‘Peter’

Safeguarding Adult Review

Contents

1. Introduction

This Safeguarding Adult Review (SAR) has been commissioned by Somerset Safeguarding Adults Board. It centres on Peter who passed away following refusal of necessary medical treatment. Peter had an extensive history of self-neglect when living in his own home which did not resolve following his admission into full time care. Whilst residing in a local care home Peter began to suffer with peripheral vascular disease in his feet. Unfortunately, due to persistent refusals of care and treatment his feet, then legs became gangrenous. Whilst P would initially agree to interventions such as wound care, hospital admissions, and amputation he would often renege on this.

Peter's mental impairment was linked to problems with his executive functioning and alcohol use. This made assessment of his mental capacity difficult as he retained many of his core cognitive skills. In regard to health-based decisions Peter was treated as having capacity. Aside from on one occasion however this was based on professionals presuming capacity rather than formally assessing it. Conversely Peter's care arrangements in the care home were subject to a Deprivation of Liberty (DoLS) Standard Authorisation which had received the additional oversight of the Court of Protection. Peter had also been determined to lack capacity in regard to his financial affairs.

Peter's case met the criteria for a Safeguarding Adult Review in that *"there is reasonable cause for concern about how the SAB members … worked together to safeguard the adult"*[1] and *"the SAB knows or suspects that the death resulted from abuse or neglect."*[2] The review period specified was two years prior to Peter's death in January 2022.

2. Methodology & Sources

Requests were made for involved organisations to provide an Individual Management Report (IMR) and a chronology. Partners submitting reports were; a) The Local Authority, b) A local Trust (encompassing hospital and community care), c) The Integrated Care Board (encompassing the GP Practice and Complex Care Team), d) The Care Home, e) Advocacy services.

The chronologies were subsequently brought together into a combined document. Following consideration of these a briefing report was formulated by the author in advance of a learning event which took place in November 2023. Not all parties were in attendance at the event so individual meetings were held with the GP, the clinical lead at the GP practice, and the treating surgeon.

[1] Care Act 2014 s44 (1a)
[2] Care Act 2014 s44 (2b)

The author also made contact with Peter's sister who provided some valuable background information via email. The local authority provided a s42 report, a Court of Protection s49 report, and the DoLS documentation covering the SAR review period. The GP provided a capacity assessment completed in regard to hospital admission.

3. Pen Picture

Peter was brought up in the South-East and had one other sibling, a sister (Sarah). She described Peter as *"always a bright happy little boy, very mischievous and charming, an early reader."* Sarah refers to difficulties in Peter's life from an early age. According to Sarah, Peter struggled through his education, either being expelled or failing to finish college courses. Sarah suggests that this was a result of a predisposition to alcohol and drug use.

As an adult Peter lived between the UK and abroad, often spending time with his parents who lived overseas in the 1970's and 1980's. Less is known about Peter as his adult life progressed, however there are reports that he worked in the Merchant Navy. Sarah recounts that "*…our parents would be without news of him for some years at a time."* It is known that Peter was married and has a son who it is reported lives abroad. Sarah reports that Peter had been estranged from his immediate family since the 1990's.

Multiple staff working with Peter reported that he was an interesting and engaging individual. Sarah commented that anyone who knew him would *"say what an interesting funny and well-read person he was."* The clinical lead at Peter's GP practice who regularly visited Peter at his care home stated, *"on a good day Peter was excellent company, he was well read and informed as to what was going on with world events."* One of the district nurses delivering his care commented that *"he had quite a good sense of humour."*

4. Events prior to admission into full time care: 2004 -2018

Peter's father passed away in 2004 at which point Peter moved in with his widowed mother. This did not prove to be a successful arrangement. Peter was drinking alcohol excessively and the situation at the house began to deteriorate with multiple safeguarding adults' alerts raised. Following an incident in 2014 where Peter was alleged to have thrown a walking stick at his mother, she moved into a local care home leaving Peter on his own at the property. Two periods of respite in different care homes occur following this. In 2015 a deep clean of the property was arranged and Peter spent a period of respite at the care home he would subsequently move into on a permanent basis.

In 2016 Peter was admitted to hospital following a serious car accident receiving treatment in intensive care and an MRI scan. At this point *"involutional changes in excess of patient's age"* were noted alongside an opinion that *'his slurred speech could be due to cerebellar atrophy and alcohol abuse.'*[3] Peter was discharged back to his property following this. An MRI scan in 2018 confirmed a mental impairment diagnosis relating to alcohol misuse and associated damage to his frontal lobe region.[4]

In 2018 Peter's mother passed away, by this point his estrangement from his family was such that he chose not to attend her funeral. Peter was described at this time as living in conditions of squalor and his home was noted to be uninhabitable. Issues at the home around this time included; i) leaking roof with ceilings at risk of collapse, ii) hoarding of items, iii) no heating or hot water, iv) rat infestation, v) poor hygiene throughout with faeces on surfaces, piles of rubbish, rotting food, and bottles of urine throughout property, vi) empty alcohol bottles throughout, and vii) brambles growing through open windows. By this point Peter was self-propelling in a wheelchair but could not use it in his home, either furniture walking or crawling around his property. Attempts to work with Peter to deal with these issues were unsuccessful.

5. Admission into full time care: October 2018

Several months later Peter was found to be suffering from *"acute delirium with hallucinations"*[5] and was admitted to an inpatient mental health setting under the Mental Health Act (MHA). After Peter had left the property Sarah shared that environmental health workers *"had to wear protective clothing to enter the house."* This detention appeared to be a traumatic event for Peter as it became a recurring grievance that he fixated upon. Peter expressed his anger to multiple parties as to what he perceived was an illegal detention. An attempt was made to explore reasons for his wheelchair dependence whilst on the ward, but he declined the involvement of physio and occupational therapy.[6]

Whilst a mental health inpatient authority for Peter's detention transferred from s2 of the MHA to a Standard Authorisation under the Deprivation of Liberty Safeguards. Explorations were undertaken to fulfil Peter's wish to return home, which was now under joint ownership with Sarah. Difficulties were encountered with securing the funding required to make the property habitable. This alongside fears that Peter would disengage with any assessed support once he returned home led to an application

[3] s49 Court of Protection report [20/3/20] pg 2
[4] ICD-10 Classifications : F101 - Mental and behavioural disorders due to use of alcohol/harmful use & F078 - Other organic personality and behavioural disorders due to brain disease, damage and dysfunction (Frontal lobe syndrome).
[5] s49 Court of Protection report [20/3/20] pg 3
[6] DoLS Form 3 [2/5/19] pg 5

being made to the Court of Protection. The Court subsequently issued an order authorising Peter's residence at a local care home in April 2019.

Unfortunately, the move into full-time care failed to resolve many of the difficulties encountered when he was resident in the community. These included; i) Peter refused *"to get his room cleaned, for waste food be removed from his bed or rotten food from his cupboard."*[7] ii) Peter attempted to hoard belongings, ordering items online that he could not use within the care home (e.g. 2x patio heaters, fridge freezer), iii) Peter refused care and support with his personal care insisting that he had completed this himself (despite evidence to the contrary), iv) Verbal and occasional physical aggression towards others, v) antisocial behaviour – having alcohol delivered, smoking indoors, and watching pornography in communal areas.

6. Review Period - 23/1/2020 to 22/1/2022

The timeframe of this review period is separated into 7 key episodes. Episodes 2 to 7 relate primarily to the management of Peter's peripheral vascular disease, the condition that eventually leads to his death. Key episode 1 runs concurrently with key episode 2 and focuses on self-neglect and financial abuse issues not specifically related to his

health.

6.1 - Key Episode # 1: 23rd January 2020 to 10th May 2021

At the end of March and beginning of April 2020 Peter's social worker was informed that following taxi journeys to the hospital there were concerns regarding excess charges and Peter having alcohol on his person. Also noted that Peter was purchasing takeaway food, not paying his client contribution, and having parcels delivered, possibly containing cannabis and alcohol. The home was advised by the social worker to make a safeguarding referral if there are *"any concerns of abuse."* Safeguarding referrals were subsequently made by the care home regarding poor nutrition and aggression towards other residents.

In August 2020, the local authority was appointed interim financial deputy for Peter following their application in February of that year. In September 2020 the care home shared the following with the social worker; i) Peter was calling taxis to go out but staff were preventing him from leaving, ii) Peter using taxi drivers to run errands for him with a £50 to £60 bonus, iii) Peter ordered £200 - £300 worth of groceries for room and not letting staff in to investigate. The advocate informed the social worker that opening of packages was not covered by the DoLS Authorisation and prompts care home to make a safeguarding referral regarding the above.

[7] s49 Court of Protection report [20/3/20] pg 8

The care home informed Peter's GP of their concerns in October 2020 which prompts the home to make a safeguarding referral. The same month the local authority noted that they have deputyship but that Peter *"won't sign."* It is noted by the advocate in November 2020 that the local authority deems that the concerns have not met the criteria for a s42 enquiry. The advocate shared that Peter was sleeping most of the day and up at night, was buying an excessive amount of food and drinking alcohol. The advocate prompted a Best Interests' meeting to discuss.

A professionals meeting was held in January 2021 regarding funding and finance where the local authority committed to paying Peter's client contribution. In February 2021 Peter alleged that staff had been stealing his items but no safeguarding referral regarding this was made. A best interests' meeting regarding opening Peter's packages was held the same month and it was agreed that parcels will be opened in front of staff, an inventory for belongings to be undertaken, and deputyship arrangements to be chased. The social worker asked the GP for support with a capacity assessment regarding alcohol intake but there is no evidence of this being completed. In May 2021, a note detailed that the Local Authority have control over Peter's bank account.

Positive Practice: 1) The matter of Peter's finances was taken to the Court of Protection, 2) The local authority agreed to meet Peter's client contribution. 3) Peter's care was authorised by a DoLS (throughout the review period), and his residence objections considered by the Court of Protection.

Areas for Development: 1) Excess length of time to gain control of Peter's finances, 2) Criteria for s42 safeguarding consideration met from March 2020, 3) Excess length of time Peter is exposed to financial abuse, 4) Outstanding issues relating to self-neglect and Article 8 human rights[8] concerns, 5) Safeguarding referrals not made.

6.2 - Key Episode # 2: 21st Feb 2020 to 13th Aug 2020

Peter began to complain of pain in his ankles and feet in February 2020. The GP practice investigates and noted that there was *"no evidence of nerve or vascular damage"* but that his toenails were *"appalling."* Pain relief and codeine use became an issue, with Peter calling the surgery directly and requesting medication. He attended the hospital at the end of the month where it was confirmed that a cyst (identified in January) is benign. Visiting the GP Practice in March 2020, Peter would not allow staff to examine his feet, however red areas and possible pressure sores on toes are noted. An issue with Peter's analgesia developed as the GP does not feel able to continue with the Codeine prescription without a recent weight and an examination of his feet. (Peter is noted to be losing weight at this time which would

[8] Human Rights Act 1998 sch 1 art 8 – *"Everyone has the right to respect for his private and family life, his home and correspondence."*

have impacted on the Codeine dose). Peter is visited by a Nurse Practitioner (NP) later that month who allowed a cursory examination (radial pulses taken) and the Codeine prescription was continued.

Further problems with the Codeine prescription occur as Peter was observed to be offering this to another resident in the care home. Measures were put in place promptly to ensure safe administration and ordering. The next reference to his feet was in August 2020, Peter was visited by the Nurse Practitioner who noted the view that Peter HAD capacity in regard to his care and that his *"foot pain is managed by codeine".* Additionally, a treatment escalation plan (TEP) was completed. Notes from the care home that same month indicate that Peter *"won't let anyone check his legs"* and that he was *"managing own personal care."* No further mention of his feet was made for 10 months until June 2021.

Positive Practice: 1) Action taken to investigate cyst is prompt, 2) Action taken in regard to medication (inappropriate use & repeat prescriptions) is prompt, 3) TEP completed proactively in community.

Areas for Development: 1) Capacity assessment regarding examination required but not undertaken in Feb / Mar 2020, 2) Presumption of capacity erroneously used in August 2020, 3) Query long term Codeine use with background of addiction without further investigation of underlying cause.

6.3 - Key Episode # 3 : 1st June 2021 to 2nd August 2021 – First Hospital Admission

In June 2021 Peter was visited by both the Nurse Practitioner and district nurses regarding foot pain. An attempt was made to carry out a Doppler scan by district nurses however Peter refused and was noted to be *"furious"* and *"demanding an x-ray."* The clinician noted that he *"does not appear to be in pain and foot pulses are reassuring."* However conflicting care home records written before and after the examination state, "*reluctant to have foot touched, jerked foot away"* and *"requested to increase the strength of his Codeine tablet."*

Over the following 3 days the Nurse Practitioner and ambulance service provided intensive support to Peter and the care home in an attempt to manage his feet and facilitate a hospital admission. During this period, the GP practice recorded a view that Peter HAD capacity. Following an initial refusal, Peter agreed to a hospital admission where his TEP was reviewed. A clinical MDT occurred where it was recorded that Peter had a *"significant peripheral vascular disease"* and 8 days after admission a view was recorded that he has *"full capacity"* regarding an angioplasty / stenting procedure. Peter did not recover well following this, further surgery was considered but deemed "*not to be in best interest, due to recovery from lengthy surgery."* The notes also

recorded a view that Peter *"…has fluctuating capacity but retained clearly enough to consent to operations.*" No formal assessments of capacity were undertaken.

At the end of June 2021, Peter was discharged to a local community hospital. Records indicate a view that Peter HAD capacity, but no decision was specified, and no formal assessment was undertaken. At the start of July 2021 amputation now appeared to be an available option (i.e. *"Peter not keen on amputation, does not want to discuss the A word.")* Nursing staff also noted ulcerating cellulitis on penis and grade 1 pressure sore on buttock. A Tissue Viability Nurse review took place with a note that district nurses would follow up in the community. Peter was discharged back to the care home at the start of August 2021.

Positive Practice: 1) Timely response regarding offer of Dopler scan, 2) Timely response regarding angioplasty / stenting procedure, 3) Intensive level of support offered by GP practice in order to facilitate hospital admission.

Areas for Development: 1) Failure to formally assess mental capacity across health services, 2) Confused use of Mental Capacity Act by hospital where referenced, 3) Better use of collateral information required from district nursing. 4) DoLS not applied for by hospital despite one being in situ at care home.

6.4 - Episode # 4: 3rd August 2021 to 25th Aug 2021 – Second Hospital Admission

On Peter's return the care home requested an urgent multi-disciplinary meeting. The district nurse team reviewed and noted that dressings were not required for his wounds, that he was refusing pressure relieving equipment, and that there was *"no reason to doubt capacity."* Unfortunately, his wounds deteriorated quickly necessitating daily district nurse intervention and dressings. Peter was offered a hospital admission on several occasions over a 11-day period receiving face-to-face warnings that he risked sepsis or death unless he agreed to an admission. On each occasion he agreed only to renege on the decision later. A capacity assessment regarding hospital admission was attempted by the GP 7 days after the initial refusal but was unsuccessful as he refused to engage. The GP prompted the care home to make enquiries about the Court of Protection with the local DoLS team, however later that day they completed a formal assessment regarding hospital admission concluding that he HAD capacity. 3 days later Peter was persuaded to attend hospital.

This admission lasted for 5 days. Hospital notes indicated the view that Peter *"has capacity to make decisions regarding his treatment and was fully understanding of his clinical situation*." At the end of August 2021, the hospital discharge letter stated, *'gangrene of right foot, to be treated conservatively'*. Prior to discharge the care home requested a professionals meeting, alongside the social worker who wanted to discuss

the option of Peter moving to another home. No meeting was convened before Peter's discharge.

Positive Practice: 1) Intensive level of support offered by GP practice and district nurses prior to hospital admission, 2) Formal capacity assessment completed by GP, 3) Proactive calls for meetings by care home and social worker prior to discharge. 4) Correct (but difficult) judgement by GP not to assume incapacity when Peter was *"shutting down conversation".*[9]

Areas for Development: 1) Presumption of capacity erroneously relied upon by district nurses and hospital staff, 2) Delay in formally assessing capacity regarding hospital admission by GP practice, 3) More appropriate route required for seeking legal advice / Court input, 4) Lack of appropriate discharge meeting. 5) No DoLS application was made by hospital

6.5 - Episode # 5: 26th August 2021 to 11th November 2021 – Third Hospital Admission

Regular input continued from district nurses. They noted the view that he HAD capacity and was intermittently compliant, regularly removing his dressings. A multi-disciplinary meeting was held at the beginning of September 2021. The care home expressed concern about their liability regarding his unwise decision making. The GP shared the view that Peter's capacity fluctuated and agreed with the social worker that it was in his best interests to remain at the care home. A decision was made not to progress a referral to the Complex Care Team (CCT) due to concerns about increasing the number of people involved in his care.

In early September 2021 Peter attended an outpatient's consultant appointment. It was noted that *"Right leg bypass working well. No further extension of the mummified necrosis. Ischaemia to left foot has also not progressed."* A visit by a primary care worker mid-October 2021 noted that he had no dressings in situ and flies were on his wounds. Peter stated that he would *"rather have flies than dressings."* Peter's case was referred onto CCT at this stage. Towards the end of October 2021 Peter was re-admitted to hospital, however shortly after arriving he refused any further treatment and asked to return to the care home.

In addition to his wounds, it was also noted that he had sepsis and damage to his sacrum. A DoLS was applied for, and hospital notes indicate that Peter was for *'antibiotics and conservative management.'* Peter's TEP was reviewed and a referral to the palliative care team was made, alongside a Do Not Attempt

[9] Department for Constitutional Affairs, MCA 2005 Code of Practice (TSO, 2007) 4.59 *"Nobody can be forced to undergo an assessment of capacity"* & Mental Capacity Act 2005 s1(2) *"A person must be assumed to have capacity unless it is established that he lacks capacity."*

Resuscitation decision. Aside from this he remained for full escalation remarking *"I want to keep my life if possible - it's the only one I've got."* Notes also detail that he would consider amputation *"in the future."*

A Safeguarding Adults referral was made by the Trust's MCA lead which was accepted as a s42 enquiry by the local authority. An attempt was made to transfer Peter to a neighbouring hospital for amputation, but Peter refused. Peter was noted to understand the risks associated with this decision. Several attempts made to discharge Peter back to the care home over next 2 weeks were unsuccessful due to a changing medical picture, a requirement for Covid isolation period, and staff availability at the care home. Peter was discharged back to the care home at the beginning of November 2021 with a catheter in situ, a grade 2 pressure sore, with a note for primary care to review and consider need for future amputation.

Positive Practice: 1) Further review of Treatment Escalation Plan, 2) Safeguarding referral raised by hospital and accepted as a s42 by the Local Authority, 3) A DoLS application is made, 4) The care home facilitated the outpatient's appointment 5) Evidence of district nurses working flexibly to try and meet Peter's needs.

Areas for Development: 1) Failure to formally assess capacity in multiple health treatment domains, 2) Query decision not to progress CCT decision in September, 3) Availability of amputation as a clinically available option appears to fluctuate with his expressed wishes, 4) Insufficient communication / meetings regarding discharge. 5) Care needs not met by home.

6.6 - Episode # 6: 12th November 2021 to 25th November 2021 – Fourth Hospital Admission

In mid-November 2021 Peter attends an outpatient consultant clinic, advised now for above knee amputation (left leg) and below knee amputation (right leg). Shortly after CCT visited and queried the care home's ability to meet Peter's needs. Peter was in a dirty pad, constipated, and had a full catheter bag. District Nurses explored a community hospital placement, but this was not progressed as it was determined that a community hospital could not meet his needs. An ambulance was called later that evening, query sepsis but Peter was unable to transfer as could not lie on stretcher due to his pain and the ambulance could not accommodate his wheelchair.

Peter however was admitted to hospital the following day, but a DoLS was not applied for. The hospital stated that it was unlikely to be sepsis and set a plan to discharge with food & fluid monitoring. CCT raised safeguarding concerns with the Local Authority and CQC about the ability of the care home to meet his needs. The following day the care home stated that they could not take Peter without a hospital bed and

pressure mattress. They also expressed concerns that they would be subject to criticism if Peter continued to refuse treatment.

There followed a discussion between the local authority and hospital MCA team towards end of November 2021 which highlighted a discrepancy of view regarding Peter's capacity in the community and hospital settings. Additionally, they stated that a discharge review and safeguarding meeting needed to occur prior to discharge. The following day the care home was contacted by the discharge team and informed that Peter was ready for discharge. The care home informed them of CCT's concerns but he was discharged on the basis that this was Peter's wish.

Positive Practice: 1) Safeguarding / CQC referral raised by CCT, 2) The care home facilitates the outpatient's appointment 3) Joint working between LA and Trust begins

Areas for Development: 1) Failure to formally assess capacity in multiple health treatment domains, 2) DoLS application not made 3) Care needs not met by care home 4) Insufficient communication internally within trust and externally regarding discharge. 4) Ambulance inability to take wheelchair

6.7 - Episode # 7: 26th November 2021 to 22nd January 2022 – Final Hospital Admission

At the beginning of December 2021 transport arranged to enable Peter to attend a pre-op appointment for surgery the next day was late. Peter stated that he now wanted to wait until Christmas. Peter continued to decline care at times *"sitting in his own faeces."* The care home and social worker agreed that a nursing placement should be sought. Discussion occurred between the local authority Safeguarding Team and hospital MCA team regarding the issue of executive dysfunction complicating the capacity issue. The hospital MCA team also prompted the district nurses and surgical team to complete formal capacity assessments in their respective areas.

A meeting under the s42 provisions was convened by a safeguarding social worker. The surgeon stated a view that Peter had capacity regarding surgery, the GP shared their view that it fluctuated. The surgeon stated that they would only carry out surgery with Peter's agreement irrespective of capacity. They stated that it was a finely balanced decision regarding progressing with amputation and that *"the surgery would not be treatment, it would be to relieve suffering."* They also stated that Peter's life expectancy with or without surgery was likely to be limited. The safeguarding social worker informed meeting of the plan to carry out a best interests' meeting regarding residence irrespective of the amputation. The social worker also prompted the care home to serve notice on Peter. Peter subsequently stated that he will not have surgery until the new year. Throughout the rest of December 2021 his condition continued to deteriorate with refusals of care and district nurses noting *"unstageable pressure sores"* towards the end of the month.

In early January 2022, Peter was admitted to hospital but immediately asked to return home. A DoLS was not applied for. The Local Authority stated that it was the *"care homes decision whether they can meet Peter's needs."* The impression from the treating registrar and consultant was that Peter had capacity regarding the request to return, but the care home refuse this. Peter was seen by a mental health worker who prompted a formal capacity assessment regarding the amputation and his stay in hospital. By mid-January Continuing Healthcare (CHC) fast track funding was applied for. Peter's expressed wishes and behaviour appeared contradictory. He was noted to be refusing most care and treatment stating, *"no more I have had enough."* Conversely, he also stated around this time that he has *"plenty of life left to give."* However, on 22/1/22 Peter passed away. Cause of Death was listed as: 1a - Peripheral Vascular Disease, 2 - Frontal lobe dementia. Rest in Peace

Positive Practice: 1) Proactive management of his case under the s42 provisions, 2) Attempts to find alternative placement commenced, 3) Continued level of intensive support by district nurses, 4) CHC fast track referral made (granted 2 days before death), 5) Noted that Peter received social work support throughout entire review period.

Areas for Development: 1) Failure to formally assess capacity in multiple health treatment domains, 2) DoLS application not made 3) Burden for discharge decision erroneously placed on care home.

7. Analysis

There were many missed opportunities relating to the use of the Mental Capacity Act and health related decisions and this is the predominant theme of the SAR. The 'what if' or counterfactual position will be considered first. If the required considerations under the MCA had been undertaken, could it have made any difference to the eventual outcome? Consideration will then be given to the input of each service involved in Peter's care. A significant section of the review period coincides with the Coronavirus pandemic, its associated lockdowns [10], and guidance discouraging external professional visits to care home.[11] Reference to where this is a mitigating factor is made explicit in the report. The deterioration of his lower limbs however occurred from June 2021 onwards when Coronavirus restrictions had been lifted.

7.1 - Counterfactual / Mental Capacity

Accounts of Peter during the review period include descriptions such as *"well informed," "able to engage in meaningful conversation," "quite intelligent," "well read," "politically aware,"* and an *"avid reader."* It might be observed that at first glance Peter may not have given an obvious reason to doubt capacity. Irrespective of this however

[10] March 2020 – June 2020, November 2021- Dec 2022, January 2021-April 2021
[11] DHSC Guidance on care home visiting – withdrawn 1/4/22

there were 3 conspicuous factors that should have prompted a formal capacity assessment. Peter had a formal diagnosis of *"alcoholic brain damage affecting his executive functioning"*[12] given in 2018. Peter had also been deemed to LACK capacity under the DoLS provisions and the Court of Protection regarding where he resided for his care and support and his property and financial affairs. Finally, Peter's refusal of medical treatment and care was placing him at risk of serious harm and death.

People who have executive dysfunction as a symptom of their mental impairment (as was the case with Peter) can prove very difficult to assess. Individuals under assessment often retain many of their global cognitive abilities but struggle with higher level skills. This often manifests itself as the person struggling to make the decision *"at the material time."*[13] because of problems with planning, organising, initiation, impulsivity, or rigidity in their thought. Therefore, Peter may have appeared capacitated when considering the decision in the abstract but have been unable to use or weigh relevant information in the moment. Executive dysfunction was not considered in GP's capacity assessment, with no explicit link to a mental impairment made. However, whilst the Courts had begun to grapple with this issue, case law[14] specifically addressing how executive dysfunction should be considered in the context of the MCA was not available until after Peter's death.[15]

Of more concern was the inappropriate reliance upon the first principle of the Mental Capacity Act, the presumption of capacity. This is often misinterpreted by professionals as a reason not to assess capacity[16] rather than its actual purpose as a *"starting assumption."*[17] Numerous SARs have highlighted this as a problem[18] and this was certainly the case with Peter. In fact, Code of Practice guidance around when capacity should be assessed maps directly onto Peter's situation. (*"the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works … and it has already been shown they lack capacity to make other decisions in their life")*[19] The fact that capacity was not formally assessed by health professionals in all, but one occasion is a significant failing in this case. Capacity assessments were not undertaken across multiple domains of health-related decision making (e.g. discharge, wound/nursing care, Hospital DoLS), most critically in regard to serious medical treatment (e.g. amputation, angioplasty / stenting)

[12] s49 CoP assessment [20/3/20] pg 3
[13] Mental Capacity Act 2005 s2(1)
[14] Royal Borough of Greenwich v CDM [2019] EWCOP 32 & Sunderland City Council v AS and Others [2020] EWCOP 13
[15] Warrington Borough Council v Y & Ors [2023] EWCOP 27
[16] Royal Bank of Scotland PLC v AB {2020} UKEAT
[17] Department for Constitutional Affairs, MCA 2005 Code of Practice (TSO, 2007) 4.36
[18] ADASS : Thematic Review of South West Safeguarding Adult Reviews (SAR) : Mental Capacity (2024)
[19] Department for Constitutional Affairs, MCA 2005 Code of Practice (TSO, 2007) 4.35

It is beyond the scope of this SAR to conduct a best interests' analysis, based on a hypothetical LACKS capacity position, not least because the legislation is designed to be used in a prospective manner. There is no opportunity in a retrospective analysis to dynamically consider risks and benefits with Peter and interested parties as the issues present themselves. Regardless of this, however, it is useful to briefly consider some of the best interests' arguments for and against enforcing care with Peter to highlight possible considerations lost through incorrectly relying upon the presumption of capacity.

Whilst parliamentary reviews emphasise the MCA's autonomy focus[20] it may also be observed that the best interests test is not simply about aiming to replicate the decision that the person would have made.[21] Case law reminds practitioners that whilst patient's *"wishes and feelings will always be a significant factor … there may be elements of a case which are of magnetic importance."*[22] This opens the door for protective interventions against a person's wishes which is an approach that the Court of Protection does facilitate.[23] It might be observed that despite the consistency and strength of his verbal objections, that Peter was deeply conflicted regarding his proposed care and treatment. Whilst he often refused this was often in the context of delay and postponing, rather than refusing interventions outright.[24] Additionally records also evidence that he appeared to have plans for the future.[25] This evidence is arguably inconsistent with his resulting death from a treatment refusal.

Conversely, the centrality of a person's views and wishes are highlighted at the highest tier of the court system[26] with outcomes in some cases refusing to authorise life preserving treatment[27] It should also be noted that the statute requires decision makers to consider *past* as well as present wishes and feelings.[28] Considering Peter's history, it might be observed that he demonstrated a consistent refusal over many years (including times when his capacity would not have been in doubt) to accept guidance or support, even where doing so significantly impacted upon his health and wellbeing. P's attitude was described by a previous social worker as *"oppositional"* with his sister sharing Peter's *"… total refusal to take orders from anyone."* Over the two-year review period there are numerous accounts of Peter expressing his anger regarding his initial detention under the Mental Health Act. Undertaking care and

[20] Select Committee on the Mental Capacity Act 2005, MCA 2005 post-legislative scrutiny (HL, 139) [15]
[21] Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC67 [24]
[22] Re M; ITW v. Z & Ors [2009] EWHC 2525 [32]
[23] Hull University Teaching Hospitals NHS Trust v KD [2020] EWCOP 35, University Hospitals of Leicester NHS Trust v TC & Ors [2020] EWCOP 53
[24] 9/8/21 - wants to leave admission for 24/48 hours, 11/8/21 - agrees to go into hospital after being informed of sepsis risk but later reneges on this, 1/12/21 – wants to wait until Christmas for amputation , 8/12/21 – agrees to amputation but not until after Christmas.
[25] 14/1/21 - P states that he is "afraid of dying" and has "plenty of life left to give"
[26] Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC67 [45]
[27] Wye Valley NHS Trust v Mr B [2015] EWCOP 60
[28] Mental Capacity Act 2005 s4(6)(a)

treatment against Peter's wishes would likely have involved deception, restraint, or sedation. Facilitating these highly restrictive measures alongside this long-standing grievance may have further exacerbated his mental distress and damaged trust with health care workers. Considered in the context of the treating surgeon's assertion that Peter's *"life expectancy with or without surgery is likely to be limited"* it might be observed that little space was available to justify intervention on a least restrictive basis.

As may be seen from the arguments rehearsed above, the case for and against care and treatment against Peter's wishes was finely balanced. One of the primary functions of the Court of Protection however is to navigate the tension between safety and autonomy in difficult cases such as these. Of course, health professionals may have come to valid conclusions that Peter HAD capacity in regard to the decision-making domains referred above. Unfortunately, by failing to consider capacity in the first place no route to a Court consideration in regard to health issues was ever 'on the table.' Not only this but the door was closed on the local adjuvant processes such as a best interests' analysis and access to an Independent Mental Capacity Advocate (IMCA) under a Serious Medical Treatment[29] criteria.

7.2 - The Local Authority

Care Act guidance states that *"Local authorities must make enquiries, or require another agency to do so, whenever abuse and neglect are suspected in relation to an adult with care and support needs."*[30] This applied in two respects to Peter, firstly in regard to alleged 3rd party financial abuse of Peter by taxi drivers providing a courier service for alcohol / cannabis deliveries and staff members he accuses of stealing money. Secondly regarding broader self-neglect concerns including those of medical treatment.

In regard to the former concerns pertaining to alleged financial abuse by taxi drivers are raised in March and April 2020. The social worker prompts the care home to make a safeguarding referral if there are "*any concerns of abuse."* Whilst the social worker is later informed *"by email"* about the concerns it appears as if formal referrals are only made by the care home pertaining to poor nutrition and an altercation with a fellow resident. The alleged financial abuse remains unresolved several months later where further incidents occur with taxi drivers. Furthermore, in February 2021 Peter alleges that he had money stolen in the care home, which the local authority was again aware of but there was no evidence that this was progressed.

Regarding the second element, that of self-neglect, the statutory guidance includes this as a specific category of neglect which may initiate a safeguarding concern. It

[29] Mental Capacity Act 2005 s37
[30] Care and Support Statutory Guidance 14.93

states that the term is a broad one which might include *"neglecting to care for one's personal hygiene, health or surroundings."*[31] It goes onto state that *'self-neglect may not prompt a section 42 enquiry'*[32] but that this is dependent on the circumstances. Whilst Peter's case was eventually accepted for consideration under the s42 provisions on 27/10/21 (and some excellent person-centred work undertaken) it is my view that he clearly met the criteria from at least 23/8/21 onwards when the care home requested an MDT from the social worker to discuss *"pressure sores, falls, malnourishment, Peter declining care or checking his pressure areas".*

It is clear from the chronology that safeguarding referrals from the care home, in regard to financial abuse & self-neglect, did not always follow the correct pathways (and this is dealt with in section 7.3) Irrespective of this, there was a clear reason to believe (with the information known at the time) that the s42 criteria would have been met in both domains. Local authority staff were aware of the concerns and should have progressed using this framework. The Care Act 2014 allows the local authority to *"cause to be made"*[33] an enquiry by others or may direct the concerns to other pathways and processes that it considers more appropriate. There is no evidence of any devolved enquiries and signposting to an MCA consideration is insufficient as a sole means of resolution. In regard to the financial abuse concerns, a resolution of financial capacity does not deal with the broader human rights[34] concerns linked with preventing access to taxis, opening his mail, and limiting alcohol consumption.

Rather than referring the matter back to the Court of Protection, it is dealt with at a local level. Whilst there is a great deal of discussion pertaining to alcohol restriction and opening his mail, there does not appear to be sufficient resolution and authority for this at the time of his death. The matter of his property and affairs expenditure is dealt with via an application to the Courts. There is a delay of 11 months between the Local Authority being appointed as deputy in June 2020 and gaining access to his bank accounts in May 2021. The Local Authority clarified that they were still waiting for the sealed orders In January 2021 so some of this delay would appear to be outside of their control. Regardless of this, there are duties incumbent on the Local Authority to be proactive in chasing this up considering; i) the fact Peter had been established as lacking capacity in regard to finances and ii) that he remained exposed to alleged financial abuse for a 6-month period. The fact that his case was not receiving s42 oversight at this time did not help.

Peter's self-neglect was complex and involved more than refusal of medical treatment. This may be seen in the poor condition he kept his room in the care home and his difficulties with alcohol consumption. (There is a strong argument that he met the s42

[31] Ibid 14.17
[32] Ibid 14.17
[33] Care Act 2014 s42(2)
[34] n8 Human Rights Act 1998

criteria on a *self-neglect basis* from March 2020) Whilst it is undoubtedly the case that issues of capacity regarding medical treatment were not adequately dealt with by health professionals, to view resolution of the self-neglect issue simply on these terms is reductive. The Care Act guidance notes that *'A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour.*'[35] There is significant evidence both proximally and historically that Peter was unable to control his behaviour and prevent self-neglect. In addition to this the Care Act guidance notes that adult safeguarding duties apply irrespective of the individual's capacity status.[36] Whilst sympathetic to arguments that the self-neglect element in the health domain was more pressing, the Local Authority had the option to open a s42 enquiry at a much earlier stage and formally devolve those aspects to health services.

Whilst the DoLS provisions do not concern themselves with specific medical decisions such as those faced by Peter, staff completing these assessments are a useful source of expertise regarding the wider application of the Mental Capacity Act. Unfortunately both DoLS assessments conducted during the review period were completed whilst pandemic visiting restrictions were in place, making it difficult for staff to pick up on collateral information. Additionally, the second DoLS assessor would not have been aware of Peter's significant health deterioration as their assessment was completed the month previous. I noted that a DoLS condition is set in May 2020 prompting a best interests' decision in regard to opening parcels and alcohol intake. This has not been actioned by the time of the May 2021 DoLS review and is repeated there as a condition. Considering this context and the responsibilities that the Local Authority has in regard to reviewing DoLS authorisations[37] there is the question of whether a shorter authorisation period should have been granted or more regular advocacy visits commissioned.

7.3 - The Care Home

There is evidence in the chronologies of the care home attempting to seek advice and support regarding Peter's complex care on many occasions. It is clear that they were struggling to meet Peter's needs. The home raised concerns both with the Local Authority and primary care with regular calls for multi-disciplinary meetings in order to try and clarify issues in regard to risk through self-neglect and his mental capacity. There are problems however with how the care home raised these issues. For instance, the home often chose to raise concerns regarding financial abuse and self-neglect via the social worker with formal safeguarding referrals lacking. As these referrals would not have been considered via a central point opportunity for scrutiny by the wider safeguarding service was lost. Another example of a problem with this

[35] Care & Support Statutory Guidance {14.17}
[36] Care & Support Statutory Guidance {14.6}
[37] *Re W [2016]* EWCOP 58

approach can be seen on 16/8/21 where the care home email the social worker with a serious self-neglect concern who is on leave and does not pick up until 1 week later. Similarly, when risk issues were not resolved or acted upon, this was not escalated in a systematic manner. Care home staff may have viewed their responsibility as discharged via the frequency with which they raised concerns. I could not see evidence however that the care home sought to escalate their concerns systematically via other routes (e.g. Safeguarding Professionals, Safeguarding Adults Board, Local Authority line management). The *'What to do if it's not Safeguarding'* guidance available at the time (now Multiagency Risk Management, MARM guidance) could have proved invaluable in this situation.

The Local Authorities IMR report details one area of concern being that the care home *"…swayed between reporting they could manage Peter's needs to reporting they could not."* Additionally, on 4/1/22 where there is discussion about Peter's return to the care home the local authority state that it is the *"care home's decision whether they can meet Peter's needs."* These statements erroneously shift the burden for re-assessing Peter's needs onto the care provider. The Care Act clearly places the statutory responsibility on the local authority for assessing if an adult has *"needs for care and support"* and if so determining *"what those needs are."*[38] This issue was raised at the learning event. The Care Home Manager stated that they did feel able to meet his needs but crucially this was contingent upon Peter receiving appropriate medical treatment. Considering that Peter would agree to the treatment on admission to hospital and was then returned via inadequate discharge planning (see section 7.6), then some uncertainty regarding meeting his needs was understandable.

Whilst the issue of an alternative care home placement was raised on a number of occasions from August 2021, there was a lack of evidence regarding formal re-assessment of his needs. Irrespective of any statement by the care home indicating that they could meet Peter's needs, the placement should be predicated on the Local Authority's assessment as to if the placement is actually capable of meeting them in the first place. Peter required support across mental health, behavioural, and physical domains throughout the review period. As his physical health deteriorated however the need for personal, wound, catheter, and pressure area care increased incrementally.

This likely took his care needs outside the scope of the care home's standard provision, it being registered by the Care Quality Commission as a residential[39] rather than a nursing care home. Decisions regarding moving individuals when their care needs exceed the registration notices however are rarely straightforward. Support around mental health and behavioural elements is often linked to established relationships with carers which would be disrupted with a move. There is also the

[38] Care Act (2014) s 9(1) (a) & (b)

[39] Care Quality Commission : Inspection Report 14/6/2021.

availability of alternative placements that can prove challenging to source where behavioural and risk issues are present. Residential care environments can be supplemented by external services such as was the case here with the involvement of the district nurse team. I am also aware that Peter wished to remain at the care home during this period. So, Peter remaining in residential care may have had mitigating factors. I could not see however a substantive consideration of an alternative nursing home option (to consider in a best interests' analysis) until 30/11/21, many months after his care needs had increased.

Watershed moments arrive with incidents in October and November 2021 where visiting professionals discover Peter with flies on his wounds, wearing dirty incontinence pads, and with a catheter bag *"full to the brim."* On first glance, these issues appear to indicate neglect on behalf of the care home, however the s42 enquiry does not substantiate any concerns in this regard. The care home was attempting to navigate a complex situation whereby on the one hand they were informed by social care professionals that Peter LACKED capacity in regard to residence, care, and finance domains and by health care professionals that he HAD capacity regarding health treatment domains. I note that the care home did not assess capacity regarding domains of decision making that they were responsible for such as personal care. Considering Peter's complex presentation however and the potential for linked decisions my expectations would be for statutory services to lead and provide guidance on this. It was also evident that DoLS conditions set were not progressed. Mitigating against this is case law supporting the view that *'the obligations of Managing Authorities are satisfied if they use their best endeavours to ensure compliance."*[40] which I believe was the case here.

7.4 - District Nurses

Two incidences occurred whereby district nurses were involved during a period of rapid deterioration in Peter's condition. The first occurred in June 2021 where the district nurse team report that whilst Peter refuses a Dopler scan, he was not in pain and allowed them to take radial pulses. It was confirmed by the district nurse attending the learning review that at this time there were no wounds on his feet. Contemporaneous records from different sources however detail that he was pulling his foot away on examination and requested an increase in his pain relief medication. Shortly afterwards Peter was admitted to hospital, received a diagnosis of *"significant peripheral vascular disease,"* and an angioplasty was undertaken within 13 days. The second occurred in August 2021 when the district nurse team reviewed his wounds post hospital admission. They deem that dressings were not required, note that he was refusing pressure relieving equipment, and that there was *"no reason to doubt capacity."* The following day, however, dressings were prescribed. He received

[40] Richard Jones, Mental Capacity Act Manual (7th edn, Sweet and Maxwell, 2016) 327

regular district nurse input regarding this until a hospital re-admission 5 days later. Collateral information from other professionals does not appear to have been considered in the June episode. Additionally, an assessment of his mental capacity in regard treatment of his wounds was not undertaken. This remains the case at the time of his final hospital admission in January 2022 despite a prompt from their organisation's MCA lead to complete a capacity assessment in regard to wound care.

It should be considered that in the counterfactual position of being found to LACK capacity a best interests' consideration would have presented an equally confounding set of problems. Simply put, how do you carry out diagnostic interventions or ongoing wound care with someone who holds strident views and who is likely to resist physically. None of these concerns however vitiate responsibility regarding the MCA. In addition to the protection of patient autonomy[41] the MCA also ensures that the treating professional *'does not incur any liability'*[42] providing the provisions of the Act have been followed. Best interests through its statutory duties to seek the view of interested parties[43] serves to gather expertise increasing the chances of finding a solution to the problem. Whilst their appropriateness cannot be determined retrospectively, restraint and/or sedation for care interventions or a pressure mattress (as opposed to heel protectors) could have been considered. These may have been dismissed as too restrictive or counterproductive however responsibility for this decision would be shared. Even where the individual is ultimately found to HAVE capacity it is good practice to consult with others when determining the relevant information for a decision. This may have helped to overcome the concerns raised above where a judgement is made regarding his pain levels in isolation.

7.5 - Primary Care (GP Practice & Complex Care Team)

A period of activity in March 2020 involved regular input from the GP practice where Peter complained of significant pain in his feet. Peter's skin was intact and *"no evidence of nerve or vascular damage is noted,"* however his toenails were noted to be *'appalling.'* Despite this pain, Peter refused a proper examination focusing instead on pain relief via Codeine and an X-ray. (ordered but no evidence of this occurring) Whilst a capacity assessment in regard to medication / examination should have been undertaken, the surgery's input coincides almost to the day with the start of the first national Coronavirus lockdown. Whilst this offers some initial mitigation, symptom control focusing on pain relief with Codeine is the prevailing paradigm of treatment for the next 14 months until June 2021. Considering Peter's history of alcohol dependence this comes with increased risks[44] and would have arguably benefited from an earlier review.

[41] Department for Constitutional Affairs, MCA 2005 Code of Practice (TSO, 2007) [15]
[42] Mental Capacity Act 2005 s5(2)
[43] Mental Capacity Act 2005 s4(7)
[44] Stock CJ. Safe use of codeine in the recovering alcoholic or addict. DICP. 1991 Jan;25(1):49-53.

A similar pattern in regard to Peter's behaviour presented itself in June 21, however on this occasion *'significant peripheral vascular disease'* was diagnosed. Two episodes occur involving multiple refusals and unsuccessful ambulance attendances involving necessary hospital admissions. During the first episode in June, he was noted to have capacity in regard to an admission, but no formal capacity assessment underpins this. An 11-day episode occurred in August 21 which on this occasion is noted to be life threatening with a risk of sepsis and death. A formal assessment was attempted (but unsuccessful due to his refusal to engage) on day 7 with the GP prompting the care home to contact the local authority DoLS team in order to make enquiries about approaching the Court of Protection. A successful capacity assessment was carried out on day 8, with an outcome stating that Peter HAD capacity.

It is of note that despite the complexity and seriousness of Peter's situation ***the GP Practice were the only service within health that formally assess his mental capacity during the SAR review period.*** It must be noted however that the presumption of capacity[45] was erroneously invoked in June 21. Additionally there was a delay in completing a formal capacity assessment for the second admission considering; a) that Peter had already been established to LACK capacity in regard to residence/care/finances by the CoP (GP Practice sent DoLS paperwork by care home on 2/3/20), b) that a repeat hospital admission was raised as a possibility 11 days prior to the first attempted assessment, c) established concerns evident relating to the refusal of care and treatment, d) his established diagnosis[46] & e) serious risk to life and limb.

It is positive that the jurisdiction of the Court of Protection was mentioned however the GP Practice raise this via two 3rd parties (care home & local authority). The matter was a clear contested health issue, legal advice should have instead been sought via their Clinical Commissioning Group (as it then was). The capacity assessment regarding hospital admission was shared with the report author by the GP Practice and was completed within the general clinical notes. Whilst the decision and functional test requirements are clearly articulated, some detail is lacking regarding the relevant information. In addition, the mental impairment is not referred to. This latter element is vital as capacity outcomes may turn on this especially when considering matters of executive dysfunction. As mentioned elsewhere in this report explicit case law regarding this issue whilst relevant to Peter would not have been available to the GP Practice at the time of completing their assessment. It does highlight however the value in using pro-forma to ensure that necessary elements of the assessment are covered.

[45] Mental Capacity Act s1(2)
[46] n4 ICD 10 Classifications

The GP made comments in September 2021 and December 2021 regarding Peter's fluctuating capacity. Considering this opinion and that three more hospital admissions occur after the events described above then a re-assessment of his capacity should have occurred. Irrespective of this, it is encouraging to see that a professionals' meeting was convened by the GP Practice in Sept 2021. Whilst some good risk mitigation occurs, a decision was made not to progress a referral to the complex care team (CCT) due to concerns about increasing the number of people involved. Peter, however, was arguably the type of individual that the CCT service is commissioned for. When CCT pick up the case the following month the extra resource and expertise they bring has clear benefits to in regard to moving Peter's case forward.

7.6 - Secondary Care (Hospitals)

The chronology details that serious medical treatment was considered by secondary care on at least 10 separate occasions in relation to the vascular disease that Peter was suffering with in his feet and then legs. In June 2021 Peter underwent angioplasty/stenting and was presumed to have *"full capacity"* in regard to this. Following on from this the medical treatment options ranged from conservative treatment to amputation, initially of his right lower limb then both. At a safeguarding meeting convened in December 2021, local authority notes indicate that the treating surgeon *"… would only carry out the surgery if Peter was in agreement. He would not make a best interest decision to carry out the surgery if Peter was not in agreement."*

This point was raised directly with the clinician as part of the Safeguarding Adult Review. They offered that the clinical availability of treatment In Peter's case was dependent upon his ability to engage with post-operative care and rehabilitation. As Peter was unable to engage with this, then the amputation was not an available treatment. The treating surgeon offered that a body of his peers would agree with this perspective. In legal terms this is referred to as the *Bolam*[47] test which compels medics to act *"in accordance with a responsible and competent body of relevant professional opinion."*[48] Historically, if a treating medic considered a particular course of action to be in a patient's best interests and a body of their peers would agree with this, then the treatment could be considered to have a sound lawful basis.

Unfortunately, the clinician's rationale is inconsistent with the body of evidence in the chronology. The amputation ***was deemed clinically available*** on many of the above occasions but did not go ahead due to Peter's refusal. This clearly brings Peter's case within the scope of the MCA which prompts *"…a subjective evaluation of the patient's wider social and welfare preferences, separately and subsequent to the doctor's determination of clinical [best] interests."*[49] Whilst the MCA sits outside the jurisdiction

[47] *Bolam v Friern Hospital Management Committee* [1957]
[48] Helen Taylor "What Are 'Best Interests'?: A Critical Evaluation of 'Best Interests' Decision-Making in Clinical Practice." (2016) Medical law review Vol 24 pg 179
[49] Ibid pg 186

of clinical decision making the two are inextricably linked. In a medical treatment scenario such as this, the decision as what treatment options are 'on the table' rests on the foundation of clinical decision making. One concern raised is that the manner in which a clinical decision is formulated can undercut the patient's rights by withdrawing options prematurely [50]

Post operative difficulties may affect the clinical availability of treatment however there are inherent difficulties with this formulation. In Peter's case there were concerns about his ability to engage in both post operative care and longer-term rehabilitation. If both issues were considered within the framework of the MCA, a broader range of views and potential solutions may be accessed. Additionally, formulating the issue solely as a clinical decision, allows less scope for considering Peter's protected characteristic of *"disability"*[51] and the associated legal duties regarding *"reasonable adjustments"*[52] under the 2010 Equalities Act. An MCA-based formulation helps to ensure patients receive fair access to treatment whilst simultaneously protecting clinicians against allegations of discrimination.

Where the chronology indicated that amputation was available or where medical treatment was actually given (see stenting/angioplasty procedure in June 2021), no formal consideration of mental capacity was made. The Trust IMR report states *"There are frequent references made within the records to Peter's capacity to make decisions about his health care, however, there appears to be no formal assessment of capacity in relation to specific health needs."* The deficits regarding formally assessing mental capacity extend into other domains within secondary care. Difficulties getting Peter to accept personal care and treatment for wounds & pressure areas in the care home remained an issue in the hospital setting and so should have received an MCA consideration from hospital nursing staff (e.g. in November 2021 he is discharged back to the home with a pressure sores). As is referenced in the mental capacity/counterfactual section, failing to formally consider his mental capacity closes down any routes to a potential best interests' analysis and IMCA support.

Over the review period Peter was admitted to secondary care on 5 occasions but a DoLS application was only applied for once during his admission in October 2021 and then not applied for during subsequent stays. This was despite the fact that Peter was subject to a DoLS throughout the review period in his care home, which had been authorised by the Court of Protection. Discussion at the learning event revealed that there was no specific system for identifying individuals DoLS status on admission to hospital. Staff rely upon family members, carers, or the provider to inform them as part

[50] Ibid pg 190
[51] Equality Act 2010 Pt2 Ch1 (6)
[52] Ibid Pt2 Ch2 s20

of usual care transfer processes. Since the end of the review period a multi-agency digital record system has been implemented which shares DoLS status.

Three out of five of Peter's discharges from hospital to the care home gave cause for concern. In regard to the August 2021 transfer of care, no discharge meeting was held despite requests by social worker and the care home. In regard to the early November 2021 transfer of care, multiple attempts are made to discharge Peter over a 2-week period. No discharge meeting is held to discuss the risks despite his case being accepted under the s42 provisions. In regard to the late November 2021 discharge, 2 days prior to Peter returning home the Local Authority and hospital safeguarding team note the discrepancy between the DoLS in the Care Home and the working assumption that he had capacity in regard to discharge. They note the need for a discharge review and safeguarding meeting prior to discharge. No discharge meeting occurred, and he returned home, despite objections from the CCT, on the grounds that this is his choice. During the learning event the care home report poor communication from the hospital contrasting this with their positive experience with primary care.

All three of the above discharges are negatively impacted on by the lack of an adequate MCA consideration as there is no basis to call a best interests' meeting. The latter two however, have a clear rationale to call a safeguarding adults' meeting. All discharges would have benefited from a risk management meeting considering the clear risks that he was presenting with. It is acknowledged that hospital beds are a valuable resource and that the issue of winter pressures in the November discharges may have been an exacerbating factor. Irrespective of this, there appears to have been a disconnect between the Discharge Team and those responsible for safeguarding and MCA considerations leading to unsatisfactory discharges. Discussion at the learning event revealed that hospital records contain a flag which serves to alert discharge teams to any outstanding safeguarding issues. This however is placed on the records by the hospital safeguarding team so is dependent upon a) the referral being raised through the Trust's internal safeguarding team or b) being made aware of the safeguarding referral by the local authority. It is clear that in Peter's situation the system did not work.

7.7 - Advocacy Services

Peter received advocacy support in relation to his DoLS at the care home. As part of this SAR process documents were reviewed to see if there was any opportunity for advocates to prompt a medical treatment MCA consideration. Input was appropriately focused upon his intermittent objection to the placement at the care home and the additional restrictions that he was subject to there (i.e. alcohol & searches of packages). Direct consultation with Peter proves difficult due to several factors. In September 2020, the meeting was virtual due to pandemic restrictions and Peter

refused to speak with the advocate. In June 2021 when his feet deteriorate the advocate attempts a face-to-face visit, but Peter had been admitted to hospital the previous night. The advocate calls back a week later before submitting their report, but Peter remained in hospital. It would not be unreasonable for the advocate to assume any medical issues would be dealt with whilst in hospital. This serves to highlight the significant deficits brought about during the pandemic. Whilst it remained possible to gather information that practitioners were specifically looking for consideration of collateral information was more challenging. One missed opportunity was evident during a September face-to-face meeting. Recent circumstances regarding refusal of treatment and his gangrene are shared, but no evidence of any signposting is evident in the relevant report. By early January 2021, Peter's advocate is prompting a capacity assessment regarding the proposed amputations.

8. Conclusions & Recommendations

8.1 -The ICB to produce guidance for primary care clinicians regarding situations warranting Court of Protection consideration, including clear pathways for seeking clinical & legal advice. This document should be submitted to the SSAB within 6 months of publication of this SAR.

Staff within the GP Practice surgery managed Peter's complex situation unaided for an extended period placing significant demand upon their resources. There was uncertainty around seeking external support and when and how clinicians might access the Court of Protection. Further evidence for this may be found in a recent survey undertaken by the SSAB in which 73% of Primary Care staff expressed a lack of confidence in this area.[53]

8.2 - The Trust to carry out a review of their policy, process, and systems giving assurance as how active risk issues are communicated to and managed by discharge teams. A report detailing this should be submitted to the SSAB within 6 months of publication of this SAR.

There was a disconnect regarding discussions centring on issues of risk (Safeguarding, Mental Capacity & DoLS) and Peter's discharge arrangements. This led to discharge occurring on 3 occasions with insufficient consideration as to his care arrangements and safety. Whilst a 'safeguarding flag' was forwarded as a method of identifying concerns it appears as if gaps in the system remain. The degree to which shared digital clinical record systems are utilised should also be considered within this report.

8.3 - The Local Authority to arrange a qualitative peer review of self-neglect referrals whereby health related and/or financial mental capacity issues are a significant factor. This review to then be shared with the SSAB within 12 months of publication of this SAR.

[53] SaR Robert MCA Confidence Survey {17/1/24} – 73% of staff in Primary Care settings stated that they were *"Not confident at all"* or *"Lacking some confidence"* – Sample size 74

The author has forwarded a view that Peter's case should have received a s42 consideration at a much earlier stage (it was eventually given this in October 2021). It appears that in Peter's case that too much focus was placed on resolving the safeguarding issues by considering capacity as a determinative factor. I acknowledge that in Peter's case that the Coronavirus pandemic may have been a contributing factor however assurance is required that this approach is not current and systemic.

8.4 - The Trust to arrange 2 separate workshops with the involved surgical and district nursing teams to discuss this SAR and application of the Mental Capacity Act. This to be undertaken with 9 Months of the publication of this SAR.

Duties in regard to using the Mental Capacity Act within the hospital setting and with the district nursing team were not met. Better engagement with the Act may have helped to identify other solutions and offered staff protection from liability. Key areas to cover should include i) Consideration of executive dysfunction, ii) Interface between clinical and patient decision-making, iii) Formulating decisions in complex cases, iv) Appropriate consideration of the 'presumption of capacity' principle, v) DoLS

8.5 – The Care Home to provide anonymised evidence to the SSAB of using the MARM and/or resolving professional differences guidance. If opportunity does not arise naturally for the use of either, then the Local Authority should provide a hypothetical scenario to work through with the care home in order for the evidence to be produced. This to be undertaken within 18 months of the publication of this SAR.

During the review period the care home had the option of using the 'What to do if it's not Safeguarding' guidance, however this was not utilised. This guidance has now been replaced by the MARM guidance (Multi-agency Risk Management) and supplemented with the Resolving Professional Differences guidance. Assurance is sought that the care home is familiar with these processes to manage risk and professional disagreement should similar situations arise.

8.6 – The SSAB should consider reviewing the MARM guidance to; a) incorporate recent imperatives from capacity-based case law judgements in a practitioner friendly manner and b) strengthen the link between it and the SSAB "Resolving Professional Differences" guidance. This action to be undertaken within 6 months of the publication of this SAR.

Considering the MARM guidance, in the context of the SAR, I believe that the SSAB should consider; i) adding a separate section pertaining to the persons capacity status in the draft agenda (detailed in Appendix 1) and ii) adding linked guidance regarding the nature of the decision (micro/macro/interlinked) and who is going to undertake this (sole/joint). Whilst the current MARM document references the "Resolving Professional Differences" guidance it does so in the context of poor participation or the need for multi-disciplinary meetings. It would benefit from an explicit reference to Care Act s42 safeguarding challenges with a clear directive that a MARM should be the vehicle to hold and consider that risk whilst the professional disagreement is resolved.