South Gloucestershire Safeguarding Adults Board News and Research

Quarter Four 2018-19

Mental Health

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult C *Author: Karen Rees SAB: Wiltshire*

Adult C was diagnosed with paranoid schizophrenia in 1989 and was resident in a local mental health hospital. However, supported by health and social care services, he was able to move out of the hospital to live independently. At the time of his death Adult C was known to mental health services at the NHS and Local Authority and the Court of Protection Team at The Local Authority. Adult C was difficult for professionals to engage in his treatment. Adult C did not accept his diagnosis or comply with medication and because of this he was managed using a Community Treatment Order under the Mental Health Act. This ensured Adult C received his monthly anti-psychotic medication injection and reduced the risk he may have posed to himself or others. Those arrangements continued until he died. In September 2017, there were increasing concerns about Adult C. There had been reports that Adult C's behaviour was changing, and the police had been involved. There were also concerns about Adult C's physical health and finally a neighbour informed the Housing Association that they were concerned for Adult C as they had not seen him that day. This led to a plan to recall Adult C to hospital for further assessment under the terms of the Community Treatment Order. It was necessary to arrange a bed for admission. This took a week. When Adult C was recalled to the mental health hospital, it was recognised that his physical health was of grave concern. Adult C was admitted to hospital after a physical examination revealed he was emaciated and starved, and he died 8 days later as a result of community acquired pneumonia and paranoid schizophrenia. After the death of Adult C his family found that payments to his personal account had been stopped and there were only a few pounds in the account. Adult C had not received regular physical health assessments and sufficient assessment of his capacity to make decisions in his own best interest are not clearly evidenced. Professionals had worked with Adult C over a number of years, however, the complexity of the case, Adult C's reluctance to engage and a failure to work effectively across agencies posed an increased risk to Adult C's health. Recommendations included: changes to the management of deputyship orders; Measures to ensure improved communication and multi-agency approaches to care planning where adults at risk are unwilling to engage; Better recognition of self-neglect and use of mental capacity assessments where someone who needs physical health care is reluctant to engage; More effective engagement with families who are undertaking a caring role of those adults at risk who have long-term complex needs.

Publication February 2019 Learning Brief: Here Full Details: Adult C SAR

Linked Research and Resources

Training in South Gloucestershire: details and booking by following this link

Mental Capacity Act information: Here

Domestic Abuse/Coercive Control

Safeguarding Adults Reviews

Safeguarding Adults Review: Harry *Author: David Mellor SAB: Bournemouth & Poole*

Harry, age 22, who was described as having global developmental delay and had autistic traits, was supported to live independently by a domiciliary care agency. In March 2014, he met Karen age 20 via social media and the pair quickly entered a relationship. He was judged to have capacity to engage in a sexual relationship when assessed in May 2013. On 3 April, there was a safeguarding alert, raising concerns about Harry's sexual relationship with Karen, which was communicated to Poole council's adult safeguarding service. This said Karen was "forcing the physical aspect of the relationship" and "bullying him for money". In the following months, Harry's relationship concerned professionals as Karen took financial advantage of him; for example, taking out phone contracts in his name. Karen also sent "threatening text messages" to Harry, prompting Poole adults' services to convene a multi-agency risk assessment conference (MARAC). Karen and her new partner John worked together to lure Harry to a flat where he was stabbed to death. Both Karen and John were jailed for a total of 41 years. Recommendations include: The review made 13 recommendations, including that Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership establish a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and MARAC agendas are more closely aligned. It said MARACs needed to better understand safeguarding adults and the vulnerability of disabled people to domestic abuse, and that adult safeguarding could learn from MARACs in areas such as tracking perpetrators who move from victim to victim, as was the case with John. Dorset HealthCare is carrying out a review of staff knowledge and application of the Mental Capacity Act in the light of the SAR, which the review said the safeguarding adults board should monitor and then ensure that the learning from it is shared across the safeguarding adults workforce. The SAR said that the Dorset HealthCare review should look at: carrying out capacity assessments where the person gives conflicting answers, with a view to developing good practice guidance on this; providing assistance, including advocacy, to help people make decisions for themselves where there is doubt about capacity; how best to assess capacity when a person is in a coercive relationship.

Publication March 2019 Summary here Full Details: Harry

Linked Research and Resources

Training in South Gloucestershire: Coercive Control Half Day training – details and booking available here

Domestic Abuse Practice Guidance: On the SGSAB website here

Home Care

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult F *Author: Paul Sharkey SAB: Lancashire*

Adult F was an elderly female who lived with her adult daughter, who had been her nominated carer since April 2016. Adult F also had a son, daughter in law and two grandsons who lived nearby. She was under medical supervision for several age related conditions and was in receipt of a care support package from Lancashire Adult Social Care.
Her daughter experienced a serious mental health episode and was detained in a hospital for several days under the mental health act. Unbeknown to agencies she had locked her mother in a bedroom. Although it was made known to some agencies, she had not herself disclosed that she was a carer and the information did not get passed on. Adult F was discovered by her grandsons five days later in a very poor state and was taken to hospital where, after a few days she started to improve.
Adult F's daughter was in contact with several agencies during her mental health episode, none of whom acted to ascertain her mother's wellbeing, despite her daughter's carer's status being known to some of the agencies. Tragically, Adult F died some weeks later of natural causes, albeit there was no causal link between her death and the previous incident. Learning included: Missed opportunities for agencies to have acted to establish Adult F's' safety and wellbeing; The use of interpretation services was not always evident in communication with Adult F; There was no review of the carer's assessment which, had there been so, may have indicated emerging difficulties and that Adult F's daughter required more support to care for her mother.

Publication: February 2019 Full Details: Adult F Learning Brief: Adult F

Safeguarding Adults Review: Mrs F 'It's all about me' *Author: Melba Gomes SAB: City & Hackney*

Ms F is a 44 year old woman who suffers from multiple sclerosis. She has two adult children living with her, her son has cerebral palsy and learning disabilities, and has a live in carer. Her daughter has depression and anxiety and has been diagnosed with multiple sclerosis. Mrs F is cared for in her own home on a profiling bed. She is transferred from the bed via a hoist and she is unable to sit out in a chair for long periods, due to reduced head and trunk control. She requires assistance with eating and drinking, managing continence, and all other activities of daily living. Her communication can be difficult due to dysarthria, as this affects her speech muscles. It is reported that, on 4th September 2017, Ms F's mattress deflated and was later found to be irreparable. It took 7 days before it was replaced. Ms F was found to have a pressure ulcer and was admitted to hospital 4 days later for treatment, where she remained for many months. There was concern when she was initially admitted to hospital that the infection had reached into her bones and that she may need an operation. However she recovered from the infection. The manager of the London Borough of Hackney who chaired the safeguarding meeting that resulted from the concern raised by The Homerton Hospital, regarding the pressure ulcer, informed Ms F of the SAR process. Ms F felt it appropriate that her situation should be looked into, to prevent future risks of a similar kind. The manager made the referral to request a SAR. Mrs F was fully involved with the SAR. Learning included: Management oversight of patients at risk of pressure sores; correct maintenance and labelling of equipment; use of escalation; additional training; promotional of a personalised approach to care.

Publication: January 2019 Full details here

Linked Research and Resources

Training in South Gloucestershire: Details of training for Care Providers here

Organisational Abuse

Safeguarding Adults Reviews

Safeguarding Adults Review: Matthew Bates & Gary Lewis *Author: Brian Boxall SAB: West Sussex*

Matthew and Gary had both been resident at Beech Lodge since 2003. Matthew, 30, was from Surrey, while Gary, 63, came from Camden. Both men have severe learning disabilities as well as physical disabilities. Both men were admitted to hospital on the same day with broken legs. On 29 March 2015, minor bruising to Gary's face was noticed by Beech Lodge staff and reported to West Sussex council's adults' services. The day after, care home handover notes indicated that Gary was taken to an unspecified hospital for a precautionary hip X-ray – for which no reason was recorded – but was not seen as no appointment had been made. On 31 March, the day after returning from a home visit, it was noted that Matthew's right thigh was swollen after he had been hoisted to his bed. The hoisting was carried out by two staff, but Matthew had been taken to his room by just one person, who initially said "he did not need any help", the review said. Matthew was given paracetamol but no further action was taken until the following day, when a nurse expressed concern that his leg could be fractured or dislocated. He was then transferred to hospital by ambulance. On the morning of the same day, 1 April 2015, two carers prepared to hoist Gary onto a shower trolley. "One of the carers then left the room and the second carried on with the hoisting procedure alone," the review noted. After showering it was noticed that Gary's "breathing had altered" and his upper left thigh was swollen – and he too was taken to hospital in an ambulance. A hospital consultant concluded the injuries to both men were unusual and may have been as a result of non-accidental injuries. Recommendations include: ensuring that all agencies' staff recognise the need to report to police without delay, serious unexplained, potentially non-accidental injuries suffered by adults at risk; use of escalation; review of policy and procedures; clear action plans from section 42 enquiries; regular updates about providers/homes where there are concerns.

Publication: April 2018 Full Details: here

Linked Research and Resources

Organisational Abuse Procedures: SGSAB procedures are found on the website here

Homelessness

Safeguarding Adults Reviews

Safeguarding Adults Review: Adult D *Author: n/a paper based review SAB: Wiltshire*

Adult D was 40 years old. He was of no fixed abode but is understood to have been living with a relative in Somerset. We know that Adult D had presented to a Hospital Emergency Department in the South of England in early 2017, reporting symptoms of alcohol withdrawal. He was advised to continue drinking on discharge, to avoid withdrawal, until he could access support. A few days later whilst travelling through Wiltshire, Adult D was asked to leave a train when it stopped at a local station after he was found to be heavily intoxicated and unable to produce a ticket.
In the early hours of the following morning, police were called to a nearby block of flats where Adult D had gained access to a communal area. Officers had difficulty communicating with Adult D, who appeared to speak little English. A local resident called 999 and police staff attended. On finding Adult D to be heavily intoxicated, officers called an ambulance and paramedics attended. Physical checks were not carried out by the paramedics and Adult D was not taken to hospital. Adult D was left with police officers who then took Adult D to a local public toilet block, in which they believed he had indicated he was content to shelter overnight. Adult D was found, deceased, the following morning in the toilet block.
A Coroner's Inquest found that Adult D's death was caused by acute alcohol intoxication and hypothermia. Learning included: A multi-agency protocol should be established to support professionals who are called to attend adults at risk who are highly intoxicated and who pose a risk to themselves and, potentially, to others; When staff from more than one agency are involved in a crisis situation, a formal risk assessment must be carried out and decisions about what actions should be taken agreed and recorded.

Linked Research and Resources

Homelessness Reduction Act 2017: available here

Policy and Practice Briefing from Shelter: available here