SAR 'Lisa' Case Summary

Nottingham City Safeguarding Adults Board

BACKGROUND:

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 ischemic heart disease. She had a long history of alcohol use disorders, mental health problems, self-neglect and concerns about domestic abuse.

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.

PRACTITIONER KEY LEARNING:

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. **Practitioners in all frontline services should ensure they are aware of and access training and resources available from Public Health on robust alcohol screening tools such as the AUDIT tool and record the level of alcohol related risk for their client.**

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 issues – she often found it difficult to engage with services. The City does have an engagement procedure document. In addition, a more organised (and professionally curious) approach to the challenge of engaging Lisa could have greatly benefited her. **Practitioners should ensure they are aware of the available guidance and tools relating to engagement and professional curiosity:**

- **Improving Agencies' Engagement with Service Users Framework**
- **Professional Curiosity Toolkit**

Lisa's son should have been considered for support as a carer. One agency acknowledged that there was no consideration of support for him, 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.**

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AGENCY KEY LEARNING:

There is a need for ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals who are find it difficult to engage with services and those with alcohol use disorders in particular. This training should ensure that professionals also feel confident to raise concerns about people who are refusing consent. **Agencies should review their current adult safeguarding training to see whether these areas are adequately covered.**

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. **Agencies 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.**

ACTION TO BE TAKEN:

Please share this briefing and discuss the learning from it to inform future practice. If you have concerns about someone who is exhibiting signs of self-neglect and are unsure how to proceed, please speak to your agency safeguarding lead, even if the individual may not meet the criteria for a referral to social care.

HOW TO USE THIS BRIEFING: As with all Safeguarding Adults Reviews, there is learning for all practitioners and services, even if they were not involved in the original case. Here are some ideas on how you can take this learning forward:

- **Include reading this briefing in your personal development time and check whether you are familiar with the policies and procedures detailed within**
- **Discuss in your supervision/ 1:1 sessions – are the themes in this case familiar with what you see in your day to day work?**
- **Share with your comms team to put on your own agency intranet**
- **Add it to your agency internal newsletter**
- **Use it in your weekly team meeting to start a conversation – are there themes in this case that your team may struggle with? Would they know where to seek support if they were faced with the situation within the briefing? Is there a training need to ensure staff are well informed and confident in dealing with self-neglect and raising a safeguarding concern?**
- **Do you know where to find the Safeguarding Adults Board resources in your agency? If not, raise this with your manager**

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