Seven-point briefing – Safeguarding Adults Review - "Brian"

BARNSLEY SAFEGUARDING ADULTS BOARD

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Introduction

Barnsley Safeguarding Adults Board commissioned a statutory SAR following the death of Brian. Brian's cause of death was pneumonia, metastatic small cell lung carcinoma and chronic obstructive pulmonary disease, smoking and ischaemic heart disease. The review was commissioned to learn lessons from Brian's refusal of support from services and concerns about self-neglect.

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Brian

Brian was 84 years old when he died and was known to be a private man, who lived alone . Brian was a music and film lover. He grew up with an older brother and a much younger sister. He was very close to his brother and moved to Barnsley to be near him.. Sadly, his brother died in 2019, which had a profound impact on Brian.. Brian had a good relationship with his sister but was very private and often did not share information about his support needs. His sister noted that you sometimes had to *"take what he said with a pinch of salt"*. Brian was known to refuse help from workers and for inconsistent engagement with services.

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What happened

Brian was receiving support from sister, sister-in-law and neighbour. Brian's sister raised concerns about Brian's wellbeing by calling 999. An ambulance from Yorkshire Ambulance Services ("YAS") was dispatched. When the ambulance arrived, there was no answer at the door and South Yorkshire Fire & Rescue attended to gain entry. The crews had significant concerns about his wellbeing. A safeguarding concern raised by SYF&R highlighted that:

- Brian looked severely thin (his weight was estimated to be 5 stone 6 pounds which is around 40 kgs). Do we need to say what he should have weighed?
- He had no working lights in his home.
- He had no food in his fridge. His freezer was full of meals but they had iced over and hadn't been accessed in some time.
- He was smoking but leaving the cigarettes he had smoked in a drawer by the sofa.
- He was lying on the sofa and didn't appear to be able to move off it, despite saying that he could.
- He was refusing help and support from the ambulance crew.

Brian refused to go to hospital. The YAS crew conducted a mental capacity assessment and believed he had the mental capacity to make this decision. They facilitated a call to an out of hours GP.

The following day Brian was contacted by his housing association housing officer who resolved the issues with his lights. Brian refused further support. Brian was contacted by Adult Social Care over the telephone, but he refused support. A visit was organised between a Social Worker and the Housing Officer; however, Brian had passed away before they arrived.

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Key findings

Brian had a long history of refusing support and hiding or minimising his health issues with his family, friends and workers. He was a private man and despite his sister living with him on multiple occasions and keeping contact with him throughout his life she explained that she didn't really know him that well. He appears to have tried to maintain his independence and privacy through much of life, evidence suggests that the impact of the self neglect was difficult to hide in the last 12 months of his life. He relied heavily on his family and friends, particularly his sister-in-law. Services did not recognise that these individuals would have benefitted from a carers assessment.. His sister attempted to support Brian to manage his health and welfare but he would often decline her help or give his sister information that is unlikely to be true. His sister did make attempts to seek support for Brian, but support was either not offered or declined on the basis that Brian would refuse it. It was presumed that Brian had the mental capacity to make those decisions. There were some missed opportunities to build a relationship with Brian, by workers, that might have enable to them recognise when he was in need and encourage him to accept support.

Good Practice

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- Brian was recognised as a potentially vulnerable tenant by his housing association. This meant that there were proactive contacts with him during covid and when campaigning around fraud and scams.
- Brian's GP recognised Brian as someone that would be inconsistent with his engagement with services. They tried to accommodate this by arranging additional appointments and taking opportunities to conduct blood tests when he arrived for appointments.
- The YAS call handler displayed good practice in considering the risks of Brian's breathlessness and not cancelling the ambulance call, despite Brian's requests too.
- SYF&R showed good practice, and curiosity, in looking around Brian's flat and being concerned that he didn't have working lights and fresh food and wondering why this was despite Brian stating that he was okay and didn't need support.
- SYF&R correctly raised a safeguarding concern based on the risks that they identified and shared this information with his housing association.
- SYF&R maintaining contact with Adult Social Care to ensure effective triage of their concern and allocation to a social worker.
- Brian's housing officer visiting Brian the day the concern was raised and resolving issues with his lights.
- Brian's housing officer and the social worker allocated because of the safeguarding concern and arranged a joint visit to Brian, despite him continuing to refuse support over the telephone.

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Practice Tips

- Be persistent if someone is refusing support. Try to build a relationship with them, or identify someone that might be able to.
- Consider if other agencies have a similar experience of the person refusing support. Engage with other agencies that might be supporting them. You are probably not the only worker or service that is also experiencing this.
- Review Was Not Brought and Self-Neglect & Hoarding guidance and tools
- Be curious and question when there is a difference between someone's behaviour compared to what they are saying to you e.g. if someone says that they can look after themselves, but you can see a severely neglected environment that they are living in. Question why this is the case? Is there an issue with their mental capacity, executive functioning or something else?
- Be mindful that there is a difference between presuming someone's mental capacity and having drawn a conclusion about their mental capacity because it has been assessed.
- Be curious about someone's consistent *"unwise choices"* or *"unwise behaviour"*. This maybe evidence that someone does not have the mental capacity to make a decision or executive functioning to act upon a decision. This may justify and require an appropriate assessment.
- Consider the experiences of someone's friends and family. If the person is reliant on carers, ask them if they feel able to meet those needs and what support they require. Offer a carer's assessment where appropriate.
- Consider the risk if the carers may not be able to continue to meet the person's needs.
- Consider using the risk tools in the SN policy to inform the need for a safeguarding adults referral

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Recommendations from the review

Recommendations were agreed to improve practice across the partnership and within individual organisations. These include reviewing guidance on *"disengagement"* from services, training for workers Progress and impact will be monitored by the Safeguarding Adults Review Subgroup monthly and will be reported in future annual reports.

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Resources

- Self-Neglect & Hoarding Guidance and Tools
- Was Not Brought Guidance