Safeguarding Adult Review
Executive Summary

Review into the death of Brian, who died in August 2021 in Bristol

Independent Chair and Author:
Parminder Sahota

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Preface

The Independent Chair, Author, and Review Panel extend their sincere condolences to everyone affected by Brian's death and gratefully acknowledge their efforts and support during this procedure.

A Safeguarding Adult Review (SAR) is a mandated multi-agency review of what the various agencies and individuals involved could have done differently to avert harm or death due to safeguarding concerns. To ensure that these lessons are widely and appropriately taught, it is vital to assess what may be learnt from each person's death and for agencies to comprehend what occurred in each case.

The Chair appreciates the panel's time, patience, and cooperation and those who provided chronologies and material.

1. Purpose and Terms of Reference: Key Lines of Enquiry

1.1. The review aims to identify lessons learnt from Brian's case and to implement those lessons to prevent deaths related to safeguarding.

1.2 The critical question to be addressed by the review was:
What can agencies learn from the case about the effectiveness of care and support of adults dependent on others to attend to their needs, and where families/carers decline additional support or refuse entry to health care professionals?

1.3 The supplementary questions to enhance the review included the following questions:

1. How did agencies assess Brian's capacity, did they share assessments, and how did this impact the care Brian received?
2. How was the principle of making safeguarding personal achieved? For example, did agencies consider Brian's wishes and feelings when providing care and treatment?
3. Did agencies consider aspects of coercion and control by Brian's son?
4. Did the son's refusal to allow agencies into the home impact professional practice?
5. Were the assessments and decisions carried out appropriately and timely way?

1.4 The panel members and advisors were all chosen by the review panel. The review's time frame was set to cover the months of June 2018 and August 2021. The panel agreed that this time frame accurately reflected the difficulties discovered during scoping and subsequent communication with agencies.

1.5 The panel agreed on which agencies must submit a comprehensive chronology and individual management review.

2. Agency contact and information learnt from the Review

2.1 Brian received input from the following agencies during the period under review:

1. Avon and Somerset Police
2. Bristol City Council – Adult Social Care
3. Bristol Community Health (service ceased 31.03.2020, BNSSG Integrated Care Board provided information to the review as data holder.)
4. BNSSG Integrated Care Board on behalf of GP
5. Personal Care Provider
6. Sirona care and health

2.2 When Brian became unwell and lived alone in his one-bedroom flat, his son moved in with him in 2016 and became his informal carer.

2.3 Brian was admitted to a therapy bed in a nursing home for rehabilitation in November 2017 following his hospitalisation in August 2017.

2.4 Brian declined therapy during his stay in the nursing home, resulting in immobility.

2.5 In February 2018, Brian was discharged and received home visits from carers.

Safeguarding Adult Concerns

2.6 In August 2017, Brian's GP reported to adult social care that Brian's son had advised him to stop taking his medication. This did not meet the criteria for a Section 42 enquiry (Care Act 2014) and would be addressed during his hospital stay.

2.7 In March 2018, Bristol Community Health reported an adult safeguarding concern to adult social care. As a result, Brian was not receiving care from Alan. The matter was resolved.

2.8 In March 2018, the ambulance reported a safeguarding adult concern to adult social care. They said that Brian's care needs were not being met, his bed had collapsed, and carers could not deliver care safely. The social worker spoke with the ambulance staff, who suspected Alan was obstructing Brian's care. The social worker visited Brian in the hospital, and following a discussion with Brian and the ward staff, the case was closed.

2.9 In June 2018, the care agency notified adult social care of a concern. Alan had dressed Brian in a damp T-shirt, and the carers could not locate a dry one. Brian was scheduled for a social care review, and it was decided that a laundry service would be discussed at this time. Thus, the concern was closed.

2.10 The care agency reported in August 2018 that Brian had received a burn from coffee. Alan had become aggressive when they attempted to involve the district nurse, and he refused input from the district nurse and GP. The social worker contacted Brian, who had accepted treatment, and the burn was healing. The matter was resolved.

2.11 The police expressed a concern in January 2021 that Alan had been hostile toward Brian. Alan expressed frustration with Brian's conduct. Social care contacted the care agency, who described Alan as a devoted son and closed the case.

2.12 The care agency reported in August 2021 that Alan was depriving Brian of water and forcing him to lift weights when he was exhausted and thirsty. Brian had a head abrasion, which he said resulted from a fall. However, given that Brian was cared for in bed, it was unlikely. A strategy meeting had been scheduled. However, Brian passed away before this occurred.

3. Key Issues arising from the review

Balancing the choice between alternative and conventional treatments

3.1 Brian ceased taking prescribed medication in 2015; the final prescription was issued in September of that year, according to the GP's records.

3.2 Alan had ordered turmeric cream to replace the barrier creams supplied by the community nurse.

3.3 A day before Brian's passing, the GP inquired about his thoughts on medication, to which he responded, "They are full of toxins and nitrates."

Alan's engagement with services

3.4 The single point of access noted that community nurses should visit in pairs due to Alan's verbal hostility.

3.5 During the visit by the carer, Alan warned her that he could prevent her from working, and the pharmacist described him as angry.

3.6 Alan disliked nurses because he believed they did not know what they were doing, and he was unhappy with the timing of their visits.

Coercion and control

3.7 The police were called to the address in January 2021 because of yelling and screaming. In this regard, they expressed a safety concern to adult social care.

3.8 The GP expressed concern that Alan may be pressing Brian not to take his medication, raising concern for adult social care.

3.9 The carers claim that Alan denied him water and instructed him to lift weights before he could drink. He would also force Brian to exercise before receiving personal care. Alan indicated that this was his strategy for collaborating with his father and that he found it effective.

3.10 The assessments of the relationship between Brian and Alan needed to be more consistent. The carer and the GP voiced safeguarding concerns. They also indicated

that Alan's relationship with his father was one of loyalty. He was cooperative and assisted the carers in providing care for his father.

Making safeguarding personal

3.11 Adult social care contacted Brian in response to the safeguarding raised by the ambulance. He did not view himself as a victim of abuse and asked that no protective measures be taken.

Safeguarding

3.12 Seven Safeguarding concerns were raised during the review; please see above.

3.13 The practitioners requested support for challenging decisions and escalation.

4. Recommendations

Recommendation One: Balancing the choice between alternative and conventional treatments

4.1 To ensure that patients' treatment preferences are not disregarded, the prescriber should discuss their preferences with them to assist patients in making informed decisions. In addition, the prescriber should document all decisions, including Mental Capacity and the principle of making unwise decisions.

4.2 To ensure that all agencies are working together, a care plan should be in place to identify individual choices that consider their opinions and requests for treatment, as well as a contingency agreement of what should happen if the individual's choice is ineffective.

4.3 The plan should also include the agreed-upon response to future emergencies, such as death or cardiac arrest: ReSPECT plan.

Recommendation Two: Engaging with carers

4.4 All carers must be offered a carer's assessment per the Care Act 2014.

4.5 Practitioners should be aware of the study identifying carer stereotypes and how this may influence their perceptions. To offer practitioners awareness sessions so they can respond to the requirements of informal carers and identify how they complete the activities, they have agreed to. For example, determining how informal carers do their tasks and providing resources to increase this and decrease carer burnout.

4.6 A carers campaign will be created and launched during Carers Week. Work with statutory and non-statutory organisations to reach informal caregivers who do not regularly use statutory services.

Recommendation Three: Coercion and Control

4.7 Consider the statutory guidance: Controlling or Coercive behaviour and ensure the partnership complies with the published guidance.

4.8 Agencies must ensure that their staff can recognise and respond to coercion and control. Staff should have easy access to documentation to record and refer concerns and prompts to consider all aspects of domestic abuse.

Recommendation Four: Making Safeguarding Personal

4.9 The review found that agencies did hear Brian's voice but that it was difficult to speak to him alone at times owing to the setting (he lived in a one-bedroom flat with his son).

4.10 To ensure that the partnership's approach for making safeguarding personal includes the concepts outlined in SCIE and is disseminated and available to all staff.

Recommendation Five: Safeguarding

4.11 The SAB will ensure that the escalation procedure is streamlined and easily accessible to all staff.

4.12 Strategic managers should encourage and empower staff to contest decisions and escalate as needed.

The Keeping Bristol Safe Partnership will develop and monitor the recommendations.

5. Conclusions

5.1 The review centred on Brian's final years of life. During this time, seven adult safeguarding concerns were reported, claiming that Alan was not providing care for Brian and was coercing or influencing his decision-making.

5.2 Brian refuted any concerns and praised Alan. He did not believe he required interventions and consented to services from carers; he had been reviewed by the GP, podiatrist, and community nurses.

5.3 Brian's death was attributed to natural causes, and the post-morten report showed no neglect or cause for concern. However, the review was spurred by many Safeguarding reports alleging Alan's probable negligence toward his father.

5.4 According to the findings of the review, adult social care received seven safeguarding concerns. Triangulating these to ensure that agencies work together to protect the adult is part of the learning process. Nonetheless, it was evident that not all agencies had the same worries, as Alan was described as a devoted son. This division should have organised a professional meeting to discuss concerns and expert opinions regarding Brian and the care he received.

5.5 The review revealed the use of alternative therapy, but there was no evidence that healthcare practitioners had discussed this option with Brian or Alan, nor had they been helped to make informed judgments.

5.6 According to reports, Brian had diabetes but had not taken medication in seven years and followed a vegan diet. According to him, this was helpful to his health, and he did not suffer any adverse effects from deviating from his prescribed treatment. Additionally, no adverse effects were reported by medical specialists.

5.7 The review concluded that Brian's death could not have been prevented, and its themes aim to promote and enhance safeguarding practice.

The learning from the review will be shared with practitioners.