SAFEGUARDING ADULT REVIEW REPORT

EXECUTIVE SUMMARY

(Mrs SK)

2022

MERTON
SAFEGUARDING ADULTS BOARD

1. Introduction

This report covers a summary of 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).

The 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. The SAR explored whether the views of SK reflected her complex situation and if her care may have been delayed due to a failure to recognise her needs and to work effectively with health and other agencies.

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).

Terms of Reference

- 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.

Family Involvement

SK was a single parent to 4 children and lived with them in Merton during the period of the Review. Her two youngest children, now in their 20s, were involved during the review and have both had the opportunity to read and comment on the report. Some amendments were made following this consultation and they have stated they were happy with the accuracy of contents, the findings and recommendations.

2. Brief Summary of the Case/ Key Practice Episodes

The author collated a chronology from the individual agency chronologies and other reports submitted by the agencies participating in this review, which focused on the final 2 years of her life. The chronology was then broken down into Key Practice Episodes (KPE), to explore involvement and identify learning from each KPE.

KPE 1(16/02/16- 10/10/16)
SK known to have liver damage and alcohol dependence, visited frequently by Community Matron and GP. MCIL undertook support with benefits and did lots of good liaison with network. Safeguarding issues identified following multiple calls to 111 and police by SK. MDART offered detox but closed her case as she refused this. Psychiatric assessments were not completed. ASC closed case without completing Care Act Assessment. SK was admitted in Sept and was detoxed during a month in hospital, before being discharged home in October.

KPE 2- (11/10/16-31/12/16)
Discharged from hospital, with a pressure ulcer, but no aftercare in place although reablement subsequently saw her, visits reduced and stopped. SK soon relapsed and began drinking again. Also, poor diabetes self-management leading to high risks of blood sugars, hospital involvement, medication prescribed although poor compliance with this.

KPE 3 (01/01/17-15/05/17)
Further physical health issues related to diabetes being poorly controlled and increased use of alcohol. Contact with ASC and several requests for an assessment, but not undertaken as put on a waiting list until April. Prescribed insulin with daily DN visits to administer, due to risks of high blood sugar. Care Act assessment done; outcome not eligible for services.

KPE 4 (16/05/17-12/12/17)
Fall downstairs and sustained injuries, including a fracture. Ability Housing Support began to work on benefits, debts along similar lines to MCIL worker. OT assessment done and case closed, deemed safe to use stairs despite sleeping in living room. Missed MH appt for assessment and support from Ability notes ongoing inability to deal with post, other missed appts. Physical health deteriorates with Ascites, leg pain, oedema, frequent calls to 111 and attendance at ED. Community Matron left, causing anxiety, DN visits to administer insulin remain, but sometimes missed by SK.

KPE 5 (14-12/17-14/01/18).
Increase in frequency of calls to LAS and 111, poorly managed blood sugar levels and range of symptoms, pain, distended stomach, sickness. Harder to engage, declining mental health, re-referred for an assessment with both MAT and MDART. Referred to ASC for self-neglect (poor self-care, faecal incontinence and chaotic) by GP, LAS, OT (for care services) but not taken on. A number of brief attendances at ED, due to poor health but not thought in need of admission on some visits, but others admission was offered, but declined by SK.

KPE 6 (15/01/18-10/02/18)
Admission to Croydon Hospital (2-week admission) Merton mental health services referred her to Psychiatric Liaison and closed her case. Discharged with no assessment or social care services, concerns raised by GP, Ability Housing and MCIL support workers with ASC. Readmission after 2 days at home (St Georges) safeguarding issues identified by support workers and SK passed away 10 days later in hospital.

3. Findings from the SAR.

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.

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.

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.

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.

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.

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.

7. 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.

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.

4. Recommendations from the SAR

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.

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.

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 Approach, 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).

   The Alcohol Problem
   The Pattern of not engaging, or benefiting from alcohol treatment
   The burden placed on public services (either directly or via the burden they place on others e.g., their family)

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.

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.

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.

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.

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 up information about the consequences of refusing services, when intoxicated, to help or mitigate the harm from the consequences of the addiction.

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.