1. AC was a 77 year old man who passed away on 25.08.20. Post mortem revealed numerous ailments which included: Cardiac Arrhythmia, poorly managed Diabetes, Chronic Obstructive Pulmonary Disease and Coronary Atheroma, which ultimately resulted in his death following being admitted to A&E.

2. AC became known to support services following a significant bereavement five years ago, which resulting in a deterioration to his circumstances. AC became known to the Police, Social Care and Health during this time, but sadly his self-care, living conditions and health declined and, sadly, one agency declined to visit AC due to home conditions.

AC was deemed to have capacity, so when he disengaged with services it was often accepted by a range of agencies.

3. AC's difficulties were well known by professionals; he had poor health, his living environment was poor, and a deep clean of his property had taken place during his last hospital stay. He also had open wounds to his body, had issues with continence and misused alcohol over a long period. Sadly, due to his emaciated appearance and poor self-care, when AC was seen in public, photos of him found their way onto social media.

4. In the 12 months prior to this death, ambulances were called to AC's home on 9 occasions. He was taken to hospital on 8 of those occasions. He often declined care and treatment in hospital and declined ASC assessments on 5 occasions. AC did however have a ASC worker when he passed away and CPG also requested a High Risk Panel, but AC passed away before this meeting convened.

5. AREAS OF CONCERN:

Barriers to referral:

Compliance to the MCA

Recording

Legal literacy

6. Positively however, thoughout this period, the community nurses were persistent in trying to engage AC, and this was recognised as good practice. Similarly, EMAS had continued to encourage AC to consent to an ASC assessment, and submitted referrals to ASC following each of their attendances. On each admission to hospital staff also tried to engage with AC and completed the appropriate referrals.

SUMMARY:

Barriers to referral: There was evidence of referrals not being progressed due to lack of consent from AC *(which relied on the presumption of capacity).* Consideration should have been given to whether consent could have been overridden and also correct referral pathways.

Compliance with the MCA: There was a readiness to place reliance on the presumption of capacity, and this led to an unchallenged acceptance of AC's views. Some concerning displays of distress were ignored when evaluating his mental state. Consideration should have been given to the impact of diabetes/diet, and alcohol/substance misuse on his capacity.

Recording: There were no records of discussions held with AC regarding his refusal to accept support/treatment. Equally no detailed capacity assessments were recorded by any professional, despite the reported views by professionals that AC had capacity. The evidence to support the views held by professionals is completely absent and as such it cannot really be ascertained whether AC did or did not have capacity/ what decisions he was assessed to have capacity for.

Legal literacy: In light of AC's circumstances, consideration of alternative legal routes e.g., the inherent jurisdiction of the High Court, should have been considered