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## Minute DSAR Briefing – Adult B (AB)

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### Background

AB was experiencing self-neglect, and alcohol misuse. It is important to note that these events took place during the first period of Covid-19 lockdown. AB broke her leg following an accident whilst intoxicated; however, she had not had a metal frame on her leg removed following this fracture (which should have been removed several months prior). AB repeatedly had not attended medical appointments. AB was unable to maintain her personal care at home. AB had a probation worker following a drink driving conviction and a tag to her leg. AB was not visited at home. The review took place due to concerns that there appeared to have been minimal partnership working to support AB, until the involvement of adult social care towards the end of her life. AB was assessed by paramedics that she had the capacity to make a decision to refuse treatment and admission to hospital. The social worker had a conflicting assessment of AB's capacity to agree to hospital admission. AB later sadly passed away at home.

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### The Purpose of a Discretionary Safeguarding Adults Review:

- Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard AB
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of AB and her family are heard regarding their lived experiences and the impact of self-neglect and alcohol misuse.

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### Resources and further information:

[How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK](#)

[Responding to self-neglect - YouTube](#) a video for professionals

[The importance of professional curiosity in safeguarding adults | Research in Practice](#)

[Combined document to Support Adult Safeguarding Referrals \(003\) \(002\) \(stopadultabuse.org.uk\)](#)

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### Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

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### Practice implications:

The DSAR highlighted that there was only limited face to face contact with AB due to the pandemic. Limitations exacerbated by lockdowns and AB's chaotic lifestyle and the fear she had of attending hospital/medical settings. It is acknowledged that agencies went to extraordinary lengths to engage with AB, however, it appears that treatment plans require the patient to be motivated to attend and engage with few options available if the patient is struggling & potentially overwhelmed. It is evident that there were missed opportunities to explore AB's level of vulnerability and engage services to explore options, opportunities to share information across agencies in order to support the development of a plan to support her. Partners are encouraged to use the Complex Safeguarding forum/ legal gateway meetings in such cases.

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### Key Themes:

#### Professional Curiosity -

Despite the number of professionals involved with AB, it appears few had met her in person due to her repeat non-engagement and no one knew her as a person/ her life etc. Increase need for Professional Curiosity – Self Neglect is not a lifestyle choice; professionals need to explore and question why someone is self-neglecting.

#### Information Sharing –

Organisations need to share information with the right people at the right time to:

- Prevent death or serious harm.
- Coordinate effective and efficient responses.
- Enable early interventions to prevent the escalation of risk

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### Recommendations:

The D-SAR made the following recommendations:

*Staff to be encouraged to go on the Substance Misuse Training with Change Grow Live*

*Partners to take advantage of the Multi-agency Complex Safeguarding Meeting*

*Agencies to consider the role of the person that has been identified as a contact for the adult at risk, ensuring consideration is given to carers and that carers are recoded and highlighted on case notes/records*

*'Did Not Attend' appointments – Organisations to consider how they are going to address 'Did Not Attend' as a multi-agency. The Safeguarding Adults Board will seek assurance around 'DNA' from all partners.*

