South Gloucestershire Safeguarding Adults Board News and Research

Quarter Two 2017-18

Self-Neglect

Safeguarding Adults Reviews

Safeguarding Adults Review Miss T *Author: Robert Lake SAB: Buckinghamshire SAB*

Miss T was a 34 year old woman of Asian origin, with a history of mental health problems and a diagnosis of asthma and type 2 diabetes, who was found dead, in an advanced state or decomposition in February 2016 having last been seen in November 2015. Cause of death could not be established. Miss T had been known to local mental health services for several years and was also known to Primary Care. She lived alone in a rented property, and had been employed part time, she had had no contact from her parents since 2013, and her partner had returned to live in his home country and therefore Miss T had a limited network of support. By August 2015, all mental health services had been withdrawn due to significant progress and good recovery. In September 2015, the GP tried to contact Miss T about her medication without success. Her friend contacted social care in October 15 as she had been unable to contact her. Police undertook a safe and well check, and sent a referral to social care due to concerns about the state of the property. In October 15 the safeguarding team tried to contact Miss T, and by the end of October the police repeated their safe and well check, forced entry and found her safe and well inside. Contact was established through November between Miss T, mental health, GP and the safeguarding team. The last recorded contact with her was 23rd November by the housing provider about the damage to her front door caused when the police forced entry. Following a call from her friend, on 23rd February 2016, the police again forced entry and found her dead. An open verdict was recorded by the coroner. Recommendations include: Raising awareness about the self-neglect toolkit and guidance among professionals, focus on multi-agency information sharing, undertake an audit of board partner agencies about the safeguarding process to ensure understanding.

Publication: July 2017 Full Details: SAR Miss T

Linked Research and Resources

RIPfa Blog by George Garrad – Understanding Multiple & Complex Needs available here

Indicators of Self Neglect (NCPEA) Article here

Working with people who self-neglect: Practice Tool (updated 2016) Professor Suzy Braye, Dr David Orr and Professor Michael Preston-Shoot, draws on their latest research, which was commissioned by the Department of Health and involved interviewing staff and people who self-neglect in order to find out 'what works'. Available to purchase for £10 here

Substance Misuse/Mental Health

Safeguarding Adults Reviews

Safeguarding Adults Review Hannah *Author: Brendan Clifford SAB: Gloucestershire*

This SAR is about Hannah, a 26 year old woman who dies aged 26 on 27th May 2016. Hannah's family requested that her real name be used in the review. Hannah died from natural causes. There were health concerns prior to her death around obesity and an ongoing wound infection for the last six months of her life. Hannah had experienced a wide

variety of mental health services and interventions from her teenage years, and increasingly prior to her death. Hannah's use of illicit substances caused difficulties because some services accepted that Hannah would take some time to reduce and stop using, and continued to work with her, while others took a zero tolerance approach and asked Hannah to leave in view of a reoccurrence of drug misuse. There were some examples of good practice, but during her extensive use of hospital services Hannah, her grandmother and friends felt her quality of care in the last 18 months of her life were not of the standard required. It was difficult to identify who the lead professional for Hannah was. Recommendations include: broader range of accommodation and pathways for people with mental health needs. A broader use of innovative models of mental health support such as the recovery college. Training in mental health awareness to include parity of esteem and dignity in care.

Publication May 2017 Full Details: SAR Hannah

Linked Research and Resources

Family Group Conferences for Adults – RipFa guide here

Drug and Alcohol Services in South Gloucestershire:

Developing Health & Independence

SGDAS

Health Services

Mental and Physical Health

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult Q *Author: Eliot Sullivan Smith SAB: Buckinghamshire*

Adult Q was a 74 year old man, who lived alone in a private rented dwelling, and his body was discovered on 6th April 2016. He had a diagnosis of Bipolar Affective Disorder and Ankylosing Spondylitis and later Parkinson's disease. Adult Q had been married and had a son, but lost contact with them both after they moved away when his son was three years old. He was a well-known character in the village, a member of the church and attended midweek social groups. He had a history of contact with mental health services, including several inpatient admissions. By 2010 his mental health was considered to be stable, and he moved into independent accommodation with support from GP, twice daily domiciliary care and his friend Mrs Y. In December 2015, he suffered a fall and was admitted to hospital, when he returned home his domiciliary care package was increased to four visits each day. In March 2016, he was displaying pattern of worrying behaviours and referral were made to several agencies, he had a Mental Health Act assessment on 21st March 16 which led to him being admitted to hospital, and he was discharged on 29th March 16. On 5th April he was found dead at home. The coroner recorded that his death was due to bronchopneumonia and severe kyphosis. Recommendations include: Publication and dissemination of clear information about options available when deterioration in mental health occurs, feedback to be given to all appropriate agencies when mental health assessment has taken place. Establishing a lead professional to act as a conduit for care and information sharing. Complete discharge plans and re-referral pathways to be completed.

Publication August 2017 Full Details: Adult Q

Linked Research and Resources

Training in South Gloucestershire:

Mental Health training in South Gloucestershire is available here

Courses include: Mental Health Awareness; Youth Mental Health First Aid; Mental Capacity Act Modules – 4 modules

Mental Capacity Act - Making Decisions here

Transitions/Out of Area placements

Safeguarding Adults Reviews

Safeguarding Adults Review: Melissa *SAB: Bristol*

Melissa was a young woman aged 18 years who was killed in October 2014 in a Bristol based independent Care Home, by another resident, a 19 year old male, YA2. He was convicted of her murder in October 2015 and sentenced to life imprisonment. Both young adults were placed in the Care Home by commissioners from different local authorities a significant distance from Bristol. Neither Bristol's Safeguarding Adults Team nor the Clinical Commissioning Group were informed of them being moved into Bristol despite their complex and multiple needs. Both Melissa and YA2 had formerly been looked after children. Melissa lived at home with her parents and sibling for most of her childhood years. At the age of ten she was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and later diagnosed with Autism Spectrum Disorder (ASD). In July 2013 Melissa was admitted to the first of two CAMHS Adolescent Units for a period of in-patient assessment. Subsequently Melissa's home authority children's services, supported by the Adolescent Unit, decided that a residential placement should be sought for her. This view was not supported by her family who expressed concern about her ability to relate to other adults in a residential placement because of her immaturity. Aged 18 Melissa was placed in the Care Home 2 months before her death. During this time she exhibited significant distress and received support from mental health crisis services. The young man who was convicted of murdering Melissa had been in care since the age of seven. He had lived in multiple placements including foster care and residential schools. The review identified a chronology of sexually motivated violent behaviour to women throughout his adolescence. A forensic assessment conducted in the year before his move to the Care Home identified his significant ongoing risk and recommended a high level of supervision and risk management strategies. These were set out in a report shared with the professionals supporting him at the time. The young man struggled to distinguish between fact and fiction. He enjoyed science fiction films and books such as Marvel Comics and Star Wars and liked time role playing in these characters. It was evident through the review that the young man should not have been placed in the same provision as Melissa because of his risk profile. It is vital that providers undertake a compatibility assessment considering the combination of needs of all adults in any group living situation whenever a new adult is placed there. Commissioning authorities should ensure this is completed as standard. Recommendations include: Notification to safeguarding adults team, and CCG when adults that pose a significant risk to themselves or others are placed in a local authority. Undertaking compatibility assessments when moving adults into a placement with other residents. Regular reviews of risk assessments. Referrals and professionals undertaking assessments should mitigate against the rule of optimism when conveying and assessing potential risk.

Publication September 2017 Full Details: Melissa

Linked Research and Resources

Practitioner Briefing Paper about Melissa – find it here

Care Leaver Transitions - Strategic Briefing available here