Adult J - Learning Summary

Background

Adult J resided on a canal boat and had lived in Oxfordshire on and off for several years since splitting with his partner who lived elsewhere in the Country.

He self-reported to professionals that he was drinking heavily from the summer of 2016 and that he occasionally suffered from a low mood.

In early 2016 Adult J got into a relationship with Adult K. There were clear indications of domestic abuse between partners, with both alternating the role of perpetrator and victim. This pattern repeated multiple times until his death in late 2018.

Adult J's history with services was described as challenging by professionals, with a noted unwillingness to engage with services or accept help that was offered.

In the summer of 2017 Adult J suffered life-changing injuries which left him with severe injuries to his hands and impaired his mobility.

He was hospitalised until he self-discharged towards the end of 2017 (against medical advice and without a care package being in place).

In late 2018 Adult J was found deceased. The cause of death was found to be acute alcohol intoxication.

At the request of the family, the Oxfordshire Safeguarding Adults Board (OSAB) are only publishing this learning synopsis. The full anonymised report can be requested by local agencies for internal learning and sharing only. Please send you request to the OSAB Board Support Unit via email: osab@oxfordshire.gov.uk.

Findings and Recommendations

1. **Team around the Adult**

In Adult J's case, it may have been preferable to consider an approach outside the confines of expected policy responses and adopt a 'team around the adult' approach.

This approach (referred to a Team Around the Family in Children's work) focusses on assessing and meeting needs in order to prevent concerns escalating whilst also drawing upon the strengths of the family. The Safeguarding Adults Board may wish

to consider how the Team Around the Family approach might be successfully adapted to the safeguarding of adults.

Recommendation 1
That Oxfordshire Safeguarding Adults Board considers how the Team Around the Family approach might be successfully adapted to the safeguarding of adults who are at risk of abuse or neglect.

Recommendation 2
That Oxfordshire Safeguarding Adults Board disseminates the learning from this SAR and highlights the potential benefits of adopting a 'Team Around the Adult' approach in circumstances in which indicate that this may be of benefit to the person concerned.

2. Self-Neglect

Adult J's self-neglecting behaviour may not have received sufficient attention from agencies. In this case, Adult J's self-neglect appeared to arise from a complex interplay of factors including a sense of loss arising from reduced contact with his children, excessive use of alcohol, the impact of the severe injuries he sustained on his physical and mental health, the difficulty in re-adjusting to life on his houseboat and his exposure to violence, coercion and control in his relationship with Adult K.

Recommendation 3
When disseminating the learning from this Safeguarding Adults Review, that the Safeguarding Adults Board makes use of this case to develop a self-neglect case study to highlight the interplay of factors which contributed to Adult J's self-neglecting behaviour. Additionally, that the Board asks the CCG to remind GP practices of the key role they play in adult safeguarding, including adult safeguarding concerns arising from self-neglect.

3. The Domestic Violence Protection Order (DVPO)

The issue of the DVPO provided a valuable 'breathing space' during which much positive work was done to support Adult J. However, to capitalise on this opportunity, it does require fairly rapid and sustained single agency and partnership working which may not always be achievable given the pressures of competing demands. Additionally, although the police quickly made a safeguarding referral to Adult Social Care, which was entirely appropriate, there is no indication that they actively managed or monitored the DVPO.

Recommendation 4

That Oxfordshire Safeguarding Adult Board shares this SAR report with the Community Safety Partnership so that the factors which contributed to successfully exploiting the opportunities provided by the issue of the DVPO in this case can be replicated in future and areas which might have been improved in this case may also be learned from.

4. DASH risk assessments

There were occasions when opportunities to conduct DASH risk assessments may have been missed. Additionally, the DASH risk assessment conducted by the Thames Valley Police was not informed by the Warwickshire incident, the details of which would have been available from PNC.

Recommendation 5

That Oxfordshire Safeguarding Adults Board shares this SAR report with the Community Safety Partnership so that they can seek assurance that professionals from a range of relevant agencies are able to conduct DASH risk assessments and that when the police conduct DASH risk assessments the PNC is checked for information about relevant prior incidents in that or other police force areas.

5. Recording the names of partners and carers

There were several missed opportunities in GP records to record the name of Adult J's partner and/or carer which, if had he been willing to divulge this information, would have been helpful in gaining as full an understanding as possible of the risk of domestic violence and abuse he faced.

Recommendation 6

That Oxfordshire Safeguarding Adults Board requests NHS Oxfordshire CCG to advise GP practices of the importance of recording details of partners and carers of adult patients.

6. The Canal and River Trust

The Canal and River Trust made two safeguarding referrals in this case which indicated positive levels of awareness of domestic violence and abuse, including coercion and control. However, the potential benefits of working in partnership with the Canal and River Trust were not fully utilised in this case. For example, the Trust appear to have had the authority both to allow Adult J to moor his houseboat in Oxfordshire for an extended period because of his level of disability and the authority to insist on Adult K moving her houseboat elsewhere when the DVPO prevented her from contacting Adult J and therefore fulfilling the role of his carer.

Working more collaboratively with the Canal and River Trust may have helped to safeguard Adult J.

The Canal and River Trust website states that it 'works with support partners such as local health services, council departments or specialist charities, to point boaters to the help and advice available to them if they are identified as having a vulnerability such a suffering from poor mental health'. The Safeguarding Adults Board may wish to approach the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect. Issues which could be explored might include the flagging of houseboats by the police and overcoming difficulties in demonstrating a local connection when a boater might wish to leave the canals and move into supported housing.

Recommendation 7

That the Safeguarding Adults Board approaches the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect.

7. Reasonable Adjustments

Reasonable adjustments, as required by law, were not always considered for Adult J. It is therefore recommended that Oxfordshire Safeguarding Adults Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

Recommendation 8

That Oxfordshire Safeguarding Adults Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

8. Warwickshire Police

The delay in formally notifying Thames Valley Police of the serious incident that occurred in Warwickshire had the potential to increase the risk of domestic violence and abuse faced by Adult J following his discharge from Hospital. The Safeguarding Adults Board may wish to share this report with Warwickshire Safeguarding Adults Board for any action they wish to consider relating to cross border communication of high risk domestic violence and abuse victims.

Recommendation 9

That Oxfordshire Safeguarding Adults Board shares this SAR report with Warwickshire Safeguarding Adults Board for any action they wish to consider.