Havering
Safeguarding Adults Board

Bradley

Safeguarding Adults Review

Havering Safeguarding Adults Board
June 2025
Reviewer Patrick Hopkinson

Dedicated to Bradley

Havering SAB expresses many thanks to Bradley's family for their support in this review and their help in sharing the learning.

We remain very sorry for your loss.

Summary

- Bradley was a 37-year-old White British man with learning disabilities who lived in a residential Care Home.
- Bradley was supported by multiple agencies for most of his life.
- A CQC (Care Quality Commission) inspection rated the Care Home in which Bradley lived as inadequate in September 2023
- On 7th November 2023, Bradley suffered several seizures which lasted for three hours.
- The Care Home's epilepsy protocols were not followed and an ambulance was not called until Bradley's mother arrived.
- Bradley was taken to hospital but his condition continued to deteriorate, and he died on the 17th December 2023.

Who was Bradley?

- Bradley was a dearly loved by his family, who had advocated for him throughout his life.
- Bradley was very interested in what was happening around him, was happy to engage in activities and to go out with support from care staff, who very much enjoyed working with him.
- Bradley loved ice cream. For his birthday, Bradley's family invited an ice cream van so everyone on the care home site could enjoy ice cream.

Bradley's needs

- Bradley had Angelman Syndrome, resulting in:
  - Mobility and balance problems
  - Learning disabilities and communication difficulties. Bradley was non-verbal
  - Sleep problems
  - Seizures.
- Bradley had a bespoke diet of thick fluids due to problems with swallowing.
- Bradley lacked the mental capacity to make decisions about his care and support needs, his safety and where he lived. Bradley's mother had lasting Power of Attorney for Bradley's health and care needs.
- Bradley had moved into the Care Home when he was seven years old. The care home provided services to both children and adults with learning disabilities in separate units.
- The Care Home was relatively to close to where Bradley lived.

Background

- Bradley lived in one of three care homes on the same site. Between July 2010 and December 2014, eight safeguarding incidents were reported including potential physical abuse, inadequate staffing levels and lack of effective leadership. Each incident was investigated and relevant actions were taken.
- Bradley's care was funded by Continuing Health Care from 15th August 2018. Bradley received 2:1 care over 24 hours each day.
- However, persistent concerns continued about the quality of care at, and management of the Care Home in which Bradley lived and the other care homes on the same site.
- These included incidents of the physical and sexual abuse of Bradley in his bathroom and of other residents. Following this, Bradley slept in a chair rather than in bed which he was happy with.
- There were also concerns about the management of Bradley's epilepsy, following which Bradley attended hospital by ambulance.
- Bradley was prescribed buccal midazolam and sodium valproate for epilepsy and promethazine, if needed, to help him sleep.

Events between 2020 and 2022

- On 28th January 2020, Bradley's mother requested that another home be found for Bradley. However, no suitable placement could be found.
- In 2021 a new provider took over the care homes, including the one in which Bradley lived. The new provider began to uncover poor practice and employed a new Care Home manager.
- However, concerns continued and safeguarding enquiries and police investigations were made.
- Adult Social Care monitoring visits and CQC inspections took place. The Care Home in which Bradley lived was rated as inadequate and an improvement plan was implemented. Placements were temporarily suspended in March 2022.
- In May/ June 2022, the care provider issued notice because Bradley's mobility needs could not be met. Alternative placements were sought but Bradley remained in the Care Home.

Events in 2023

- Bradley's physical health deteriorated (indicated by more contact with Bradley's GP following which Bradley was prescribed antibiotics). Bradley acquired pneumonia.
- Following concerns raised by the Care Home, on 15th May 2023, an epilepsy nurse requested that Bradley's epilepsy medication be reviewed following a cluster of seizures which had resulted in two hospital admissions in the past months.
- On 24th May 2023 Bradley injured his head in a fall. An ambulance was called but the crew determined that Bradley did not need to be taken to hospital. A safeguarding concern about lack of action by staff to prevent the fall was raised.
- Further concerns about the treatment of other residents (not Bradley) were raised leading to an unannounced inspection by the CQC, which issued a Notice of Proposal to cancel the registration of the registered manager at the Care Home in which Bradley lived on 12th October 2023.
- On 7th November 2023, Bradley had a seizure at the Care Home. There was a delay in the administration of buccal midazolam whilst Care Home staff contacted Bradley's parents. Bradley was taken to unconscious to hospital by ambulance.
- Bradley died in hospital on 17th December 2023.

What can we learn about:

1. Meeting and understanding Bradley's needs?
2. How do we respond to persistent abuse and neglect in care services?
3. How do we respond to (and resolve) differences of opinion between "professionals" and family members about care needs etc?
4. How do we assess and respond to epilepsy risk?
5. How do we work together (across practitioners, providers, commissioning and regulation) to share information and coordinate our actions?

1.Meeting and understanding Bradley's needs

- Bradley was vulnerable, because he was non-verbal. This meant that he could not say if he had been abused or describe what had happened to him.
  - Some of the ways in which Bradley behaved, for example not sleeping in his bed, may have been in response to having been abused by care staff. For example, the sexual abuse of Bradley was only identified when the member of staff responsible disclosed that they had abused Bradley.
- Bradley's form of epilepsy meant that he required buccal midazolam (epilepsy medication), which is a Schedule 3 (Misuse of Drugs Act 1971) controlled drug however:
  - Safeguarding concerns were raised about staffing levels at the Care Home and a lack of authorised staff to administer epilepsy medication as required.
  - The Care Home did not always call for an ambulance when one was required when Bradley had a seizure.
- Following consultation, CCTV cameras were installed by Bradley's family in his room to monitor his epilepsy. However, Bradley often left his room and he would sometimes sleep on a sofa in the lounge, as well as in a chair in his room. There was also a camera in the lounge.

Learning

- Bradley had complex needs which he relied on services to meet.
- Bradley was unable to protect himself and so required professionals to act in his best interests to keep him safe.
- Immediate risks of severe harm may lead to an urgent need to move people urgent to another location and service provider to protect them.
- However, there are often multiple less severe incidents which appear to be:
  - The result of errors,
  - The result of lack of knowledge and training
  - Discrete, unrelated events
  - Possible to manage by quality assurance or enforcement interventions.
- However, these incidents can combine into a risk of severe harm if there is no improvement despite interventions and assurances of change.

2.How do we respond to persistent poor practice, abuse and neglect in care services?

- There was a persistent history of neglect and abuse on the care site in which Bradley lived, which continued after a change in provider. However, it appears that problems with managing Bradley's epilepsy increased from 2022.
- Despite efforts by the CQC, commissioners and quality assurance officers to work to improve the quality and safety of care on the care site abuse, neglect and poor practice continued.
- Further placements were temporarily suspended in 2022.
- There were concerns about:
  - staffing levels,
  - the use of agency staff,
  - training in administration of epilepsy medication,
  - availability of on-call staff and contact with managers in the event of serious incidents,
  - competence and the ability to support residents with complex needs.
- These were responded to by the Care Home provider but lessons from incidents were not always turned into action. Assurances were given by the Care Home that training would be provided but incidents continued.

Regulatory response

- However, in September 2023 the CQC, the care sector regulator, identified numerous concerns about:
  - Medication
  - Governance
  - Staffing levels
  - Care plans
  - Risk assessments
  - Multiple breaches of regulations.
- As a result, the ratings of the the on-site services were downgraded to “Inadequate” or “Requires Improvement”.
- The CQC issued a Notice of Proposal (NOP) to cancel the registration of the Registered Manager at the service in which Bradley lived and a NOP to cancel the registration of the location on 12th October 2023.
- The Care Provider respond on 9th November 2023 to challenge the NOP for the location. Consequently, the location remained registered
- The Registered Manager did not challenge the NOP and on 23rd January 2024, a Notice of Decision (NOD) was issued to cancel their registration.

Learning

- The service model of providing lifelong support to people with learning disabilities on the same site means that:
  - The number of moves of location is reduced, familiarity with the environment is increased, and long-term relationships can develop with residents and their families.
  - However, the environment may not be suitable to meet each person's needs as these develop and it can be even more difficult to move people when services are unsuitable or provision is of poor quality.
- Bradley's family did not want Bradley to move and there was no guarantee that another suitable service would be available or would be able to support Bradley more effectively.
- There is a need to weigh up the advantages of maintaining a placement in a familiar location with staff who know them, against the evidence of abuse, neglect and poor practice.

3.How do we respond to (and resolve) differences of opinion between “professionals” and family members about care needs etc?

- Bradley’s family were closely involved in Bradley’s care. This could mean that sometimes there were disagreements between care staff and Bradley’s family on the best ways to support Bradley.
- These disagreements may have been influenced by parental experience of poor practice and of the abuse and neglect of Bradley in the onsite care services.
- Bradley’s parents also had a close relationship with the Integrated Care Board which funded Bradley’s placement at the Care Home.
- It appears that care staff would defer to Bradley’s family and wait for them to provide direction on what to do rather than act on their own initiative.
- This was despite guidance and training which equipped them to act independently to protect Bradley.

Learning

- Bradley’s family were involved in creating plans to manage Bradley’s epilepsy. There is a need to:
  - Use the same terminology when families and care staff describe different types of seizure.
  - Provide procedures and guidance and emphasise that care staff are not to rely on families for permission to act.
  - Use Best Interest meetings which involve families where there is a lack of mental capacity.
  - Consider the use of independent advocates to represent people who cannot represent themselves.
- Key learning for providers includes:
  - Engaging with families at a senior management level and holding frequent family meetings. These can be used to ask families to talk about, describe and the explain the history of their loved ones who are using the service. This empowers both families and the staff team and helps them to better understand the needs of residents and families
  - Registered Managers are vital in creating a positive culture in services. They need to be supported to manage staff and relationships with families, regulators and commissioners. However, the focus must be on meeting the needs of individual adults with care and support needs.
  - Recruitment and retention of staff is essential. Consistency of care staffing improves relationships with families and the quality of care.

4. How do we assess and respond to epilepsy risk?

- Bradley's epilepsy was triggered by infections or lack of sleep. Bradley had acquired pneumonia and his normal sleep patterns had been disrupted by sleeping in a chair. These factors would appear to have increased the risk of Bradley experiencing seizures.
- An epilepsy care plan had been agreed with care staff, which was clear about the circumstances in which Bradley should be given buccal midazolam. Care staff had also been trained in medication administration. An old epilepsy care plan was, however, not removed from Bradley's room until after his death.
- One staff member qualified to administer buccal midazolam was on shift on 7th November 2023.
- Despite Bradley having a long history of epilepsy, on 7th November 2023 Care Home staff:
  - Did not recognise that Bradley was having more than mini seizure. There was an underestimation and lack of understanding of the nature of Bradley's epilepsy.
  - Did not record or respond to Bradley's raised temperature (from pneumonia) in the context of seizure risk. It appears that the Care Home's electronic record system was not working.
  - Tried, but were unable, to contact the Registered Manager for advice despite clear signs that Bradley's health was deteriorating and the epilepsy care plan being clear about the need to call for an ambulance.
  - Care staff tried to care for Bradley but deferred their duty to protect him until his mother arrived who then telephoned for an ambulance.

Learning

- The subsequent s42 Care Act 2014 adult safeguarding enquiry identified a need for:
  - Epilepsy training including emergency situations;
  - Increased awareness of needs, highlighted in care plans;
  - Hospital passports to accompany people with learning disabilities to hospital.
- There is a need to ensure that care staff understand and are able to administer controlled medication and to have basic first aid skills to recognise illness and to seek further medical help, including calling for an ambulance.
- There is a need to ensure that old guidance/ care plans are removed when new ones are created.

5 How do we work together (across practitioners, providers, commissioning and regulation) to share information and coordinate our actions?

- Information appears to have been shared between commissioners, quality monitoring and the CQC.
- Feedback from visits by the council quality team were shared with the CQC, the ICB and at Quality and Safeguarding meetings and Quality Surveillance Group meetings.

Learning

- A lot of support was provided to the Care Home to meet Bradley's needs. This included direct contact with a specialist epilepsy nurse for advice and guidance.
- However, a professionals' meeting may have helped to share and review concerns and to weigh the risks to Bradley of remaining at the Care Home against the risks of moving to a suitable alternative placement.
- A 'system of care' approach may be useful. In this, commissioners, practitioners, clinicians, providers and families are considered as partners in the provision of care. There is a shared responsibility for resolving problems in the system and ensuring that needs are met.

Recommendations

- Havering Safeguarding Adults Board to receive assurance from Havering ICB, Havering Adult Social Care, the Havering provider network that:
- Multi-Agency Professionals meetings are used to:
  - discuss and review persistent or repeated quality and safeguarding concerns
  - Weigh up and decide on the risks of supporting a provider to improve against the risks of moving an adult at risk to a suitable alternative placement to meet their needs.
- Professionals and care homes are enabled and supported to recognise the need for Multi-Agency Professionals meetings and Best Interest Meetings. This include how to arrange them, who to invite, how to chair them and how to manage and resolve disagreements in them to agree a shared action plan.
- Independent advocacy is provided for people who cannot speak for themselves.
- Residential care providers have been reminded that they should telephone for ambulances using 999 or NHS 111 and require that an ambulance attends regardless of the qualification level of the staff on duty.
- Commissioners and contracts teams have agreed the checks that should be made on new providers when they take over existing services. These could include assessing evidence of relevant skills and experience and of the abilities, knowledge and competence of staff members.
- Learning from this Safeguarding Adults Review is shared with the provider network.
- Building on the provider concern procedure, an multi-agency Organisational Safeguarding Protocol has been created and implemented.

Resources

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- SAR report: **here**
- Making Safeguarding Personal