‘Matthew’

Safeguarding Adults Review: Final Report

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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 with care and support needs 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 improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and the way organisations 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. Each organisation involved in Matthew's (pseudonym) care in the approximately 13-month period prior to his death submitted reports, documentation and records that were considered along with other relevant information at a desktop review meeting. The information considered included detailed chronologies and information from a Safeguarding Enquiry that had been undertaken under Section 42 of the Care Act (2014) that was completed after Matthew's death.

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

- Matthew's General Practitioner
- Safeguarding Adults Team, NHS Somerset Clinical Commissioning Group
- District Nursing Team, Somerset Partnership NHS Foundation Trust[1]
- Adult Safeguarding Service, Somerset County Council
- Adult Social Care Service, Somerset County Council

1.5 Apologies received for the desktop review meeting included South Western Ambulance Service, NHS Foundation Trust, Somerset Partnership NHS Foundation Trust's Home Treatment and Community Mental Health Teams, Somerset Mind and Matthew's provider of domiciliary care. Information, including detailed chronologies, was included in the process from these

[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.

organisations, and any questions emerging from it followed up with the organisation concerned and incorporated into this report.

1.6 The review focuses on the multi-agency response to Matthew's deteriorating health in the autumn of 2017, and specifically his failed admission to a community hospital, while drawing on his history to provide context, and in particular the arrangements that were put in place for his admission to hospital in January 2018.

1.7 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.

1.8 Matthew appeared to have had a very distant relationship with his family and had explicitly told different professionals on a number of occasions that he did not wish his family to know about or be involved in his care. After debate during the desktop review, it was agreed that this should be respected in terms of the SAR process. However, when an attempt was made to contact Matthew's family to offer them the chance to review a draft copy of this report no response was received.

1.9 This report has been anonymised and information summarised unless directly relevant to the learning from the case. Where changes have been made to quotations these are shown in square brackets.

1.10 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.

2 About Matthew

2.1 Matthew was 44 when he died in January 2018 as a result of a significant deterioration in his health linked to self-neglect. His ethnicity was White British. At the time of his death, he had been living in a town in Somerset since at least 2008, latterly in a ground-floor flat that he rented from a social housing provider, although little is known about his history before he came into contact with local health and social care services.

2.2 Matthew had Type 2 Diabetes[2] and his height to weight ratio would be classified as 'obese'[3] at the time of his death. He was also known to be a very heavy smoker.

[2] Type 2 diabetes is a common condition that causes the level of sugar (glucose) in the blood to become too high.

[3] See Height and weight chart - NHS (www.nhs.uk). 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/m^2, resulting from mass in kilograms and height in metres. If an individual has a BMI above 25 then they are considered to be overweight.

2.3 His cause of death was determined to be:

1a: Pneumonia[4]
1b: Supermorbid obesity, Chronic Obstructive Pulmonary Disease[5]
1c: Type 2 Diabetes Mellitus

2.4 Matthew had a history of substance misuse and personality disorder, as well as severe physical issues connected with his weight, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and skin infections. Throughout the period under consideration records from the organisations involved in his care and support state that he would decline support with managing his diabetes, despite indications he was struggling to do so himself. It was also believed that he was using illegal drugs (thought to be limited to cannabis) up until January 2018, however substantiating whether this was the case or not was outside of the scope of the SAR.

2.5 The professionals involved in Matthew's care said that he was believed to be living on take-away meal deliveries, despite repeated advice being given of the impact that doing so was having on his health.

2.6 Matthew's wife died from cancer a number of years before the period under consideration. From background information provided by the organisations that attended the review meeting she appeared to have been a moderating influence on him, and that the loss of her influence had a significant impact on Matthew's health.

2.7 District Nurses employed by Somerset Partnership NHS Foundation Trust were involved in the care of Matthew's wife. They said that their experience was that, at times, he could be both verbally and physically aggressive, which they felt affected how they were able to work with both Matthew and his wife.

2.8 Matthew's General Practitioner (GP) described how Matthew became more housebound after his wife died; that he could be quite threatening at times, and that, from their perspective, Matthew appeared to have formed a view that health services were to blame for his wife's death.

2.9 Matthew was a very heavy smoker. The District Nursing Service understood he was smoking in excess of 80 cigarettes a day, with what was believed to be cannabis in addition, and was described during the desktop review meeting as '*almost always having a lit cigarette*'. Support was offered to help Matthew to stop smoking in the form of nicotine patches, but he declined it.

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[4] Pneumonia is swelling (inflammation) of the tissue in one or both lungs. It is usually caused by a bacterial infection. It can also be caused by a virus, such as coronavirus (COVID-19).

[5] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. COPD is a common condition that mainly affects middle-aged or older adults who smoke.

During the desktop review meeting it was stated that while he would stop smoking when a patient in hospital, he would start again as soon as he returned home.

2.10 As Matthew's health deteriorated he became increasingly housebound, and latterly bed bound. Chronologies indicate that his weight increased from 35 to 37 stone (222 to 235kg) during the period under consideration.

2.11 Matthew had a dog that was extremely important to him. He also had a friend who visited most days who it was alleged purchased cannabis for him.

3 Matthew's history prior to 2017

3.1 From the records considered Matthew appears to have had little involvement with services other than those provided by his GP prior to 2015.

3.2 Matthew was in receipt of a domiciliary care[6] package on discharge from hospital in 2007 until he declined further services after about 3 months. His next contact with the Council's Adult Social Care Service (ASC) was not until 2014 when his wife made contact about difficulties they were both experiencing to bathe. This resulted in an application being made for a Disabled Facilities Grant and, shortly after, the involvement was closed with the note "*Rails are proving helpful for* [Matthew and his wife]". There was then a further break in contact until August 2015.

3.3 GP records show various discussions with Matthew regarding his mental health, about signs of paranoia and pseudo hallucinations[7] of his deceased wife. Matthew's GP made a referral to Somerset Partnership NHS Foundation Trust's local Community Mental Health Team (CMHT) in May 2015. Matthew was subsequently assessed by the CMHT at the end of May 2015 and offered medication and talking therapies[8]. Matthew declined this support. A month later Matthew changed his mind and contacted the CMHT requesting

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[6] Domiciliary care is defined as the range of services put in place to support an individual in their own home.

[7] Pseudo-hallucinations are fleeting episodes of seeing or hearing someone or something that is not really there. They are a normal part of the grieving process, and are distinct from 'hallucinations' which can be a sign of severe mental illness.

[8] Talking therapies can help with common mental health problems like stress, anxiety and depression. They include:

- Cognitive behavioural therapy (CBT) – a family of talking therapies all based on the idea that thoughts, feelings, what we do, and how our bodies feel, are all connected. CBT works to help us notice and challenge patterns of thoughts or behaviours so we can feel better.
- Guided self-help – where a therapist supports you as you work through a self-help course in your own time, either using a workbook or an online course.
- Counselling for depression – a type of counselling developed specially for people with depression

Talking therapies can be provided: using a self-help workbook with the support of a therapist, as an online course, over the phone, one-to-one or in a group

therapy. During July 2015 Matthew was admitted for a short period of time to an acute mental health ward due to an intentional overdose of Tramadol[9].

3.4 Records from the South Western Ambulance Service NHS Foundation Trust (SWASFT) show that Matthew made five 999 calls during 2015. They were all to report medication overdoses. The records considered by the desktop review did not contain a view as to whether these were deliberate or accidental.

3.5 In February 2016 a care package commenced provided by a local domiciliary care provider funded by ASC.

3.6 In March 2016 arrangements were put in place for Matthew to manage his own care using a Direct Payment[10], however, he changed his mind a few days later, and therefore his care continued to be commissioned by ASC.

3.7 GP records show Matthew made little contact with his GP practice during 2016. During April 2016 GP records indicated that Matthew was not taking his medication as he had been advised to, weighed 35 stone and had several open sores.

3.8 During November/December of 2016 Matthew contacted his GP due to low mood and requested to be re-referred to the CMHT. His GP made a referral in response to this request.

3.9 In late December 2016 Matthew was referred to Somerset Mind for support by his Social Worker. Somerset Partnership NHS Foundation Trust had also offered him an anxiety course in another part of Somerset which would start in January, which the Council's records state he was "*keen to start*".

4 Matthew's deteriorating health during 2017

4.1 In early January Matthew's allocated Adult Social Care Worker made a referral for an Occupational Therapist to assess Matthew. The carers employed by the domiciliary care agency said that they were experiencing difficulty as Matthew was saying that he could no longer be washed in the wet room that had been installed in his home, and wanted to remain in bed. However, the carers were reporting difficulty in washing Matthew in his existing bed due to his weight and the position of the bed. An assessment subsequently identified that a bariatric[11] bed was required, which it was felt should also assist Matthew in being able to stand. Following authorisation, a new bed was ordered five days later.

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[9] Tramadol is a strong painkiller that is only available on prescription. It is used to treat moderate to severe pain, for example after an operation or a serious injury.

[10] Direct Payments are when an adult chooses to receive a payment from a Council with adult Social Services responsibilities to arrange their care and support rather than asking the Council to do it for them.

[11] Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.

4.2 In the second week of January 2017 Matthew contacted his Adult Social Care Worker to ask if a different domiciliary care agency could support him, as he was unhappy that carers had said that they were having difficulty washing him. The reasons why the carers were experiencing difficulty were explained to Matthew, but he continued to request a new agency be commissioned, and a request was therefore made for a new agency to be identified. The Council's records state that Matthew was also asking that he only be visited by female carers. Matthew contacted the Council later the same day and made the request again.

4.3 A new bed was delivered in mid-January; however, Matthew contacted his Adult Social Care Worker to say that the remote control wasn't working and that this had meant that carers employed by the domiciliary care agency had been unable to wash him. He also said he was unhappy with the time that it had been arranged for the carers to visit him. The Social Worker contacted the care agency. The records state "[Matthew] *has been offered to have a wash while sitting on the edge of the bed or in the shower but has been declining that. They have one day in a week that the carers could visit* [Matthew] *earlier. I have explained that* [Matthew] *would like to have earlier visits everyday and* [staff member name] *will look at* [this] *when they have capacity"*.

4.4 Two days later Matthew contacted his Adult Social Care Worker. Their records state "[Matthew] *is happy with the bed. He changed his mind about changing the care agency and doesn't want to do it anymore* [change care agency]*. He is not able to walk at the moment and his GP is visiting* [Matthew] *tomorrow*".

4.5 At the end of February 2017 Matthew's Adult Social Care Worker had a discussion with the worker from Somerset Mind. The Adult Social Care Worker's records state that Somerset Mind had offered a "*support group to build up* [Matthew's] *confidence. It starts next week but we are not sure if* [Matthew] *is going to follow it through*". On the same day Matthew also contacted his Adult Social Care Worker. Their records state that Matthew "*called me yesterday saying that he can barely walk and needs support at tea time with the meal and emptying urine bottle. He said that he has lesions on his legs and DN*[12] *is coming to dress them.* [Matthew] *also is worried what would happen if he wasn't able to go out to get the cash as he only deals with cash. I have asked if he could appoint a family member but* [Matthew] *would like someone else*". An assessment was competed in early March 2017 which stated that Matthew had said "*I am managing my money and believe I receive all the benefits, I am entitled to*". Following this assessment, a request was made to increase Matthew's care package, and he contacted

[12] District Nurse

his Adult Social Care Worker six times over the following two days as they sought to get it authorised and arranged.

4.6 Two days later Matthew's Adult Social Care Worker spoke to the Integrated Rehabilitation Team (IRT)[13] which had been in contact with Matthew. Their records state Matthew was telephoned "*yesterday and he told them that he can walk to the toilet with 2 sticks with difficulty but is managing. He still insisted on the urgent visit but they have explained that if he is managing to walk to the toilet. He told me that is not managing. IRT will see* [Matthew] *next week*".

4.7 Three days later Matthew called his Adult Social Care Worker to say that he had been in hospital with a suspected heart attack. He asked them to cancel his attendance at the Somerset Mind support group for the following day, which they did, and also a visit to an Extra Care Housing scheme[14] that he was at that point considering an application to move to.

4.8 In mid-March 2017, 11 calendar days after it was requested, Matthew's Adult Social Care Worker received approval for a six week increase in Matthew's care package. It was arranged for his existing domiciliary care agency to provide it at Matthew's request. The rationale for the initial time limit on the increase was that other options were also being considered, including Matthew potentially moving to an Extra Care Housing scheme. The arrangements were subsequently extended on several occasions before being made permanent (with an overall reduction of 1 hour per week for non-care tasks such as shopping that Matthew was told that he would need to pay for himself if he wanted them to continue to be undertaken by agency staff) at the end of June.

4.9 During March 2017, Somerset Partnership NHS Foundation Trust's CMHT conducted an assessment and concluded that Matthew did not require a secondary mental health service and he was therefore discharged. Matthew was unhappy with this and made a complaint via the Patient Advice and Liaison Service (PALS).

4.10 Matthew also called 999 several times in March making threats to take an overdose. His risk of suicide was assessed as low by the CMHT; however, it was identified by a worker from Somerset Mind that although Matthew had

[13] An Integrated Rehabilitation Tea is a multi-disciplinary team that provides rehabilitation after an illness or injury for adults registered with a Somerset GP. At the time of writing teams are made up of an occupational therapist, physiotherapists, rehabilitation assistants and pharmacy technicians.

[14] Extra Care Housing is a form of housing, usually provided on a site (often referred to as a scheme) comprising of flats or houses, where care staff are situated on-site to support residents.

made no serious attempt to take his life, his levels of self-neglect[15] may have the same outcome.

4.11 Records show that a professionals meeting was held in late March 2017 between Matthew's GP, a staff member from the CMHT, the worker from Somerset Mind and Matthew's Adult Social Care Worker. The meeting was initiated by the worker from Somerset Mind. In information considered by the desktop review they said:

> *When* [Matthew] *was referred to me he was already grossly obese. It was clear [that] he needed to address this issue and I talked to him about eating more healthily and the need to move more, he was also lonely and isolated. We had a plan to get him out to engage with one of our groups, unfortunately there was always a reason why this was not possible for* [Matthew]*.*
>
> [Matthew] *always had a reason why he couldn't stick to the diet or why he was unable to move further than to the toilet. I called a case review meeting because of my fears for* [Matthew's] *heath and to make sure all avenues were being covered. At this meeting the GP said he was giving* [Matthew] *palliative care and Somerset Partnership mental health team said he had capacity and needed to help himself. It was clear that the prognosis for* [Matthew] *was poor unless he helped himself, I was frank with* [Matthew] *and explained clearly to him that he was in grave danger because of his obesity and associated health issues. I was clear to him that he needed to control his diet and to move. As* [Matthew] *continued to put on weight and became less mobile it was clear that there was little I could do for him. I agreed to phone* [Matthew] *once a month in the hope that he would take the necessary steps to control his diet and then I could engage with him to get him out and about. I carried on making these calls until he died.*

4.12 As far as could be determined by the desktop review there were no minutes recorded from this meeting. However, individual professional's case notes show that it was discussed that, due to Matthew declining the therapies that had been offered by the CMHT, there was nothing else that they could offer at that time due to his relatively low mental health needs. The Council's records state, that the CMHT's position during the meeting was that "*There are no medication for* [Matthew's] *personality disorder and the support*

[15] 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)

workers they have encourage independence"[16]. The Council's records go on to state that "[Matthew] *didn't want this kind support and* [the CMHT staff member] *believes that* [Matthew] *wants a personal assistant rather that support worker*". The records also state that Matthew also declined input from Somerset Drug and Alcohol Service (SDAS). Records indicate that Matthew's GP reported that they were treating Matthew as a "*palliative mental health patient*" and that an agreed outcome was to pursue Extra Care Housing (ECH) for him. However, he subsequently turned this down in mid-June. Matthew was also offered the opportunity to attend a men's group, including transport to get to it, but this was declined.

4.13 In early May 2017 Matthew was assessed by an Occupational Therapist who ordered a set of bariatric crutches with the aim of helping him to improve his mobility. Matthew's Adult Social Care Worker recorded that these were not delivered until early July, and that when they did arrive Matthew contacted them to say that they were very heavy to use.

4.14 In mid-June 2017 Matthew's Adult Social Care Worker and the worker employed by Somerset Mind visited Matthew. They discussed his need to eat more healthily and his mobility. Matthew's Adult Social Care Worker's record of the visit concludes with the statement that "*We see that* [Matthew] *is not willing to take the responsibility and we have explained to* [Matthew] *that he is the only one who can make these changes to his lifestyle."*

4.15 In July 2017 Matthew's Adult Social Care Worker completed a Continuing Healthcare (CHC)[17] eligibility checklist, and concluded that he would be ineligible.

4.16 In August 2017 hospital and GP records show that Matthew spent 7 days in Musgrove Park Hospital where he received treatment for suspected

[16] The NICE guidance "Borderline personality disorder: recognition and management" (clinical guideline CG78 states that "when considering a psychological treatment for a person with borderline personality disorder, take into account:

- the choice and preference of the service user
- the degree of impairment and severity of the disorder
- the person's willingness to engage with therapy and their motivation to change
- the person's ability to remain within the boundaries of a therapeutic relationship
- the availability of personal and professional support" (section 1.3.4).

In terms of the role of drug treatment it states that "Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms)" (section 1.3.4).

[17] NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals have to be assessed by Clinical Commissioning Groups (CCGs) according to a legally prescribed decision-making process to determine whether the individual has a 'primary health need'.

septicaemia[18]. During this admission Matthew declined a referral to a dietician, at times declined support with personal care tasks and on a single recorded occasion also declined physiotherapy.

4.17 Matthew had a trauma and orthopaedic outpatient appointment at the end of August that he did not attend, and was therefore discharged from the service.

4.18 In early September 2017 Matthew called his Adult Social Care Worker. Their records state that he said "*that he would like to have a mobility scooter instead of motability car but he would need ramping and maybe doors would need to be wider*". Matthew was advised that he should call Motability to ask if they would have a mobility scooter that was suitable for his weight. A suitable scooter was subsequently identified, and Matthew's Adult Social Care Worker made a Disabled Facilities Grant application for his gate and path to be widened. They also arranged for the Occupational Therapy assessment required for the grant to be considered to take place.

4.19 At the end of September 2017 Matthew's Adult Social Care Worker left their role. Matthew did not have an allocated Adult Social Care Worker from this point onwards, but remained open to the local team, which would allocate a member of staff to support him on contact being made[19]. They spoke to Matthew and recorded that "[Matthew] *said everything is going ok at the moment*" and that "*I have reassured* [Matthew] *that he can always call Somerset Direct*[20] *if he has any questions. He is ok with that and I have sent out the letter to him*". They also spoke to the domiciliary care agency which said that there were no current issues, that Matthew was trying to eat more healthily, and the carers are supporting him with that. Although Matthew had been advised to call Somerset Direct the Council's records indicate that Matthew's level of contact dropped very significantly.

4.20 Matthew initiated contact with the Council on two further occasions during this period. These contacts were in relation to a concern that he was being financially abused (see 4.22).

4.21 Throughout the autumn Matthew's health appears to have continued to decline, with a chronology analysis undertaken by the Council's Safeguarding Service referencing repeated statements in documentation to Matthew's low mood and, at times, suicidal thoughts.

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[18] Sepsis is a life-threatening condition that arises when the body's response to an infection causes it to attack its own tissues and organs. In sepsis, patient's immune system goes into overdrive setting off a series of reactions including widespread inflammation. This can cause a significant decrease in blood pressure reducing the blood supply to vital organs and starving them of oxygen. Sepsis can lead to multiple organ failure and death especially if not recognised early and treated quickly.

[19] This is normal practice

[20] Somerset Direct is Somerset County Council's contact centre

4.22 In November 2017 the Council's Safeguarding Service began working with Matthew following concerns from Matthew that he was being financially abused. One of the concerns at the time was that Matthew was unable to get out of bed and therefore left his front door unlocked, and that this resulted in people entering his flat and stealing from him. In particular an adult that was known to Matthew would stay at his home when they had nowhere else to sleep, and Matthew had alleged that he would wake up in the morning to find cash had been stolen from his wallet. The Council's Safeguarding Service continued to work with Matthew during the autumn of 2017 to put arrangements in place to help him keep himself safe from the risk of financial abuse. This included agreeing steps with Matthew to help him keep himself safe, and the Safeguarding Service making contact with Matthew's housing provider to request that an intercom system be installed and to follow this up.

4.23 GP and hospital records show that Matthew had a nine-day hospital admission in late October 2017 through to early November 2017 for COPD. Matthew was diagnosed with obstructive sleep apnoea[21], obesity hypoventilation[22] and hyperglycaemia[23]. Records considered by the desktop review stated that, on admission, Matthew was "*feeling generally unwell, tired and short of breath. He was diagnosed with likely chronic type 2 respiratory failure[24]. He was treated with non-invasive ventilation[25]. The patient could not have CTPA[26] to look for a pulmonary embolism because of high BMI.* [Matthew's] *symptoms improved with BiPAP[27] and steroids. He was also reviewed by the diabetes team during admission, who managed his medications. He has been discharged with BiPAP. This will be reviewed by the respiratory lab team. The diabetes specialist nurses will follow up the patient's diabetes*".

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[21] Sleep apnoea is when your breathing stops and starts while you sleep. The most common type is called obstructive sleep apnoea.

[22] Obesity hypoventilation syndrome is a breathing disorder that affects some people who have been diagnosed with obesity. The syndrome causes you to have too much carbon dioxide and too little oxygen in your blood. Without treatment it can lead to serious and even life-threatening health problems.

[23] Hyperglycaemia is the medical term for a high blood sugar (glucose) level.

[24] Respiratory failure occurs when the respiratory system fails to provide the body with adequate amounts of oxygen and/or fails to remove the carbon dioxide. Type 2 respiratory failure is where the carbon dioxide is not removed sufficiently from the body. The onset of symptoms can be sudden (acute) or can happen more slowly (chronic).

[25] Non- invasive ventilation is a treatment to help with your breathing. It involves wearing a mask connected to a machine which makes your breathing in and out easier and supports the muscles which make your lungs work.

[26] A Computed Tomography Pulmonary Angiography (CTPA) scan

[27] Bilevel Positive Airway Pressure (BIPAP)

4.24 Records considered by the desktop review indicated that during this admission Matthew would at times refuse to be repositioned or moved from bed to chair, or vice versa. He also refused the oxygen mask provided to him to treat his shortness of breath, ignored advice given to him on healthy eating (at times requesting multiple portions of food) and stated he had stopped smoking. On discharge daily visits were arranged from Somerset Partnership NHS Foundation Trust's local District Nursing Team as Matthew had developed pressure sores. These continued throughout November, December (2017) and early January (2018).

4.25 In early December 2017 Matthew was seen by a specialist paramedic from his GP surgery due to reports of shortness of breath, concerns around his diabetes medication administration and deterioration of pressure areas. Records show that the paramedic believed Matthew was no longer safe at home, they assessed his capacity to make decisions regarding the care he received and where he received it and determined that he did have capacity to make such decisions at that point in time. A referral was not made to the Council. Matthew declined admission to hospital, however he did agree to a period of respite, and work began to attempt to identify a nursing home that could accommodate him. In the days prior to this visit from the paramedic, carers employed by the domiciliary care agency had recorded that, at times, Matthew was hard to wake and appeared confused, and that on the day before the District Nursing Team had begun making a second visit in the afternoon due to Matthew presenting as unwell in the morning. On the same day that the paramedic visited it was also agreed that District Nurses would manage Matthew's diabetes medication going forward.

4.26 On the second visit that day District Nurses recorded that Matthew "*requested no dressing changes today as not feeling well. Was not clear as to why feeling unwell. Questioned* [Matthew] *as to whether taken blood sugars which he said he had but would only say they were ok.*" District Nurses also recorded that "*When asked* [Matthew] *felt his mobility was decreasing and said that he was holding his bowel movements and urinating off the bed into a bottle*".

4.27 On the following day the first visit took place from district nurses to help Matthew manage his diabetes medication. Records state that "*it was explained to* [Matthew] *that DNs*[28] *would help him get into routine with diabetes care with the hope that* [Matthew] *will gain back his independence of this*".

4.28 On the next day the domically care agency's records showed that in the morning Matthew was low in mood and having suicidal thoughts, however he was in better spirits in the evening. On the same day the District Nursing

[28] District Nurses

Team's records state "*DN*[29] *team lead to discuss with SW*[30] *the possibility of NH*[31] *bed*"

4.29 On the following day District Nursing records state that it was agreed with Matthew that "*he would be contacted by telephone for evening insulin*[32] *and blood sugar reminder as he has shown he is competent in carrying out task. No answer when trying to contact* [Matthew] *so message left by DN*". Records on subsequent days do not indicate that there were further problems with contacting Matthew other than on one further occasion.

4.30 In mid-December 2017 the domiciliary care agency noted that Matthew was not wanting to get up and they were now unable to provide the care he required in bed due to the position of the bed, and therefore contacted Matthew's GP to share their concerns. Their notes state that "[Matthew] *refused to have a wash as he cannot stand up. Offered a wash in bed.* [Matthew's] *trousers were soaked but he refused to let carers change them as he had no energy.* [Matthew] *said he was too heavy for the carers to move*". They also expressed concern to the District Nursing Team about whether the information that Matthew was giving them about his diabetes management was correct. The District Nursing Team also left a message for Matthew's GP on the same day highlighting concerns about his increasing dependency and decreasing mobility, having ordered a Bariatric commode for delivery the next day. Matthew's GP conducted a home visit two days later. On this visit Matthew's GP noted that he was experiencing more shortness of breath than normal and his GP recorded that they would follow-up on the Nursing Home assessment.

4.31 In the following days the domiciliary care agencies records state that Matthew refused personal care that its staff were visiting him to provide on at least two occasions, and on a third that he "*found it hard to move for personal care*". Their records state that this was reported to supervisors, but do not state what was done with these reports. On Boxing Day, the care agency stated that *"District Nurses called for* [Matthew's] *blood sugar readings,* [he/she] *was calling back later to get another reading.* [Matthew] *said he would lie about it*". Records state that this was reported to a manager at the Care Agency but there is no record in chronologies received from the Care Agency or District Nursing Team of this information being shared.

4.32 At the end of December 2017 both the domiciliary care agency and District Nursing Team made further contact with Matthew's GP surgery due to concerns that they were unable to care for Matthew safely at home. District

[29] District Nursing
[30] Social Worker
[31] Nursing Home
[32] Matthew's diabetes medication

Nurses referenced the difficulty that was being experienced in sourcing a bed in a nursing home due to Matthew's bariatric needs and his relatively young age. The District Nursing Team recorded that they had conducted a capacity assessment with Matthew in relation to his ability to make decisions regarding his health and care needs, which determined that Matthew had capacity to make these decisions at that point in time.

4.33 Two days later the District Nursing Team contacted the Council's Safeguarding Adults Service (which at that point was conducting an ongoing enquiry under Section 42 of the Care Act into the allegations of financial abuse) requesting a respite bed in a care home for Matthew. District Nurses reported that Matthew had been unable to move for ten days, had been opening his bowels in bed, had been unable to wipe himself or have the sheets changed and therefore had faecal burns. District Nurses and domically care staff said that they were unable to undertake all personal care tasks due to the difficulties in moving Matthew but were doing all they could to manage his personal care and wound care. The Safeguarding Service made an immediate urgent request to the ASC locality team, which in turn contacted the District Nursing Team to advise that they should make a referral to primary link[33] as the concerns they were raising related to Matthew's health. This referral was made to seek community hospital admission for Matthew, however *"there was no capacity for any of the Hospitals to take him"* and he therefore remained at home until a bed was identified 10 days later (see 5.1).

4.34 In early January the domiciliary care agency's records state that they were informed by the District Nursing Team that Matthew was now in stage 2 Renal failure[34]. On the following day they contacted ASC to request an urgent Occupational Therapy assessment. At this point an Occupational Therapist was already involved, and was investigating whether a specialist bed could be provided. However, they recorded that that this would require a survey from Matthew's housing provider to establish whether the floor could support the combined weight of Matthew and the bed. The Occupational Therapist also attempted to progress a hospital referral but their records state that the District Nurse said that they had "*tried acute hospital and primary link - neither will take* [Matthew]*, saying it is a social problem. Mentally he is so depressed that physical recovery is affected: rehab potential very low at present. He is 37 stone and can't reach his bottom. The bed is against the wall and is too heavy to move. A male nurse of 6' is the only person who can reach across to wash him*". On reviewing a

[33] 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

[34] Kidney failure

draft of this report, the view of NHS Somerset CCG was that, at this point, Matthew's needs would have been able to be met through a period of care in an appropriate setting to stabilise his health, although it cannot be determined if Matthew would have consented to this.

4.35 On the following day an Adult Social Care Worker and Occupational Therapist had conducted a joint visit to Matthew at his home address. While they were there it was noted that they assisted two carers and a district nurse, to complete Matthew's personal care using sliding sheets. As a result, a request was made for 4 carers to attend care calls to enable them to complete Matthew's personal care. Records state that, after consideration, senior managers within the Council's Adult Social Care service *"determined that as the request related to* [Matthew's] *health needs this should be funded by the NHS"*, and the ASC service therefore declined to fund it. However, while there is a record of a phone call with Matthew's GP, there is no record of the Council contacting Health Commissioners to request funding from the NHS or to complete a further NHS CHC checklist to determine if Matthew was now eligible for a full NHS CHC assessment.

4.36 Two days later the domiciliary care agencies records state that "[Matthew] *had 3 nurses there helping with personal care, nurses said they will try and arrive at the same time as carers so they can work together to provide adequate personal care.*"

4.37 A further two days later the District Nursing Team recorded that three members of the team visited, that Matthew had opened his bowels in bed, and that a skin assessment had found further wounds developing down left side of body as a result of Matthew's lack of movement. Their records state "*discussed with* [domiciliary care agency] *carers the importance of spending at least 30 minutes on personal care in the mornings. Discussed this with* [Matthew] *and explained the importance of allowing carers to care for him and keep him clean and allowing them to check his skin*". It was agreed that the District Nurse would raise these concerns with NHS managers/ commissioners and that a second primary link referral should be made with a view to admission to hospital.

4.38 A further visit from an Adult Social Care Worker and Occupational Therapist took place 2 days later. This was a Thursday. At this point it was recorded that Matthew agreed to a hospital admission to allow an assessment of his condition. Their records state that Matthew "*consented to this plan and to a referral being made to the rehab team to address his physical rehab needs. I advised him that the hoist* [this was a bariatric hoist that had been ordered to help with providing Matthew with personal care] *will be delivered on Thurs or Fri and that I will visit next mon with a rep to try various slings*". The Adult Social Care Worker further stated in their notes: "*Expressed to* [OT] *that I feel* [Matthew's] *health issues are the priority, not social care needs. With*

pressures sores along one side of his body, bottom and groin, added to his diabetes, smoking and poor diet, then the lack of movement his skin is going to continue to break down unless he is treated holistically and within a medical facility such as a community hospital. If he remains at home he will continue to access tobacco and take away foods". They also recorded in their notes that "[the OT] *also mentioned he is at high risk of overdosing on his insulin", and that they were "disappointed to hear that when another NHS colleague had contacted local hospitals none were willing to take* [Matthew]. [DN] *also felt this is wrong and will escalate this to senior NHS managers/commissioners that this is a crisis and could escalate further very quickly*". In the absence of an admission a multi-disciplinary meeting was planned for the following Monday.

5 Planned admission to Community Hospital which did not take place

5.1 On the day following the discussion between the District Nurse and Adult Social Care Worker (a Friday) a bariatric bed was made available for Matthew at a community hospital operated by Somerset Partnership NHS Foundation Trust in another part of Somerset, and plans were initiated to support the admission. Records considered by the desktop review meeting referenced that these arrangements included arranging for South Western Ambulance Service NHS Foundation Trust to transport him and for Devon & Somerset Fire and Rescue staff to support him leaving his home. Records from the District Nursing Team also state "*Arrangements made to care for* [Matthew's] *dog.* [Matthew] *aware of this and agrees to this*". They also note "*Suggested that this is formalised in writing*", however the information provided to the desktop review meeting did not include confirmation that this had happened.

5.2 On the same morning District Nursing Team records state that they worked alongside domiciliary agency care staff to wash him and check his left side. They also state that when domiciliary care staff arrived "[Matthew] *declining wound care until he is clean. Carers say they are unable to roll him and have not been trained to use hoist that has recently been placed*". This was the hoist that the Occupational Therapist had referenced would be delivered the day before.

5.3 On the same day Somerset Partnership NHS Foundation Trust made a safeguarding referral with concerns of significant self-neglect. This was accepted as meeting the criteria for an enquiry under section 42 of the Care Act. However, no immediate action was taken by the Council's Safeguarding Service as, at that point following checks, it was satisfied that the plan of admitting Matthew to a community hospital was the best way to safeguard him from further self-neglect.

5.4 Records from Somerset Partnership NHS Foundation Trust state "*Safeguarding has been sent, SW* [Social Worker] *updated, GP updated, agreement letter for care of* [Matthew's] *dog completed and ready for signing in afternoon*".

5.5 During the desktop review it was noted that it is relatively unusual for South Western Ambulance Service NHS Foundation Trust to provide prearranged transport. Both the District Nursing Team and ASCW confirmed that this had been arranged through Primary Link and agreement had been made for it to be provided by the Ambulance Service because the contracted provider wasn't able to transport Matthew.

5.6 When the South Western Ambulance Service NHS Foundation Trust ambulance crew arrived to transport Matthew to hospital he declined admission, and the ambulance crew left the property 39 minutes later. Devon and Somerset Fire and Rescue Service have no record of being in attendance or being asked to attend on this occasion.

5.7 The records from South Western Ambulance Service NHS Foundation Trust state "*On arrival patient was not aware that his GP had arranged for hospital admittance. He was adamant from the start that he would not be travelling today as he needs at least 2 days to arrange care for his dog. Pt*[35] *was deemed to have capacity and the reason for non conveyance was feasible. Pt refused most observations saying there is no need because he is not going to hospital today. Refusal form signed by patient*". Before leaving the records also state that Matthew was given advice on what to do if his condition worsened. This was to dial 999. South Western Ambulance Service NHS Foundation Trust's records do not indicate that other professionals were in attendance.

5.8 The District Nursing Team's records state "*Somerset Primary Link suggest that* [Matthew] *has said he knew nothing about being moved to*" the community hospital. They also state "[Matthew] *contacted by DNs and he implies there is no point in him going as he doesn't think they can do anything to help him.* [Matthew] *adamant he will not go anywhere. GP and SW informed*"

5.9 Shortly after the ambulance had left Matthew contacted the District Nursing Team to say he had changed his mind and was now in agreement for an admission to the community hospital, and asked for paramedics to return.

5.10 The Council's records state "*After the ambulance left* [Matthew] *then said he did want to go into hospital. Primary Link are in the process of asking the ambulance crew to return, to see if the Matron at* [the Community Hospital] *will still take* [Matthew] *and can get the equipment and agency staff that*

[35] Patient

were cancelled back in. Hopefully this can be done today, otherwise the move may have to wait until Monday". Within the information available to, and considered by, the desktop review there was no record to confirm if Primary Link received this request.

5.11 The ambulance did not return. In response to a request for an explanation as to why following the desktop review South Western Ambulance Service NHS Foundation Trust stated that "*The patient was free to change his mind at any time, but this would have required the patient using his call line or phoning 999 were* [when] *a response would have been arranged for him. A crew would have returned should the patient have summoned help. A patient cannot forcibly be taken from a residence, unless there are extreme circumstances such as mental health breakdown. The crew advised the patient of the potential issues he could face should he remain at home and the patient has signed a refusal to this effect. It is not within our capacity as an ambulance service to return to patient unless they recontact us. The patient would have been advised by the crew that should he change his mind then to call 999. I am not aware of any other calls to our service besides the call the following day, which resulted in the patient being taken to hospital*"

5.12 There is no record within the information available to, and considered by, the desktop review that the Council or any other organisation were aware that that the ambulance did not return, and there is no reference in any of the records considered of further contact being made with the Council until the Monday morning.

5.13 The domiciliary care agencies records state that when staff visited in the evening Matthew "*appeared spaced out and not really with it*".

5.14 The domiciliary care agency's records also state that when the carers arrived at Matthew's home the following morning (a Saturday) they "*must of just missed District Nurse's.* [Matthew] *eye's were rolling slurred speech- in and out of consciousness.* [Matthew] *was covered in dried Feces, while waiting for the ambulance* [carers] *continued to try and clean* [Matthew] *as best they could*". They dialled 999.

5.15 An ambulance was dispatched and South Western Ambulance Service NHS Foundation Trust paramedics and Devon and Somerset Fire and Rescue Service staff helped Matthew out of his home. He was then transported by ambulance to Musgrove Park Hospital in Taunton.

5.16 Both the District Nursing Team and domiciliary care agency's records refer to arranging care for Matthew's dog.

5.17 Matthew was admitted to the emergency department with pneumonia and type 2 respiratory failure. Hospital records state that he had been bedbound

for a long period of time and had become unable to roll causing pressure damage to his skin.

5.18 Matthew was intubated[36] in the emergency department; "*he had a very high oxygen requirement of 90% and had low sats despite this. Sedation and neuromuscular blocking agents were used in an attempt to improve his oxygenation, however, he remained in type 2 respiratory failure despite maximal therapy*".

5.19 Two days later Matthew's family were involved in deciding to turn off his life support. His death was certified early the following morning. At the desktop review meeting it was stated that Matthew's family had been contacted through a family member that was identified by the hospital, despite it being recorded that Matthew had been clear that he did not want his family to be involved.

5.20 Matthew's family only became involved after this admission to hospital, otherwise they would have not been involved.

6 Changes made since the events described in this report

6.1 The District Nursing Team has put arrangements in place for 'complex care' meetings where people have complex needs, and although during the desktop review it was questioned whether this would have made a difference it may have provided an opportunity to initiate a multi-agency discussion.

6.2 Since the events described in this report the Somerset Safeguarding Adults Board has published guidance called "What to do if it's not Safeguarding?" in response to learning from another case where a multi-disciplinary discussion did not take place. It includes guidance on arranging multi-disciplinary meetings and a template for recording the outcomes of meetings.

6.3 Although no further changes were highlighted during the desktop review, there have been significant changes to the joint working arrangements between Somerset County Council's Adult Social Care service and services provided by Somerset NHS Foundation Trust, and formerly provided by Somerset Partnership NHS Trust (which the District Nursing Service is now part of) as a result of the Coronavirus Public Health Crisis.

7 Learning and conclusions

7.1 The desktop review considered the detailed information from Matthew's case, and was unable to conclude whether Matthew's death could have ultimately been avoided given the impact of his own behaviours on his health over many years. The desktop review did identify a number of themes where professionals and organisations could have worked differently to attempt to protect him from these, which may have had the effect of

[36] The insertion of a breathing tube is known as intubation

delaying his death. Significant concerns were also expressed about his loss of dignity in the period prior to his death. Although this is a Safeguarding Adults Review much of the learning relates to good practice and considerations that should be made regardless of whether there is a safeguarding concern.

7.2 Matthew's deterioration during late December 2017 and early January 2018

7.2.1 Matthew was clearly deteriorating from late December onwards, but the organisations involved in supporting him failed to respond in a timely or coordinated way.

7.2.2 Although briefly considered, it was explained during the desktop review that a care home placement was not pursued during December 2017. This was queried and it was explained that, at that point, the focus was on getting Matthew well and then (once he was) supporting him to live as independently as possible in the community. A short period of access to 24-hour care may have provided an opportunity to work with Matthew and enable some of the changes Matthew needed to make to his lifestyle and could have prevented some of the deterioration in January 2018.

7.2.3 However, by the beginning of January 2018 Matthew's health had deteriorated to such an extent that 24-hour care was required – either in a care home placement, if available, or in a community hospital - and his needs could no longer be effectively met in his own home. A successful planned admission to either may have provided an opportunity to work more effectively with Matthew to prevent further deterioration. This did not happen.

7.2.4 On the morning that the Domiciliary Care Agency found Matthew to be unresponsive he had deteriorated to a state where he needed emergency admission to an acute hospital.

7.3 While it is not possible to conclude that the need for an acute hospital admission could have been avoided, there should have at the very least been a multi-disciplinary approach with a lead organisation (i.e. the Council as the commissioner of his care) identified and clear actions agreed, allocated to a named individual, recorded and followed up. However, there is no record of such an approach being attempted at any point during the autumn. The District Nursing service did reference the need for one, but it did not take place. It appears as though organisations were instead trying to 'fire-fight' concerns that they felt that were their responsibility, and attempting to pass on others those that they did not, while all the while Matthew continued to deteriorate.

7.4 The failed community hospital admission

7.4.1 Logistically there were a number of arrangements that needed to be in place to enable the admission to take place, but the desktop review could not establish whether there was any form of robust plan in place on the day. There also appeared to be little or no coordination between the organisations involved. Communication, before and after Matthew made his decision not to travel to the Community Hospital also appeared to be poor. There appears to have been a decision to try to hold things together until after the weekend, without any consideration of how quickly the situation appeared to be deteriorating. There was also no-one who Matthew knew present when the ambulance arrived.

7.4.2 Although mental capacity is time and decision specific, and therefore cannot be assessed retrospectively, based on the evidence available, the desktop review concluded that Matthew almost certainly had capacity to make the decision that he did when the ambulance came to collect him. On this basis the ambulance crew were correct in their decision to respect his right to make an unwise decision under the Mental Capacity Act (2005).

7.4.3 South Western Ambulance Service NHS Foundation Trust make no reference to a second request being received. It is unclear from the information available to this review at what point in the communication chain this request wasn't acted on. However, what is clear is that, regardless of where the communication breakdown occurred, Matthew had changed his mind. An opportunity was therefore missed by the system for an intervention to be made that may have prolonged his life and enabled him greater dignity.

7.4.4 While it is acknowledged that the arrangements to admit Matthew to the community hospital needed to be made quickly once a bed had been identified, this should have highlighted the need for there to be a robust and well-coordinated plan to all the organisations involved. The desktop review identified learning for the system that, in situations where multiple organisations are working to enable someone to be transported that require specific logistical arrangements, this should be coordinated by a single individual/organisation, with all organisations taking ownership and accountability for ensuring that the elements they are responsible for are delivered. There should have been agreement of a lead agency and or professional to co-ordinate the transfer. There should also be a requirement on the individual/organisation with the agreed coordination responsibility to communicate changes to the agreed plan to all the organisations involved. For example, in Matthew's case his decision not to be admitted should have been communicated to all involved, who then should have reconvened to reassess the risk and agree the next plan of action. Another example would be for the coordinator to ensure that all involved received a confirmation that an action has been completed. Unfortunately, no such arrangements were in place.

7.4.5 Given his past history of accepting offers of support only to change his mind shortly afterwards the possibility of Matthew declining the admission to the community hospital could and should have been considered as a risk to the plan, and someone he knew and trusted should have been there when the ambulance arrived. The desktop review identified learning for the system that, in situations where someone has a history of changing their mind, arrangements should be made for someone they know and trust to be available to support them when critical actions are being undertaken. These arrangements were not put in place for Matthew.

7.5 Safeguarding Service response

7.5.1 The safeguarding response in relation to the allegations of financial abuse was considered to be appropriate. There are no further records of financial abuse, which suggests that the actions taken were effective.

7.5.2 With regard to the safeguarding referral in early January 2018 it was concluded that this had been correctly accepted by Somerset County Council's Safeguarding Service following triage, and that the decision not to take any further immediate action, due to the plan that had been agreed to keep Matthew safe, was also correct at that point in time. However, no further concerns were raised with the Safeguarding Service when this plan failed. Had this communication taken place then this would have been an opportunity for the Safeguarding Service to reconsider the decision and if additional action was needed.

7.5.3 While the safeguarding response was considered to have been appropriate when referrals were made, it is unclear why concerns were not raised about Matthew's physical health much earlier in 2017. From the records considered, the professionals supporting him were clearly concerned, but they appear to have attempted to manage the situation themselves until a critical stage was reached.

7.6 Matthew's capacity

7.6.1 Matthew's GP stated during the desktop review that they never had any doubts about Matthew's capacity to make decisions about this care and treatment, and that this was why no capacity assessments were undertaken by them.

7.6.2 Although mental capacity is time and decision specific, and therefore cannot be assessed retrospectively, based on the evidence available it was concluded that Matthew almost certainly had capacity throughout the period under consideration. He did not have a disorder of the brain or mind that would have affected his decision making and there were also no concerns raised about his executive functioning, although his physical health would clearly have limited the tasks he could carry out for himself.

7.6.3 While in no way suggesting that Matthew did not have capacity at any point, at different times during the period under consideration professionals had said that they had questioned if Matthew had the capacity to make some of the decisions that he was choosing to make. Unfortunately, the recording of information relating to this was poor. The desktop review identified learning for the system that records should include all occasions where an adult's capacity has been considered and why.

7.6.4 Because of the decisions Matthew was making he lost his dignity very quickly in the final weeks of his life. He was incontinent and urinating into an empty drink bottle because he could no longer get up from his bed. His dog was described during the desktop review as licking his faeces and then licking him, exacerbating the skin infections that Matthew had. Yet, despite this, Matthew refused advice around smoking and eating, and would frequently refuse support from carers employed by the domiciliary care agency when they visited.

7.6.5 At times Matthew had up to five people supporting him with very intimate personal care tasks, and it is unclear what, if any, steps were taken to try to maintain his dignity.

7.6.6 During the desktop review a district nurse who visited Matthew regularly described him as a complex character, with whom they attempted to have difficult conversations about his health, but which would ultimately "*fall on deaf ears*". Overall, they said that while there were lots of serious concerns, Matthew appeared to both understand the risks he was taking and not want to take advice on board – in fact he would often do the opposite. Other professionals also reflected on their personal frustrations that, despite regularly offering Matthew advice, they had been unable to make a difference to him as a result of the decisions he was making.

7.6.7 The District Nursing Team explained during the desktop review that they had tried to look at how they could support Matthew differently, in order to help him to address their concerns about his health and wellbeing, but in practice this was difficult to achieve when he clearly had capacity and appeared to be actively ignoring advice.

7.6.8 Matthew had a history of mental ill health and substance misuse, but there does not appear to have been an exploration of the underlying reasons for the way he was behaving. During the desktop review it was questioned whether a fear of not being able to smoke or eat what he wanted to if he left his home may have been a factor in some of his decisions.

7.7 Responsibility of the Commissioner of Care

7.7.1 Matthew was last assessed by the Council in July 2017, and then reviewed in early October 2017, however this review does not appear to be revisited when his condition rapidly deteriorated after this. The Council also has a

responsibility to follow local policy in relation to applying for NHS Continuing Healthcare funding as set out in the Care Act 2014. From the information available to the desktop review, it appears as though there was a missed opportunity to follow due process by the Council when Matthew deteriorated further in December 2017.

7.8 Multi-agency response

7.8.1 Throughout the autumn of 2017 different professionals were identifying concerns, but the response appeared to be primarily reactive from the organisations involved until Matthew became very unwell towards the end of December. There also appears to have been a gap within the local system in relation to the provision of resources for adults with bariatric needs. This included nursing homes, community hospital capacity and the length of time to source and deliver some equipment, for example, bariatric crutches which took 58 days to be delivered.

7.8.2 A referral was made to the Council's Safeguarding Service in January 2018 in relation to concerns about Matthew's neglect of himself, however, based on the information considered this had clearly been a concern to those directly involved in supporting him throughout 2017, and this should have been recognised as something that required action and/or escalation earlier.

7.8.3 While there was a multi-disciplinary meeting in March 2017, no notes appear to have been taken and opportunities were not taken for all those involved in supporting Matthew to meet again to consider how to support him. At the very least a multi-disciplinary approach should have been taken, with a lead organisation (i.e. the commissioner of his care) identified and clear actions agreed, allocated to a named individual, recorded and followed up when Matthew's health clearly began to deteriorate during the autumn of 2017. This approach should have again been taken when putting the arrangements in place for his admission to the community hospital. However, while the desktop review recognised that while more could have been done earlier, and that there should have been more ownership by the organisations involved, it was not possible to conclude that it would have ultimately made a difference due to Matthew's ongoing decisions to ignore advice from multiple professionals.

7.8.4 In particular it was identified that there was a missed opportunity for a holistic assessment during Matthew's 9-day hospital admission in October/November 2017, to look at how he could be diverted from doing the things that were affecting his health. At the very least his needs should have been considered by the commissioner of the care package and the hospital discharge team to determine if the package was sufficient, and what other interventions or support might have been required. This should then have prompted a multi-disciplinary meeting, but this does not appear to

have been recognised by the commissioner or any other organisation involved, nor is there a record of Matthew's care being formally reviewed.

7.8.5 Matthew appeared to ignore the advice he was given about improving his health during the admission (see 4.24), and on discharge returned to a home environment that was far from ideal.

7.8.6 It was also identified during the desktop review that information about Matthew's sometimes threatening presentation did not appear to have been shared with all partners at the time, leading to some staff being unaware until the circulation of the documentation used during the desktop review. However, although the question was posed by the Council's Safeguarding Service, there was no indication from the information considered by the desktop review that professionals or agencies had classed Matthew as difficult, non-engaging and aggressive as a means to not offer him support. In fact, from descriptions given, it was evident that attempts to engage with him continued despite the way in which he responded at times.

7.8.7 As Matthew's health continued to deteriorate there was disagreement between the organisations involved in Matthew's care and support over who would pay for the additional care that it was identified that he needed. In particular, the Council did not follow due process which would have been to complete a further NHS Continuing Healthcare (CHC) Checklist to determine if Matthew was eligible for a full CHC Assessment, and/or to contact the NHS Somerset CCG to agree how his individual needs could be met whilst the CHC assessment took place.

7.8.8 It was clear in the information considered by the desktop review that:

- Matthew's health was deteriorating
- That individual professionals were at times frustrated with the responses they received from both their own and partner organisations
- That from the Council's perspective the most junior member of staff appeared to be the main point of coordination, when this should have been escalated to a manager with responsibility for the locality.
- That an opportunity was missed to consider how all those involved could better work together in a coordinated way to stabilise the situation.
- In hindsight the status quo was clearly becoming untenable, but those involved in his care were left to make do as best they could.

7.8.9 An opportunity was also missed to explore if Mental Health services, other than the monthly telephone call that was being provided by Somerset Mind, should have been engaged during the autumn of 2017 given that Matthew has a history of mental ill-health.

7.8.10 The identified learning for the system was that:

- Opportunities were missed by the Council to initiate the agreed process for applying for NHS CHC funding, or for initiating a conversation with NHS Somerset CCG about how the organisations could work together to support Matthew, whilst assessments to determine eligibility for funding were underway.
- Opportunities were missed to pursue alternative accommodation, for example a care home.
- Opportunities were missed to initiate a multi-disciplinary discussion focusing on Matthew's needs as an individual. This would have allowed concerns to be shared, which don't appear to have been, and alternative approaches to be considered. While it is unclear whether this would have made a material difference given that Matthew appeared to be ignoring the advice he was given, had professionals taken this opportunity there would have more shared clarity and understanding of the risks and measures in place. A multi-disciplinary discussion would have provided a more effective response.
- Information should be shared with the organisations involved in an adult's care where there are concerns about the way that they may respond to professionals.
- Notes should be taken of multi-disciplinary meetings and should be shared with all involved in the meeting by the organisation with lead responsibility.

7.9 Involvement of Matthew's family after he was admitted to hospital in January 2018

7.9.1 Matthew had clearly expressed a view to multiple professionals that he did not wish for his family to be involved in his life or know about his health.

7.9.2 It is unclear whether the staff who made the decision to involve Matthew's family in decisions about the cessation of his treatment were aware of his wishes at the time.

7.9.3 If staff were aware of Matthew's wishes, the approach that should have been taken was to arrange for the involvement of an Independent Mental Capacity Advocate in relation to this decision.

8 Recommendations

The following recommendations for the local system have been structured using a SMART approach to ensure that they are Specific, Measurable, Achievable, Realistic and Timely.

Please note that, while organisation names at the time of the events described have been used throughout this report, the current names of the organisation(s) to which each recommendation applies as at the date of publication have been used in this section.

Recommendation 1:

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

- All providers of domiciliary 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
- Employees of Somerset NHS Foundation Trust
- NHS Somerset Clinical Commissioning Group
- NHS England and NHS Improvement

The SSAB Business Manager will evidence to the Board's Executive Group 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 Somerset County Council and NHS Somerset Clinical Commissioning Group undertake an exercise to evaluate current capacity within the registered care homes in Somerset to support adults with bariatric needs and, should any gaps be identified, develop a plan to address them.

The exercise should be completed within 6 months of the publication of this review, and progress on any work to address any gaps identified reported to the Board's Executive Group as part of its monitoring of the implementation of SAR recommendations.

Recommendation 3:

That Somerset County Council's Adult Social Care service provides the Somerset Safeguarding Adults Board with evidence that its staff are aware of the process of how to initiate the process for applying for Continuing

Healthcare funding, and the local policies and procedures related to doing so.

The written assurance should be received within 3 months of the publication of this review, and reported to the Board's Executive Group as part of its monitoring of the implementation of SAR recommendations.

Recommendation 4:

That Somerset County Council, and Somerset NHS Foundation Trust, ensure that there are appropriate arrangements in place to:

- Ensure that an adult's wishes are sought, known and understood in any safeguarding process
- Share, and where appropriate escalate, concerns about an adult's responses with other professionals that are involved in supporting them
- Allow professionals to balance the adult's rights, in line with the Care Act (2014), Human Rights Act (1998) and Equality Act (2010), with an assessment of any risks posed.

Written confirmation that such arrangements are in place should be received within 3 months of the publication of this review, and reported to the Board's Executive Group as part of it's monitoring of the implementation of SAR recommendations.

Recommendation 5:

That all Somerset Safeguarding Adults Board member organisations actively promote "What to do if it's not Safeguarding?" within their organisations, and remind staff of the importance of clear minutes being taken of any multi-disciplinary meetings that take place (which include clear actions allocated to named professionals/organisations and shared with all involved in the meeting); and of any capacity assessments undertaken.

The SSAB Business Manager will request written confirmation within 1 month of the publication of this review and provide a collated list of responses to the Board's Executive Group when it next meets following this.

Recommendation 6:

That where a complex transfer is being considered that involves multiple organisations a lead professional is identified (in most cases this will be an employee of the organisation with the lead responsibility for commissioning the adult's care and support) to coordinate the process, ensure decisions are made in a timely way and that actions are both allocated to named individuals and followed up on to ensure that they have been carried out as agreed. They should also act as the point of contact if the plan cannot be carried out as agreed.

Somerset Safeguarding Adults Board member organisations should provide a written briefing to their staff to remind them of the importance of doing so within 1 month of the publication of this review. The SSAB Business Manager will then request written confirmation and provide a collated list of responses to the Board when it next meets following this.

Recommendation 7:

That Somerset NHS Foundation Trust and Yeovil Hospital NHS Foundation Trust review their policies and guidance for staff in relation to circumstances where an adult is unable to express their wishes for themselves, but have previously expressed a clear wish that their family should not be involved in decisions about their care. This should include:

- Circumstances where there is a legal duty to involve an Independent Mental Capacity Advocate (IMCA)
- Circumstances where an IMCA may be involved where there is no legal duty
- Contact details for the IMCA service
- Advance Statements of a patient's wishes, which should be weighed as part of Best Interests decision making (this should include an example of advance statements in relation to who to involve in best interest decisions, or who to share information with).

This review should be completed, and any proposed changes agreed, within six months of the publication of this Safeguarding Adults Review, and reported to the Board's Executive Group as part of its monitoring of the implementation of SAR recommendations.