

SAFEGUARDING ADULT REVIEW REPORT

(Mrs SK)

2022

**MERTON
SAFEGUARDING ADULTS BOARD**



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1. Introduction

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the Merton Safeguarding Adults Board (MSAB) relating to the death of an adult in the borough during 2018 (referred to as SK throughout this report to preserve her anonymity).

1.2 The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from the cases and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Merton in the future.

1.3 The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews.

The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to ‘promote effective learning and improvement action to prevent future deaths or serious harm occurring again’.

The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, states¹:

14.168 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

1.4 Why was the case chosen to be reviewed?

The Merton Safeguarding Adult Board (MSAB) received a referral for SK in February 2018, a month after her death, from Merton Centre for Independent Living (MCIL). The concerns raised by MCIL at this time centred around the long delays in getting support in place for SK, and the concerns raised regarding the discharge from hospital shortly before her death. SK repeatedly asked for help, but MCIL were told that she had a “history of manipulating professionals”, that SK “knows alcoholism is ruining her health” and “making unwise decisions”, and “not engaging with services”. Also, that she is a frequent ambulance caller and although her GP has made frequent adaptations requests, she has been seen “running up and down stairs”. MCIL didn’t feel that these views of SK reflect her complex situation and are concerned that her care may have been delayed as a result of a failure to recognise her needs and to work effectively with health and other agencies.

There was a significant delay in MSAB subsequently commissioning the SAR following the referral, which formally commenced with the appointment of the SAR author in February 2021, 3 years after the referral was received.

¹ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

This was due to unforeseen circumstances, which meant the initial reviewer was unable to complete the review process. The recommissioning of the Safeguarding Adult Review was further delayed due to pandemic pressures.

This delay has led to some limitations on the review, as staff involved at the time of the case had moved on, affecting the collection of first-hand experience of the case and service changes since this time could compromise the relevance of subsequent findings from the case review.

1.5 Timeframe, Terms of Reference, Methodology and Scope

The SAR was initially commissioned from the current independent reviewer in February 2021 and a SAR Panel was set up to oversee the themed review. Information was requested from a number of agencies involved with SK, who submitted chronologies of their individual agency involvement. The SAR Panel decided that the focus for this review should be on systems issues, with Terms of Reference agreed for the SAR (see below).

The methodology agreed upon was for all individual agency reports and submissions to be collated by the reviewer into an integrated chronology covering records for multi-agency contacts with Mrs SK. The Timeframe for review was agreed by the SAR Panel to focus on the final 2 years of her life, from February 2016-February 2018. The reviewer produced an integrated chronology for this time period, which was then summarised for narratives of work done (see section 2 for details). The narrative account was then divided up into sections, called Key Practice Episodes (KPE's) for further appraisal and analysis of practice, which were shared with the SAR Panel.

1.5.1 Terms of Reference

The specific areas for focus for this review were agreed by the SAR Panel in April 2021. The SAR (and by extension all contributors) will consider and reflect on whether the care provided by all organisations and professional was consistent with expected standards and in line with primary legislation, statutory guidance and codes of practice.

- The impact of both SK's mental and physical health conditions on her vulnerability, risks and needs, including the management of her chronic and complex conditions.
- The systems in place to respond to self-neglect and substance misuse during the period subject to review.
- The effectiveness of mental health services, including housing-based services (e.g. support workers), which were provided to manage the impact of SK's conditions on her health and wellbeing.
- The quality of services delivered in response to periods of acute crisis (including use of emergency services) as well as the long-term difficulties experienced by SK.
- The circumstances and events leading to the SK's death
- The thresholds used for decision-making in response to concerns reported to the local authority for safeguarding enquiries to be undertaken.

1.6 Agencies and Teams that had involvement in the case subject to review:

- London Ambulance Service NHS Trust-numerous ambulances called to SK address at times throughout the period
- Ability Housing Association-provided a community support worker
- Norbury Medical Practice (GP Surgery)-extensive involvement by GP, Community Nurse and District Nurses.
- Merton Adult Social Care Services- Reablement Team, Hospital Social Work Team, Adult Assessment Team, First Response Team, Occupational Therapy Team were all involved in different stages of the chronology
- Merton Centre for Independent Living (MCIL)- provided support with finances and benefit issues
- St Georges University Hospital NHS Foundation Trust-had both inpatient and outpatient involvement
- Croydon University Hospital NHS Trust-had both inpatient and some outpatient involvement
- South West London and St Georges Mental Health NHS Trust, including Alcohol Services-Merton Assessment Team (MAT) and Merton Drug and Alcohol Recovery Team (MDART) received a number of referrals about SK and arranged inpatient admission for alcohol withdrawal
- Westminster Drug Project-received referrals for SK for support with alcohol
- Job Centre Plus and Department of Work and Pensions-involvement with SK's Welfare Benefits
- Metropolitan Police, Merton-several calls to SK's address
- DWP, provided welfare benefits and had contact with SK and her support workers

1.7 Reviewing expertise and independence

An Independent Consultancy undertook the SAR with the appointment of an Independent Lead Reviewer. All relevant documentation was then shared with and scrutinised by the Independent Lead Reviewer, to compile the Independent Overview Report. Mick Haggart is the author of this Overview Report, which has been completed on the basis of submissions of Individual Agency Documents, conversations with individuals and Chronologies (as outlined above). Mick is a registered Social Worker with over 10 years experience of undertaking Serious Case Reviews and SARs.

1.8 Involvement of family members

The input and opinions of family members of the deceased are an important aspect of the SAR process, both to inform them of the review, and to include them to take account of their first-hand experience of services provided to them/their relative. SK was the mother of 4 children (3 daughters and 1 son) and the report author met with the 2 youngest daughters (K&L) to discuss the care offered to their mother. They are also provided valuable background information concerning SK's life and family circumstances, their views are set out in full below.

SK was of a Caribbean heritage, her mum (referred to as nanny by K&L) and Dad were from Guyana she grew up in Balham with a "traditional, strict" upbringing.

As a teenager SK rebelled from this and moved out to live with her cousins. She used to be chatty, fun and very sociable but over time lost contact with her circle of friends and cousins. When K&L were younger they lived in North London, their parents split up in 2002 then they moved to Tooting in 2006. SK was drinking then but was functioning OK at that time. When she came to Tooting she stopped coping and without the input of their nanny L&K felt they may have ended up being taken into care. Children's services had briefly been involved before they moved back to Merton. Nanny had a property company and she provided them with the family home, eventually taking over and paying off the mortgage on the house. SK's brother and Nanny both gave SK money.

K is 24 and L is 22 now, but at the time of the SAR period they were 15 & 17, their needs for support were never recognised and they didn't receive any help looking after SK. They were aware their lives were not normal and both had to get paid jobs while young as there was never enough money in the household. No one questioned them about this and they weren't recognised as children in need/or at risk. Their nanny did get SK some private counselling sessions, but SK only went to one, she reported that everything was fine and stopped going. Nanny didn't want K&L to tell anyone what it was really like at home, SK would be drunk when talking to their teachers, she was rude and embarrassed them both with how she was with the school, but again the school didn't ever recognise them as needing help.

As regards SK's history of drinking it was very long term, as far back as they can remember she was drunk, but it did get worse after their Uncle passed away when they were 14/16 (2013). SK never managed to recover from the grief/shock of his passing as it was very sudden and unexpected. Before this SK used to do the cooking and enjoyed making meals, but lost interest in this and did less and less, the children had to cook their own meals and whilst also trying to encourage SK to eat during the period under review.

In 2015 SK had been in an abusive and sometimes violent relationship for 3 or 4 years, there was always shouting and he would hit her, one time he poured boiling water on her. He would also take advantage of her financially. After this she stopped eating regularly. SK was working, as a teaching assistant for children with special needs, accompanying them on the council bus. After this she was unable to work and most of her income was via Child Support Allowance (CSA), these were taken over by their Nanny. She had wanted SK to come and live with her in 2016, but was told by Wandsworth that this wasn't allowed, because she was under the care of Merton at the time and this couldn't be transferred, Nanny even offered to pay for private care but was told this was not allowed.

At this time, the children were not being looked after at all by SK, they were doing the cleaning, housework and cooking meals for their mum. The only services who worked well with SK was the nurse from the GP surgery, who took the time to get to know her, developed a good rapport. Her GP was very caring, the other staff didn't seem to take much interest in her, discounting her as an alcoholic who couldn't be helped. K&L did acknowledge SK was difficult in how she responded to offers of help, she would shout and not make sense, especially when intoxicated and she was drinking every day. SK's nurse saw the deterioration in SK over time, it was shocking, but when she left (to go on maternity leave) the new staff were

not around for long so didn't witness how much she changed in the same way. She definitely never ran up and down stairs, as some notes suggested, as she was very frail thin and hardly ate anything, surviving on Guinness and little else at the end. They acknowledged that she did manage to get out of the house to buy alcohol, or later would get neighbours or random others to go to the shops to buy her alcohol when she was too sick to leave the house.

K&L got used to seeing the police and ambulance turning up at their house when they were younger, on one occasion a female officer did ask them if they needed help, but this wasn't followed up. SK at this time was always either drinking, or on the phone calling up people/services. SK couldn't cope with her losses and traumas, she was stuck in the past, which became worse as she deteriorated towards the end. Her memory was very bad, one time she left the gas on- she would use the hob for heating the house rather than put on the central heating. On one occasion K found her asleep in the front room with the hob left on. She did have insight to some extent that she was harming herself.

K&L felt that they were keeping her going, she couldn't take care of herself or the house, she was incontinent and it was her kids who'd clean her up. She was depressed and spoke sometimes of suicide but again her mental health was never assessed. They both moved out of the family home at the end of 2017, K went to Enfield to live with her dad and L went to live with friends. They felt guilty about this, but were told SK would get help if she was on her own, only she didn't. They were both exhausted with the strain of trying to look after her while pursuing their education/careers and working too (waitressing & childcare). They were aware that things would deteriorate for SK without them around to care for her. They tried to understand how to help her but weren't even given advice about what to do or how to do it

She was discharged from hospital in early 2018 but seemed to be getting better when admitted again, but she collapsed and fell in St Georges Hospital, subsequently dying of a cardiac arrest, with the autopsy revealing she had sustained fractured ribs. She had been released back to the same environment with no care, she was doubly incontinent at this time and so weak she couldn't go out so K&L had no idea quite how bad it got until after she passed away.

They wanted to know why there were such long delays in services giving their mother help after she had been referred, especially by ASC. Also, that when she did receive help it wasn't the right kind, she was seen as having purely an alcohol problem but K&L both felt she had clear needs for mental health support, which were never addressed. Furthermore, they felt she was at times clearly not capable of making her own decisions and yet her capacity was not assessed as it should have been.

L&K have both had the opportunity to read and comment on the draft report. Some minor amendments were made following this consultation and they have stated they were happy with the accuracy of contents, the findings and recommendations.

2. SUMMARY OF THE CASE

The section below sets out a brief summary of the multi-agency chronology of services involvement with SK. The author collated the chronology from the individual agency chronologies and other reports submitted by the agencies participating in this review.

Information submitted prior to timeframe for the review

SK had been offered an assessment with the MDART service in 2014 for her alcohol dependence, but didn't engage in the process, she registered with her GP in 2015, who re-referred her once more in July 2015-she was offered support but again was discharged due to her non-engagement in December 2015. Her GP referred her for an assessment of her mental health in January 2016. The previous history of her alcohol use and its impact on her is not known, as outside the scope of the review timeframe, but see Family views for a summary of SK's social history.

2.1. KPE 1- (16/02/16- 10/10/16)

SK attended the Emergency Department of St Georges Hospital (ED) after a fall from her stairs and subsequent swelling to her leg, in February 2016, she had blood tests and a scan-but left before the results were known. However, when her results came back the doctor phoned and she returned the next day, when she was admitted to hospital (no details of this admission were provided to the review, other than it was for unexplained symptoms-oedema, alcohol related liver disease and ascites). This coincided with an appointment with MDART, which she was unable to attend. She did attend with her mother for a re-arranged assessment with MAT, but this was cancelled as the consultant was off sick and no further appointment was made.

In March she was referred by her GP to Adult Services, an Occupational Therapist and Occupational Therapist Assistant (OT/OTA) visited her at home (they noted that she had stair rails but had a fear of falling. SK requested help with shopping, cleaning and personal care, which was then referred to Merton Social Work (SW) Team from the OT duty service.

In April SK had another fall at home and an ambulance was called, but she declined to go to hospital. Her GP re-referred her for an assessment with MAT and a further appointment was offered for the end of the month, although SK this was cancelled on the day by MAT, the reason for this was not known.

In May her GP requested she make an appointment via a letter, which SK's mother responded to, saying SK was unable to visit the surgery, but was due to see a Community Matron. Her GP then received a medical information request from her OT after the above assessment (this was required as medical information was needed for the OT to assess the need for stairlift). During this assessment SK was observed climbing her stairs and transferring from sitting to supine, both of which she was able to achieve, albeit slowly and breathless at the end of it. The assessment also noted severe grief following a recent bereavement of her brother. It further noted she thought her deceased brother was moving her curtains and still talking to her. She did not sleep in her bedroom as this reminded her of previous trauma, where a previous

partner had assaulted her. This did not prompt any concern about either a severe grief reaction or underlying mental health problem. SK's mother informed her GP that she was due to see a psychiatrist, although again this was cancelled twice more, with a further appointment re-scheduled for June 2016.

The next day SK contacted Merton Centre for Independent Living (MCIL) for help with her finances, benefits advice and debts with utilities, she couldn't remember who advised her to do this. A home visit was then arranged to meet her to discuss this. Her mother updated the GP that the psychiatric appt had again been cancelled by MAT. This was the third appointment which was cancelled by Merton Assessment Team (MAT).

She was then visited by a Reablement support worker, in mid-May-but as SK was seen walking up the road with shopping it was viewed that no care was needed. A subsequent home visit by the GP & Community Matron noted that her health was thought to have improved. She was seen with her mother and reported feeling very low, her mother felt she still needed a psychiatric assessment and possibly an admission. OTs did not make an adaptation recommendation (as required to apply for a Disabled Facility Grant, for stairlift, as this was assessed to be unsafe due to her frequent intoxication).

The GP referred her again for a psychiatric assessment, requesting a home visit, due to her difficulties with engagement. SK felt she didn't need mental health input, but her mother wanted her to be sectioned. The GP prescribed her fortisip (as a dietary supplement, due to her very low weight) and recorded doubt about her compliance with the medication. The GP had a copy of a letter inviting SK into an office appt for a psychiatric assessment, it appears this may have again been cancelled as the GP subsequently wrote a letter of complaint about this, however again there were no details of this in mental health records submitted for review.

The GP prescribed SK an antidepressant (citalopram 10mg) and then discussed her care at an MDT, where St Georges Hepatology dept had discharged SK, due to her non-attendance for appointments with them (again no details about this known). In June the GP again chased up her psychiatric assessment and MCIL arranged a home visit (they also recorded concerns about her Mental Health following this phone call, as she seemed not to follow the discussion over the phone about a visit). At this visit SK talked about her financial problems and relationship/DV issues (later notes indicate she had been assaulted by an ex-partner-who was in prison). Later that day SK phoned MCIL to ask about a visit-she appeared to not remember she had been seen earlier in the day. At the end of the month a home visit was undertaken by MDART at which SK was intoxicated and unable to answer questions, her abdomen was distended and her liver enlarged. MDART concluded a detox plan was required but SK refused to engage with this

The department for Work & Pensions (DWP) were contacted by MCIL about her Disability Living Allowance (DLA) and this was in process of being changed over to a Personal Independence Payment (PIP). SK then continued to repeatedly call MCIL about appointments, leaving 8 voicemail messages, some at night time-again indicating her memory problems and intoxication. Her advice worker established SK had missed a medical appointment with the DWP in March, which was why her

benefits had been stopped, she updated SK and gained consent for contact with her children to gather more information about her. There was good liaison with SK by MCIL case worker in Mid June 2016, who visited and worked both on her benefits (her Employment Support Allowance (ESA) had also stopped and she had no income, she was known by DWP to be vulnerable at this time) and she gave consent for her to be referred to Merton Adult Social Care (ASC) for help with cleaning, shopping and lack of company, which was done (an OT had already also referred her and she was on a waiting list). Notes from ASC of the call about needing help indicated that she had been signposted to Wimbledon Guild (WG) for help, although there were no records of any actual contact with Wimbledon Guild either by SK or ASC.

In June a discussion between her GP and the Consultant at MDART recorded that SK needed an inpatient detox, for her alcohol dependence, but she was unwilling to have this. Notes of the conversation indicated that a community detox was inappropriate and MDART would discharge her if she was not ready to engage with the plan. Further contact was made between her MCIL worker, DWP and GP to obtain a backdated medical certificate for the missing period, so she could receive her benefits, which had been stopped. Another MDT at the GP surgery identified further concerns, including yellow eyes and the need for the detox to be arranged for her as an inpatient. Further liaison between MCIL and the GP discussed the difficulties of working with SK, due to her poor memory and frequent calls, on the same day LAS requested her GP speak to SK, as she had been making frequent calls to them as well.

A home visit was offered by MDART, with MCIL notified and arranging family attendance for this, SK was offered again an inpatient admission for a detox (due to risks, her enlarged liver and risk of seizures), but she was not in agreement with this, she felt unable to leave her children and couldn't commit to abstinence, she was then discharged from the MDART team at the end of July. The plan was to offer detox, if/when she was readmitted to hospital and a need for joint work with gastroenterology dept. She was not thought to be appropriate for a Mental Health Act assessment for this. She also did not attend a diabetic screening for her eyes and was also discharged from this clinic in July. She called an ambulance, who attended her about pain in her leg, but refused admission to hospital, the GP was informed of this. In July her medication use was reviewed by her pharmacy and she was not taking any of the antidepressant medication, which was then stopped. At the end of the month her GP prescribed antibiotics for a UTI, with increased temperature.

Police and LAS attended her house at the end July, in response to SK calling, stating she felt suicidal, but on attendance she said she would not harm herself, but was conveyed to hospital and assessed in the Emergency Department. Liaison psychiatry saw her and she was intoxicated, had had a fall and a number of physical health checks were done. She was re-referred to hepatology due to her worsening liver function and back to MDART for her alcohol use. Her GP was informed and a MASH Merlin referral sent to Merton Children's services, partly as there was a 15 year old daughter in the house, which was very messy with empty bottles of wine, SK was said to be consuming 2 bottles of wine a day.

In August MCIL closed her case, having completing benefits applications for her. Children Services followed up the Merlin from the police, with the outcome that her youngest daughter didn't want to live with her mother anymore and was taken to stay

with older sister, who lived in Tooting. Further notes stated she had been taken to her grandmother's house instead, no further input was recorded about this.

The following week SK again called police in distress (a neighbour's car blocking her parking), with a Merlin sent to notify Adult Services about this, graded amber by police. Children's Services closed the referral after a discussion with her daughter's grandmother. 111 notified the GP that SK had made over 20 calls to them in the past month. SK had also phoned MCIL for help with her Council Tax Benefit, apparently forgetting this had already been done.

Further contact between the pharmacy and her GP, discussed SK's non-compliance with medication, her Community Matron had continued 2x weekly visits, she noted alcohol consumption and raised a safeguarding referral to ASC. The referral was closed, as concerns were said to be health related (no consideration of self-neglect as a safeguarding issue) but the GP was informed that a Care Act Assessment was due to be done.

In September MDART team phoned SK again to offer a detox which was again refused-this was presumably in response to referral from ED in July. Another GP home visit noted SK had lost weight, looked jaundiced and her blood count was abnormal, again admission was recommended-but was refused. Although contact with her mother later led SK being persuaded to agree and an ambulance was arranged to convey her to hospital the next day. Screening tests were completed and she was admitted on 07/09/16 for liver failure. The same day ASC visited to do the Care Act Assessment, but as she was in hospital the referral was closed. She was discharged from Hospital after a month, she'd had more tests identifying liver damage and was advised to stop drinking, due to the extent of her liver damage, which could put her life at risk if she continued. Seen by STG drug and alcohol team who know SK well. SK stated she had reduced alcohol to 2 glasses of wine daily, but did not want to stop. Known to Merton team. Merton outreach worker from MDART visited SK on the ward.

2.2. KPE 2- (11/10/16-31/12/16)

SK was visited at home by a Reablement worker the day after her discharge from hospital to settle her back in at home, she had a dressing for a pressure ulcer on her buttock, but checks with the ward revealed no wound care referral or equipment was done prior to her discharge. Her Community Matron arrived and planned to refer to District Nursing (DNs), for dressing her pressure wound, her incontinence issues and for an assessment for a pressure cushion.

SK was unable to go upstairs and lived on the ground floor of her house from this period onwards (she used a commode in the living room), a package of care was reportedly set up after this for 2 carers to visit twice a day to assist with personal care and meals (presumably from Reablement).

An OT assessment 2 days later from the Reablement Team identified her loss of confidence and inability to use stairs but she was able to transfer between her sofa, commode etc and also notes 3 of her 4 children were living with her. Over subsequent days SK declined care and visits were reduced to once a day in the morning as she

could manage her evening meals independently. Medical follow up and blood tests showed SK had high blood sugar, related to food and sugary drinks intake, this was checked daily over the next week by the District Nurses (DN).

10 days after discharge SK was seen drinking wine by a Reablement worker and was thought to be managing her personal care and meals independently. The same day SK went to Emergency Department (ED) on the advice of DN due to her persistent high blood sugars (over 30), she was given fluids, discharged and advised to attend a diabetic one stop clinic. The following week her GP visited her at home, she was drinking Guinness, had had a visit from MDART (which she didn't think was helpful) her GP reviewed an admission avoidance and diabetes self-care plan and also planned to refer her to a day centre.

At the end of October her blood sugars were off the scale and the DN advised her to return to ED (where Gliclazide 40mg daily prescribed), MDART were made aware of her relapse and attempted to monitor her, but she'd thrown away a chart they had provided to record her alcohol consumption. Reablement closed her case in early November as she had been declining care. Her blood sugar levels were up to 38.9 again which was thought to be diet related and due to her not taking Gliclazide² (a drug to treat type 2 diabetes, by increasing production of insulin)-she was referred to the Diabetes Clinic at Croydon Hospital, but was unwilling to attend.

Further DN notes in November showed SK had continued high blood sugar levels, poor compliance with medication and SK refused advice to attend hospital (although was taking a different drug for her diabetes-Sitagliptin³) a review later in November noted weight loss (due to ascites-fluid in abdomen) her blood sugars being poorly managed, a plan was made for a fasting blood test and referrals to podiatry and a community diabetic service.

In November further medication issues were noted by the GP with SK not wanting to take Furosemide⁴ (which is a diuretic which is prescribed for high blood pressure/fluid retention). In December a note from her DN to the GP stated SK had to be re-referred to Croydon Hospital Diabetic Clinic. SK attended an outpatient appointment at Croydon Hospital for post-menopausal bleeding and a biopsy was done, the outcome of this was no cause for concern. She missed an appointment with Podiatry at Croydon later in December and a foot care update sheet was faxed to her GP.

Ongoing DN visits through December were felt to be helpful for support with SK more stable and not calling surgery so frequently, but still calling 111 often. She went to hospital for appointment on the wrong day in December, and also mistook MCIL for home carers, suggesting her memory was once more problematic. She had further financial trouble, about her mortgage with legal action being threatened, notes also suggest a reassessment by ASC had occurred in December, although no details of this were found on ASC records.

² <https://www.nhs.uk/medicines/gliclazide/>

³ <https://www.nhs.uk/medicines/sitagliptin/>

⁴ <https://www.nhs.uk/medicines/furosemide/>

2.3. KPE 3 (01/01/17-15/05/17)

Her GP had re-referred her to MAT at the end of December, which was then discussed in January in a MDT, with a plan to raise a safeguarding concern and to discuss with MDART. This referral was then forwarded to Engage Merton⁵ (A counselling service) who sent SK an appointment which she did not attend. More concerns were noted by her GP about SK's alcohol consumption and that her Blood sugar levels were still worryingly high and she was still not taking medication. The GP stated that she had capacity about this, but no test was done as she was presumed to have capacity. SK phoned and asked for help from ASC with her shopping and cleaning, she was signposted to Wimbledon Guild again (but as before there were no records of whether they did offer help to SK). MAT then discussed a plan for a home visit at the end of the month and contacted ASC about the safeguarding concern, where possible alcohol related dementia was raised. She was then discharged from MAT, without being seen.

In February 2017 medical issues of a urine problem and the side effects of Furosemide, her dose was reduced. SK contacted ASC again requesting for another OT assessment, she was not placed on the OT, but was still on the First Response Team waiting list for a Social Work assessment, which was presumably from the referral in December 2016. SK was seen by a community physiotherapist, as she had shakiness in her legs and was using 2 sticks to walk with. In March, an OT noted the referral to them was again for a stairlift and adaptations, presumably as SK felt that she was still unable to manage at home. In response to this an OT wrote to her GP at the beginning and end of March. Continued high blood sugar levels were still noted by the DNs in March as well as a viral infection. ASC duty spoke to SK over the phone about her request for help at home, their notes say that eligibility was explained and the referral was then abandoned, unclear but this appeared to be without an assessment.

SK requested Buspirone⁶ (anti-anxiety/sedative liquid medication) from her GP who said he was unable to administer this. It was stopped as viewed to be a risk it would not be taken by SK reliably/correctly. SK was reporting to be in a lot of pain, also that she had diarrhoea and blood in her stools, leading to tests which were found to be normal and a home visit by her GP, where increased alcohol consumption was in evidence and ongoing non-compliance with her "water tablets" was still an issue. MCIL had more contact with SK and the Housing Benefits Team to assist with her Council Tax issue.

SK made 2 further calls at the end of March to ASC to chase her assessment, notes stated she denied having had a previous conversation with a social worker. MCIL also sent emails to ASC to try and chase up the request for a Care Act Assessment. Later in April MCIL chased up ASC again for this assessment. This was acknowledged and at that point she was said to still be on the waiting list MCIL reported their experience

⁵ <https://www.gettingiton.org.uk/services/merton/engage-merton>

⁶ <https://www.medicines.org.uk/emc/product/5736/smpc#gref>

of other clients who also experienced long delays waiting for a Care Act assessment during this period, which was raised with ASC.

Medical updates during April noted that SK was still having nosebleeds and had a further UTI, with advice given for her to go back to hospital and an urgent visit from the DN Out of Hours (OOH) service. A letter from her Community Matron (CM) in mid-April following a Home Visit after a urine test which noted a positive trace of leucocytes (white blood cells), nitrites, blood and protein and also “Ketones++ and glucose++” and SK refused their advice to go to hospital. There was more evidence noted of SK’s house being very messy and an increase in her dependency on alcohol, where SK was agitated and looking for wine during the CM visit, the letter notes she had full mental capacity to make unwise decisions, although again no assessment was done.

SK did go to St Georges hospital later that day where her blood levels were stabilised, her diabetes medication was changed and she was referred to gastroenterology for her ascites (fluid retention in her abdomen).

A date was made at the end of April for a home visit by ASC to undertake a Care Act Assessment, which was shared with MCIL and via them with SK and her daughter. SK called a dietician, the content of her call was noted to be quite inconsistent and confused, but it resulted in a referral via her GP for a community dietician, who also referred her once again for an OT. During this period community DNs continued to visit her daily to give SK insulin injections. She was again placed on the OT waiting list at this point, she was deemed to be non-urgent based on OT Priority Indicators (at this time, referrals to Merton OT dept were 159 referrals on the waiting list and the average waiting time was 59 days).

The Care Act assessment of her needs occurred following a home visit by a SW. SK had been drinking earlier on this day and made some statements that were subsequently corrected by her daughter (such as owning a house in Tottenham). Her poor memory made cooking dangerous (leaving food on the hob), her poor mobility especially on stairs led to her having “accidents” when she needed to use the toilet, her children helped her with shopping and cooking, as SK was unable to go to the shops. Her diet was very poor at home during the day when she was mainly on her own, as her children were all out at school or work. SK fell asleep midway through the assessment and her daughter provided some further background information on her.

SK began drinking more heavily after her daughters’ father left her, she did manage to cut down and worked for a while prior to a further relationship, which was abusive and that had ended 3 years previously. Since this time SK had been drinking heavily everyday, following her deterioration and admission at the end of 2016 no care was put in place on discharge and she was back drinking again after a week. Following this assessment, financial assessment information was left with AK (SK’s daughter) and she was told that help was going to be offered with her personal care needs.

Police were again called to SKs after a dispute with her neighbour over money she said he had borrowed, at which the police officer stated she was “having a mental health episode”, as she was repeating herself and her neighbour subsequently stated that the loan hadn’t happened.

In May the DN stated SK's blood sugar levels had improved (around 15) probably due to the daily insulin. She did attend her podiatry outpatient clinic in Croydon hospital, other than long toe nails no issues were noted. An ambulance was called when SK fell downstairs again after drinking a bottle of wine, but SK declined to go to hospital. A physiotherapist visited to carry out a mobility assessment, where SK walked with 2 sticks, she complained of pain from her recent fall and showed some further cognitive difficulty, jumping from topic to topic, being also unable to concentrate and having difficulty with her memory.

A safeguarding referral was then sent to ASC from Croydon Social Services, but this was said by the receiving SW to be not for safeguarding but for services from Croydon for a package of care, although no details were available for review of what this was about. Police were called out to SKs about another neighbour dispute, at which police thought SK still had mental health issues, repeating herself, answering her own questions, she appeared malnourished and the police referred her again to ASC by raising a Merlin report. This was also noted on ASC notes following receipt of the Merlin and police concerns of SK's alcohol use, her malnourishment and her Mental Health were recorded-but no action was taken in response to this.

Her GP also referred her to ASC as a Safeguarding issue, following ongoing frequent calls to 111, but was informed this would not be progressed as her self-neglect was due to her alcohol use, which she was not accepting help for. DNs reported raised blood sugar levels with her GP, who advised them to keep a diary for a week and perform a pre & post mealtimes Blood Sugar checks.

A further contact from MCIL to ASC about the outcome of the Care Act assessment noted the outcome was that SK was deemed not to be eligible for services, on the basis that her care needs arose out of her alcoholism. MCIL worker questioned her mental capacity, on the basis of her poor memory/ mental health problems, but the Social Worker felt that she had capacity and was making unwise decisions. Also, her alcoholism was said by the Social Worker to pose a risk to carers (although there were no details of what this was). MCIL checked with SK, who had not heard the outcome of her Care Act assessment. The ASC subsequently informed MCIL in writing that SK was not eligible, due to her alcoholism. Police were again called to her address after another dispute with her neighbour and submitted a Merlin report, raising concerns about her mental health, as she was talking to herself and jumping between topics.

2.4. KPE 4 (16/05/17-12/12/17)

MAT did receive the Merlin report about SK's mental health made at the end of the last KPE and did the only recorded home visit. The outcome of this was that "no variables were seen in her mental state". She was thought to have capacity and she was discharged from the service after this, not seen again. SK made multiple calls to 111, with various topics including DNs and waiting for insulin, she also had 2 more falls downstairs at home, both resulting in hospital attendance, sustaining a fracture to her elbow, which was put in a sling and a CT scan of her head as it was bruised, she had unequal pupil size-but no acute head injury was found and she was referred to the outpatient fracture clinic for follow up.

In June SK was visited in the morning by a worker and her manager from Ability Housing (AH), during which SK was already drunk, with wine. A number of financial issues to do with benefits, bank problems and bills were discussed and it was clear that SK wasn't coping with these at all with paperwork being scattered around the floor of her living room. AH support services provided more direct support whereas the focus of MCIL was on more advice and advocacy, their work was ongoing whilst her financial issues were addressed from this time. There was no communication between MCIL and AH about their work during this KPE and their areas of work appeared to overlap at times.

The AH worker found a letter in SK's home, amongst piles of correspondence for an office appointment with Mental Health services for an assessment, which was due to happen the next day, SK was unaware of this and did not attend. There was no information about this in Mental Health records. Her MCIL support worker visited her the day after this. She also tried to assist with SK's complex financial matters, she noted SK's landline was no longer working. Two weeks later the AH worker visited and again looked into her complex PIP, ESA form, Child Tax Credit-noted paperwork was still scattered around the home. SK was noted to be very under weight (5 stone) and needed support with this and also with her communication with other agencies. A support assessment was completed at this visit with ongoing support worker visits proposed. Her GP had a 3 way call with DWP and SK re; medical certificates and benefits.

In July MCIL contacted ASC to see whether their request for a Floating Support referral for SK had been actioned/decided on yet, no decision had been made at this stage by managers. MCIL called SK and were very concerned as she sounded so unwell. Subsequently it appeared that the floating support referral related to the involvement of Ability Housing and (as above) they had already begun their assessments with SK.

On a Community Matron home visit in July SK was tearful, drinking a bottle of wine, stated she's not eating and does not care. Her AH worker updated the nurse that SK was not taking her medication, but the nursing team were already aware of this.

SK had phoned 111 about being punched in the face by her partner, her GP was called to clarify and this related to an incident years ago (for which her partner had been imprisoned). Further information with 111 about an eye patch from Moorfields and another CT at St Georges also turned out to be untrue. Another visit was done in mid-July by the AH Support Worker to complete their assessment, at which SK had not attended her Mental Health assessment, her support worker left a voicemail requesting another appointment, although she was not offered one.

SK was still not opening her mail and not able to handle her various bank, mobile, utility bills etc. SK called the OTs about her assessment, to be told that she was still on the waiting list. Her AH worker helped her with a debt for her child tax credit. SK was said to be in denial about this, the letters were then to be given to her mother to resolve, as her mother had LPA to deal with SK's financial affairs and she received SK's benefit money on her behalf, giving SK an allowance on a weekly basis for her day-to-day needs.

Her GP advised her to attend the ED again in late July for her ascites and abdominal pain, which she did, she then had a number of tests but again left prior to the results being known. Over the next 4 days, ambulances attended SK, for her bloated stomach and a fever. On the second occasion she was conveyed to St Georges, where she was given advice and referred for an outpatient appt, for routine assessment which she did attend. An MDT discussion at the GP practice at the end of July noted her continued drinking, calls to 111, allocation of a social worker (which was not in fact correct) and consent from SK to be added to the Coordinate my Care system.

In August SK was once more taken to hospital and started on Furosemide (a diuretic) and spironolactone⁷ (a drug to help with her fluid retention related to her liver disease) once a day for 7 days, but a visit that day by a Community Matron confirmed she was not taking either medication and did then attend a follow up appointment at STG on 10/08/17, where she was seen with her mother. There had been no improvement in her liver function and she was advised to take prescribed medication to manage her ascites. SK was not sure whether she had been taking this, but agree to try. Information was shared with her GP and Community Matron, including advice to re-check her bloods and refer her back to Hepatology Dept if necessary.

She was allocated to an OT for an assessment later in the month (following the GP referral in April and after a 4 month wait), the OT contacted with SK who requested collection of the commode which had previously been supplied to her. At the assessment it was noted she was drinking and slept on sofa downstairs, she was assessed as safe to use the stairs and for a trial with a bathlift, a perching stool for the kitchen and was then referred for a physio assessment. The physio team stated they had tried to work with her since 2016, but due to her alcohol consumption she was unable to engage with exercises etc. SK was thought to be independent with stairs so was not deemed to be appropriate for a stair lift.

A MDT discussion at the GPs noted her Community Matron had left, causing SK anxiety (handover was needed to a new CM), her continued ignored of advice re; ascites. Another visit from AH worker, tried to help with PIP, her debts and need for services, at the visit SK was drinking and had trouble focussing on tasks which were needed, including filling out the PIP form.

In September contact with her GP noted ongoing stomach bloating and needing an appointment for drainage, more tests were done which were OK, she reported blood in her urine and nose bleeds. Contact with her OT led to an order of bathing equipment. Her GP visited again in response to leg pain and SK agreed to a "Coordinate My Care" referral and advised against making continued inappropriate calls to 111 and other health services. Her AH worker accompanied SK to her bank, there was no money in her account and she had not found a new bank card which had been sent out to her, so had no access to money at this time.

At this visit it became known that her mother had LPA for her finances (which was later confirmed by MCIL). There were no recorded contacts with her mother, who as she had LPA was in receipt of her benefits. Equipment ordered by her OT had not been delivered as SK had not responded to contacts made by company, this was resolved

⁷ <https://www.medicines.org.uk/emc/product/12015/smpc#gref>

and her OT visited to supervise use of bath aids, also the OT explained why she was not eligible for a stair lift (as able to use stairs). A perching stool was ordered for her to use in the kitchen and her case closed to the OT. Her case was then closed again by MCIL as she was receiving PIP, there were no records of what if any benefits her mother received on her behalf.

In October the AH worker attempted to support SK with keeping a diary for her various medical appointments and found another stack of unopened post. Several calls by SK were made to the OT, SK informed of another fall on the stairs and requested a stairlift again. SK also reiterated her perceived need for carers and she was advised to use a commode instead of going upstairs to use her bath and toilet. A visit with the physiotherapist was discussed by the OT, which was agreed as a one off joint visit but Physiotherapy would not accept a re-referral, due to SK's alcohol use and compliance issues known previously.

Another home visit from AH support worker attempted to address further debts, SK stating she was too unwell to deal with these and felt HMRC had made a mistake and owed her money, she said she'd been in touch with her MP about it and was unhappy with her mother being in charge of her finances. A neighbour complained about the large number of empty wine bottles left outside and not in the bin. The OT followed up request for medical information about SK's fall on the stairs and whether any medical cause for this, which was needed to consider SK's stair lift request again. At the end of the month SK phoned police complaining about her children, she was not making sense and police shared concerns over her mental health again with ASC via a Merlin, which was received but considered that this did not require any action and her case not re-opened by ASC, no further contact was made with Mental Health about this.

In November SK phoned the OT again about whether a physiotherapist would visit and she phoned ASC about her Meals on wheels not arriving, which she was not in receipt of, both calls may indicate SK's cognitive problems (confusion and poor memory). She then contacted the OT to report another fall down the stairs and also contacted the police to request her children be removed. On attendance her children said this was normal for her and she makes nuisance calls when intoxicated. Police raised another Merlin report, as SK was confused, repeating herself, not understanding why police were there-the report was received by ASC and deemed not for any action or referral to Mental Health. Also, her GP notes indicated ongoing nuisance calls by SK to 111 and resource issues for DNs who are now only visiting in pairs, sometimes SK was not in at others she was intoxicated.

A visit in the morning by AH worker in late November noted again various letters and papers strewn around the house, she tried to help sort through these (included DWP benefits deductions for arrears, 3 missed eye appts, 3 missed DN visits) SK was low, upset about her children and had been drinking. Another retinal scan appt was sent and unsuccessful attempts to contact SK following her missed appointments.

In December her GP received a complaint letter from an MP, following a call from Royal London Insurance Co (SK had called them appearing distressed and agitated), this was discussed in a MDT and a plan for a review of SK made, where GP did a home visit. SK had gone out and her daughter said they had fallen out and were no longer talking to each other. DNs were unable to administer insulin as either SK was

out or not eating and drinking alcohol so it was dangerous to give her insulin. A further visit from AH working was similar to previous, with papers strewn around the house, including a review with DWP, which the worker arranged to accompany SK to another review the next week. Issues with children were discussed, where her son was due to move out and her youngest 2 daughters were planning to leave as well, there was further evidence of SK's confusion and poor memory in the content of her speech.

2.5. KPE 5 (14/12/17-14/01/18)

GP notes from mid-December show discussion & concern that SK's Blood Sugar levels were very low and as a result, Insulin injections were stopped-with SK referred to DN night service for increased monitoring. Ongoing concerns were reported to GP from 111, as a result of SKs frequent calls with a range of symptoms. Her GP referred her to the Mental Health Team again. She was out when her AH worker visited to accompany her to the DWP interview. She did not attend this appointment and her worker left notes informing her of plans to visit her in January. The OT received a letter from her GP, on the basis of which no stair lift to be provided, as mobility issues only present when intoxicated and therefore unsafe to recommend a stair lift, in line with usual OT procedures.

Following a call to LAS on 21/12/17 re diarrhoea, distended stomach and pain she was taken to St Georges again, where she was seen by the Alcohol Liaison Team and discharged the same day with advice that she needs support to reduce her alcohol consumption and referred back to MDART. After a DN visit on 29/12/17 SK made another call to the LAS about her swollen stomach, pain, breathlessness. She was taken to hospital where she was again discharged following urine and blood tests, with advice to restart her diuretics and for her GP to refer her to see a specialist for liver disease/ascites. There was no clinical reason identified for an admission on these occasions. At the end of December her GP referred SK again to Merton Assessment Team (MAT). The MAT manager liaised with MDART Manager who agreed to reopen SK's case and attempt to engage her again. Her GP also referred SK to ASC for self-neglect.

In early Jan her GP attempted another visit, which encouraged SK to go back to hospital, but she refused. Throughout January and February MDART notes stated that attempts were made to engage SK (no details of how or what the outcomes of this were). LAS were again called and an ambulance attended in response to SK's chest and abdominal pain, her leg was also swollen and painful, she had a temperature-possible sepsis was indicated and she was taken back to St Georges. There was some treatment (chest infection, ascites, liver damage, injury to leg, spine after fall) antibiotics & advice were given. SK was offered admission for further assessment, but refused this and deemed capacitated to take decision, despite a risk of death. GP liaised with SK's mother who updated GP on this visit to hospital the previous evening. She reattended on 05/01/18, had a consultant review, but was deemed not in need of an admission.

On 10/01/18 SK called an ambulance and SK was taken back to hospital for a planned review, spitting blood and blood in her urine, bloated stomach, jaundiced and had vomited. She was treated for cellulitis and discharged with a course of IV antibiotics prescribed over the next 2 days. She attended the next day for this and through ED

on the 12/01/18. She was discharged with advice to reduce her drinking and went home on oral antibiotics. Two days later SK called LAS again with similar symptoms but after assessment she decided not to go to hospital. Her mother updated the GP that SK was now living alone as her daughter had moved out and her mobility had deteriorated. The pattern every day of further LAS calls, attendance and not conveyed to hospital continued over the next 3 days.

On 09/01/19 her AH worker visited but SK not home/answering the door, this was thought to be a combination of her poor memory and alcohol use. Another call to and subsequent visit was then made by LAS that evening. Also, on this day the OT duty service received another GP referral for downstairs adaptations-outcome of this was a home visit was planned (a letter was sent to notify SK of this at end of the month), self-neglect was also noted on the records of this referral on Mosaic and the OT considered re-referral for support services from ASC. MCIL worker contacted OT and ASC for update and OT duty suggested that she attended the next planned home visit.

Another call to LAS of similar content and outcome as before, on this occasion she was reported to be not admitted as there were no beds. Her GP visited the next day, by chance seeing another ambulance outside SKs property and persuaded her to return to hospital as the oedema on her leg was worse, as was her distended abdomen and jaundice. She was discharged again after being seen in ED, she was given IV antibiotics for leg cellulitis. SK called LAS again in the afternoon but advised to take medication and call again if things got worse.

Her GP visited on 12/01/18 with Community Matron, noting more self-neglect, with faeces in her living room, v messy house. GP then left a letter at her address for the LAS to advise them to take her to Croydon University Hospital, not St Georges and recommended MHA assessment in hospital. LAS were called again later that day by SK and she was taken to CUH. She was seen to have swellings of both legs, more pain and IV antibiotics were given again and again she was discharged. A further 2 calls by SK to LAS that day did not result in hospital, following advice from LAS frequent caller team. Another similar call on 14/01/18 where SK was recorded as being covered in faeces and declined hospital, but agreed to LAS raising a welfare concern with ASC. ASC spoke to GP the following day after this welfare concern, said SK needed another GP review before ASC could get involved (unclear why). Another visit by her GP noted worse self-neglect faecal incontinence and again needing to go back to hospital, an ambulance was called to take her back to CUH where she was finally admitted.

2.6. KPE 6 (15/01/18-10/02/18)

SK attended Croydon hospital with diarrhoea, pain and worse abdominal swelling, she had a CT scan as was now unable to mobilise, her ascites were worse and she was amenable to drainage. She was admitted to a Medical Assessment ward, where she had a chest x-ray, showing some abnormality of her right lung. She was reviewed by a ward doctor, prescribed medication and referred for a gastro assessment. This led to a treatment plan and a transfer to another ward at CUH. Pharmacist noted her history of non-compliance with medication and need for support for this on discharge.

Notes from MAT after the GP made a re-referral for an assessment due to her deterioration and living alone. MAT team spoke to Safeguarding Team (ASC) where her case was open and agreed need for urgent review (notes say she was declining a package of care, but this was not accurate). Discussion was then made with ward staff at CUH, resulting in a request for a psychiatric liaison assessment her while in hospital resulting in a view that prognosis was said to be poor for her and so she was discharged from MAT, without being seen.

The OT planned to visit on 17/01/18, but subsequent calls to St Georges and GP-led to an update that she was currently in CUH, was not fit to be discharged and needing assessment by OT/Physiotherapist prior to this, which would usually be expected to be the responsibility of the hospital OT and Physio prior to discharge.

She had an ascites drain inserted in hospital on 19/01/18 and a review by dietician noted a high risk of re-feeding syndrome, with a number of recommendations made for this. She pulled out her drain the next day and on review was felt to be unsafe to reinsert, due to her poor health, she was advised that any more alcohol in future could be fatal.

SW did attempt a home visit on 20/01/18, but recorded that SK was not in (she was in CUH) and noted that her phone was not working. She was given a blood transfusion on 22/01/18 and a further dietician review noted her ascites was related to anorexia and recommended nutritional support and a MUST (Malnutrition Universal Screening Tool⁸) screening by ward staff. SK's mother shared concerns about SK's imminent discharge with the Ability worker, who attempted to visit SK at home, but she was still in hospital. On 23/01/18 MCIL worker contacted by SK's mother who updated her on recent admission and planned discharge today, also concerns about not coping and need for care at home. Her AH support worker attempted a home visit that day, but she was not in (appeared she also didn't know about the hospital admission).

On 24/01/18 her ascites drain was recommenced on the ward and 8 litres of straw coloured fluid removed, some of which was then sent for analysis. SK then refused a MRI and requested to be transferred to St Georges Hospital, with staff initially unable to contact gastro dept there to facilitate a transfer. A chest Xray identified issues and suspected a hospital acquired pneumonia. Her OT assessment planned for 26/01/18 could not go ahead as she remained in hospital, liaison with GP to update that SK still in hospital MAT (Merton Assessment Team, mental health service) updated ASC about SKs admission, poor health and plan for psychiatric liaison assessment while in CUH.

On the 29/01/18 SK was reviewed by a consultant who planned for her discharge that day, a staff nurse informed her mother and referred her for District Nurses to follow up in the community. The ward physiotherapist attempted to assess her safety climbing stairs, but SK didn't complete this and said she'd be fine, as she had capacity was deemed able to decline this. She was provided with a roller frame to use when upstairs (she already had one downstairs). Her mother updated the GP that SK had been discharged from CUH and was advised by the GP this was a failed discharge

⁸ https://www.bapen.org.uk/pdfs/must/must_full.pdf

and SK ought to be in hospital, also to contact ASC for commode as there was none downstairs, poor mobility (GP to refer for physio) and visited the next day for a medical check and possible need for a peritoneal tap (to drain fluid in abdomen).

GP then got in touch with the OT service at ASC and was told to re-refer her (although she already open to OT services). MCIL updated ASC on the discharge and needed to update AH worker as well, which was done and discussed her need for care at home. Her AH worker contacted the ward to see whether a package of care had been set up for her, but was informed there wasn't. The Ward matron then called back to say she would refer SK to the Rapid Response Team, who would come out to assess her, although this didn't happen. The AH worker escalated concerns to her manager, who then liaised with ASC to again request a care package for her.

AH worker then visited SK at home, she looked very unwell and self-neglected (unwashed) no care package was in place and her worker called the ward sister at CUH, who said nothing was set up for her, but she would refer to the Rapid Response Service for an assessment, as above.

She had been sleeping on the sofa and needed a commode as was unable to get upstairs to use the toilet. Further discussion was noted about raising another safeguarding concern with ASC re; the lack of aftercare on discharge from CUH. MCIL worker also spoke to SK on this day, who was out of food and couldn't go out, she was wanting to give a taxi driver money to collect shopping for her. Liaison with ward matron who said SK was independent and able to look after herself, had been seen by physio who said she was well enough to be discharged home.

SK was spoken to and she said she was advised to drink protein drinks but instead was drinking Guinness, milk and nutmeg. Also, on 30/01/18 OT duty received another referral from the GP. LAS attended on 31/01/18 again and took SK her to St Georges hospital due to worsening abdominal and leg pain, with poor mobility.

31/01/18 AH worker spoke to MCIL worker, who had found someone that could help SK with bathing and food prep, but might be only at weekends-also needed urgent care from ASC and messages were left for her social worker however further contact from MCIL later that day with ASC noted that she didn't have a social worker and they advised the MCIL worker to liaise with Home from Hospital Team. When this was done they said that they had no capacity to help SK and that worker should contact MERIT team. When her worker called the number given this was not MERIT but the STAR Team (Social Therapies and Rehabilitation) who don't deal with care issues, according to the Home from Hospital team. SK collapsed at home and was taken to St Georges and admitted later this day. The Merton Hospital team received a request to assess her prior to leaving hospital.

SK was then allocated a social worker from the hospital team for an assessment prior to discharge and attempted to see her on the ward, was told "she was still medical" so not fit for discharge. Further liaison from MCIL on 07/02/18 with Hospital SW re possible Safeguarding referral due to earlier discharge without care being put in place. A dietician visited SK on this day re; weight loss, malnutrition and advised a food fortification plan. On 08/02/18 MCIL discussion with previous SW who had been in touch with St Georges Safeguarding Lead to ensure that a plan for a Mental Health

assessment and an assessment for care pre-discharge, on this occasion. However, sadly SK passed away in hospital following a cardiac arrest on 10/02/18.

3. Analysis of Practice against Terms of Reference

In this section, the practice outlined above is considered to discuss potential learning for local services, in line with each of the priority areas agreed as the Terms of Reference for this SAR. These were agreed as follows, each of which is explored with reference to the case and relevant legislation and guidance.

3.1. The impact of both SK's mental and physical health conditions on her vulnerability, risks and needs, including the management of her chronic and complex conditions.

3.1.1. Physical Health.

SK had poorly controlled diabetes, which was adversely affected by her inconsistent use of a number of medications which were prescribed mainly from her GP. Her Blood Sugar levels were frequently high in early 2017 requiring daily District Nursing to visit and administer insulin injections, as she was not taking oral medication. This was effective in stabilising her after some months, however then her poor dietary intake led to this being stopped when her blood sugars were found to be very low later on in the year.

Often she was also intoxicated on visits, making insulin unsafe to administer. She was referred to a diabetic clinic, but did not attend this and was discharged from the service. During several attendances at ED, after SK had called an ambulance her blood sugars were stabilised and she was given advice on management, which she did not follow. There were significant health resources committed to improving her diabetes management and symptoms from primary care services, given the challenges of her case these were in line with good practice requirements.

SK also suffered from ascites, significant water retention, causing bloating in her abdomen, which became increasingly severe during the course of the review timeframe. Again treatments with diuretic medication were ineffective, due to non-compliance with prescribed medications, she was referred to gastroenterology after attending hospital in April 2017.

In July 2017 her GP advised her to return to hospital, due to pain from this, which she did, but left prior to the outcome of tests being known. Her symptoms worsened in July and she returned to hospital again at which she was given advice and referred for an outpatients appointment. In August she was again seen in the ED where 2 new medications were prescribed, but a week later her Community Nurse noted she was not taking this. She was again seen in December 2017 at the ED, where again she was advised to take medication and her GP was asked to refer her again for specialist outpatient appointment. In January 2018 she was seen on a number of further occasions at the ED, where she was given the same advice and refused an offer of hospital admission. Her ascites was directly linked to her liver disease and caused her to suffer a number of symptoms, including pain and coupled with her malnutrition was linked to her poor functioning within and outside the home. SK was very underweight throughout the review period and rarely ate if not prompted to by her children, which

again affected her ability to cope as she had very low energy levels and poor motivation to comply with treatment and advice offered to her.

Another impact on her was frequent falls, mainly down the stairs in her house, which were at times due to her being intoxicated, but at other times associated with her general frailty and limited strength. She used to 2 walking sticks to help her mover around and clearly struggled with navigating her stairs at a number of periods, especially towards the end of the review, when she effectively lived in her lounge, using a commode as she was unable to get to the bathroom. Also, possibly related to this she was doubly incontinent and without any care there was faeces seen spread around her house. Her children said they had to clean this up often when they lived with her.

In summary, her physical health problems were linked directly or exacerbated by her alcohol addiction and were challenging to manage by both community and hospital services, that rely on a patient's willingness and participation to comply with treatment. That was also a feature of her treatment for her alcohol addiction, as outlined below (3.2). Overall the review found that her complex physical health conditions did clearly put her at risk and were directly linked with her death in 2018, which was recorded on her death certificate as primarily due to heart disease and secondarily to her alcoholic liver damage and Type 2 diabetes.

(Finding 1)

3.1.1. Mental Health

Unlike SK's physical health conditions, which she received intensive support for as outlined above, she received very little support or treatment for her mental health. She was referred for mental health assessments at numerous points during the review She was only actually seen for an assessment by MAT once, despite repeated referrals, her mental health was not fully assessed and so it was not known whether she had a treatable mental health problem, which was clearly a significant gap in practice. During the review period, Psychiatric intervention, focusing on her use of alcohol would have been part of the treatment from MDART. However, since recommissioning of services from WDP, this will now be the responsibility of MAT.

At one point possible alcohol related dementia was mentioned, but this wasn't explored or assessed. The only treatment she received was via her GP, who prescribed an antidepressant in May 2016. Her GP and support workers from MCIL and AH had a number of concerns about her cognitive functioning, related to her poor memory, low mood, anxiety-all of which contributed to her vulnerability and poor compliance with professional appointments and recommendations for treatment.

Her children felt that her alcohol use was at least in part affected by her trauma from domestic abuse and bereavement following the unexpected death of her brother. Domestic violence is a known risk factor for substance misuse and should lead to improved pathways for accessing support, in conjunction with other services, as

recommended by Public Health England⁹, however this was clearly not done in her case.

Furthermore, the police were frequently called to SK's address during the review and observed her to be experiencing some acute symptoms indicating a need for mental health support, resulting in multiple referrals through the Merlin reporting system to Adult Social Care Services, all referred to concern over her mental health. However, none of these were passed onto mental health services for a response, which was another significant gap in practice. Whilst clearly it was difficult to assess her in the community there was a lack of follow up to both referrals and missed appointments resulting in no meaningful involvement, assessment or support from mental health services. Good practice would have been for a joint assessment with substance misuse services to explore whether there was a relationship between her alcohol use and underlying mental health issues, but this was not done in her case. This was likely to have had a negative effect on her engagement with support for her physical health services and significantly raised the risks for her. In the absence of involvement from mental health services, SK did receive some support around this through her AH and MCIL support workers.

(Finding 2)

3.2. The systems in place to respond to self-neglect and substance misuse during the period subject to review.

As outlined above there were repeated concerns about her self-neglect, which were raised to Adult Social Care, whether via direct safeguarding adults referrals or via Merlin reports from the police. However, neither the direct referrals, nor Merlin Reports led to any action under safeguarding procedures to explore the impact on SK of her self-neglect. These were all closed with no action taken, where reasons were recorded these were either as the referral was seen as a health issue and referred onto the GP, or as the cause of her self-neglect was her alcohol problem which she was not accepting help with. This is directly contrary to good practice in assessing Section 42 Care Act duties, where self neglect may require a formal enquiry, or at least an assessment of eligibility for this;

“There is no single operational definition of self-neglect, however the Social Care Institute for Excellence (SCIE) describes self-neglect as “an extreme lack of self-care” and specifies “that it may be a result of other issues such as addictions”.¹⁰

That approach would have been valuable to coordinate the various agencies involvement with SK and could have been helpful in managing the risks to her health from her self-neglect. The fact this was not done was felt to be another significant missed opportunity to improve interventions and outcomes for SK.

⁹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

¹⁰ <https://www.scie.org.uk/self-neglect/at-a-glance>

One agency which would have had a key role in the above multi agency process would have been substance misuse services, which were delivered at this time from MDART. The systems in place at the time during the review have since been changed with a new provider having taken over to deliver this in Merton (Westminster Drug Project, <https://www.wdp.org.uk/>). The systems at the time were managed by MDART, which was part of South West London and St Georges Mental Health Trust. MDART encouraged SK to agree to an admission to manage a detox from alcohol and updated her GP in Feb 2016. Notes of the discussion between the Consultant at MDART and her GP were recorded as follows;

"If she continues refusing going to the hospital for detox (community detox is out of the question due to her significant enlarged liver and ascites) we will have to discharge and wait for another opportunity when she is detoxed on the medical ward or changes her views on detox and maintaining abstinence."

It would appear from the above that MDART felt there was no role in harm minimisation, or further support to engage SK in the planned admission. At the end of July 2016, liaison psychiatry assessed SK during attendance at St Georges ED, where she reported feeling suicidal and had injuries after a fall. Liaison psychiatry re-referred her back to MDART following this assessment, where SK was intoxicated (reportedly drinking 2 bottles of wine a day). There were no notes of any response to this re-referral until September 2016, when an admission was again offered for her liver damage, initially SK refused this but her mother persuaded her to accept this and she was admitted to St Georges on 06/09/16, where she remained for a month. MDART notes had no recorded contacts with her during the admission, however St Georges notes stated that she was reviewed by the drug and alcohol team at that time, including Merton Outreach worker. It was not known what happened regarding the care for her children during this admission.

There were also no notes available on any contact from MDART after her admission on what (if any) support was offered to her SK in the community, which was a significant gap. GP notes of a visit in October did mention SK had reported a home visit from MDART, which she hadn't found helpful. By this time she was known to be drinking again and her DN had informed MDART of this. There were no further records of contact with MDART until December 2017, when the MAT manager liaised with them, following a re-referral to MAT by the GP. MDART agreed to re-open her case and attempts were made to engage her in January 2018, however no details of this were made available to the review.

The involvement of MDART was limited to facilitating a detox admission in hospital, but no other ongoing involvement to help SK manage her addiction in the community. The reviewer acknowledges the challenges of working with adults who do not wish to engage in abstinence for a substance misuse problem but the model of harm minimisation and support did not appear to be part of the role of MDART for SK's case. The links between her use of alcohol, domestic violence history and depression following bereavement do not appear to have been explored by either MDART, or MAT, according to notes supplied. This was a significant gap, as without at least attempting to address these factors with SK, her use of alcohol would seem unlikely to change. As a recent report by Change UK (legal powers to safeguard highly vulnerable dependent drinkers in England and Wales 2021) states;

“By combining the power of positive interventions (assertive relationship building, harm reduction and motivational interventions) with the effective and careful use of legal powers, practitioners can help vulnerable, chronic, dependent drinkers to be safer, healthier and stand a better chance of achieving longer-term outcomes.”¹¹

The report looks at some common myths held by practitioners working with this client group, which appear relevant to the SK case in relation to self neglect and substance misuse, for example;

“A person is not vulnerable or self neglecting if they have mental capacity.” This is simply wrong. Under the Care Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making free choices that lead to self-neglect, it is still self-neglect and action is still required under the English Acts”¹².

Many of the above factors appear relevant to barriers experienced by SK during this review, which prevented her engaging with substance misuse offers of support. It is also relevant that in the context of these for the majority of the period under review SK was not open to the MDART team and therefore was not offered support with her problematic and ultimately fatal alcohol addiction.

(Finding 3)

3.3. The effectiveness of mental health services, including housing-based services (e.g. support workers), which were provided to manage the impact of SK’s conditions on her health and wellbeing.

As outlined above SK was frequently referred to mental health services during the review period. However, she had very minimal engagement with them and most referrals were closed without her being seen. There was a reference to consideration for a MHA assessment as part of an attendance at ED but it was felt this was not appropriate for her situation as her problems were viewed as arising from her alcohol addiction and therefore exempt from consideration of the MHA. This has been further clarified in the revisions to the Mental Health Act in 2007 and is helpfully summarised in the following extract from the Safeguarding Guide referred to above published by Alcohol Change this year, which is based on an overview of recent SARs involving the death of adults who had alcohol dependency (See Appendix 4 for details).

It would have been conceivable therefore that SK could have had a disorder or disability related to her use of alcohol (for example cognitive impairment, depression) and may have benefited from a period of formal assessment and treatment in a suitable inpatient facility. However, as she was not assessed this option was never explored for her. In relation to other contact with MAT, SK was only recorded as being assessed at home on one occasion-the outcome of this was that she was deemed not

¹¹ <https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>

¹² Page 8 <https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>

in need of any input, with her case closed after this point. While there were no detailed notes available to comment on this decision, they do state that

“MAT offered apt – seen at home. No remarkable variables on mental state assessment. Apparent confabulation. Possible Ascites / physical health for which she has carers and GP and medics treating. Discharged from MAT”

Confabulation is a false statement made by a person but may well indicate an underlying mental disorder, rather than an intentional deception (see Appendix 4 for details). Therefore, rather than citing SK’s confabulation as no grounds for assessment by MAT it ought to have prompted further consideration of the possible causes of this and possible assessments of her cognitive ability, as many professionals and relatives identified SK had persistent memory and attention deficits throughout the review period.

Linked with the statements above about the use of the Mental Health Act to apply to people with conditions arising out of substance misuse and the explanation about Alcohol Related Brain Damage, one can see how this could have applied to SK and if it had been this may have significantly affected the outcomes for her. In summary the mental health services offered to SK were clearly completely ineffective in managing the impact of her conditions on her health and wellbeing. However, if she had been assessed, she may have not been detainable as she would also need to have been deemed in need of a treatable mental disorder, which could have been unlikely.

(Finding 4)

The other element of this section of the terms of reference asks about the housing based support services that were offered to her, in considering this I will refer to the role of Ability Housing Support Worker’s (AH) input to SK, following referral (prompted by MCIL) in June 2017 until her death in February 2018. An initial assessment (where SK was intoxicated) led to the worker developing a support plan for SK, initially supporting her with her financial issues, which arose partly due to her inability to deal with correspondence from the DWP and others. She was helped with a number of issues relating to PIP and ESA claims with a plan for regular home visits for addressing these and assisting SK with the large amount of unopened mail she had accumulated. AH also communicated extensively with her GP, Community Matron and Mental Health services to try and advocate for her to have a further assessment (which was not responded to by MAT).

Whilst AH were involved, MCIL were also visiting SK at home and working in parallel on similar issues, as highlighted earlier, the role of both would have been better if it were coordinated, but at least initially there was no evidence of communication between these services. In September 2017 the AH worker supported SK to go to the bank as she was not receiving her benefits, at this stage it became known that SK’s mother had LPA for her financial affairs and benefits were being paid into a joint account that was controlled by SK’s mother. However, there were no records of the subsequent involvement of her mother in addressing SK’s financial affairs, which was a gap in practice.

Overall the role of the AH worker was consistent and offered regular assertive outreach and undoubtedly managed to engage well with her. She supported her with practical and emotional matters, as well as advocating for her with statutory services, which was good practice. It would have been improved through better coordination with other agencies, but as outlined elsewhere ASC and MAT had both closed her case during this time, which clearly made liaison difficult with them. Despite which AH did a lot of work to help manage the impact of her cognitive difficulties on her wellbeing.

3.4. The quality of services delivered in response to periods of acute crisis (including use of emergency services) as well as the long-term difficulties experienced by SK.

In addressing this aspect of SK's care, her frequent calls to emergency services were clearly a significant aspect of her contact both during periods of crisis and a feature of her long term difficulties. This was complicated in that at times she was in significant distress but also used services inappropriately while intoxicated, making it hard to assess her needs. She made lots of calls to the police, 111 and the LAS, some of which resulted in an ambulance being sent to her address while at other times these were relayed to her GP as being problematic. This prompted the GP to raise concerns both under safeguarding processes and to refer her for mental health assessments. However, as explored elsewhere neither resulted in action from ASC or MAT, which were not appropriately assessed nor responded to. Her calls to the police usually resulted in no police action but these were shared with ASC through the Merlin system but again these did not result in any action, either as a safeguarding issue or for a reassessment of her needs.

In June 2016 her frequent calls to the LAS were fed back to her GP which did result in a home visit from MDART and the offer of admission for a detox, although this was refused by SK. In July 2016 she phoned both the police and LAS, reported being suicidal and was taken to the ED, where she was seen by Liaison Psychiatry while intoxicated, leading to a re-referral to MDART and a Merlin to Children's services, due to the presence of her 15-year-old daughter in a chaotic environment. This was responded to briefly, however as her daughter had gone to stay with her grandmother the referral was closed, with advice that she could get back in touch if she needed more help. However, there was no assessment of her daughter as a child in need or at risk, if this had been in done there was a possible need for input to support her daughter, at least as a child carer, if not in her own right, which was a missed opportunity to help her.

In August 2016 her GP was informed she had made over 20 calls to 111 in a month and further calls were noted in September but this did not prompt any further action.

In December 2016 she was recorded as being a frequent caller to 111, although this had reduced through daily support being provided at that time by DN's to administer her insulin. In May 2017, the GP did raise a safeguarding referral to ASC (closed as thought to be not appropriate for safeguarding as a "health issue relating to her alcohol use"), following further updates from 111. She had 2 falls during this month, both resulting in LAS taking her to hospital and one identified a fractured elbow requiring treatment. Calls to 11 in July 2017 including a number of false statements, possibly arising due to her confabulation about previous historical incidents, including DV.

These were discussed at an MDT held at the GP surgery resulting in her being added to the “Coordinate My Care” system, which was good practice on the part of the GP. (See Appendix 4 for details).

However, following her agreement to be added to this system she continued to make use of emergency services despite advice against this from her GP in September 2017. Ongoing concerns were again reported to her GP from 111 in December 2017, he attempted to visit but she was out and this led to a re-referral to MAT. Following this SK became more unwell and made numerous calls to the LAS. In late December she was taken twice to the ED at St Georges, given tests and advice to start medication and reduce her drinking, but not offered admission.

In January experiencing more pain she was once more conveyed to St Georges by the LAS, on this occasion she was given antibiotics for an infection and offered admission, but refused this. Notes indicate she was thought to be capacitated, despite a risk of death-however no assessment was undertaken of her capacity. The next day she rang an ambulance and was again seen at the ED, on this occasion she was not offered an admission as this was not thought to be a clinical need at the time. There were frequent LAS calls for the rest of the week, but despite paramedics attending to SK she declined the offer of being taken back to St Georges as she felt they would not offer her admission. By chance her GP saw an ambulance outside her address and managed to persuade her to go back to hospital, but again she was given antibiotics for a leg oedema and not offered admission. Her abdomen was more swollen, painful and her jaundice was also worse.

Her GP was so concerned about this that he left a letter for further LAS consideration, advising them to take her to CUH instead of St Georges the next time, which they did. This resulted in further IV antibiotics, with advice to stop drinking but again she was not thought in clinical need of an admission. Her self-neglect was worse by this time (covered in faeces) and her GP raised another safeguarding concern with ASC (which was not responded to). 2 further calls to LAS did not result in admission, on the advice of LAS frequent caller service (presumably this was informed by her CoordinateMyCare plan). Finally she was taken back to CUH on 14/01/18 by the LAS, whilst her GP was at her house and on this occasion she was admitted.

(Finding 5)

3.5. The circumstances and events leading to the SK’s death

SK died from a cardiac arrest in St Georges Hospital on the 10/02/18, following her admission on the 31/01/18. The cause of death was recorded on her death certificate as follows;

- “1a. Ischeamic Heart disease
- 1b. Critical stenosis of the right coronary artery
- 2. Alcoholic Liver disease, Type 2 Diabetes”

She was noted to also be significantly malnourished, to the point where she was thought by a dietician to be at risk of “re-feeding syndrome”, requiring a MUST screening and nutritional support (see Appendix 4 for details).

As, above, due to limited information contained in CUH notes, as to the assessment and treatment for this, there was insufficient detail to explore the degree of risk that SK faced, due to this condition, but clearly her health was significantly considered to be at risk. She was further noted to have contracted hospital acquired pneumonia following a chest x-ray, putting further strain on her system. However, within 2 days of this being diagnosed she was thought to be ready to be discharged home. Her ability to manage her nutritional needs in the community was not assessed, clearly putting her at high risk-especially as she also had pneumonia.

Prior to her discharge home, usual practice would be for an assessment of her needs for care and support, however this was not done. The Merton Hospital Team were not notified of her discharge and no care was set up for her upon her return home. She was known to be living alone and notes indicated she was unable to mobilise, although she was known to be at a significant risk, was still thought medically fit to be discharged on the 29/01/18, with no services in place.

Her mother informed her MCIL worker about her return home and several attempts were made to advocate for her urgent for an assessment at home. The MCIL worker was advised initially to contact the Home From Hospital Team, The Rapid Response Team, MERIT and STAR Team, none were able to help her. MCIL then considered raising a safeguarding referral about the unsafe nature of her discharge. Her GP had advised that SK should not have been discharged and needed to be in hospital. The GP also referred her for both an OT and Physiotherapy assessment. She was known to be doubly incontinent and unable to climb her stairs, so was in need of a commode downstairs. SK then collapsed at home, at which point she was readmitted, this time for care at St Georges, where she passed away 2 weeks later.

The above summary clearly demonstrates some significant learning about the discharge process at CUH, given her discharge without any community health or social care services being put in place.

(Finding 6)

3.6. The thresholds used for decision-making in response to concerns reported to the local authority for safeguarding enquiries to be undertaken.

To some extent these have already been discussed above in Section 3.2, where self-neglect processes were explored, in the context of The Care Act 2014, Section 42 Safeguarding duties. There were 5 referrals specifically requesting a Safeguarding Enquiry and 5 Merlin reports, where safeguarding issues were also referred to as part of the information sharing. None of these were accepted as being appropriate to instigate an Enquiry for SK. In order to determine eligibility for S42 duties in her case, an assessment would be expected to be done against the “3 stage test” as set out below.

“Safeguarding duties will apply where the adult has care and support needs (many people who self-neglect do not), and they are at risk of self-neglect and they are unable to protect themselves because of their care and support needs. In most cases, the intervention should seek to minimise the risk while respecting the individual’s choices.

It is rare that a total transformation will take place and positive change should be seen as a long-term, incremental process”¹³.

Given that SK had Care and Support Needs arising from the consequences of her alcohol addiction, was known to be at risk and was also known to be unable to manage her alcohol use, making her effectively unable to protect herself from this, she could have been seen to have met the criteria set out in S42.1¹⁴.

However, from the information supplied to the review it would appear that all safeguarding requests were declined without any prior additional information gathering about the concerns, nor whether the concern was in fact formally assessed against the 3-stage test prior to it being declined. This is to some extent more worrying than if there were clear grounds to decline the various referrals over the Review period. This appears to be contrary to the duties and guidance set out in relation to The Care Act 2014 and subsequent further guidance on this published by ADASS in 2019 (see Appendix 4 for details).

There was no evidence that the above S42.1 duties were met in sufficient detail, either by the receiving worker information gathering about the concerns, nor whether the information was evaluated against the S42.1 threshold to decide the most appropriate response to the issues raised. “The Care Act does apply to people with alcohol problems and in particular the inclusion of self- neglect as a form of neglect will encompass many in this client group.”¹⁵

(Finding 7)

This clearly links with a lack of assessment about SK’s Care and Support Needs for the majority of the review and where these were assessed (in April 2017) she was deemed ineligible for services. Firstly, being ineligible for services is not a reason to exclude someone from Section 42 duties. As no safeguarding enquiry was attempted for SK it is not possible to comment on any potential outcome from this approach, but would have enabled a formal structure to bring services from health, social care and the voluntary sector together to consider and assess risks for SK (as outlined in Section 3.2).

Secondly, the threshold judgements also relevant were related to this decision that during the ASC assessment, under The Care Act 2014 Section 9 SK was deemed ineligible for services to meet her needs. This decision was taken on the basis that her needs arose out of her alcohol problem and therefore were ineligible. This had significant consequences for SK and those in the health and voluntary sector who tried to assist her, without the input of ASC or any commissioned care and support. This is as a result of a mistaken view that needs arising from substance misuse are excluded from eligibility criteria. However, as set out in the SCIE guidance and Statutory Guidance, below, this is clearly not the case. “The Care Act 2014 applies to people

¹³<https://www.scie.org.uk/self-neglect/at-a-glance>

¹⁴ <https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted>

¹⁵ <https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>

who have care and support needs, including those related to substance misuse.”¹⁶ The Safeguarding Guide published by Alcohol Change UK (How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales 2021) sets these out in detail (see Appendix 4). Given the above guidance it is conceivable that had the assessor not deemed SK ineligible purely on the basis that she was a “problem drinker”, she would have been eligible for support with the above, as she struggled with several of these areas throughout.

(Finding 8)

¹⁶ Social Care Institute for Excellence (SCIE), *Eligibility determination for the Care Act 2014*, SCIE (2020) <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp>

4. Findings and Recommendations from the Review

This section contains the priority findings from this SAR, including references to key examples from the work done with SK. Recommended actions in response to each Finding for service improvement are set out for consideration by Merton Safeguarding Adults Board (MSAB) in this section of the report.

4.1. Finding 1

The management of chronic physical health problems arising as a consequence of alcohol addiction are challenging, especially where an adult is unable or unwilling to comply with medical advice and treatment in the community. This puts considerable resource pressures on Primary Care Services and requires cooperation and support from specialist alcohol services.

Example from the case

SK had the majority of input from services provided by her GP, including regular GP Home Visits, a Community Matron and at times daily District Nurse visits. Despite this she struggled with her diabetes, ascites, leg oedema and injuries from falls. The management of these risks were seen as purely a health concern without sufficient coordination or support from other services, who worked in parallel, rather than together with health providers.

Recommendations for the Board to consider

1. MSAB to ensure that information is shared between services to agree a joint health and care plan, which is developed to assess and manage the risks for problem drinkers, including crisis and contingency arrangements to manage the harm arising from alcohol addiction.
2. As part of the above plan, guidance should be produced for all practitioners about how to better estimate someone's level of drinking, by using evidence additional to self-reporting, such as the involvement of family members in thorough, holistic assessments.

4.2. Finding 2

Adults with significant alcohol problems do not always receive sufficient assessment where concerns are reported about their mental health, either as a cause or a consequence of their alcohol misuse, whether they are in hospital or in the community. Referrals are either closed without assessment, or passed over to Substance Misuse Services to respond, as alcohol was deemed to be the primary problem, without consideration of its use as a coping mechanism or its impact on an adults' mental health.

Example from the case

Merton Assessment Team did not assess SK's mental health, despite frequent requests to do so, referrals were closed, due to her non-attendance at office appointments, or due to the view that alcohol was her only problem, also Merlin

Reports from the police requesting mental health assessment not being passed onto them by ASC.

Recommendations for the Board to consider

3. MSAB to have assurance that people thought to have both substance misuse and mental health problems and who are referred to Mental Health Services are sufficiently assessed through home visits (where needed) including all relevant agencies (for example with substance misuse, or other specialist services), rather than have the referrals closed without them being seen. This should apply where adults are either thought to have both a mental health and alcohol problem or an alcohol related brain injury/dementia.
4. That the Mental Health Trust has adequate guidance in place for Mental Health Services working with people who may use substances following trauma, such as domestic violence as a coping mechanism to deal with anxiety and depression.

4.3. Finding 3

If Substance Misuse Services limit involvement with adults who have problematic alcohol use to just arranging inpatient hospital alcohol detoxification, without providing ongoing support before, during and following such an admission, this adversely affects that adults' ability to make sustained change. Also, if abstinence is insisted upon this may exclude problem drinkers from engaging with services.

Example from the case

MDART did not work with SK for the majority of the period subject to review, apart from when she was encouraged to accept an appropriate admission for her withdrawal from alcohol. Following a month in hospital there was very limited follow up involvement, other than a visit 3 weeks after her discharge, by which time she had already re-commenced drinking again. There was no evidence of any attempts to engage or support her from this time onwards, despite the high risks of her alcohol use.

5. MSAB receive adequate assurance that both the commissioning and delivery of substance misuse services includes sufficient provision for ongoing assertive outreach support and harm minimisation for people with the most problematic alcohol use.
6. That substance misuse services define and prioritise clients considered to be at most risk, for example using the Blue Light Approach¹⁷, as part of the above commissioning and service provision to scope and meet the demand in the borough (these are defined in terms of the three factors below).
 - a. The Alcohol Problem
 - b. The Pattern of not engaging, or benefiting from alcohol treatment
 - c. The burden placed on public services (either directly or via the burden they place on others e.g. their family)

¹⁷ <https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project>

4.4. Finding 4

Consideration of the use of the Mental Health Act 83 to assess SK's needs for any mental disorders arising from her alcohol use was not done in line with the revised guidance in the Code of Practice accompanying the MHA 2007 amendments. SK had significant evidence of persistent low mood, suicidal ideas and confabulation, which may all be considered symptoms of mental disorders for the purposes of the act.

Example from the case

There were limited references to consideration of the use of the Mental Health Act '83 through the review period, as the MAT did not assess her either formally or informally. However, both her mother (2016) her GP (2018) did raise the possibility of a MHA assessment, but in both situations, this was not explored further as she was thought to be ineligible for these, as her problems were viewed as purely alcohol-related without any mental health assessment being attempted.

Recommendations for the Board to consider

7. The MSAB are assured that Mental Health Services have adequate guidance, systems and processes in place to suitably assess mental disorders arising from substance misuse problems, especially where there are symptoms consistent with alcohol related brain damage, such as confabulation, forgetfulness and confusion when the person is not intoxicated.

4.5. Finding 5

Where adults make frequent calls to emergency services if they have both serious physical health problems and problematic alcohol use, it is challenging to determine the true need for either urgent health care. This may result in the inappropriate use of these resources, however following this contact subsequent information sharing from emergency services about health and/or safety risk should be adequately followed up by the relevant agency.

Example from the case

There were numerous examples of the police and ambulance being called out by SK at various points of the review period. Whilst no formal police action resulted from these, the Merlin reports were closed without any action taken by ASC and concerns were not shared with Mental Health Services. Ambulances frequently attended SK, sometimes she was conveyed to hospital, but she was usually discharged with advice to change her behaviour and/or take medication. It was not clear that these contacts were shared with her GP by the relevant medical professionals, other than when this was done by the LAS, or NHS 111

Recommendations for the Board to consider

8. MSAB to be assured that an adequate review of the ASC response to Merlin reports (highlighting either safeguarding or mental health concerns following police attendance), to establish that these concerns are sufficiently responded to.
9. Where a CoordinateMyCare plan is agreed that this is available to the assessing physician at the emergency department, to enable decisions on the viability/suitability of alternatives to hospital admission are known by the doctor when making this judgement at the Emergency department.

4.6. Finding 6

When Merton residents are admitted to hospital outside of the area, their needs for assessment for care and support on discharge are not always assessed before being sent home, putting them at very high risk, especially when living alone and not in receipt of services pre-admission.

Examples from the cases

Clearly the decision made at CUH to discharge SK home in January 2018, without notifying the Merton Hospital Social Work Team put her at risk, she was known to be doubly incontinent, unable to weight bear, at risk of re-feeding syndrome and living by herself. There were no records of any attempts to notify, or liaise with local health or ASC services before she was discharged and if her mother had not contacted MCIL and AH workers this would not have been known. Despite attempts by the voluntary sector support workers, there were no assessments or care in place before SK collapsed and was re-admitted for the final time.

Recommendations for the Board to consider

10. MSAB to receive assurance from relevant hospital trusts that adequate discharge planning are undertaken following referrals to ASC and assessments either pre-discharge or as part of a discharge to assess pathway.
11. MSAB to commission an audit of a sample of hospital discharges and whether these were investigated either under safeguarding or serious incident procedures, for additional learning.

Finding 7

- 4.6. **Referrals for self-neglect are not currently always sufficiently assessed by ASC, or shared with Mental Health Services, to establish whether the criteria are met for Section 42 Enquiries to be undertaken.**

Examples from the Cases.

As discussed in Section 3.6. there were 10 referrals in total shared with ASC for concerns about Self-neglect, none of which were responded to with sufficiently information gathering to clarify whether the 3 stage test was met in order to determine further safeguarding duties under S42 in this case.

Recommendations for the Board to consider

12. MSAB to clarify the systems in place for ASC to respond appropriately to referrals for safeguarding enquiries into self-neglect where there are reasonable grounds to suspect that concerns indicate the S42.1 criteria are met.
13. That the thresholds for safeguarding adults duties are sufficiently understood to apply where self-neglect may arise as a direct or indirect consequence of substance misuse issues and may require a referral to the CMARAC as part of the response.

Finding 8

That referrals for the assessment of an adult's care and support needs are not always currently undertaken in line with the requirements of the Care Act 2014 and Statutory guidance (6.104) where an adults needs arise as a consequence

of a substance misuse problem. An assessment should include information from family, especially where they are informal carers, to establish both eligibility for services and consideration of the adult's capacity to deal with the consequences of their addiction

Example from the Case

There were a number of referrals made to ASC for SK to be assessed for her care and support needs, most of which were closed without her being seen. On the occasion of her assessment, in April 2017, she was deemed ineligible for services as her needs arose due to the impact on her of her alcohol addiction, which was viewed inappropriately as a lifestyle choice, which was considered to be a capacitated, albeit unwise decision.

Recommendations for the Board to Consider

14. The MSAB are assured that ASC are able to undertake Care Act assessments with sufficient understanding of eligibility criteria following referrals for adults with substance misuse problems, involving independent advocacy services, where appropriate.
15. Where children are providing care that their needs for support are also assessed as part of Care Act 2014 duties and where necessary are referred to Children's Services if they are thought to be in need or at risk, due to the impact of the substance abuse on their parents' ability to care for them
16. Decisions about MCA assessments for people with addictions takes into account all relevant circumstances of the case, particularly the impact of addictive behaviour on an adult's ability to use and weigh information about the consequences of refusing services, when intoxicated, to help or mitigate the harm from the consequences of the addiction.

Additional Recommendation following discussion of case with DWP re; SK's benefits.

17. Where an adult is known to have an authorised and valid Lasting Power of Attorney for Property and Financial Affairs, that this information is shared with the DWP by any agency supporting the adult with welfare benefits, to ensure that the LPA is the point of contact to deal with the adult's financial affairs on their behalf.

**Mick Haggar
SAR Author
January 2022**

Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
SAR	Safeguarding Adult Review	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. It is a statutory review, commissioned by SAB, under Section 44 of the Care Act 2014.
MSAB	Merton Safeguarding Adults Board	Merton Safeguarding Adults Board (MSAB) are a statutory partnership as defined under the Care Act 2014, providing leadership for adult safeguarding in the London Borough of Merton. Our overarching purpose is to ensure proportionate responses and adequate systems to safeguard adults with care and support needs (whether or not they are in receipt of a service). https://www.mertonsab.org.uk
Merton Centre for Independent Living	MCIL	We are Merton Centre for Independent Living (also know as Merton CIL). We are the only user-led pan-disability Deaf and Disabled people's organisation based in the London Borough of Merton. Our organisation works hard to address the marginalisation of Deaf and Disabled people and make a real difference in Merton and the wider community. https://www.mertoncil.org.uk/about-us/
Merton Assessment Team	MAT	The single point of access for all new referrals for service users who live in Merton borough. https://www.swlstg.nhs.uk/our-services/find-a-service/service/merton-assessment-team
Merton Drug and Alcohol Recovery Team	MDART	Merton's Drug and Alcohol Recovery Team (DAART) can provide help and treatment for Merton residents, as well as support for people affected by the addictions of those close to them https://www.merton.gov.uk/healthy-living/alcohol-drugs-and-substance-abuse

Child Support Allowance	CSA	<p>Child maintenance is regular, reliable financial support that helps towards a child's everyday living costs.</p> <p>https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672432/how-we-work-out-child-maintenance.pdf</p>
KPE	Key Practice Episode	<p>Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term 'key practice episodes' to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects.</p> <p>https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp</p>
OT	Occupational Therapy	<p>We provide a range of services to people with a physical disability living in the London Borough of Merton. We aim to help people to keep as safe and as independent as possible in their own homes.</p> <p>Assessments By talking to people about what they are able to do and what they find difficult, we can advise on the different ways their needs can be met. This is called an assessment and may lead to the offer of services as appropriate, such as <u>equipment and adaptations to your home</u> or <u>disabled facilities grant</u>.</p> <p>https://www.merton.gov.uk/social-care/adult-social-care/disabled-adults/occupational-therapy</p>
DWP	Department for Work and Pensions	<p>The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service department it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers</p> <p>https://www.gov.uk/government/organisations/department-for-work-pensions</p>
(DLA)	Disability Living Allowance	<p>Disability Living Allowance (DLA) is being replaced by Personal Independence Payment (PIP) for disabled people.</p> <p>https://www.gov.uk/dla-disability-living-allowance-benefit</p>

PIP	Personal Independence Payment	<p>Personal Independence Payment (PIP) can help with extra living costs if you have both: a long-term physical or mental health condition or disability and a difficulty doing certain everyday tasks or getting around because of your condition</p> <p>https://www.gov.uk/pip</p>
(ESA)	Employment Support Allowance	<p>You can apply for Employment and Support Allowance (ESA) if you have a disability or health condition that affects how much you can work. ESA gives you: money to help with living costs if you're unable to work and support to get back into work if you're able to.</p> <p>https://www.gov.uk/employment-support-allowance</p>
MASC	Merton Adult Social Care	<p>Adults of all ages can need extra support in day to day life for various and often complex reasons. Adult social care is the support provided to adults with physical or learning disabilities, or physical or mental illnesses, and older people who require extra support. This could be for personal care (such as eating, washing, or getting dressed) or for domestic routines (such as cleaning or going to the shops).</p> <p>https://directories.merton.gov.uk/kb5/merton/directory/site.page?id=JYXTudJBu7w&adultchannel=0</p>
WG	Wimbledon Guild	<p>If you and our team decide that you would benefit from ongoing support, we can continue providing practical and emotional support on a regular basis. We're here to help, and we know from experience that managing problems, difficulties and worries becomes easier if we talk about our concerns.</p> <p>https://www.wimbledonguild.co.uk/how-we-help/staying-independent</p>
LAS	London Ambulance Service	<p>As the mobile arm of the health service in London, our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.</p> <p>https://www.londonambulance.nhs.uk/about-us/what-we-do/</p>
ED	Emergency Department	<p>St George's Hospital's modern Emergency Department (also known as Accident & Emergency) provides a 24-hour emergency service, 365 days a year, and sees around 150,000 patients a year.</p>

		<p>This service is led by an Emergency Medicine Consultant presence 24 hours a day, throughout the year.</p> <p>The department assesses and provides initial treatment and management to patients who are severely injured or who have developed a serious illness. St George's Hospital Emergency Department not only provides a local emergency service but is also one of London's four Major Trauma Centres. https://www.stgeorges.nhs.uk/service/emergency-department/</p>
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**APPENDIX 2
TERMINOLOGY EXPLAINED**

Medical Terminology	Meaning	Reference
Oedema	Oedema is the build-up of fluid in the body's tissues making them puffy and swollen. Oedema can affect any part of the body, but because gravity makes fluid fall downwards, the feet and ankles are most frequently affected.	https://londonmedical.co.uk/oedema-of-the-feet-and-ankles/

Liver disease	Alcohol-related liver disease (ARLD) refers to liver damage caused by excess alcohol intake. There are several stages of severity and a range of associated symptoms.	https://www.nhs.uk/conditions/alcohol-related-liver-disease-arld/
Ascites	<p>Portal hypertension is a common complication of cirrhosis and, less commonly, alcoholic hepatitis. It occurs when the blood pressure inside your liver has risen to a potentially serious level. When the liver becomes severely scarred, it's harder for blood to move through it. This leads to an increase in the pressure of blood around the intestines. A person with portal hypertension may also develop a build-up of fluid in their abdomen (tummy) and around the intestines. This fluid is known as ascites. Initially, this can be treated with water tablets (diuretics). If the problem progresses, many litres of fluid can build up, which needs to be drained. One of the problems associated with the development of ascites is the risk of infection in the fluid (spontaneous bacterial peritonitis).</p> <p>This is a potentially very serious complication and is linked to an increased risk of kidney failure and death.</p>	https://www.nhs.uk/conditions/alcohol-related-liver-disease-arld/complications/
citalopram 10mg	Treatment of depressive illness in the initial phase and as maintenance against potential relapse/recurrence. Citalopram is also indicated in the treatment of panic disorder with or without agoraphobia.	https://www.medicines.org.uk/emc/product/5152/smpc#gref
MASH Merlin referral	The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all safeguarding concerns regarding children and young people in Merton. It brings together expert professionals, called “navigators”, from services that have contact with children, young people and families, making the best possible use of their combined knowledge to keep children safe from harm.	https://www.merton.gov.uk/assets/Documents/0403%20merton_mash_leaflet_professional.pdf

<p>The Wimbledon Guild - Ageing Well</p>	<p>The Ageing Well programme helps older people who struggle with meal preparation & meeting nutritional needs.</p> <ul style="list-style-type: none"> • Ageing Well workers will visit you at home, assess your needs and go through options for meeting nutritional needs. This can be part of 10 week coaching programme. • The Homefood Cafe at Guild House on Worple Road is open every weekday from 10.00am offering hot meals and snacks at very reasonable prices. • Alternatives to the above may be organised via volunteers at weekends. 	<p>https://directories.merton.gov.uk/kb5/merton/directory/service.page?id=Ud7UldUSaew</p>
<p>Gliclazide</p>	<p>Non insulin dependent diabetes mellitus (type 2) in adults when dietary measures, physical exercise and weight loss alone are not sufficient to control blood glucose.</p>	<p>https://www.medicines.org.uk/emc/product/2044/smpc#gref</p>
<p>Sitagliptin</p>	<p>Sitagliptin is a medicine used to treat type 2 diabetes. Type 2 diabetes is an illness where the body does not make enough insulin, or the insulin that it makes does not work properly.</p>	<p>https://www.nhs.uk/medicines/sitagliptin/</p>
<p>Furosemide</p>	<p>Furosemide is a type of medicine called a diuretic. It's used to treat high blood pressure, heart failure and oedema (a build up of fluid in the body).</p>	<p>https://www.nhs.uk/medicines/furosemide/</p>
<p>Buspirone</p>	<p>Buspirone is indicated for the treatment of short-term management of anxiety disorders and the relief of symptoms of anxiety with or without accompanying symptoms of depression.</p>	<p>https://www.medicines.org.uk/emc/product/5736/smpc#gref</p>

APPENDIX 3 REFERENCES

1. <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>
2. <https://www.nhs.uk/medicines/gliclazide/>
3. <https://www.nhs.uk/medicines/sitagliptin/>
4. <https://www.nhs.uk/medicines/furosemide/>
5. <https://www.gettingiton.org.uk/services/merton/engage-merton>
6. <https://www.medicines.org.uk/emc/product/5736/smpc#gref>
7. <https://www.medicines.org.uk/emc/product/12015/smpc#gref>
8. https://www.bapen.org.uk/pdfs/must/must_full.pdf
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10. <https://www.scie.org.uk/self-neglect/at-a-glance>
11. <https://s3.euwest2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>
12. <https://s3.euwest2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>
13. <https://s3.euwest2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>
14. https://en.wikipedia.org/wiki/Confabulation#cite_note-4
15. <https://www.pat.nhs.uk/downloads/New%20NCA%20Leaflets/Alcohol%20Services/1100%20-%20Alcohol%20Related%20Brain%20Injury%20-%20ARBI.pdf>
16. <https://www.coordinatemycare.co.uk>
17. <https://www.bsuh.nhs.uk/library/wp-content/uploads/sites/8/2019/06/RefeedingJuly2017.pdf>
18. <https://www.scie.org.uk/self-neglect/at-a-glance>
19. <https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted>
20. <https://www.adass.org.uk/media/7326/adass-advice-note.pdf>
21. <https://www.adass.org.uk/media/7326/adass-advice-note.pdf>
22. <https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>

APPENDIX 4 REFERENCES IN DETAIL

1. How to Use Legal Powers to Safeguard Highly Dependent Drinkers, Alcohol Change UK. September 2021. Page 29 of this report states;

“ Although dependence itself is not a mental disorder, conditions which arise from alcohol use could be considered mental disorders. This is confirmed in section 2.9-2.10 of the Code of Practice. The Code goes on to identify circumstances under which action related to alcohol dependence can be taken under the Act:

“2.11 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act’s definition. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person’s alcohol or drug dependence.

2.12 The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – for example withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

2.13 Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.”¹⁸

2. Description and definition of Confabulation, taken from Wikipedia

“Confabulation is distinguished from lying as there is no intent to deceive and the person is unaware the information is false. Although individuals can present blatantly false information, confabulation can also seem to be coherent, internally consistent, and relatively normal. Most known cases of confabulation are symptomatic of brain damage or dementias, such as aneurysm, Alzheimer's disease, or Wernicke–Korsakoff syndrome (a common manifestation of thiamine deficiency caused by alcohol use disorder).”¹⁹

3. Alcohol related Brain Injury, an Information guide. Northern Care Alliance.

“Alcohol-Related Brain Injury (ARBI) and Alcohol-Related Brain Damage (ARBD) are umbrella terms used to describe damage that can occur in people that drink at heavy levels over a prolonged period of time. Alcohol can disrupt communication between brain cells, destroy brain cells, lead to structural changes in the brain and even cause shrinkage of the brain. Wernicke’s Encephalopathy and Korsakoff Syndrome are included under these umbrella terms. Signs and Symptoms depend on the individual’s brain, where the damage has occurred in the brain, the amount of damage that has occurred and whether the damage is reversible or not. People with

¹⁸ Page 29 <https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>

¹⁹ https://en.wikipedia.org/wiki/Confabulation#cite_note-4

Wernicke's or Korsakoff don't always notice their symptoms, but friends and family can notice symptoms that include:

- Confusion.
- Problems with Short Term Memory, including confabulation.
- Problems with Cognition or Cognitive Impairment.
- Increased Risk of Falls (due to impairment of balance & coordination).
- Problems with motivation
- Problems with assessing risk and problem solving.
- Personality changes.”²⁰

4. Explanation of “Coordinate My Care”, from the NHS

“Coordinate My Care is an NHS service that coordinates urgent care for patients. It starts with the patients filling in an online questionnaire called MyCMC. MyCMC then goes to a doctor or nurse who knows the patient who completes the Coordinate My Care (CMC) plan by adding the patients diagnosis, medical details, resuscitation status, medications and recommendations for the urgent care services to follow in an emergency. Once completed the plan is approved and is immediately visible to all the urgent care services including 111, out of hours GPs, the ambulance (in their vehicles) and the emergency departments. This way everyone is in the loop with the patient in the middle.”²¹

5. Explanation of re-feeding syndrome, Brighton and Sussex University Hospitals

“Refeeding is potentially a fatal condition defined by severe electrolyte and fluid shifts as a result of a rapid reintroduction of nutrition after a period of inadequate nutritional intake. The route of nutrition does not affect the risk of refeeding, therefore oral, enteral and parenteral nutrition can precipitate refeeding in severely starved patients. Risk can be categorised as; at risk, high risk or severe risk.”²²

6. ADASS guidance on duties under S42 of the Care Act 2014.

“The S42 duty on the local authority exists from the point at which a concern is received. This does not mean that all activity from that point will be reported under the statutory duty to make enquiries (S42 (2) of the Care Act (2014)). It may turn out that the S42(2) duty is not triggered because the concern does not meet the S42 (1) criteria (points i.-iii. above). The local authority is responsible for that public law decision as to whether the statutory S42 (2) duty is triggered.

Where the decision is that the criteria do not apply and therefore the duty will not continue into S42(2), issues may still need to be addressed and/or risks mitigated under other processes and powers. This needs to be explicit and recorded. (Activity within S42(1))

²⁰ <https://www.pat.nhs.uk/downloads/New%20NCA%20Leaflets/Alcohol%20Services/1100%20-%20Alcohol%20Related%20Brain%20Injury%20-%20ARBI.pdf>

²¹ <https://www.coordinatemycare.co.uk>

²² <https://www.bsuh.nhs.uk/library/wp-content/uploads/sites/8/2019/06/RefeedingJuly2017.pdf>

includes determining whether, within a human rights context, it is fair, reasonable, lawful to 'interfere')."²³

7. Statutory Guidance on the duty for assessment, including those needs arising out of substance misuse.

"The Department of Health and Social Care has stated that: *"To meet the national eligibility threshold for adults needing care... local authorities... must consider... if the adult has a condition as a result of... (among others) ... substance misuse or brain injury"*. This section also emphasises that a formal diagnosis is not required to prove eligibility."²⁴

8. Care Act duties in relation to eligible needs arising from alcohol misuses, Alcohol Change UK Report.

'Section 9 of the Act requires a local authority to assess a person who appears to have needs for care and support, regardless of the level of need. These needs should arise from or be related to physical or mental impairment or illness including substance misuse. The duty is to complete an assessment of needs, decide what those needs are, determine their impact on well-being, identify the outcomes the person wishes to achieve and agree what contribution care and support could make to maintaining or improving well-being. If the needs are urgent, care and support can be provided before an assessment is completed (section 19(3)).

Following an assessment, if the person has *eligible* needs this triggers a duty to provide care and support (see section 13 of the Care and Support (Eligibility Criteria) Regulations 2014). Eligibility requires the person to be unable to meet two or more of a number of specified outcomes, with a consequent significant impact on well-being.

The outcomes include problems:

- managing and maintaining nutrition;
- managing toilet needs;
- being appropriately clothed;
- being able to maintain a habitable home environment; and
- being able to use facilities and services in the community.²⁵

²³ Page 5 <https://www.adass.org.uk/media/7326/adass-advice-note.pdf>

²⁴ Department of Health and Social Care, *Care and Support Statutory Guidance*, (London, 2014), 6.104

²⁵ <https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers>