South Gloucestershire Safeguarding Adults Board News and Research

Quarter Four 2017-18

Learning Disability

Safeguarding Adults Reviews

Safeguarding Adults Review 'Danny' *Author: Julie Foster SAB: Gloucester SAB*

Danny was a white British man, aged 64 when he died. Throughout his life he had significant mental health and learning disabilities, with diabetes diagnosed in 2001. His physical health was exacerbated by lifestyle choices he made regarding his diet. He lived in Supported Accommodation with an extensive care package aimed at supporting his independence whilst ensuring personal and home care needs were met. His support worker team was consistent over many years and the service was effective, despite several hospital admissions, until his final few months when his needs became complex and challenging in this setting. Danny had complex and changing needs throughout his lifetime. Significant input was made by the Community Mental Health Service, who were the lead agency, and by Primary Care, which provided universal services appropriate to his age and diabetic care. From May 2016, Danny attended the Emergency Department seven times due to a combination of physical and mental health related matters, leading to six inpatient admissions. The acute hospital setting was not ideal for Danny as his condition improved and the Review concluded that he would benefit from support from familiar staff, which was not arranged in time. Danny's discharges from hospital were planned in advance but delays and failure to communicate effectively and in a timely way led to rapid readmissions. The Review has concluded that good practice was evident in this case. It has also highlighted a number of areas where improvements are needed to avoid this situation occurring again. Learning includes: Reviewing multi agency hospital discharge policy, clarity of funding responsibilities, additional support in hospital for people with substantial difficulties from support workers with whom the person is familiar and improving understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Publication: March 2018 Full Details: Danny and Executive Summary

Safeguarding Adults Review 'P' *Author: Professor Hilary Brown SAB: Enfield SAB*

This is the Report of a Safeguarding Adults Review that was commissioned by London Borough of Enfield Safeguarding Adults Board (SAB) to examine the way that service providers, Local Authorities and other agencies worked together to provide services to a man P, who was between 18 and 28 years old in the period covered by the report. He is of White British origin and has mild learning disabilities as well difficulties as a result of having experienced a very difficult childhood. P was placed by the London Borough of Hackney in residential services managed by Hillgreen Care Ltd in Haringey and then Enfield. He went on to commit a series of sexual assaults over at least a ten-year period and those victims included other people with learning disabilities as well as members of the public. His victims vary in age, gender and ethnic origin. Learning includes: supporting people who have been abused, sharing court reports, enhanced care planning and case coordination, transitions, making safe placements, acknowledging risks to others in making placements.

Publication: March 2018 Full Details: SAR 'P'

Safeguarding Adults Review Christopher *Author: Professor Michael Preston-Shoot SAB: Bristol*

Christopher is described by his family as a 'loving, funny and life-loving young man who had many friends and acquaintances throughout his life'. Christopher had complex health needs and learning disabilities throughout his life. In December 2015, age 31, Christopher died in hospital as a result of a respiratory tract infection and his existing health conditions which were compounded by recent weight loss, being an in-patient with poor mobility, a poor

cough reflex and a recent general anaesthetic to fit PICC and feeding lines. Christopher moved into supported living for fifteen months before his death having lived with his father for the majority of his adult life. He was admitted to hospital after becoming ill and losing significant weight as a result of refusing food and medication in his supported living. The SAR found that Christopher experienced systemic organisational neglect as a result of the lack of coordination of his care to manage his complex needs. Learning Includes:

- Hold professionals meetings with family members included as appropriate as a regular part of care management for adults with complex needs
- Improve person-centred care so that adult's views are sought and are central to decision making. Where adults have additional communication needs professionals should use communication aids and tools and not rely on verbal communication to seek these. In Christopher's case this would have been particularly helpful in respect of discussions about nutrition.
- Advocacy should be sought at the earliest opportunity, particularly where there are difference of opinion between professionals and family members acting as advocates.
- Organisations must have structures for ensuring that complex cases are allocated to professionals with sufficient training, qualifications and management oversight to enable them to safely coordinate and respond to complex care issues.

Publication: March 2018 Full Details: Christopher Briefing for Professionals: here

Linked Research and Resources

Training Opportunities in South Gloucestershire here

SCIE Learning Disability Services and Resources here

Mate Crime

Safeguarding Adults Reviews

Safeguarding Adults Review Thematic Mate Crime Review *Author: Becky Lewis & Tom Hore SAB: Bristol*

Derrick was a 51 year old Black Caribbean man living in supported accommodation. The care provider specialises in services for adults aged 18 to 55 with moderate to severe mental health and learning disabilities. This accommodation was commissioned and funded by Bristol City Council. Derrick had qualified for support under the Care Act 2014 criteria. When Derrick died concerns were raised that he had been the victim of Mate Crime while living in supported accommodation. His death was sudden and unexpected, and due to the circumstances surrounding it his family questioned whether Derrick's death was suspicious and could have been linked to the crime he was experiencing.

Following two post-mortems, including one forensic post mortem, both pathologists concluded that Derrick died of a heart attack that could not have been caused by another party. An Inquest was held in January 2018 which also concluded that Derrick died as a result of a heart attack As Derrick's death did not result from abuse or neglect, the criteria for a Safeguarding Adults Review were not met. However the Board agreed with the Safeguarding Adults Review Sub Group's recommendation that the case raised concerns about agencies' knowledge and ability to respond effectively to Mate Crime and exploitation of adults with disabilities. On the 10th May 2017 the Bristol Safeguarding Adults Board agreed that a joint Thematic Review with the Safer Bristol Community Safety Partnership would take place.

Findings include: Awareness and Identification of Mate Crime, Preparing Adults and Families for increased independence, Reviewing care and Protecting Vulnerable Adults from Mate Crime.

Publication January 2018 Full Details: Thematic Review

Linked Research and Resources

SGSAB and BSAB Joint Annual Conference – Adult Exploitation, Mate Crime and Coercive Control. Tuesday 12th June 2018. Book a place here

Fake or Friend, Easy Read Booklet here

Getting Away with Murder Report here

Self Neglect

Safeguarding Adults Reviews

Safeguarding Adults Review: Mrs A *Author: Michele Tynan SAB: North Yorkshire*

Mrs A was an 88-year old lady who died in June 2015 of septicaemia. She had received domiciliary care four times a day since 2010 and despite some physical frailty, she socialised with friends and was described as having an 'iron constitution, sharp views and a strong mind' by her family.
In March 2015, she broke her femur whilst being assisted with her personal care and due to difficulties with communication between professionals, the team looking after her in the community weren't aware of this and her support plan was not amended to reflect her changed needs. Subsequently the complications of this injury led to septicaemia and Mrs A refused treatment for this condition. She had two admissions to hospital between in the three months leading up to her death and passed away in June 2015.

Publication March 2018 Full Details: Mrs A

Safeguarding Adults Review: Beryl Simpson *Author: Paul Pearce SAB: Kent & Medway*

Beryl Simpson, aged 82 years, lived with her daughter Margaret, aged 62 years, in a house that Beryl owned in Town A, Kent. On 6 December 2016, following concerns raised by Kent County Council Adult Social Care & Health (ASCH) about Beryl's welfare, officers from Kent Police used their power under Section 17 of the Police and Criminal Evidence Act 1984 to enter the house. They found Beryl in a very poor state of health; she was emaciated and malnourished. Margaret was also present in the house, which was in poor repair. There was no working toilet, it was cold and there was evidence of long-term extreme hoarding. After Beryl's condition was stabilised by paramedics, she was taken to Hospital. Despite intensive treatment she failed to thrive and died in hospital on 15 December 2016. Learning includes: when dealing with cases of self-neglect in a household, organisations must consider the safeguarding of each person living in it and make every effort to ensure that each is spoken to separately. It is necessary to establish the mental health capacity and/or the mental health condition of a person who is suffering from self-neglect. When new multi-agency policies, protocols and procedures are introduced, which cover specific safeguarding issues, consideration must be given to how training is delivered to staff from those agencies to which they are intended to apply. Professionals must understand the powers that exist in law to intervene in cases where a person is behaving in a way which places them or someone else at serious risk.

Full report here https://www.kent.gov.uk/__data/assets/pdf_file/0008/78056/SAR-Executive-Summary-Beryl-Simpson-Final-January-2018.pdf

Publication January 2018 Full Details: Beryl Simpson

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: 'Case A' *Author: Pete Morgan SAB: Bedford Borough & Central Bedfordshire*

Miss A was born on the 9th April 1981 in London. She was diagnosed with 'borderline hyperactivity' at the age of four. At primary school, she struggled to read and found it hard to form friendships. At the age of seven, she was diagnosed with Dyslexia and, at the age of eight, transferred to a specialist school, where she began to read within a term. At the age of ten, she returned to mainstream education at her old school. She attended an all-girls secondary school where she was academically successful but became isolated and ill through the increasing impact of her Anorexia.

Miss A, despite appearing unhappy and becoming obsessive about her weight and socially isolated, completed both her GCSEs and A levels. She completed a Foundation course at Wimbledon Art College but was too unwell to take up a place at university as she had planned. After several hospital admissions, Miss A subsequently completed, with a Distinction, a part-time creative writing course at Birkbeck College, London. This enabled her, at the age of 26, to read English at the University of Sussex.

Miss A could also be lively, funny, articulate and full of life. The artwork and creative writing she produced was very impressive and is an indication of what she might have achieved. The tension between the creative and the self-destructive in her life is clear to see and needs to be remembered.

Miss A had had contact with mental health services from the age of twelve and spent 5 years in the Maudsley Hospital for treatment of her Anorexia Nervosa. During this time she was placed under Section 3 of the Mental Health Act 1983.

She was further assessed under the Act in 2012 and 2014 but was not detained on either occasion. She was described as presenting with symptoms of Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Anorexia/Bulimia and personality difficulties that meet the diagnostic criteria for Borderline Personality Disorder. In 2014, Miss A was diagnosed with High Functioning Autism Spectrum Disorder, though Miss A disputed this, as she had most diagnoses. Prior to her admission to the Milton Park Therapeutic Campus, Miss A was living in a residential hostel in Brighton, and was described as living a chaotic lifestyle involving the misuse of alcohol, illicit drugs and inappropriate sexual liaisons and abusive relationships with men. She was not cooperating with support services offered to her and a referral was made for a placement in a specialist locked rehabilitation facility, resulting in her placement at the Milton Park Therapeutic Campus as an informal patient, initially on two locked wards before she transferred to Pathway House, a residential home.

Miss A could be articulate and clear about her wishes and would often push any boundaries that might be imposed upon her. She could understand the need to change her behaviour and life-style, but was unable to make those changes. Despite increasing risks being identified about her behaviour, including one probable suicide attempt, Miss A remained a voluntary resident at Pathway House. She was offered an informal admission to the in-patient facility on the Milton Park Therapeutic Campus, but declined it. Three applications were made for an assessment under the MHA during June and July 2016, though none were actually carried out and at no time was Miss A made the subject of a detention order. There was also a fourth application in this period, but this was subsequently withdrawn at her parents' request in case it jeopardised a possible new placement.

On the 27th July 2016, Miss A left Pathway House in the morning to attend an appointment with her GP; she didn't return to Pathway House but was in regular telephone contact with staff during the day. Several times during the evening, she advised them she was about to return. She had also been in contact through the evening with her parents, who also encouraged her to return to the placement. Miss A's parents were also in contact with Pathway House and asked that they contact the Police, the final time at 11pm. They were advised that contact would be made at 1am if Miss A hadn't returned, which they considered too late.

At 2 am on the 28th July 2016, when Miss A had not returned and she had not been in contact for 45 minutes, the Police were alerted and she was registered as a Missing Person. At 5 am, the Police contacted Pathway House to advise them that Miss A had died in a traffic accident at 3 am.

The death of Miss A is the subject of a Coroner's Inquest; but at the time this Report was written, it had been postponed until later in 2018. Learning includes Risk assessment and care planning, Risk management and escalation, Use of the Mental Capacity Act 2005.

Publication March 2018 Full Details: Case A

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

Health Care/ Hospital

Safeguarding Adults Reviews

Safeguarding Adults Review: 'Alan' *Author: Robert Lake SAB: Worcestershire*

Alan was aged 68 at the time of his death. He had lived with his wife and was an active man who was still driving his car until a few months before his death. He had a son and two daughters. In the latter part of his life, Alan had care and support needs which were met by his wife and family with the support, as required, of primary and psychiatric care services. In February 2016, the onset of dementia, related to the Parkinson's disease, was diagnosed and the depression confirmed, for which medication was prescribed. In late March 2016, Alan was admitted to acute hospital, for physical and psychiatric assessment. It was determined that he was fit for discharge within the first week, but he remained in the hospital for a period of 10 weeks. On 9th June 2016. Alan was admitted to a specialist care home on a "Discharge to Assess" (DTA) basis Alan was admitted to (a different) acute hospital on 6th July 2016 in an unconscious state and found to be suffering from a chest infection and septicaemia. It was also found that he had pressure injuries to his heels and bruising to his ankles. Alan died 5 days later. Learning Points include timely discharge, tissue viability as part of care planning, transfers, carers and whistleblowing.

Publication February 2018 Full Details: Alan Learning Briefing: here

Safeguarding Adults Review: 'Violet Hughes' *Author: Paul Pearce SAB: Kent & Medway*

This SAR considers the case of Violet Hughes, who lived in Kent. Violet was a white British woman aged 89 years at the time of her death. On 27 May 2015, Violet was admitted to Hospital 1 due to "poor oral intake for a few days and general unwell and off legs. On 23 June 2015, Violet was discharged from Hospital 1 and went to stay at Care Home 1 (CH1) in Town B. For the duration of her stay there, she was registered with GP Practice 2 (GPP2) in Town B. Violet was visited 12 times by Community Nurses or Health Care Assistants from the Community Trust, Town E Community Nursing Team (CNT) during her 10-day stay in CH1. They dressed wounds on the back of both her legs and requested antibiotics to help treat the wounds. Antibiotics were prescribed by GPP2. On 1 July 2015, Violet was transferred from CH1 to CH2 in Town A. During her stay at CH2, Violet was under the clinical care of the town A CNT, whose staff made five visits. On 9 July, Violet became unwell and carers at CH2 called 999 to request an ambulance. She was taken to Hospital 2 in Town C, where she was found to be suffering from sepsis, bilateral leg ulcers and cellulitis. On 14 July, while at Hospital 2, Violet was found to have a hip fracture, which an independent expert later assessed as being three to six weeks old. Violet died in Hospital 2 on 29 July 2015. Learning includes: Ensuring policies are implemented, Accurate record keeping is important in ensuring effective safeguarding, Sharing information.

Publication September 2017 Full Details: Violet Hughes

Linked Research and Resources

Training in South Gloucestershire:

Dementia Awareness training here

Managing Good Practice training here