South Gloucestershire Safeguarding Adults Board News and Research

Quarter Three 2017-18

Learning Disability

Safeguarding Adults Reviews

Safeguarding Adults Review Mr C *Author: Karen Rees SAB: Hampshire SAB*

Mr C had a mild learning disability, epilepsy and a history of psychotic depression. After a series of moves of placement, Mr C's behaviour deteriorated, he stopped eating and drinking resulting in a deterioration in his physical health. Concerns were expressed by his care team that there may be an underlying physical cause for him not eating and drinking and losing weight. He was admitted to the local acute hospital trust for observations and diagnostic tests and he was discharged 7 weeks later as it was felt that his condition was due to behavioural and not physical causes. He was discharged to a nursing home in a poor physical state where he received end of life care and he died four days later. Following Mr C's death, a section 42 safeguarding enquiry was commenced due to concerns raised that during his admission to the acute hospital, he had not received the necessary tests to rule out a physical health condition as a root cause of his physical presentation. There were also concerns that he was transferred to a nursing home apparently at the end of life when this was not known to those that were receiving him into their care or the community learning disability team. In addition to the Mr C SAR, the Hampshire Safeguarding Adults Board also commissioned a thematic review to examine two previous SARs carried out under similar circumstances Mr A (June 2013) and Ms B (Dec 2015). In all three cases, the adults had a learning disability and died because of physical health care conditions and concerns were raised that their deaths had been premature and not expected. Common Issues identified: Understanding and application of the Mental Capacity Act, Access to advocacy, Effective management of transitions in placements and transfer to acute hospital care, Involving family in treatment decisions, Availability and access to the Learning Disability Liaison Nursing Service, Effective hospital discharge planning, Use of the Hospital passport, Continued used of the Care Programme Approach during hospital admission.

Publication: December 2017 Full Details: SAR Mr C and Thematic Review

Linked Research and Resources

Training Opportunities in South Gloucestershire here

SCIE Learning Disability Services and Resources here

Organisational Abuse

Safeguarding Adults Reviews

Safeguarding Adults Review Mendip House *Author: Margaret Flynn SAB: Somerset*

A Safeguarding Adults Review was commissioned by the SSAB following a whole service safeguarding enquiry into allegations of the mistreatment of residents living at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society (NAS). Mendip House was home to six people with autism and complex support needs. Mendip House was closed by the NAS in November 2016 following multi-agency investigations into allegations from whistle-blowers of mistreatment and abuse of some residents by a number of staff which were made in May that year. Several staff members were dismissed and the review highlights weaknesses in the system by which authorities making care placements outside of their local area monitor the care being provided. None of the people living at Mendip House were Somerset residents; however, the review findings and recommendations include important learning for the commissioning and monitoring of out-of-area placements. Recommendations include: The Department of Health and Social Care, NHS England and the Local Government Association carry out a national

consultation on steps to regulate of the commissioning of care placements. That the Care Quality Commission (CQC) makes clear in its inspection reports that it will no longer register 'campus' model care arrangements. That commissioners should be required to notify the local authority in the area where a placement is being made. The Care Provider Alliance issues its members with guidance about roles and responsibilities in quality assurance and safeguarding. A way of working be agreed by which information about grievances, disciplinaries and complaints can be shared with the CQC and pooled with local authority safeguarding referrals and intelligence from police and others.

Publication January 2018 Full Details: SAR Mendip House

Linked Research and Resources

Training available in South Gloucestershire

Managing and Preventing Organisational Abuse – book a place here

Self Neglect

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult E *Author: Pete Morgan SAB: West Sussex*

Adult E was a 79 year old woman who died on 8th August 2016, with the cause of death recorded after the Post Mortem as 'multi organ failure, dehydration and long lie and collapse due to underlying co-morbidities. Prior to the period of review, she had previously been unknown to Adults Social Care. On 18th July concerned neighbours contacted the police as they had not seen Adult E for a week. Police called an ambulance as they suspected she may have had a stroke. Adult E refused to go to hospital and the paramedics arranged for her to be transported to her GP. A referral was made to Adult Social Care. On 7th August the neighbours contacted the police again, and the police forced entry and found Adult E lying on her kitchen floor, it appeared she had been there for several days. When she arrived in hospital it was assessed she had been on the floor for approximately ten days.
Recommendations include: Assurance that non-urgent referrals for health or social care and support are effectively risk assessed and response times communicated to both the referrer and the service user. Effective and proportionate multi-agency processes should be in place for monitoring the provision of repeat prescriptions and the flagging of failures to either request, collect or have made up repeat prescriptions, particularly for those living alone or known to be at risk.

Publication February 2018 Full Details: Adult E

Safeguarding Adults Review: Adult A *Author: Suzy Braye & Michael Preston-Shoot SAB: East Sussex*

Mr A, aged 64, died on 24th July 2016. A post-mortem established his cause of death as systemic sepsis, cutaneous and soft tissue infection of the legs, diabetes mellitus and idiopathic hepatic cirrhosis. Mr A had Korsakoff Syndrome. He lived in a Nursing Home, and in August 2015 was admitted to hospital for treatment of ulcers. The nursing home made it known that it was unable to manage his complex needs and challenging behavior, which included care and treatment refusal. As a result, when he was ready to be discharged from hospital in September 2015, he was placed in a nursing home in East Sussex. This was intended to be a short-term placement, pending a move back closer to his home in Kent, but such a move did not subsequently take place. Mr A continued to refuse care and treatment. He did not feel the East Sussex placement was suitable and wished to move nearer to his home. Mr A was assessed as lacking capacity to make decisions about his care and treatment, and deprivation of his liberty was authorised in order to ensure his continued stay at the nursing home in his best interests. In July 2016 the care home manager noted bilateral infestation in maggots in Mr A's ulcerated legs, and attempted to secure a Mental Health Act 1983 assessment and/or a general hospital admission. In the absence of either being possible, and having made a safeguarding referral to adult social care, the manager called for out of hours GP assessment, which took place the following morning. The GP attempted to secure admission to Kings Hospital, London, which was in line with Mr A's wishes, but the hospital was unable to admit him. The following day, the nurse in charge became concerned about Mr A's laboured breathing and called an ambulance, which attended. Due to health and safety risks from Mr A's condition, and given he was by now breathing normally, the ambulance crew (having sought supervisory guidance) did not further enter his room, leaving him in the care of the nurse in charge. Mr A's condition later

deteriorated again and he died that evening. Recommendations include: Creation of a database of specialist placements, assurance that commissioning processes are robust in ensuring suitability of placements, Produces briefings to promote and refresh safeguarding literacy in the context of the Care Act 2014, with particular reference to the referral pathways and thresholds for section 42 safeguarding enquiries and the use of complex case procedures and multi-agency meetings in challenging cases, as well as awareness of, and confidence in, understanding factors contributing to self-neglect.

Publication October 2017 Full Details: Adult A

Linked Research and Resources

Training in South Gloucestershire:

Hoarding and Self Neglect Training available here

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

Financial Abuse

Safeguarding Adults Reviews

Safeguarding Adults Review: Thematic Review of Financial Exploitation *Author: Sylvia Manson SAB: Lincolnshire*

In 2014, the Lincolnshire Safeguarding Adults Board (LSAB) received information relating to thirty- four people who were victims of financial exploitation in a Lincolnshire market town. It was believed the people had been targeted because of their vulnerabilities. The Police led a multi-agency investigation that revealed individuals had been subject to exploitation for many years. This SAR looked in detail at the experience of ten people. Three of the people were willing to contribute their views into the review. Their stories detail some harrowing accounts of their day-to-day lives. This was not a hidden picture and their abuse was known to the agencies working with them. Recommendations include: Record keeping and chronologies, multi agency working, safeguarding responses to non-engaging adults, reviewing the competence and confidence of their workforce in identifying and responding to financial exploitation and extortion and revise training and guidance accordingly

Publication June 2017 Full Details: Overview and Summary Reports

Linked Research and Resources

Financial Abuse Evidence Review: Age UK 2015 Can be found here

SCIE Financial Abuse Services and Resources can be found here

Signs and Indicators of Financial Abuse can be found here

Scam and Fraud Prevention information can be found here