Learning Event for Brian James Lloyd

January 2023

1. The details of the individual subject to this review

Brian James Lloyd

2. About Brian

In the words of Lloydie James Lloyd, one of Brian's sons:

Dad lived a full life. He was born just before the Second World War broke out and he remembered the Coventry bombings from when he was a small boy. He grew up in the West Midlands, returning there to campaign politically in later life

Dad did not go to university. He was an Apprentice book binder and became an archive conservator. He worked his way up and became recognised as a Fellow of the Society of Archivists, and he influenced the industry tremendously. Dad was a playful person and had a mischievous sense of humor. He was very silly, but stubborn when he needed to be. I suspect it was one of the many factors at play when his anxiety took hold and I'm sure he became quite stubborn.

He was a Parish Councillor for Elmswell and was praised for his work, he was people centered and socially aware. He stood for the borough council in Eastbourne, and I helped run his campaign when I was 17. Although dad lost, he did pave the way for that ward to be won many years later.

He cared for his friends and was always very social, always the first to help-out and keener to be the helper than to be helped it would be fair to say. Above all he was concerned with making the lives of individuals better through his strong sense of social justice.

Dad wasn't rich growing up, however he was lucky enough to inherit some money after his retirement and that fueled his love of travel. He and mum then travelled a fair bit.

Bladder issues caused Dad a lot of trouble over a good decade or so from his 70's onwards, and he had some operations. He also suffered with anxiety and struggled when caring for mum for three years when she had dementia. He never knew what was coming next and he always wanted everything pristine, so if there was any kind of incident it could be dealt with, and everything was to hand. He always had a good support network around him from me, my brother, and Dad's friends, as well as from services.

Phillip Lloyd, Brian's other son, has been given the opportunity to comment by email.

3. Focus of the Learning Event

The focus for Brian's Learning Event centred around how he was supported as an older person with mental health issues. The key areas explored were:

- How well a person who gets older and has declining mental health and anxieties is supported.
- Using Brian's case as an example, how might agencies support people in similar positions to Age Well and Stay Well?
- Is there something that could have been done differently?
- Does the system put too much emphasis on dementia rather than anxiety/mental health when a person reaches a certain age?

- When agencies are withdrawing services, is this being communicated effectively enough between other professionals involved e.g., MH withdrawing but Home First thinking it would still be ongoing?

4. Purpose of a Learning Event

A Learning Event seeks to determine what the relevant agencies and individuals involved in a person's care might have done differently. This is so that lessons can be learned, and those lessons applied to future cases to prevent similar circumstances arising again.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that the Learning Event is a trusted and safe experience that encourages honesty, transparency and sharing of information to obtain maximum benefit from them.

Its purpose is **not to hold any individual or organisation to account,** other processes exist for that, including where relevant, criminal/civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC. The anticipated outcomes are always centre around:

- Promoting a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults,
- Identifying opportunities to draw on what worked well and promote good practice, and what could have gone better and learn from them,
- Understanding practice from the viewpoint of the family and organisations involved at the time rather than using hindsight, and
- making use of any relevant research and case evidence to inform the findings.

5. The Review Group

This is the core group of people who either attended the Learning Event, or who were invited to participate virtually to the learning.

Role	Organisation (if applicable)
Sons of Brian Lloyd	
Independent Chair	Suffolk Safeguarding Partnership
Designated Adult Safeguarding Nurse	Suffolk and North East Essex Integrated Care Board
Safeguarding Team	Norfolk and Suffolk Foundation Trust (NSFT)
Integrated Neighborhood Lead	Adult and Community Services
Partnership Coordinator	Suffolk Safeguarding Partnership
Safeguarding Partnership Manager	Suffolk Safeguarding Partnership
Professional Advisor (Adults)	Suffolk Safeguarding Partnership
Safeguarding Lead	Norfolk and Suffolk Foundation Trust (NSFT)
Adult Safeguarding Lead	Suffolk Constabulary

6. Learning event outcomes

	Learning point/Action
1	Brian was just seen for his physical needs when care was instated when in fact, physically, he was able to care for himself. Home First (HF) reablement had been sourced to support Brian with daily living skills and his physical health needs. Reablement support could have considered his mental needs and how they were stopping him from caring for himself. **ACTION:** Front line staff to be reminded that co-mobilities need to be considered, a person seen as whole and not just focusing on physical needs as a standalone.
2	HF could have shared insight about Brian with Norfolk and Suffolk Foundation Trust (NSFT). Learning identified that this communication about risk between HF and other professionals needs to be strengthened. **ACTION:** Adult and Community Services (ACS), NSFT, and HF to work together to determine a good way of sharing information about mental health issues, which could be through strengthening the Integrated Neighbourhood Teams (INTs) and replicating the model in the West where HF are a part of the INT. Suggested this is actioned through commissioning channels through the Integrated Care Board (ICB) **ACTION:** HF to remind staff about the importance of sharing information about mental health concerns with other agencies involved in a person's care, or to follow up/check if unsure.
3	There was insufficient co-production with Brian's close family in his acute phase. Whilst agencies were kind to Lloydie and his brother after their dad died, they did not communicate properly with them from mid-December onwards where more could have been done to consider the risk to Brian taking his own life. **ACTION:** Health to review their Multi-Disciplinary Team arrangements and how this can include families / stakeholders when managing risk.
4	The language used when reporting and gathering information either from family or professionals, being seen as the whole person and not the presenting issues that is supported. **ACTION:** All agencies to ensure unconscious bias is part of their mandatory learning for frontline staff.
5	NSFT using Risk and Safety Assessments as commonplace, but NICE guidance says assessments should not be used. There was also no Mental Capacity Act (MCA) assessment for Brian. **ACTION:** NSFT to review the use of assessments in line with NICE guidance. **ACTION:** NSFT to review the use of how MCA's are used early on in a case to help inform support for a person. This can be done by checking policy recommends as standard practice, and by undertaking a spot check of a sample of cases to test out if this is being done.
6	**ACTION:** The SSP to share learning from Brian's case with Suffolk's Suicide Prevention Strategy Group, and Dementia Group.
7	**ACTION:** Health to explore with NSFT why the early learning NSFT undertook was not shared as part of the Rapid Review process.