‘Luke’

Safeguarding Adults Review: Final Report

Contents

Appendices

1 About this Review

1.1 The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of, or is thought to have suffered, abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.2 The purpose of the SAR is to promote effective learning and improve action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and the way agencies work together improved. It is **not** to re-investigate an incident, nor is it to apportion blame - other processes exist for such investigations including, where appropriate to the circumstances of a case, criminal proceedings and disciplinary procedures. However, that does not mean that a review should not highlight areas where practice was not as good as it could or should have been – in fact it is essential that this happens in order to effectively identify learning.

1.3 The methodology used for this review was our own Local Learning Review (LLR) process which has been developed based on work by the Wiltshire Safeguarding Adults Board. Each organisation involved in Luke's care in the approximately two-year period prior to his death submitted reports, documentation and records that were considered along with other relevant information at a desktop review meeting. Due to the circumstances of Luke's case the desktop review also considered his past history in order to provide context to some of the areas under consideration. The information considered included a Safeguarding Enquiry that had been undertaken under Section 42 of the Care Act (2014) that was completed after Luke's death, and an investigation report commissioned by NHS Somerset Clinical Commissioning Group (NHS Somerset CCG). The Board wishes to make clear that this investigation report found that both of his General Practitioner (GP) practices provided appropriate and timely advice to Luke on his health and that, over time, he made it clear to his GPs and to others that he did not wish to change his behaviour.

1.4 The desktop review was attended by the organisations[1,2] listed below, and chaired by the Independent Chair of the Somerset Safeguarding Adults Board who had had no prior involvement with Luke's case.

- Care Home A
- Care Provider A
- GP B
- Safeguarding Adults Team, NHS Somerset Clinical Commissioning Group
- District Nursing Team, Somerset Partnership NHS Foundation Trust
- Safeguarding Service, Somerset Partnership and Musgrove Park Hospital NHS Foundation Trusts
- Adult Safeguarding Service, Somerset County Council
- Tissue Viability nursing, Musgrove Park Hospital
- Acute Care Diabetes Specialist Podiatry, Yeovil Hospital NHS Foundation Trust (to provide specialist input on behalf of local podiatry services, however, Yeovil Hospital NHS Foundation Trust itself did not have any involvement in Luke's care)

1.5 Luke's allocated Social Worker (SW A), who was employed by Somerset County Council's Adult Social Care Service, during the time when he lived at Care Home A did not attended the desktop review. The SSAB Business Manager met with them before and after the meeting, and also had access to their case notes via Somerset County Council's (SCC or the Council) electronic case management system.

1.6 This report has been produced by the Business Manager for the Somerset Safeguarding Adults Board based on the documentation, desktop review and responses to questions that emerged from the desktop review meeting.

1.7 Luke's family were invited to be part of this process but declined to do so. This report has therefore been anonymised and information summarised unless directly relevant to the learning from the case. Months or seasons have been used rather than specific dates in order to try to preserve this anonymity, and where changes have been made to quotations these are shown in square brackets.

1.8 We encourage all those working with adults to read this report, and reflect on how they can challenge their own thinking and practice in order to protect adults in the best way possible.

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[1] On 01/04/2020 Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust (which operated Musgrove Park Hospital) merged to form the Somerset NHS Foundation Trust, however, the organisational names at the time of the events described within this report have been used.

2 Not all the professionals who attended the desktop review were involved in Luke's care and, where this was the case, their attendance was to provide specialist input to help identify learning.

2 About Luke

2.1 Luke (pseudonym) was 67 when he died. His ethnicity was White British, and he had spent the majority of his adult life living in or around a town in Somerset, latterly in a sheltered housing scheme from 2015, before moving to a care home with nursing (Care Home A) in July 2016.

2.2 Luke had a history of significant self-neglect, and it was his GP's and others concerns about the impact of his self-neglect on his health that prompted the move to Care Home A. It is unclear from the documentation how much involvement Luke had in this process, beyond a statement that Luke was "*in agreement with a short stay"* that was recorded by a member of staff employed by Somerset County Council's Adult Social Care (ASC) Service. This short stay was subsequently extended and was eventually made permanent.

2.3 Luke had suffered a lot of loss in his life which appears to have had a significant impact on him.

- He had been married twice. In the absence of family involvement little is known about his first marriage. His second wife left him for someone he knew in the 2000s and initiated divorce proceedings during the spring of 2017.
- He had two sons, one of whom passed away unexpectedly in 2016, shortly after he moved to Care Home A.
- Luke was also reported to have had a good relationship with his father who took his own life when he was a teenager.
- Luke had a difficult relationship with his family, and rarely saw them despite them also living in Somerset.
- He had a cat that he was very fond of which he had to give up when he moved to the sheltered housing scheme.

2.4 When Luke was living in his own home he was in receipt of benefits, and was described in documentation as struggling to manage his finances. In the latter years before he moved to Care Home A it was documented that Luke wouldn't pay bills unless he had support to do so.

2.5 Luke was described to be unaware of fire risks. For example, he was noted to throw cigarette butts onto the floor before he moved to Care Home A.

2.6 Luke was described as very isolated, of not leaving his home in the latter period when living alone and that he saw few people. Those that he did see were understood to be mainly professionals.

3 Concerns prior to moving to Care Home A

3.1 Luke had historically been known to neglect a number of areas of need, including his diet and fluid intake. In 2005 his Body Mass Index[3] (BMI) was recorded as 30. In 2009 his BMI was recorded as 25. He was reviewed by a dietician in June 2016 when his BMI was recorded at 17, and was prescribed nutritional supplements and discharged with a recommendation that another referral should be made if he needed further assistance. There was no record of a subsequent referral contained in the documentation considered by the desktop review.

3.2 Luke was diagnosed with agoraphobia[4] and panic attacks in the 1980s. A referral letter from his GP (GP A) to Somerset Partnership NHS Foundation Trust's Community Mental Health Team (CMHT) in 2005 stated that his "*agoraphobia used to be a lot worse 7 or 8 years ago*". Limited references are also made in documentation to Luke suffering from depression although, based on these references, he appears to have declined support around this. Luke had a long-term prescription for an antidepressant which ended in June 2016.

3.3 There were also concerns about Luke neglecting himself. The first record in the documentation reviewed was in November 2005 when raised with GP A by his son. Self-neglect[5] was then noted on several subsequent occasions by professionals from different agencies in 2013 (twice), 2014, and 2016 (four times). There was also a known history of Luke declining medical interventions from 2005 through to 2016.

3.4 Luke made self-referrals to ASC on four occasions. Twice in 2005 (once for an assessment regarding care and support and a second for an Occupational Therapy assessment), once in 2006 (Occupational Therapy) and once in 2007 (Occupational Therapy which he followed up with a second contact approximately 3 weeks later).

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[3] Body mass index is a value derived from the mass and height of a person. The BMI is defined as the body mass divided by the square of the body height, and is expressed in units of kg/m², resulting from mass in kilograms and height in metres. If an individual has a BMI below 18.5 then they are considered to be underweight. Source: https://www.nhs.uk/common-health-questions/lifestyle/what-is-the-body-mass-index-bmi/

[4] Agoraphobia is a fear of being in situations where escape might be difficult or that help wouldn't be available if things go wrong. Many people assume agoraphobia is a fear of open spaces, but it is actually a more complex condition.

[5] Self-neglect is one of the ten types of abuse and neglect defined by the Care Act (2014). The term "self-neglect" covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings. Examples of self-neglect include: A refusal or inability to cater for basic needs, including personal hygiene and appropriate clothing; Neglecting to seek assistance for medical issues; Not attending to living conditions – letting rubbish accumulate in the garden, or dirt to accumulate in the house; Hoarding items or animals. (Source: Ann Craft Trust)

3.5 Luke was diagnosed with Peripheral Vascular Disease[6] (PVD) in 2006. He was reviewed by a vascular surgeon and an operation was *"recommended but not offered because [he] continued to smoke"*[7]. He was offered smoking cessation support, but is not recorded as having given up smoking until after he moved to Care Home A. No re-referral was made.

3.6 Luke was diagnosed with Type 2 Diabetes in 2007[8]. His diabetes was managed with prescriptions and monitored via blood tests by GP A. However, there was a history of poor compliance with diabetic care in 2007 (twice), 2008 (three times), 2009 (twice), 2012 (three times), 2014 (three times) and 2015 (twice).

3.7 In May 2011 a referral was made to ASC by a neighbour regarding safeguarding concerns related to self-neglect. They described the state of Luke's house as "*absolute squalor*". A pattern of further concerns being raised with ASC followed; from neighbours, town councillors and his housing provider. Throughout this period the records show that ASC and his housing provider attempted to engage with Luke, however there are multiple references to Luke declining support and that he was able to make an *"informed choice"* throughout this period, which culminated in Luke moving to a sheltered housing property approximately a mile away in 2015.

3.8 During this period Luke was also admitted to hospital in 2014 following an accidental fall. The discharge summary notes that he was unkempt on admission and stated that he was struggling at home. He was discharged on the same day and a referral was made for him to receive support to maintain his independence

3.9 Care Provider A provided domiciliary care and support to Luke while he lived in the sheltered housing scheme. They described him as often struggling to accept support, and that involvement was minimal because of this, but that care staff had made lots of changes in an attempt to support Luke in a way that worked for him in order that he might be more accepting of it. Care Provider A described staff as struggling to support him because of how variable Luke could be in terms of the level of support he would accept even though staff were worried about him.

3.10 Referrals to ASC continued after Luke's move to sheltered housing. On one occasion staff employed by Care Prover A visited on a Monday and found that Luke had stayed in bed all weekend, and that both he and the bed were

[6] Peripheral vascular disease (PVD) is a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm. This can happen in both arteries or veins.
[7] Taken from the Investigation Report commissioned from NHS Somerset Clinical Commissioning Group
[8] Type 2 diabetes is a form of diabetes that is characterised by high blood sugar, insulin resistance, and relative lack of insulin. Diabetes can be a contributory factor to Peripheral vascular disease.

covered in faeces. Throughout this period concerns appear to have centred around self-neglect and Luke's neglect of his home rather than self-harm, although during desktop review it was noted that Luke's behaviour had included some actions such as faecal smearing.

3.11 In 2015 Luke was referred to Somerset Partnership NHS Foundation Trust's Community Podiatry Service which resulted in a referral being made to a toenail cutting service provided by a charity. Following their first visit they contacted Somerset County Council's contact centre about the state of Luke's feet which were described as "*caked in filth with thick dirt all over them and sore patches".* The Council's Safeguarding Service was involved, and his housing provider raised concerns about faeces being trodden into the carpet, recorded in documentation as possibly because Luke "*could not be bothered to walk to the bathroom*", putting his tenancy at risk. Whether an undiagnosed dementia was a potential underlying cause for Luke's behaviour was suggested at this time (see 3.13), but no further exploration appears to have been undertaken beyond this. He was described as being socially isolated and there were unsubstantiated allegations about Luke being subject to financial and material abuse by someone who had befriended him and was described as his only regular visitor other than care staff. An Enquiry was undertaken under Section 42 of the Care Act (2014) and it was concluded that money that had thought to be missing had been spent on cigarettes. Concerns were raised about his ability/capacity to make some decisions on at least two occasions during this period, although no reference is made in the documentation considered by the desktop review to an assessment of Luke's capacity being undertaken.

3.12 A further Enquiry under Section 42 of the Care Act (2014) in January 2016 concluded that, as a result of adaptations to his care package and Luke being more accepting of contact from carers, support workers and a new housing manager, Luke *"is not presently self-neglecting"*.

3.13 Luke was reviewed by Somerset Partnership NHS Foundation Trust's Mental Health Nursing Service in March in 2016 when he was diagnosed with a mild cognitive impairment and discharged with the advice to rerefer once problems he was having with his vision (it was later recorded that Luke had bilateral cataracts in June 2016) and concerns about his non-compliance with medication had been resolved.

The notes of the appointment state:

- Luke uses a taxi firm and has the same driver each time. He considers him as a friend and said he takes advice from him on what he should and shouldn't be doing, including what medication he should be taking
- Luke had not been taking most of his medication as he didn't want to be dependent on tablets like his father was

- Luke cooks his own meals however he says he doesn't cook much as he prefers easy snack foods like pasties and sausage rolls
- He stated that if Doctors "*say I need more medication then I won't take it*"
- "*Poor vision and non-compliance with medication [are] contributing to presentation and [Luke] should be reassessed once these have been addressed*"

3.14 This rereferral did not happen and there was no follow-up, meaning that a thorough cognitive assessment was not completed.

3.15 Luke was admitted to Musgrove Park Hospital in April 2016 due to vomiting and self-neglect, and was discharged home the next day. At this point Luke was described as very frail and weak due to problems with his kidneys that were considered to be likely to be linked to his fluid intake. Luke was also described as not eating properly or taking medication for several weeks. A discharge summary was received by GP A a week later which states *"intermittent vomiting, poor appetite and refusing personal care no history from patient (AMT[9] 4/10) felt better the next day, signs of self-neglect, wasted leg muscles (uses mobility scooter) patient declined physio input, reviewed by OT[10] and patient felt was coping at home and declined input, medications have been reviewed, physical ability and cognitive function not applicable"*.

3.16 The investigation report commissioned by NHS Somerset CCG states that there *"is no record of capacity assessment [being undertaken as part of the discharge process] and no record of communication with GP prior to the discharge summary being received 7 days following discharge"*. There is no record of ASC being involved in the discharge. Contact was, however, made with ASC the following day by a support worker expressing concerns. This was closed with no further action. Four days later a concern was raised with ASC as Luke did not have any money to buy food (this was resolved) and his mobility. An Occupational Therapist (OT) employed by ASC visited, their notes describing Luke as being in poor health and arrangements were made for a GP *"to visit [Luke] and advise that wither for admission to MPH[11] or for emergency respite in a nursing home - this would go through primary link[12]"*

3.17 Luke was admitted to Musgrove Park Hospital the day after the discharge summary was received by GP A with "*self-neglect, cognitive impairment,*

[9] The Abbreviated Mental Test (AMT) is used to rapidly assess elderly patients for the possibility of dementia. A score of 6 or less suggests delirium or dementia, although further tests are necessary to make a diagnosis.

[10] Occupational Therapist

11 Musgrove Park Hospital

[12] This is a local process where someone who has health needs, but does not require an admission to hospital, has a temporary placement arranged through Somerset County Council's Adult Social Care service

recurrent UTIs and bilateral cataracts. Patient with prolonged admission due to general decline and social issues. Has evidence of cognitive impairment and poor motivation". Records also indicate that he required hoisting from his bed to a chair and *"requires assistance with all activities of daily living. [he] will be going home with doubled up QDS*[13] *POC*[14]*. Information given to patient nil. Patient has cognitive impairment however deemed to have capacity by SW*[15] *team. [His] wish is to return home. AMT 3/10"*. While an inpatient Luke was also referred to Somerset Partnership NHS Foundation Trust's Mental Health Team. They attempted to complete a cognitive assessment but concluded after two questions that Luke didn't feel up to it, but their notes state that a scan showed "*excessive small vessel disease*". The mental health nurse described Luke a sad man who had talked about the difficulty in having to give up his cat, the problems he had had with his family and the fact that no-one wanted him as he was 'old' (Luke was 65 at this point). Luke was aware of his memory problems, was disorientated to time and got his birth year wrong.

3.18 The Council's records show that ASC staff visited Luke in hospital and were of the understanding that he would be initially be discharged to a community hospital, where they would visit him again to look at the support he would need on return home.

3.19 In mid-May the Council's records state that Luke was not able to go to a community hospital as he was *"not engaging at all with physio[therapy] or care"*.

3.20 During this admission an assessment of Luke's capacity by ASC staff determined that he had *"capacity in regards to returning home and this is what [Luke] would like to do".* However, no documented assessment of Luke's capacity has been identified beyond this statement.

3.21 In mid-June Luke remained in hospital. The Council's Hospital Interface Service were visiting him, and an OT had visited the sheltered housing scheme as part of planning for his return home. Luke was discharged from hospital at the end of June, with an increased care package in place from Care Provider A and a mobile hoist and sling that the Council's records state was prescribed by an OT employed by Musgrove Park Hospital.

3.22 The day after he was discharged from hospital the Council's records state:

- *"carers are unable to use the hoist provided as slings are wrong size (provided by Hospital OT)".* An OT employed by the Council attempted to source the right size slings the following day, but was unable to do so as their supplier did not have any in stock.

[13] Four times a day
[14] Package of Care
[15] Social Work

- Luke *"had little food in - we went to [Supermarket name] to buy some basic provisions"*. A further food voucher was provided by the Council two days later.
- Luke *"is not comfortable at home and it will be difficult for all [his] needs to be met in a timely way - therefore recommend a two week respite stay in a general nursing home to allow further recovery and all aids to be delivered at home (hoist, chair, wheelchair etc)".*
- Luke *"is in agreement with a short stay".*
- Luke gave no indication that he *"lacks the mental capacity to make the decision to receive respite and therefore capacity is assumed. [Luke] was able to weigh up the information and recall the information later during the visit. DN [District Nurse] will need to assess. It is unsure as to whether [Luke] has pressure sores".* The District Nurse was recorded as being due to visit two days later.

3.23 Two days later a Community Nurse from GP A's practice visited and contacted the Council. The Council's records state that they said that Luke was *"not very safe at the property and felt it was not appropriate- [they] did not fill in a DN [District Nurse] assessment as not a DN [District Nurse] but feels [Luke] needs some respite in a nursing home. [They] explained that [they] spoke to a GP at the surgery about primary link or getting [Luke] back into hospital as [he/she] doesn't think [Luke] should have come home, but the GP has advised they wouldn't do this. [They] did say [GP A] who knows [Luke] is off today but feels [he/she] may agree to Primary link otherwise [they] will get the DN [District Nurse] out asap [As Soon As Possible]".*

3.24 Arrangements were made for a two-week respite placement for Luke at Care Home A the following day through Primary Link. The admission was arranged urgently by ASC following a request from GP A as he was considered to be no longer managing at home and at risk of harm. Documentation states that Luke had acutely deteriorated within four days from hospital discharge and was unsafe to live at home.

4 Concerns after moving to Care Home A

4.1 Luke registered with GP B after moving from the sheltered housing scheme to Care Home A in July 2016. This was initially on a temporary basis which was subsequently extended on a number of occasions before being made permanent.

4.2 An assessment completed by ASC prior to the admission stated that he "*had been struggling with managing at home, and although had care support in place, [Luke] often refused support and was not eating properly which in turn made [Luke] very poorly*".

4.3 Luke's history of self-neglect was not referenced beyond this, and this document was subsequently used as the basis of further assessments that

appended further information to it. Although these included statements such as a *"substantial history of self-neglect and hospital admission"* there is little detail of Luke's behaviours contained within these documents.

4.4 GP B met Luke the day after admission to Care Home A with the Manager of the home. They noted during the desktop review that, at the time, there were concerns from Care Home A over whether he wanted to be there with documentation also stating *"Clear evidence of severe cognitive impairment - Is not fit to leave the nursing home at the moment*". However, GP B noted that Luke seemed happy and chatty and wasn't verbalising a wish to leave or attempting to do so. They arranged for blood tests and these came back as normal.

4.5 When Luke moved to Care Home A he weighed 47.3kg with a BMI of 19[16] Over the next 18 months he continued to lose weight and was admitted to Musgrove Park Hospital in December 2017 weighing 30.8kg with a BMI of 11[17]. Concerns about the accuracy of information about Luke's weight were raised and considered during the desktop review process as, for example, the record provided by NHS Somerset CCG dated February 2017 stated that Luke's BMI on admission was 14. However, in the case of this example, cross refencing with Care Home A's records indicates that this was Luke's BMI as at when the information was provided in February 2017 rather than on admission.

4.6 No dietitian referrals were made by GP B. During the desktop review process GP B explained that this was because Luke was getting appropriate food at Care Home A, and it was therefore more that he was not eating. They described that at the time the question for them was what a dietician would add as, when they talked to him about his eating Luke would increase his intake for a short period, then slip back to eating little or nothing.

4.7 Seven days after moving to Care Home A Luke's case was allocated to SW A who was employed by the Council's ASC Service. This was a Thursday and they arranged to visit him the following Tuesday. The member of ASC staff that had been previously allocated Luke's case was on holiday and SW A was unable to speak to them at the time, and although they did subsequently, it is unclear from the documentation provided by the Council how much information regarding Luke's history of self-neglect, and the behaviours that he exhibited, was shared with Care Home A beyond brief summaries in assessments.

4.8 Twelve days after Luke moved to Care Home A he was visited by SW A whose notes state Luke told them he could walk unaided when he actually required hoisting, and that Luke had no understanding of his current

[16] Care Home A's records on admission

[17] A BMI of 11 is considered to be dangerously low.

situation, where he was or why he was there. Luke refused to believe he was currently at Care Home A, though acknowledged he had heard of it. SW A's notes also state that that he told them that he wanted to be at Care Home A, and that they did not receive any information contrary to this from Care Home A's staff at the time of their visit. However, they noted his reported behaviours which raised concerns to them that he may be objecting to the placement, and that Care Home A did not feel that it could meet his needs in the long term. During their visit Luke made two disclosures. The first related to alleged financial and material abuse by his son which they attempted to explore with him (Luke told them that he did not want the police to be involved). The second related to an allegation of historical child on child sexual touching that Luke had said he had witnessed, which Social Worker A sought advice from their line manager regarding, and recorded that *"due to [Luke's] levels of mental capacity and confusion, referral to CSC[18] is not required".* A further case note two days later stated that Luke continued to be very confused and muddled, and that he had told GP B that he had been living at Care Home A since October and they were keeping him in the garage, but that he was happy to stay there despite this. The note also states that Luke had been *"very reactive towards carers during interactions such as personal care and has been 'hitting them away.'"*

4.9 Fourteen days after Luke moved to Care Home A SCC's Deprivation of Liberty Safeguards (DoLS) Team received an urgent application. An Independent Mental Capacity Advocate (IMCA) visited the following day. SW A's notes state that Luke was able to *"clearly"* tell them that he wanted to stay at Care Home A. Luke was recorded as being able to say how much care he needed and how he felt but also that he had said *"I don't know one thing from another, I don't know if I'm clean or dirty, I need help with all that now"*. The notes also state that in their report received 18 days after Luke moved to Care Home A the IMCA advised that Luke had made his views known to the best of his ability and in conjunction with the information regarding his care needs. They identified that Luke would now benefit from a permanent nursing home placement and suggested that it would be in his best interests to remain at Care Home A if possible.

4.10 SW A stated that, at the time, they did not assess Luke's capacity as a DoLS referral was in progress, and that this would include an assessment of his capacity. This was allocated to a Best Interests Assessor at the end of July 2016.

4.11 Eighteen days after Luke moved to Care Home A SW A's notes state that he was "*more settled and appears more used to care staff though will still scream a bit during personal care interventions but this is infrequent*".

[18] Somerset County Council's Children's Social Care Service

4.12 Shortly after Luke moved to Care Home A contact was made with ASC to say that Luke's son had died and asked for this to be passed on to him.

4.13 At the beginning of August 2016 SW A visited with a member of staff from Somerset Partnership NHS Foundation Trust's Older Persons Mental Health Nursing Team. They subsequently contacted the Best Interest Assessor stating that they didn't think he was able to recall fully where he was, or why he was there, but stated that he was *"adamant"* that he liked it at Care Home A and that he wouldn't want to be anywhere else. Luke was also recorded as talking about his son who had died without this being mentioned to him and the staff report that he was *"at times very tearful about this which is obviously to be expected"*. They go on to say that Luke *"actually appeared much more 'lucid' on the last couple of occasions I have visited"* than on the first day they met him noting that that it may be due to him being more settled, and that they understood from the member of staff that had worked with him when he was living in sheltered housing that he did seem to fluctuate in terms of his understanding quite significantly. They also state that the manager of Care Home A had told them that he had settled in the last week or so and *"appears to be more accepting of help and support too"* and that in their view (that of SW A) it was in his best interests to remain there. Their notes state that they spoke to Luke about the fact he seemed to be remaining in his room all the time and that he had said that he "*hasn't felt up to coming out, what with everything that's happened with [his Son]"* and suggested to him *"that to begin to make friends in some of the other residents at the home, should [he] wish to do this, it might be good to attend some of the activities which [Luke] agreed"*.

4.14 Luke was discharged from the Older Persons Mental Health Nursing Team following this visit, with the chronology received from Somerset Partnership NHS Foundation Trust stating "*Happy in placement, discharge*"

4.15 Two days after the visit an email was received from a District Nurse employed by Somerset Partnership NHS Foundation Trust, who had been asked to assess Luke for funding for the nursing care element of his care package, stating that they would be unable to visit until they returned from holiday in September.

4.16 GP B prescribed dietary supplements in August 2016 following a recommendation from a dietician. However, records indicate that Care Home A continued to experience difficulty in managing Luke's nutritional intake and weight.

4.17 At the end of September 2016, it was recorded that it had been agreed to extend Luke's placement at Care Home A for a further 4 weeks and also to make a referral to the Court of Protection for a decision by the Court regarding how Luke's care and support needs should be met as his capacity

appeared to fluctuate and his wishes were unclear. Luke's case remained open with SW A pending a decision by the Court. Social Worker A stated as part of the desktop review process that, had this not been the case, their involvement would have been closed at this point and Luke's case reallocated at Review or on further contact if required.

4.18 Best Interests and Mental Capacity assessments undertaken as part of the DoLS process in early October 2016 stated that Luke had regained capacity regarding care and accommodation and SW A agreed with this. The Councils records indicate that these assessments had been delayed due to Luke's level of distress following the death of his son, which was an appropriate approach in line with Mental Capacity Act (2005) guidance. It was noted in the documentation reviewed that Luke's capacity seemed to fluctuate initially after he moved, but that at the time he was also dealing with the sudden, unexpected, death of his son. It was also felt that Luke had regained capacity due to receiving the appropriate level of care in terms of nutrition, fluid and nursing. For the remainder of 2016 the Council's records indicate that contacts primarily related to the funding arrangements for Luke's placement at Care Home A, with SW A continuing to follow up on the visit from a District Nurse which was yet to take place. It was also noted that the application to the Court of Protection was no longer appropriate as Luke had regained capacity to make the decision himself. No concerns were documented about Luke's health or the quality of the care and support he was receiving at Care Home A.

4.19 At the end of September 2016 SW A completed a Mental Capacity assessment around Luke's ability to manage his own finances. The outcome of this assessment was that it was determined that Luke was unable to weigh up, or communicate, decisions relating to his affairs and that there was no one appropriate, or whom Luke felt 'safe' to support him in managing his money. It concluded that a Court of Protection Deputyship was therefore required for the Council to act on Luke's behalf. This assessment was subsequently updated in mid-February 2017.

4.20 In late October SW A stated in a case note that they had sought and received legal advice in relation to his tenancy at the sheltered housing scheme, as a result of Luke being assessed as not having capacity in relation to making decisions with regard to his financial affairs.

4.21 In mid-December 2016 Care Home A contacted GP B as Luke had a leg ulcer. This was subsequently dressed, swabs were taken, an infection was identified, and Luke was prescribed two courses of antibiotics. Around this time a Pharmacist reviewed Luke's supplements, and changed the prescription to a lower volume of fluid as it was reported by Care Home A that Luke was struggling with this and had been refusing fluids.

4.22 GP B visited Luke in early January 2017 and did not record any concerns at this time.

4.23 In early January 2017 a referral was made by the Care Quality Commission (CQC) to SCC's Adult Safeguarding Service after a member of Luke's family reported concerns to CQC following a visit in December 2016. The concerns centred around Luke's physical care and appearance and that he was not wearing a bandage on his leg, leaving a blistered area uncovered, red and hot. The family member also felt that the Manager was dismissive of Luke's needs and had not intervened in an incident involving another resident and a non-resident that they had observed.

An Enquiry was undertaken under Section 42 of the Care Act (2014) by SW A, which included a visit to Care Home A to meet with Luke, concluded at the end of January 2017 having been unable to substantiate the allegations stating:

"*There are conflicting reports from the [family member] and Care Home regarding the events that took place [in December], in terms of the contents of the discussion held. In my opinion, it appears as though there could have been some miss-communication and lack of understanding from both parties."*

They further stated that:

- Care Home A had been unaware of the incident they observed and were taking appropriate action;
- There was evidence that Luke's care plan was appropriate;
- That Luke's GP had been informed, swabs taken and strategies considered to prevent this from becoming infected and proportionate to his care needs, and;
- Luke's leg wound had now healed.

SW A concluded that "*I could not identify any concerns in the delivery of care from the information I was provided. I will complete review notes which will be distributed to the home for their reference. The home will continue to monitor [Luke's] skin*" and would also encourage him to have his to have nails cut as SW A felt that this would reduce the risks of further sores developing from him scratching and causing open wounds.

They also stated "*The review completed will be sent to the District Nurse, who was unable to attend this meeting for input. They will need to make a separate appointment to visit [Luke] and input to the review. [Luke] will then be 'care managed' on an ongoing basis by the District Nurses. I will need to remain involved with [Luke] whilst an application to the Client Finances Team is pursued*".

A letter confirming the outcome of the Enquiry was subsequently sent to Care Home A that included the statement "*On a long-term basis [Luke] will be care managed by the District Nurse Team, who will complete annual reviews*".

Between the end of January and the end of May 2017 the Council's records indicate that contacts primarily related to communicating the outcomes of the enquiry, Luke's tenancy and the ongoing application to the Court of Protection for a Deputyship to manage his finances, along with the funding arrangements for his placement at Care Home A.

4.24 The chronology provided by Somerset Partnership NHS Foundation Trust does not include any visits from, or contact with, the District Nursing Team during this period.

4.25 In January 2017 GP B recorded Luke as "*Unwell, feverish, chesty and breathless Eaten nothing today, drinking fairly well. Eats little anyway, won't take more than a sip or two of supplements.*". Oral antibiotics were prescribed, and it was stated that the Care Home Manager was going to contact his family about whether he should be admitted to hospital if he did not respond to treatment.

4.26 In early February 2017 a telephone assessment took place between NHS Somerset CCG and the Manager of Care Home A for the purposes identifying Luke's eligibility for funded nursing care. The notes state: "*Telephone assessment, nursing needs identified but borderline – assessment review required as improving since nursing home admission via P.link*[19]". With regard to Luke's capacity the notes state "*Has capacity, can make all level of decisions, even poor ones*" and conclude with a summary of needs a recommendation of "*Personal care, hoist 2 people, nutrition, monitoring diabetes, skin, and general well-being*".

4.27 In mid-March GP B recorded that Luke was "*Hardly eating - BMI 14*[20]*. Put on 1.2kg last week when staff brought [him] down to dining room for meals*" but that he preferred to be in his room "*only picks at food then, won't let anyone help with feeding. Bottom is getting red and sore, so not good to spend too long in chair, however. Catch 22*". Adding that Luke appeared to be able to take in and consider information to some extent, but was very dismissive of concerns about his weight and sore bottom. GP B didn't think Luke believed they were linked, nor did they think he understood the severity of the nutritional compromises he was making. However, they recorded that Luke was able to weigh it up and communicate his decision. During the Desktop Review GP B described that they had explained to Luke that they

[19] Primary Link

[20] If an individual has a BMI below 18.5 then they are considered to be underweight. Source: https://www.nhs.uk/common-health-questions/lifestyle/what-is-the-body-mass-index-bmi/

thought that better nutrition would help his sore areas and general condition, but it was unclear to them as to whether he would act on the advice.

4.28 Luke's preference was to eat in his room and Care Home A relied on GP B's capacity assessments rather undertaking their own, for example with regard to a best interests decision as to whether Luke should continue to eat in the dining room. No best interests decision was taken by Care home A and Luke therefore returned to eating in his room and his weight began to decrease again.

4.29 An ulcer was recorded on Luke's foot in Care Home A's records at the beginning of April 2017. A paramedic based at Luke's GP Surgery wished to make an urgent referral to podiatry, but it was recorded that Luke refused to consent to this. It was first recorded in GP B's notes at the end of April 2017 their records stating:

"*Started as black spot on foot, now has a hole. Diabetic, so needs review - for visit tomorrow ? urgent diabetic foot clinic referral. Described as mucky rather than obviously infected, consider when seen if needs antibiotics. Note patient generally lacks capacity, treat on best interests basis*".

4.30 GP B next saw Luke in May 2017, there were again concerns about nutrition and his BMI was 14. Bloods were tested and there were no additional concerns identified from these. His Diabetes was stated as controlled. Another GP at the practice also saw Luke in May. Following these visits Care Home A contacted SW A with their notes stating "*The GP discussed DoLS and could not understand why [Luke] is not subject to a DoLS authorisation*" to which SW A responded "*I advised yes, I did think it was a good idea to re-apply because despite the authorisation previously completed suggesting [Luke] did have capacity, I do not think that [Luke] now does. However, I have not formally assessed other than for finances*".

4.31 Luke was referred to the Community Podiatry Service operated by Somerset Partnership NHS Foundation Trust in early May 2017 for a wound measuring 0.8cm x 0.8cm to the lateral[21] aspect of his foot. He was seen by a podiatrist who deemed a simple dressing plan appropriate at the time. This plan was provided to Care Home A. In line with the Somerset Diabetes Foot Integrated Pathway, Care Home A was also advised to refer back to the Community Podiatry Service if there was a deterioration to the wound or further concerns.

4.32 The report produced by the Acute Care Diabetes Specialist Podiatrist considered by the desktop review stated that it was advised by Care Home A "*that patient would pick and remove dressings indicating care compliance*

[21] The upper, outer surface

was no[t] consistent. It was also noted that podiatrist was unable to carry out neurovasc [neurovascular] checks as patient was agitated".

4.33 There was no further contact made with the Community Podiatry Service by Luke or Care Home A on his behalf, so a discharge letter was sent to GP B in mid-November 2017. However, the letter did not inform GP B that there had not been any further contact with the Community Podiatry Service.

4.34 During the spring of 2017 Luke's wife initiated divorce proceedings. SW A visited Luke four days later. The record of their visit indicates that Luke understood what a divorce was but that he could not tell them where he was living, and appeared to no longer be aware that his son had died in 2016. This suggests that his cognitive abilities may have declined, but no further assessment of his capacity appears to have been undertaken. SW A made a referral for an advocate to support him with regard to the divorce, which was declined by the Council's contracted advocacy provider as they did not feel that divorce proceedings were something they had expertise to advise on.

4.35 At the end of June 2017 another GP (GP C) at Luke's GP's surgery attempted to make contact with SW A regarding Luke's capacity and DoLS, referencing his ongoing low weight and weight loss and a planned trial of laxatives to identify whether his lack of appetite could be linked to constipation (Luke's low weight remained on-going after this date). SW A's records indicate that they attempted to respond unsuccessfully on two occasions. GP C attempted to contact them again, unsuccessfully, and wrote to SW A in mid-July which SW A responded to on the same day by email. In their email they explained why a DoLS had not been authorised and that, when they had visited Luke four days earlier, Care Home A had raised this with them to which they "*suggested that the home did apply for an urgent re-authorisation*" adding "*I have not checked with the home again whether this has been done, but I will speak to them about this*", which they documented that they did the same day. However, the documentation considered by the desktop review did not contain any reference to a referral being made.

4.36 SW A did not visit Luke again after their visit in July until mid-October, when they did so with the member of staff who was an Advanced Practitioner to discuss the divorce petition. During this period the Council's records do not indicate that any concerns were raised by Care Home A about Luke's health or care.

4.37 In early August 2017 GP B's records refer to a "*worsening necrotic[22]/diabetic foot ulcer worsening over months*". They visited two days later recording that Luke had "*improved since visit arranged, - dorsum[23] of foot was dusky[24].*

[22] Dead tissue

[23] The upper, outer surface

[24] Dark in colour

Now back to ulcer about 3 x 1.5cm on lateral aspect of (L) foot on lateral aspect. Clean and slightly overgranulated[25]*. Feet are nice and warm but pulses not palpable and no sensation in them. In bed, communicative, not distressed, very thin and frail*".

4.38 By the end of August 2017 Luke had developed a necrotic area to the top/ bridge of his left foot. By early October 2017 wounds to this area were again referenced but it is unclear from the documentation whether they were the same as those in August, and Luke had developed a sore to his left heel. Documentation states that Care Home A arranged for a chiropodist to visit but did not make contact with Somerset Partnership NHS Foundation Trust's Community Podiatry Service.

4.39 While there was, overall, a lack of documentation from Care Home A regarding the monitoring of Luke's wound care, for example a formal wound care assessment was not being used, documentation considered by the desktop review stated that Luke was self-harming and was picking at and rubbing faeces in to his wounds. However, Care Home A's concerns about behaviours that they described during the desktop review as including active acts of self-harm do not appear to have been shared with other professionals and organisations involved in his care. It was also not possible to determine from documentation considered by the desktop review that these concerns had been discussed with Luke.

4.40 During the desktop review it was explained by the Tissue Viability Nurse from Musgrove Park Hospital who was present that, in circumstances such as Luke's, the bandaging would normally be toe to knee, with sealing bandage tape at the posterior and the use of coverings such as tights, trousers and cotton gloves in order to manage risks. However, reports state that Luke's bandaging was not applied in this way, therefore increasing the risk of poor outcomes. During the desktop review Care Home A stated in response that, while this type of bandaging may work where the risk relates to accidental interference with a wound, they believed it would be less effective when the interference was deliberate.

4.41 At the beginning of October SW A met Luke with a colleague who was an Advanced Practitioner to discuss the divorce petition. They undertook a capacity assessment which determined that Luke had capacity in relation to this matter at that point in time. However, they stated that Luke's capacity and understanding of his *"present situation and even of the past can be described as fluctuating and is not always consistent*". They also noted that Luke could not remember that he lived at Care Home A and had told them that he had an ulcer on his foot "*and had pulled the bandage off because it*

[25] Granulation is the medical term for the part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries forms around the edges of a wound.

was itching". The Manager of Care Home A "*confirmed that this happened yesterday*", and that Luke had one ulcer that healed and now has another ulcer on his leg which needed daily dressing. No further discussion appears to have taken place regarding these ulcers, with SW A appearing to have been reassured by statements made by the Manager of Care Home A. The Council's records do not include any reference to further contact from Care Home A regarding Luke's health until mid-December (4.51), with those contacts that did take place either relating to the divorce proceedings or financial matters.

4.42 The day after SW A's visit GP B met with the Manger of Care Home A at the surgery for a medication review during which they discussed Luke's ulcers. There notes state:

"One ulcer better, but has one on dorsum of foot. Granulating. Examination O/E - weight 36.5 kg • Body mass index 14 kg/m2 Malnutrition universal screening tool 3 Eats well."

A report by Care Home A provided as part of the Enquiry under Section 42 of the Care Act (2014) that concluded after Luke's death states:

Medication R/V[26] with [GP B] – discussed weight, BMI – 16, continue to feed as desired and supplements. Discussed pressure ulcer to bridge of foot, ligaments on view, area granulating and healthy – will refer to Diabetic clinic for health and foot check.

However, there is a refence later in the same report that Luke had developed an ulcer to the bridge of his *"foot and a necrotic area to the left heel in October"* and that this was discussed with GP B during the same visit and that a referral would be made to the foot ulcer clinic.

A further report from Care Home A regarding the same visit states *"Wound to the top of foot with ligaments on view but granulating with a good blood supply. Refer to diabetes clinic for health and foot check".*

A review of Luke's case by the Acute Care Diabetes Specialist Podiatrist present at the desktop review states that, had ligaments been on view as stated in the subsequent report by Care Home A, *"Given the patient is diabetic and has PVD, signs of infection are masked and should be over treated rather than undertreated as infection can be more severe then visually indicated. According to the Diabetic foot infection gradient PEDIS[27], patient with known PVD and ligaments/tendons/bone of view should be admitted [to hospital] for IV[28] antibiotics".* They also noted that it was

[26] Review

[27] PEDIS is a classification used for lesions in patients with diabetic foot syndrome.

[28] Intravenous

possible that his lack of appetite and poor mental awareness could partly be because he felt so unwell and were signs of systemic symptoms.

GP B confirmed during the desktop review and in a report considered as part of the review process that:

The tendons (not ligaments) were visible in December when Luke was admitted to hospital *"but not in October. The ulcers were being well dressed and cared for by the nursing home and there was no indication to arrange a podiatry referral. There was no evidence of systemic infection, so I do not think that [Luke's] poor appetite and poor mental awareness, which were longstanding, were caused by infection. In addition, there was no clinical evidence of wound infection and so it was not appropriate to give antibiotics - avoiding inappropriate treatment which could lead to antibiotic resistance is particularly important in frail patients with co-morbidities".*

The Enquiry undertaken under Section 42 of the Care Act (2014) that concluded after Luke's death states, in relation to this review, that *"that the review did not take place face to face with [Luke], but over the phone with [the Manager] or [the Manager] visiting the surgery [Care Home A's notes state '@ surgery']. What information was actually shared with [GP B] at this point as both note different records about the condition of the foot? It would appear that [GP B] was not made aware of the tendons being on view at this point and if [they] had been, a different course of treatment may have been given. It seems as though [GP B] did not have sight of [Luke's] foot until December 2017 [their next visit was actually the end of November - see 4.48] as this is when [he/she] states the tendons were on view*".

The significant differences in these statements was characteristic of issues in recording observed during the desktop review process with different records from different professionals describing things very differently, for example the state of Luke's wound, contradictory information regarding the wounds, systemic infection referenced in one document, but not in others. This was also exacerbated by a lack of consistent recording of wound monitoring by Care Home A, which explained that during the period under consideration staff may not have always recorded when a check had been made. For example, Luke's care plan stated that there should be an inspection of the wound every 3-5 days, but when reviewed Luke's records contained large gaps in the entries of up to 10 days. A statement from the Manager to professionals during the Enquiry under Section 42 of the Care Act (2014) that concluded after Luke's death that staff did daily skin checks was not evidenced in written notes.

4.43 One day later the wound was noted by Care Home A to be granulating well and looking cleaner

4.44 Two days later Care Home A's notes state that Luke was found to have removed his dressing and the wound was bleeding; it was suspected that he had been scratching it.

4.45 A reference in a care plan dated 4 days later states *"wound to the bridge of left foot with exposed tendon"* with the following actions:

- *Wound will be washed in warm water or saline.*
- *Will apply inadine[29] and foam dressing to the wound.*
- *Redress in 3-5 days or sooner if required.*
- *Will report to the GP if things worsen.*

4.46 A further 3 days later the wound was described in a care plan as "*malodorous with green/ yellow exudate[30]*" but it was not until this point that it was discussed by telephone with GP B whose notes state "*Ulcer very offensive, but is healing*". Swabs were taken and Luke was prescribed antibiotics. These were changed 5 days later following the results from the swabs.

4.47 An out of hours paramedic visited Luke at the end of October 2017 following him removing the dressing to his foot and picking at his heel wound causing it to bleed heavily. A report provided by South Western Ambulance Service Foundation Trust, states:

He [Luke] *'has a 6cm x 4cm open wound to the lower tibial area of the left leg / upper foot, tendon clearly visible with necrotic tissue surrounding wound. Also a 4cm circular hole in heel, also necrotic'*

The paramedics agreed with home staff that this would be followed up with District Nurses employed by Somerset Partnership NHS Foundation Trust the following day, but this did not happen, and it was the home's own nurse who did so. GP B was not informed about this incident as Care Home A incorrectly assumed that it would happen automatically, with GP B explaining that a visit by South Western Ambulance Service Foundation Trust would normally only be shared with the GP surgery if the patient was conveyed to hospital or follow up was required by them.

4.48 At the end of November GP B's notes state:

Ulcer on dorsum of ankle is very shallow and looks clean, the one on the back of [his] heel is less good.

GP B also noted that Luke only complained of pain during dressing or as soon as it is mentioned, but rarely accepted pain relief medication and was absolutely insistent he would not go to hospital. They further noted that they would attempt to visit again to assess his capacity as Luke was very

[29] Inadine is a brand of non-adherent surgical dressing containing a disinfectant

[30] An exudate is any fluid that filters from the circulatory system into lesions or areas of inflammation. It can be a pus-like or clear fluid

distressed because the ulcer was open, and his wife had asked for a divorce and he had no one to represent him.

4.49 Five days later GP B visited Luke again. Their notes state that the purpose of the visit was to:

1. To make decisions about hospital admission if his leg ulcers were to deteriorate
2. To assess his understanding of his wife's request for a divorce stating "*social worker has been asked to assess but not able to do so, and is looking into other sources of advice*"[31].

   The notes state *"Discussed leg ulcers, understands that they are stable at present but could become 'dangerous'* [it is stated that this is the specific word that Luke used] *in the future. Advised that if this were the case, I would recommend referral to a specialist".* The notes go on to state that he said that he would agree to this as long as someone from the home went with him and that *"I felt that [Luke] currently has capacity to make this decision"* and while he knew that his wife wanted a divorce he didn't know why as neither of them owned property or had significant financial reserves. The notes conclude that there was *"No evidence of lack of capacity today",* but that it would be advisable for him to have legal advice about the implications before making any decisions about his wife's request for a divorce. The final comment was that the care home manager noted, and GP B agreed, that Luke was functioning particularly well that day.

4.50 Three days later a paramedic based at GP B's surgery visited Care Home A following concerns about Luke vomiting, but this had stopped by the time they arrived. GP B's notes state "*Staff describe poss[ible] coffe[e] ground vomit presentation[32]. Pt[33] now feeling much better. Has eaten breakfast and had meds[34] with no further nausea or vomiting. described as normal self,,,, unable to examine as pt staying under blanket*" and that Care Home A was "*advised to monitor for any further signs of haematemisis[35] or malaena[36]. safety netting- self care and worsening advice provided*".

[31] At this point GP B does not appear to have been made aware by Care Home A that SW A had assessed capacity in October 2017, and the concern was that Luke had no means to pay for legal advice as the Court of Protection was yet to reach a decision regarding a Deputyship.
[32] Coffee ground vomit is a sign of possible upper gastrointestinal bleeding.
[33] Patient
[34] Medication
[35] Hematemesis is the vomiting of blood.
[36] Melena is the passage of dark tarry stools containing decomposing blood that is usually an indication of bleeding in the upper part of the digestive tract and especially the oesophagus, stomach, and duodenum

4.51 At the end of November 2017 SW A recorded that a meeting had been arranged for mid-December with the Council's Client Finance Team to discuss how Luke might be able to get legal advice regarding the divorce petition initiated by his wife, which was being chased by her solicitors. They noted that Luke was not entitled to legal aid and he currently had no means to pay for advice as a decision had not yet been made by the Court of Protection on the Deputyship application. Social Worker A had also received explicit advice from the Council's legal department as to the extent to which they and the Council should be involved.

4.52 Care Home A continued to dress Luke's wounds during the beginning of December without further contact with GP B, with their notes on various occasions during this time stating that they were *"malodorous"*, that Luke's foot was "*very smelly and bandages stained*" and that, on the day before the next telephone contact was made with Luke's GP Surgery, the "*area up back of heel remains sloughy, heel remains black and soggy".*

4.53 In mid-December 2017 a telephone consultation took place with another GP at Luke's GP Practice. The notes state:

"*Home have taken a swab from the wound, feel it is infected. Start abx*[37] *empirically awaiting swab result. Leg ulcers deteriorating, staff would now like the DN*[38] *referral, [Luke] not well enough to go to an outpatient appointment at present. Lots of pain during dressing change, will have oramorph*[39] *to take for dressing changes. Referred to District Nurse*"

This was the first time reference was made to a referral being made to other professionals in relation to Luke's wound care since the referral to the Community Podiatry Service in May 2017 (see 4.31). While Care Home A's records state they had liaised with the District Nursing Team for advice on wound management the only request recorded by Somerset Partnership NHS Foundation Trust for District Nursing input was on this date, there are no records of any other contacts during 2017 contained within the chronology provided the Trust.

4.54 Three days later SW A made an "*ad hoc*" visit to Care Home A during which they were informed by the Manager that Luke was unwell, could be approaching the end of his life and that they were waiting for GP B to call them back to discuss. Their notes state that they were told by the Manager of Care Home A that Luke had a very infected foot that required amputation; that Luke was refusing treatment and food/ drink and weighed 36kg. SW A stated in documentation provided to the desktop review that this foot infection came as a huge surprise to them as they "*hadn't been made aware*

[37] Antibiotics

[38] District Nursing

[39] Oramorph is a morphine-based medicine used for the relief of severe pain in adults

of the problem prior to this" and there had been no "*indication of infection when visiting*" before this date.

4.55 On the same day GP B visited Luke for the last time, following significant deterioration over 3/4 days, having been started on oral anti-biotics three days earlier [a Friday] as a result of the telephone consultation (4.53). GP B's records state:

"MArked deterioration over w/end[40]. Pus running from under skin, dorsum of foot 'spongey' - tendons visible on anterior[41] aspect of ankle, bone visible on heel. Not very responsive today but agrees to be admitted.'

4.56 Luke was admitted to Musgrove Park Hospital the following day. The notes on admission stating:

Very deep sloughy[42] ulcer approximately 10cm x 8cm on over dorsum foot, plus 4 x 5cm over calcaneum[43]. Pus discharging ++. Surrounding erythema[44] over dorsum foot

4.57 On admission Luke was described as emaciated, with a body map detailing sores on his hips and posterior as well as his feet. His wounds were described as very pungent. His haemoglobin was 71 g/l[45]. His reactive protein was 187[46]. Hospital records also noted that inappropriate dressings were in place on arrival.

4.58 A safeguarding referral was made by the hospital to ASC's Safeguarding Service, and arrangements were also made for a turning mattress and a dietician to see him that afternoon/the following day. The Safeguarding referral was accepted, and an Enquiry was initiated under Section 42 of the Care Act (2014). The Enquiry remained on-going while Luke was in hospital and did not conclude until after his death.

4.59 It was determined that Luke would need a below the knee amputation, but at that point he was considered too frail to be able to survive/recover from the operation and he remained in hospital over the Christmas period.

4.60 Luke was deemed fit for discharge in early January 2018 as he was medically stable, but the discharge did not proceed as his condition deteriorated; there

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[40] Weekend

[41] Front

[42] Sloughy is a type of necrotic (dead) tissue. Sloughy tissue is separating itself from the body/wound site, and is often stringy. Because most, if not all, of the sloughy tissue is already dead, it is often white, yellow or grey in colour.

[43] Heel bone

[44] Erythema is redness of the skin or mucous membranes, caused by hyperemia (increased blood flow) in superficial capillaries. It occurs with any skin injury, infection, or inflammation.

[45] Normal results for adults vary, but in general are: Male: 13.8 to 17.2 grams per decilitre (g/dL) or 138 to 172 grams per litre (g/L) Female: 12.1 to 15.1 g/dL or 121 to 151 g/L.

[46] During the desktop review it was stated that this would normally be 0-10

were also concerns about his capacity (a Social Worker employed by ASC based at the hospital made three visits over two days to do this as his capacity was fluctuating) and whether it would be appropriate for him to return to Care Home A that were being explored. This capacity assessment determined that Luke did not have capacity to make the decision himself.

4.61 Luke died five days later. The cause of death was recorded as a diabetic foot infection and Type 2 Diabetes.

4.62 Following his death Luke's family contacted SW A to express concern that they had not been contacted by Care Home A about Luke being admitted to hospital, as they were only contacted by hospital staff once there. This is disputed by Care Home A whose records indicate that a call was made immediately after Luke left. Luke's family also expressed concern about how Luke was being cared for at Care Home A, and said that when a family member visited Luke they took photos of his dressings falling off and their other concerns about the care he was receiving. They said that they had spoken to the staff about their concerns and were told that Luke had capacity, although his family felt that he lacked capacity.

4.63 No decision had been made by the Court of Protection on the Deputyship application by the time of Luke's death.

5 Changes that have made to the arrangements for Funded Nursing Care in Somerset since Luke's death

5.1 Since Luke's death changes have been made to the arrangements for Funded Nursing Care.

5.2 These changes were not made in connection to Luke's care, and have been included in this Review in order to provide background information.

5.3 At the time of Luke's death, District Nurses employed by Somerset Partnership NHS Foundation Trust were responsible for undertaking reviews of individuals who were in receipt of Funded Nursing Care. This is no longer the case, and Reviews are now undertaken by Assessors employed by NHS Somerset Clinical CCG's Continuing Health Care Team.

5.4 At the time of writing the Assessors undertake the following functions.

- Review whether the person remains eligible for Funded Nursing Care
- Complete a Continuing Health Care eligibility checklist and progress if appropriate
- Complete a care home review document and check the provider is providing safe care and meeting the person's needs. If there are any concerns about the care or being provided, then these are flagged to a senior person in the home, and it is the responsibility of the home to action these and take forward

5.5 During the time that Luke lived in Care Home A, Somerset Partnership NHS Foundation Trust's District Nursing Service had the responsibility for undertaking Funded Nursing Care assessments, monitoring the quality of the care and providing care management. However, this has changed since Luke's death. The current arrangements are that the Funded Nursing Care assessments are now undertaken by NHS Somerset CCG who undertake the functions described in 5.4, above. They do not include care management.

5.6 Luke's placement at Care Home A was funded by Somerset County Council's Adult Social Care Service. Under these circumstances this means that the County Council is the commissioner of the care, and has responsibility for ensuring the safety and suitability of the placement, and that the care home is meeting the person's needs. This responsibility currently remains the same, except that care management is no longer delegated to any other organisation, as it was to Somerset Partnership NHS Foundation Trust's District Nursing Service at the time of Luke's death.

6 Learning and Conclusions

6.1 The desktop review considered the detailed information from Luke's case, and was unable to conclude whether Luke's death could have been avoided given the impact of his own behaviours on his health over many years. For the same reasons it is also impossible to conclude that Luke would not have been admitted to a nursing home had the correct slings been available to him on discharge from hospital in June 2016, or that his health would not have declined in similar way had Luke remained in the flat at the sheltered housing scheme. However, the desktop review did identify a number of themes where professionals and organisations could have worked differently to attempt to protect him from these. These are outlined in 6.13 to 6.8.

6.2 During the desktop review Care Home A acknowledged that record keeping had been poor and described the changes that had been made as a result of this.

6.3 Luke's history of self-neglect

6.3.1 Luke had a history of self neglect but none of the many professionals or organisations involved in Luke's care over a long period appear to have explored the underlying reasons for this beyond whether Luke could have an undiagnosed dementia in 2016.

6.3.2 Prior to moving to Care Home A, Luke's self neglecting behaviours were being described in documentation as a *"lifestyle choice"* and that Luke was making *"informed decisions"* to live in the way that he did. Given the types of behaviours described and Luke's history it is questionable how these conclusions were reached in the apparent absence of further exploration of any potential underlying causes.

6.3.3 Luke was placed in Care Home A to protect him from self-neglect, which he had a long history of, and the impact this was having on his health. It appears to have been assumed that, by virtue of being placed in registered care environment, he would be protected from his behaviours. This assumption appears to have been reinforced by the initial improvements in his capacity that the Best Interests Assessor concluded were as a result of him receiving the level of care, nutrition and fluids that he required.

6.3.4 Unfortunately, Luke's self neglect continued, and his health also continued to deteriorate. During the desktop review Care Home A stated that "*Everything that legally could be done was done because [Luke] had capacity*".

6.3.5 Detailed documentation of fact where people self-neglect can enable an understanding of the circumstances, particularly where there may be multiple professionals and/or organisations involved over an extended period of time. Unfortunately, around the time of his move to Care Home A Luke's history appears to have been at least partially lost with the many changes to those who were responsible for his health and care. This may have provided those new to supporting Luke with context to the behaviours they subsequently observed, and the decisions Luke was making after he moved to Care Home A.

6.3.6 Research into the findings from SARs nationally states that where a person is known to be self-neglecting *"Assessment must be contextual, cognisant of relationships surrounding the individual and include triangulation with the known information, for example, a person's mental health history"*[47]. It also states that *"Assessments should be broadly rather than narrowly configured, not just concentrating on presenting problems or on what is visible and practical"*[48]. However, assessments undertaken at the time of Luke's move to Care Home A gave only brief summary information about his history. These summaries were then appended to with new information which, though making reference to Luke's history of self-neglect, did not provide the level of detail that would be necessary to provide context to the care staff and other professionals now attempting to support him.

6.3.7 Luke had also experienced a number of very traumatic events prior to and after moving to Care Home A. Self-neglect guidance advises that trauma can be a factor that leads to self-neglect; that this level of trauma can be very difficult to overcome and can require recovery support over a long period of time. Luke had been self-neglecting for a number of years, with little

[47] Preston-Shoot, Michael. (2018). *Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change*. The Journal of Adult Protection. 20. 00-00. 10.1108/JAP-01-2018-0001. Page 83.

[48] Preston-Shoot, Michael. (2018). *Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change*. The Journal of Adult Protection. 20. 00-00. 10.1108/JAP-01-2018-0001. Page 84.

evidence of support from those involved in his care and support, resulting in behaviours that were very embedded by the time he moved to Care Home A. These traumas and embedded behaviours were substantial factors in the circumstances that arose whilst he was a resident at Care Home A.

6.3.8 Research identifies practice *"should avoid generalised assumptions and respond to each person's history, levels of risk and mental capacity. Loss, family history and trauma not infrequently lie behind refusals to engage, yet little has often been known about adults who self-neglect"*[49], and there are clear parallels to Luke's case in this statement.

6.3.9 In addition to the learning with regard to the context of Luke's history of self-neglect, the desktop review concluded that where there are concerns about an individual self-neglecting these should be clearly documented alongside details of any capacity assessments, any exploration of whether their behaviour is an attempt to communicate something and approaches used to support them to address their self-neglect.

6.4 Luke's Capacity and Decision Making

6.4.1 It is unknown as the extent to which Luke's history of traumatic loss, agoraphobia, anxiety and depression impacted on his decision making both before and after he moved to Care Home A. The combination of all of these factors could well have had an impact on his day to day life and may have been part of the reason he self-neglected. However, this doesn't appear to have ever been explored in any depth or discussed with Luke. The documentation reviewed as part of the desktop review did not evidence that anyone had tried to consistently work with Luke to try and unpick the reasons behind his behaviour and the possible links with his mental health. In this respect, research into the findings from SARs nationally states a *"person-centred, relationship-based approach is emphasised to establish trust, appreciate the reasons behind self-neglect, explore perspectives and preferred options, offer support and wherever possible negotiate interventions. A person-centred approach should not exclude the expression of concerned curiosity or inquisitorial questioning. It does not mean avoiding difficult conversations, including respectful challenge of decisions. Working with individuals should be characterised by empathy, respect and attention to the person's dignity, paying due regard also to their history".*[50]

6.4.2 Prior to Luke moving to Care Home A there had been occasions when his cognitive ability and mental capacity was questioned, yet plans for full

[49] Braye, Suzy, Orr, David and Preston-Shoot, Michael (2015) *Learning lessons about self-neglect? An analysis of serious case reviews*. Journal of Adult Protection, 17 (1). pp. 3-18. ISSN 14668203. Page 16.
[50] Preston-Shoot, Michael. (2018). *Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change*. The Journal of Adult Protection. 20. 00-00. 10.1108/JAP-01-2018-0001. Page 83.

testing were not followed up either before or after his move there, and there are there do not appear to be detailed records of the capacity assessments undertaken by GP B. In addition, Care Home A does not appear to have recorded their concerns about Luke's capacity in detail or made a re-referral under the DoLS process despite it being their responsibility, and SW A's case notes stating that they had been advised to do so.

6.4.3 Although mental capacity cannot be assessed retrospectively, based on the evidence available to the desktop review Luke's capacity was considered to be likely to be fluctuating. GP B stated that they had identified through their own reflective process that more detail should have been recorded with regard to the capacity assessments they undertook while Luke was their patient. It was concluded by the desktop review that GP B had provided support to Luke in a way that was over and above the expectations of their role to support both Luke and Care Home A by undertaking capacity assessments that should have been done by Care Home A.

6.4.4 Significant support was provided to Luke by SW A with regard to his decision specific capacity in relation to the divorce petition received from his wife's solicitors. This went beyond that would normally be appropriate under the Care Act (2014), as a result of SW A's concern for Luke being a situation where he could not pay for legal advice. However, they also reflected that Luke's fluctuating capacity and the wider impact of this should have been better explored.

6.4.5 Following the move to Care Home A Luke was considered to have the capacity to make decisions that were clearly having negative impact on his health without exploration, resulting in referrals not being made to health professionals that would otherwise have been. Concerningly, this appears to have been exacerbated by a view expressed by Care Home A during the desktop review to the potential personal legal consequences for staff if they made the 'wrong' decision, including to staff facing possible imprisonment. This appears to have had the unintended consequence of staff defaulting to Principle 1 of the Mental Capacity Act (2005)[51] when considering the decisions that Luke was making, rather than recognising that Luke's responses needed further exploration or that he might need help to make a decision.

6.4.6 While the Mental Capacity Act is clear that capacity should be assumed unless someone has concerns otherwise, concerns should have been identified about Luke's decision making by some of his responses, in particular to treatment for his ulcers. It is inappropriate for Principle 1 of the Act to be used to avoid considering whether someone may need help to

[51] A person must be assumed to have capacity unless it is established that he lacks capacity. Source: https://www.legislation.gov.uk/ukpga/2005/9/section/1.

make a decision where there is evidence that they may be struggling with their capacity and "*when there is good reason for cause for concern… the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way*"[52]. In addition, consideration should also be given as to whether further exploration is required where an adult appears to be making repeated unwise decisions. For example, if someone is presenting to a professional in a way that makes them really worried then they should attempt to understand and document whether they have doubts about their capacity to make a particular decision and why, along with what may need to be put in place to help them. This is what should have happened in Luke's case.

6.4.7 Giving care that is restrictive (as long as it is the least restrictive available) is not a breach of human rights - but is a mechanism to uphold human rights, of which the right to life is one. The state may interfere with one human right if it can demonstrate through evidence that by doing so it is upholding another (e.g. the right to life). In Luke's case Care Home A's staff defaulted to upholding one right without adequately considering the impact on another, or attempting to explore or evidence why a different decision should be made in Luke's best interests.

6.4.8 While communications to staff and training on the Mental Capacity Act (2005) should rightly emphasise the need to ensure that the Act is at all times followed, the potential unintended consequences of how this is communicated needs to be considered. This should include a focus on the need for good evidence and appropriately detailed recording where there are concerns about someone's capacity in order to provide a sound basis to support them to make a decision.

6.4.9 In Luke's case his capacity was described as fluctuating on multiple occasions by multiple professionals, and in this type of situation it can be beneficial to consider a longitudinal approach in order to establish a better understanding of the person and how they can be best supported to make a decision. This is what should have happened in Luke's case.

6.5 Luke's wound care while living at Care Home A

6.5.1 Luke's medical conditions and reluctance to engage in care significantly increased the risk of developing ulcers which could become problematic.

6.5.2 Throughout the period when Luke's ulcers continued to deteriorate during the autumn of 2017 the Somerset Integrated Foot Pathway and supporting

[52] Ruck Keene, Alex. Referencing paragraph 26 of Swift J in Bank Of Scotland Plc v AB [2020] UKEAT 0266_18_2702. *When not to presume upon a presumption*, 28/02/2020, retrieved 02/03/2020. Available from: https://www.mentalcapacitylawandpolicy.org.uk/when-not-to-presume-upon-a-presumption/

Diabetic Foot Infection Guidelines (PEDIS)[53] were not followed, and it was not until the discussion took place with Luke that resulted in an admission to hospital that the action recommended by the pathway was taken.

6.5.3 There is reference in a report provided by Care Home A following Luke's death that he was able to discuss his wounds, was aware that he should not interfere with his dressings, and that he was aware that his behaviour caused him harm as corroborated with his history of self-neglect and malnutrition. However, the extent to which concerns were discussed with Luke himself is unclear and his capacity around wound care does not appear to have been questioned by Care Home A. While some of the records provided by Care Home A are illegible, the majority that are discernible refer to Luke being greeted at the start of the day, how he slept, personal care provided and occasionally his mood, but not of any discussion of his wounds with him. While it is possible that this was included in some of the illegible notes, any discussion with Luke appears to have been noted infrequently if at all. Where plans were written using language that implies that they were for Luke's use these are also at times illegible, and even where not it is questionable whether Luke could have read them given his poor eyesight.

6.5.4 Concerns about Luke's ulcers deteriorating were not shared in a timely way, for example, they should have been shared with GP B at an earlier stage. Although GP B's description of the wound in early October differs from some of the reports from the Manager of Care Home A, it would appear from both sources' notes that the wound was improving. However, there was clearly a significant change in the following two to three weeks when the tendons were recorded as being visible and there was infection in the foot.

6.5.5 During the desktop review the Acute Care Diabetes Specialist Podiatrist who reviewed Luke's case emphasised that while Luke said at the end of November that he would consider a hospital admission if the ulcers became 'dangerous' they were likely to have become so when the wound became larger in size and no longer responded to dressing management, and certainly when the tendons/ ligaments became visible. This is because this could indicate the presence of osteomyelitis[54] and a requirement for long-term antibiotics rather than the sporadic treatment that was evident in the documentation considered. Therefore, while there were differences in the recording of the state of Luke's wounds (4.42), the ulcer could have been deemed dangerous to Luke's health from as early on as October and he should have been told that there was a potential for amputation or death if he was not admitted to hospital. On this point the desktop review concluded that professionals need to be explicit with individuals as to what the

[53] Available from: https://viewer.rx-guidelines.com/TSTYDH/Abx#content,6ZdLdG8TVU

[54] Osteomyelitis is an infection of the bone

potential benefits and risks of decisions are in order that they are able to weigh up information and make an informed decision.

6.5.6 The Acute Care Diabetes Specialist Podiatrist who reviewed Luke's case confirmed that the Somerset Diabetes Foot Integrated Pathway states that should the condition deteriorate prior to any appointment with podiatry, under the category of 'active/ ulcerated foot' an urgent referral should be made to the Hot Foot / Ulcer clinic within 24 hours for assessment by a member of the Foot Protection Team when a decision would be made about appropriate course of treatment, this being either admission to hospital for treatment (for example with via intravenous antibiotics) or management in the community. However, no referral was made, and this was a missed opportunity for specialist input into Luke's care.

6.5.7 By December 2019 Luke had been living at Care Home A for almost 18 months, and while Luke is said to have repeatedly expressed a view to Care Home A about his preference for treatment (i.e. not being admitted to hospital) the reasons why he did not want to be admitted to hospital do not appear to have been explored with him.

6.5.8 The dressings on Luke's wounds should have been applied in a way that made it less likely that he would access the wounds given the known risks of his picking at/infecting them. Given the concerns about Luke's memory, his interference with the wounds should have also been discussed with him regularly to reinforce the potential impacts of him doing so, and these discussions documented.

6.5.9 Overall, the documentation of Luke's wound care was poor leading to gaps in records. Recording practice should be founded on a position that if something hasn't been recorded it didn't happen, and tested through auditing processes.

6.6 Multi-agency involvement in Luke's care and support

6.6.1 Almost every aspect of Luke's care seemed to be 'owned' by Care Home A and, to a lesser extent, GP B with little involvement from other professionals or organisations. As a result, there did not appear to have been any concerns raised, conversations with or the involvement of professionals and specialist services in order to better support Luke until his health had deteriorated very significantly. Research into the findings from SARs nationally states *"A clear message emerges of the importance of multi-agency meetings, to support reflection and shared decision making, with one agency or practitioner having a lead co-ordinating role to develop and oversee case management planning. Multi-agency meetings are highlighted as particularly beneficial when a case has yet to reach the safeguarding*

threshold but where there are concerns about how agencies are working together to understand and manage risks".[55]

6.6.2 The involvement of SW A, who had the responsibility for the commissioning and monitoring of Luke's placement on behalf of the Council at Care Home A was, during 2017, primarily related to carrying out an Enquiry under Section 42 of the Care Act and supporting Luke regarding his wife's request for a divorce. While it is acknowledged that their involvement remained open when it would normally have been closed[56] (as a result of a Deputyship application being made to the Court of Protection), which may have led to confusion, there is no evidence that they or any other professional other than his GP practice was informed of the extent to which Luke's health was declining by Care Home A until three days before he was admitted to hospital in December 2017.

6.6.3 SW A stated in the review undertaken in January 2017 that Luke would be care managed by the Somerset Partnership NHS Foundation Trust's District Nursing Team. However, there was no involvement recorded in the chronology supplied by Somerset Partnership NHS Foundation Trust until a referral was made in December 2017 (with regard to which no visit was made due to Luke being admitted to hospital before one was made). While they held an assumption that care management would be undertaken by the District Nursing Team[57], there is no record in SW A's notes of any discussions taking place with the District Nursing Team, or any documentation being shared with it. SW A subsequently confirmed that they had assumed that the involvement would be automatic because NHS Somerset CCG was funding the nursing care element of his care and support.[58]

6.6.4 It is clear from the Council's records that SW A had attempted to engage the involvement of District Nurses employed by Somerset Partnership NHS Foundation Trust. However, there will always be the inherent risk of an individual 'falling through the cracks' in any process that assumes that another professional and/or organisation will take-over reasonability for a case where there has been no hand-over. While such a hand-over need not be bureaucratic there does, as a minimum, need to be a discussion between the releasing and accepting professionals/organisations. Confirmation that hand-over has been agreed and the date on which it takes place should then be recorded. Unfortunately, no record of such a discussion appears to exist,

[55] Preston-Shoot, Michael. (2018). *Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change*. The Journal of Adult Protection. 20. 00-00. 10.1108/JAP-01-2018-0001. Page 84.

[56] While SW A's personal involvement would have normally been closed, Luke would have remained open to their team and then re-allocated for Review or if further involvement was required.

[57] See section 5

[58] Since Luke's death the arrangements for Funded Nursing Care have changed. Please see section 5 for details of these changes.

which if it had taken place should have alerted the District Nursing Service to their responsibilities under the arrangements in place at the time[59] in relation to the care management; and may have prompted a review to be prioritised. It may also have prompted the completion of a joint review that included both the SW A Worker and the District Nurse (SW A had attempted to do this when they undertook the Enquiry under Section 42 of the Care Act 2014 in January 2017). A joint review would have ensured that both organisations fulfilled their responsibilities and Luke would have received a co-ordinated approach that may have improved the response he received.

6.6.5 In a statement provided to the desktop review SW A stated that "*doing nursing reviews without NHS expertise means social care staff are reliant on the nursing staff from the home*" to give advice on the medical aspects of the care that is being provided. This risk remains under the new arrangements described in Section 5, as there do not appear to be clear arrangements in place for staff employed by ASC to access advice on the health aspects of the care provided to an individual living in a nursing home.

6.6.6 While GP B described Luke of being a "*closed book*" in terms him showing little emotion when concerns were raised about his health, and of him not engaging in decisions about his mental health, a referral to mental health services had been made in 2016 to explore concerns about his memory. However, a decision was made by Somerset Partnership NHS Foundation Trust to not proceed with further assessment while issues with his non-compliance with medication and vision were resolved was not followed up on. Given the on-going concerns about Luke a re-referral should have been made to identify if there was an underlying cause for the behaviours that were causing concern, however this did not happen.

6.6.7 In addition, Luke's state of mind and indicators about his lack of self-worth could have been more fully explored. Luke was known to have suffered a lot of trauma in his life, and was in the process of being divorced by his wife, but the impact of this does not appear to have been explored. Was there an underlying depression? Had he simply given up any hope or will to live? Were his behaviours while living in Care Home A symptomatic of him being unhappy with his situation and attempting to exert control over the elements of his life (e.g. his food intake) that he had control over? In the absence of exploration this will never be known.

6.6.8 Research states that *"a robust multi-agency approach to identification, assessment and management of needs and risks, together with a culture that encourages constructive challenge and debate, are all emphasised. This approach includes appointment of a lead professional to coordinate multi-agency contributions to need and risk assessment, care planning and*

[59] See section 5 for changes that have been made since Luke's death

reviews. Also recommended is the use of panels or meetings where agencies, regardless of who is currently involved, come together to use their specialist contribution to mitigate risks and to coordinate action"[60]. However, this did not happen, and the desktop review concluded that opportunities were missed to initiate such a multi-disciplinary discussion. This would have allowed concerns to be shared which don't appear to have been, as well as alternative approaches to be considered and specialist referrals made as required. While it is unclear whether this would have made a material difference given Luke's documented lack of engagement and possible self-harm, it should still have happened and the fact it may have resulted in a different outcome cannot be discounted.

6.7 Luke's weight

6.7.1 Whether Luke's wounds had an impact on how he felt physically and his mood, and if this was possibly a factor which resulted in his aversion to eating, is unknown.

6.7.2 It was noted that there were inconsistences in the BMI figures recorded in different documents at different times. In 1995 his BMI was recorded as 30, in 2009 it was recorded as 25. A dietician recorded his BMI (and therefore likely to be an accurate indicator) as 17 in 2016. A BMI below 18.5 is considered to be underweight.

6.7.3 At times GP B was given both Luke's weight and BMI by Care Home A, but at others it was a calculated BMI that the desktop review felt may not have been correct masking changes in his weight.

6.7.4 Luke was prescribed supplements because of the concerns around his weight, but records indicate that he frequently ignored advice when concerns were raised about the nutritional risks he was taking.

6.7.5 No best interests decision appears to have been taken by Care Home A with regard to Luke eating in the dining room, despite evidence that this was having a positive impact on his weight, a reference to this being in his 'best interests' was clarified by the Manager of Care Home A in documentation considered by the desktop review as being in his 'social best interests' and that he did not lack capacity in relation to this decision.

6.7.6 Although there were disparities in Luke's BMI around and following his move to Care Home A, the evidence that ongoing low weight and weight loss over time was a long-standing problem both before and after Luke moved to Care Home A, which was also inter-related to Luke's history of self-neglect, does not appear to have been effectively recognised or explored. For example, a dietary care plan produced in September 2016 notes that Luke did not wear

[60] Braye, Suzy, Orr, David and Preston-Shoot, Michael (2015) *Learning lessons about self-neglect? An analysis of serious case reviews*. Journal of Adult Protection, 17 (1). pp. 3-18. ISSN 14668203. Page 16.

dentures and had no issues with his teeth/ mouth, so his poor intake was due to behaviour/ choice rather than physical problems. The dietary needs care plan does not note the severity of Luke's needs and there was no clear risk management plan other than to encourage him to go downstairs for meals where he tended to eat a little. A second plan produced in February 2017 made a similar statement. These were both missed opportunities to explore the nutritional choices that Luke was making with him.

6.8 Disclosure made by Luke in July 2016

6.8.1 The disclosure made by Luke with regard to an alleged incident of historical child on child sexual touching has been discussed with the Business Manager of the Somerset Safeguarding Children Partnership.

6.8.2 The disclosure should have been referred to Somerset County Council's Children's Social Care Service at the time. While the ages of the children allegedly involved and the small amount of information which Luke provided does not indicate whether this was persistent harmful or exploratory childhood behaviour, a referral should have been made so that it could be considered in context with any other information available and assessed using the Brook Traffic Light Tool on Harmful Sexual Behaviour.

7 Learning already implemented

7.1 The desktop review noted that the following actions had already been taken as a result of Luke's case:

- Care Home A: Action taken to improve recording systems and their monitoring, including implementation of auditing processes.
- GP B: All of the clinicians in the practice are invited to a monthly meeting to discuss any cases that are causing them concern.
- Community Podiatry Service (now operated by Somerset NHS Foundation Trust): GPs are now informed where there has not been any further engagement.

7.2 In addition, outside of work in relation to Luke's case, Somerset County Council and NHS Somerset Clinical Commissioning Group have undertaken a quality improvement processes with Care Home A.

8 Recommendations

The following recommendations for the local system have been structured using a SMART approach to ensure that they are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely

Recommendation 1:

That the Somerset Safeguarding Adult Board ensures that the learning from this Review is shared with:

- All providers of residential and nursing care operating in Somerset
- The Somerset Registered Care Provider Association (RCPA)
- The Care Quality Commission
- The Local Medical Council
- Employees of Somerset County Council's Adult Social Care Service
- NHS Somerset Clinical Commissioning Group's Continuing Health Care Team

The SSAB Business Manager will evidence to the Board when and how the learning has been shared, and where not doing so directly request evidence from the Board Member representing the relevant organisation that they have done so.

The learning should be shared within 7 calendar days of the publication of this Review and monitored through a request made to Board members responsible for sharing it within their own organisations to confirm that this has happened within 30 days of receipt, and reported to the SSAB Board at its next meeting following this date.

Recommendation 2:

That the Community Podiatry Service now operated by the Somerset NHS Foundation Trust raises awareness of Somerset Integrated Foot Pathway and supported Diabetic Foot Infection Guidelines (PEDIS)[61] with:

- All residential care and nursing care providers operating in Somerset
- All GP Practices in Somerset

The Community Podiatry Service will be asked to provide evidence to the SSAB Board of the actions it has taken to raise awareness and the plans that is has in place (and the monitoring arrangements that it has in place for these plans) to continue to raise awareness on an ongoing basis.

The awareness raising should take place within three months of the publication of this Review and be reported to the SSAB Board alongside plans for ongoing awareness raising activities at its next meeting following this date.

Recommendation 3

That NHS Somerset CCG provides guidance about recording capacity and information on the tools that are available to GPs in Somerset for GP

[61] Available from: https://viewer.rx-guidelines.com/TSTYDH/Abx#content,6ZdLdG8TVU

practices to assist them in recording information regarding an individual's capacity to an appropriate level of detail.

This should be circulated within 1 month of the publication of this Review, with confirmation provided the next SSAB Board.

Recommendation 4

That Somerset County Council provides guidance about recording mental capacity, and information on the tools that are available, to all providers of Care and Support to adults operating in Somerset to assist them in recording information regarding an individual's capacity to an appropriate level of detail.

This should be circulated within 1 month of the publication of this Review, with confirmation provided the next SSAB Board.

Recommendation 5

That the Community Podiatry Service now operated by the Somerset NHS Foundation Trust confirms the contact that they have had with an individual to their GP when closing a case, unless the closure is because the person has died.

Changes to the process on closure should be made within three months of the publication of this Review and reported to the SSAB Board at its next meeting following this date.

Recommendation 6

That, when recording information about an individual's weight, all providers of residential care and nursing care operating in Somerset record the actual weight and the unit of measurement at the time of documenting the calculation as well as the BMI in order to mitigate against the potential for mathematical errors in calculations. Where someone cannot be weighed physically and the Measuring mid-Upper Arm Circumference (MUAC) is used in place of the individuals weight the measurement should be recorded. In addition, if an adult's BMI is requested by a GP or other health professional, their weight should also be provided alongside the BMI, or if the MUAC has been provided in place of the BMI then this should be clearly stated.

Compliance should be checked through internal auditing processes and evidence that these checks are being undertaken should be made available to commissioners as part of quality monitoring processes.

All providers of residential care and nursing care should be prepared to evidence to commissioners that they are monitoring compliance no later than three months from the date of publication of this Review.

Commissioners will be asked provide evidence to the SSAB Quality Assurance Subgroup after 12 months, at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 7

Where a provider of care and support to adults has concerns about an individual self-neglecting these should be documented alongside details of any capacity assessments and the approaches used to explore the reasons for their behaviour and support them to address their self-neglect that are tailored to their individual needs and circumstances.

Compliance should be checked through internal auditing processes and evidence that these checks are being undertaken should be made available to commissioners as part of quality monitoring processes.

All providers of care and support to adults should be prepared to evidence to commissioners that they are monitoring compliance no later than three months from the date of publication of this Review.

Commissioners will be asked provide evidence to the SSAB Quality Assurance subgroup after 12 months, at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 8

If a provider of care and support to adults is experiencing difficulty in confirming capacity because of lack of engagement, and the consequences of the decision outcome could result in harm to the person, then they should have arrangements in place to escalate this to the relevant Commissioner or the Safeguarding Service for advice; or to call a Multi-Disciplinary Team meeting as appropriate to the circumstances of the case

Arrangements should be put in place by all providers and compliance with them should be checked through internal auditing processes and evidence that these checks are being undertaken should be made available to commissioners as part of quality monitoring processes.

All providers of care and support to adults should be prepared to evidence to commissioners that they are monitoring compliance no later than three months from the date of publication of this Review.

Commissioners will be asked provide evidence to the SSAB Quality Assurance subgroup after 12 months at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 9

That, on advising that a re-referral be made for memory assessment, that Somerset NHS Foundation Trust clear criteria to the adult's GP for when this should be considered within in any discharge letter.

Compliance should be checked through internal auditing processes and evidence that these checks are being undertaken should be made available to commissioners as part of quality monitoring processes.

Commissioners will be asked provide evidence to the SSAB Quality Assurance Subgroup after 12 months at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 10

That Somerset County Council's Adult Social Care Service and NHS Somerset Clinical Commissioning Group issue jointly agreed guidance to staff employed by Somerset County Council's Adult Social Care service on the role of NHS Somerset's Continuing Health Care Team where an individual is in receipt of Funded Nursing Care and, specifically, the circumstances in which advice and/or involvement should be sought from specialist health services, and from where it should be sought. It should also include an escalation process for if advice and/or involvement is sought but declined.

The guidance should be completed, signed-off and published within three months of the publication of this report. Somerset County Council should test awareness and report its findings to the SSAB Quality Assurance Subgroup after 12 months, at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 11

For the Somerset Safeguarding Adults Board's Policy and Procedures Subgroup to review its existing self-neglect guidance to ensure that the fact that it is applicable to the specific circumstances where there are concerns about an adult living in a registered care environment self-neglecting is explicit.

The revised guidance should be completed, signed-off and published within three months of the publication of this report.

SSAB member organisations should the test awareness and report their finding to the SSAB Quality Assurance Subgroup after 12 months, at which

point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.

Recommendation 12

For the Somerset Safeguarding Adults Board's Policy and Procedures Subgroup to agree guidance for staff working with adults who may make disclosures regarding alleged historical incidents involving children with the Somerset Safeguarding Children Partnership. In addition, the SSAB should also disseminate a link to access South West Child Protection Procedures to all Providers of Care and Support to adults to raise awareness that these need to be taken account of in organisational policies and procedures. For example, domiciliary care providers for consideration in relation to where there is a child within a property that staff are visiting and Residential and Nursing homes where a child is visiting an adult resident.

The link should be circulated within 1 month of the publication of this Review and the guidance should be completed, signed-off and published within three months of the publication of this Review.

SSAB member organisations should test awareness and report their findings to the SSAB Quality Assurance Subgroup after 12 months, at which point the Subgroup should determine what, if any, further monitoring is required and the frequency of any such monitoring.