South Gloucestershire Safeguarding Adults Board News and Research

Quarter One 2018-19

Domestic Abuse

Safeguarding Adults Reviews

Safeguarding Adults Review Adult AB *Author: David Mellor SAB: Manchester*

Adult AB died on 30th December 2015 aged 56. He was diagnosed with multiple sclerosis. During the final months of his life AB had moved from his flat to the flat upstairs to be cared for by Adult B2. Adult B2 neglected AB and subjected him to violence that contributed to his death. B2 was convicted of manslaughter and sentenced to 10 years in prison.
There were signs of abuse and neglect, elements of self-neglect, financial abuse/exploitation and mate crime. There were a number of referrals, but communication between agencies was rare and feedback to referrers was lacking. Coercive behaviour by B2 was described by his partner. Recommendations include; Assurance that self-neglect is being addressed thorough multi-agency policies/guidance. Training about coercive control and sharing learning with Department for Work and Pensions to highlight false claiming of carer's allowance.

Publication May 2018 Full Details: SAR Adult AB

Linked Research and Resources

Domestic Abuse and Coercive Control

The Safeguarding Adults Board has commissioned three 4-hour workshops on DOMESTIC ABUSE and COERCIVE CONTROL

The full details, on the L&D website, are copied in below. **The course dates are (all 9.00am – 1.00pm) and you can book on a course by clicking on the date:**

- **Friday 5th October 2018**
- **Thursday 24th January 2019**
- **Monday 11th March 2019**

Fake or Friend, Easy Read Booklet here

Getting Away with Murder Report here

Self Neglect

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult D *Author: Amanda Clarke SAB: Lancashire*

Adult D 'Amy' died on 28th November 2016, aged 50. Amy had a number of health issues including diabetes and epilepsy. The house was noted to be strewn with litter and rubbish with the house piled high with possessions, with little room to walk. Cause of death was attributed to natural causes, pyelonephritis with ketoacidosis, with diabetes as a significant contributory factor. Amy had received services from a number of agencies during the period of the review. Themes identifies include: Self Neglect – there was evidence throughout the review period that Amy may have been affected by self-neglect. She was deemed to have capacity to make decisions by all professionals.

Professionals seemed uncertain about what action to take following visits to the property. Hoarding – there was evidence of hoarding of possessions and of animals. A lack of knowledge and understanding of hoarding was evident among the professionals who visited. Carers – there was confusion about whether Amy's partner, David was her carer. There was a carer's assessment undertaken eventually which stated 'no evidence of self-neglect' despite detailed information otherwise. Non safeguarding enquiries - the report by the RSPCA was not categorised as a safeguarding alert, and therefore not dealt with as a section 42 enquiry. Information sharing – some evidence of good practice, but other elements lacking and protocols not followed.

Publication March 2018 Full Details: Adult D Learning Brief Here

Linked Research and Resources

Training in South Gloucestershire:

Hoarding and Self Neglect Training available here

Self Neglect Practice Guidance published on the SGSAB website and available here

Mental Health

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult CA *Author: Hayley Frame SAB: Manchester*

Adult CA sadly died aged after sustaining head injuries following a fall from a bridge in March 2016. It appeared CA had jumped and a note of intent was in her pocket. CA was 22. CA had a history of anxiety self-harm and alcohol and substance misuse. She was known to multiple agencies at the time of her death. Recommendations include: creation of a multi-agency referral pathway, waiting list management of psychological therapy referrals, think family approach to domestic abuse, mobile phone policies to consider service users expectations out of office hours.

Publication June 2018 Full Details: Adult CA

Safeguarding Adults Review: Adult F *Author: Leighe Rogers SAB: West Sussex*

Adult F died in January 2016. He was 23. He was in hospital waiting for a mental health bed and absconded from the clinical decision unit. He was found in cardiac arrest in the hospital grounds and died at the scene, his injuries were consistent with a fall from a roof. At the time of his death F had contact with and was in the care of several agencies, and was an adult with mental health care and support needs. There was delay in finding him a suitable bed.

Publication: April 2018 Full Details: Adult F

Linked Research and Resources

Training in South Gloucestershire:

Mental Health Awareness book here, *Mental health First Aid book* here, *Building Resilience book* here

Mental Capacity Act Information here