Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

SAR 057 – Adult G

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1. Introduction

A Safeguarding Adult Review (SAR) referral was submitted to Northamptonshire Safeguarding Adults Board (NSAB) from Kettering General Hospital on 20th March 2024. The referral raised concerns relating to self-neglect and the possible failure of agencies to support. The referral was considered at the NSAB SAR Subgroup and the Chair and statutory partners agreed with the recommendation that the referral met the criteria for a Safeguarding Adult Review (SAR) under s44 (1) (2) of the Care Act 2014.

2. Safeguarding Adult Reviews (SAR) - Legal Context & Purpose

2.1 Section 44 of the Care Act 2014 requires Safeguarding Adult Boards to carry out safeguarding adult reviews involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if –

a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) Condition 1 or 2 is met

(2) Condition 1 is met if –

a) the adult has died and

b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse of neglect before the adult died)

(3) Condition 2 is met if

a) the adult is still alive and

b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs).

2.2 A SAR is a supportive multi-agency review process for partner agencies to look at agency contact and practice and identify lessons that can be learned from complex or serious Adult Safeguarding cases where an adult at risk has died or been seriously harmed, and abuse or neglect has been suspected. The review will not re-investigate or apportion blame, but aims to identify gaps in process and practice, including where agencies could have worked better together, and to recognise any good practice. Recommendations are made to change and improve practice and services.

2.3 The review process necessitates openness and critical analysis to allow an exploration of the decisions made and actions taken to identify any lessons to be learnt to improve practice from the circumstances, and to apply those lessons to future cases.

2.4 All agencies involved with Adult G were required to contribute to the review and a scoping of information from all known agencies involved was requested. Adult G was known to the following agencies/services:

Department of Work and Pensions, DHU Healthcare NHS 111 Service, East Midlands Ambulance Service (EMAS), Kettering General Hospital (KGH), Linden Medical Centre, North Northamptonshire Adult Social Care (NNC ASC), Northamptonshire Healthcare Foundation NHS Trust (NHFT) and Northants Fire and Rescue Service (NFRS).

2.5 A desktop review was the agreed methodology used as the most proportionate way to approach the review. All agencies involved in the SAR provided a chronology to enable the author to review key aspects leading to the incident. The SAR was approved on 24th August 2024, but commencement of the SAR was delayed due to a number of ongoing SARs and capacity within the partnership. The referral was discussed in May 2024, July 2025, and October 2025.

2.6 The agreed scope of the SAR was 01.07.2022 to 25.02.2024.

2.7 This report summarises the key findings from the review. The main key lines of enquiry in the audit were:

1. What happened in the 6 months leading up to the event?
2. Was the assessment of care and support needs by agencies accurate?
3. What were the opportunities and the barriers to work more effectively with Adult G and her husband and what can we learn from them?
4. Was self-neglect identified and how did agencies respond?
5. In light of Adult G's health issues and addiction, was appropriate risk assessment undertaken?
6. What multi-agency support was put in place for Adult G and her husband?
7. What can we learn from the case i.e. was appropriate information shared?
8. What could we do differently as a system to stop similar issues happening?

3. Who was Adult G

3.1 Adult G was a 62-year-old female who lived with her husband. Unfortunately, we have little information about Adult G's history, family connections, and personal interests.

3.2 Adult G had a diagnosis of Chronic alcoholic liver disease - alcohol-related liver disease does not usually cause any symptoms until the liver has been severely damaged. When this happens, symptoms can include:

- feeling sick
- weight loss
- loss of appetite
- yellowing of the whites of the eyes or skin
- swelling in the ankles and tummy
- confusion or drowsiness
- vomiting blood or passing blood in your stools

3.3 Adult G had a diagnosis of Korsakoff's syndrome - a chronic memory disorder caused by severe deficiency of thiamine (vitamin B1). Korsakoff syndrome is most commonly caused by alcohol misuse, but certain other conditions also can cause the syndrome.

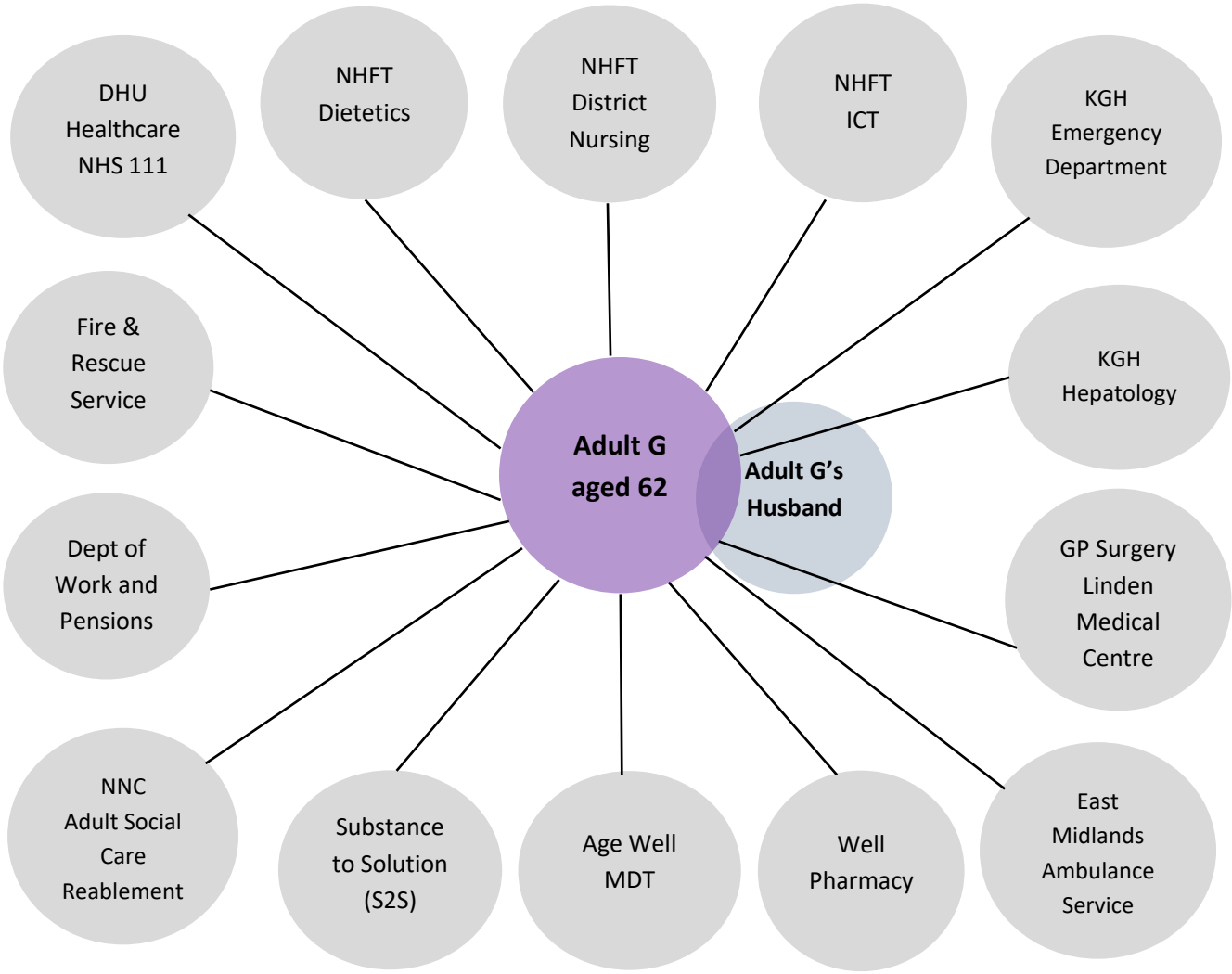
4. NSAB Contact with Adult G's husband

4.1 We wrote to Adult G's husband advising that a Safeguarding Adults Review (SAR) was commencing and offering the opportunity to speak with the SAR author. The letter was collected but we did not receive a request to find out more about the process.

4.2 A report will be shared with Adult G's husband.

5. Ecomap[1]

This Ecomap identifies the agencies involved with Adult G during the period of review.



Adult G refused support, cancelled or did not attend appointments from S2S, Age Well MDT, GP and Hepatology.

[1] An ecomap is a visual assessment tool that maps a person's or family's relationships with their social environment, including friends, community, and services

6. Chronology of events during the scoping period 1st July 2022 to 25th February 2024

- **2nd July 2022** - Contact with NHS 111 from Adult G' s Husband on her behalf - health issue relating to blisters on leg popping. Advised to attend pharmacy.
- **7th July 2022** - NHFT Referral to Dietetics for high protein liver disease.
- **1st August 2022** - NHFT Dietetics plan and review completed. GP has prescribed supplements.
- **5th August 2022** - Registration with GP surgery and subsequent note on 19th August stating 'HCA to record weight'.
- **10th August 2022** - NHFT Dietetics review completed. Monitor bowels, skin, weight, and nutritional intake.
- **7th September 2023** - Adult G and her husband attended KGH's emergency department via ambulance following a fall (husband reported they had both fallen the previous night). Bruising noted all over body with some skin tears to arms and legs. Adult G unable to state when she last had fluids or food. Whilst in hospital, Adult G was seen by the Substance to Solution (S2S) Acute Substance Misuse Liaison Nurse, but she did not want to engage in a structured service, so referral information was provided. There were no further contacts made.
- **7th September 2023** - Northamptonshire Fire and Rescue Service were called by EMAS to gain access to the property (relating to the incident above). Following the incident, Fire Crews raised significant concerns regarding the welfare of the occupiers, noting that Adult G appeared unable to care for herself and that neither individual receives external support nor were known to local services. While crews were on scene, Adult G was assessed by the Ambulance Service and found to be in a serious condition, having reportedly vomited blood for an extended period. Crews identified that the couple would be unable to safely evacuate their home in an emergency and recommended both an urgent care package and a comprehensive Home Fire Safety Visit (HFSV). Adult Social Care Customer Services were contacted and confirmed that the occupiers were not on their system. Telephone contact with Adult G's husband established that he had been discharged from hospital while his wife remained admitted. He reported rib pain and was advised to contact his GP. He agreed to a Home Fire Safety Visit scheduled with the Complex Case Officer and a Home Safety Adviser for 12:30pm on Monday 11th September.
- **11th September 2023** - Northamptonshire Fire and Rescue Service - Home Fire Safety Visit completed with Adult G's husband as Adult G continued to be in hospital. Consent was gained to contact the hospital discharge team to look at care support for when Adult G returns home.
- **12th September 2023** - Northamptonshire Fire and Rescue Service - contact made with ASC Kettering Hub. Couple not known on ASC system. Details of incident shared with ASC.
- **12th September 2023** - NHFT Dietetics and nutrition assessment.
- **18th September 2023** - NHFT Dietetics Clinic review.
- **2nd October 2023** - Adult Social Care - Adult G was accepted onto the Residential Discharge to Assess (DTA) pathway at the MDT meeting, and the case was forwarded to Brokerage to identify a suitable provider. This followed the incident on 7th September 2023, when both Adult G and her husband were brought to KGH by EMAS after being found on the floor and requiring medical assistance. ASC duty contacted Adult G's husband to inform him of the referral for Adult G to move to a residential DTA placement. He expressed a preference to be placed in a local care home but stated he would care for her at home if this was not possible. He was advised that Adult G would become financially responsible for her care following the social care assessment. He confirmed agreement with the current discharge plan.
- **13th October 2023** - ASC change pathway to Package of Care. Needs to be discussed at MDT.

- **19th October 2023** - Adult G was discharged from KGH. During this time, Adult G's husband had conversations with North Northamptonshire Council (NNC) regarding a package of care for his wife as he was struggling to cope. After discharge from KGH, Adult G was being supported by NHFT's Intermediate Care Team (ICT).
- **21st October 2023** - Admission to KGH due to swelling in legs and arms. A referral was made to the Dietetics Team as she was malnourished due to excessive alcohol intake.
- **27th October 2023** - NHFT Adult G refused nasogastric tube whilst an inpatient.
- **2nd November 2023** - Discharged from KGH. District nurses visited at home to assess, clean and dress wounds. No signs of infection. Adult G remained under ICT care for support in the morning.
- **4th November 2023** - NNC ASC Reablement assessment completed. Need for support with morning routine only (washing, dressing, toileting, and mobility) identified by Adult G, as stated husband supports her throughout the day. Concerns noted re nutritional needs not being met as Adult G struggling with appetite - advice given for husband to contact GP following day to request nutritional drinks.
- **9th November 2023** - NNC ASC Reablement - Adult G husband completed a financial assessment form and stated they are under the threshold - later established Adult G is a self-funder. Adult G husband was contacted, and it was confirmed Adult G was above threshold and informed that the care will be given a weeks' notice and will end on 15/11/23. A care directory was sent so he could find a care provider of his choice. It was mentioned that Adult G's eating was a concern and ASC requests GP to prescribe fortisips.
- **11th November 2023** - District Nurses last visit – 'all wounds have dried and healed. [Adult G] to be discharged from case load.'
- **20th November 2023** - Discharged from Dietetics service.
- **27th November 2023** - Adult G husband advised GP surgery that he needed further help with personal care for his wife in the mornings stating she was weak since discharge from hospital, and he was struggling to get 'Ensure[2]' drinks but managed to locate from the Well Pharmacy at the GP surgery. The Care Coordinator said she would book a video call at the Age Well Multi-Disciplinary Team (MDT) with Adult G and her husband on 01.12.23. The Age Well MDT is usually a weekly event, once agreed by the patient and an appointment made, a member of the AgeWell team will visit them at home, at the agreed date and time and set up a video Teams link with the GP, Advanced Nurse Practitioner, and a member of the Care Co-ordinator Team at the surgery, plus other members of the Age Well team. It may also include other services if the GP feels they would be appropriate for the patient's care going forward. Members of the Age Well team include people who work for Adult Social Services, NHFT and Age UK, as well as Advanced Nurse Practitioners (ANPs).
- **1st December 2023** - Age Well MDT appointment was scheduled but Adult G cancelled the day before. The GP practice attempted to rearrange with two follow-up calls and sent a text with a rebooking link. Due to annual leave and the festive period, the next MDT slot was 17 January 2024. On 15 January and 5th February 2024, the GP surgery tried to contact Adult G again but received no response.
- **4th December 2023** – KGH - Hepatology appointment attended - there is no indication that a safeguarding referral was submitted, considering at this point Adult G would have likely to be showing signs of self-neglect.
- **22nd January 2024** - KGH - Hepatology appointment cancelled by patient.

[2] Ensure is a high-protein, vitamin-rich nutritional supplement drink designed for disease-related malnutrition, weight management, and energy recovery.

- **23rd February 2024** - EMAS – the ambulance crew attended and found Adult G lying on sofa in the foetal position, unresponsive and only making moans and groan noises. She was covered in open wounds to both legs, arms, body, face/neck, crew reported some covered with dressings (husband stated he was applying) but very little skin intact across her body. Adult G was found to be wearing incontinence pads which were soiled of both faeces and urine. Crew reported Adult G looked skeletally thin. Crew unable to gain reliable history from husband (main carer) with no formal package of care in place. Crew made blue light transfer to ED (green resus) at Kettering General Hospital. On admission Adult G weighed just 27kg (4.25 stone). EMAS referred to the Fire and Rescue Service as they assessed a clutter rating of over 4. EMAS have advised that in circumstances where there is a clutter rating of 4 or more, the safeguarding referrals are automatically shared with the Fire and Rescue Service.
- **25th February 2024** - Adult G died in KGH. Cause of death: a. Infection of unknown aetiology b. Malnutrition/self-neglect c. Chronic alcoholic liver disease and Korsakoff's syndrome.

7. Key lines of enquiry findings

This section explores the findings from the chronology and discussions with colleagues.

7.1 **Care and Support Needs:** Adult G had clear needs for care and support from September 2023 onward**.**

7.2 **Agency Involvement:** Multiple agencies were involved, but coordination was fragmented. No evidence of a holistic, multi-agency review before February 2024.

7.3 **Supporting Engagement:** Adult G repeatedly declined or cancelled appointments (Age Well MDT, substance misuse support, Hepatology), but escalation was minimal and capacity to decline or cancel the appointments does not appear to have been considered or assessed.

7.4 **Safeguarding:** No safeguarding referrals were made until two days before her death, despite indicators of self-neglect and vulnerability**.**

7.5 **Nutrition Monitoring:** Dietetics discharged Adult G in November 2023 without ongoing monitoring or contingency planning.

7.6 **Support for Adult G's husband:** Was a follow up call been made to Adult G's husband to ascertain whether he requires any support.

8. Good Practice

8.1 **Hospital Safeguarding Alert:** KGH and EMAS raised safeguarding concerns promptly on 23rd February 2024.

8.2 **Consistent Wound Care:** District Nurses provided regular wound care until healing was achieved.

8.3 **GP Attempts to Engage:** Multiple attempts were made to involve Adult G in an Age Well Multi-disciplinary Team (MDT) and provide nutritional support (fortisips prescription).

8.4 **Financial Assessment:** Adult Social Care (ASC) completed a financial assessment and provided information for self-funding care options.

9. Missed Opportunities

9.1 **Carer's Assessment:** Adult G's husband was not offered a carer's assessment despite clear signs of carer strain.

9.2 **Follow-up on Care Directory:** ASC sent a care directory but did not confirm whether care was arranged or sought to understand whether the couple required support to source the care despite previous information received from the Fire and Rescue Service relating to significant concerns for the welfare of the couple, noting that Adult G appeared unable to care for herself and that neither individual receives external support nor were known to local services.

9.3 **Escalation After Non-Engagement:** The GP practice relied on calls and texts; a home visit could have been considered. In addition, contact with social services could have been triggered at the point of the Age Well MDT appointment being cancelled seeing the husband had informed the GP he required support with his wife's personal care in the morning.

9.4 **Holistic Assessment:** District Nurses focused on wound healing but did not escalate concerns about weight loss or overall health decline. Adult Social Care appeared to place primary emphasis on the clinical components of the discharge process and did not give sufficient consideration to wider wellbeing factors as required under the Care Act 2014. In particular, limited attention was given to indicators of self-neglect, the suitability and safety of the home environment, and the sustainability of the informal care being provided by Adult G's husband. These non-clinical factors should have been fully assessed in accordance with the Care Act's wellbeing and prevention duties before determining that a Pathway 1 discharge was appropriate.

9.5 **Safeguarding Thresholds:** Agencies did not act on cumulative risk factors early enough. For example, missed opportunities from Hepatology and Dietetics services to consider and submit a safeguarding referral, and missed opportunity from ASC to consider from a safeguarding lens when ASC Reablement completed their assessment.

9.6 **Nutrition Support:** No proactive follow-up after Dietetics discharge despite ongoing malnutrition concerns.

9.7 **Consideration of Mental Capacity:** There is no evidence that a Mental Capacity Act Assessment was considered or carried out regarding decisions to decline substance misuse support, cancel the Age Well MDT, or refuse nutrition interventions (e.g., nasogastric tube). These were critical decisions impacting life and health.

10 Agency learning and what has changed since the incident

Local agencies provided assurance that they have implemented the following changes to policy and practice relevant to this case:

Northamptonshire Fire and Rescue Service have:

- Embedded the Self-neglect toolkit since it was thoroughly reviewed in 2023.
- Ensured the use of the Adult Risk Management toolkit when appropriate.

Northamptonshire Healthcare NHS Foundation Trust (NHFT):

- The creation of policies for hard to engage patients include:
    - Did Not Attend Policy for Adult Mental Health.
    - Was Not Brought, Did Not Attend, Disengagement (children and families).
    - Gender Identity Services Managing DNA.

- There is a robust patient engagement service and feedback system to improve care for the most vulnerable adults.
- Self-neglect and Adult Risk Management (ARM) processes are a key feature in training.
- ARM processes are measured and reported to the Trust wide safeguarding group.

Northamptonshire Police have:

- Reinforced the need to consider self-neglect as a specific vulnerability to all front-line officers and staff, this message was supported with the organisation wide publication of the bite-size NSAB Vlog for Self-neglect and other material.
- Promoted and enforced the use of professional curiosity within investigative and safeguarding process.
- Implemented structural change embedding a dedicated team within the police Multi Agency Safeguarding Hub team who are responsible for the assessment and onward sharing of Public Protection Notices (PPNs) completed by officers/staff. This function includes:
    - Performance scrutiny and additional missed risk, such as repeat incidents etc.
    - Administration and facilitating Adult Risk Management (ARM) process and actions.
- Implementation of the Adult Safeguarding Working Group in force. This is chaired by the head of PVP and to ensure Chief Officer strategic governance it will report into the force Vulnerability Board, chaired by Assistant Chief Constable Emma James. The meetings will have senior leader attendees from police and internal partners providing scrutiny and delivery at a force level. The meeting agenda will include:
    - Safeguarding Adult Reviews (SARs)
        - Individual action plan and thematic learning
        - National and local learning events
    - Mental Health
        - S136/S135
        - Suicide Prevention
    - Adult PPNs
        - Quality assurance / volume / efficiency
        - Adult Risk Management (ARM)
        - Individual case escalation / thematic review
        - Process performance and monitoring

North Northamptonshire Council Adult Social Care has:

- Undertaken a review of the Adult Risk Management (ARM) process internally and reinforced with colleagues the importance of undertaking multi-agency and / or ARM meetings.
- The Lead Principal Social Work was a key member of the team in place to review the ARM process across the partnership which resulted in the guidance and paperwork being revised. In conjunction with the revised guidance, they led on a number of re-launch briefing sessions in January 2025.
- Reviewed and refreshed the Non-engagement Protocol. The protocol was updated in July 2025. The ARM toolkit can be found here on the NSAB website.
- The NSAB Principles of Engagement resource was shared in staff bulletins and with staff teams. The information sheet can be found here on the NSAB website.

11. Local and Second National Safeguarding Adult Review Analysis 2024 – Self-neglect

11.1 In Northamptonshire, of the 34 SAR referrals received in the last two years (1st April 2023 – 31st March 2025), 21 (61%), referenced elements of self-neglect. This is in line with the findings in the national SAR analysis:

- 60% of the cases reviewed as part of the 2nd National SAR Analysis found self-neglect to be the highest abuse type. 46% of the SARs reviewed related to individuals with substance dependency, 13% featured homelessness and 72% of individuals were reported to have mental ill health.
- 72% of the SARs reviewed identified that inter-agency case co-ordination and working together remain the greatest challenge. The identification of risk/management of risk feature in 82% of the SARs reviewed, and in 56% of cases it was found that there was poor recognition of the abuse or neglect.
- Many of the SARs reviewed identified issues with how agencies failed to engage with individuals and how professionals failed to understand a person's history with a view to overcoming barriers. There was a failure to identify repeated patterns of engagement followed by disengagement, and a lack of professional curiosity to explore what might be happening 'beneath the surface.' There was also a focus upon what was presented rather than what was not. In terms of safeguarding and missed opportunities, the 2nd National SAR Analysis found that alcohol dependency, neglect of health care and self-harm were not recognised as forms of self-neglect that warranted a safeguarding referral.

12. Recommendations

The following recommendations are unique to this case:

All recommendations should be actioned and completed within six months of publication other than where stated. When considering the recommendations and the action needed to be taken, agencies should consider what metrics could be utilised to provide evidence of positive change. Metrics might include benchmarks and key performance indicators (KPIs), audit findings, additional training provided and the number of staff trained, number of team meetings where new policies and guidance have been shared including the number of staff. Case studies evidencing good working practices are always welcomed. This information would provide an additional level of assurance, not only for the agency, but for NSAB.

1. **Safeguarding:** No safeguarding referrals were made until two days before Adult G's death, despite clear indicators of self-neglect (considering cluttered home), malnutrition (considering Adult G weighed 4.25 stone), and vulnerability (alcohol dependence, Korsakoff's and associated impact on physical health). All agencies involved in this case should consider cumulative risk factors and escalate earlier when multiple indicators are present.

   Recommendation: All partner agencies must implement a structured framework for assessing and responding to cumulative risk in self-neglect cases, including escalation thresholds for safeguarding referral. Agencies must demonstrate improved practice through regular audit and NSAB should monitor for increased self-neglect referrals.

2. **Carer Support and Care Coordination:** Adult G's husband was experiencing significant difficulty in his caring role but was not offered a carer's assessment, despite expressing that he was struggling. In addition, Adult Social Care provided a care directory but did not confirm whether care arrangements were successfully established following discharge. Signposting alone is insufficient for households with complex needs or where self-neglect is a concern, and a lack of coordinated follow-up can result in gaps in essential support.

   Recommendation: All partner agencies must implement a coordinated approach to identifying and responding to carer distress and post-discharge risk, ensuring that carers who express difficulty coping are routinely offered or referred for a statutory carers assessment and that care arrangements are confirmed as established following discharge, particularly in high-risk cases such as self-neglect. Agencies must demonstrate that learning from this case has been applied through audit of carers assessments offered, evidence of follow-up being completed post-discharge, and formal assurance reporting to the Safeguarding Adults Board.

3. **Advocacy:** Adult G had cognitive impairment and substantial difficulty engaging with services, yet advocacy was not considered. Independent advocacy should be offered under the Care Act when individuals cannot participate fully in decision-making and may lack suitable support - considering we were aware that the husband also misused alcohol, therefore may not have been able to suitably support his wife.

   Recommendations:

   3a. Local Authorities must implement a coordinated approach to identifying and responding to individuals who are unable to effectively engage in assessment, care planning or decision-making, ensuring that independent advocacy is routinely considered and offered in line with Care Act duties, particularly where there is cognitive impairment, self-neglect, or concerns about the suitability of informal support. This should include mandatory prompts for practitioners on case management systems.

   3b. Local Authorities must demonstrate that learning from this case has been applied through audit of advocacy referrals, evidence of timely access to advocacy support, and formal assurance reporting to the Safeguarding Adults Board.

4. **Non-Engagement Escalation:** After Adult G cancelled the Age Well MDT and did not respond to calls, no home visit or escalation occurred. Where adults have difficulty accepting support and there are indications of risk, this should prompt proactive outreach, such as home visits, multi-agency review and/or contact with relevant agencies.

   Recommendation: All partner agencies must implement a coordinated approach to identifying and responding to non-engagement where there are indicators of risk, ensuring that cancelled appointments, repeated non-attendance or disengagement trigger proactive outreach, including home visits, multi-agency review and appropriate escalation. Agencies must demonstrate that learning from this case has been applied through audit of follow-up activity, evidence of timely escalation in high-risk cases, and formal assurance reporting to the Safeguarding Adults Board.

5. **Holistic Assessment**: District Nurses focused on wound care but did not escalate concerns about weight loss or overall health decline. ASC focussed on clinical elements for discharge. Discharge decisions should consider the whole person, not just the presenting issue as there were clear indications in the home that the couple were struggling. Adult G attended Hepatology appointment in KGH on 4th December, and no safeguarding referral was submitted, considering at this point Adult G would have likely to be showing signs of self-neglect.

   Recommendation: All partners must implement a coordinated approach to holistic assessment, ensuring that practitioners identify and respond to wider indicators of deterioration, including physical health decline, living conditions and self-neglect during their contact with people and that this information informs decision-making across care pathways. Where such indicators are present, this must trigger appropriate safeguarding consideration and escalation. Agencies must demonstrate that learning from this case has been applied through audit of holistic assessments, evidence of increased safeguarding referrals where cumulative risks are identified, and formal assurance reporting to the Safeguarding Adults Board.

6. **Nutrition Monitoring**: Dietetics discharged Adult G without ongoing monitoring despite persistent malnutrition concerns and Adult G's low body weight. Nutrition risk should remain under review until stability is achieved, particularly in high-risk cases such as those with Alcohol Related Liver Disease (ALRD)[3] seeing some of the symptoms include feeling sick, weight loss and loss of appetite. Where deterioration or persistent risk is identified, this must trigger appropriate escalation and safeguarding consideration.

   Recommendation: The Dietetics Team should evaluate and strengthen its existing processes to ensure a robust, effective, and standardised discharge pathway for all patients transitioning out of the team's care to ensure that there is a plan to meet nutrition needs post discharge.

[3] Symptoms of liver disease - British Liver Trust

7. **Mental Capacity Act assessments:** When an adult refuses care or support, professionals must consider whether they have the mental capacity to make that decision, especially if there are indicators of cognitive impairment (e.g., Korsakoff's syndrome) and self-neglect.

   Recommendation: All agencies involved in this review should ensure that mental capacity assessments are considered and recorded whenever a vulnerable adult refuses essential care or treatment (highlighted in SARs 019 and 022). (Note, multi-agency training was provided after publication of these SARs) and/or when planning hospital discharge. Assurance by way of an audit of 6 cases should be provided to NSAB within 6 months of the publication of the review.

QR Code and useful links to the NSAB website, policies, procedures, and guidance:

Adult Risk Management (ARM) Toolkit

Bite sized learning videos – Professional curiosity and self-neglect

Professional curiosity practitioner guide

Self-neglect guidance

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