Bath & North East Somerset
Community Safety & Safeguarding Partnership

Safeguarding Adult Review: Angus

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1. Introduction

1.1 This review focuses on the treatment and support afforded to Angus, who died as a hospital inpatient, having been admitted a week previously. At the time of his death Angus was 72 years of age.

1.2 Angus had a history of chronic alcohol abuse and presenting with signs of self-neglect. Angus had a diagnosed cognitive impairment (ARBI) and had been resident in a care home under a Deprivation of Liberty Safeguard (DoLS) in 2019.

1.3 In early 2020, Angus returned to living in the community with a support package but a pattern of self-neglect, alcohol abuse and regular falls in his home followed. Angus developed an infected leg and more latterly serious pressure sores. Angus declined some medical treatment and refused admission to hospital, despite the risk of not doing so being made clear to him. Health professionals, and in particular his GP, were concerned about Angus' mental capacity and after undertaking an assessment, which deemed he did not have capacity in relation to medical care, attempted to get Angus admitted to hospital for assessment and treatment. This course of action was considered in Angus' best interests.

1.4 On two occasions the ambulance service and police attended Angus' address to convey him to hospital, having been arranged by the GP, and on each occasion the ambulance service deemed that Angus did have mental capacity and they were unable to convey him to hospital against his wishes. The police view was that they did not have a lawful basis on which to assist the conveyance without Angus' agreement.

1.5 At the beginning of December 2020, the condition of Angus' infected leg improved slightly. There had been a concerted effort to manage the infection with medication, but he developed severe pressure sores. As Angus' condition deteriorated, he was conveyed to hospital and after being an inpatient for a week he died.

1.6 This review was undertaken to focus on a relatively short period time to understand how the agencies, which worked tenaciously to support Angus, understood and used the Mental Capacity Act (MCA). It is also important to consider that the period of the review was undertaken during periods of the Covid pandemic and the challenges that this presented to agencies in terms of contact, capacity and delivery of services.

2. Methodology and Terms of Reference

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally.

- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the Bath & North East Somerset (B&NES) Community Safety & Safeguarding Partnership to improve its services and prevent abuse and neglect in the future.

- Agree how this learning will be acted on, and what is expected to change as a result.

- Identify any issues for multi or single agency policies and procedures.

- Publish a summary report, which is available to the public.

2.2 The B&NES Adults Review sub-group decided that a proportionate review would be undertaken. Each agency identified as being involved was requested to provide information and a chronology detailing their involvement. Practitioners who were involved in the case were invited to take part in a reflective discussion event. The discussion from these events is reflected throughout the report.

2.3 Unfortunately, key agencies for this review, ambulance service and police were unable to attend the reflective discussion event. The author has sought to speak with representatives from these organisations individually and gain the necessary understanding and information. Whilst the difficulty for organisations which span many Safeguarding Partnerships is recognised, it undoubtedly detracted from the richness of the discussion by not having all relevant partners represented.

2.4 Terms of reference for the review were agreed and these are at appendix A. The terms of reference identified the timeline of the review as between 19th October 2020 and 16th December 2020.

The areas identified by the panel for consideration were:

- To what extent did agencies understand the principles of the MCA and their application of it?
- The initial consideration identified that there were professional differences regarding Angus' admission – should these have been addressed and if so, how?
- Who or which agency is the priority decision maker for admission to hospital in the situation experienced by Angus?
- The GP made the decision and signed the conveyance paperwork, which was subsequently overridden by SWAST. What is the legal framework around this?
- Was the care provided to Angus in line with good practice in regard to meeting his health care needs?
- How were Angus' previous views and wishes taken into account in the decision-making process?

3. Background

3.1 At the time of his death, Angus was 72 years old. He was a divorced man with two sons, with whom he had little contact. For a number of years Angus was supported by his niece but this support declined due to his niece's own commitments. Angus had abused alcohol for a number of years and records show that he would consume a bottle of whisky every two days[1], although more latterly it was said that this had increased to a bottle of whisky daily.

3.2 Angus had moved regularly and there appeared to be a cycle of him refraining from using alcohol and managing, but after a short period re-starting the use of alcohol and this affected his ability to care for himself and led to concerns regarding self-neglect and his overall health condition.

3.3 In March 2019, Angus was admitted to hospital following a fall. In April 2019, Angus was assessed as lacking mental capacity in relation to being able to meet his care and support needs. He was resident at a care home between this time and February 2020. During this time there was a DoLS authorisation in place.

3.4 During the period that Angus was in the care home he continually requested to return to supported living, with his own tenancy. In December 2019, there was a Care and Support

[1] Care and Support assessment December 2019

Assessment undertaken for him which showed that he met the eligibility threshold for care and support. It was assessed that Angus did not have mental capacity for discharge planning and that he was unaware of the support that he required to facilitate his daily living. With the support of an Independent Mental Health Advocate (IMCA) it was decided that it was in Angus' best interests that he return to independent living with support as this was the least restrictive option. The assessment recognised that Angus had previously been reluctant to receive care, and this could pose a challenge. The assessment also recorded that Angus' Mental Capacity and Care Act assessment should be reviewed should he start to use alcohol again.

3.5 In January 2020, a multi-agency self-neglect risk meeting[2] (MARM) took place. It was recognised that if Angus should start drinking alcohol and smoking again there would be risks. Whilst at the care home he had refrained from alcohol and smoking but just before his return to community living had started drinking and smoking again. Angus' family had been in the background, but one son and his ex-wife had visited. They expressed a concern regarding Angus returning to independent living. A social worker from the discharge team recognised that if Angus was unable to maintain the property, it would present a crisis situation which may require an application to the Court of Protection.

3.6 In February 2020, Angus returned to living in the community with a support package. On Angus taking up residence, staff from the Livewell team had difficulty contacting him. At the time of his discharge, 'Options for Living' were visiting him 3 times a week and a care provider was visiting 3 times per week which very quickly increased to visits every day.

3.7 In May 2020, District Nurses (DN) went to see Angus over a concern regarding an infected foot. This is the first record of the infection. In June 2020, Angus was discovered on the floor by carers, having fallen. He was conveyed to hospital by ambulance and found to have a fractured hip (he had previously fractured his hip in March 2019). The ambulance staff noted that Angus had been drinking whisky and cider and the home living conditions were poor. Neither the ambulance service nor carers made a safeguarding referral at this time. Angus was in hospital until July 2020, at which time he was transferred to a Community Hospital for rehabilitation. During this period Angus was offered and declined alcohol support. He was also assessed by the Mental Health Liaison Team as he was having suicidal ideation. After assessment no further mental health support was required and he was discharged in mid-August 2020. Angus was to receive help from district nurses to support him with care for his wound.

August 2020-December 2020

3.8 Within a day of being discharged from hospital an ambulance was called to Angus as he had fallen in the bathroom. The ambulance staff recorded that he stated he was drinking a half bottle of whisky per day. Angus was not conveyed to hospital. This became a regular pattern, with falls recorded on at least eight occasions between September and December 2020. Most of these falls occurred in the early hours of the morning in the bathroom. On each occasion Angus declined hospital admission. On the first fall following hospital discharge in August 2020, the ambulance service made a safeguarding referral for self-neglect and for an assessment for aids in the bathroom to help prevent falls. Safeguarding referrals were also made in October 2020 for falls, self-neglect, alcohol use and skin infection. In November 2020, the ambulance staff made a referral again for self-neglect.

3.9 At the beginning of September 2020, the GP visited Angus at home in response to the number of falls he had suffered. The GP recorded that Angus was not suffering from low mood and

[2] BSCCP Self Neglect Policy and best practice guidance - https://bcssp.bathnes.gov.uk/sites/default/files/2020-07/self-neglect_policy_and_guidance_.pdf

stated that he was happy to live the way he did. The GP assessed at this time that Angus possessed mental capacity to make this decision.

3.10 At the beginning of September 2020, it was decided that the s42(2)[3] enquiry resulting from the referral from the ambulance service could be closed with no further safeguarding enquiries needed at that time. It was recognised that reablement team were to be involved and Angus was accepting a care package. The enquiry noted that Angus had a history of alcohol use and not coping, but there was nothing in the referral to link this to alcohol abuse. Over the beginning of September Angus declined support from Age UK and the reablement service.

3.11 At around the same time a new care provider started to support Angus. He was not allowing the DNs to dress his feet and the DN's gave instruction to the care provider as to how the feet should be treated. Angus seemed to be engaging with the care support but not with the GP, reablement or DNs. At the end of September 2020, Angus was discussed at the GP MDT meeting, and it was recorded that whilst he was not engaging with services, he was felt to have mental capacity to make those decisions.

3.12 Through October 2020, concerns were raised regarding Angus' infected foot. The care workers took photos that were forwarded to the GP and reported that it looked like there were maggots present. The foot was also reviewed by an ambulance crew when they attended on the report of a fall, but Angus declined hospital attendance. He was deemed to have capacity by the ambulance staff who made a safeguarding referral on the basis of neglect, alcohol use and skin infection. Subsequently the GP prescribed antibiotics 4 times daily but this was difficult for the carers to support as they were only visiting once daily. The prescription was altered to one daily dose. The GP visited Angus at home and informed him of the risk of not attending hospital, but he remained adamant that he would not agree to a hospital admission.

3.13 The GP made an urgent referral to the Primary Care Liaison Service (PCLS)[4] for a review of Angus' mental health, whether there was scope for DoLs and a care home placement.

3.14 At the end of October 2020, Angus was visited at home by his GP and a senior practitioner from PCLS, this visit was to assist the GP with decision making regarding Angus' ability to make decisions regarding his ongoing health condition.

It was noted that Angus had historically and currently suffered an Alcohol Related Brain Injury (ARBI) which combined with current excessive alcohol use. It was deemed that Angus lacked mental capacity regarding his decision around medical treatment and hospital admission, as he did not demonstrate the necessary understanding and was not able to weigh up the risks and benefits of treatment and the potential loss of limb and life. Angus was to be conveyed to hospital under a best interest decision and staff could use reasonable force to facilitate this. It was agreed that the Mental Health Act was not applicable in the circumstances as the symptoms of mental illness were not sufficiently noticeable. The GP was to advise the ambulance service of the decision. Angus maintained that he did not care about his health or whether he died. The GP called an ambulance to convey Angus to hospital and completed a form requesting conveyance for a patient who lacked capacity setting out the grounds for the decision, which included the provision to use reasonable and proportionate force.

3.15 The ambulance attended Angus' address the following day, in the early hours of the morning some 17 hours after the GP's request had been made. Angus maintained that he was unwilling

[3] Section 42 Care Act 2014 - The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

[4] Primary Care Liaison Service F- The AWP Primary Care Liaison Service (**PCLS**) teams are the main integrated referral points into adult secondary mental health services.

to attend hospital and the ambulance staff recorded that he did have capacity to make this decision and recorded that he '*was able to retain and repeat information about the concerns*.' The ambulance requested police attendance and police agreed that Angus had capacity and there was no lawful basis on which to convey Angus to hospital against his wishes. The ambulance staff made repeated requests for Angus to attend hospital which he declined, they made a safeguarding referral on the basis of self-neglect.

3.16 The following day an ambulance again attended Angus' address as a result of him having a fall coming from the bathroom. He again declined hospital treatment, his foot was noted as being very hot and a further safeguarding referral was made on the basis of self-neglect.

3.17 At the beginning of November 2020, the GP arranged for an ambulance to attend Angus' address to convey him to hospital. The GP and senior PCLS practitioner arranged to be present to liaise with the ambulance staff. Again, the ambulance arrived in the early hours of the morning and after Angus had repeatedly refused to be admitted to hospital the ambulance crew deemed that he had mental capacity to refuse hospital admission. In discussion between the GP and ambulance staff, the ambulance staff stated that the GP's assessment of capacity *'overruled'* theirs but despite this Angus was not conveyed to hospital. Police again attended and maintained that there was no lawful basis on which to remove Angus forcibly from his address. Angus remained in his address contrary to the views of the GP.

3.18 On 5th November 2020, a decision was made by ASC that no further safeguarding enquiries were required, and that the safeguarding referral could be closed at S42(1) stage. It was found that there was reasonable cause to suspect that Angus met all three Care Act criteria to be considered an adult with care and support needs, at risk of neglect. It was acknowledged that Angus' care package had been increased and that a change of antibiotics was having a positive effect on his infected leg. There was an action for ASC to initiate formal self-neglect policy procedures and to convene a MARM meeting as soon as was possible. It was acknowledged that there was a dispute over the level of mental capacity for Angus to make decisions regarding his medical treatment and that these parties should be part of the MARM meeting.

3.19 The following day ambulance again attended Angus' address on a report that he had fallen on leaving the bathroom. He was advised to attend hospital but declined. The same occurred five days later, with the same outcome. On this occasion Angus was advised to attend hospital on the basis of his ECG reading, but he again declined.

3.20 On 9th November 2020, a MARM meeting did take place attended by the GP, social worker, Carewatch manager, district nurse and a safeguarding manager from the ambulance service. A number of issues were identified and discussed. This included the carers working outside of their experience and jurisdiction as Angus would not allow the district nurses to care for him. Recurrent falls were discussed, and it was noted that an Occupational Therapy assessment was required for more grab rails. There was a concern over the development of sacral pressure sores, which the district nurses were to review. There were concerns regarding self-neglect, the carers were to continue three daily visits and the social worker was to discuss family and Independent Mental Capacity Advocate (IMCA) involvement with Angus. The important area and dispute over the mental capacity assessment was discussed but there is no recorded resolution apart from the GP forwarding their assessment to the ambulance service for them to have on record. There was no date set for another meeting to assess impact of the agreed actions.

3.21 On 18th November 2020, the social worker undertook a care and support assessment on Angus. There is evidence that this was person centred and Angus' voice and wishes were presented and recorded. The assessment put in place additional daily care and a referral was

made for advocacy to represent Angus' views and wishes on health care. On 21st November 2020, Angus fell again, with ambulance attending his address, he was found to be unable to mobilise due to his bandaged feet slipping on the vinyl floor. This had been a re-occurring problem which had not been addressed.

3.22 On 3rd December 2020, the Carewatch manager raised Angus' case at the BCSSP Mental Capacity Act Sub-group meeting. In particular, the difference of opinion between the GP and ambulance service/police. As a result, the Carewatch manager sent details of the case to a manager in adult social care, this included concerns regarding the presence of pressure ulcers that had not been examined by a health professional. It is not clear that there was any outcome from this discussion.

3.23 Angus continued to refuse for the district nurses to assess his pressure sores. On 7th December the sores were seen by a Tissue Viability Nurse (TVN) and recorded as ungradable and nearly down to the bone. On the same day an ambulance attended Angus' address on the report of him having fallen. Angus refused hospital admission, the ambulance staff noted that Angus had not washed for several days and was living in unhygienic conditions. A safeguarding referral was made.

3.24 On 8th December 2020, the GP contacted all interested parties by email. The GP had been attempting to obtain details of the unusual ECG reading from an earlier ambulance attendance. It was a private ambulance company that attended and therefore the records were more difficult to access. The GP reminded all parties of the history of the case and highlighted the fact that Angus was deteriorating. The GP also made arrangements for a hospital bed to be delivered to Angus on a best interests basis and also made enquiries around hospital admission and DoLS.

3.25 On 9th December 2020, the district nurse attended and found Angus to be lethargic and slurring his speech. An ambulance attended and recorded that Angus had fluctuating capacity and had previously been assessed by GP as lacking capacity. Angus did not wish to leave his home but was persuaded onto a stretcher and was conveyed to hospital. On admission he had suspected sepsis and deep wounds to left and right buttocks.

3.26 On 11th December 2020, a s42(2) safeguarding enquiry commenced. The enquiry was to look at whether the self-neglect protocol had reduced the risk to a satisfactory level and whether neglect or omission was a factor in relation to the ungradable pressure sores.

3.25 On 16th December 2020, Angus died in hospital. The cause of death was recorded as acute chronic renal failure and peripheral vascular disease and hypertensive nephropathy[5].

4. Analysis of Involvement

4.1 Background of Case

Angus' return to the Community

4.1.1 Whilst the terms of reference of this review focus on a very short time frame from October 2020 to the time of Angus' death in December 2020, it is appropriate that key areas which impacted on Angus and the care and support he received, feature.

4.1.2 From an historical perspective Angus had been supported in residential care under a DoLS authorisation. It had been his wish to return to more independent living and have his own

[5] hypertensive nephropathy – chronic kidney disease

tenancy in the community. He was deemed not to have capacity to participate in discharge planning and was represented by an IMCA. It was decided that it was in his best interests that he lived in the community, with a support package and that this was the least restrictive option.

4.1.3 Any decision being made must be made in the persons best interest and on occasions this will not be the least restrictive alternative but the best interest consideration and that of least restrictive will be made together[6].

4.1.4 The assessment recognised that should Angus start using alcohol then the assessment and his mental capacity should be reviewed again. Before his discharge there was also a MARM meeting, this meeting also acknowledged the risks of Angus returning to the community and that there may have to be an application of the Court of Protection should Angus not be able to maintain his tenancy.

4.1.5 It was apparent that prior to Angus' discharge from residential care that he had started to use alcohol and had returned to smoking and it is hard to see how this would not be exacerbated when he resumed his own tenancy and the risks that had been identified would be realised.

4.1.6 Angus left residential care with a support package in February 2020 and in May 2020 he suffered a fall in the home and fractured his hip. This is the same injury that had led to his previous residential care under the DoLS authorisation. Angus then spent an extended period in hospital (June to August 2020). There is no record of consideration to the previous discussions regarding action that would be taken if Angus started to struggle to cope despite there being evidence that he had been drinking and his accommodation was in a neglected condition.

Learning Where a decision is made in a person's best interests the decision should be reviewed in light of a change of circumstances and an increase in risk.

What is in a person's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be regularly reviewed.[7]

4.2 Self-neglect and Safeguarding Enquiry

4.2.1 On Angus' discharge into the community in August 2020, he fell in his home within the first 24 hours. There then followed a repeating pattern of him falling, ambulance attendance and him declining hospital admission. There were 8 recorded falls between September and December 2020, three of these falls were within a ten-day period. Many of the calls occurred in the early hours of the morning and it was apparent that Angus had been drinking. Other factors were discussed as being a slippery floor exacerbated by bandaged feet and lack of mobility aids.

4.2.2 There were three safeguarding referrals made:

August 2020 – by the ambulance service for self-neglect, which suggested an assessment for aids in the bathroom to prevent falls.

October 2020 – by the ambulance service for falls, self-neglect and the skin infection.

November 2020 – by the ambulance service for self-neglect.

The August Safeguarding Referral was opened as s42(2) enquiry but was closed in September 2020, on the basis that no safeguarding enquiry was required. The closure relied on the

[6] MCA Codes of Practice, 2017
[7] Para 5.14 Mental Capacity Codes of Practice

package that was being delivered to Angus and the fact that the reablement team were to be involved. The enquiry noted that there was a history of alcohol abuse and self-neglect but that there was no link from the referral to the alcohol abuse. It was clear at this stage that Angus was likely to continue to abuse alcohol and neglect his care.

The October safeguarding referral was opened as a s42(2) enquiry and again it was closed at stage 1. Whilst it was accepted that Angus met the Care Act criteria to be considered an adult with care and support needs at risk of neglect, the closure relied on the care package and medication having a positive effect on the infected leg. This was set against a background of Angus continuing to neglect himself and refusing hospital care. He had been deemed to lack capacity and the GP was attempting to get him admitted to hospital in his best interests.

4.2.3 The closure of safeguarding enquires was premature and did not effectively consider the history of the case. When the decision had been made for Angus to return to his own tenancy it was recognised that there were risks and should these be realised consideration should be given to referring to the Court of Protection. The was a clear deterioration in Angus' health and concerns regarding his ability to cope and whilst it is recognised that there was much interagency discussion and liaison there was a lack of decisive action.

4.2.4 Prevention is a key principle in safeguarding adults. There was a lack of consideration about falls prevention which were occurring regularly. A request was made for an assessment at the time of the first ambulance safeguarding referral, but this did not seem to get addressed until the MARM meeting in November.

4.2.5 There is no evidence that throughout either s42(2) safeguarding enquiry that there was involvement of Angus or family members. There is also no evidence of consideration of the use of an independent advocate should Angus have been unable to contribute, or a suitable person being available to represent him.

4.2.6 On the closure of the second safeguarding referral it was recommended that a MARM should be convened. This did not occur until 12th November 2020. There should have been consideration of a MARM at a much earlier juncture in the context of continued self-neglect. By the time of the meeting on the 12th November 2020, the GP had deemed that Angus lacked mental capacity regarding his decision around medical treatment and hospital admission, as he did not demonstrate the necessary understanding and was not able to weigh up the risks and benefits of treatment and the potential loss of limb and life.

Learning Where there is identification of self-neglect, particularly in cases where there is a history of this, professionals should make early use of the B&NES self-Neglect Best Practice Guidance. Where a s42(2) enquiry is opened it should not be closed prematurely on the basis that other measures are in place until it is established that they are effective, and the enquiry should fully consider the history of the case. The person should be involved in the enquiry or where there is a substantial difficulty, a person known to them or family member involved. Where this is not possible consideration should be given to using an independent advocate

4.3 Mental Capacity

4.3.1 The circumstances of this review stemmed predominantly from a professional disagreement other whether Angus had mental capacity to make decisions regarding his medical care. To fully understand this, it is helpful to reflect on the timeline.

February 2020 - Angus discharged from residential care, deemed not to have capacity to make decisions on his care planning.

September 2020 - GP attended Angus' home address due to number of falls and deemed that Angus had capacity at this time to make decision on his care.

30th October 2020 - GP attended Angus' home address with a mental health practitioner experienced in assessment of Mental Capacity and deemed that Angus did not have capacity to make decision on his health and it was in his best interests to go to hospital. GP filled out documentation for conveyance without mental capacity.

31st October 2020 - Ambulance and Police attend Angus' address and deem that he does have capacity and it would not be appropriate to convey Angus to hospital against his wishes.

2nd November 2020 - At the request of the GP, Ambulance and police attend Angus' address to convey him to hospital on the basis that he does not have capacity. The GP makes themself available and is present. Ambulance staff agree that the GP's decision on capacity takes precedence, but they require police assistance to convey and police state that they have no powers to assist conveyance in the circumstances.

4.3.2 It should be noted that the GP made their decision in respect of Angus' mental capacity from a position of having knowledge of the history of the case; the fact that Angus had previously been subject of a DoLS authorisation; and that Angus had been diagnosed with an Alcohol Related Brain Injury. The GP had, in September, made a time specific decision that Angus did have mental capacity. As Angus' medical condition declined and the risk to his health increased, the GP liaised carefully with other agencies and sought the assistance of a health professional with experience of dealing with mental capacity. It has to be said that careful consideration was given to the matter of mental capacity, and it was deemed at the end of October that Angus lacked capacity in relation to his medical treatment, which could become life threatening if not treated in hospital.

4.3.3 The GP took the step of completing a form, which was sourced from NHS colleagues to facilitate the conveyance of a person without mental capacity. The form is headed Royal United Hospital Bath NHS Trust and the existence of such a form would indicate that there is or has been a pre-existing policy/protocol for the conveyance of persons lacking capacity. This review has been unable to identify such a process, or the provenance of the paperwork used by the GP. The form also addresses the fact that reasonable and proportionate force may be used balanced against the potential harm of amputation, increased infection and sepsis if the action is not taken.

4.3.4 There is evidence that the principles of the Mental Capacity Act were appropriately considered with best interests and other less restrictive measures in the form of increased care, support and medication, all discussed and implemented.

4.3.5 The Mental Capacity Act deals with best interest decision making at section 4[8] and determines what 'life sustaining treatment' is '*Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life'.* We are further helped by use of example by the Mental Capacity Code of Practice (para 5.30)

'Whether a treatment is 'life-sustaining' depends not only on the type of treatment, but also on the particular circumstances in which it may be prescribed. For example, in some situations giving antibiotics may be life-sustaining, whereas in other circumstances antibiotics are used to treat a non-life-threatening condition. It is up to the doctor or healthcare professional providing treatment to assess whether the treatment is life-sustaining in each particular situation.'

[8] Mental Capacity Act 2005, Legislation.gov.uk - https://www.legislation.gov.uk/ukpga/2005/9/section/4 (accessed 01/11/21)

In this case it was the view of the GP that life sustaining treatment for Angus was required and there is evidence to support this view.

4.3.6 Section 5 of the Mental Capacity Act deals with restricting liability to those carrying out tasks to support a person who lack mental capacity. For these restrictions on liability to be relied on the persons would have to be satisfied that the person lacked capacity, this has been appropriately assessed and that the action being taken is being done so in the persons best interests. The code of practice states in relation to section 5 – '*Section 5 also allows actions to be taken to ensure a person who lacks capacity to consent receives necessary medical treatment. This could involve taking the person to hospital for out-patient treatment or arranging for admission to hospital. Even if a person who lacks capacity to consent objects to the proposed treatment or admission to hospital, the action might still be allowed under section 5'* (para 6.15)

4.3.7 Section 6 imposes some important limitations on acts which can be carried out with protection from liability under section 5. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

4.3.8 There was a conflict in decision between the GP and ambulance staff. When considering who the most appropriate decision maker is, the code of practice state '*Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.'* (para 5.8). Although the GP was not going to carry out the procedure, they would have to be deemed in the circumstances to be the most appropriate decision maker. Although this was not accepted on the first ambulance attendance it appears to have been accepted on the second occasion (2nd November 2020).

4.3.9 The benefit on the second occasion was that the GP had gone out of their way to be present for the ambulance attendance. The difficulty then arose that the ambulance crew did not feel able to convey Angus, who was not consenting to hospital attendance without police support. The view of the attending police was that there was no lawful basis for them to intervene and if necessary, use force. The police officers would be able to avail of the protection afforded under section 5 and 6 of the Mental Capacity Act.

4.3.10 The College of Policing guidance on Mental Capacity [9] states

'*In situations where health or social care professionals are on the scene, police should defer to their expertise and provide support as appropriate and in accordance with local protocols*

The MCA does not specifically apply to any agency or individual, and chapter 6 of the MCA Code of Practice outlines where the police, other agencies and individuals may justify action taken by the police to detain, restrain and convey a person to hospital (this includes actions taken in private premises).'

4.3.11 The difficulty for both the ambulance service and police was that they were confronted with a complex issue on mental capacity without the in-depth knowledge of the case or background and were trying with the best of intentions to make dynamic decisions. It is sometimes easier to

[9] College of Policing guidance on Mental Capacity - https://www.app.college.police.uk/app-content/mental-health/mental-capacity/ (accessed 01/11/21)

make such decisions where the risk to life is more immediate and the risk clearer to those involved.

4.3.12 Considering the circumstances of the case, the legislation and available guidance, the decision to convey Angus to hospital for life sustaining treatment was appropriate in his best interests. The difficulty for the services then is the practicalities of doing so.

4.3.13 Angus had stated on numerous occasions that he would not attend hospital, ultimately this was achieved when he was too weak to oppose this action. Angus is described as being large in stature and his unwillingness and health conditions may have led to the use of restrictive options or force being less than desirable. It is possible that having recognised the various stages of best interest decision making had been met and that the agencies were acting within the protections of the legislation that formal requests and influencing from the police and ambulance service would have achieved the desired objectives. Had this have not been the case, then a best interest decision would have to be made on the use of force and to what degree this would have been proportionate. It is fully accepted that these decisions are difficult to achieve in real time, but this case and scenario allowed for some element of pre-planning and discussion.

4.3.14 It would be preferable that where there are cases of mental capacity involving best interest decisions regarding life sustaining treatment, which involves more than one agency, that there should be pre-planning to allow all agencies to understand their role, understand the legislation and what is considered appropriate and proportionate.

4.3.15 There is good evidence of agencies considering the complexities of the case and seeking expert advice, but they did not have a coherent multi agency discussion to understand all the issues and how these might be overcome. This included consideration of the potential necessity for a Deprivation of Liberty authorisation once Angus was admitted to hospital. This likewise would have benefited from pre-planning and discussion.

4.3.16 Discussions for this review with the ambulance service has established that there is a significant amount of work within the service on mental health and mental capacity. This will include providing frontline staff with easy access to information on more complex areas, including mental capacity. A challenge for the ambulance service is that it operates over a number of safeguarding partnerships and any agreed protocols would need to be agreed across these partnerships.

Learning Mental Capacity and Best Interest decisions can be complex, it is difficult for front line, first attending staff to be fully equipped to deal with all eventualities and agencies need to be able assist them to allow decision making to be as straightforward as is possible. Where cases allow, it would assist to have an agreed process and protocol signed up to by all agencies who may perform a function in relation to the care and support which would allow for pre-planning and discussion regarding how desired outcomes can be achieved. Where best interest decisions are being made it is important that other persons close to the person who lacks capacity are consulted. If there is no one to consult, then consideration should be made to involving an Independent Mental Capacity Advocate.

4.4 Escalation

4.4.1 There was an impasse on the issue of conveying a person to hospital who lacked mental capacity. There was a MARM meeting which discussed some of the issues in November 2020 but the issues were not properly discussed and resolved although a number of the involved agencies were present. This was a missed opportunity to resolve the issue.

The partnership protocol for resolving professional differences[10] was not considered or used. This would have allowed professionals to work through the different stages to reach a resolution.

4.4.2 At the beginning of December 2020, the case was raised at a BCSSP Mental Capacity Act subgroup meeting by the care provider representative. It was agreed that the social care representative and care provider would discuss the matter outside of the meeting and a transfer of information took place. There is no evidence that there was any resolution discussion around escalation.

5. Conclusion

This was a case which hinged on a disagreement of professional opinion on the issue of mental capacity and best interest decision making in relation to life sustaining treatment. There is a wealth of evidence that professionals expended a lot of time and resource in trying to achieve the best outcome for Angus. This is most apparent in the case of the GP, who did their utmost to achieve the best outcome in the circumstances.

It is apparent that at some stage there was a process with associated paperwork to allow the conveyance of persons who lack capacity to hospital, but this is not now available. Discussion with the ambulance service for this review has revealed that the circumstances of this review is not unique. It would benefit all those involved in the process to have an agreed process and protocol that could be relied on.

The case has also highlighted the issues of self-neglect and how, if agreed interventions are not used at an early stage, the situation can deteriorate causing distress and harm to the individual and increased pressure on agencies.

6. Recommendations

Recommendation 1

Where a decision is made in a person's best interests the decision should be reviewed by the relevant agency, in light of emerging risks and measures should be taken to mitigate those risks.

Recommendation 2

All partner agencies involved in support and care should ensure that they are aware of and adhere to the BCSSP self-neglect procedure and that the Multi Risk Assessment Meeting (MARM) process is used at an early stage.

Recommendation 3

All agencies participating in a section 42(2) enquiry should ensure they include: -

- Effective consideration of the history of the case.
- Effective consideration of the current information including views and information from all those involved with the person.

[10] Multi-Agency Protocol for resolving and escalating professional differences of opinion regarding safeguarding decisions

- That there is clear involvement of the person, their family and consideration of use of an independent advocate where appropriate.

Recommendation 4

BCSSP should review what information and support is available to professionals on the prevention of falls in the home. Agree with key partners whether this is comprehensive and ensure that a revised version is available to all partners agencies with an expectation that all relevant front line staff be made aware of the new policy

Recommendation 5

BCSSP should ensure that relevant partner agencies develop an agreed protocol and understanding on how persons who lack mental capacity can be conveyed to hospital or other settings for life sustaining treatment where it is in their best interests.

Recommendation 6

All agencies when making best interest decisions for persons who lack mental capacity should ensure that they consult others close to the person who lacks capacity and where this is not possible that consideration is given to the involvement of an independent advocate.

Recommendation 7

BCSSP should ensure that the Multi-Agency Protocol for resolving and escalating professional differences of opinion regarding safeguarding decisions is promoted to and understood by all partner agencies.

Recommendation 8

BCSSP should consider how issues regarding current cases raised during partnership meetings are escalated, recorded and addressed and agree to revisit existing protocols and revise them with cross partnership dissemination.

Appendix A – Terms of Reference

Safeguarding Adult Review

Angus

Introduction

A notification was received by Bath & North East Somerset (B&NES) Safeguarding Adult Review (SAR) subgroup on the 18th December 2020 from B&NES Council Safeguarding Adults and Quality Assurance Team regarding a potential SAR.

The notification was discussed at the SAR subgroup meeting on 22nd January 2021 and again on the 29th January 2021 due to the complexity of the case and the decision to request further information, namely regarding the documentation related to the decision making about Angus capacity.

Background

The review concerns Angus:

- On 16th December 2020, Angus died whilst an inpatient at Royal United Hospital, Bath.
- Angus had a history of self-neglect and alcoholism
- He had previously been subject to self-neglect processes
- Angus had leg ulcers which were being managed by carers
- Questions were asked about Angus capacity to understand the risk to his health as he continued to decline hospital admission

Legal Framework

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

The case was considered by the PRG on 22nd and 29th January 2021 and concluded that the SAR criteria had been met. The Independent Chair of the BCSSP approved this decision.

Review Scope

The review will include information in relation to:

Name: Angus

The timeframe the review will consider is from the 19th October 2020 until 16th December 2020.

There may be significant events or information outside of this time period which influence the decisions made during the period in its scope. If information is identified it will be included within the review terms of impact on the decisions and actions taken.

Review Principles

The review will be underpinned by the following principles, as set out in the Care Act 2014 Statutory Guidance.

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

Of key importance will be the engagement with family members and all organisations involved.

Methodology

The review will be conducted using a blended approach, including:

- A review of all relevant agency information undertaken by a person independent of any of the organisations involved
- A SAR panel comprised of relevant and nominated senior persons representative of the agencies involved to provide advice and support to the reviewer in regard to local arrangements and existing policies/procedures
- Early discussions with the family to agree to what extent and how they wish to be involved, and to manage expectations
- Appropriate involvement of professionals and organisations who were working with the adult so they can contribute their perspectives without fear of being blamed for actions taken in good faith
- Individual and integrated chronology reports from agencies who were working with the adult
- Due to the current impact of COVID-19, the methodology will remain flexible in response to information received and how learning can best be facilitated

The methodology will be supported by a Terms of Reference that sets out the focus and scope of the SAR, timeframes within which it will focus, roles, expectations and outcomes required.

Outcome

A final learning briefing which clearly identifies learning and how it can be effectively disseminated it to partners.

Agencies expected to contribute to the SAR process

Avon and Wiltshire Mental Health Partnership

B&NES Safeguarding and Quality Assurance Team

Carewatch Bath

Abney and Baker

General Practitioner – Hope House Surgery

Avon & Somerset Constabulary

Royal United Hospital

South West Ambulance Service Foundation Trust

Virgin Care – Health

Virgin Care – Adult Social Care

Key lines of enquiry

- To what extent did agencies understand the principles of the MCA and their application
- The initial consideration identified that there were professional differences regarding Angus' admission – should these have been addressed and if so, how?
- Who is the priority decision maker for admission to hospital in the situation experienced by Angus?
- The GP made the decision and signed the conveyance paperwork, which was subsequently overridden by SWAST. What is the legal framework around this?
- Was the care provided to Angus in line with good practice in regard to meeting his health care needs?
- How were Angus previous views and wishes taken into account in the decision-making process?

Appendix B – The Author

The author is Independent of this case and any of the agencies involved. He is the chair of the Cambridgeshire and Peterborough Safeguarding Adults Review sub-group.

He is a retired police officer and senior investigating officer. He has since been involved in working with local authorities, the health and third sector and the Church of England in a safeguarding capacity.

He has authored Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.