BRISTOL SAFEGUARDING ADULTS BOARD BRIEFING

DATE: 25TH APRIL 2018

ABOUT BRIEFINGS

This is produced by the BSAB to help practitioners reflect and continuously improve their practice.

Thank you for taking the time to read this Information.

There are three areas of learning:

- What you must know
- What you should know
- What is good to know

At the end is a feedback form to help us assess how you and your organisation have implemented the changes.

@BristolLSAB

www.bristolsafeguarding.org

SAFEGUARDING ADULTS REVIEW BRIEFING - 'CHRISTOPHER'

WHAT IS A SAR?

The Care Act 2014 states that Bristol Safeguarding Adults Board (BSAB) must commission a Safeguarding Adult Review when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult;
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

'CHRISTOPHER' SAFEGUARDING ADULTS REVIEW

Christopher is described by his family as a 'loving, funny and life-loving young man who had many friends and acquaintances throughout his life'. Christopher had complex health needs and learning disabilities throughout his life.

In December 2015, age 31, Christopher died in hospital as a result of a respiratory tract infection and his existing health conditions which were compounded by recent weight loss, being an in-patient with poor mobility, a poor cough reflex and a recent general anaesthetic to fit PICC and feeding lines.

Christopher moved into supported living for fifteen months before his death having lived with his father for the majority of his adult life. He was admitted to hospital after becoming ill and losing significant weight as a result of refusing food and medication in his supported living. The SAR found that Christopher experienced systemic organisational neglect as a result of the lack of coordination of his care to manage his complex needs.

The full report can be found on the BSAB website https://bristolsafeguarding.org/adults/safeguarding-adult-reviews/bristol-sars/ alongside the Board's Response and a public statement from Christopher's family.

WHAT CAN YOU DO?

Read the full report on the BSAB website.

Check the local Adult Safeguarding policies on the BSAB website.

Ensure your organisation's Mental Capacity Act Training is being implemented effectively.

Deliver staff briefing sessions to discuss the case.

CASE OVERVIEW

Throughout his adolescence and adult life, when Christopher was anxious he would refuse to eat and drink. Assessments found that if he was faced with too many options he could become confused. Christopher could not undertake daily routines independently. His dietary routine was of paramount importance as this impacted his health, mood and willingness to cooperate. Christopher could not cope with too much choice as he became confused. He needed support with decision-making and was at risk of personal neglect regarding dietary and health needs. Family members believe that this was the crux of Christopher's mental capacity, namely that he was unable to make informed decisions about his health or social care needs.

Following a significant illness for his father who had been Christopher's carer between 2000-2015, the family reviewed Christopher's needs and requested a social care review for him to move into appropriate provision. Towards the end of 2015 Christopher moved into a supported living placement with a specialist learning disabilities provider. Whilst Christopher had some challenges adjusting to the new living situation the first year was relatively smooth with Christopher's weight being maintained. During one health-related hospital admission in this period Christopher was assessed as not having the mental capacity to make decisions about his medical care.

Towards the end of his first year in placement Christopher's refusal of food and medication escalated. Between November and December 2015 (a 32 day period) it is noted that he refuse food and medication on 74 occasions. A referral to BIRT (Bristol Intensive Response Team) was made citing his low mood, refusal or delayed acceptance of medication, supplements and some meals, and challenging behaviour. The supported living provider recommended to the commissioner that he be moved to a different provision more able to manage his behaviour.

Relationships between Christopher's family and professionals worsened over this year. The family were not always consulted with or informed of professionals meetings. They did not agree with the approaches professionals were taking with nutrition, medication and care approaches. The family told the review that they were not given nursing home options when Christopher was moved, however professionals involved dispute this recollection and say the move to supported living was directed by the family's wishes.

A safeguarding referral was made by the supported living provider in mid-November in relation to food refusal and self-neglect but was screened out because Christopher was being seen regularly by his GP, CLDT and BIRT. The referral was found through the review not to include sufficient information and analysis to aid a section 42 decision. A multi-agency professionals meeting was held to review Christopher's care.

Christopher's weight and hydration continued to be a concern and he is admitted to hospital in the first week of December. He weighs 35kg having lost 10kg in two and a half months. Soon after his hospital admission Christopher was assessed as not having mental capacity to make decisions regarding his medication and his

Hold reflective discussions with staff about best practice placement transition discussions with families and adults

Familiarise yourself with the BSAB escalation procedure

Review what communication tools and aids you have available

nutritional and hydration intake. It was noted that he was assessed to have the capacity to make some decisions, for example about choice of food. His Father is noted as saying that Christopher has been offered choices for decisions that he does not understand. Drug charts record many occasions on which drugs were refused. Fluid/food charts record many occasions when food was declined.

In hospital family members expressed concern at the delays in implementing a sequence of decisions designed to tackle his nutritional and hydration intake. A best interest meeting was held, with family members present. Hospital records note agreement on pursuing the least restrictive approach in line with clinical need and Christopher's condition, given the risks and distress associated with restraint and sedation. After 6 days, when other options are unsuccessful, a PICC line and naso-gastric feeding tube were inserted under a general anaesthetic. 18 days after admission, Christopher died of a cardiac arrest. His family believed they had agreed a Do Not Resuscitate order, however the hospital medical consultants had this in place for the operation not subsequent acute illness. This differing understanding of what was in place left the family very distressed when CPR was initially attempted when Christopher went into cardiac arrest.

COORDINATION OF CARE AND FAMILY MEMBERS

The Safeguarding Adults Review concluded that the absence of "whole system" meetings to consider how to manage challenges of family perspective and balance independence and safety, was a significant oversight.

Family members may, on the basis of their lived experience, have strong views about what they regard as the appropriate extent and nature of support for a particular individual. As in Christopher's case, family members may believe an individual's agency, mental capacity and choice to be more compromised than practitioners appreciated. Notwithstanding the importance of paying due regard to self-determination, this has to be considered alongside an informed understanding of an individual's decisional mental capacity and the evidence that family involvement can be supportive. Had meetings involving family members and practitioners been instituted from the outset and held regularly, a consensus position could have been established about how to manage Christopher's needs and how to respond to occasions when he was perhaps seeking to assert greater independence, for example regarding what he chose to eat.

Practice should include respectful challenge and exploration of the extent to which choice is really chosen, using advocates where appropriate, without seeking to deny a person's wishes and feelings. Constructive professional dialogue with family members is fundamental to this.

Delay in holding professionals meeting was a barrier in Christopher's care. Indications of escalating concerns (including nutrition and medication refusal for example) should trigger any professional to call a multi-agency meeting. Professionals meetings can be helpful and appropriate, however where there are disagreements between professionals and family members it is important that meetings are held to resolve these in a timely way. Providers may need the support of commissioning authorities and coordinators such as social workers to chair these meetings to enable difficulties to be worked through.

WHAT WE LEARNT/NEED TO DO DIFFERENTLY:

- Hold professionals meetings with family members included as appropriate as a regular part of care management for adults with complex needs

- Improve person-centred care so that adult's views are sought and are central to decision making. Where adults have additional communication needs professionals should use communication aids and tools and not rely on verbal communication to seek these. In Christopher's case this would have been particularly helpful in respect of discussions about nutrition.

- The Safeguarding Adults Team referral form has been updated to prompt professionals to provide sufficient analysis and details for a section 42 decision to be made.

- Advocacy should be sought at the earliest opportunity, particularly where there are difference of opinion between professionals and family members acting as advocates.

- Organisations must have structures for ensuring that complex cases are allocated to professionals with sufficient training, qualifications and management oversight to enable them to safely coordinate and respond to complex care issues.

WHAT IS GOOD PRACTICE - MENTAL CAPACITY:

- Professionals working with adults should be supported to ensure that Mental Capacity legislation is appropriately applied. At times it appears that Christopher was allowed to assume responsibility in areas that he could not manage. Respect for choice has to be balanced with a duty of care.

- Concepts of independence should be explored with family members and adults. Christopher was being told that he was living independently and could make choices but to varying degrees at different times these choices were being curtailed and he was criticised for the unwise choices he made. It is unclear that any limitations to his ability to make decisions were discussed with Christopher.

- Approaches and interventions should be informed by capacity assessments and should be updated and adjusted following new assessments. Mental capacity assessments must be time and decision specific. 'Informal' or ongoing Mental Capacity Assessments are not an appropriate approach.

- In complex cases where duty of care issues are escalating and risk of harm is significant, legal advice should be sought. As an example, despite Christopher being assessed as lacking capacity to make decisions about taking medication, the provider did not alter their approach with him. If medication could not be given by them in his best interests, that should have triggered a multi-agency meeting to discuss options, including possible referral to the Court of Protection.

IDEAS/WAYS TO REDUCE RISK IN THE FUTURE:

- Professionals should escalate disagreements using the BSAB Escalation procedure in cases where there is dispute.
- In the complex area of legislation concerning Do Not Resuscitate decisions, families should have access to clear written information.
- Reflective supervision is important for all professionals to enable them to consider different hypotheses and potential 'scripts' or 'stories' that may be impacting decision making for adults. The importance of supervision lies in part in the ability of the supervisor to explore both the stories being told and those that are not being considered. Supervision should be professionally challenging as well as supportive.
- All referrers should expect a response from the Safeguarding Adults Team when they refer. If they do not hear, they should follow this up.
- Referrers should challenge screening out of Section 42 safeguarding referrals if they disagree with the decision made

@BristolLSAB

www.bristolsafeguarding.org

FEEDBACK, SUGGESTIONS AND IDEAS:

Tell the BSAB how you have used this briefing in your team by:

Email: bsab@bristol.gov.uk

Website: https://bristolsafeguarding.org/adults/contact/contact-the-bsab/

Twitter: @BristolLSAB

Please let us know if you identify work that could be completed by the BSAB which would support multi-agency professionals to implement the report's findings.

