



South Gloucestershire Safeguarding Adults Board News and Research  
Quarter Four

## Self-Neglect

### Safeguarding Adults Reviews

#### *Safeguarding Adults Review 'Ted'*

*Author: Robert Lake SAB: Gloucestershire*

'Ted', aged 72 was found deceased (Feb 2016) in his sheltered housing flat along with his dog. Ted activated alarm in his flat and was admitted to hospital with kidney problems. Significant self-neglect noted and care of dog. Discharged after 4 weeks, with catheter fitted and reablement package. His flat was deep cleaned and dog returned to him. Last recorded sighting of Ted mid Jan 16. Seven weeks later neighbour alerted police about Ted's safety and the police found Ted dead. Coroner recorded open verdict: No ascertainable cause of death. Recommendations include raising formal safeguarding concerns in circumstances of significant self-neglect; More comprehensive details to be provided to GP on discharge from hospital; follow up when repeat prescriptions are not requested; Consideration of information sharing between health & housing providers.

Publication: February 2017

Full Details: [SAR Ted](#)

#### *Safeguarding Adults Review RN*

*Author: Mark Dalton SAB: Worcestershire*

RN, aged 48, suffered from several chronic health conditions at time of his death, and was alcohol dependent. RN had a history of non-engagement and his refusal of care and patterns of behaviour were construed as 'lifestyle choices' rather than self-neglect requiring multi agency action under self-neglect procedures. History of poor engagement meant that when RN could not be seen, it did not lead to raised anxieties initially. After 15 days, concerns were escalated and RN was found dead in his flat, it was apparent he had been dead for some time. Recommendations include revision of self-neglect policy; appointment of a key person or lead professional to co-ordinate multi agency information sharing and a review of information sharing when appointments are missed.

Publication: January 2017

Full Details: [SAR RN](#)

### Linked Research and Resources

*Joint Bristol and South Glos Safeguarding Adults Board Conference:* Tuesday 13<sup>th</sup> June 2017 9.30am-3pm at BAWA - **'Self Neglect in Care Homes and the Community'** with keynote speaker Michael Preston Shoot. Book a place [here](#)

*Community Care Article* by Elaine Aspinwall-Roberts (March 2017) [Missed Opportunity?](#)

*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](#)

## Transitions

### Safeguarding Adults Reviews

*Safeguarding Adults Review Adult H*

*Author: Donna Ohdedar SAB: Nottinghamshire*

Adult H, aged 21, has a diagnosis of Spina Bifida and Hydrocephalus. Lives at family home. A safeguarding adult referral was made by the ambulance service following severe burns. Adult H suffered 14% skin loss and chronic wounds indicative of urine burns. Adult H's transition to adult care showed minimal multi agency working. There was insufficient focus on non-attendance at medical appointments. The family's lack of engagement disabled the safeguarding process repeatedly with no escalation by professionals. Adult H was consistently seen with her mother, hence lack of her own voice was evident. Recommendations include a review of transfer between children's and adult's services. Creation of a multi-agency self-neglect policy and a multi-agency escalation policy. Guidance to be provided on working within the context of service refusal.

Publication: February 2017

Full Details: [SAR Adult H](#)

### Linked Research and Resources

*The Care Act – Transition from Childhood to Adulthood (SCIE)* Includes information, resources, video diaries and can be accessed [here](#)

*The Transition Information Network* [website here](#)

*Nice Guidelines* Including Interactive flowchart can be found [here](#)

## Substance Misuse/Financial Abuse

### Safeguarding Adults Reviews

*Safeguarding Adults Review Tom*

*Author: Paul Cheeseman SAB: Rochdale*

Tom was found dead at his home, aged 61, in Spring 2016. Tom was caring man, who had held a responsible job in the charitable sector, but unfortunately he began to misuse alcohol and this led to him losing his career and his long term relationship and he ended up living on his own. He began to mix with other people who also had alcohol problems and was ultimately exploited by other people who came to his home. They stole money and possessions. Labelling Tom as 'a drinker' by professionals led to a lack of analysis of his vulnerability. A Safeguarding Alert was triggered and this led to a Strategy meeting. Sadly Tom was found dead by his former partner. Male A – an acquaintance, who frequented Tom's home, pleaded guilty to Tom's murder and was sentenced to life imprisonment with a minimum of 21 years imprisonment. Recommendations include establishing a lead professional, better engagement with family members, a clear and standard template for strategy meetings so that concerns can be clearly seen, working with banks at an early stage when suspicion of financial abuse.

Publication March 2017

Full Details: [SAR Tom](#) also see [Tom - 7 minute learning](#)

### Linked Research and Resources

*SCIE Alcohol Misuse Resources and Services* [Can be accessed here](#)

*Strategic Briefing – Supporting people with Multiple Needs (Lucy Terry)* Available to purchase £3.99 [here](#)

*Drug and Alcohol Services in South Gloucestershire:*

[Developing Health & Independence](#)

[SGDAS](#)

[Health Services](#)

# Dementia Care

## Safeguarding Adults Reviews

*Safeguarding Adults Review Mrs BB*

*Author: Chris Brabbs SAB: Norfolk*

Mrs BB was diagnosed with dementia, probably due to Alzheimer's, in October 2012. She lived alone from February 2013, when her husband was admitted to a care home. Mr & Mrs BB have four children who provided fluctuating levels of care. She received twice daily home care visits, but was frequently not at home because she would travel to visit her husband. There were concerns about her safety doing this alone. From January 2015 she displayed increasingly erratic and agitated behaviour. Her carer arranged an urgent GP appointment on 20<sup>th</sup> January 2015, as she was so concerned. The GP advised that she be taken to A&E as this would provide a place of safety and for further tests. Mrs BB refused to go to the hospital. The carer contacted Mrs BB's daughter who was unable to visit on the same day. The carer left Mrs BB at home. Sometime overnight Mrs BB went missing and was found dead by a member of the public the next day. Recommendations include updating procedures, training and guidance regarding risk management. Written information and agreed actions to be given when a carer accompanies a service user to a medical appointment. Clear inter agency arrangements for people with dementia considered to be at risk. A flagging system on recording systems. Learning events for home care providers including risk assessments, escalation policy, seeking assistance when service users cannot be left alone.

Publication December 2016

Full Details: [SAR Mrs BB](#)

## Linked Research and Resources

*Training in South Gloucestershire:*

[Connecting with people who have Dementia 11th July](#)

[Dementia Awareness 13th September](#)

[Dementia Awareness: Supporting Adults with Learning Difficulties 16th October](#)

*Enablement in Dementia* (Imogen Blood) available to purchase £4.99 [here](#) and Practice Tool (£10) [here](#)

*SCIE Dementia Resources* can be accessed [here](#)