# 7 minute briefing

Safeguarding ENFIELD

Mr K was a 69 year old man with a complex medical background including COPD and Diabetes. He had frequent hospital admissions and a number of referrals into Adult Social Care. He had a history of declining services and treatments.

In December 2018, a number of reports were received around his reporting that he did not have food in the house. A referral was made to Single Point of Access Team in Enfield Council, and a visit was organised – contact could not be made with Mr K and a neighbour stated he was still in hospital. This was not the case.

Mr K was found dead, cause of death undetermined, on 31st December 2018.

There is a lot of learning to be gained from this SAR and it is recommended you read it in full here.

**Professional Challenge and Curiousity when care is declined or cancelled**.

Mr K frequently declined care packages and clinical care at points of discharge and assessment. There is not always evidence in the record that his reasons for doing so (or his suggested alternatives/ understanding of consequences of doing so) were explored with him. This is a point that has come up more than once in Safeguarding Adults Reviews.

Given the extreme financial issues that were eventually identified, he may have been worried about the cost of care (and concerns about potential financial abuse). If so, this could have been addressed with him. Conversations about why people are declining services need to be sensitive but also direct. Prompts to support professionals working with adults who decline services are available on the Safeguarding Adults Board website with this briefing.

**The presumption of Mental Capacity.**

Throughout his engagement with partner agencies, Mr K's mental capacity around his care and treatment was presumed. There are examples of professionals discussing and getting more information about his mental capacity in general, but there are no specific Mental Capacity Act Assessments in place which clarify his understanding of the consequences of declining care/ services.

The Mental Capacity Act (2005) states that unwise decisions are not, on their own, a reason to say that an adult lacks capacity. But high risks resulting from said unwise decisions can, and should, be a prompt to further explore and assess mental capacity.

Guidance around Mental Capacity can be found on the Enfield Intranet or here.




**Unable to make contact…**

Where an adult is not responding to attempts to make contact after concerns about welfare have been raised, it is vital that staff confirm their whereabouts.

This could involve:

- Checking the Health Exchange system on Eclipse.
- Contacting local hospitals and the LAS.
- Contacting any known relatives.
- Dialling 101 to request a Life-and-Limb check from Police.

**Issues that might have led to questions about capacity:**

- Incidents of delirium which appear not to have been followed up on.
- Inconsistency around decision making.
- An acquired brain injury that was not always recorded so some professionals were unaware of it.
- Frequent readmissions in circumstances that suggested self-neglect.

**Multi-disciplinary team meetings.**

A multi-disciplinary team (MDT) approach to supporting Mr K and clarifying the situation could have been very useful. Several recommendations were made by various professionals at different points and appear not to have been followed up. No agencies had the full picture of how often Mr K was declining care and treatment.

Where adults are declining care, an MDT approach is vital to share information, establish the real situation and what can be done to support them and mitigate risk. Any partner agency can set up an MDT meeting where there is concern.

The Enfield SAB is in the process of developing an escalation policy to support with disagreements between partner agencies (which will be available on the SAB website when agreed).

**Clarifying the role of informal carers.**

Mr K would frequently refer to friends (in a general sense) who would support him – leading to the belief that more formal care or support wasn't necessary. Sometimes friends were seen peripherally by professionals. However, the subsequent events, and his family's statements, call into question how involved these friends really were.

It is vital to clarify the role of informal support networks and how far these extend or can be relied upon. When Mr K had no food in his cupboards, he called the London Ambulance Service and not his friends.



ENFIELD Council