Safeguarding Adults Review
for Lambeth Safeguarding Adults Board

Thematic Review
Adults H, I and J

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Glossary

This report includes a significant number of abbreviations.

While each abbreviation is preceded by the full title on the first occasion of its use in the document, it is felt to be helpful to include this glossary for those who are not fully familiar with all the terms.

AMHP	Approved Mental Health Professional
CMHT	Community Mental Health Team
DKA	Diabetic Ketoacidosis
LIFT	Look Ahead Assertive Medication Support Service (also referred to as LIFT)
KCH	Kings College Hospital
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
PA	Personal assistant
SLaM	South London and Maudsley NHS Foundation Trust
SUI	Serious Untoward Incident
TVN	Tissue Viability Nurse

Summary

This thematic review has considered the cases of three individuals, where the Safeguarding Adults Board believed there were common elements from which organisational learning could be achieved. All three experienced mental ill health and vascular disease, although this review identified significant differences in relation to one of the individuals, leading to several of the findings being relevant mainly to the other two people. Some findings are relevant to all three.

Two individuals had chronic and severe mental illness and were receiving long term psychotropic medication, one through depot intramuscular injection, the other by oral route. The third had experienced two strokes and had recently been diagnosed with dementia. The combination of the strokes and dementia had significantly impacted on his cognitive abilities.

The two individuals with severe mental illness had both been diagnosed with type 2 diabetes; one within the past year and the other several years previously. The individual with cognitive impairment due to strokes and dementia was reported to have diabetes and was certainly experiencing severe vascular disease, but the review found no evidence of a formal diagnosis of diabetes throughout the period covered.

All three subjects of this thematic review are men. They are all black British or of black Caribbean heritage. The review has found no evidence to indicate that the care they received was any different as a result of their ethnicity. It is important to note the national picture of the significant over-representation of black British and African-Caribbean men with severe mental illness and their increased presence within the psychiatric population, particularly those subject to restrictions and detention under the Mental Health Act. This review has considered the ethnicity of the men and not identified any relevant factors that need to be raised here.

Two of the men were admitted to hospital with severe necrosis of their lower leg, resulting in below-knee amputations. One of these men has since sadly passed away, but his death is outside the scope of this review. The third man was found deceased at his home address after not being seen by professionals for approximately ten days.

The review has identified potential learning in relation to the Mental Capacity Act (MCA) for all three individuals. The issues are not identical for all three, but there are common themes. The purpose of the MCA is to assist the person in making a particular decision (or decisions) and if they are unable to make the decision, provides a structure in which decisions can be made by others. The consideration of capacity is time- and decision-specific, and when it is identified that someone is unable to make the decision, further work needs to take place to identify who will make the decision in the person's best interests, and what should be done

In one situation, an individual was assessed as lacking capacity to manage his diabetic care, but no further action was taken to determine what action was in the person's best interests, and how that could be achieved. It is not disputed that there are considerable difficulties in ensuring a person manages their diabetic care on a day-to-day basis. However, the failure to follow up an assessment of lack of capacity leads to inertia and lack of any strategic plan on how to respond.

In another case, an assessment was made that the individual lacked capacity to consent to admission to hospital, and a referral was appropriately made for a further

assessment under the Deprivation of Liberty Safeguards (DoLS), but no further capacity assessments were undertaken, and it appears that the original assessment was used to determine that the person lacked capacity for his medical treatment, including amputation. The records of the discussion with the patient suggest that, with appropriate assistance, he may have had capacity to make that decision himself.

In cases where capacity may be fluctuating, or there may be differences of opinion regarding the person's capacity to make a decision, it is important that this is addressed clearly and explicitly. Staff should be enabled and encouraged to respectfully challenge their multi-disciplinary colleagues. There are risks that professional seniority may inhibit such challenge, but full discussion of unclear or contentious assessments can only benefit the service user.

It is important not to over-bureaucratise the capacity process, but it is possible to record legally robust assessments without extensive recording. At the same time, assessments of capacity, particularly where the decision is particularly could or will have grave or life-changing impacts must be adequately recorded.

Multi-disciplinary communication was evident in all the cases, often to good effect. There were times, however, when the communication between the different agencies and professionals was less than optimal. Changes in care provision were not communicated in one case, leading to an assumption that the person was being seen by another agency, when he had not been seen by anyone for ten days.

It was also noted that sometimes communication appeared to be an end in itself, and difficulties within the overall care provision were not brought to the multi-disciplinary forum to consider ways to address some of the issues.

Care planning is important for all individuals who receive support from the state. For those people subject to section 117 of the Mental Health Act, there is a clear and explicit responsibility to provide a plan for the service user's aftercare. This is particularly important when there are multiple agencies and professionals involved, to ensure clarity and coordination of provision.

Both of the individuals with severe mental illness were subject to section 117 aftercare but neither had care plans recorded in their notes. Such a care plan should not be restricted to the treatment for their mental disorder, but should be a holistic plan covering all their needs. While the existence of a written care plan is no guarantee of coordinated care, it would be a focal point for all professionals and provide clarity in relation to their respective responsibilities. It will also assist in ensuring consistency in relation to multi-disciplinary communication.

The final theme arising out of this review relates to the chronic risks of poor diabetes management. Diabetes is a particular risk for individuals with severe mental illness, and those receiving anti-psychotic medication, some drugs in particular. This population have poorer health outcomes than the wider population, and diabetes poses particular and specific risks, both acute and in the long term. It is vital that all professionals who are working with people with severe mental illness are aware of the risks of poor compliance with diabetes care, have access to specific expertise and have routes to escalate concerns.

Terms of Reference

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All Lambeth Safeguarding Adult Board (LSAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Legislation

Section 44 of the Care Act 2014 places a statutory requirement on the LSAB to commission and learn from SARs in specific circumstances, as laid out below, and confers the LSAB the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) *there is reasonable cause for concern about how the SA(P)B, members of it or other persons with relevant functions worked together to safeguard the adult, and*
b) *the adult had died, and the SA(P)B knows or suspects that the death resulted from abuse or neglect…, or*
c) *the adult is still alive, and the SA (P)B knows or suspects that the adult has experienced serious abuse or neglect.*

…Each member of the SA (P)B must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) *identifying the lessons to be learnt from the adult's case, and*
b) *applying those lessons to future cases.*

Governance and accountability

This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures (London ADASS 2019); and
- LSAB SAR sub-group Policy and Procedure (2020)

As the accountable body responsible for its commissioning, the LSAB will receive updates on progress of this SAR at Board meetings or via offline written briefings as required.

SAR methodology

A mixed methodology using a system analysis approach and significant event analysis has been selected as the methodology for conducting this SAR. This methodology was selected because this will allow for a focus on structured reflection

around key themes drawn from management reports, with learning events used to explore people's perspectives of events, and analyses what happened and why, with input on recommendations for learning and development.

Specific areas of enquiry

The SAR panel (and by extension all contributors) will consider and reflect on the following:

1. Partnership working - with focus on Joint risk management.
2. Understanding of diabetes management – learning for partner agencies.
3. Executive functioning / MCA work when working with vulnerable service users refusing support.

The SAR should cover the time period **from 8 months prior to concern being raised for each case.**

Timescales for completion

This SAR will commence on **29/11/2021** and should complete within six months, with view to present final report to the Lambeth Safeguarding Adults Board in April 2022. Everyone involved in the SAR process must be mindful of not jeopardising any criminal proceedings.

Evidence and submissions to the SAR

It has been agreed that the following organisations are to submit evidence to the SAR:

Organisation	Nature of the evidence to be submitted	Deadline
Lambeth Adult Social Care	Safeguarding Enquiry and Conclusion (H/I/J)	*Submitted*
Guys and St Thomas' NHS Foundation Trust	Serious Incident Report (EC)	06/10/2021 (submitted)
South London and Maudsley NHs Foundation Trust	Serious Incident Investigation Report (EC) *SLaM Serious incident declared to CCG 01/12/2020*	03/01/2022
Kings College Hospital NHS Foundation Trust	To be determined.	TBD

Organisation	Nature of the evidence to be submitted	Deadline
All partners identified above, and any other relevant partners identified as review process proceeds.	Overview of information relevant to persons long-term condition beyond the 8-month specified for review, via brief chronology	TBD

Summary of concerns that triggered this SAR

The SAR Subgroup and the Lambeth SAB Chair has agreed to a thematic review of three cases which relate to management of diabetes treatment where person lacks capacity, and which demonstrate the complexities that interplay with the Mental Capacity Act and Mental Health Act.

It was initially intended that this SAR would refer to the respective individuals as 'H', 'I' and 'J'. In order to improve the narrative, a decision was made to create pseudonyms based on those initials. Therefore 'H' will be referred to throughout this review as 'Henry', 'I' will be referred to as 'Ivan', and 'J' will be referred to as Jackson. There is one named family member, who will be referred to as 'Keith'. All of these names are pseudonyms.

Case H (Henry):

Henry was a black British man with longstanding, chronic paranoid schizophrenia, who has been under the care of mental health forensic services in Lambeth since the 1980s. Henry was 58 at time the safeguarding concern was raised in February 2019, and he had been living in a mental health supported accommodation scheme with a rehabilitative focus, since 2013. In February 2019, Henry was detained on MHA s3 and diverted to Kings College Hospital A&E because of serious physical health concerns. At A&E he was found to have infected necrotic first, second and third toes of the right foot with underlying osteomyelitis (bone infection) as well as an infected wound on the upper surface of his left foot. His blood-sugar level was also extremely high. He was immediately treated with intravenous antibiotics and his blood-sugar level stabilised. Henry required a below-the-knee amputation of his right leg.

Henry lacked capacity in relation to his diabetes care yet there was no comprehensive care plan developed for this. The safeguarding enquiry found that whilst a number of professionals had worked hard to engage Henry, there had been overall failure to manage his physical health with serious consequences and as such, found neglect by involved professionals.

Subsequent to the start of the review, the SAB was notified that Henry sadly passed away on 4th February 2022.

Case I (Ivan):

Ivan is a 64 year old, housebound man who has a severe cognitive impairment following strokes and relies on other people to anticipate his needs. He had double-handed care four times daily and was known to the GP, district nurses, Tissue Viability Nurses (TVN) and podiatry in the community.

Ivan was admitted to St Thomas's Hospital in March 2019 due to a chronic right heel necrotic ulcer (determined to be a diabetic foot ulcer by TVN), and on admission also had a pressure ulcer to his left hip. This led to amputation of his right leg in March 2019.

The Safeguarding enquiry found that more effective communication between professionals could have made a difference to the outcome.

Case J (Jackson):

Jackson was a 41-year-old man with type 2 diabetes who was insulin dependent following an admission to King's College Hospital (KCH) for severe diabetic ketoacidosis (DKA) in April 2020. Upon discharge the patient was referred to the Integrated Local Services, Neighbourhood Nursing for insulin administration and blood sugar monitoring. He was scheduled for daily visits. Jackson had a diagnosis of schizoaffective disorder, though symptoms were well-controlled, and he was well-known to mental health services. It was possible Jackson also had an undiagnosed learning disability.

On a number of occasions Jackson sought to limit his contact with professionals, such as asking district nurses to stop attending (this happened in May 2020, where the district nurses attempted to schedule a multi-disciplinary team meeting whilst continuing to attempt home visits in the meantime). At a later multi-disciplinary team meeting in November 2020, it became clear that no agency had been in contact with Jackson for several days. In line with his protocol, the care co-ordinator alerted the police to force entry to the patient's home where he was found deceased.

Jackson did not appear to understand his illness and there was evidence that he was not managing his nutritional needs, as well as refusing insulin regularly (but considered competent to manage mental health medication). Jackson's mental capacity was not formally assessed.

Brief chronologies

This is a thematic review, focusing on three individuals. A full chronology of each case will not be undertaken in this report, but brief chronologies of the circumstances of the respective cases will be included, in order to help with drawing out themes later in the report. Brief background histories of each individual are also included, in so far as they are relevant to the overall themes of the report.

Adult H (Henry)

Background history

Henry was a black British man who was born and raised in Lambeth. His first contact with mental health services was in 1981 in his early 20s, following a violent criminal offence. He was diagnosed with paranoid schizophrenia.

Henry had numerous admissions to psychiatric care during the 1980s and 1990s. He spent approximately 10 years in a forensic rehabilitation placement outside London. He was transferred to low secure units in London during the 2000s, including Lambeth Hospital.

Henry was diagnosed with type 2 diabetes in 2003. He was prescribed metformin (an oral diabetic medication), which was administered by ward staff. He was escorted to regular reviews at the diabetic clinic.

In 2006, Henry was discharged from hospital to a high-support forensic hostel. During the next two years he stepped down to medium support but returned to high support due to poor compliance with his self-administered diabetic medication and blood sugar monitoring.

The first recorded incidence of Henry refusing his metformin was in 2008, when he claimed he did not need the medication because he was Superman. The GP at this point advised that Henry should be escorted to Accident and Emergency Department if his blood sugar (BM) levels reached 30.

Henry was made subject to a Community Treatment Order (CTO) under s17A of the Mental Health Act 1983 (MHA) in 2008. This provides for a degree of compulsion in the community and the power for the Responsible Clinician[1] to recall the patient to psychiatric care if their mental state deteriorates significantly.

In 2013, Henry moved to Fanon House mental health supported accommodation scheme. He remained living at Fanon House until his admission to hospital and subsequent lower leg amputation in 2019.

It is reported that Henry intermittently accepted his metformin, although he maintained that he did not need it. He believed that he did not have diabetes and the treatment for this condition was either intended to kill him or had side effects, such as making his semen watery. He refused all BM checks and GP reviews while at Fanon House.

It is recorded that in 2015, a psychiatrist from the forensic community mental health team assessed Henry as lacking capacity in relation to his diabetic care and treatment. However, this assessment was not followed up with any discussion or

[1] The Responsible Clinician is the term to describe the clinician (normally a consultant psychiatrist) who has overall responsibility for the case of a patient who is subject to some form of compulsion under the MHA.

determination regarding Henry's best interests, in relation to this decision. Throughout this time and beyond, Henry refused to see a GP or have his BM checked. The staff at Fanon House expressed increasing concern about this element of his care throughout his stay there.

A new GP practice took over responsibility for the primary care of all residents of Fanon House in 2017. The GP lead for mental health in the practice planned to undertake annual visits to the scheme alongside a nurse to ensure regular physical health checks were completed. She reported that Henry did not engage at any point with her or any other member of the team.

It is noted in the SLaM timeline that a document was uploaded onto the SLaM electronic system (EPJS) in May 2018 relating to the GP 12-month physical review. It is commented that this was "good practice demonstrating liaison with GP".

> **Comment: While it is certainly welcome that GP health review notes are uploaded onto the mental health database, it is important that any relevant outcomes of the review are considered and acted upon.**

It seems clear from all reports that Henry did not and would not engage with any monitoring of his diabetic care, from at least three years prior to this review. Fanon House staff had expressed concern regarding Henry's diabetic care the previous year

<u>Events during the 8 months period of this review</u>

Henry continued to be seen regularly although his care coordinator changed during this period. There is no indication that the change of personnel had a particular impact on the work undertaken.

The care coordinator was working on a range of issues, including Henry's financial arrangements – this involved arranging appointeeship to enable Henry's DWP benefits to be managed by the local authority client affairs team.

The CPA meeting in June 2018 does not include any specific reference to Henry's diabetic care, although it does refer to the urgency of the financial issues and appointeeship. The report concludes that Fanon House will "…continue to support [Henry] to comply with both his mental health and physical health medication."

> **Comment: The lack of detail given to Henry's diabetic care and the acute and chronic risks associated with his non-compliance with his diabetes medication is an ongoing feature of the records during the period of this review. Significantly more attention is given to Henry's financial situation. While important, this should not have overshadowed other issues.**

It is a recurring theme that records repeat the expectation that support staff will support and encourage Henry to comply with his medication, despite the well-established pattern that he was refusing the same.

> **Comment: There is no evidence of any attempt to develop a strategy regarding the chronic difficulties in supporting Henry in managing his diabetic care.**

Fanon House staff were expressing “grave concerns” about Henry’s physical health in early July 2018, by both email and telephone contact. They were proposing to initiate a safeguarding alert and requesting an urgent professionals meeting in July. These concerns were raised by email and telephone call, referencing his “drastic weight loss”. There is repeated mention of poor diet and excessive intake of sweet foods. There was also reference to Henry being “unsteady on his feet”.

> **Comment: there is little doubt that the Fanon House staff were aware of Henry’s diabetic status and concerned about his non-compliance with the treatment plan.**
>
> **It is arguable that a better understanding of the potential long-term effects of diabetes-related health issues may have alerted the team to the possibility of diabetic peripheral neuropathy, with the reports of Henry’s unsteadiness on his feet, as well as other features, mentioned in the Lambeth management review.**

A GP review was requested but Henry refused to see the GP when they visited. Henry was discussed in two mental health multi-disciplinary meetings in early August. A decision was made to hold a professionals meeting in order to draw up a plan.

A meeting involving professionals from different agencies was finally held on 30th October. It is variously described as a professionals meeting and a CPA meeting. Fanon House staff had asked for a ‘best interests’ meeting There was no CPA care plan or s117 care plan resulting from this meeting.

Henry’s consultant psychiatrist, GP and Fanon House staff were present. The topics of discussion were Henry’s appointeeship and his physical health. Henry’s mental health was also clearly discussed in relation to these issues. This meeting is recorded in the SLaM chronology and in Fanon House documentation. The GP enquired about the possibility of using the MHA to admit Henry to hospital due to his physical health, but Henry’s consultant psychiatrist felt that he was not suitable for admission to inpatient psychiatric care at this point.

A decision was made for a further professionals’ meeting in three months. Henry agreed to be weighed but refused a blood test. He agreed to attend for a check-up with the GP the next day, but this did not happen.

There is mention in two documents produced by Fanon House (one undated, but from some time in 2018, and the other a quality of life key-working session in November 2018), of staff sometimes being able to persuade Henry to accept his medication either when he wants a cup of tea, or when he wants “safety pins to attach to his layers that he wears”.

> **Comment: These fleeting moments of cooperation indicate consideration regarding strategies that could possibly have been utilised to improve Henry’s compliance with his medication regimes. It is not clear whether these references are to his diabetic or his psychotropic medication, but there was potential here for a more detailed conversation within the multi-disciplinary team about how to develop a strategic plan on improving his cooperation and with medication compliance.**

Care coordinator involvement remained consistent, with Henry being visited regularly throughout 2018. There are communications with the GP and with the consultant psychiatrist in charge of Henry's care. The SLaM timeline comments on the good practice in this multi-disciplinary and multi-agency liaison.

> **Comment: While the reviewer agrees that there was regular and ongoing liaison between agencies, there appears to have been little if any active consideration of how to respond to the chronic situation that was unfolding in relation to Henry's physical health.**

During the last months of 2018 and the beginning of 2019, it appears that Henry's mental health was deteriorating. The repeated references to Henry's physical health also included increasing concerns about his mental state. This deterioration triggered the decision in 2019 to initiate a MHA assessment.

A decision was made to initiate a MHA assessment on 1st February, with a view to detaining Henry for treatment of his mental disorder. For a variety of reasons, the assessment did not take place until 21st February, and the staff at Fanon House did not identify acute concerns regarding Henry's foot until 19th February (as a result of a strong unpleasant smell).

It was at this point that the care team was alerted to the possibility of sepsis (by the GP), and on receipt of this information, the AMHP who was allocated to undertake the MHA assessment the following day replied that this appeared to be a medical emergency requiring immediate attendance at A&E, potentially requiring the use of the Mental Capacity Act. The treating psychiatrist replied that he felt this was not a practical suggestion as Henry would not cooperate.

The MHA assessment went ahead first thing the following day and Henry was detained under the MHA and taken to KCH Emergency Department.

> **Comment: This is indicative of good practice by the AMHP who correctly identified a medical emergency which required immediate attention and possibly the use of the Mental Capacity Act rather than (or in addition to) the Mental Health Act.**

The SLaM timeline comments on the time lapse between the first medical recommendation for admission and the submission of the police risk assessment, suggesting it appeared unnecessarily protracted.

It was established on assessment at Kings College Hospital A&E that Henry had developed diabetic peripheral neuropathy as a result of chronic neglect of his diabetic care.

> **Comment: While in other circumstances, the delay of two weeks before a MHA assessment may lead to dramatic consequences, the state of Henry's health was a result of long-term non-compliance with his diabetic treatment. It is not clear whether admission to hospital one or two weeks earlier would have made a significant difference to the medical outcome.**

Discussion

Care planning

In the long term, beyond the immediate remit of this review (the eight months prior to the concern being raised), it is important to consider the care planning process that the local authority and NHS were required to follow.

Henry was subject to section 117 aftercare, which places a joint duty on the local authority and CCG to provide aftercare to certain categories of patient[2] to meet needs arising out of the person's mental disorder, and to prevent deterioration leading to readmission to hospital for mental disorder.

While Henry's diabetes is a separate condition to his mental disorder, it has been confirmed that there was a direct relationship between his mental health and compliance with his diabetic treatment. The MHA Code of Practice and the SLaM section 117 policy make it clear the section 117 care planning should be part of CPA care planning and should be based on a thorough assessment of the person's health and social care needs[3]. The MHA Code of Practice states that the assessment of the patient's needs is likely to include consideration of "…any specific needs arising from, e.g. co-existing physical disability, sensory impairment…"[4]

The reviewer has confirmed that there was no formal CPA or section 117 care plan in Henry's notes. The latest reference to a 'plan' was in the running notes at the time of Henry's last depot injection in late 2017. The notes of this meeting contain detail of the communication between the nurse and Henry, including mental health monitoring, discussion about drug use and financial competency. These discussions are well noted and take up the majority of the recording.

There is a heading "non-concordance with physical health screenings" to which the following comment is made:

> "…only agreed to blood glucose check once, in November 2017 with prompting from [consultant psychiatrist]."

The plan at the end of the recording includes in the five points

> "3. Psycho education about importance of concordance with oral physical health medication and physical health interventions such as blood glucose, BP, heart rate, etc. Sign-post to Lorraine Hewitt House for illicit substance reduction support."

The reviewer is not criticising the content of this note of the contact with Henry at the time of the administration of his depot medication. However, this is not a substitute for a formal care plan laying out the expectations of all professionals and agencies in relation to the patient's overall care and treatment.

The plan at the end of the recording is an ad hoc list of activities for the professional to undertake during the period leading up to the next depot injection.

Use of the Mental Health Act

The mental health team, including Henry's consultant psychiatrist, correctly confirmed that it is not appropriate to detain a person under the Mental Health Act simply to provide them with care or treatment for a medical condition (in this case

[2] H was subject to s117 aftercare due to his previous detention on long term treatment sections of the MHA.
[3] See SLaM section 117 aftercare policy and procedures (10.10)
[4] MHA Code of Practice (34.19)

diabetes). Equally, the 'Consent to Treatment' provisions of the MHA[5] do not permit treatment for a physical condition to be provided to a patient without their consent, unless that treatment is intended to treat a manifestation of a symptom of the mental disorder. It is not disputed that treatment for diabetes in this case could not be considered to fall within that remit.

However, there is also an argument that Henry's compliance with his diabetic care was intrinsically linked to his mental health. It is recorded in the SLaM notes that when Henry's mental health was well-managed, he was more compliant with his diabetic care and cooperative with his treatment. As his mental state deteriorated, even though he was not exhibiting florid psychotic symptoms, it could be the case that a more assertive approach to his psychiatric treatment may have improved his compliance with his diabetic treatment.

Henry's consultant gave the view repeatedly that during the latter stages of 2018 and January 2019, the grounds were not met for detention under the MHA. It is worth exploring this further in the light of the previous paragraph. The grounds for detention under the MHA are broadly speaking, that the person is suffering from a mental disorder of a nature or degree requiring assessment and/or treatment in hospital, and that detention is necessary ***for the patient's health, or safety***, or for the protection of others[6]. (emphasis added)

This was a professional decision by the consultant psychiatrist in charge of Henry's care, taking into account the requirement always to consider the least restrictive option in relation to a patient's care[7].

It is however, worth considering whether a broader interpretation of the grounds may be indicated in circumstances where a patient is living with chronic medical conditions which are impacted upon by the degree of their mental disorder. Particularly when the potential outcome of ongoing non-compliance with treatment is dramatic.

It is the opinion of this reviewer that such a response should not be interpreted as more 'risk-averse', but indicating a clear understanding of the very severe and potentially life-changing physical risks present as a result of this condition.

Use of the Mental Capacity Act

With the use of the MHA effectively ruled out in relation to impacting on Henry's diabetic care and treatment, there was an opportunity for further consideration of the Mental Capacity Act (MCA) to explore ways in which Henry's diabetic care could be managed more effectively. However, although it was established in 2015 that Henry lacked capacity to make decisions regarding his diabetic care, there was no subsequent best interests consideration, or any plan to develop a strategy to support improved compliance with this element of his health care.

[5] Mental Health Act Part 4.

[6] For a patient with as well-established treatment history as Henry, it could be argued that the most appropriate detention section would have been MHA s3, although detention to assess response to a different treatment may yet fall under MHA s2. The grounds for detention are slightly different for these two sections.

[7] "The Least Restrictive Option and Maximising Independence" is the first guiding principle of the MHA set out in the MHA Code of Practice.

The MCA is clear that capacity is time- and decision-specific, and assessments of capacity should be made in relation to a particular decision, or action, at a particular time. While the earlier records fall outside the timescale of this review, it is relevant to mention them in relation to the relevance to the outcome of Henry's case.

There is strong evidence to suggest that Henry lacked capacity in relation to his diabetic care in 2008, when he declined his metformin medication as he stated he was Superman. This reviewer cannot make any conclusions about the intervening period, but the chronic and severe nature of Henry's mental disorder, combined with the reports that he intermittently accepted the diabetes medication, although consistently maintained that he did not need it, suggest that he continued to lack the relevant capacity for much, if not all of the intervening period.

The formal assessment by the psychiatrist from the forensic CMHT should have prompted a best interests decision on how to manage the issue. This assessment established that Henry was unable to make decisions regarding his diabetes so others needed to make those decisions in his best interests.

The failure to proceed to a best interests decision-making process meant that there was no consideration within the care team on how to respond to this issue. There is no doubt that enforcing repeated medication compliance on a reluctant or resistant individual would be problematic in the extreme, but the process would have enabled a more thorough discussion of the options as well as the short- and long-term risks if the situation continued unchanged.

It is notable that in September 2018, while negotiations were taking place regarding Henry's financial management and potential appointeeship, a request was made for a recent capacity assessment and best interest decision regarding his finances.

Fanon House documents leave no doubt about the degree of concern the staff felt in relation to Henry's physical health, and there is clear evidence that they made several attempts to involve the other members of the multi-agency to become more involved. In the absence of any strategy to attempt to address Henry's non-compliance, the key work sessions and other documents show that the plan continued to be to encourage Henry to take his medication. This strategy had been shown to be broadly ineffective over a long period of time.

A Fanon House risk assessment, in November 2018 reviewed the risks in relation to a range of domains, one of which was 'physical health'. The two recorded risks were "non-compliance with medication" and "weight loss". A linked document written at the same time[8] stated "[Henry] is in denial about his diabetes". A further document written in February 2019[9] comments that Henry has a diagnosis of diabetes and "disputes his condition". There was no doubt or dispute about the reality of his diabetes.

Given the chronic nature of Henry's mental disorder and the records of his statements, it is suggested that the words 'denial' and 'dispute' fail to accurately reflect the nature of his decision-making, that he lacked capacity to manage his diabetes.

[8] The reviewer has seen two documents produced by Fanon House on 09/11/18, entitled "Client Risk Assessment Form" and "Risk Assessment Review Form"

[9] Keeping Me Well And Safe Assessment

Identification of risk in relation to diabetic management

For individuals with chronic and severe mental disorder, particularly where there are associated forensic risks, risk assessment and management will inevitably focus to a considerable extent on the mental health risks to the individual and those around them, including the public.

It is vital, however, that this focus is not at the expense of other risks that may be present, which may not be as clearly and explicitly linked to the person's mental ill health.

As mentioned above, several Fanon House risk documents include the risks to Henry's physical health. However, few explicitly reference diabetes. This may have been implicit in the documentation, but the references tend to be related to his diet, including in particular his like of sweet and sugary foods, and his weight-loss. There is no further exploration of the chronic risks posed by Henry's diabetic non-compliance, such as peripheral neuropathy, wounds at the limb extremities, particularly the feet, and vascular disease. All of these conditions developed over a prolonged period of time.

A more explicit awareness and consideration of the range of risks (acute and chronic) associated with non-compliance with diabetic treatment would have provided the opportunity to consider what actions may be appropriate and how to work with Henry to improve his cooperation.

Adult I (Ivan)

Background history

Ivan was born in Jamaica in 1956 and was therefore in his early 60s during the time covered by this review. He had experienced multiple strokes. Notes from St Thomas's Hospital following his admission state that his first stroke was in 2008, although this is not recorded in the GP notes. This significantly impacted on his mobility, and although reported to be housebound and using a wheelchair, he was reported to be mobilising with a Zimmer frame.

Ivan had a further stroke in 2018. This caused significantly increased disability, such that he was unable to walk. Ivan was also diagnosed with vascular dementia in hospital at the time of the second stroke.

Events during the 8-month period of this review

Ivan was discharged from hospital in June 2018 with a four-times-daily package of care and a family member was staying with him providing care. He was reported to have "severe cognitive impairment" and he "relies on other people to anticipate his needs". The caring family member was variously described as his brother and his cousin.

> **Comment: This discharge appears unremarkable with a comprehensive package of care provided in conjunction with a family carer.**

A referral was made to community podiatry at the end of July due to very long toenails and at the same time it was noted that Ivan's weight was 127.9kg (with a Body Mass Index of 37.8). This was a dramatic increase from a recorded 64kg (BMI 22.8) just 3½ years earlier in December 2014.

> **Comment: The dramatic increase in Ivan's weight in the three and a half years from the end of 2014 is likely to have had a considerable impact on his well-being. It is not clear what caused this increase as the timescale is outside the remit of this review. However, it is noted that there were no references to Ivan's obesity, or any consideration of how to try to address it.**

Ivan was re-referred to podiatry at the end of September as he had not been seen following the original referral.

> **Comment: It is unfortunate that the original referral to podiatry was not actioned. However, there is no evidence that this impacted on the eventual outcome, as the original referral was for his toenails, and subsequent podiatry input did not identify acute problems.**

In early October, the GP had a discussion with a social worker from the local authority discussing Ivan's mental health. There was concern from Ivan's sister that he had 'given up' since his stroke and that he was essentially bedbound.

A referral was made to the Lambeth Living Well Network and the existing prescription of anti-depressant medication was increased.

> **Comment: It is positive that a referral was made to the Lambeth Living Well Network, which suggests a wider assessment than relying solely on psychotropic medication.**

It would appear that this referral was not actioned until January 2019, when an email was sent from a clinical practitioner to the GP requesting contact details for Ivan or his carers. That information was provided on 10th January. The same standard introductory email was sent on 14th January 2019 as was sent on 16th October 2018.

> **Comment: It is unfortunate that the referral was not actioned until January 2019. While there is no evidence that this had any impact on the outcome, it was important that the concern for Ivan's mental health was addressed as soon as possible.**

Ivan was taken to Kings College Hospital Emergency Department on 1st February and discharged the same day. The London Ambulance Service received a call from a neighbour who had heard Ivan shouting for help. On arrival they found Ivan in bed, alert and oriented. He reported severe pain from a headache. He informed the paramedics that his carers had not visited. It was reported he was lying in his own urine and faeces. The LAS submitted a safeguarding concern to the local authority, although the reviewer has seen no record of this. A range of blood results was recorded in the GP notes for that day.

The carers reported to adult social care on 14th February that Ivan's feet and heels were sore, black and with a heavy smell. The care agency contacted the GP asking for an urgent home visit. The agency reported Ivan's entire body was covered in sores.

> **Comment: It is noted that on admission to St Thomas's Hospital on 20th February, there is no record of Ivan's entire body being covered in sores. The ulcer on Ivan's heel was recorded along with one further pressure ulcer (stage 2) on his hip.**

The neighbourhood nursing team were consulting with the GPs during the middle of February, with a GP prescribing pain killers to manage the pain secondary to the sore. A neighbourhood nursing team member emailed the Akerman Practice on 18th February requesting a GP review of Ivan for the purpose of pain management. It records the nurses visiting to dress an unstageable pressure ulcer which is "causing him a lot of pain at rest and on movement".

The safeguarding enquiry conclusion mentions several requests from the nursing team for the GP to review Ivan, although there are no clear records of these requests.

> **Comment: Other reports of Ivan's care and treatment during this time have noted the fact that he had not been seen by a GP since 2017, and that the nurses had repeatedly asked for a GP visit. While it is noted that Ivan was being seen regularly by a range of other professionals, the particular request for more direct GP involvement related to pain management.**

A neighbourhood nurse sent an email and photograph of Ivan's heel to the Tissue Viability Nurse on 22nd February. The TVN determined it was diabetic and required a referral to podiatry. Further advice was given regarding care and treatment of diabetic wounds.

> **Comment: This is the first suggestion in the chronology or notes seen by the reviewer that Ivan had diabetes.**

The community podiatrist visited Ivan on 26th February and discussed Ivan's circumstances with a GP the following day. The GP agreed to make a home visit two days later, on Friday 1st March. A referral was also made for the diabetic foot clinic and an appointment was made for 13th March.

There is no record of a GP visit on 1st March, but a nurse visited on the two subsequent days (Saturday 2nd and Sunday 3rd), emailing the GP on 5th reporting Ivan to be in considerable pain, but unable to take the prescribed pain killers due to nausea and vomiting. An urgent review was requested.

Two further failed telephone consultations were recorded on 5th and 6th March as "failed encounter". There is no record of a face-to-face review of Ivan by the GP.

A podiatrist visited again on 7th March, reporting that the heel was dry and of a similar size to their previous visit on 26th February.

The appointment at the diabetic foot clinic on 13th March failed as Ivan was taken to the hospital by ambulance but without information about where he should be taken. He was dropped off at the wrong location and missed the appointment.

> **Comment: Ivan was not accompanied to this appointment, and the individuals in charge of his transport did not make any enquiries as to the location of his appointment once it was established he was in the wrong part of the hospital. The trust report states that the hospital system would have been able to identify where he should have been taken if those questions had been asked. This breakdown in communication led to a failure to attend this appointment, a delay in identifying the severity of Ivan's condition and a further week of considerable pain. There is no evidence that the one-week delay to the appointment made a difference to the medical outcome.**

A pressure ulcer was identified on Ivan's hip by the carers on 18th February, who informed the neighbourhood nurses who visited and dressed the wound. The evidence from the care teams in the community and also in hospital following Ivan's admission show that he was reluctant to cooperate with turning, favouring lying on his left side, which may have aggravated the pressure area.

Ivan attended the rearranged appointment at the diabetic foot clinic on 20th March and was admitted to St Thomas's Hospital that day.

On admission it was noted that Ivan had a grade 2 ulcer on his left thigh and buttocks, and a necrotic right heel, which was considered of vascular origin. He was scheduled to see the vascular team the following morning.

During the subsequent week, the vascular team assessed Ivan's condition and came to the conclusion that the only option to prevent further deterioration and possible death was amputation.

Discussions took place with Ivan and his family members. Ivan was assessed as lacking capacity in relation to his hospital admission on 21st March, and was also referred for an assessment under the Deprivation of Liberty Safeguards (DoLS)

It is noted in the trust chronology that despite regular references to Ivan's lack of capacity, there was no formal capacity assessment completed, or evidence of a legally robust assessment of his capacity.

Comment: It is important to note that the assessment of capacity is time- and decision-specific. The first reference to Ivan's capacity was made on the day after his admission, when it was stated that he lacked capacity "re hospital admission". A DoLS referral was correctly initiated.

It appears that all further references to Ivan's capacity follow on from this initial assessment. While a nurse recorded that Ivan was "unable to retain and weigh up information relating to his hospital admission…", there is no evidence either of a formal assessment of capacity, or a comprehensive assessment in the notes

It is also important that a lack of capacity to make decisions regarding hospital admission does not necessarily imply a lack of capacity for other decisions. There is no evidence of consideration of Ivan's capacity to consent to the treatment of his necrotic foot. A professional from the vascular team would appear to be the most appropriate person to undertake such an assessment and determine whether or not Ivan had capacity to make the decisions.

Ivan originally stated that he did not want his leg amputated, but later in the week, when presented with the reality of amputation or likely death, he expressed a wish that the amputation go ahead.

Comment: Following Ivan's statement that he would rather lose his leg than die, the doctor comments that Ivan has vascular dementia and cannot retain or weigh up the decision, although provides no detail on how she came to that conclusion. It is suggested that a more detailed assessment of Ivan's capacity may or may not have concluded that he had capacity to make the decision regarding the proposed treatment.

Following the conclusion that Ivan lacked capacity for this decision, a best interests decision was made. This involved Ivan, obtaining his own wishes and feelings, and consultation with his family. Ivan was told about the best interests meeting which took place on 27th March and stated he wanted to be present. He was, however, not involved in this meeting.

Comment: Most of the best interests decision-making process appears to reflect good practice. Ivan's wishes and feelings were sought and those people close to him were consulted. A best interests meeting was held involving family members.

It is unfortunate that Ivan was not involved in the meeting, particularly as he had stated the previous day that he wanted to attend. The Mental Capacity Act requires the decision-maker to "as far as reasonably practicable, permit and encourage the person to participate…as fully as possible in…any decision affecting him."[10]

Ivan's leg was amputated above the knee on 28th March. Discharge planning was disrupted due to the need for revision surgery on the stump, which took place on 19th April. Ivan was discharged to a nursing home placement on 17th May.

[10] Mental Capacity Act s4(4)

Comment: The final events are not directly related to the reasons for this review. However, the post-operative care and discharge planning appear reasonable and within normal practice expectations.

Discussion

The safeguarding concern which has led to Ivan being included in this review was made on 18th April, four weeks after his admission to St Thomas's Hospital and three weeks after his amputation.

The concerns raised in the original safeguarding enquiry cover two questions: Given the level of care and support that Ivan had in place,

1. How Ivan's wound got to the stage that he required amputation, and
2. Why Ivan developed an unstageable pressure ulcer on his hip.

It has been established that the pressure ulcer on Ivan's left hip was of grade 2 severity on admission to hospital and not unstageable. It had been identified by the care staff two days earlier. They contacted the neighbourhood nurses who visited and dressed the wound.

This information was confirmed during the safeguarding enquiry and it is the conclusion of the reviewer that the safeguarding conclusion was correct in finding no cause for concern in relation to this issue.

GP contact

It is noted in several places that Ivan had not been seen by a GP since 2017. He was housebound following two strokes and was unable to attend the GP surgery. The only way he could be reviewed by a GP was via a home visit.

It is noted that Ivan was seen regularly by the neighbourhood nursing service, and during late 2018 and early 2019 the Tissue Viability Nursing and Podiatry services were also involved.

It was the GPs view that sufficient monitoring was taking place by a range of professionals and therefore Ivan was receiving an appropriate service throughout the period of this review.

There is no evidence that an earlier face-to-face review by the GP would have led to a more favourable outcome for Ivan, but the district nurses felt that a review was necessary in order to manage Ivan's significant pain.

The GP practice has commented that a home visit was planned but did not happen due to Ivan's admission to hospital. The surgery acknowledges that "we should have had an earlier MDT meet and earlier home visit arranged with [the nursing team]".

While an earlier visit may not have changed the outcome of Ivan's treatment, it is likely to have provided further information in relation to his pain management, and may have reduced the time Ivan was at home in considerable pain.

Causes of skin breakdown

Whether or not Ivan's foot ulcer was caused by diabetes remains unclear (see below), but there is general agreement that it was of vascular origin and not caused by ongoing pressure to the area. The safeguarding report records that the podiatrist recorded no noticeable change to the wound on the foot in the first week of March, but there appears to be a dramatic deterioration during the following week.

Failed appointment at diabetic foot clinic

Ivan was taken to the diabetic foot clinic without an escort. It appears that no one identified that he would need an escort to this appointment and no escort was arranged.

The transport personnel did not have a letter and spent one and a half hours at the hospital before returning Ivan to his home. The GSTT report states that the staff could have checked on the system to see where he was due to be taken.

This delayed Ivan's appointment by one week. A pressure sore developed on Ivan's hip in the intervening period. Ivan continued to experience considerable pain for the following week and the nurses increased their visits. However, there is no evidence that this delay impacted on the eventual outcome.

Diabetic status

There is lack of clarity regarding Ivan's diabetic status. The GSTT report states that Ivan's past medical history includes diabetes, but there is no record of this in the GP record, other than a family history of diabetes. The GP notes record no medication for diabetes.

The first mention of diabetes is in the Tissue Viability Nurse record on 22nd February in response to an email from the Neighbourhood Nursing Team regarding the wound on Ivan's heel. The TVN states "need referral to podiatry as diabetic with foot ulcer". This does not appear to be supported by any other diagnostic information.

As a result of this advice, Ivan was given an appointment for the diabetic foot clinic on 13th March. Following his failed appointment on 13th March, a further appointment was made on 20th March which resulted in Ivan's admission to the vascular ward at St Thomas's Hospital the same day.

There is very little mention of diabetes in the records taken from Sarah Swift Ward, St Thomas's Hospital when Ivan was admitted in March 2019. On 31st March the nursing notes record "diabetic BM stable". Again on 6th April the nursing note states "patient is diabetic, CPG [capillary blood glucose] stable. Throughout Ivan's hospital stay the notes repeatedly state "BM stable" and there is no record of any medication administered for diabetes.

Mental capacity

It appears clear that Ivan had significant cognitive impairment following his two strokes. He is described in June 2018 as having "severe cognitive impairment" and "relying on other people to anticipate his needs". However there does not appear to be any formal assessments of his capacity in relation to the various elements of his care.

Once admitted to KCH, Ivan was assessed as lacking capacity to consent to his admission and a referral for a DoLS authorisation was correctly initiated. This assessment of his capacity to consent to hospitalisation appears to have been relied upon throughout his inpatient episode, and is referenced by the clinicians who concluded that he lacked capacity to consent to the treatment of his wound and the eventual amputation of his leg.

The record of the discussion between the clinicians and Ivan regarding the choice between amputation or likely death suggests a degree of understanding on the part of Ivan, and also some ability to weigh the options. Ivan stated he would rather lose the leg than die.

The doctor continued to rely on the fact that Ivan had vascular dementia and could not retain or weigh the decision, but provided no evidence to support that conclusion.

It is impossible for this reviewer to confirm whether or not Ivan had the capacity to consent to the treatment at the time, but notes that lack of capacity cannot be established merely by reference to a condition [or diagnosis][11], and the person cannot be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success[12].

There appears to be extremely limited information regarding the efforts made to help Ivan make the decision, or the evidence that he lacked capacity for this decision.

It is noted that the debate over Ivan's capacity for this decision did not make any material change to the medical outcome.

[11] Mental Capacity Act s2(3)(b)
[12] Mental Capacity Act s1(3)

Adult J (Jackson)

Background history

Jackson was a 41-year-old man with a well-established diagnosis of schizophrenia (it is described as schizoaffective disorder in the SAR introduction) and had been prescribed Clozapine for this diagnosis for some years. Clozapine has particular side effects and patients receiving this medication are required to receive regular blood tests to ensure their physical health is not compromised. Jackson attended the Clozapine Clinic, which is part of the Low Intensity Treatment Team (LITT) monthly for these blood tests.

Jackson had three sisters living locally but had not consented to professionals sharing information with them, either in relation to his mental health or subsequently his diabetes.

It is suggested in the Terms of Reference to this report that Jackson may have had an undiagnosed learning disability, and a GP report in July 2020 records a "longstanding history of learning difficulties and behavioural difficulties dating from 1989". It is widely acknowledged that there is a significant difference between a learning disability and learning difficulties[13]. The SLaM report notes that Jackson achieved normal developmental milestones, although it also reports he attended Mortimer secondary school in Streatham for children with dyslexia. There is no further evidence of learning disability, and it is recorded that he achieved GCSE level in art and completed a course in English Communication at Norwood College.

Jackson's mental health had been stable for some years and was receiving support from a personal assistant (PA) employed by a local care provider "Essence2Care". The PA visited Jackson three times per week to support him with his medication compliance, cooking and domestic tasks. The care package was suspended in February 2020 when Jackson was admitted to hospital.

Jackson's mental health deteriorated, he was assessed under the Mental Health Act on 19th February 2020 and was detained on MHA section 3. While an inpatient at Lambeth Hospital, he was diagnosed with type 2 diabetes and was prescribed metformin tablets to manage this condition. While subject to MHA section 3, Jackson developed severe diabetic ketoacidosis (DKA) and was admitted to Kings College Hospital (KCH). He spent two days in intensive care and was treated with insulin.

Jackson returned to his home on discharge from KCH while remaining subject to section 3 MHA (on section 17 leave). A referral was made to the district nursing service at Elmcourt who started to visit him daily from 15th April. He was discharged from section 3 on 28th April 2020.

The Look Ahead Assertive Medication Support Service (LIFT) was commissioned to visit Jackson twice daily (morning and evening) to support him with his Clozapine medication compliance.

Events during the 8-month period of this review

It is reported in several places that Jackson was a private person and found the number of visits by different professionals problematic. The PA from Essence2Care

[13] https://www.mencap.org.uk/learning-disability-explained/learning-difficulties

who had been supporting Jackson up to his admission to hospital was asked by Jackson's care coordinator to resume contact with him but by telephone only, due to the number of professionals visiting him to support him with the other issues. This left the district nurses supporting Jackson's insulin administration and the LIFT team supporting and monitoring his psychiatric medication.

> **Comment: there is no mention of a discussion or consultation with Jackson regarding his views on visits. It is not clear whether Jackson had a positive relationship with his PA, but this was a person with whom he was familiar, and they were now being replaced by a new set of professionals.**

During the first month of this arrangement, Jackson missed a number of doses of insulin due to him being out when the district nurses called. The district nurses expressed concern regarding this and were in frequent communication with the GP and the pharmacist. A safeguarding referral was also made initially to the Guy's and St Thomas's safeguarding team. This was passed on to the Lambeth safeguarding service as a self-neglect issue which was in turn forwarded to the SLaM service.

> **Comment: Although there appears to have been no formal response to this referral and there is no recorded decision regarding how it was addressed, the liaison between the mental health service and the district nurses was frequent and effective during this period.**

As a result of the concerns in relation to Jackson's compliance with the administration of his insulin, the visit times were changed in late May from morning to evening. This appeared to significantly improve Jackson's cooperation with the visits for the following four months, until mid-September.

Despite this improved compliance with his medication regime, Jackson repeatedly expressed his unhappiness about the number of visits he was receiving, and also asked the nurses several times how long he would need to continue to take the insulin. This was recognised as a concern, that Jackson did not appear to understand the nature of his diabetes, which meant that he would need to continue to take the insulin in the long term.

The district nurses made several enquiries about the possibility of reverting to oral diabetic medication, and the insulin dose was gradually reduced during June and July. However, the reduction in insulin dosage made no difference to Jackson's unhappiness about the need for the nurses to visit, and the decision in May that Jackson needed to remain on insulin remained unchanged.

> **Comment: There is no doubt that the district nurses found their work with Jackson challenging. He expressed a regular wish not to have them visiting. On several occasions they were required to telephone him when he was not at home when they visited and they had to return to his home multiple times when this happened.**

This frustration was clearly articulated in an email to the GP in September when it was stated that "…we find he is still going out most visits therefore missing his insulin doses. The patient has expressed multiple times that he does not want nurses visiting. Our pharmacist has been looking into whether he can come off the insulin as he is much more complaint at taking oral medications himself. Please can this be looked into and can we please have an update as we cannot continue to visit this man when he is willingly going out each time he knows we are visiting."

Comment: While there is no disputing the difficulties the district nurses were facing in the context of their busy caseloads, the lack of cooperation appears to have been overstated in this message. According to the GSTT report, Jackson had missed three consecutive days of insulin, which was of course extremely concerning to the nurses. However, according to the records he had only missed one day in the previous seven weeks. On one other day during that period, the nurses had needed to make several attempts before seeing Jackson and administering the medication.

The period covering August and September, apart from the three days missed at the end of September, appears from the notes to be the most steady and consistent period of insulin administration of the period.

Early in the period under consideration, a doctor in the KCH Diabetes Virtual Response Team commented on the type of insulin that was being administered to Jackson. He stated in an email that "The duration of action of this gentleman's once-daily insulin (Toujeo) is up to 36 hours, therefore occasional missed doses (as long as they are not on consecutive days) are not likely to pose a major problem."

Comment: The corollary of this is that consecutive missed doses would pose a major problem, and there would need to be an urgent response if this occurred.

During October, Jackson's cooperation with visits from the district nurses deteriorated, although he only appears to have missed five or six days' doses between 1st and 27th October.

The SLaM notes include evidence of Jackson's care coordinator working with him on the implications of diabetes and the need for treatment.

It was during the summer period that there was a review of Jackson's psychiatric care and as a result of his positive compliance with the LIFT team, a decision was made to reduce the service from daily visits to telephone prompts and a single weekly visit to check medication compliance and welfare check. This change of regime from the mental health service was not passed to the district nurses, who assumed that Jackson continued to be seen daily by the LIFT team.

A further reduction in service by the LIFT team occurred at the end of October, following another review involving Jackson, the care coordinator and the LIFT manager. It was felt that Jackson was able to self-medicate his psychiatric prescription and it was planned to discharge Jackson from the LIFT service in 4 weeks. Pending discharge, visits would be reduced to two-weekly and all phone prompts were to be discontinued.

Again, the district nursing service were not involved in this review and were not informed about the changes.

Comment: The district nurses therefore continued to believe that Jackson was being seen daily by the mental health support staff. This was not problematic while they were seeing him regularly, but risked providing a false sense of security when they failed to make contact with him from the end of October.

From 28th October onwards, Jackson only received one dose of insulin (on 31st). The Care Notes chronology included no comment regarding his future plans. He was

seen by LIFT on 29th but missed his Clozapine clinic appointment on 2nd November. LIFT attempted to visit on 5th November but received no answer. However, no alarm was raised until a professionals meeting on 10th November, attended by the mental health professionals, district nurses and pharmacist. It was at this point that all professionals established that no one had seen Jackson for ten days. The subsequent welfare check by the police resulted in Jackson being found deceased at his home.

The cause of Jackson's death was not confirmed until March 2021. The final cause was recorded as

a) Pulmonary embolism [*disease or condition that led directly to death*]
b) Deep vein thrombosis (right leg) [*intermediate cause of death, or disease or condition leading to 'a'*]
c) Diabetes mellitus, schizophrenia [*underlying cause of death, or disease or condition leading to 'b'*][14]

The coroner advised that this was considered a natural cause of death.

Discussion

The question of mental capacity

The question of Jackson's capacity to make decisions regarding his diabetic care was raised several times from his discharge from hospital until his death. This was raised at an early stage following Jackson's discharge from hospital. A professionals' meeting was organised in early May and comments were made regarding "…his lack of understanding around managing his diabetes."

There was also a statement that "Diabetes was a new diagnosis for him, so [the professional] was concerned that he did not fully understand the risks…" There was also a suspicion expressed that Jackson had a "low IQ and struggled to retain information."

The care coordinator "raised concerns regarding his capacity to understand the diabetes diagnosis."

The safeguarding referral from the district nurses to GSTT safeguarding team was made without Jackson's consent and the box "in the best interests of the client" was checked. The referral contained the statement "client is not processing information well…"

Into June, comments continued to suggest there were concerns regarding Jackson's understanding of his diabetes diagnosis. One day at the beginning of the month, he asked one of the district nurses when their visits would end. The nurse explained that he had a chronic illness and the visits would continue for the foreseeable future.

While these descriptions do not clearly evidence a lack of capacity in relation to Jackson's diabetes care, they paint a clear and recurring picture of concerns

[14] Government guidance on completing causes of death on death certificates: https://www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death/guidance-for-doctors-completing-medical-certificates-of-cause-of-death-in-england-and-wales-accessible-version

regarding his understanding of his condition. Most comments did not include the term ‘capacity’ but alluded to the question through descriptions of the interactions.

As the year progressed, the records suggest a more relaxed attitude to the question of capacity. In July one of the district nurses commented that Jackson sometimes declined his insulin and that he had fluctuating capacity. In August, on one of the occasions that Jackson told the district nurses he did not want them to visit any more, the nurse stated she believed that he had capacity.

There is no record of a formal assessment of Jackson’s mental capacity in relation to this issue. Given the concerns that Jackson may have had fluctuating capacity, a single assessment may have been insufficient, but a formal consideration may have enabled a more thorough understanding of Jackson’s ability to make these decisions.

A further report that the nurse considered Jackson had capacity was made on 24th October, again following a refusal by Jackson to accept his insulin dose. On this latter occasion, the nurse recorded that on previous occasions, Jackson had been able to retain and understand the information, indicating a knowledge and use of at least part of the test for mental capacity.

This reference to the elements of the capacity test was repeated on 7th November, after Jackson had been seen for the last time, and after the team had been unable to see him for a week. A district nurse wrote to the GP stating “We cannot keep this patient on our caseload as he is continuing to refuse our care. I believe this patient does have capacity as on my visits in the past he is able to retain information and understand it, however he does have a history of schizophrenia”.

The use of the term ‘best interests’ was repeated in November when the district nurses requested a ‘best interests meeting’ when they were unable to see Jackson in the first week of that month. See further consideration of the term ‘best interests’ below.

It is clear that the professionals were aware of issues around mental capacity, but the actions which flowed from the comments did not reflect an effective use of the Act or robust assessment and recording. Jackson did not provide a straightforward presentation and it may have been the case that his capacity fluctuated over time. This indicates a need for more careful consideration, particularly when the risks are significant.

A number of Court of Protection judgements in the past few years have addressed the issue of diabetic care in the context of mental ill health. One judgement in particular[15] considered whether a person with a diagnosis of emotionally unstable personality disorder and diabetes had mental capacity to manage their diabetic care. Their mental disorder was characterised by episodes of severely dysregulated behaviour, leading to failure to manage their diabetic care. At other times they were able to manage their care effectively. The debate was whether the decision in question (managing diabetic care) comprised a series of individual (micro) decisions, such as medication, blood tests, diet, etc., or should be considered a single (macro) decision. The judge in that case decided that it was a ‘macro-decision’ which encompassed all the micro-decisions which might arise.

[15] RB Greenwich v CDM [2019] EWCOP 32

While the case referenced above cannot simply be transposed onto the circumstances of Jackson, it illustrates the difficulties involved in addressing the issues of capacity for someone with a fluctuating presentation and significant risks of acute and/or long-term harm if a particular regime is not followed. In that case, the multi-disciplinary team identified the level of complexity and a decision was made to take the case to the Court of Protection for consideration.

While that may not have been necessary in the case of Jackson, an escalation for more detailed consideration may have led to further actions being taken to address the issue. For example, a formal assessment of Jackson's capacity to manage his diabetes, which was never undertaken, or a clear plan on provision of health education to assist him in understanding and self-managing his condition more effectively.

The comments in May and November regarding 'best interests' indicates a lack of understanding of the term in the MCA. When used in common parlance, the phrase may mean to be concerned about and wanting to help someone[16]. However, in relation to the MCA it has a very specific context. Best interests only come into effect when it has been established that a person lacks capacity to make a particular decision. It these circumstances the individual themselves has been assessed as unable to make the decision themselves, and it must be made by someone else in their best interests, using the statutory checklist as set out in the MCA and its Code of Practice[17]. Without evidence of lack of capacity, professionals have no legal authority to take actions without an individual's consent.

The references to best interests described in this report clearly indicate a serious concern on the part of the professionals for Jackson's health and safety and attempts to ensure that his welfare was protected. A more robust approach to the question of capacity would have enabled the multi-disciplinary team to come to a conclusion regarding Jackson's capacity, and to escalate it to a more specialist arena if felt necessary.

Whether Jackson had capacity to manage his diabetes or not, or whether it fluctuated, such considerations could have led to a clear strategy on how to respond to the difficulties posed by his variable co-operation.

Jackson's absence from his home

It was reported in the GSTT SUI report that at the end of October, Jackson had advised the nurses not to come any more and that he was going to stay with his sister. This information is not included in the records of 31st October, when the final administration of insulin was made.

There are, however, several references in September and October when Jackson told the district nurses that he was going to visit his sister. Comments to this effect were recorded on 17th September, 16th, 17th and 19th October. On each occasion Jackson was present at home to receive his insulin the following day. There are no written records to state that Jackson told the nurses he was going to stay with his sister.

[16] https://www.merriam-webster.com/dictionary/have%20someone's%20(best)%20interests%20at%20heart
[17] MCA s4, MCA Code of Practice chapter 5.

If Jackson was going to ***stay with*** his sister (as opposed to visit her), it seems important that further investigations should have been undertaken with regards to how he would continue to receive his insulin. If the nurses had believed Jackson was staying with his sister when they were unable to contact him at the beginning of November, it is suggested that they could have contacted the mental health service to attempt to find a way of contacting him to clarify how his diabetic care could be managed.

Care planning

Jackson was subject to section 117 aftercare, which places a joint duty on the local authority and CCG to provide aftercare to certain categories of patient to meet needs arising out of the person's mental disorder, and to prevent deterioration leading to readmission to hospital for mental disorder.

While Jackson's diabetes was a separate condition to his mental disorder, it has been confirmed that there was a direct relationship between his mental health and compliance with his diabetic treatment. The MHA Code of Practice and the SLaM section 117 policy make it clear the section 117 care planning should be part of CPA care planning and should be based on a thorough assessment of the person's health and social care needs[18]. The MHA Code of Practice states that the assessment of the patient's needs is likely to include consideration of "…any specific needs arising from, e.g. co-existing physical disability, sensory impairment…"[19]

Inter-professional and inter-agency communication

During much of the period following Jackson's discharge from hospital in April 2019, there was ongoing and effective communication between the different professionals and agencies involved in providing health and social care to him. A significant range of agencies were involved, including the secondary mental health service (Focussed Support Team and Clozapine Clinic/LITT), LIFT medication support service, district nursing service, GP, pharmacist (providing advice to the professionals) and Essence2Care PA. Not all services were seeing Jackson on a regular basis and some were only keeping in telephone contact.

This was complicated by Jackson's reported private personality, although it can reasonably be argued that many people would find the number and frequency of visits by professionals intrusive to their personal lives. Attempts were made by the care coordinator and other professionals to limit the impact of these visits and reduce the number of times that professionals would need to attend Jackson's home. This was a recurring theme throughout the year and reflected a genuine concern by the professionals to support and respect Jackson's right to a private life.

Given the complexity of the arrangements to support Jackson with his health and social needs, and the importance of compliance with his treatment plans (both psychiatric and diabetic), it was important that there was a clear strategy for ongoing communication between agencies, and any changes to the schedule of visits to be shared across the team.

[18] See SLaM section 117 aftercare policy and procedures (10.10)
[19] MHA Code of Practice (34.19)

During the first few weeks post-discharge, there was increased communication amid concerns about Jackson's fluctuating cooperation and compliance with the treatment regime. The diabetic diagnosis was new to Jackson and there were concerns about his understanding of the implications (discussed above in the section on mental capacity).

As the year progressed, the provision of care settled down and despite Jackson's expressed ambivalence about the contacts, and ongoing and episodic difficulties visiting him, treatment was provided on a reasonably consistent basis. Jackson was taking his clozapine medication himself and being monitored by the LIFT team. The district nurses continued to attend daily to administer the insulin and it appears that these visits caused Jackson the greatest concern. The district nurses were very aware of this and on several occasions attempted to explore the possibility of changing from insulin to oral medication.

Reviews of Jackson's mental health took place on a regular basis and included appropriate consideration of the ongoing need for support for his medication compliance. An urgent medical review was requested and undertaken at one stage following significant concerns following repeated failures to meet with Jackson.

When a decision was made on 25th August to reduce the service to Jackson, reflecting a positive development in relation to the self-management of his psychiatric medication, that change was not shared with the district nurses. This left the district nurses as the only service which was seeing Jackson daily, although this was not an issue in the following few weeks as Jackson was meeting the nurses on a consistent basis.

A further reduction in the LIFT service was arranged at the end of October, again without informing the district nurses. This had a more significant impact as Jackson effectively disengaged with the nurses shortly afterwards. The nurses continued to believe Jackson was being seen regularly by the LIFT team although this had not been happening for some time.

In addition, Jackson failed to attend the Clozapine clinic at the start of November, nor did he collect the next month of his Clozapine medication. This appears to have been out of character, as he had previously attended his monthly appointments.

None of these changes caused an immediate response or escalation to the care coordinator and it was not until a professionals' meeting on 10th November that all in the care team realised that Jackson had not been seen for, by that time, ten days.

Jackson was found deceased in his home on 10th November. It is not clear from the records when he died, although the district nursing records comment on the light being on in the property on 6th and 8th November, and the television playing on 6th. The light was off on 8th and Jackson's phone was "switched off" (or the battery had drained) on 8th. When the ambulance staff attended on 10th, they recorded a neighbour reporting they had seen Jackson a day or two previously. None of these records can be considered unequivocal evidence of the date of Jackson's death.

However, it is notable that Jackson's care plan included regular contact with a wide range of professionals and teams, with well-established and significant risk factors in the event of him disengaging. Jackson was not seen for ten days at the beginning of November, including failing to receive his insulin injection for that period and uncharacteristically failing to attend the Clozapine clinic for his blood test, but no

alert was raised until a multi-disciplinary meeting brought this information together on 10th November.

Jackson's death at home

It is noted that the coroner has confirmed that Jackson's death was as a result of natural causes. The primary and secondary causes on the death certificate are not immediately linked to an acute diabetic crisis.

While it is deeply unfortunate that Jackson was not seen for ten days when he was receiving multi-agency support which should have guaranteed daily contact, there is no evidence that provision of that care and treatment would have prevented this event from occurring.

Views of family members

Henry

The Safeguarding Board contacted Henry's brother (Keith), who was his designated next of kin. When informed that a review was being undertaken regarding themes of mental capacity and diabetes, Keith felt this was positive and stated that he would be happy to speak to the reviewer.

The reviewer spoke to Keith by telephone in August 2022.

Keith stated that Henry had a sweet tooth and would eat sweets and drink cola. Keith said that he always said that they should take care of his diet.

Keith agreed that it would be difficult to control Henry's dietary intake, but felt that when patients are diabetic they need extra attention. He suggested that the staff should have taken Henry aside and advise him about his diet.

The reviewer noted that the records stated that Henry's cooperation with his medication was variable. Keith agreed that his cooperation fluctuated, and from his point of view it was random, there was not clear pattern of cooperation, it depended on Henry's mood.

Keith suggested that sometimes Henry could be bribed, for example with cigarettes, as he smoked. Keith also stated that the care staff at Fanon House would sometimes telephone him to speak to Henry, telling him that Henry was not taking his medication and asking Keith to have a word and persuade him. Keith said that he was often able to persuade him to take the medication. He told his brother that it was in his best interests.

Keith felt that there needed to be more of a strategy based on the individual's circumstances. He added that you cannot force someone so you have to find a way. There needed to be a strategy that breeds cooperation.

Keith said that Henry did not accept the importance of diabetes to his health. He said that Henry did not believe he had diabetes.

The reviewer asked Keith if he was ever involved in any discussions around the development of a strategy to improve Henry's cooperation with his medication regime. Keith replied that the only time he was involved was after Henry had been admitted to Guy's Hospital with his infected foot.

When asked his understanding of why he was involved at that stage, Keith replied in Guy's they were clearly aware that Henry did not have capacity, so they had to involved Keith.

Ivan

Notes indicated that Ivan's sister was not well and did not want to be contacted regarding Ivan.

Ivan's designated next of kin was his cousin. Attempts to contact him via telephone and email did not elicit any response.

Jackson

Attempts by the Safeguarding Board to contact Jackson's sister for this report were not successful.

Jackson's sister was however involved in the preparation of the GSTT serious incident report. She submitted the following questions, to which comments and answers were provided in their report

1. Why were the next of kin not informed of any problems, for example not being able to gain access to the property?
2. Why was the patient the only point of contact for decisions about his diabetes, for example increase/decrease of insulin or metformin (the patient's family were not informed)?
3. NOK was telephoned once before, was the number stored on the patient's electronic file?
4. What were the dates and times of access and no access to the property by the district nurses?
5. What was the protocol followed by the district nurses when they were unable to gain access or give insulin?
6. What type of system was in place for the patient's continuous health?
7. Did the nurses suspect that the patient may not of understood his condition and the risks, for example around his food intake?
8. What was the liaison between the other agencies involved with the patient's health, for example the Mental Health Team, Lookahead, GP?
9. A district nurse informed the patient of health risks when newly diagnosed, how effective was this information for someone with mental health crisis?
10. What was the delivery style when communicating the diabetes risks to the patient? Did he show any interest or understanding?
11. Why were no concerns raised with the Mental Health Team about the patient's level of understanding, if any were observed?
12. Are there records available of district nurses checking whether the patient had sufficient food in the property?
13. What was the protocol to be followed when the district nurse attended home visits, start to finish?
14. What were the patient's blood sugar readings?
15. Did the patient have a blood monitoring machine and did he know how to use it?
16. What were the insulin doses? What type of insulin was the patient receiving?
17. Was the patient asked what he ate each day, and was any adjustments made to the insulin doses?
18. What was the handover procedure for the district nurse?
19. At any time the district nurses were unable to gain access to the property, why wasn't section 135 used to get a police officer with a warrant or no warrant section 17 of PACE.
20. How were the Covid protocol guidelines followed by the district nurses? The pandemic restrictions would have affected the patient's routine, for example shopping, how was this managed?
21. Why did it take the Mental Health Team to raise the alarm on the fatal day?
22. The patient was a very heavy sleeper and spent a lot of his time at home for this reason, why would the district nurses assume the patient was refusing access?
23. Was the patient referred to a dietician?

The reviewer is not proposing to address each of these questions as a response has been given in the GSTT report. This review is a thematic review covering the circumstances of three individuals, and it is not felt necessary to reanalyse these questions. Some of the issues raised by these questions are dealt with in the thematic analysis.

Thematic analysis

Ivan

The reviewer has concluded that the thematic analysis will primarily be confined to the care and support provided to Henry and Jackson. Both of these individuals had long term severe mental illness, were prescribed anti-psychotic medication (Henry received regular depot injections and Jackson was prescribed clozapine) and had diagnoses of type 2 diabetes.

Ivan had cognitive impairment as a result of strokes and latterly vascular dementia. He had vascular disease but there is no clear evidence of him ever being diagnosed with diabetes.

Concern was raised that despite Ivan being severely disabled and housebound, he was not seen by a GP throughout 2018 or the first two months of 2019 before he was admitted to hospital. A home visit had been arranged but Ivan was admitted to hospital before this occurred.

It is correct that Ivan was being seen by a range of professionals, including the district nurses, podiatry and TVN. However, the request for direct medical input was made in relation to concerns regarding pain management, which fell outside the remit of either podiatry or tissue viability.

The GP practice has confirmed in their original response to the safeguarding investigation that they should have had an earlier multi-disciplinary meeting and an earlier home visit to Ivan. The reviewer has nothing to add to this analysis.

Care planning

The first two paragraphs of the care planning section for Henry and Jackson are almost identical. This reflects the similar nature of the aftercare duties owed to these two individuals by the local authority and the CCG.

The mental health trust has section 117 policy and procedures, to which LB Lambeth as partner has signed up. This policy reflects MHA Code of Practice guidance that individuals subject to section 117 aftercare are provided with a care plan setting out the support that will be provided in order to prevent relapse and readmission to hospital.

As mentioned within the discussion above, The Code of Practice states that the assessment of needs is likely to include "…any specific needs arising from, e.g. co-existing physical disability, sensory impairment…"

While not directly related to their mental disorder, both Henry and Jackson's diabetic care were crucial in their overall care plan and also had close links to their mental health care.

Neither Henry nor Jackson had a written section 117 care plan as required by national guidance and local procedures.

Whilst the existence of a formal care plan does not automatically guarantee coordination of care, it does provide a clear strategic document for all agencies to follow. This is particularly important when there are multiple professionals and agencies involved, and is also important for the service user, and family or carers, where relevant.

The SLaM report notes the importance of a care plan, crisis plan, risk assessment and management plan, particularly in the context of discharge from hospital. While this is important for all patients, the requirement is more explicit and set out in statutory guidance for individuals subject to section 117 aftercare.

Awareness of risks relating to diabetic care

There is evidence that individuals with long term mental illness, in particular schizophrenia, have a greater risk of developing type 2 diabetes than the general population[20]. There may be a variety of reasons for this, but there is a range of evidence from both psychiatric and endocrinology sources that individuals prescribed certain psychotropic medication are at significantly higher risk[21].

CQC suggests as many as one third of patients taking clozapine may develop diabetes after 5 years of treatment, the majority of these within the first six months[22]. In one study in the United States, 42.7% of patients prescribed clozapine were diagnosed with diabetes against a nationwide prevalence of 13.7% in a similar age group[23].

It is vital that mental health professionals are aware of the risk factors for developing diabetes and also the chronic risks of poor or non-compliance with diabetic treatment. The Lancet has made a statement regarding the importance of psychiatrists and diabetologists to work together, and it is this reviewer's opinion that it should apply to all staff working with individuals at higher risk of developing this condition, both in the community and in provider organisations.

> "Psychiatrists and diabetologists need to work together. Patients with diabetes are at higher risk of mental health disorders — including depression and psychotic disorders — than the general population. Likewise, patients with mental health disorders are at higher risk of developing diabetes. However, patients with such comorbidity are frequently under-recognised and undertreated, meaning that the risk of long-term complications from either type of disorder is high."[24]

In Jackson's case there is no doubt that there was a clear understanding of the need for close monitoring and oversight of his psychiatric and medical care, and the concerns relate to the failure of communication between the professionals.

In Henry's case, his poor and intermittent compliance with diabetic care was well-established and clearly understood across the multi-disciplinary team. There

[20] "Clozapine and diabetes". GP Notebook July 2020 https://gpnotebook.com/simplepage.cfm?ID=x20200715211616830153

[21] "Association between antipsychotic medication use and diabetes" Current Diabetes Reports Sept 2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6718373/pdf/11892_2019_Article_1220.pdf

[22] "Adult Social Care: information for providers". CQC 2022 (last update) https://www.cqc.org.uk/guidance-providers/adult-social-care/high-risk-medicines-clozapine

[23] "Clozapine, Diabetes Mellitus, Cardiovascular Risk and Mortality: results of a 21-year naturalistic study in patients with schizophrenia and schizoaffective disorder". Clinical Schizophrenia and Related Psychoses Dec 2019 https://pubmed.ncbi.nlm.nih.gov/29164928/

[24] "Diabetes and mental health disorders". The Lancet May 2015. https://www.thelancet.com/diabetes-and-mental-health-disorders

appeared however, to be limited awareness of the range of risks to Henry of his chronic failure to manage his diabetic treatment.

The eventual outcome, the amputation of Henry's leg was caused over a long period of time. The development of diabetic peripheral neuropathy, identified on admission to KCH took place over a considerable period of time. It is for this reason that regular physical checks are advised for all individuals with diabetes.

The psychiatrist caring for Henry determined that consideration for admission to hospital (most likely under MHA compulsion) was not indicated until he was displaying florid symptoms of relapse. While a delicate balance must always be struck between the use of compulsion and the least restrictive option, it is suggested that important consideration is always given to a broad definition of health and safety, particularly where the possible medical impacts are dramatic.

Multi-disciplinary communication

There is evidence of good multi-disciplinary communication and collaboration in all three cases. The SLaM chronology of Henry comments on good practice and liaison between agencies.

It is important to be aware of the purpose of multi-disciplinary and inter-agency liaison; It is not an end in itself, but it is required to ensure any issues regarding the effective care, treatment and support to the individual are addressed and resolved in a timely manner.

There were also occasions when the communication was problematic, causing a discontinuity between the focus on the individuals' mental health care and treatment, and their medical care, particularly in relation to diabetic care in the cases of Henry and Jackson.

The joint reviews and liaison between professionals with regard to Henry's physical care repeatedly identified difficulties, in monitoring and reviews, but there is little evidence of amendments to the planning or detailed analysis of how to improve Henry's engagement with physical health monitoring.

There appears to be no doubt that the deterioration in Henry's vascular supply to his foot, which resulted in the amputation in March 2019 was a process which had been developing over a considerable period of time. Comments are made below in the section on mental capacity issues regarding the use of the MCA, including issues which arose outside the period of this review.

It has been noted in the reports in relation to Jackson that the district nurses and the mental health support workers were both visiting regularly throughout the year. It was well known that Jackson was unhappy with the frequency of visiting and a previous PA was stopped from visiting due to the number of other professionals involved.

However, when the frequency of mental health support and monitoring was reduced twice in August and October 2018, this information was not shared with the district nurses who continued to visit Jackson daily. This exacerbated the breakdown in communication at the beginning of November when Jackson was not being seen by any professionals. The district nurses continued to believe the mental health support workers were in contact.

While there was communication between the community health professionals and the GP during that time, there was no liaison between the primary care and mental health teams for ten days, until 10th November when a multi-disciplinary meeting was held, to check the status of contacts with Jackson.

Jackson failed to attend his Clozapine Clinic appointment at the beginning of November which was out of character. The Clozapine Clinic did not alert Jackson's care coordinator or care team to this non-attendance. It has already been raised in the SLaM investigation that a clear protocol is needed by the Clozapine Clinic to alert relevant professionals when a patient fails to attend.

Mental capacity issues

Professionals were aware of issues in relation to the mental capacity of these individuals, and consideration was given to their capacity to manage their care and support, particularly their diabetic care.

However, it appears that the MCA was used inconsistently, either without proceeding to a best interests decision, or without fully clarifying the existence (or lack) of capacity in the context of differing professional views.

The purpose of the MCA is to maximise the person's ability to make a decision, by providing all practicable assistance, or if it is concluded that they are unable to make that decision, to determine what action to take in the person's best interests. The use of the MCA must be for a clear purpose which will lead to a specific outcome.

It is also important that professionals are confident in constructively challenging colleagues across the multi-agency, and are able to escalate issues if required, for more detailed consideration.

In the case of Henry, it had been established that he lacked capacity regarding his diabetic care some years previously, although there had been no further formal review of this. The records suggest that a reassessment is likely to have come to a similar conclusion. However, little consideration appears to be given regarding the possible use of the MCA, and the focus was primarily on the MHA in the context of Henry's chronic and severe mental ill health.

In relation to Ivan, there was frequent reference to mental capacity but no evidence of a formal assessment of capacity for any particular decision. The assessment that Ivan lacked capacity to consent to his hospital admission appears to have been considered transferable to also apply to the decision regarding the treatment for his necrotic foot. This may well have undermined the opportunity to assist Ivan to understand and weigh the decision, and to consent to the treatment himself.

The reviewer is aware of the risk of over-bureaucratising the mental capacity assessment process and forcing professionals to complete over-burdensome documentation at the expense of service user/patient care. However, it is possible to ensure a legally defensible recording of capacity without onerous recording. It is particularly important for capacity to be accurately and legally recorded for more grave decisions which may have life-changing consequences.

The GSTT SUI report comments on the district nurses' view that Jackson had capacity to understand and could retain information about managing his diabetes. It goes on to say that other agencies and professionals had a different view and there

was a difference of opinion regarding Jackson's capacity in relation to his diabetic treatment.

The SLaM report recommends that any service user with a diagnosis of severe mental illness and newly diagnosed insulin-dependent diabetes, should have their capacity assessed in relation to their ability to make decisions regarding their care and treatment.

The reviewer considers this blanket guidance a disproportionate response to the question of mental capacity. That is not to say that consideration of a person's capacity to consent to and to make decisions about their treatment is extremely important.

There is clear guidance in the MCA Code of Practice[25], which is likely to be reinforced in the new edition of the Code when it is published, regarding when a person's capacity should be assessed.

Recent case law[26] has set out the order in which the test of capacity should be undertaken, which should militate against a blanket policy of assessing a group of individuals based on their diagnosis.

With both Henry and Jackson, there were doubts regarding their capacity in relation to their diabetic care, including various occasions where professionals expressed a view that they lacked such capacity. These were more than sufficient to trigger a formal assessment. However, there were either no recorded assessments of capacity, or when one assessment clearly concluded that Henry lacked the relevant capacity, no resulting best interests decision-making process. Where there were disagreements on the individual's capacity, this was not addressed clearly and openly to identify the different views and come to a consensus.

[25] Mental Capacity Act Code of Practice 4.35

[26] Set out in PC & NC v City of York [2013] EWCA Civ 478 and confirmed in A local authority v JB [2021] UKSC 52

Recommendations

1. All individuals subject to section 117 aftercare have a s117 care plan which specifies the range of care and support provided to them, and differentiates the support provided under s117 and that provided under other provisions (e.g. Care Act 2014)
2. Care plans, when they involve multi-agency involvement, include explicit provision for communication between agencies when circumstances change.
3. Where individuals with chronic and severe mental illness refuse or do not cooperate with annual health checks, further consideration is given within the care planning process on how to ensure such health care support.
4. Due to the prevalence of diabetes within the population of those people with chronic and severe mental ill health, the trust establishes a professional who can 'champion' diabetic care and provide advice and assistance to colleagues, including escalation to a specialist if necessary.
5. Community professionals and providers of services to this group of individuals are reminded of the range of chronic and acute outcomes of poor compliance with diabetic care, and advised on how to escalate concerns.
6. The Safeguarding Board considers how best to enhance understanding of the practical complexities of the MCA across all professionals, including particular reference to professional differences of opinion, fluctuating capacity and legally robust but proportionate recording of capacity.