Bury Safeguarding Partnership

Working together to safeguard adults and children in Bury

Bury Safeguarding Adults Board

Safeguarding Adult Review – Ann

Final v1.0

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February 2024

Contents

1. Introduction

Ann[1] was a 66 year old white British woman who was found dead in an alley beside her home on 2nd January 2023. She had died of hypothermia and pneumonia. She had a long history of contact with various public services, but most specifically Substance Misuse and Mental Health Services.

A Section 44 referral for a safeguarding adult review (SAR) was submitted by the NHS Integrated Care Board because it was felt that there might be important learning from her case, particularly about the management of people with a co-occurring disorder of substance misuse and mental disorder.

The SAR Referral Panel agreed that the case highlighted a number of areas of potential learning, and decided that that a SAR should be undertaken. This SAR considers a period from January 2022 until Ann's death in 2023.

2. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning.
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything, prevented them from being able to properly help and protect Ann from harm.

3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of twenty SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in

[1] Ann is a pseudonym chosen by the family

the last decade has worked mainly on developing responses to change resistant dependent drinkers.

4. Methodology

A multi-agency panel of the Bury Safeguarding Adult Board was set up to oversee the SAR and commissioned the author to complete the review. Initial chronologies had been sought and received from key agencies using the SAB's SAR Chronology Form. This seeks a brief chronology of each agency's involvement.

It is important to note that Bury SAB wanted a swift process and, therefore, it was agreed to develop the final report using the information in the SAR referral, the initial chronologies supplied and a brief report form (learning summary) that was developed to gather information about this specific case rather than asking agencies to submit more detailed Individual Management Reports. This also reduced the work impact on the agencies involved. In addition, more detailed information was sought from the involved agencies via a practitioners' workshop in November 2023.

The following agencies were involved in the process:

- NHS GM Bury (on behalf of the GP practice involved)
- Adult Social Care (ASC)
- Northern Care Alliance NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Greater Manchester Police
- North West Ambulance Service
- Six Town Housing
- Greater Manchester Mental Health NHS Foundation Trust

Some of the information provided included information from outside the review's time period enabling a fuller picture to be developed. All of the material was analysed by the author and an initial draft of this report was produced and went to the Review Panel in January 2024. Further changes were made and a final draft was completed at the end of January 2024.

5. Family contact

An important element of any SAR process is contact with family. Ann had two sons who both live in the North West region. The younger of these two sons agreed to contribute to this process. The author met with him online in October 2023 and he contributed very useful insights into his mother's life and care. The author is very grateful to him for his input.

6. Parallel processes

There were no Police inquiries that coincided with this review; however, a Coronial inquiry was pending during the review.

7. Background and personal Information

Ann was a 66 year old White British woman at the time of her death. Her husband had died in January 2019 and she had a sole tenancy on a 2 bed bungalow which she had previously shared with him. Her son described her as someone who had been "drop dead gorgeous" when she was younger and was "a very decent person".

She had worked as a Nurse but had not been in employment for approximately 30 years as a result of contracting septicaemia which had left her in a coma for six weeks. Her son suggested that this also contributed to the development of her problems with alcohol.

Ann was married twice and it is documented that her first marriage was unhappy and featured domestic abuse, which again contributed to her alcohol use and struggles with her mental health. Her second marriage was much happier, and she was married for 30 years until her husband's sudden death. The grief she felt for him was a factor in her low mood and her risk of relapse into mental health problems or alcohol use around the date of his death each year.

Ann had two sons both of whom had supported her in various ways in the years since 2019. The older son lived with Ann throughout the Covid lockdown. The younger son was actively trying to support her at points in the last year. Both struggled because of the challenges posed when Ann was intoxicated and the younger son was particularly concerned about her impact on his young family.

The notes suggest that she also received some support from other people living locally. However, the Primary Care notes suggest that these relationships were limited.

Although not working, Ann sought to remain active and over the years she liked to go out shopping and she participated in local groups. She did cooking with people with learning disabilities at a nearby Adult Learning Centre. However, the PIP process declared her fit to work and she had to fight this which led to accumulated debts. However, ultimately the decision was reversed and by 2022 she was financially secure, debt-free, and in a good position.

Ann had an alcohol use disorder and experienced alcohol-related seizures (a sign of dependency) and fatty liver disease. She is recorded as having been alcohol dependent since 1993. In addition, she was a heavy smoker for much of her life and had a diagnosis of COPD. She was consequently involved with the COPD Team.

Ann's drinking appears to be episodic with periods of abstinence interspersing her drinking. For example she had an 18 month period of abstinence in the 1990s. In the periods 2012 – 2015 and 2015 – 2019 there was a general reduction in her use of services suggestive that her mental health and alcohol use were well controlled. In the years since her second husband's death she tended to be relatively abstinent in the summer but drinking as the anniversary of his death approached in January.

However, there had been a general increase in her alcohol consumption since she was widowed, particularly during the Covid lockdown.

She was engaged with Alcohol Services on and off for close to thirty years prior to the period under review. This included an inpatient alcohol detoxification in 2019. This followed an A&E department attendance due to a fall. At the point of that admission, she was not weight bearing and appeared distressed. She described a period of sobriety for most of late 2019-2020 following the detoxification. While she was undergoing the detox Ann had another fall. A CT brain scan was completed which showed an old lacunar infarct (stroke) but no new difficulties.

Ann also had a long history of mental illness, she took an overdose in 1998 and, as a result, was diagnosed with depressive disorder. She also had significant involvement with the Mental Health Trust who describe her as having "good engagement". She also regularly made contact with her GP who provided her with very positive support. The GP practice commented that *"A lot of the time, the contact took place over the telephone, however there is significant evidence that Ann wanted help/support and engaged with services.*"

The Ambulance Service had multiple call outs to Ann over the years as a result of either 999 or 111 calls. These calls repeatedly followed the consumption of alcohol and reports of being upset regarding bereavement or concerns around her mental health.

Ann struggled during the Covid lockdown. She was not known to the Police prior to 2020. However, between 2020 and 2023 the Police were contacted on six separate occasions in respect of concerns for Ann's welfare. These contacts included Ann contacting them herself, concerns raised by neighbours and concerns raised by partner agencies. Generally these contacts were referred to the Ambulance Service as the incidents were believed to have been medical matters. However, on the Police IT system Ann had warning markers for: mental health, self-harm, suicide and being a vulnerable person.

During 2020 and early 2021 there were a significant number of telephone contacts with the Hospital Alcohol Liaison Team. Again the winter appears to have been a higher risk period than the summer. At the beginning of 2021 Ann presented at the Emergency Department and was seen by the Mental Health Liaison Team on at least four occasions. Letters to her GP highlight that there were no indications of mental illness. She was seen as a vulnerable female who was alcohol dependent, lived alone and was at risk of falls. Mental Health Services recognised that her vulnerability and the impact that alcohol had on her wellbeing was impacting on her ability to carry out daily activities of living and to have healthy relationships.

The following winter Ann became unstable again. Between January and May 2022 the Ambulance Service had nine contacts with Ann and she was transported to hospital on six occasions. Four safeguarding concern notifications were sent to Adult

Social Care by the Ambulance Service in 2022. Her family also lost contact with her during early 2022 because of her drinking.

In March 2022 Ann was admitted under Section 2 of the Mental Health Act (this was then changed to informal). This followed an overdose and superficial cuts to her wrist. She had also taken half a bottle of vodka and had written a suicide note to a Mental Health Duty Worker who was visiting her that afternoon. She was discharged on 20th April 2022.

The Older People's CMHT was involved in her discharge planning and a period of home leave went well. She then received support from a Care Co-ordinator until discharge in September 2022. She remained open to a Consultant Psychiatrist for regular outpatient review.

During this admission, Ann was ostensibly diagnosed with Alzheimer's Dementia (atypical or mixed type). However, this diagnosis was not added to Ann's list of diagnoses and it didn't appear to be referenced again by either the GP or Mental Health Trust in assessments, plans or treatment. Her family were unaware of this diagnosis and learned about it for the first time when the Coroner talked about it.

It has since transpired that this apparent diagnosis was an error. A Doctor appears to have written Alzheimer's Dementia on to her medical notes by hand by mistake: presumably it was meant to apply to another patient. This "diagnosis" does not seem to have been seen by anyone involved in her care nor to have influenced the care she received. However, it has impacted on the Coroner, caused distress to her family and may have been a factor in deciding to have a SAR. The Doctor involved has since left the Trust.

Parallel to the mental health crisis in early 2022 Ann entered Alcohol Services and engaged well with them and as a result she was abstinent from alcohol until just after Christmas 2022. She was described as being in a "positive mindset, she had refrained from drinking, she had completed a mindfulness course, she had been attending alcohol support groups and adult learning courses where she received an award." As a result, for the second half of 2022 the Ambulance Service has no contacts with Ann.

Her relationship with her family also improved. She went to Blackpool on holiday during this period and the sons and her family went to see her there as a surprise and that restarted their relationship.

Ann was receiving support with her social care needs at this point. Age UK were supporting Ann and a care package is also referenced. Her family was very positive about Age UK saying that they were *"a lifesaver, they were like a family to her…there were two women who rang her every day"*. However, the family were more critical, of the Alcohol Service, the family feel that they *"just signed her off when she stopped drinking. I don't think they do enough. She talked about that gap before, if you drink you get help once you stop you don't."*

By November 2022, Ann's presentation had changed. This followed the pattern she had shown in the last three to four years: a deterioration as Christmas and the anniversary of her husband's death approached. There were five GP consultations in which Ann reported symptoms such as very low mood, being tearful, not sleeping, not eating and requesting help. She was seeking support from alcohol groups and wanted to see someone regarding her mental health. Ann stated that she had never dealt with her depression before without alcohol.

The GP repeatedly attempted to support Ann, signposting her to local support services, listening to her and encouraging her as well as attempting to engage other agencies to support her.

The GP notes state that attempts were made to liaise with the Mental Health Trust on a number of occasions in this period. The details of this interaction are dealt with later in the report. However, Mental Health practitioners saw Ann in mid-December and the GP practice received a letter from the Trust on the 23rd December, detailing that they were altering her medication and a CPN would visit to deliver the drugs.

It appears that her mental health continued to worsen in the run up to Christmas. Ann also had a cold or chest infection which was also causing her to feel low. She was unable to engage with her family at Christmas due to feeling unwell and she isolated herself from them. Immediately after Christmas she started drinking again and the situation deteriorated markedly.

On the 1st January 2023, Ann's neighbour reported that she had approached his property at approximately 2.30am and banged on his window asking for a cigarette. He watched Ann return home. At 03:36am the Ambulance Service attended her home after a call from her. They report that Ann had been drinking after a relapse two days earlier. She had also had a chest infection for which she had just finished a course of antibiotics. Ann was described as fully alert and able to say that she did not want to go to hospital. Instead she was referred to the Urgent Care Service.

08:08am the same day, Ann again called 999 stating that she had not been able to collect her prescription from Urgent Care because she could not contact her son. Paramedics attended and Ann again declined to attend hospital. The Paramedics contacted Urgent Care who agreed to conduct a home visit.

Just over three hours later, Urgent Care made a 999 call requesting that Ann be transported to hospital. Ann was not answering the door, so the Police were called but before they arrived the Paramedics entered via the back of the house. Ann was found intoxicated and crawling around on the floor. Ambulance staff recorded that Ann was unable to confirm if she had taken any medications due to her reduced level of consciousness. She was transported to the local Hospital Emergency Department. On arrival, Ann disclosed she had consumed alcohol and had not taken an overdose.

This brief period in Hospital is seen by her family as a key point in her care. The Hospital notes to the GP state that Ann *"came in alcohol excess, now has sobered down, was scoring for pneumonia, curb 2, did not comply with hospital admission and IV antibiotics, had full capacity, went home with TTO amoxicillin, I have safety netted her, may come to you if feels unwell, kindly do the needful, many thanks."*

There seems to have been a difference in staff attitude in the Hospital with Nursing staff being concerned about Ann and putting 1:1 care in place, whereas Medical staff allowed her to sign a leaving against medical advice form 15 minutes later. Ann then left the Hospital in a taxi. The Hospital did make sure that Ann had all emergency and support contact numbers available to her and knew to contact emergency services should she require support / intervention.

The family raised other concerns. Her son reported that: "*Hospital staff tried to say that it was his responsibility to look after her and she was allowed to self-discharge…she should have been held in hospital for longer. If she hadn't come out she would still be alive."* Her son also reported that "*A nurse on the ward asked me to bring keys (Ann's house keys), I said I couldn't and they said, "thanks very much." The hospital needed to understand the impact on the family and to understand that I had other responsibilities, for example, the children. There should be more support for the family, it tore the family apart at times. It impacts the family as much as the drinker."* His view is that the "*Hospital just wanted to be rid of her*."

On the 2nd January 2023 (the day after discharge) the Police receive a report from a member of the public that Ann was collapsed in an alleyway next to her house. Officers attended but Ann was found deceased on the ground, a hospital gown was nearby and she was still wearing what appeared to Officers to be ECG pads. She had no clothing on her upper body and was covered in mud.

It is understood that she had been able to enter her house after returning from Hospital, so it does raise the question of why she was she outside on the night of her death? Her son said that she was possibly going to the shop but she had no money with her. She had also been known to wander and she had walked around outside in pyjamas in the past.

The death was investigated and it was concluded that there were no suspicious circumstances or third party involvement. It appears that she collapsed there at some point during the early hours of the morning. The cause of death was hypothermia.

8. Key themes

Ann's life and the circumstances of her death highlight a number of key themes:

- Her discharge from hospital on 1st January 2023
- The response to people with alcohol use disorders including alcohol screening, attitudes to this group and longer term support for people in recovery
- The response to people with co-occurring disorders
- Multi-agency working
- Risk assessment
- Safeguarding
- Mental capacity
- The importance of smoking

9. The circumstances of her discharge from hospital on 1st January 2023

A key point in Ann's care is the decision-making around her self-discharge from Hospital before receiving appropriate treatment on 1st January 2023. As was set out above this is a point of real concern for the family. They feel that Ann should have been detained in Hospital. This period has been subject to a Serious Incident Investigation Report by the Acute Trust. This was completed in April 2023 and was provided to this Review. The version received was the one that was also supplied to the family.

There are no significant inconsistencies between the accounts of this episode in the report and that received via other sources. However, it does provide some additional context. It reports that the Department was very busy at this point with 23 patients waiting for a bed and 10 patients placed on the corridor.

The report focused on five key lines of enquiry:
1. Whether the patient had capacity to make the decision to discharge herself.
2. What advice was given to the patient on her discharge.
3. Confirmation of the patient's clothing and attire on discharge.
4. What mobility state the patient was in when she left the department.
5. Why was a mental health section not considered at this presentation.

The report provides an analysis against each of these themes:

Whether the patient had capacity to make the decision to discharge herself? *It is documented that the patient understood the information relevant to the decision to self-discharge, that she could retain that information, that she could use or weigh that information as part of the process of making the decision and that she could communicate her decision.*

What advice was given to the patient on her discharge? *The patient was advised that the consequence of refusing treatment was sepsis, respiratory failure, and death. It is*

noted that the patient understood the information relevant to the decision to self-discharge

Confirmation of the patient's clothing and attire on discharge. *On the CCTV footage the patient was observed wearing a thick deep red dressing gown covering and slippers when leaving the hospital and getting into the taxi at the hospital.* (It should also be noted that it was a relatively mild day in Bury).

What mobility state the patient was in when she left the department. *The patient was observed on CCTV to walk in a straight line from the ED doors, past the Orangery (approximately 20 metres) and get into a taxi with no indication that she was struggling with her mobility.*

Why was a mental health section not considered at this presentation? *The Mental Health Liaison Team identified that the patient was referred to mental health services in August 2019, February 2020, January 2021, twice in February 2021, twice in January 2022 and in March 2022. She was referred to the alcohol liaison team in July and August 2019, January 2020, January and February 2021 and March 2022. She was admitted to a medical ward in May 2022 due to an overdose of medication and alcohol dependency and was seen by the older persons liaison team. The patient was admitted informally to a mental health ward in March 2022. She was placed on a section 2 on 27th March 2022, but this was rescinded on 30th March 2022, and she was discharged on 27th April 2022. On this attendance the patient was deemed to have capacity following her assessment. The patient was not referred to the Mental Health Liaison Team as staff did not doubt her capacity at the time.*

The Acute Trust presents clear evidence of Ann's mobility, her attire and her understanding of the consequences of her conditions. It is also hard to see that her mental state was such that it warranted detention under the Mental Health Act. There is no evidence of delusion or mania and, although certainly depressed, her manner appears positive in that she is clearly asking to return home.

Nonetheless, staff in the Department clearly felt that her physical health would have benefited from admission. The thing that prevented this is the decision about her mental capacity. The question, therefore, is the appropriateness of this decision.

The answer about capacity above states that Ann *understood the information… could retain that information… could use or weigh that information…and that she could communicate her decision.* The main question must be whether she was really able to use or weigh that information. This can be considered from two angles.

Firstly, mental capacity needs to be assessed against a specific decision. In this case this seems to be whether she had the capacity to discharge herself. However, is this the most relevant decision? Is the crucial decision not rather – can Ann keep herself safe when she returns home? Considering this question may well change the answer. Her history of multiple admissions to the Hospital in the previous year would have suggested that this was not the case.

Secondly, it needs to be asked whether Ann is really able to use or weigh information about her situation? Does she have executive capacity? Can she put the decision to care for herself at home into effect? Both subsequent events, but more relevantly, Ann's past history suggest that this was not the case. Over the previous year Ann had had a number of similar crises in the Hospital where capacity decisions were made that Ann was unable to execute. Section 4.30 of the Code of Practice on the Mental Health Act indicates that it is relevant to consider past history when taking a current capacity decision.

All of this raises questions about the use, and understanding, of the Mental Capacity Act. These are addressed further in section 14.

However, the discharge raise a more fundamental question. Ann's family questioned whether attitudes to people with alcohol use disorders influenced this decision. It is not possible to determine people's attitudes in retrospect and the Serious Incident Investigation Report does not address this theme. Nonetheless, this situation does raise sufficient questions about Ann's care to suggest that the Acute Trust or the SAB should undertake work to ensure that professional attitudes generally do not impact on people with alcohol use disorders receiving the medical (or other) care that they require.

It is easy to believe that chronic heavy drinkers are "choosing" to behave in this way. In reality, it is unlikely that Ann is "choosing" this lifestyle; rather, there will be a complex set of compulsions and barriers that are impacting on her behaviour. Professionals need to ensure that their beliefs about the nature of the choices that drinkers are making do not impact on care.

10. Tackling alcohol use disorders

10.1 The AUDIT tool

Ann's care is a reminder of the importance of robust alcohol screening processes to ensure that alcohol-related risk is routinely and consistently identified. Without such data it will not be possible to build an appropriate response; but it will also be harder to build a case for a general improvement in the approach to alcohol use disorders.

Therefore, in accordance with NICE Public Health Guidance 24, best practice would ensure that the AUDIT alcohol screening tool[2] is routinely being used at assessment by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other relevant adult service. Professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore, record and communicate information about this issue.

[2] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)

10.2Tackling alcohol use disorders: a community pathway

Ann had a long history of alcohol dependency over at least 30 years. During this time, she engaged with support services from both a regional Mental Health Trust providing inpatient detoxification and community alcohol services as well as the local Acute Trust's Hospital Alcohol Liaison Team. As a result of these interventions Ann did have long periods where she was alcohol free. This presents a positive picture of the availability of help for people with alcohol use disorders locally.

It also needs to be noted that from 2020, much of this care would have been over the telephone due to Covid restrictions. However, there is no evidence that this significantly impacted her care.

The main concern that has been raised about this care, by her family and it was reported by Ann herself, is the lack of aftercare following discharge. The Acute Trust state that *Ann voiced that she struggled when she no longer had access to key worker or groups due to being sober. It should be asked whether Ann faced a cliff edge support if she was not eligible for services once she was sober. This potentially put Ann at higher risk of relapse. Is there support for those individuals who are abstinent from alcohol and if so, was Ann aware of these services?*

With Ann this was particularly important because services, e.g. the Acute Trust, were aware that her mood tended to worsen over the winter.

It is interesting that concerns about a too early discharge were also a feature of her inpatient alcohol detoxification in 2019. The regional Mental Health Trust providing Alcohol Services acknowledge that *Aftercare …following discharge in 09/2019 appears to have been overly optimistic. Social care assessment could have been indicated at this time with the potential for a care package and formal consideration of capacity… the situation was more complex and would have benefitted from further time as an inpatient to facilitate a more structured discharge.*

Just over five weeks prior to her death, Ann called the Alcohol Service. She reported that: "*she was in a very low mood and can't get out of this deep depression. Not getting out of bed. No suicidal thoughts or thoughts to harm self or others."* The Alcohol Worker talked through her support network: Age UK, family, friends Older adults CMHT, and the Alcohol Service's Kaleidoscope Group. *"Reassurance given and suggestion made to call into the group when she is feeling better for a chat about community activities."* The Alcohol Service report acknowledged that: *Face to face would have been useful at this point to see Ann's environment after she was reporting not getting out of bed for over a week, self-neglect could have been a factor along with executive capacity. It is not known if or who had eyes on her after this date. No further contact from the Alcohol Service*.

In October 2023, the Office for Health Improvement And Disparities published the *UK clinical guidelines for alcohol treatment.* This talks specifically about the need for long-term aftercare: *It takes 5 years or more before the risk of returning to problematic alcohol use drops below the 15% in the general population (White 2012). So, ongoing monitoring and management to maintain recovery is essential. Recovery support*

should begin early in treatment and continue after the person has left. Outcomes improve significantly when treatment is combined with long-term recovery support (Simoneau and others 2018)… Services should support recovery through 'recovery check-ups' to strengthen recovery outcomes. These check-ups involve keyworkers regularly contacting people (by prior arrangement) who have left treatment, to offer encouragement and to identify any extra support they might need.[3]

The concerns in this area are summed up in the Primary Care report: *when Ann was abstinent from alcohol, services wouldn't work with her anymore as she wasn't drinking now and there appears to be a gap for individuals with an addiction who aren't going through the acute/initial phase of breaking the addiction.*

However, Ann herself often rejected longer term help that was offered. The regional Mental Health Trust providing alcohol services notes that: *Ann was offered Antabuse*[4] *medication but did not wish to use this treatment option… Ann did not wish to engage with AA and also did not wish to engage in virtual meetings.* In January 2022, Ann stopped drinking and told her GP she didn't need Alcohol Services.

It is not the role of this report to adjudicate whether the problem is that services were providing insufficient aftercare or whether it was that Ann was rejecting that care. The simple lesson is that long-term support is essential for recovering drinkers. Therefore it would be worth local Commissioners and service providers considering whether there is sufficient support and where and how it is best provided. This could include access to Talking Therapies.

10.3 Hospital Alcohol Liaison

Ann was known to Alcohol Liaison Team in the hospital and was helpfully seen both in the Emergency Department and whilst an inpatient on a ward.

11 Mental Health

11.1 General

Ann had diagnosed mental disorders in addition to her alcohol use disorders. There appears to have been a long running theme of low mood and anxiety for her, which was both driven by, but also drove, her alcohol use. There was a history of overdose and following the death of her husband in 2019 Ann became more isolated and again . this exacerbated her low mood and alcohol use.

In the early months of 2022, Ann had a marked pattern of suicidality and a diagnosis of depression. In the period until March 2022 there appear to have been two or three incidents of self-harm or suicidality. These include cutting herself and overdose.

[3] UK clinical guidelines for alcohol treatment - GOV.UK (www.gov.uk)

[4] Antabuse (Disulfiram) blocks an enzyme that is involved in processing alcohol. It produces very unpleasant side effects (such as fast heartbeat, chest pain, nausea, dizziness, flushing, and thirst) when combined with alcohol in the body. This is used as a deterrent to relapse in people who are in recovery. It is not used to control active drinking.

After a hospital admission in March 2022 she was referred by Psychiatric Liaison to the Older People's Community Mental Health Team who accepted her as a client.

On the 26th March 2022 Ann was detained under Section 2 of the Mental Health Act. A few days later she became a voluntary patient. Ann was viewed as having: "*a mild to moderate depressive episode with mental & behaviour disorder due to alcohol abuse. Risks to self, identified as risk of death either intentional (by suicide) or by misadventure from maladaptive coping mechanisms (alcohol, overdose) currently mitigated by admission to hospital; risk is elevated when using alcohol & reduced by abstinence.*"

She was discharged in April 2022 and then had ongoing support from a CPN but, in May 2022 there was a further overdose. However, from that point forward she enters a positive period in which she was supported by a CPN, the Alcohol Service and community agencies like Age UK.

Adult Social Care's report comments positively on the work to address Ann's mental health: "*In the period from around Oct / Nov 21 to April 22 there are a number of different Mental Health services involved in her care (in-patient; liaison and community services) in response to her fluctuating presentation and frequent admissions to hospital…Ann appears to have responded well to a dedicated care co-ordinator and the joint support of the Alcohol Service…"*

The local Mental Health Trust themselves comment that: the Older People CMHT's Community Psychiatric Nurse (CPN) had a good working relationship with Ann and there are no identified concerns about the management of her mental health. This does seem to be borne out by the period of stability she experienced in the summer of 2022.

However, the agencies involved identify three areas for consideration with regard to the management of her mental health.

Firstly, on leaving the alcohol detoxification unit in 2019 (run by a regional Mental Health Trust), the staff supported Ann to make a referral to the local IAPT service[5]; however, it is acknowledged by the referrer that this was potentially overly optimistic given the long-term nature of her needs and that possibly a referral to CMHT should have been considered.

Secondly, the Primary Care report highlights that *"learning for the GP practice has been identified relating to the risk assessment/management of self-harm including the risk of overdose…It isn't clear in Ann's GP records how the GP practice risk assessed further prescriptions or what mitigation plans were in place."* However, nothing suggests that this was a contributory factor in her death, therefore no recommendation has been made about it.

[5] The NHS Talking Therapies, for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT)

Thirdly, in the six weeks prior to her death, Ann entered another mental health crisis. Her GP sought advice, without success, from her Psychiatric Consultant. The Primary Care report says that: *the delays in communication result in Ann being without care, treatment or support for over a month.*

The Mental Health Trust have a different perspective on this period. The Trust has an Access and Crisis team which should be the contact point in these situations. The Primary Care notes suggest that the GP was attempting to contact a specific Consultant and their team instead. Ultimately, the Trust received a referral from Primary Care on 16th December. The GP was asked if Ann needed a weekend visit (17th / 18th December), but this was not felt to be necessary, and they responded with a visit on the 19th December. This was in line with expected practice.

These notes suggest a confusion about how to access crisis help on the part of one Primary Care team. This report is not in a position to do other than ask whether this is indicative of a need to disseminate more information to Primary Care about the route for crisis care.

11.2 The episodic nature of alcohol use disorders and mental health problems

In a health and social care system that is under resource pressure, it is very easy to take a short term perspective that deals with the crisis but fails to recognise the need to prevent the repetition of that crisis. This is an approach that saves resources in the short-term but may cost more in the long-term.

Ann would have undoubtedly benefited from a recognition of the need for longer term support. This approach may not be possible with every client; but given the length of her history this does seem to be a necessity. This is even more so because the Christmas period is a recognised trigger point for her deterioration, following the death of her husband.

It may not be possible to keep Ann on as a full, open case with an allocated worker. However some ongoing monitoring and checking in would have been beneficial if combined with fast access back into care if there is a crisis.

11.3 Co-occurring disorders

Ann has a co-occurring disorder – a dual diagnosis of both a substance use disorder and a mental illness. Across England the management of this client group has often been challenging and, as a result, there are currently three pieces of national guidance on meeting the needs of this group:

- NICE (National Institute of Health and Care Excellence) – National Guidance 58 – Co-existing severe mental illness and substance misuse - 2016
- Psychosis with coexisting substance misuse – NICE Clinical Guideline 120 – 2011

- PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017

These documents highlight the high rate of prevalence of these conditions. The key problem that these documents address is that of responsibility for this client group with the concern being that both Substance Misuse and Mental Health Services may push back at managing these clients on the basis that the main problem lies with the other service.

However, this does not appear to have been the case with Ann. She was being worked with by both services concurrently. The question raised by Ann's care is whether the two services were working together on her care. The Primary Care report commented that *the GP practice appears to have been in the centre of services, looking at the situation as a whole, whereas mental health and (the alcohol service) have responded appropriately to their area, although not considered how this will impact on the other.*

Similarly, the regional Mental Health Trust providing Alcohol Services comments that: *"There is very little evidence of joint management on our system in relation to work with CMHT, there was some joint work and concerns shared with Ann's GP, however this appears to have predominantly been concerns about Ann's physical health at these times."*

The local Mental Health Trust comment that both within the review period and historically there is no robust evidence of joint care planning with Alcohol Services. It is acknowledged that while there was positive individual practice, there was limited collaboration with other services outside of the Trust. Joint care planning could have considered what the plan would be during identified pressure points, for example Christmas, when Ann was feeling low or when having difficulties in relationships with her sons.

The agency reports raise two other questions about co-occurring disorders:

- whether generic services recognise that individuals may have both problems? In March 2022, the Alcohol Service commented that the Acute Hospital had responded to Ann on the basis of her alcohol use rather than recognising the possible impact of her mental illness.
- Whether a more preventative approach could have been used. Helping her to understand the triggers and underlying factors precipitating episodes of low mood and / or the impulse to use substances.

It was noted that since the death of Ann action has been taken around co-occurring conditions. All Mental Health Trust staff can access training regarding co-occurring conditions via the Trust's learning management system.

More strategically, the Mental Health Trust and the Alcohol Services have also now produced a Bury Joint working Protocol which is awaiting ratification. This is

specifically for Co-existing severe and enduring mental health difficulties and substance use issues (Dual Diagnosis). The protocol is intended to foster joint working between services whilst maintaining and capitalising on each organisation's specialist role. The aim is to tailor intervention and management plans wherever possible around the individuals and set out an inclusive approach. It follows principles set out in the national guidance set out above.

12 Multi-agency management

Agency reports are very clear in suggesting that Ann's care would have benefited at points from escalation to a multi-agency forum involving Emergency Services, Health, Mental Health, Drug & Alcohol Services, Adult Social Care and Housing Services, among others.[6]

The Mental Health Trust states that *"Although there is evidence of liaison between agencies, it is not clear as to whether there was a consideration of a multi-agency meeting during the times when Ann had relapsed and was voicing difficulties. Liaison could have ensured better care planning and a clearer plan of what support was being offered in respect of prevention and situations where there was a relapse."*

As an example, the Mental Health Trust highlights that: *Ann had a clear pattern of being abstinent and then relapsing. Triggers for this were the loss of her husband and relationship difficulties with her son. A multi – agency meeting such as a team around the adult could have made it clear to all parties about what the risks were to Ann when drinking and what support was available to her, Ann could have been included in this process.*

Primary care did refer Ann to the local Integrated Neighbourhood Team in 2019, but agreed that: *multi-agency working in the broadest sense, could have been better when working with Ann. This includes, communication & information sharing, risk assessment, risk management, and escalation of need.* However, it was also highlighted that the multi-agency working would only be beneficial if there were other options to offer her.

The Police state that: *there is a lot of evidence regarding agency support and involvement, although there is limited evidence of agencies working together...At the time of her death Agencies were involved, although again working in silo.*

Management via a multi-agency group could have ensured:

- Information was shared
- A jointly owned plan was developed
- Points of disagreement could be debated
- Agencies were challenged to try different approaches.

[6] Police and Community Safety could also be regular members of such a group, albeit less relevant for Ann.

A regular multi-agency framework would also have facilitated agencies identifying the deterioration in her well-being in the last months of her life.

Bury could benefit from having a standing specialist multi-agency group that focuses on complex and difficult to engage individuals. This would provide a structured alternative to ad hoc meetings. This approach has worked well with people with alcohol use disorders in other areas e.g. Sandwell, Northumberland.

13 Safeguarding and other Adult Social Care interventions

Ann was an adult with care and support needs and the agency reports identify four Safeguarding Concerns that were raised about her during the relatively brief review period. Prior to 2022 she is identified as having been subject to two other Concerns, one from the Ambulance Service the other from Age UK (October and November 2021). Both of these were addressed by ensuring there was contact with the Alcohol Service.

The four Concerns in 2022 primarily came from the Ambulance Service.

- In January 2022, Paramedics found that Ann was intoxicated and threatening suicide, living in an unkempt home, struggling with daily tasks such as medication administration, and was in low mood. She was taken to A&E but left before being seen. As a result a Safeguarding Concern was raised. This referral was closed as Ann was open to local Alcohol Services. The Alcohol Services viewed this as a potential missed opportunity to complete an assessment of need.
- On 22 February 2022, a Safeguarding Concern was raised by the Ambulance Service following a suicide attempt. The Adult Social Care notes appear to indicate that her engagement with Mental Health Services was sufficient response.
- On 26 March 2022, the Ambulance Service was called to Ann after reports of taking medications over prescribed limits and consuming alcohol to excess. Ann was transported to the Emergency Department and a Safeguarding Concern was sent to Adult Social Care. At this point Ann was detained under the Mental Health Act and became involved with the Older Peoples Mental Health Team. This is an Adult Social Care team and was viewed as the appropriate response to the Concern.
- On 14 May 2022, the Ambulance Service found that Ann was withdrawing from alcohol and needed to attend hospital but was reluctant due to worries around caring for her dog. Ambulance Service staff managed to secure a suitable pet sitter and Ann was transported to the Emergency Department. A Safeguarding Concern was again sent to Adult Social Care. At this point she was engaged with a Social Worker in the Older Peoples Mental Health team and she was referred into the Reablement team.

Adult Social Care comment that: "*on reviewing the case history there appears to have been a timely and proportionate response to concerns raised in order to safeguard Ann. Ann was provided with appropriate information and signposted to relevant agencies as necessary".*

Action is taken in response to each Safeguarding Concern. However, the repeated Safeguarding Concerns may suggest that more action was required. After the sixth Safeguarding Concern in nine months, was a multi-agency meeting required? This links back to, and underlines, the concerns about the lack of a multi-agency response in section 12.

In particular, those working in safeguarding need to recognise that simply referring someone to Alcohol and Drug Services may not be a sufficient response to a safeguarding concern. Alternatively, Alcohol and Drug Services need to be supported to develop a more specific response to people with alcohol use disorders who require safeguarding. This might be built around a more assertive outreach response using harm reduction techniques. This is an approach being used in other parts of the country e.g. Northumberland.

On the other hand, there were also a larger number of missed opportunities to raise Safeguarding Concerns or make a referral for assessment of her care and support needs under section 9 of the Care Act. This goes back before January 2022. For example, Alcohol Services recognised several missed opportunities to safeguard Ann e.g. *"on her discharge from RADAR in 09/2019 and ongoing throughout 2020 and 2021."* During the review period:

- On 26th March 2022 the Mental Health Trust undertook a home visit, the notes state that: *self-neglect assessed as moderate risk - increases with mood and anxiety - unkempt denied consuming alcohol. Ann later that day disclosed that she had omitted to disclose information about her alcohol misuse*. However, a referral to Adult Social Care was not made.
- On a couple of occasions after her admission under section in March 2022, her CPN in the Older People's CMHT documented concerns about self–neglect. The Trust's notes acknowledge the there is no evidence of exploration of the need to complete a Safeguarding Concern.
- On 24th April 2022, she had a seven day follow up after hospital discharge. She was noted to be unkempt. The notes say that it was not clear if there was any consideration of self-neglect.

From June 2022, Ann achieved a sustained period of sobriety and improved mental state and, other than an email received on 30/12/22 just before her death, there is no record of any Concerns received by Adult Care Services in relation to Ann.

Alongside concerns about safeguarding, it is also noted that Ann was not subject to a Section 9 Assessment of her Care and Support needs at any point. The Mental Health Trust providing Alcohol Services believed that a Social Care referral could have been

beneficial, particularly with her needs following the death of her husband in 2019 and her concerns about debt.

However, in May 2022 the Older People's Social Care CMHT did engage with her and engaged the Reablement Service with her care. However, this ended just over a week later following a further overdose. Following this Ann entered a period of stability in which this level of support was not required.

This highlights that:

- all agencies need to consider use of both section 9 and section 42 referrals for people like Ann with substance use and / or mental disorders; &
- consideration to be given as to whether the response to the safeguarding concerns submitted for Ann is robust enough for someone with a pattern of relapsing crises.

14 Using the Mental Capacity Act

The agency reports mention Ann's mental capacity at several points.

- Twice on 13th January 2022 (the anniversary of her husband's death), the Ambulance Service was called, initially Ann refused to be transported to Hospital, as she didn't want to wait in the Emergency Department. Paramedics stated that she had capacity to retain, understand and weigh up information and several attempts were made to persuade her to consent to attend Hospital. However, they were called again and on this occasion determined that she lacked capacity to make the decision about whether to be transported to Hospital. She was taken to Hospital but absconded.
- In March 2022, Ann was reviewed on a Mental Health Ward and was assessed as having capacity regarding her care and treatment.
- In May 2022, Ann was repeatedly leaving an inpatient ward to vape throughout her admission and on one occasion paramedics saw her slip from a bench. She was deemed to have capacity to leave the ward despite being advised not to.
- At the start of June 2022, she was deemed to have capacity to self-discharge from a ward following admission for an overdose.

Most critically, on the 1st January 2023, Ann discharged herself from A&E against medical advice and was deemed to have capacity to do so. Ann had been relatively stable for a long period prior to this relapse and at this distance and without a detailed picture of how Ann presented that day, it is impossible to say definitively whether that was the appropriate decision. However, it does raise questions about the assessment of capacity with people like Ann who have compulsive, impulsive or repetitive behaviours.

The Primary Care report comments that: *There were occasions when capacity assessments may have been required and therefore a missed opportunity that they weren't conducted. It appears that capacity was presumed, however there were*

occasions when she was either intoxicated, possibly taken an overdose or there was evidence of her mental state declining, that may have meant she was unable to make specific decisions at those times.

Ann may understand and retain information about her problems. She may be able to communicate decisions. The question is whether she can use the information to keep herself safe. At points in the past, she did not take the steps that she acknowledged were required to protect herself e.g. not to drink, to maintain her hygiene. Almost certainly, at times, she failed to do this because of the compulsion associated with alcohol dependency. This concept of compulsion is specifically acknowledged in section 4.22 of the current Code of Practice on the Mental Capacity Act.

In assessing capacity with vulnerable and self-neglecting individuals like Ann it is important to consider executive function / executive capacity. The Teeswide Carol SAR (about a chronic dependent drinker) talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *make* a decision and *put it into effect* (i.e. use information)?

This will necessitate a longer-term view when assessing capacity with someone like Ann. Repeated refusals of care, as happened with her, should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

The Alcohol Services report concludes that: *executive capacity should have been a consideration and formally explored considering long term substance misuse.*

Again, the lack of a clear multi-agency framework and clear leadership around Ann's care would have hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered her mental capacity from a number of angles and have professionally challenged situations in which they felt that the approach was inappropriate.

15 NB - Smoking

Ann had been a long-term smoker and this may have contributed to or worsened some of her physical health problems. Her GP had looked at smoking with Ann prior to 2022. There is no suggestion that smoking had any role in her death and by the end of her life she had positively moved on to vaping. However, reducing smoking among people with mental health problems is an Office for Health Improvement and Disparities priority. There has also been a governmental focus on smoking among people with substance use disorders. It contributes to the worsening of lung disease but also liver disease, pancreatitis and cognitive impairment as well as raising the risk of fire hazards. Therefore, it is important that professionals recognise the need to address this issue with people with mental health problems and substance misuse problems.

16 NB - Covid 19

The period under review was in the later stages of the Covid pandemic. It is acknowledged that earlier in her care the lack of direct contact with workers may have impacted on Ann. This needs to be acknowledged when considering Ann's care. However, it is not possible to draw a direct line between the Covid restrictions and Ann's death. As a result, no comments have been made on Covid's impact.

17 Key Learning Points

The most striking feature of Ann's care is the dementia diagnosis that was mistakenly added to her medical notes. The fact that this was a mistake has been acknowledged and it did not impact on the care she received or her subsequent death. However, it did have an impact on her family, the Coroner's process and possibly the SAB's considerations. It will be important to ensure that such errors are eliminated. The local Mental Health Trust will need to consider what steps are required to prevent a reoccurrence.

Ann died after leaving the Emergency Department despite being unwell. When she was found the next day she still had pads on her chest where monitors had been attached. Her family feel that she should have been admitted and detained in the Hospital for her protection. The family are also critical of the attitude of staff towards them – e.g. not recognising that they had other caring responsibilities other than Ann.

Ultimately the family felt that the "*Hospital just wanted to be rid of her*", presumably because of attitudes to / unconscious bias against people whose problems are related to alcohol use. It is difficult to analyse staff attitudes and the impact that they had on Ann's care at this distance. Nonetheless, the Acute Trust, but also other agencies, should consider whether unconscious bias is a factor in the care of dependent drinkers and, if so, how this can be addressed.

However, her care does raise questions about the assessment of mental capacity in the Emergency Department and more generally. The agency reports mention Ann's mental capacity at several points. Most critically, on the 1st January 2023, Ann discharged herself from A&E against medical advice and was deemed to have capacity to do so. Her care highlights the importance of considering someone's "executive capacity" as well as their "decisional capacity". Can someone both *make* a decision and *put it into effect* (i.e. use information)? The Alcohol Services report specifically states that: *executive capacity should have been a consideration and formally explored.* This will necessitate a longer-term view when assessing capacity with someone like Ann. Repeated refusals of care, as happened with her, should raise questions about the ability to *execute* decisions.

At the very least, Ann's care highlights the importance of standardised alcohol screening tools. In particular, following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of identifying, and communicating information about, alcohol-related harm. This would have helped identify her risk at the earliest point and provided a consistent picture of that risk.

In general, Ann had very good care from the local Alcohol Service. The main question about the community pathway is whether there needs to be a longer term perspective on treatment and rehabilitation. The *Clinical guidelines for alcohol treatment* talk specifically about the need for long-term aftercare and both Ann and her family expressed concerns about the loss of support once the main treatment element was completed. This is a difficult balancing act for services; do they put limited resources into new clients or longer term interventions. Certainly Ann's relapse does highlight the need for more aftercare. Therefore, the commissioners of alcohol treatment services will need to review long term aftercare in the light of the *Clinical Guidelines* and Ann's care and decide on what developments are required. A similar question needs to be asked about Mental Health Services: is longer term aftercare required for people like Ann?

Primary Care raised a concern about a perceived delay in accessing a crisis response from Mental Health Services when Ann began to relapse. The Mental Health Trust state that there was a misunderstanding about how to access crisis care. Referrals were being made to a specific Doctor and their team; instead referrals should have gone to the Trust's Access and Crisis Team. Once this happened the Trust's response was relatively swift (one working day). This raises a question about whether further work is required to make Primary Care aware of the Access and Crisis Team. This report can only raise that question; it is not in a position to answer it.

Ann had a co-occurring disorder – a dual diagnosis of both substance use and a mental illness. Across England the management of this client group has often been challenging. The key problem is that both Substance Misuse and Mental Health Services may push back at managing these clients on the basis that the main problem lies with the other service. However, this does not appear to have been the case with Ann. She was being worked with by both services concurrently. The question raised by Ann's care is whether the two services were working together on her care. Work is being undertaken locally to provide training and develop a joint protocol to improve work on co-occurring conditions. The SAB will need to review this (in the light of the national guidance on this issue) and consider whether it has improved the gaps in joint working identified with Ann.

This point about co-occurring disorders links into a theme mentioned by many of the agency reports: the need for multi-agency working. Several reports suggest that Ann would have benefited from better joint working. Management via a multi-agency group could have ensured, for example, information sharing, joint planning and earlier Identification when her well-being begins to deteriorate. Bury could benefit from having a standing specialist multi-agency group that focuses on complex and difficult

to engage individuals. This approach has worked well with people with alcohol use disorders in other areas.

Ann was an adult with care and support needs and the agency reports identify four safeguarding concerns that were raised about her during the relatively brief review period. However, there were also a larger number of missed opportunities to raise safeguarding concerns or make a referral for assessment of her care and support needs under section 9 of the Care Act. This goes back before the review period.

Adult Social Care comments that: "*on reviewing the case history there appears to have been a timely and proportionate response to concerns raised in order to safeguard Ann.* Latterly, Ann was referred into the Older People's CMHT (a Social Care team). However, at points: *Ann was provided with appropriate information and signposted to relevant agencies as necessary".*

This highlights two themes. The need for:

- all agencies to be considering both section 9 and section 42 referrals for people like Ann, especially those with substance use disorders; &
- consideration to be given as to whether signposting in response to the safeguarding concerns submitted is ever a robust enough response for someone with Ann's pattern or relapsing crises.

Ann had been a long-term smoker and this may have contributed to or worsened some of her physical health problems. Therefore, it is important that professionals recognise the need to address smoking with people with mental health and substance misuse problems. This is also consistent with Department of Health Policy.

18 Good practice

Many agencies made efforts to help Ann. Most professionals appear to have worked appropriately with her within the framework of their individual disciplines. In particular, much of the work undertaken with her was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, specific points of good practice did emerge:

- She received very positive support from Age UK. This input was particularly highlighted by her family.

- On a couple of occasions, Ann perceived finding care for her dog as a barrier to appropriate treatment. Both Ambulance and Older People's Mental Health staff sought a satisfactory pet-sitter. This enabled Ann to be comfortable to access care.

- Alcohol and Mental Health Services achieved a long period of sobriety with her in the middle of 2022. In particular, there appears to have been a good working relationship between Ann and her CPN in Mental Health Services.

- Ann appears to have had a very good relationship with her GP. She mainly saw the same Doctor and, therefore, received consistent care from someone who knew her well.

19 Recommendations

Recommendation A

Bury SAB should engage with the local Health and Wellbeing Board to ensure that Bury's Public Health Team is following NICE guidance that all frontline services should be made aware of, and are able to use, robust alcohol screening tools such as the AUDIT tool to identify and record the level of substance related risk for clients.

Recommendation B

The SAB should ensure that there is local training and guidance that addresses unconscious bias against people with alcohol and drug use disorders so that this is not influencing the way health and other services are provided.

Recommendation C

The Public Health Team who commission Alcohol Treatment Services will need to review the local provision of long term aftercare in the light of Ann's experience of care and of the Department of Health's Clinical Guidelines for Alcohol Treatment and decide on whether developments are required.

Recommendation D

The SAB will need to reassure itself that recent changes in the local response to people with co-occurring conditions has led to greater joint working on this client group.

Recommendation E

The SAB will need to reassure itself that information about how to access support in a mental health crisis is regularly disseminated to Primary Care.

Recommendation F

Bury SAB should ensure that vulnerable individuals who require multi-agency management can be escalated to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable clients is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation G

Bury SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals and those with alcohol use disorders in particular; and that, within Adult Social Care, practitioners are building a robust response to self-neglect among dependent drinkers including, where appropriate, a multi-agency safeguarding meeting under s42(2)

Recommendation H

Bury SAB should ensure that guidance or protocols are available to support professionals to consider the use of the Mental Capacity Act in the context of people with alcohol use disorders generally and those who are repeatedly declining care specifically. This should include reminders about the importance of considering executive capacity.

Recommendation I

Bury's Public Health Team should ensure that all frontline services are aware of the importance of encouraging smoking cessation with people with alcohol use disorders.

Appendix 1 Key lines of enquiry

The key lines of enquiry were set as a focus on:

- Dual diagnosis pathways (mental health and substance misuse)
- Approach to prevention when working with individuals with a dual diagnosis
- Multi-agency working with both of the above.

Agencies were also asked to comment on:

- the management of Ann's substance use disorders (individual and multi-agency)
- the management of Ann's mental health (individual and multi-agency)
- the joint management of Ann's co-occurring mental health and substance use disorders (dual diagnosis)
- How can a preventative approach be used with individuals with a dual diagnosis?
- Did Ann have any form of cognitive impairment and, if so, please comment on the management of those problems?
- Were appropriate and sufficient steps taken by agencies to safeguard Ann?
- Was the Mental Capacity Act used appropriately and sufficiently with Ann?
- Details any other concerns about Ann and the actions taken by agencies in the last year of her life
- What worked well in this case?
- What could have been done better?