understanding of self-neglect as an aspect of potential care and support needs.

Interagency working – improvement required around the timeliness of interagency shared strategy processes such as Multi-Agency Risk Management Framework (MARM).

Recommendations

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.

Useful Links for Best Practice

1. SAR Nicola Executive Summary report
2. Self-Neglect: Building an Evidence Base for Adult Social Care
3. Working with people who self-neglect: Practice Tool (2020)
4. 4LSAB Multi-Agency Risk Management Framework - MARM
5. Tackling Adverse Childhood Experiences (ACEs) State of the Art and Options for Action
6. Borderline Personality Disorder has the strongest link to childhood Trauma
7. Alcohol Change UK – Learning from Tragedies
8. Executive Functioning – The Science of Adult Capabilities