South Gloucestershire Safeguarding Adults Board News and Research

Quarter One 2017-18

Self-Neglect

Safeguarding Adults Reviews

Safeguarding Adults Review 'X' *Author: Leighe Rogers SAB: Brighton & Hove*

This SAR relates to the death of X, a 59 year old male, who also sometimes presented as female, sleeping rough in the city of Brighton. The coroner recorded a verdict of 'misadventure to which self neglect contributed'. There was a diagnosis in 2009 of Paranoid Personality Disorder and possible Learning Disability. There were frequent episodes of self harm and self-neglect. X was found in a caravan with a pipe into a sleeping bag attached to the gas cylinder outside. X was known to multiple agencies. Recommendations include: Management oversight of cases which should include assessment of risk, appropriate recording which captures professional judgment and collective agreement where a person's wellbeing is influenced by multiple agencies. The SAB needs to satisfy itself that all agencies who work with the homeless population understand the wider remit and value of Safeguarding Policies and procedures together with their individual agency responsibilities. The SAB needs to assure itself that all agencies represented on the Board who work with people who self-neglect understand and agree the threshold, which makes this a safeguarding issue. Services who work most closely with the homeless population have developed a clearly understood and coordinated assessment, referral and interventions pathway for people with a diagnosed or suspected Personality Disorder based on best practice.

Publication: April 2017 Full Details: SAR X

Linked Research and Resources

RIPfa Blog by George Garrad – Understanding Multiple & Complex Needs available here

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

Substance Misuse/Mental Health

Safeguarding Adults Reviews

Safeguarding Adults Review Carol *Author: Deborah Jeremiah SAB: Teeswide*

This SAR is about Carol, a 39 year old woman. Carol was attacked and murdered in her own home. Two teenage girls aged 13 & 14 were arrested for murder and later convicted and both sentenced to 15 years imprisonment.

Carol had multiple care and support needs, and many agencies had been involved in her life over a number of years. Carol led a chaotic lifestyle, mostly due to her alcohol addiction and personality disorder. Her primary care during the period of the review was from the integrated mental health team. Carol was reported to have fluctuating mental capacity. During the period of the review there were 472 reported incidents to the police. Carol made 219 calls herself. There were 175 police incidents, mostly committed while Carol was intoxicated. A legal order was issued to prevent purchase of alcohol.

Findings include: Lack of clearly defined pathway with appropriate clinical oversight. Lack of join up between commissioning bodies and frontline practice. Understanding of mental capacity & how to assess it is not robust. Lack of clarity about thresholds. Disjointed/lack of links between child and adult safeguarding processes.

Publication June 2017 Full Details: SAR Carol

Safeguarding Adults Review: The Death of 'Tom' *Author: Margaret Flynn SAB: Somerset*

Tom suffered a significant brain injury aged 22, resulting from a road traffic accident in 1993. He also suffered subsequent head injuries in 2011, 2102 & 2013 all associated with being intoxicated. Tom took his own life in June 2014. He had been assessed as being at 'low risk' of deliberate self harm and suicide in October 2013. Services were found to have failed to provide an integrated response to Tom's needs. Tom's family reported that he used heroin and alcohol in addition to prescription medication to treat chronic pain & insomnia. He had a number of accidents when intoxicated. The review says that "A professional-led, multi-agency approach was required and this was entirely absent as gatekeeping criteria and service thresholds meant that he was placed in remained in harm's way"

Recommendations include: Multi Agency training for practitioners using lessons from 'Tom's Story' and an assurance that multi-agency work with individuals with complex support needs is shaped by shared goals and clear leadership. The fact of a person's traumatic brain injury and mental capacity is foregrounded in all professional assessments and referrals and that family involvement is prioritised. Housing partners identify how tenants with extensive support needs, including those with acquired brain injuries, may access supported housing. Review to be shared widely and learning adopted.

Publication June 2017 Full Details: Tom

Linked Research and Resources

Community Care Article Aug 2017 – Social Workers role in supporting adults and alcohol misuse here

Public Health Guidance – Adults with Learning Disability and Substance Misuse June 2017 here

Information for Professionals working with Brain Injury here

Drug and Alcohol Services in South Gloucestershire:

Developing Health & Independence

SGDAS

Health Services

Dementia Care

Safeguarding Adults Reviews

Safeguarding Adults Review: Gladys *Author: Karen Rees SAB: Darlington*

Gladys was an 86 year old woman with a diagnosis of Alzheimer's and Vascular Dementia. She was initially placed in a care home as an emergency when her husband was not coping. After going home, after just 36 hours she was returned to the Care Home permanently on 15th December 2015. Between 15th December 2015 and 14th January 2016 Gladys fell 12 times. She was admitted to hospital on 14th January and was found to have several injuries attributed to the falls. She was placed on an end of life pathway and died on 31st January 2016. The coroner recorded a verdict of accidental death following a succession of falls.

Recommendations included: Development of an effective and succinct information sharing pathway for health professionals to use when visiting care homes to assess residents or to provide advice or treatment. Head Injury policies and procedures that meet NICE guidance are in place in all care settings. Multi Agency guidance is strengthened around strategy discussions. Assessments robustly recorded, including a rationale for not undertaking a full assessment.

Publication April 2017 Full Details: Gladys

Linked Research and Resources

Training in South Gloucestershire:

Dementia Awareness 13th September

Dementia Awareness: Supporting Adults with Learning Difficulties 16th October

Supporting Confident Social Work Practice with People Living with Dementia (May 2017) RIPfa Open Access Learning Resource can be accessed here

Free Resources from Dementia UK here