Safeguarding Adult Review Report
Mr K

December 2022

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1	Introduction
1.1	Section 44 of the Care Act 2014 places a statutory responsibility on Safeguarding Adults Boards (SAB) to conduct a Safeguarding Adults Review (SAR) into certain cases under certain circumstances. A SAB is required to arrange a Review where there is reasonable cause for concern about how the SAB, its members or some other person with relevant functions involved in the case worked together to safeguard an adult with needs for care and support and, either the adult died and the SAB knows or suspects that the death resulted from abuse or neglect; or, the adult is alive, and the SAB knows or suspects that they experienced serious abuse or neglect.
1.2	The London Borough of Enfield (LBE) SAB has accepted the request for a SAR to be conducted into the circumstances surrounding the death at home of Mr K. His age at the time of his death was recorded by the coroner as being 70, however unopened birthday cards found in his flat would suggest that he died prior to his 70th birthday.
1.3	The SAR panel agreed that the situation met the Care Act criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk.
2	The purpose of the review
2.1	• Establish what lessons can be learned from the circumstances of the case • Review the effectiveness of the procedures and processes of the agencies involved • Analyse how organisations work together • Analyse and expand upon the findings of the various reports • Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes or policy
2.2	This specific SAR is to consider how organisations, individually and collectively, may have worked better to correctly assess the needs of Mr K whilst he was receiving treatment in the weeks and months prior to his body being discovered at his home on 31st December 2018.
2.3	Secondly, this specific SAR is to consider the responses from organisations, individually and collectively, concerning whether Mr K's capacity to consent was impaired due to any mental health condition

	(delirium) and if assessments were correctly undertaken as per the guidance outlined within the Mental Capacity Act.
2.4	Finally, this specific SAR will consider, based upon responses from the organisations involved, if there are gaps in the service delivery for adults, which can be identified from this case.
2.5	Partner reports were received from each of the organisations involved, a template was provided which included following details: Full chronology A narrative of service involvement- between dates of 9th January 2017 and 31st December 2018. A description of the specific service provided to Mr K between those dates. Any significant factors which impacted upon the actions or decisions taken. An evaluation of how services were delivered to Mr K. Lessons learned including a judgement of the level of service received when compared against policy, procedure and practice standard. Recommendations for action.
3	Methodology and process information
3.1	The author was appointed to undertake the SAR in February 2021.
3.2	Partner Reports were completed and supplied by safeguarding adult leads from a number of organisations involved. These included: North Middlesex University Hospital Royal Free University Hospital LBE Multi Agency Safeguarding Hub (MASH) London Ambulance Service (LAS) Mr K's GP service LBE Single Point of Access (SPA) team Barnet, Enfield and Haringey Mental Health Trust Metropolitan Police Service (MPS)
3.3	In addition, the author met with Mr K's next of kin, his ex-wife, on 9th March 2021. She had initially raised concerns about the treatment he had received prior to his death via an email to the Enfield Social Services dated 7th January 2019.

3.4	She was able to supply a substantial amount of background information about Mr K and was keen to put forward the family's perspective about the treatment he had received. She also submitted statements, documents and photographs to support her observations.
3.5	Following the author's initial review of the information provided, a number of issues were identified that required clarification.
3.6	On 12th April 2021 the author met with the MASH manager, to discuss the referral process and MASH procedures around the safeguarding of adults.
3.7	The author also met with the Associate Director for Safeguarding and Safeguarding Adults Lead Nurse both from North Middlesex Hospital University Trust in order to get a better idea about how MCA assessments are undertaken, what framework is used when performing an assessment, what procedures are in place around the provision of care packages and discharge decision making.
3.8 Annex A	The Associate Director for Safeguarding and Safeguarding Adults Lead Nurse were able to provide the author with copies of the North Middlesex University Hospital Mental Capacity Act 2005 and Deprivation of Liberty and Safeguarding Policies
3.9	A written response to questions submitted was received from the service manager for the Single Point of Access team.
4	Background
4.1	Mr K was born in Lancashire in 1948.
4.2	He spent most of his life living in and around north London.
4.3	He was married (and subsequently divorced) to Mrs K and they had one child.
4.4	According to Mrs K, Mr K suffered a serious head injury about 20 years ago and was admitted to Royal Free University hospital where he remained in an induced coma for some days.
4.5	After receiving his injury, Mr K apparently encountered difficulties communicating, which resulted in frustration on his part, and this ultimately impacted upon their relationship. Eventually they separated and according to Mrs K, the brain injury was severe enough that it made it more difficult for him to co-ordinate his work, communicate with customers or work to a routine. This, coupled with his severe COPD, prevented him from doing physical work.

4.6	The chronologies provided detail Mr K's medical history going back to the start of 2017. What can be seen from the information available is that he appeared to have complex medical needs. These included Chronic Obstructive Pulmonary Disease (COPD is a disease which causes a restricted airflow to the lungs) and Diabetes as well as a number of problems associated with these diseases.
4.7	Mr K moved into his address in 2011 which was private accommodation supplied via the Homefinders arrangement in the London Borough of Barnet.
4.8	Dean Housing Ltd purchased the property in December 2013 with Mr K as the tenant.
4.9	His medical treatment has been outlined as follows:
4.10	Between 9th January 2017 and 14th January 2017 Mr K was an inpatient at North Middlesex University Hospital (NMUH) having been brought in with a chest infection following a fall at home the previous day. It was noted that he was suffering from COPD and had previously been a patient at Whipps Cross Hospital and was awaiting a further bronchoscopy.
4.11	It is noted that Mr K informed medical staff that he believed he had been admitted to hospital approximately 20 times in the preceding 12 months. His family state that "He had been in/out of hospital continually for a long period of time prior to 2017. He would go downhill soon after discharge."
4.12	It was also logged within the notes that capacity was presumed and there was no reason to undertake a capacity assessment at that time.
4.13	He was then discharged from the hospital on 14th January 2017. This is described within the notes as being 'into the care of a friend' however Mrs K, upon reviewing this report casts doubt upon this as she recalls him reporting that he had to get a taxi service to return home from the hospital. She was unaware of any close friends who would have come and helped him. It is noted that he had a clear discharge plan which included further outpatient appointments.
4.14	He subsequently failed to attend two further outpatient appointments. There is no record of why he failed to keep those outpatient appointments.
4.15	The landlord describes within his written response that police attended Mr K's home address in May 2017 as he had collapsed within his flat. They forced entry and found Mr K collapsed on the floor and as a result he was taken to hospital.

4.16	The case chronology shows that on 24th May 2017 Mr K was admitted to NMUH having been found collapsed, suffering from shortness of breath. He then remained in hospital for an extended period of time whilst issues were being dealt with at his home. These included eradicating an infestation of bed bugs, cleaning the property and the replacement of some of the furnishings and flooring. He was initially offered a short stay by ASC at a residential home but declined.
4.17	During this period issues were identified around the chemicals that were being used to clear the infestation and the fact that they could possibly have a harmful impact on Mr K's on-going lung issues. This was one of the factors which further delayed his return home.
4.18	The de-contamination appeared to take longer than was anticipated so eventually Mr K agreed to a short-term placement. He declined to be placed outside of Edmonton area and his notes record that he was *"deemed captious to make this decision".*
4.19	Within the notes it is described that Mr K was suffering from some "anxiety" about being discharged from hospital and appeared to be exhibiting behaviour that was described as *"difficult".*
4.20	Mr K had discussions with Social Services about the plan for his discharge and what support was required. He felt that he required a 24hr care package, but it was noted that he was offered 4hrs per day.
4.21	On 4th July 2017 he was discharged into sheltered living and was taken there by a community co-ordinator.
4.22	A Community Matron assessment was conducted on 5th July 2017. Mr K was described as having a good understanding of his medication and was managing this independently.
4.23	He had an enablement package but reports that it was not providing him with anything he couldn't do himself and he was thinking of stopping it. During the Community Matron's assessment there was a friend present who planned to bring him food. The arrangements with the friend do not appear to have been properly explored to ensure that it would be a sufficient or satisfactory arrangement.
4.24	It is noted in the records that there appeared to be good support from District Nurses, and he had an allocated social worker from the time he left hospital in mid-October.
4.25	On 3rd August 2017 he was reviewed at home by the Senior Respiratory Physiotherapist who made enquiries on his behalf about a referral to Social Services. Mr K was apparently concerned about paying for the electricity required for his oxygen concentrator. It is

	noted that *"will clarify re reimbursement of electricity charges"*. The Partner report notes that this was a "*good review and co-ordination with other services".* Mr K returned to his flat on the 10th of October 2017.
4.26	On 24th November 2017 Mr K spent four days in hospital having been brought in by LAS suffering from shortness of breath. He eventually went home with a friend who came to collect him from the ward.
4.27	On 15th December 2017 he was reviewed at home by a district nurse. This was described by the IMR author as being a thorough nursing review. There was no contact with other services eg. GP, Respiratory Services or Social Services
4.28	The next treatment is on 6th June 2018 when Mr K presented at hospital with a toe infection (gangrene right foot). As a result he was transferred to the Royal Free Hospital.
4.29	Whilst at the Royal Free Hospital Mr K received treatment for Chronic Limb Ischemia and was eventually discharged on 26th June 2018 with follow up podiatry and outpatient appointments arranged. In addition, he went home by hospital transport and the nursing notes describe that a care package had been arranged, although it does not document what this consisted of. However, it is also noted that an Occupational Therapist visited Mr K the same afternoon and he declined all care packages.
4.30	28th June 2018 Mr K was brought into NMUH by LAS for what is described as *"exacerbation of COPD – not eating – not taking medication and not coping at home"*. He was described within the district nurse chronology as appearing a bit confused. His next of kin (ex-Mrs K) was contacted.
4.31	The attending doctor formed the impression that this was a social rather than a medical issue.
4.32	It is noted that Mr K declined all offers of referral to support services and said he will ask for support when he feels he needs it.
4.33	On the same day (28th June 2018) Mrs K phoned the Single Point of Access (formerly Access Team, team name change to Single Point of Access in November 2019) with concerns that MR K has been left alone at home without oxygen or food and very distressed. This was prompted after she had received a call from a District Nurse.
4.34	Telephone contact was made with Mr K by Single Point of Access, however Mr K stated, *"it's none of your business"* and asserted that he was coping fine and didn't need any help. There were no other entries from SPA team until 7th December – then three other entries about

	unsuccessful attempts to contact Mr K.
4.35	Mr K was discharged from hospital on 1st July 2018 but then re-admitted to NMUH on 16th July 2018 suffering from shortness of breath and weight loss (2 stone). He was described as irritable and refused a central nervous system exam as well as cognitive impairment exam and a delirium assessment. Doctor noted that it was *"unlikely he has delirium".* There was no accompanying rational within the IMR to explain how they came to that conclusion.
4.36	It is during this period of admission that Mr K went missing from the ward. This was subsequently reported to police who apparently sent the LAS to do a welfare check at his home address. Due to the time that has passed since this occurred there is no further information available from the police to clarify how it was resolved. The notes state that Mrs K was notified of the fact that her ex-husband had gone missing from the ward, however she states that she was never contacted about this incident, nor would it appear were Social Services.
4.37	On 31st July 2018 Mr K was admitted NMUH after suffering an attack of shortness of breath whilst being visited by a district nurse. He was subsequently diagnosed as possibly having sepsis and dehydration and was described as being *"argumentative but obeying commands".*
4.38	During this inpatient stay there are entries in Mr K's medical notes regarding an incident where he appeared to have hurt himself (cut across left wrist) with a penknife he had in his possession when admitted. As a result of this, he was referred to the mental health team who assessed him and recommended that he receive one to one nursing. They advised that if he tried to leave the ward then staff were encouraged to utilise Section 5:2 of the Mental Health Act (power for a doctor to detain a patient for up to 72 hours to allow a mental health assessment to be conducted). Mrs K raised her concerns about Mr K's mental health at the time and this was documented via email.
4.39	Mr K was discharged from the mental health service with a recommendation that he commence a delirium pathway. However, there was no evidence that a delirium pathway was commenced and, further to this, the medical consultant documented that the likely cause of delirium was a raised white cell count that was due to prescribed steroids.
4.40	Between 7th August – 20th August 2018 Mr K was an in-patient at the Royal Free hospital.
4.41	He was seen by the occupational therapists and physiotherapists on a number of occasions. He stated that he was able to complete domestic tasks and claimed that friends were helping him with shopping. This

	does not appear to have been explored further.
4.42	On various occasions during this inpatient period he refuse to co-operate with therapists, declining to take part in assessments. He was unable to articulate his reasons for his lack of co-operation. The Occupational Therapist recorded that they found it difficult to follow his trail of speech and contacted the district nurse as they were concerned that Mr K was not managing well at home.
4.43	Within the notes he was described as being verbally aggressive. It also shows that a therapist contacted the GP and district nurse in order to gain further information on Mr K's past medical and social history.
4.44	It would appear that the occupational therapists offered to arrange a care package for Mr K in the community, however he declined and said his community respiratory team would arrange support. They were contacted and stated they would not provide a care package.
4.45	Mr K also declined a referral to social services and it was recorded within his notes that there was no indication of any brain disturbances and it was presumed he had capacity to decline.
4.46	Occupational Therapists contacted the GP regarding the head injury Mr K had suffered in order to establish his capacity to decide. The GP had indicated that the injury did not impair his ability to give consent and there were no concerns from the GP about Mr K's ability to manage at home. He was again offered a referral to social services to arrange a care package but he again declined and only agreed to a referral to the district nurse. A discharge summary was sent to his GP.
4.47	On 6th September 2018 Mr K was admitted to NMUH with gastroenteritis. He was described as being discharged home via transport the following day, however he was subsequently re-admitted with the same symptoms later the same month and was an inpatient between 26th September and 17th October 2018.
4.48	This is a particularly long stay as an inpatient during which Mr K is seen by a number of professionals from different specialisms. The chronology writer notes – *"It has been noted in this admission that the patient was seen by many clinicians and therefore there appears to be inconsistencies with what the patient is reporting and what the clinicians are seeing".*
4.49	During this time Mr K had a positive result for Glutamate Dehydrogenase (GDH), which meant that he was carrying Clostridium Difficile (C Diff) bacteria in his large bowel, but that he did not have a C Diff infection. This was confirmed by the second stage of testing which confirmed the presence of the C diff bacteria (germ) in the bowel but no C Diff infection.

4.50	It is noted within the IMR that there is no evidence to suggest that the tissue viability nurse review was completed, however the patient had a vascular review completed on 9th October 2018.
4.51	It is further noted that Mr K frequently refused support with washing and dressing, initially refused to have the dressing changed on his foot and refused blood tests throughout his admission. The documentation shows that there was a discussion with Mr K regarding the risks in refusing treatment and he reluctantly agreed intermittently to have his dressing changes and blood tests when they were really required.
4.52	He was seen by a dietitian and encouraged to eat more and it was acknowledged that he was not feeling well and had a poor appetite. Mr K refused to be seen by the occupational therapist on more than one occasion and within the physiotherapy documentation was described as demonstrating inappropriate behaviour and attitude.
4.53	There was also an ongoing assessment relating to the issues with gangrene in Mr K's foot. A district nurse referral was made regarding wound care and he was referred to the vascular team as it was identified that Mr K would need to have three toes amputated.
4.54	There are two entries within the IMR that record Mr K's failure to keep out patient appointments at Royal Free Hospital vascular surgery department. There is no explanation as to why he missed these appointments.
4.55	It is recorded that between 10th August and 23rd September there were at least three district nurse appointments missed due to Mr K not being at home.
4.56	On 31st October Mr K was visited at home by his GP for a COPD review. He was described as being "in very high spirits".
4.57	On 1st November 2018 Mr K was admitted to the Royal Free Hospital as an inpatient so that he could have a surgical procedure to have three toes amputated. There appears to have been a standard mental well being assessment conducted by nursing staff with no issues identified. He was assessed as being independent.
4.58	Following the surgical procedure he was discharged from the hospital on 6th November 2018 with a district nurse referral for his wound care.
4.59	On 9th November 2018 a district nurse visited him at his home address following discharge from hospital for the elective amputation of three of his toes. He declined to have his right foot re-dressed.

4.60	On 12th November 2018 Mr K was admitted into the North Middlesex Hospital by London Ambulance Service as he had been found wandering in the street by a neighbour. It was noted that he appeared to be delirious.
4.61	The notes state: *Patient appears to be delirious* *Not responding to unseen stimuli* *However at time appears to have difficulty answering simple questions (despite using voice and written notes to clarify he understands the questions)* Mini mental state assessment: *States this morning he was watching TV and a police officer on the TV told him to go into the street to protect a woman – does not appear to have insight. However, on another occasion he will have a perfectly normal conversation and use statement that demonstrate a high level of cognitive function.* *Impression:* *Confusion with unknown Cause*
4.62	On the evening of 13th November 2018 Mr K attempted to leave the ward stating that he wanted to go to Edmonton. Staff managed to distract him with a cup of tea and persuaded him to stay. He was then described as being rude towards staff and was transferred to another ward.
4.63	Again Mr K was seen by a number of different specialisms including a dietitian, occupational therapists and physiotherapists. There appear to be a number of instances where he was described as being un-cooperative and became abusive towards staff.
4.64	It is recorded that he told staff that he *"does not have heating at home and would like support".*
4.65	His notes record that he is fed up with being in hospital and reportedly during one examination repeatedly told the doctor to *"shut up"* and *"stop nagging".*
4.66	On 21st November 2018 Mr K was transferred to Royal Free Hospital. The admission process was completed and this included a mental health wellbeing assessment. No issues were identified.
4.67	Over the course of three days Mr K refused three separate physiotherapy assessments. It is noted within his records that he told staff that he did not believe that he would manage at home alone.

4.68	In addition, on one of these interactions the physiotherapist recorded "*Mr K* said he *will not manage at home and will need help; if he goes home he will die".* It goes on to record that Mr K requested support for cleaning and laundry and was informed that the hospital does not provide this. The same entry assesses that Mr K is able to walk and lives in a ground floor flat but suffers from shortness of breath due to advanced COPD. It notes that community therapy support was offered but Mr K declined and that Sainsbury's Over the Phone home delivery service contact details were offered, but was also declined.
4.69	On 30th November 2018 Mr K was discharged from Royal Free Hospital.
4.70	The nursing discharge documentation shows that Mr K was offered community therapy support, which he declined. It describes that contact was also apparently made with the GP and District Nurses in order to establish risk factors in the community, mental capacity and social support.
4.71	It is around this time that Mrs K believes she had her last contact with her ex-husband during a telephone call after he had been discharged from the Royal Free Hospital.
4.72	On 3rd December 2018 the London Ambulance Service (LAS) were called to Mr K's home address. It was reported that Mr K possibly had a stroke as he was reporting that he had slurred speech and had something wrong with his mouth. It was noted that Mr K lived alone with no care packages and was able to cope. LAS conducted an assessment on Mr K, however he declined to be taken to hospital and was deemed to have capacity to refuse. Mr K was left at home with advice to ring back if his condition deteriorated. There does not appear to have been any referral made by LAS to the MASH or Adult Social Care
4.73	On 4th December 2018 Mr K was seen at home by the podiatrist, however he would not permit a comprehensive foot exam. Within the notes he was described as *"hostile and aggressive"*. He wouldn't discuss his health and was angry when the podiatrist enquired about prescription medication. One entry states *"withdrew foot hence withdrew consent".* There is no mention that he appeared confused.
4.74	On 5th December 2018 the London Ambulance Service (LAS) were called to Mr K's home address. They conducted an assessment on him and identified that he was hypoglycaemic. He stated that he felt unwell and was confused and weak.
4.75	The LAS crew noted that there was no food in the house and milk was three months out of date. Mr K declined to be conveyed to hospital but asked if LAS crew could get him some food. They purchased milk,

	bread and butter for him.
4.76	The LAS crew completed a safeguarding welfare concern, which was submitted to the MASH and then passed to the SPA. This case was allocated to a member of the SPA team to progress on 7th December 2018.
4.77	On 10th December 2018 a 999 call was received at 01:06am and a LAS crew attended Mr K's home address. Mr K complained that he had been suffering from shortness of breath but this had now resolved. He stated that he wanted something to eat as had not eaten in 2 days.
4.78	It was noted by LAS crew that there was no food in the house. Mr K declined to be taken to hospital and was deemed to have capacity.
4.79	The LAS crew submitted a safeguarding welfare concern report to the local authority (via MASH) and it was noted within that MR K stated he would like some help with his shopping and food as he was struggling with this due to reduced mobility.
4.80	There was nothing else within the LAS report that suggested any other safeguarding concerns, or that alternative referral options were explored by the crew.
4.81	There was a second call the same day at 09:05. This was a similar set of circumstances whereby MR K requested that LAS get him some food as he stated he had not eaten for three days. The LAS crew declined, but offered to call family and friends on his behalf, however he declined this request.
4.82	Again, these reports were passed to the SPA (Access) team via the MASH and the chronology notes that unsuccessful attempts were made by the SPA team to contact MR K via phone. There are two mobile phone numbers held on file for Mr K, however it is not known which of these numbers were called. Mrs K disputes that these calls were made as they do not appear on any of the call logs she has for Mr K's phones.
4.83	On 13th December a member of the SPA made a welfare visit to Mr K at home. There was no reply to knocking or phone calls. Following a phone call to the Access Manager, enquiries were made with a neighbour who stated that they believed that MR K was still in hospital. A note was left asking that MR K contact the SPA.
4.84	Mrs K heard nothing from her ex-husband over the Christmas period and as a consequence raised her concerns with the MASH on 29th December 2018. She subsequently spoke to a social worker who advised that if she had concerns for his welfare she should contact the police. She did so and Police visited his address but did not force entry.

4.85	The brother of Mrs K, who lived nearby, also visited the address but was unable to gain access. The police were subsequently contacted and a missing person report was created (CAD332/29/12/18). They attended the address on two occasions on that day but did not deem it appropriate to force entry.
4.86	Following further requests from Mrs K, the police forced entry to Mr K's flat on 31st December 2018 and found him dead within.
4.87	The coroner was notified and an investigation was commenced on the 3rd January 2019. On 11th March 2019 an Inquest took place and the medical cause of death was recorded as unascertained due to advanced decomposition.
4.88	Within her statement Mrs K records that she entered the flat of Mr K about a week after his body was discovered. She found that there was no food in the flat apart from a tin of steak (no tin opener), a jar of coffee and half a box of stale cornflakes. There was no electricity as there was no money in the meter and there was no money in the flat with which to feed the meter.
4.89	On 7th January 2019 Mrs K received a phone call from Social Services asking if she knew of the whereabouts of Mr K. This appears to have been in response to the failed attempts to locate him on 13th December. Given that his body had been discovered seven days previously, and a Coroner's investigation had commenced, this call proved to be very upsetting for the family.
5	Summary of events and findings
5.1	It would seem from the records examined as part of this SAR that Mr K may have died some weeks before his body was discovered on 31st December 2018. The last recorded contact with him was on 10th December 2018. By the time police forced entry to the flat his body was so badly decomposed that the coroner was unable to establish a cause of death.
5.2	A search of his home revealed that he had no food in the cupboards, other than a tin of steak and a box of cereal and the electricity meter (which he relied upon to heat the home and power his oxygen concentration machine) was out of credit.
5.3	Having reviewed the chronologies, what is apparent is the large amount of good work taking place to help and support Mr K from a number of different professions. This activity occurs every day within the care setting and is undoubtedly successful in the majority of patients. Clearly, the rate of success is greater when the patient is co-

	operative and a good communicator, but is perhaps less effective when they are not as receptive to the offers of support. This then makes the situation more challenging for the professionals involved.
5.4	From both the laypersons and professionals' perspective an obvious question to ask would be, who is co-ordinating all of this activity? The hospital wards have a responsibility to ensure that information is passed onto community services, including district nurse and community Occupational Health and Physiotherapy and again on the whole this system works well. However, it only requires one small breakdown in communication and a vulnerable person could easily fall through the net. This appears to be what happened with Mr K.
5.5	What became apparent during this review is the fact that there is no single department that co-ordinates this system. It is reliant upon hospital staff passing on referrals to the right community service who then implement their activity. If this is not done correctly there is the risk that the community service are unaware that they need to provide care/support to a patient within their area. This can lead to vulnerable patients lacking the necessary support.
5.6	The ideal solution would involve a single point of contact to co-ordinate all of the community services, however it is accepted that this would be very difficult to arrange and ultimately constrained by budgetary considerations.
5.7	In his particular history, Mr K's ex-wife describes that his personality changed after he suffered a traumatic brain injury. She believes that this ultimately led to the breakdown in their relationship and left Mr K on his own.
5.8	An additional obstacle in the case of Mr K was that he sometimes demonstrated what was described as "difficult" behaviour, which proved to be a challenge to staff. Whilst this may have been his natural personality there is information to suggest that his could have been as a result of his previous brain injury. There also appears to be clear evidence to show that he may have been suffering from delirium, or some interruption of his cognitive functioning, at various stages during his treatment.
5.9	Clearly Mr K had complex medical needs. In addition, there seems to be clear evidence to suggest that he was suffering at times from some form of mental impairment, whether that be delirium (as described within some of his notes) or as a result of the traumatic brain injury suffered some years ago. These episodes manifested themselves in him attempting to leave the ward on a number of occasions as well as one incident of self harm.
5.10	As such, during those episodes it is questionable that he had capacity

	to make decisions about his care and treatment? Were medical staff aware of the impact this injury had had on his mental function, which was severe enough to change his personality?
5.11	When considering his on-going medical conditions and instances where he was suffering from delirium or confusion, he does not appear to be sufficiently lucid to be able to decide about treatment, give consent, or decline offers of support? In these circumstances he was clearly at risk of self neglect.
5.12	Perhaps then the issue to be addressed should be if the system of assessment, referrals and interventions is acceptable for the vast majority of patients, what should be done when professionals are faced with a case that is particularly challenging and falls outside the realms of what might be considered to be 'usual'.
5.13	MCA code of practice states '*it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made'*. The code of practice goes on to describe that someone's '*behaviour or circumstances may cause doubt as to whether they have the capacity to make a decision'*. A MCA assessment can therefore help to guide the professional in determining if further support is required from a mental health specialist, multidisciplinary panel or even from a family member.
5.14	All patients have freedom of choice but there will sometimes be a point where those rights are overridden in the patient's best interest – if the patient lacks the relevant capacity. Given his complex health needs, attitude and behaviour and documented weight loss, it seems clear that this was a case where self-neglect was evident and professionals had a duty to intervene in the best interests of Mr K.
5.15	It would seem appropriate that in these instances a formal mental capacity act assessment be conducted. Mr K had on-going issues relating to shortness of breath and infection in his feet. There are notes within his medical records, which suggest that there may have been a link between his medical condition and possible delirium episodes. On numerous occasions he was described as 'confused' and did not appear to properly understand what was happening. An additional complicating factor was that he had previously suffered a traumatic brain injury. On those occasions consideration should have been given to conducting a formal MCA assessment.
5.16 Annex B	For reference the author examined the NICE guidelines regarding mental capacity, which provide a clear pathway of assessment. It is clear from admission documentation supplied to the author that MCA forms part of the admissions to all hospitals. In addition, there is clear

Annex C	guidance that this should be an on-going process, not purely confined to the period when a patient is being admitted. There is also additional guidance where it is recognised that a patient may be suffering from delirium. This is described as the delirium pathway. During one hospital admission there is a suggestion that Mr K should be placed onto the delirium pathway, however there is nothing within his notes to suggest that this actually occurred.
5.17	Mr K was seemingly determined to be independent however his ex-wife states that he was concerned about paying for services. Whilst NHS care is free at the point of delivery it is true that there may be some cost incurred when accessing other services i.e. food preparation and delivery. This could have been discussed with social services and grants or reimbursement discussed and organised.
5.18	It was not always clear from reviewing the information supplied how the different services co-ordinate their response / treatment of Mr K. At that time the responsibility fell to the department discharging him and clearly there were instances when this was not conducted effectively, which resulted in his support being less than satisfactory. However, it is noted that since this incident a new Integrated Discharge Team has been put in place at NMUH in order to co-ordinate the discharge of patients.
5.19	There are numerous instances within the chronologies where Mr K was offered care packages to be implemented when he was discharged from hospital. He repeatedly refused these care packages deferring instead to the district nursing team. Where a care package is offered and subsequently declined with no clear reason given, there should be a professional challenge to the patient's decision. This is particularly true in Mr K's case when there were clear signs that he did not properly understand what was happening, or appeared not to be coping i.e. obvious weight loss and unkempt?
5.20 Annex D	The Care Act 2014 outlines that where an adult has eligible needs, and these include managing and maintaining nutrition, a support plan should set out how these needs can be met. These may involve a number of options including; a care worker going shopping on behalf of a client to get food, assisting with heating up meals, or making a lunch or dinner. Additionally, clients can order cooked food that is chargeable. This also works on a self-referral system that does not have to be accessed via social care.
5.21	Social care services are means tested for anyone appearing to require this service. If Mr K had been assessed as not having to contribute due to his low income then the care service would have been free. The financial status of Mr K is not known, however, he appears to have never consented to an assessment or a means test.

5.22	On three occasions the LAS attended Mr K's house and were confronted with the fact that he had no food in his house. They rightly raised this concern via a referral through the MASH, who correctly passed it on to the SPA team. It does not appear that SPA dealt with the concerns in a timely manner or with the correct level of urgency. Clearly this was a case whereby an urgent intervention was required, unfortunately this did not occur.
5.23	A home visit took place by a member of the SPA who got no answer at Mr Ks flat. A neighbour was spoken to who thought that he was still in hospital as he had not seen him around.
5.24	SPA records state *"Although the neighbour has stated that Mr K is in hospital there is no information from the hospital team on record indicating Mr K is in a hospital."* Clearly at this stage alarm bells should have been ringing, however there is no evidence available to suggest that any decisive intervention occurred. There should have been further checks conducted at the time of the visit to establish if this was in fact the case and consideration should have been given to involving other partner agencies (Police) to assist with forcing entry to the address to confirm if Mr K was within.
5.25	There was a case discussion evidenced between the social worker and assistant team manager the day before the visit where it was agreed a welfare visit was required, but no follow up discussion following the visit. Given the level of concern as to Mr K's whereabouts and welfare, when it was apparent there was no answer from his home address, an immediate discussion and escalation with police should have happened. I would expect such a discussion to be evidenced in SPA records which should include, analysis of the risk, information gathered and a decision made about how the matter was to be progressed, including how this will be followed up with police.
5.26	There were a number of examples of good practice highlighted within the chronologies. These included attempts by physiotherapy and Occupational therapy teams to engage with Mr K to help him mobilise as well as the district nursing team who provided good care and support to Mr K.
5.27	There were instances when Mr K stated that he did not feel that he was able to cope at home. Somewhat contradictorily he also declined the offer of assistance. A referral to social care should have been made and if progressed appropriately, may have ensured that Mr K was correctly supported in the community. The discharge summary passed to the GP should have highlighted the fact that Mr K stated he could not cope and needed assistance.
5.28	Whilst it is accepted that Mr K at times presented with behaviours that challenged professionals and had complex needs, a lack of joined up

	planning and support ultimately resulted in his undiscovered demise at home.
6	**Service Improvements since 2018**
6.1	There is clearly a need to maintain good communication between different services. The author is aware that since the death of Mr K, The North London Partner's Health Information Exchange project has resulted in better information sharing across Barnet, Camden, Enfield, Haringey and Islington (North Central London). This enables access to joined-up care records providing a view of a resident's health and care history, current and past medications and a summary of previous events and episodes of care as well as discharge summaries and clinic letters. Enfield Adult Social Care professionals have been able to access this information since August 2021.
6.2	There are several limitations with the system (information may not be live), however if it was in place at the time of Mr K's death it may have assisted professionals with their risk assessments and subsequent decision making.
6.3	In addition, there is now an Integrated Discharge Team in operation at NMUH consisting of senior discharge facilitators, social workers and ward liaison officers. Their role is to support patients on wards who may have complex medical and healthcare needs to allow them to be discharged from hospital with adequate help and support. This may involve working alongside other professionals to ensure the patient is discharged to the most appropriate setting for their future care. They are now also able to arrange the supply of appropriate medical equipment and liaise directly with community and other professional services.
6.4	This would undoubtedly have been an assistance to professionals who were trying to co-ordinate the care and support for Mr K both within the hospital setting, but more importantly it would have helped them to put a plan in place to support Mr K when he was discharged home.
7	**Recommendations**
7.1	**The importance of establishing whether the adult is able to consent to care, treatment, referrals to other services such as social services at admission and ongoing as and when decisions need to be made should be delivered to staff as part of on-going training.** This should also highlight the need for ongoing MCA assessment of patients, particularly in relation to decisions that will be time and decision specific, if it is suspected that there may be some

	form of impairment.
7.2	**Multidisciplinary meetings should be convened by any / all professionals involved, where there are concerns that an adult is self-neglecting, and a multi-agency risk assessment created detailing how risk can be managed**. Where risk is unmanageable, agencies should consider escalation options with Safeguarding leads. Measures should be put in place to ensure that cases where self-neglect is suspected are referred to social care prior to the discharge of a patient from hospital.
7.3	**An internal audit should be conducted of the processes, procedures and record keeping of cases where MASH have made an onward referral to support services to ensure that appropriate action and follow up is taken in a timely manner.** This sample should include cases where concerns have been raised by family and friends. The MASH may want to update their processes to ensure feedback from the onward referral is received or acknowledged prior to the case being closed.
7.4	**Clear information should be provided to patients about the cost of additional support services should they be required, as well as clear information about how costs can be reimbursed.** Clear, concise and easily understood information should be provided to the patient about what services are available and how services are means tested where appropriate. The work of the Integrated Discharge Team should be quality assured to ensure that clear information is given to people about support options available to them, associated costs and whether these can be reimbursed.
7.5	**A review should be conducted regarding the suitability of providing oxygen concentrators to patients whose electricity supply is accessed by way of coin fed meters**. It may be necessary to engage with energy suppliers about this issue to establish what options would be available to clients to ensure that they are not reliant upon coin fed or metered electricity supplies when using essential equipment at home.
7.6	**Clarification to be given to Adult Social Care staff about basic checks of NHS indices to establish the whereabouts of patients.** This is particularly relevant if they are not at their home address and have not been seen for some time. The minimum standards / checks to be conducted should be outlined to professionals if they are trying to trace a patient but are unsure of their whereabouts within the care system. Whilst mindful of the introduction of the Health Information Exchange to assist professionals, it must be stressed that this information may not always be up to date or current and should be double checked before being used as a basis for decision making.

7.7	**Single Point of Access to review responses to referrals to ensure timeliness of assessment and intervention based on levels of risk.** This should include where referrals need to be re-directed to appropriate teams such as MASH.
7.8	Training and/or clarification should be provided to staff regarding policy and procedure when family members request information or wish to be consulted with when someone has care and support needs. Staff should be provided with training and/or clarification on when the consent of the adult is required. Each agency should review how they record and review contact/emergency contact information and what permission is held to share information. **Disclosure of information should either be with the consent of the adult, or, in the event that the adult lacks the mental capacity to consent, in accordance with best interest principles and data protection principles.**
7.9	**There should also be information supplied to staff to assist them to identify the appropriate action to take in instances of people refusing services. This should help inform staff and assist them when completing their risk assessments around this type of behaviour.** This will also help to raise awareness around this issue and establish a consistent multi-disciplinary approach.
7.10	**Referral pathways to High Risk panels and Complex Older People panels should be shared with LAS/Police/GP and should include all contact details to use when raising a safeguarding alert.** The awareness of these panels should be raised across the health economy.