Investigation into the care and treatment of Mr H

mentalwelfare
commission for scotland

Contents

Section 1

Introduction

1.1

The Mental Welfare Commission had a duty under the Mental Health (Scotland) Act 1984 generally to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their person or their interests. Similar responsibilities and authority to undertake investigations are given to the Commission under Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This investigation, while largely conducted under the 1984 Act, spanned both pieces of legislation with the implementation of the new legislation in October 2005.

Section 2

Background

2.1

Council A was granted welfare guardianship powers in respect of Mr H on 17 March 2004. The Commission reviewed the application, subsequently visited Mr H, and corresponded with social work and care staff in carrying out its responsibilities under Section 9 of the Adults with Incapacity (Scotland) Act 2000.

2.2

In reviewing his guardianship, the Commission learned that Mr H, who is diagnosed as having dementia, which was possibly caused by his long-standing abuse of alcohol, had been known to the social work department and to the health service, since the 1980s; his contacts primarily being a consequence of his long history of alcohol problems. His guardianship followed from admission to hospital in August 2003 where he was reported as being 'very unkempt and malnourished and suffering from lice and scabies infestations'. When he was admitted to hospital his house was found to be 'uninhabitable with the floor contaminated with urine and faeces. There was no food and no gas or electricity supply'.

2.3

As it was evident that Mr H had been known to both health and social work services for some considerable time and that the level of self neglect was of such a degree that it must have gradually deteriorated to that state, the question arose as to whether action to protect Mr H, because of his lack of capacity to look after his own interests, could and should have been taken earlier by statutory services.

2.4

After reviewing preliminary reports sought from both health and social work, it was evident that there had been considerable activity at various points. This activity, however, appeared unstructured and lacked focus and any sense of urgency. The Commission decided that the circumstances of the case were such that a more in-depth investigation surrounding Mr H's care and treatment was required. Case files were requested for review.

Section 3

Methodology

3.1

In deciding to carry out this investigation, the Commission acknowledges certain key factors that influenced the way in which we have decided to proceed with this investigation. The first is that there is no way of knowing exactly when Mr H may have developed Alcohol Related Brain Damage (ARBD) which is now believed to be associated with his dementia. Prior to developing ARBD, he would not have fallen within the Commission's remit. The other factor is that services for people with ARBD are widely acknowledged to be deficient throughout Scotland, not just in the area where Mr H resided. It is for these reasons that we have taken an atypical approach to this investigation. We have not interviewed staff, though the factual details have been agreed to by both health and social services. The Statement of Fact was drawn up by reference to medical and social work case files and related correspondence alone.

3.2

We have also decided, in the interests of fairness, that we will not identify the services subject to this investigation in this report.

3.3

Our aim in this report is to try to highlight the deficiencies in services to people with ARBD in the area of Council A and NHS Board A; to ask them to review their services in light of the report; and, that they determine an action plan for improvements. More widely, we would hope that this report will remind health and social work services across Scotland that staff awareness of ARBD needs to be improved and that services need to be able to respond to this very vulnerable group of individuals much earlier than is often the case at present. This is essential if NHS Boards and local authorities are to be in a position to meet their general statutory duties, as well as their specific statutory responsibilities under both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. This awareness is essential as well for health and social work staff to maintain professional standards of practice in working with people who may be affected by ARBD.

Section 4

Statement of facts

4.1 Brief biographical background

4.1.1

Mr H was born in a village in the Council A and NHS Board A area, one of a family of ten. He left school at 14 and worked on coal lorries, ultimately working as a lorry driver, through to 1982. He was married in 1952 and divorced in 1986, reportedly due to his alcohol abuse. He has five children but appears to have had no contact with them for a number of years, save for one daughter.

4.1.2

He reportedly has been drinking since the age of 14 and had begun drinking increasingly heavily by 1975. During this time he lived intermittently with his wife and children, mostly when sober. He also maintained a flat of his own at times. He was in prison on a number of occasions during this period, often on charges of 'Breach of the Peace' following incidents associated with alcohol abuse.

4.2 Early history (1984-1990s)

4.2.1

Mr H was charged around 1985 with serious assault. This related to an incident in which he assaulted a man while intoxicated. From 1984 to 1986/87, hospital and general practitioner records refer to Mr H's alcohol problems, his suicidal wishes (particularly after domestic disputes), overdoses, duodenal ulcer, non-insulin-dependent diabetes, arthritis and various injuries, including fractures resulting from fights and falls, often associated with alcohol abuse. As early as 1985, medical reports refer to his 'long history of alcoholism' and, in 1986, to his 'chronic alcoholism'. He had two periods of hospitalisation in Hospital 1 in NHS Board A in 1985 for detoxification. In 1986, Mr H was referred to a psychiatrist and there were various contacts with medical practitioners in 1986/87. He was encouraged repeatedly to attend Alcoholics Anonymous. In 1989 there was speculation that he may have been developing a peripheral neuropathy. His medical records throughout this period generally reflect varying degrees of sympathy, scepticism and pessimism about the outcomes of intervention.

4.2.2

In 1995 Mr H was removed from his GP's (Dr A) list transferring to another GP, Dr B. It is not known why he was removed from the list.

4.2.3

While early social work contact would appear to date from the mid-1980s and seems to relate to his various offences, his more recent contacts date from June 1996 when he presented at the local social work office in a drunken state requesting assistance. He was assessed and referred to home care and a referral was made to a voluntary organisation (VO 1) to get him a three-piece suite. There were a number of contacts over the next few years, largely relating to food, finances and heating.

4.3 Events from 1999

4.3.1

Dr B made a referral to social work on 7 October 1999, specifically requesting home care and OT assessments. Concerns were expressed about mobility, general social problems and the state of his house. Following this referral the Social Work (Intake) Team visited on 12 October 1999 and noted, 'house is filthy, décor filthy, flies around'. Mr H reported difficulty bathing, and asked for help cleaning up the house. He said he had no food as his money was all spent on alcohol and that he had given up on getting help with his alcohol dependency. The team discussed Mr H's situation with a social work team manager (SWM 1) and a decision was made to make a referral to home care and OT services. On 14 October 1999, Mr H's neighbours contacted social work saying that Mr H was starving and had no food. A decision was taken that social work could not assist financially or give a food parcel, but arrangements were made for a voluntary organisation (VO 2) to provide a food parcel.

4.3.2

The Social Work (Intake) Team wrote to Dr B on 29 October 1999 stating that a referral for home care and OT assessments had been made but Mr H was not at home when the Home Care Manager (HCM 1) visited. This letter ended rather ambiguously by stating that a card was left for Mr H to advise him to contact home care if he still required assistance. This seems at odds with the memo sent by HCM 1 to the Social Work (Intake) Team on 27 October 1999 in which it was stated that the request for a home care service was turned down, as it was not felt 'appropriate… given his social situation and the current condition of the house.' It is not clear from social work notes what happened to the OT referral. There are no case notes and no correspondence from the occupational therapy services within the social work files.

4.3.3

The local Alcohol Advisory Service (VO 3) telephoned the social work department on 14 December 1999 advising that Dr B had referred Mr H to them. They said they were unable to provide a befriending service due to the state of the home and Mr H's inability to meet up with the befriender. His case was then discussed at a team meeting where the possibilities of a detox programme, house clear-up and rehabilitation were considered. VO 3 wrote to Dr B on 15 December 1999 informing her that they did not feel Mr H was appropriate for their befriending scheme. They also noted concerns about his drinking, physical health and general social circumstances, and stated that, 'The combination of diabetes, poor dietary intake and the excessive alcohol intake would seem to be a rather dangerous one.' They further stated that, 'He seems to spend most of his time in a house which is extremely run down with internal structural damage as well as being poorly maintained… It would seem that he spends most of his

time wrapped up in a blanket in front of a one-bar electric fire worrying about where his next drink is coming from…, He certainly needs some input to improve his standard of health and general lifestyle… On the face of it he would seem to be a candidate for some sort of supporting accommodation and with this in mind I am contacting the [Social Work Intake Team] to request input from them.' This letter, which was copied to that team, ended by stating, 'I cannot stress in the strongest terms my concern for this man's wellbeing.'

4.3.4

A subsequent team discussion on 16 December 1999 resulted in the decision to offer no service at that time to Mr H. Dr B records a discussion with SWM 1 on 17 December 1999 that merely states: 'Chat with [SWM 1]. Poor scenario – alcohol and DM but Mr H not willing to accept help'. SWM 1's letter to Dr B of 16 December 2005 states that 'It would appear that he [Mr H] still does not which (sic) to address his alcohol problem. Social work will be unable to offer him a service unless he is willing to co-operate.' Mr H's file was marked 'NFA [not for action] at present'.

4.3.5

The local housing department office made a referral to social work on 30 December 1999. Mr H was in the local office refusing to go home. It is noted that his daughter had broken all the windows in his house, for the third time that year. The housing department was informed that social work would not get involved as Mr H had previously refused social work services and because the police were already involved. Social work advised housing that Mr H should seek medical help if necessary. Police escorted him back to his house. They reportedly said he had only received a small bump on his head and believed he was able to look after himself.

4.4 Events from 2000

4.4.1

On 7 January 2000 Dr B notes contact with an area housing officer (HO 1) who apparently stated that Mr H 'wants to go into a home – seems ok to us'. A subsequent case file entry by Dr B notes a discussion with HO 1 who is reported as saying, 'we would support an application for residential care'. Apparently, from the case file entry, Dr B mistakingly thought HO 1 was a social worker. Mr H reported to the local social work office requesting that he be taken into care on 12 January 2000. A joint visit was made by SWM 1 and HO 1. It was noted that Mr H had been having 'difficulty with his daughter re violence and vandalism at his home, he had requested that he be admitted to residential care. Discussed care available and decided to refer for home care assessment.' Social work files record subsequently that when home care assessment was carried out, Mr H declined an offer of services.

4.4.2

On 30 January 2000, Mr H was taken by ambulance to A&E in Hospital 1 with facial injuries, having been found in the street by a passer-by. He was intoxicated when seen at A&E. Dr B referred Mr H to the geriatric day hospital (DH 1) and on 3 February 2000, she was informed that Mr H was to be offered a placement every Tuesday and Thursday, commencing on 8 February 2000. A subsequent letter of 24 February 2000 from a Clinical Assistant, Care for the Elderly (Dr C), to Dr B stated that Mr H had refused to attend DH 1 and that no further arrangements had been made from that end.

4.4.3

On 9 February 2000, HO 2 from the Housing Investigations Team contacted social work. She reportedly said that when they visited Mr H he had a black eye and stated his daughter did it. He also repeated his desire to go into residential care. On 17 February 2000 a neighbour called into the office expressing concern that Mr H had no food or heating. A joint visit was carried out by social work and housing on 15 February 2000. Concern was noted over the state of the house – 'no heating, apparently gas board had called to do repairs but refused to do work as syringes lying about. Electric lights ripped out of ceiling. Only bare wires. Levels of hygiene in the home also causing health hazard. All windows broken and boarded up.' Mr H was reported as saying most of the damage had been caused by his daughter who was in prison at that point. SWM 1 made another home visit on 22 February 2000. It was recorded that, 'Fan heaters were in use, windows still boarded up and central heating not repaired.'

4.4.4

Housing took the decision not to re-house Mr H at this time. A meeting was held with housing on 25 February 2000. They agreed to arrange a clean-up of his house. All felt that Mr H could remain in his present housing, with support. The social work file records that the case was discussed with the community care team in terms of the potential of 'elder abuse'. The notes state that, 'Since (his daughter) neither cares for her father nor lives at the address – it would be a police matter. Mr H also invites his daughter into his house when they both have drinking sessions.' The entry concludes that, 'The main issue seems to be difficulty with his daughter's aggressive behaviour. Suggest Mr H contact the police if his daughter causes further difficulty.'

4.4.5

On 21 February 2000, a housing manager (HM 1) at the local housing office wrote to a colleague (HM 2), expressing her concerns about this case and reporting much of what has already been noted above. She said that social work had been very reluctant to help. She asked about the boundaries between social work and housing responsibility, saying that, 'these cases take up a lot of my Area Officers' time but it seems we are now liable for their welfare as well?' On 13 March 2000, a senior social work manager (SWM 2) in town X, sent a memo to team leader of the Social Work (Intake) Team (SWM 3), attaching the previous internal housing

memo, saying this was a legitimate referral to social work and asking that he arrange an assessment. SWM 3 responded to SWM 2 in a memo of 14 March 2000 outlining social work involvement in the case and countering some of the assertions in the internal housing memo. He said in this memo that he was compiling a report for the area co-ordinator on what he considered to be examples of good practice in dealing with 'these cases'. He said that SWM 1 would continue to monitor and assist as appropriate. It does not appear that a formal, comprehensive assessment of Mr H's community care needs was undertaken at this point. It was not clear to us whether the report mentioned above was ever completed.

4.4.6

Mr H appeared at the local social work office at 5 o'clock on 20 March 2000 requesting cash for his bus fare home. He was unsteady on his feet and intoxicated. He was given the fare and shortly afterwards was found lying on the grass outside the social work office. Police refused to escort him back home when social work requested this. Two social workers took him home and social work checked up on him the following day at 10am. When visited, he was seen drinking vodka and cider with his daughter and another man. His daughter said she was looking after him. Another joint visit was made on 18 April 2000 to organise house cleaning. There were a number of visits and telephone contacts between social work and housing during this period. SWM 1 visited the next day when Mr H was at home with his daughter and another man drinking vodka and cider. His daughter said she was looking after him. The file was marked NFA.

4.4.7

HO 1, housing and SWM 1 carried out a joint visit on 24 March 2000. They organised repairs on doors and windows and a house clean-up. They recorded that Mr H was willing to accept home care services to maintain his home to a reasonable standard. They arranged for a community policeman to visit Mr H 'to discuss ways of excluding (his daughter) from the house.' An OT assessment must have been made at some point earlier though this is not evident in social work files. It was noted during this visit that OT equipment had arrived but had not as yet been fitted.

4.4.8

A home visit was made on 17 May 2000. An entry in Mr H's social work case record on that date states: 'Mr (H) has had frequent contact with the Social Work (Intake) Team over recent years, the gentleman is elderly and acknowledges that he has a drink problem. Liaising with local office over recent months has highlighted difficulties Mr H is experiencing as the result of his daughter's violent and aggressive behaviour when she is under the influence of alcohol…Visits to Mr H's home raised concern where most windows were broken, all internal doors were removed, electrical equipment and fitting broken and dangerous. The general state of the home presenting health hazards… Mr H's daughter has her own tenancy and has caused major damage at her own home, during periods where she stays with her father she has assaulted

him as well as causing major damage to his home… Advised Mr H to report assault to the police and to discourage (his daughter) from staying at his home.' The case file indicates the case was discussed with Community Care Team Leader (SWM 4), and the community care team. This appears mainly to have been for the purposes of securing funding for a gas cooker. It was further noted that the local office arranged to have repairs carried out and to have the house cleaned. Most of the furnishings and carpets had to be thrown away but it was noted that the local office 'has access to some carpets, etc.' A further joint visit was made accompanied by a worker from VO 3 to arrange a befriender to meet with Mr H on a regular basis. Carpets, bedding and a gas cooker were delivered.

4.4.9

The cleaning and repairs to the house appear not to have been completed until 26 September 2000. During this time Mr H's daughter was expressing her intention of moving in with her father. Mr H told SWM 1 that he would not allow her to stay there. The case was at that time discussed with the daughter's social worker in the criminal justice team due to the potential implications of her moving in with her father. Mr H received a letter from HCM 1 on 28 September 2000 saying that he had been assessed as 'medium priority' for a home care service and had been placed on a waiting list. In October problems emerged with shopping and collection of pension, his daughter having previously helped him with the latter. A shopping delivery service was due to start on 13 October 2000. SWM 1 referred the case to HCM 1 for assistance with collecting his pension.

4.4.10

Dr B saw Mr H on 24 October 2000 when he was 'unwell' and drinking cider. It was noted he reportedly could not walk, could not get a bus and could not get a taxi. He was willing to try the day hospital placement again. He was subsequently offered a placement at DH 1 every Monday and Thursday on 9 November 2000.

4.4.11

By November, the shopping delivery service, which had just started the previous month, was withdrawn. SWM 1 and HCM 1 carried out a home visit on 17 November 2000. The case file states that before the shopping delivery service could be re-started a 'risk-assessment' was to be carried out by HCM 1. This was related to the safety of the shopping delivery staff and despite HCM 1 saying that staff safety could not be guaranteed, the service was re-started. Mr H was not seen as a priority for pension collection, however. On 22 November 2000 a further home visit was made. Mr H was in bed and his daughter was in the living room drinking with two other women. There was a broken window in the living room that reportedly was caused by local youths throwing stones. This was reported to the police.

4.4.12

A report dated 12 December 2000 by Clinical Assistant, Care of the Elderly (Dr D) at DH 1 on Mr H, who attended twice between 13 November 2000 and 4 December 2000,

described Mr H as 'dishevelled looking with evidence of self-neglect.' During this time the notes record alcohol abuse and an MSQ (a brief assessment/ measure of cognitive function) of 7 October 2000, which suggested some impairment. There was no speculation or suggestion, however, as to the cause of the impairment, and no stress on the importance of vitamin B. He was observed as walking unsteadily with a stick but refusing to use a zimmer. He was thought to be wearing shoes two sizes too big for him. He stopped attending after the initial two visits, as he had not been there for the ambulance crew to pick up. Dr D concluded that, 'It is thought that the problem is mainly social in nature and it might be a good idea to ask the social work department to arrange for him to attend day care.'

4.4.13

On 20 December 2000, SWM 1 wrote to HCM 1 saying that Mr H now had a hoover and still required a home care service. One hour of home care per week appears to have been allocated subsequently on 9 April 2001.

4.5 Events from 2001

4.5.1

On 12 January 2001, VO 3 wrote to Dr B to pass on concerns noted by Mr H's befriender. The letter states that Mr H 'appears to be confined to his flat now and has recently had to endure no heating due to an apparent fault… He does not appear to eat outwith the odd sandwich and cereal. The befriender is again concerned about Mr H's ability to access services he may require i.e. health. I am unsure if Mr H has had any contact with yourself or if his prescriptions etc are being picked up.' Dr B contacted VO 3's befriending project team leader on 15 January 2001 after receipt of the above letter and suggested the befriender might be able to assist with transport and prescriptions. It is not clear whether this ever happened. There were only two other contacts with Dr B recorded that year in Mr H's medical notes – on 13 August 2001 when he picked up a prescription, and on 26 November 2001 when he was given a flu jag by the district nurse (DN 1). In addition to the initiation of the one-hour per week home care service in April 2001, there is only one further mention of Mr H in the social work files in 2001. From this it would appear that the home care service was withdrawn and the home care case closed on 5 October 2001.

4.6 Events from 2002

4.6.1

On 23 April 2002, Dr B again referred Mr H to the day hospital. A staff nurse and an OT visited Mr H from the unit to assess his suitability for the day hospital. They found him to be experiencing difficulty when walking. He admitted that he had had several falls recently. They felt he would benefit from day hospital attendance with physiotherapy and OT input but he refused to attend and they were unable to persuade him to do so. The OT service referred Mr H for adaptive equipment for his flat, but the letter indicated that they were 'not certain this will be carried out due to the appalling condition of the flat.'

4.6.2

DN 1 subsequently referred Mr H to the social work department on 16 May 2002, requesting help for him with bathing and housework. The enquiry form summary states: '(Mr H) has had problems with his feet; he is an alcoholic. Please assess for help with bath and housework.' There appear to be two referral forms relating to this one contact initiated by the district nurse. One was opened by a social worker (SW 1) at 9:12 and marked 'resolved' at 9:27 on 20 May 2002. This states that, 'District Nurse visited Mr H with the chiropodist. Requested home care assessment and referral to social worker for Day Care. House is in a very filthy state so will probably have to be cleaned before Home Care go in. Home Care Manager to visit as soon as possible.' The other contact recording by SW 1 was opened at 9:31 on the same day and marked 'resolved' on 20 May 2002 at 9:33. This latter form is marked in writing 'NFA' and, 'Does not wish to have any assistance from home care at the present time.' The case file is somewhat confusing here as HCM 1 does write to Mr H on 29 May 2002 offering a visit to assess him for home care services. It is not clear whether Mr H was allocated a home care service as a result of this contact. Ultimately, following this visit by DN 1 and the chiropodist, and what the case file records as their 'concern at Mr H's ability to self care and the state of living conditions', he was allocated to SWA 1, a social work assistant with the community care team in town Y, on 9 October 2002.

4.6.3

After visiting Mr H on 24 October 2002, SWA 1 noted that he was sitting with no heating, wrapped up in a blanket. She referred him for day care and requested a benefits check as he was only getting the basic pension and income support. After attending the house on 22 November 2002 to check the boiler, the gas board requested that social work staff accompany them to the house stating they were not keen to continue due to conditions in the house. This subsequently took place on 18 December 2002. It does not appear the gas was restored at that point as there is a note from 15 January 2003 which states that there was still no gas in the house.

4.6.4

On 19 December 2002, SWA 1 wrote to Dr B after several contacts with Mr H. She reports that she has concerns about 'the extent to which Mr H really understands the consequences of the decisions he makes', and gives a clear indication that a psychiatric assessment would be helpful in determining how to proceed with Mr H's case, concluding, 'If he continually rejects assistance and understands his reasons for doing so, then there is little I can do. If, however, there are psychiatric issues, then Mr H's case would be better handled by the mental health team who would have a far better understanding of his problems'. This letter is never mentioned in the medical file case notes and does not appear to have been picked up and acted upon by Dr B. A handwritten note on this letter says, 'Still no reply' and is dated 18 February 2003.

4.7 Events from 2003

4.7.1

A Housing Officer (HO 3), telephoned social work on 15 January 2003 and expressed concern that Mr H was 'looking more frail'. She reported that he had no gas or electricity and there was no evidence of food in the house. Mr H, she said, was sitting in a chair with a blanket wrapped around him. Respite was suggested but he refused to consider this. The caller was concerned about his vulnerability. Case notes state, 'Discussed how Mr H has the choice to refuse our services if he wishes, which is what he is doing.' SWA 1 discusses Mr H's case and his refusal to accept services in supervision on 12 February 2003. The decision was taken to close the case and send Mr H a letter, inviting him to get back in touch if he changed his mind. The case was closed on 18 February 2003 without following up SWA 1's letter to Dr B on 19 December 2002.

4.7.2

There is no further reported contact with Mr H in either the social work or GP case files until 26 September 2003, when he was referred to social work following admission to Hospital 1 A&E on 14 August 2003 and transfer to Hospital 2 on 11 September 2003. He was admitted to hospital via ambulance after a neighbour found him in 'squalid, indescribable' conditions in his flat.

4.7.3

Upon admission to Hospital 2, Mr H was hostile and aggressive, lacking in motivation, was doubly incontinent, had poor personal hygiene and socially isolated himself. He could not remember why he had been admitted to hospital, displayed no insight into his own limitations in being able to care for himself. He wished to return home. He vacillated between agreeing to go into a care home and wanting to return home. A referral was made to social work on 26 September 2003. An entry in his hospital medical notes on 1 October 2003 states, 'If he wants to go home – to be discharged against medical advice.' At that point it was known that the housing department was refusing to re-house him.

4.7.4

A social worker, (SW 2), attended a ward meeting on 9 October, by which time Mr H had been in Hospital 2 for 4 weeks. Mr H was said to be verbally aggressive and unco-operative. He was seen by the social worker the following day when he said he would return home and did not require any assistance. The case notes indicate that, 'He had no answer to how he had managed to be admitted to hospital or any answer to the self-neglect'. He agreed to the social worker and the housing officer visiting his house to assess the damage.

4.7.5

SW 2 and a housing officer carried out a joint visit to Mr H's house on 13 October 2003. A community policeman's presence had been sought due to concerns about safety. The following entry was made in the case file: 'Entered house. Unable to breathe due to the extreme odour and flies. No food or furniture in the house. Bathroom inaccessible due to the floor covered in faeces. Evidence there had been a fire in the kitchen around the cooker area. No gas or electricity supplies to house. Housing Officer agreed the house would require environmental health, then extensive repairs before it could be occupied.'

4.7.6

SW 2 attended a ward meeting the next day to give feedback. Staff reported that Mr H continued to be unrealistic about his abilities and unco-operative. They also reported concerns about his daughter who had visited twice and on both occasions had demanded money from him resulting in verbal and physical aggression between them both. Ward staff had to demand that she leave or be removed by the police. The social work file notes that at one point she was caught forging his signature and the pension book was withdrawn by DSS. She did not return to visit following this. By 28 October 2003, Mr H was again refusing to consider any alternatives and was adamant that he would return home. The social work case file entry suggests that a return home was being viewed as an option at that point as they planned for a cleaning service to give an estimate for cleaning up the house. Mr H agreed to pay for this. It further states that, 'If house is cleaned then (Mr H) will be discharged home with the offer of services.' Entries in the medical file on 30 October 2003 suggest that a discharge home was still a possibility and that they were awaiting further information from the social worker. A further visit by the social worker to Mr H on 3 November 2003 revealed that he had no memory of the previous discussion and was now refusing to allow anyone access to clean his house. It was at this point that the decision to proceed with plans to make Mr H's house habitable were put on hold until a psychiatric assessment was completed.

4.7.7

A Clinical Assistant in Geriatrics (Dr E) referred Mr H for a psychiatric opinion on 3 November 2003. After outlining his past history and social circumstances, Dr E detailed the management problems he had presented on the ward and the difficulties in discharge planning. He ended the referral letter by saying,

‘Everybody is at their wits end and we wondered if there is a mental health problem here that needs treatment?’

4.7.8

Dr B was sent a copy of a letter from a Locum Consultant in Old Age Psychiatry (Dr F) to Dr E following his request for a psychiatric assessment. In this letter he states that it was apparent that Mr H had a significant cognitive impairment, scoring 11/30 on MMSE. This is indicative of moderate to severe cognitive impairment. He further stated that he had no insight about this cognitive impairment; that he said was as a result of ‘possible alcohol related dementia’. (This same letter was also sent out on the same day under Dr G’s name. She is a consultant in old age psychiatry. It is not clear why this happened.) A subsequent CT scan organised by Dr F confirmed ‘general cerebral and cerebellar atrophy’.

4.7.9

SW 2 wrote to Dr F on 24 November 2003 stating that he understood that a psychiatric assessment had been requested from him and that his ‘initial assessment outcome was that Mr H is unable to make an informed decision’. SW 2 requested that he indicate in his report whether he would support a guardianship/ intervention order. It is not clear from the records we received whether there was ever a formal response to this request.

4.7.10

In Dr E’s discharge letter to Dr B on 19 December 2003, he stated that upon admission to hospital in August 2003, Mr H was ‘very unkempt and malnourished and was suffering from lice and scabies infestations’. A home visit, he said, showed that his house ‘was almost knee deep in human excreta and was completely unfit for human habitation. It would appear that this is the third house that Mr H has destroyed and, not surprisingly, the Council were unwilling to re-house him.’ There is evidence in the social work files to support the latter assertion. In this letter Dr E said that Mr H had at one point assaulted a nurse by grabbing her by the throat. This precipitated the transfer to Ward A at Hospital 3 in town X on 15 December 2003.

4.7.11

Ward A records of 23 December 2003 state that, ‘SW 2 can attend case conference on 8 January 2004. He states problems with house have been ongoing since 1990. House has required to be cleaned twice a year. Daughter has been financially abusing her dad. Also physically abusing him.’

4.8 Events from 2004

4.8.1

At the case conference on 8 January 2004 it is recorded that a return home was no longer an option due to Mr H's vulnerability and abuse from his daughter. It was agreed that residence in a care home was the only viable option and that welfare and financial guardianship would be required.

4.8.2

A subsequent case conference on progressing the guardianship application was held on 26 January 2004. The minutes state that when Mr H was admitted to Hospital 2 he was in a severe state of self-neglect. He was confused, disorientated and unco-operative. In planning for discharge, his house was found to be uninhabitable. There was no gas supply, no furniture, light switches and fittings had been removed and some rooms were unable to be entered because they were so unsanitary with faeces. The minutes also record that he had no concept of danger and no insight into his difficulties. Concern was expressed over his vulnerability to physical and financial abuse from his daughter and others if there was no guardianship order to protect him. Under the heading of 'assessment of risk' it was recorded that Mr H has very poor short-term memory. 'He is at risk from self-neglect, fire hazard, poor mobility, physical and financial abuse from others, including his daughter. The risks are such that they could not be safely managed in the community.'

4.8.3

In a memo to a local authority solicitor, SW 2 notes under diagnosis: 'Dementia. Damage associated with long term alcohol abuse.' A guardianship application was lodged on 18 February 2004. Dr B and Dr H, Hospital 3, submitted medical reports. Both referred to dementia or a dementing illness, but neither mentioned the likely relationship between alcohol abuse and the dementia. And while the mental health officer's (MHO) report mentions long-term alcohol abuse there is no mention of the likely relationship between his alcohol abuse and his dementia. Nor is this mentioned in the summary application. An interim guardianship order was granted on 19 February 2004. Mr H was transferred to a care home on 26 February 2004. The order was finally approved on 17 March 2004.

4.8.4

Since his admission, Mr H's general health and personal circumstances would appear to have improved considerably. He was clinically malnourished when admitted to Hospital 2 A&E in August 2003. In December 2003 he weighed 55 kgs. A year later his weight had increased to 67 kgs. Since his admission to the care home he has been participating in an art class at a local college. He also enjoys regular outings. He is said to enjoy good relations with staff and reportedly has been well settled and wishes to remain at the care home. His daughter has not been in contact.

Section 5

Discussion and conclusions

5.1 The assessment of capacity

5.1.1

There are often quite complex ethical considerations involved in the decision by professionals to intervene against someone's wishes when they are affected by ARBD. Central to teasing out these ethical dilemmas is the assessment of the individual's capacity in respect of key areas that need to be addressed in any care plan. An individual who retains capacity retains the right to make decisions that may subsequently place him/her at risk. It is only when the impact of the ARBD adversely affects the individual's capacity in respect of his/her welfare, property or financial affairs that the state can intervene to protect the individual.

5.1.2

The question of Mr H's capacity does not appear to have been considered by health or social work professionals until several months after he was admitted to hospital in August 2003. The mental health officer service was noticeable in its absence throughout the social work department's involvement with Mr H, until latterly. There is no evidence that social work staff involved in the case considered the potential value of specialist input from a MHO. There were a number of points at which a referral to, or at least consultation with, a MHO may well have moved things forward. The Mental Health (Scotland) Act 1984, particularly the guardianship provisions of the Act, had been used for protective purposes in respect of people with ARBD. The implementation of the Adults with Incapacity Act in April 2002 however should have further sensitised professionals to the need to assess the capacity of individuals and consider the implications of their incapacity in terms of the potential to use legislation to support proposed care plans. Training materials aimed at staff in both statutory and voluntary agencies were widely disseminated and all staff should have had, at the very least, a basic understanding of the provisions of the 2000 Act and the central role MHOs played in its implementation. MHOs in Council A would have had specific training on the Act.

5.1.3

Prior to Mr H's final hospital admission, none of the doctors who assessed him appeared to understand the link between prolonged alcohol abuse and impaired mental capacity. They appeared to take his poor co-operation with treatment as indicative of a conscious, informed choice, and therefore made little effort to pursue assertive treatment or consider the use of relevant legislation. Dr B did attempt to involve social services on several occasions and referred him to the Care of the Elderly Services, but did not refer him for a mental health assessment. The district nurse saw Mr H. Though she was concerned about his living conditions, she too did not appear to recognise that he might require a mental health assessment.

5.1.4

We could find little evidence that Dr B had assessed Mr H's cognitive function. There was a point during

1999 where Dr B prescribed vitamin B. We were not clear, however, to what extent Dr B was able to assess whether Mr H had taken this medication. If, as seems likely, his memory was failing at that time, his ability to remember to take this treatment may have been impaired.

5.1.5

Following Mr H's referral to the Care of the Elderly Services, he was assessed at the day hospital in December 2000. His case notes contained a brief assessment of his cognitive function, which showed some impairment. He was known to drink heavily and he was observed to be unsteady on his feet. These signs were suggestive of alcohol-related brain pathology, but there was no evidence that the day hospital medical staff investigated them further. There was no record of ARBD having been considered. The clinical assistant wrote to Dr B, but made no mention of the cause of his cognitive impairment. On the evidence from the case records, we think that this was an unacceptable standard of care.

5.1.6

The geriatric medicine service had further opportunities to assess Mr H in December 2001 and April 2002, at which point staff of the service recorded evidence that he was unable to function sufficiently to protect his own welfare. They do not, however, appear to have investigated this further or take any action to protect him. They offered him services, but failed to pursue his refusal to engage. There is no evidence that they considered whether he had the capacity to understand his welfare needs, or make decisions about accepting interventions. There was clear evidence that Mr H's brain functions were impaired, yet at no time did they record any assessment of his cognitive function beyond basic testing until the point when guardianship was being considered. There was no evidence that DH 1 even considered the necessity of thiamine treatment. This appears to reflect a lack of awareness of the consequences of alcohol dependence and poor nutrition.

5.1.7

Guardianship powers were sought only after Mr H's condition had deteriorated to the point where his capacity to look after his own interests was grossly impaired in many key areas. The only safe service response at that stage was to seek wide-ranging guardianship powers that removed most of his basic rights to make decisions in respect of his own welfare. Earlier identification may have resulted in a less extreme list of powers having to be sought. Use of the Act could have proved useful at an earlier date in securing the support and oversight essential to ensure Mr H's protection and possible improvement, or, at the very least, avoiding his further significant deterioration. His right to self-determination would have been acknowledged and respected to a greater degree than was ultimately possible. Using the powers available in the Adults with Incapacity Act in the least restrictive manner is one of the Act's core principles. Earlier identification and intervention where incapacity is present would help

ensure that the Act, when used, is used as intended.

5.1.8

The complexity of untangling the ethical dilemmas that may be present for any professional involved in the assessment, care and treatment of a person with ARBD requires comprehensive input from a wide range of people. Information must be collated from all relevant parties. While social work should play a key role in co-ordinating the process of assessment, decisions taken regarding capacity are essentially ones made by a medical practitioner. It is recognised good practice that these decisions must involve consultation between medical and social work staff and relevant others. There was evidence of considerable contact between social work and health professionals at various times throughout the period we investigated. What was starkly apparent, however, was that there was never a focused, recorded examination of the question of Mr H's capacity at any point prior to the making of the application for guardianship. Assumptions were made, it appears, based on a lack of knowledge of the disorder and the relevant legislation. We can only assume that these assumptions were influenced by the values, prejudices and misconceptions present in the wider society about individual responsibility and autonomy in relation to serious prolonged abuse of alcohol. This area of practice presents complex ethical questions which demand a sophisticated professional and organisational response if they are to be seriously considered to the benefit of the adults concerned.

Conclusion: The complex task involved in assessing Mr H's capacity to protect his own interests was seriously impaired by the failure of practitioners to appreciate the potential impact of Mr H's drinking on his mental capacity. We think that this failure directly contributed to delays in implementing appropriate medical and social work intervention at an earlier stage, that could have reduced the extent of Mr H's later disability.

5.2 Community care assessment

5.2.1

There is nothing in Mr H's file, until after the decision was taken to pursue a guardianship application, that remotely approximates to a comprehensive assessment of his community care needs – this is after years of evidence that they were considerable and complex. The word 'assessment', moreover, seems to have been used extremely loosely and largely with regard to specific areas of potential service provision, mostly home care services. The responses to contacts with Mr H were meagre and invariably service-led rather than needs-led. Contacts precipitated by his alcohol addiction and its impact on his physical, social and financial welfare often were responded to solely as requests for food, money and/or help with cleaning up his house. It is now accepted as good, standard practice that comprehensive community care assessments should be both shared and co-ordinated. 'A Fuller Life: Report of the Expert Group on Alcohol Related Brain

Damage' commissioned from Stirling University by the Scottish Executive affirms this as well in stating 'single, shared and comprehensive assessment is central to the provision of better health and social care for people with ARBD'. It further adds, 'Assessment must be ongoing and subject to continuous monitoring and review'.

5.2.2

A feature of this case, which will be not be uncommon in working with people with serious addiction problems, is that it is difficult to know exactly when services should step back and review their response to referrals in respect of an individual. There is a danger that the response, through time, becomes routinised and unproductive, repeatedly failing to address underlying problems. Even with this in mind, it is evident that in Mr H's case there were a number of key points at which a comprehensive community care assessment would have been helpful and arguably should have been carried out. At the very least there were times when there should have been a focused, recorded, multidisciplinary discussion collectively reviewing how services were responding and how they might move forward in the future.

5.2.3

The first instance where it is evident that Mr H should have been the subject of a comprehensive assessment of his community care needs was in June 1996, several years after the implementation of the National Health Service and Community Care Act. This contact resulted in him receiving a three-piece suite and little else.

5.2.4

The second clear point at which the local authority should have co-ordinated a comprehensive assessment of community care needs was in October 1999. This was following a referral from Dr B requesting home care and OT assessments. She expressed concerns about his mobility, the state of his home and general social and financial problems. A report after a follow-up visit by the Social Work (Intake) Team noted that the house was filthy. SWM 1 made a referral to home care and OT services. There is no indication in the case files whether OT followed this up. (Input into the case files by OT appears to be wholly absent. It may be that separate files are kept by the local authority OT services and these have not been forwarded to us.)

5.2.5

When an attempt was made by HCM 1 at this point to visit Mr H, he was not at home. A card was left suggesting he contact the service should he continue to need help. The onus was left on Mr H to make contact. Significant concerns as to Mr H's welfare had been expressed by Dr B on a client well known to the social work department for well over a decade. Concerns were also noted when a visit was made by the Social Work (Intake) Team which confirmed, to some extent, those raised by Dr B. Nevertheless, Mr H was left to his own devices when he did not respond to the card left for him advising he contact home care if he still needed help. No assessment of any depth was made before the decision was taken to place

the responsibility on Mr H to initiate contact for help in the future.

5.2.6

Entries in the social work case file following this contact are confusing and appear contradictory. Entries state both that Mr H was advised to contact home care if he needed help as well as the fact that the request for home care services was turned down as it was not felt 'appropriate – given his social situation and the current condition of the house'.

5.2.7

A third point at which a full, proper assessment co-ordinated by social work would have been indicated was six weeks later on 14 December 1999. At that time, VO 3, which was involved as well with Mr H following a request by Dr B for a befriender, telephoned the social work department expressing serious concerns about Mr H's health and welfare. VO 3 said they were unable to provide a service because of the state of the house. They went so far as to suggest he needed supported accommodation, something not evidently considered up to that point by those responsible for assessing Mr H's care needs – presumably because they assumed a lack of co-operation. The social work file says at this point Mr H's case was discussed at a team meeting and the possibilities of a detox programme, house clear-up and rehabilitation were considered. There is, however, no separate recording of this meeting indicating who was present, or the reasons why these services were felt to be inappropriate or not practicable. The reason recorded by social work for not taking any further action at this point was because Mr H 'still did not wish to address his alcohol problems'.

5.2.8

VO 3 subsequently wrote to Dr B, on December 15 1999, copying the letter to the Social Work (Intake) Team. They were quite clear in stating their concerns: 'The combination of diabetes, poor dietary intake and the excessive alcohol intake would seem to be a rather dangerous one… He seems to spend most of his time in a house which is extremely run down with internal structural damage…' The letter ends by emphasising strong concerns for Mr H's well being. When the letter was received the case was again discussed in a team meeting where the decision was taken to send a letter to the GP advising that no service would be offered and the case was again closed. Again there is no separate recording of who was present at this team meeting/ case discussion and the reasons for the decisions taken. This response, along with previous ones, raises the question about lack of knowledge of the possible long-term effects of alcohol abuse on cognition and capacity and the potential usefulness of protective legislation in supporting a care plan. There is not, at this point, any indication of whether he had ever been assessed for evidence of memory impairment.

5.2.9

A further crisis which could usefully have triggered a comprehensive needs assessment, including an assessment of risk, took place on 30 December 1999, when Mr H appeared at the local housing office after his windows had been smashed by his daughter for the third time that year. He had also fallen and hurt himself. He refused to leave the office. Social work was contacted. They refused to get involved, as Mr H had refused help for his alcohol problem. The police returned him to his home. The social work file records that the police indicated, when contacted by phone subsequently, that Mr H was capable of looking after himself. This effectively delegated the social work department's responsibility for assessing Mr H's capacity and associated risks to the police.

5.2.10

This incident and the response of services again reflect what was becoming a strongly held, almost inflexible, stance that Mr H could not be helped until he accepted the need to address his addiction. Although there is no mention of this in the case files examined, there may well have been a role for motivational interviewing, a well-established method of working with someone in Mr H's position who at times seeks help and demonstrates dissatisfaction with some areas of his life. Mr H's refusal to address his problem seems to have been too easily accepted as a static condition. This assumption coloured service responses as a result. And while the belief that Mr H's inability or even refusal to address his addiction may well have been a reason for not seeing him as a promising individual with whom alcohol rehabilitation services might work, this was not a proper response from local authority social work services and health services at the point where an individual's capacity is affected by the impact of his/her addiction over time. In such cases and at such times, other legal, professional and organisational responsibilities clearly come to the fore. The strongly held position of not intervening, coupled with the lack of points at which there was a considered multidisciplinary reflection on how they were responding to Mr H, effectively stopped a proper assessment from proceeding. Such an assessment could have shed light on the existence of any cognitive impairment and could have led to consideration of possible interventions and the role of legislation in implementing future care plans.

5.2.11

Subsequent opportunities to stop, reflect and properly undertake an assessment of Mr H's community care needs arose on 7 January, 2000 when he made contact with Dr B; on 12 January 2000 when Mr H attended the local social work office requesting to be taken into residential care following his report of violence and vandalism at his home by his daughter; on 30 January 2000 when he was taken to A&E with facial injuries having been found in the street by a passer-by; on 9 February 2000 when housing contacted social work after Mr H was seen at his home when he claimed that his black eye had been inflicted by his daughter; on

18 February 2000 when Mr H was visited jointly by housing and social work staff and they discovered there was no heating in the house, electric lights had been ripped out of the ceiling, the state of hygiene in the house was considered a health hazard and all windows were broken and boarded; and, when housing and social work staff met on 25 February 2000 to discuss the case.

5.2.12

It was following this last contact that the social work case file indicates that the case was discussed with the community care team to see whether it should fall within elder abuse guidelines. There is no detailed note of this discussion, other than the comment that as Mr H's daughter did not care for or live with her father this should be addressed as a police matter. While the Commission has not had sight of the Department's guidelines on suspected elder abuse which were extant at the time, it would be hard to credit that guidelines would be so tightly constructed as to exclude the possibility of abuse or neglect unless perpetrated by a carer or someone who lives with an elderly person. In any event, a key decision is taken here relating to the safety of an elderly vulnerable adult without the benefit of a community care assessment or a focused assessment of risk. This, despite Mr H having been known to the department for well over a decade at this point.

5.2.13

Tension between housing and social work came to a head at this time when HM 1 wrote to HM 2 on 21 February 2000 complaining about the poor response from social work in this case. The memo includes comments as to the following:

(a) The tenant is a chronic alcoholic.

(b) At the present time he is very unwell.

(c) His daughter has gone into the house and cut the light pendants off, damaged doors, broken all his windows and beaten him up several times in the last few months.

(d) He has asked us to put him into a home.

(e) The gas heating in his home is not working.

(f) British Gas have refused to go in and fix the gas due to the condition of the house.

(g) Mr H is sitting freezing as he has no fan heaters.

The memo goes on to state that, 'We have tried to get the help of Social Work in these cases but to date they are very reluctant to help in these situations…These cases take up a lot of my Area Officers time but it seems we are now liable for their welfare as well? Where do we stop and social work begin?'

5.2.14

It would appear from a handwritten comment on this memo that this was passed on to SWM 2 who managed the Social Work (Intake) Team. SWM 2 subsequently forwarded this memo to SWM 3 on 13 March 2000 with the comment, 'This is a legitimate referral to Social Work. Please arrange assessment and then liaise with (SW 1). Referral route via Social Work (Intake) Team to appropriate team.'

5.2.15

SWM 3 replied by memo to SWM 2 on 14 March 2000 outlining social work involvement with Mr H since 1996. He advised SWM 2 that, 'The main block to progress has been Mr H's resistance to either co-operate with or accept services.' There is no great clarity in the social work case file as to exactly what services other than home care and befriending were offered, not surprisingly as there was no clear assessment of his community care needs at that point in time. SWM 3 ends by stating that the team would continue to monitor the case. It is not clear either in this letter or from the case file as to how they intended to do this. It would appear that this would be, once again, by responding to various crises as they emerged. It seems that the request from his line manager to carry out an assessment and to route the case to an appropriate team has effectively been ignored. As there is no response from SWM 2, we can only assume that he accepted the reasons SWM 3 put forward for not carrying out his instructions.

5.2.16

A week later Mr H turned up at the social work office requesting financial assistance, as he had no bus fare to return home. He was reported as unsteady on his feet and under the influence of alcohol. He was given £1. Five minutes later he was found lying on the grass outside the social work office. When the police were contacted with the request that they take him back home, they refused. He was escorted home by two social workers. He was visited by social work at home the next day where he was found drinking with his daughter and another man. His daughter stated that she was looking after him and the case was again marked NFA, despite the fact that the department knew of earlier concerns that the daughter may well have been abusing and exploiting her father.

5.2.17

There were a number of visits to Mr H, some of them joint visits with housing staff, as well as telephone contacts, over the next several months. These focused, however, on specific practical problems such as the need for furnishings, carpets, cleaning, etc. There was undeniably considerable activity at various points, but it remained unstructured and unfocused with little sense of urgency. Ultimately these interventions were of little effect, as they were not planned on the basis of a proper assessment.

5.2.18

In addition to the above, there were a number of opportunities that existed when various medical practitioners saw Mr H. Proper input from social work and housing staff at these points, in an attempt to undertake a comprehensive assessment of community care needs could have been extremely timely and helpful.

5.2.19

It does not appear that Mr H was actually referred for allocation to the community care team until October 2002 when he was allocated to a social work assistant on that team. This was the first point at which it appears anyone began to conceptualise a possible link between Mr H's drinking, his behaviour, and impaired capacity. She wrote to Dr B in December 2002 when she effectively raised the issue of a possible mental disorder affecting Mr H's decision-making capacity. There was contact on 15 January 2003 from housing, again expressing concern that Mr H had no food, gas or electricity and was looking 'more frail'. The caller was concerned about his vulnerability. Once again, the record states 'Mr H has the right to refuse our services if he wishes, which is what he is doing.' The social worker records that she discussed this case in supervision – one of the few and possibly only times there is reference to supervision in the case file – and the decision was taken to close the case due to his refusal to accept services. Once again, the onus was placed on Mr H to get back in touch should he change his mind. The decision to close the case at that point was made before ever receiving or even chasing up a response from Dr B to the letter from the social work assistant. Mr H did not have contact again with social work until after his admission on an emergency basis to hospital in August 2003, when he was referred to social work in September 2003.

Conclusion: The responsibility for co-ordinating the comprehensive assessment of the community care needs of Mr H clearly rested with the local authority social work department. They failed in this respect over a prolonged period. The provision of a comprehensive assessment of Mr H's social care and health needs would have had the potential of considerably enhancing his health and welfare and providing him with the protection he so evidently needed over a number of years.

5.3 Communication and co-ordination

5.3.1

A key issue related to the lack of a comprehensive assessment of community care needs was the poor co-ordination of assessments and services. Unless otherwise agreed as a result of a multidisciplinary, multi-agency case discussion or some tightly drawn local protocol, the task of co-ordination would fall to the local authority social work service. There were a considerable number of services and professionals involved in responding to Mr H at various points in time. In addition to social work, these included home care, OT, housing, the local Alcohol Advisory Service, A&E, geriatric day care, psychiatry, GP and district nursing; each agency and professional involved with their own organisational and professional responsibilities in responding to Mr H's needs. There was considerable evidence of a willingness to communicate on the part of all those involved. What was lacking was the focused co-ordination of the efforts

of the practitioners and services involved, which was essential to proper assessment and care planning. This would appear to be a consequence of social work not taking ownership of the case from a community care perspective. They appeared to deal with the case, until late on, solely on a duty or intake basis, except for the brief period when seen by the social work assistant from the community care team. This affected the quality of the communication as referrals were not officially responded to and issues raised by individuals from their own contacts were often not followed up.

5.3.2

The lack of co-ordination even within the social work department is perhaps most evident in the absence of case file entries from the local authority's OT service. This is despite the fact that they must have been involved in assessing Mr H to some extent, as case file entries note that OT equipment had been delivered to Mr H's house. There is no indication of the nature and scope of the OT assessment and whether this assessment was shared with and considered by the Social Work (Intake) Team. It would appear that it had not been shared. An OT assessment could have made a valuable contribution to both a comprehensive assessment of community care needs as well as a specific assessment of risk.

5.3.3

There seemed to be an assumption on the part of some of those intervening that Mr H was primarily a social work responsibility. When social work did not accept ongoing responsibility due to Mr H's refusal of help, no one stepped into the breach. The social work response to Mr H and whether the case was opened or closed at any particular point did not appear to materially affect the service provided by housing, the local Alcohol Advisory Service, primary care, or specialist medical care from geriatricians or psychiatrists. There was no proper engagement with key staff from external agencies aimed at properly assessing both the needs of Mr H and a co-ordinated service response to these needs. It is not clear that these other services and practitioners were even made aware of decisions by social work at certain points to take no further action and effectively to close the case. This is some distance from what 'A Fuller Life' advocates in respect of services to people with ARBD. It recommends 'whole-system approaches should characterise all levels of service planning and provision'.

Conclusion: Poorly co-ordinated service provision and poor communication both within and between services adversely affected Mr H's ability to receive an appropriate assessment of his community care and health needs.

5.4 Risk assessment

5.4.1

Aside from the fact, as stated above, that there was little, if any, co-ordination of assessment and care planning in respect of Mr H, it was also evident that there was no structured, focused, assessment of risk, despite the fact he had evidently and repeatedly placed himself at risk for a number of years and was continuing to do so. That he was vulnerable and at risk was both well accepted and well established. The risks associated with falls, fights, beatings, malnutrition, very poor hygiene, exploitation and continued excessive drinking were never properly considered. This effectively stopped social work, housing and health services from collectively exploring methods by which, at the very least, they may have been able to intervene to reduce the risks and resultant harm that Mr H was likely to have faced. It is ironic that the only reference to risk assessment in the file, until guardianship was being considered, is in relation to an assessment of the potential risks to which home care staff may have been exposed in offering a service to Mr H.

5.4.2

It is evident from the circumstances of the admission to hospital of Mr H in August 2003 that the failure of those involved to undertake a focused, co-ordinated assessment of risk resulted in Mr H deteriorating to a dangerous state. What is perhaps even more surprising is that once Mr H was in hospital for an extended period following this, and medical, nursing and social work personnel were seeing him routinely, he was very nearly discharged before a multidisciplinary assessment of risk was undertaken. This was after medical, nursing and social work staff noted many key risk factors. Staff also reported that he had been unco-operative and unrealistic about his abilities. Mr H, it was noted, was consistently unable to account for the circumstances precipitating his admission. When his house was visited, two months after his admission, there was evidence that a fire had taken place in his kitchen. Nursing staff also reported concerns about his daughter who had visited him in hospital twice and demanded money from him and was verbally and physically aggressive towards him. The role of medical staff must come into question here as they seemed to take a very passive role in future care planning in respect of Mr H, until social work forced their hand by refusing to proceed with discharge planning until their community care assessment could be informed by a psychiatric assessment. This was despite Mr H's obvious medical and social impairments related to his alcohol abuse.

5.4.3

One very concerning fact is that, prior to seeking the psychiatric assessment, the working care plan was for social work to arrange to clean up Mr H's house prior to his discharge from hospital with the offer of support should he wish to accept it – threatening to repeat the pattern of response that had led to his hospitalisation in the first place. It is not clear from the

case file, but it would also appear that housing had meanwhile apparently decided not to re-house Mr H. Once again, there is no evidence that any consideration was given to undertaking a co-ordinated multidisciplinary assessment of risk prior to his proposed discharge. In the event, it was only when Mr H, when asked again by social work, did not recall giving them permission to gain access to his house to clean it, and he subsequently refused them permission, that the discharge plan was thwarted. It was at this point that the social worker appeared to consider the possibility that Mr H may have been suffering from a cognitive impairment of some sort and a psychiatric assessment was requested.

5.4.4

When the referral for a psychiatric assessment was made by the clinical assistant in geriatrics at Hospital 2, he gave no indication of suspecting any cognitive impairment related to Mr H's alcohol abuse and queried whether he had a 'mental health problem' that needed treatment. The report back from the consultant in old age psychiatry confirmed significant cognitive impairment as a result of possible alcohol related dementia. A case conference in January finally provided the co-ordinated, multidisciplinary assessment of risk which had previously been lacking and concluded that a return home was no longer an option due to Mr H's vulnerability and abuse from his daughter. There is no evidence that consideration was given to attempting to support Mr H at home, even with a care plan underpinned by guardianship, but it would appear that when a proper assessment of his care needs was finally undertaken, this was not viewed as a safe, viable option. In a short period of time, Mr H had moved from being seen as someone who could be discharged home, despite the fact that it was felt he would not be likely to co-operate with any support that would be on offer, to someone who needed full-time residential care, secured by the authority of both financial and welfare guardianship. It is arguable that Mr H had been in a very similar position for the previous several years but that positive intervention had been delayed because a psychiatric opinion had never been actively sought or obtained.

5.4.5

There is no mention of vulnerable adults guidelines/protocols in the case file material. It is not known whether they were in existence in Council A at that time but, if so, they were not referred to in the social work case files or his medical records. In February 2000, Mr H's case was discussed with the community care team in respect of the potential of elder abuse, but this was not followed up. The reason given why this did not fall under these procedures/guidelines was that his daughter was neither his carer nor living with him. Any suspicion of abuse was therefore considered to be a police matter. This reflects either a fundamental flaw in procedures or a gross misjudgment on the part of practitioners. Given that there was virtually universal agreement that Mr H was vulnerable, and it was not

apparent to any of the parties exactly how to proceed to minimise his vulnerability, vulnerable adults procedures/ guidelines would have been ideally suited for ensuring that he was afforded a co-ordinated assessment of risk involving all the key parties. A focused assessment of risk should follow naturally from the implementation of such procedures.

Conclusion: There was a failure on the part of the professionals involved to undertake a focussed assessment of risk in respect of Mr H at many key points, over a number of years, despite the acknowledgement of his vulnerability throughout this period. Such an assessment had the potential, at the very least, of leading to services aimed at reducing the risks to which Mr H had been exposed over a number of years.

5.5 Knowledge of relevant legislation

5.5.1

Up until the end of 2003, there is no mention of the potential usefulness of legislation in helping to authorise and secure a care plan focused on minimising the risks to which Mr H was routinely exposed and from which he appeared unable to protect himself. This is likely to be related, to some extent, to the lack of knowledge about ARBD and underlying views relating to alcohol addiction and the right to self-determination, as mentioned above. It is difficult to know to what extent professionals may have lacked knowledge as to the potential value of legislation in implementing a care plan, or whether the more significant factor was not appreciating that Mr H may have had a mental disorder that would have afforded him the protection of the Adults with Incapacity Act.

5.5.2

There were a few points at which consideration arguably should have been given to the use of the National Assistance Act. This was true in December 1999, in February 2000, and in January 2003. In each case the Act could have been used to secure temporary placement of Mr H while his house was made fit to be occupied. This could have facilitated a better assessment and care plan at these crucial points. There was no mention of the National Assistance Act anywhere in the case file.

Conclusion: There was no evidence that key health and social work staff had any knowledge of the potential relevance and usefulness of legislation in enabling a comprehensive assessment to be undertaken and securing key elements of any subsequent care plans. The absence of referral to and consultation with the local authority's mental health officer service was particularly noteworthy and is likely to have impacted negatively on the management of the case.

5.6 Recording practice

5.6.1

The social work case files examined by the Commission were deficient in a number of respects. This may have been as a result of policy or management failures as well as individual poor judgement on the part of practitioners. The net result was that these failures resulted in Mr H not being allocated to a community care team until late on. Until that point he was effectively dealt with on a duty or intake basis. There is no evidence of an assessment or a care plan in his file until after he was being considered for an application for welfare guardianship. Prior to that there was no way of knowing, for the most part, by looking at the file, what exactly was being done by the social work department as well as other statutory services at any one point in time. There was poor evidence of follow through on correspondence, decisions and suggestions. With few exceptions, referrals, once made, appeared to take a considerable time to be acted upon. Case file information was further compromised by the fact that they contained apparently contradictory information at times. The heart of the information contained in these files rested in the numerous copies of sequential 'Social Work Service Enquiry Forms' and NFA notes. It does not appear there was any management oversight of the content of these files/records beyond those directly involved.

Conclusion: The poor recording evident in the relevant social work department case files reflected and is likely to have contributed to the overall lack of direction evident in this case over a number of years. We believe it is indicative of the low priority afforded Mr H.

5.7 Quality monitoring and managerial oversight in social work department

5.7.1

It appears from the examination of the social work files of the Social Work (Intake) Team that the casework and related decisions of the team did not attract the attention or oversight of management beyond the team manager level. As we argue above, this was a case that attracted a significant amount of social work activity over the years. Given the nature of the presenting problems the case would have benefited from periodic reflection on whether the responses continued to be appropriate. Oversight by someone not directly involved in managing the case might well have prompted a considered review of the case management. While it is appreciated that there has been a restructuring of the service since that time and the Social Work (Intake) Team no longer exists, this case does highlight the need for local authorities to put in place some system of quality assurance which focuses on short-term/intake/duty work

activity carried out by department staff. This case highlights the need for screening and intake systems to have sufficient sophistication to be able to pick up those cases that require a more thorough approach to assessment and care planning if the authority is to properly fulfil its responsibilities under the Adults With Incapacity, Mental Health and the NHS and Community Care Acts as well as future Vulnerable Adults legislation. Systems of single shared assessment add a different layer of complexity to the management task. Managers need to ensure that all staff involved in some aspect of screening and assessment have the appropriate training and access to information. This is essential if they are to be able to tailor the assessment in such a way as to pick up on needs that may be associated with more fundamental problems than may be initially apparent. Staff have to involve the appropriate specialist staff in the assessment process as required. They need to know the general circumstances in which such referrals may be appropriate as well as how to access this specialist input.

Conclusion: The managerial oversight of the social work department's frontline enquiry/intake system was seriously deficient. This deficiency allowed a vulnerable person to remain at risk of abuse, exploitation and neglect over a number of years without a proper assessment of his community care needs.

5.8 Strategy for service provision for people with ARBD

5.8.1

The Scottish Executive's plan for action on alcohol problems published in January 2002 required local Alcohol Action Teams to draw up and publish by April 2003 and subsequently implement, a local strategy covering a period of at least three years. The Scottish Executive subsequently published a framework for these 3-year action plans in July 2002. This outlines the information to be included in these plans. The framework document sets out service needs across 4 main tiers of service. In respect of ARBD, we would expect this to be addressed at Tier 3 and Tier 4 services.

5.8.2

Tier 3 services are those for people with more complex needs. The framework includes a number of suggested ways in which services can respond. Among those having most relevance for the purposes of this case are:

- Specialist assessment, advice, detoxification, relapse prevention and follow-up in partnership with GPs and other primary care staff;
- Training and advice to primary care on alcohol problems;
- Joint working between social work, voluntary sector organisations, community mental health teams and local alcohol action teams;
- Direct access for referrals to specialist services;
- Protocols in A&E Departments covering recognition of alcohol problems, information to GPs about their patients' management of alcohol withdrawal, use of thiamine, and assessment of neurological status;
- Provision of crisis management services;
- Alcohol liaison nurses providing services to wards and departments which links them to support from alcohol and liaison specialist services and provision of brief intervention, particularly to hazardous drinkers;
- Access to specialist neurological and gastro-intestinal investigations; and
- Protocols with local mental health services dealing with arrangements to identify and intervene where appropriate, and setting out links from general psychiatric services to specialist alcohol liaison psychiatry or psychology services for complex cases.

5.8.3

Tier 4 services relate to people with highly specialised needs and are where you might most expect to see reference to services for people with suspected or confirmed ARBD. It suggests that services can respond in the following ways:

- A resource for a region or group of NHS Boards, and their partner local authorities, working through local AATs to manage complex alcohol-related neuropsychiatric problems with inpatient provision as well as services for individuals with established ARBD; and
- A managed clinical network for the treatment, care, rehabilitation and after-care of those with severe and complex alcohol problems which would include early, expert and multidisciplinary diagnosis and re-assessment, expert multi-professional clinical care, access to mental health services, and respite care and appropriate long-term placement.

5.8.4

The (Council A and NHS Board A) Drug and Alcohol Action Team Corporate Action Plan for 2004-2005 was drawn up in response to the Scottish Executive's requirement mentioned above. What is most notable in the context of this report is that it is wholly silent on the issue of ARBD. In response to Tier 3 support and treatment services for people with more complex needs, there is only a general mention of the service providers and not the services provided by them. Nor is there an indication of how they relate to each other. There is no way of knowing how or whether services to people with

ARBD fit in here. In particular, the role of the Community Alcohol Teams may well be implicit but is not at all clear. Given the problems cited above in terms of co-ordination and communication, it is important their role is clearly set out and widely known.

5.8.5

In respect of Tier 4 support and treatment services for people with highly specialised needs there is only reference to 'a clinical meeting taking place as and when a psychiatrist wants to send a client to residential' treatment rehabilitation services outwith the NHS Board A area. Comment is made that every effort is made to treat clients within the community rather than send them away to residential establishments. Again, however, there is no way of knowing how or whether people with ARBD fit in here. They do not appear to have attracted the specific attention required given their often complex and highly specialised needs.

Conclusion: There was a lack of a strategic approach in Council A and NHS Board A to the planning and provision of services to people with ARBD during the period under review. The Council A and NHS Board A Drug and Alcohol Action Team Corporate Action Plan for 2004-05 still did not address this issue.

5.9 Training

5.9.1

What has been starkly apparent throughout this investigation is that there appears to have been a widespread lack of knowledge and awareness of ARBD on the part of the professionals across the spectrum of agencies with whom Mr H came in contact. Even in the medical reports accompanying the application for guardianship there is no association made between Mr H's dementia and his alcohol abuse.

5.9.2

ARBD occurs because of the direct toxic effects of alcohol and because of vitamin B1 (thiamine) deficiency due to poor diet. A person who drinks heavily also risks vascular disease and head injury. Both of these can worsen mental function. Treatment with thiamine at an early stage can offer protection against ARBD. If damage has occurred, abstinence coupled with high dose thiamine treatment can result in improvement over time. Thiamine deficiency results in the 'Wernicke-Korsakoff

Syndrome'. This includes neurological disturbance in the acute phase followed by memorising deficits. A person's ability to retain new information may be specifically impaired. It is easy to test for this. Any apparent memorising deficits should result in treatment with thiamine.

5.9.3

While people affected by ARBD are a diverse group, Mr H did fit a profile of someone at risk of developing it. 'A Fuller Life' notes some of the features and social consequences of problem drinking associated with ARBD, all of which are noted throughout Mr H's case files:

- Unemployment, or periods of unemployment
- Divorce or separation
- Lost contact with family members
- Social isolation
- Financial difficulties
- Temporary or insecure housing
- Risk of head injury from falls, assaults and road accidents
- Mental health problems, including depression
- Multiple substance abuse, most commonly opiates and benzodiazepines
- Medical conditions such as neuropathy and gastro-intestinal problems
- Poor nutrition
- Inability to maintain or develop social relationships
- Poor budgeting skills
- Anti-social behaviour
- Impaired cognitive functioning including memory, attention, planning judgement and processing new information
- Change in personality
- Apathy
- Disinhibition
- Impulsivity
- Neglect of personal care

5.9.4

All of the above, especially when co-existing and viewed in the context of how Mr H came in contact with health and social services, should have alerted professionals to the possibility that Mr H's cognitive abilities and behaviour may have been seriously affected by the development of ARBD. Even without the possibility of this underlying disorder, there were numerous occasions when Mr H's care needs should have been comprehensively assessed. With the possibility of ARBD, this becomes more of an imperative. Mr H's capacity to appreciate the full consequences of failing to change his drinking behaviour, as well as his ability to change, needed to be addressed before services could begin to plan with him how they may have addressed his assessed needs. The long catalogue of wasted time and effort in attempting to intervene to help him, and the resultant, inexorable deterioration in Mr H's condition over the years, is likely to be partly the consequence of this failure.

5.9.5

Knowledge of ARBD is important primarily because of what we know about the importance of early identification and intervention. While, admittedly, early identification may be difficult, it can play a crucial role in affecting its development in, and impact on, individuals affected by it. 'A Fuller Life'

asserts that without early identification it is unlikely that the associated problems will be dealt with until they are severe. The report goes on to state that of those who have ARBD, or who are at risk of developing it, a significant number have the potential to recover substantially, or even completely, given the right management of the disorder and appropriate support. This distinguishes ARBD, the report notes, from other forms of dementia or brain injury where recovery is unlikely.

5.9.6

In highlighting in its recommendations the need for training across a range of services with whom people with ARBD are likely to come into contact, 'A Fuller Life' points out that 'appropriate staff training in the identification, assessment and management of ARBD will allow opportunities for early intervention to be maximised'.

5.9.7

There is a further reason why an understanding and knowledge of ARBD is important. This relates to local authority responsibilities under Section 57(2) of the Adults with Incapacity (Scotland) Act 2000 which requires the local authority to apply for guardianship or intervention orders where it is necessary for the protection of the property, financial affairs or personal welfare of the adult and no-one else is making the application. The local authority may be failing on a routine basis to carry out its protective role under this section of the Act if staff in services which come into contact with people with ARBD do not have knowledge of the illness, or the potential effect on the individual's ability to protect their own interests.

Conclusion: The apparent lack of knowledge and awareness of ARBD among the health and social care professionals involved in his care and treatment is likely to have compromised Mr H's health and social welfare over a number of years.

5.10 Stigma/attitudes

5.10.1

An overriding impression from the review of Mr H's experiences with statutory services is that when he sought help or was in a position to receive help from the various agencies, he was met not only by an unco-ordinated response but also by services disinclined to adequately assess his needs. The reason for this bears close examination. In 'A Fuller Life' there is discussion as to the context in which most services approach people who may have ARBD. The report states that alcohol occupies such a prominent place in our society that professionals involved in planning and delivering services cannot but help being affected by some of the prevailing attitudes and perspectives towards the use and abuse of alcohol. Many are likely to feel an unjustified pessimism about the possibility of rehabilitation or recovery; many may feel that the individual is undeserving of help having brought the problem on him or herself; and others may feel reluctant to make value judgements

about someone else's drinking. The net result can often be that 'it is less likely that the complications of alcohol problems will be detected or appropriately addressed until they are severe'. The report emphasises the importance of staff being aware of their own values, beliefs and prejudices.

5.10.2

The above comments certainly have a resonance in reviewing the management of Mr H's alcohol-related problems in Council A and NHS Board A. He was known to statutory services because of these problems since the early 1980s. By the mid-1980s he was very well known to health services. As early as 1985, when he had two periods of inpatient alcohol detox, medical reports refer to his 'long history of alcoholism'; in 1986, his 'chronic alcoholism'. While it is very likely he did not at that point suffer from ARBD, a pattern in his relationship with statutory services was emerging that continued until well after the point where it is likely he was experiencing the effects of ARBD. Services and treatment were offered, but the onus was on Mr H to accept and use them. When he repeatedly did not avail himself of the help on offer, he did not emerge again on the radar of statutory services until he was experiencing a health or social crisis brought on by his drinking. This pattern continued until he was living in a situation of absolute degradation and had to be admitted to hospital on an emergency basis in August 2003.

5.10.3

For whatever reasons, and it is likely that individual as well as institutional attitudes played a role here, Mr H and his needs were not viewed more widely than his immediate presenting social and/or medical problems. Opportunities for a more comprehensive assessment of his needs associated with his alcohol addiction existed throughout Mr H's contact with statutory services. Such assessments did not appear ever to have been made until shortly before the application for guardianship. Very short-term crisis management was the norm. The letters 'NFA' repeatedly appear at the end of social work contact sheets.

Conclusion: It is hard to escape the conclusion that the assessment, planning and delivery of care by those professionals involved with Mr H over a number of years was adversely affected by prevailing critical attitudes towards people who abuse alcohol.

Section 6

Summary of key conclusions

6.1 The assessment of capacity

The complex task involved in assessing Mr H's capacity to protect his own interests was seriously impaired by the failure of practitioners to appreciate the potential impact of Mr H's drinking on his mental capacity. We think this failure directly contributed to delays in implementing appropriate medical and social work intervention at an earlier stage that could have reduced the extent of Mr H's later disability.

6.2 Community care assessment

The responsibility for co-ordinating the comprehensive assessment of the community care needs of Mr H clearly rested with the local authority. They failed in this respect, over a prolonged period. The provision of a comprehensive assessment of Mr H's social care and health needs would have had the potential of considerably enhancing his health and welfare and providing him with the protection he so evidently needed over a number of years.

6.3 Communication and co-ordination

Poorly co-ordinated service provision and poor communication, both within and between services, effectively prevented Mr H from receiving an appropriate assessment of his community care and health needs which he required.

6.4 Risk assessment

There was a failure on the part of the professionals involved to undertake a focussed assessment of risk in respect of Mr H at many key points, over a number of years, despite the acknowledgement of his vulnerability throughout this period. Such an assessment had the potential, at the very least, of leading to services aimed at reducing the risk to which Mr H had been exposed over a number of years.

6.5 Knowledge of relevant legislation

There was no evidence that key health and social care staff had any knowledge of the potential relevance and usefulness of legislation in enabling a comprehensive assessment to be undertaken and securing key elements of any subsequent care plans. The absence of referral to and consultation with the local authority's MHO service was particularly noteworthy and is likely to have impacted negatively on the management of the case.

6.6 Recording practice

The poor recording evident in the relevant social work department case files reflected and is likely to have contributed to the overall lack of direction evident in this case for a number of years. We believe it is indicative of the low priority afforded Mr H.

6.7 Quality monitoring and managerial oversight in social work department

The managerial oversight of the social work department's frontline enquiry/intake system was seriously deficient. This deficiency allowed a vulnerable person to remain at risk of abuse, exploitation and neglect over a number of years without a proper assessment of his community care needs.

6.8 Strategy for service provision for people with ARBD

There was a lack of a strategic approach to the planning and provision of services to people with ARBD during the period under review. The (Council A and NHS Board A) Drug and Alcohol Action Team Corporate Action Plan for 2004/05 still did not address this issue.

6.9 Training

The evident lack of knowledge and awareness of ARBD among health and social care professionals involved in his care and treatment is likely to have compromised Mr H's health and social welfare over a number of years.

6.10 Stigma/attitudes

It is hard to escape the conclusion that the assessment, planning and delivery of care by those professionals involved with Mr H over a number of years was adversely affected by prevailing critical attitudes towards people who abuse alcohol.

Section 7

Recommendations

Council A Social Work Department and NHS Board A

1. Assessment and care management procedures: When an individual who is dependent upon alcohol repeatedly comes to the attention of health and/or social work services, procedures should ensure an assessment of the individual's capacity to consent to and co-operate with proposed care and treatment necessary to protect his/her health, safety and/or welfare.
2. Communication and co-ordination: Council A Social Work Department and NHS Board A should develop joint protocols for the assessment, care management and related information sharing in complex cases where individuals may be affected by ARBD. This should include a shared understanding of risk assessment and management strategies and procedures.

3. Training issues: All relevant health and social work staff should be made aware of this report, its key conclusions and recommendations. All appropriate staff should be trained in the identification, assessment and management of ARBD. They should also all be formally reminded of their responsibility to assess the impact of persistent alcohol abuse on an individual's capacity to respond to proposed care and treatment plans and the potential role of protective legislation in implementing care plans to protect such individuals.
4. Audit: Council A Social Work Department and NHS Board A should audit the assessment, care management and treatment of people who are repeatedly referred because of the consequences of alcohol dependence, to help inform future service developments. This should include an audit of front-line health and social work responses.
5. Strategy development: The (Council A and NHS Board A) Drug and Alcohol Corporate Action Plan should be revised and updated to include specific reference to the needs of people with alcohol related mental disorder, especially in relation to Tier 3 and Tier 4 services.

Council A

6. Council A social work and housing departments together should review the interaction of the two departments as outlined in this report. They should specifically consider what action may be required to ensure a better understanding of the respective roles of staff in working to provide people vulnerable because of ARBD with the required support.

NHS Board A

7. Geriatric medicine: Departments of medicine for the elderly should develop a protocol for the assessment of decision-making capacity. They should also develop procedures for identifying and investigating impaired cognitive function, including alcohol-related cognitive impairment. Such protocol and procedures should identify appropriate referral and treatment options. This work should be done in consultation with old age psychiatry.

The Scottish Executive

8. The Scottish Executive should formally respond to the recommendations of the 'Report of the Expert Group on Alcohol Related Brain Damage', commissioned by the Scottish Executive and published in March 2004.
9. The Scottish Executive should audit all local Alcohol Action Plans to ensure that they adequately address services for people affected by ARBD.

Annex A

Key dates from NHS files

1960

Diagnosis of duodenal ulcer.

1980

Appears at surgery again drunk and offensive.

1984

Diagnosed with non-insulin-dependent diabetes. Brought to A&E by police having been involved in a fight while in a drunken state and fallen down a concrete stair. Extensive bruising, lacerations and a fracture as well as head injury noted.

1985

Admitted to hospital for detox twice in October. Given diazepam to cover withdrawal and he remained on this after discharge. Noted to be taking diazepam and pain killers not as per doctor's instructions.

1986

Admitted to hospital in January following overdose of amitriptyline and alcohol. Admitted again in March following an overdose of amitriptyline, diazepam, Tagamet and alcohol.

1987

At surgery inebriated asking for help regarding alcohol problem. Seen by psychiatrist on outpatient basis. In December, attended A&E two days after falling down stairs and fracturing ankle.

1988

Brought to A&E in June having been drinking heavily and been assaulted. Appeared again in August with painful swollen right hand with poor explanation of how injury occurred. Ultimately admitted in September to administer intravenous antibiotics as hand was infected and oral antibiotics were unsuccessful. Later in September he was brought into A&E by ambulance, smelling of alcohol with a head laceration.

1989

Attended A&E under the influence of alcohol with a laceration to his right middle finger, with no explanation of how received. Abusive and refusing tetanus.

Report in April for Mobility Allowance Unit, DHSS raised the possibility that he was developing a peripheral neuropathy.

1990

In January attended A&E having been drinking heavily and assaulted. Had a supra orbital haematoma. In October he again attended A&E having been brought there after drinking heavily, having been subject to an assault and falling over and hitting his head.

1991

Seen at diabetic clinic for the first time in five and a half years.

1992

Still being prescribed diazepam. Drunk and abusive at surgery at times. Requesting painkillers.

1993

Brought to A&E by ambulance crew allegedly having been assaulted but with no memory of events. Reportedly consumed two bottles of vodka during the day. Admitted to hospital for head injury observations.

1994

Seen at surgery for arthritis. Requesting painkillers. Still prescribed amitriptyline.

1995

Removed from GPs list in April. File marked ‘no reason given’. Seen at A&E in late April complaining of pain in lower right chest. This was as a result of fall four days previously. Fractured ribs.

1996

GP discusses trying to reduce use of diazepam and ultimately stopping it. He is reluctant and stays on it.

1997

Continues with diazepam and co-codamol. Often appears drunk at surgery.

1998

Not attending diabetic clinic. Contact by GP with social work, housing and (Voluntary Organisation C).

1999

Not attending diabetic clinic. At surgery in late October seen trembling, smelling of stale alcohol and possible weight loss. Agrees to referral to social work and VO 3 again.

2000

Brought into A&E in January by ambulance having been found in the street by passer-by. Intoxicated. Superficial lacerations to face and forehead. Admitted for observation. Dr B referred to Hospital 1. Does not attend as arranged. Given vitamin B compound tablets. Re-referred later in the year and again does not attend beyond first two visits.

2001

Bloods checked at surgery for diabetes. Flu shot given.

2002

Visited by DN 1 and chiropodist. Referred to social work. Referred to day hospital. Still on diazepam and co-codamol.

2003

Brought into A&E by ambulance after neighbour found him in ‘squalid’ flat. Viewed as social admission as house was uninhabitable and he was malnourished and covered in lice and scabies.

Annex B

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