

1 Introduction:

Jeanette was fifty-eight when she passed away in February 2022. The cause of her death was found to be small cell carcinoma of the right lung. She had been known to mental health services for many years. Jeanette's health records show a period of hypomania in 1984, alongside a diagnosis of manic depression the same year. Jeanette took many overdoses between 1998 and 2007. During 2006 she took four overdoses of her medication, and was sectioned, at this point she received a formal diagnosis of bipolar disorder. Other diagnoses over the years included paranoid personality disorder and obsessive-compulsive disorder, alongside periods of anxiety and psychosis.



Local Safeguarding Adult Review: SAR Jeanette



2 Background:

Jeanette was also known to have problematic alcohol use and physical health issues. Jeanette was diagnosed with hyperthyroidism in 2014, in 2015 Jeanette was recorded as being obese, and was diagnosed with diabetes mellitus in 2016. Jeanette was known to be a heavy smoker. In May 2021 she was diagnosed with lung cancer.

Jeanette was described by practitioners as knowing what she wanted and being very able to communicate this. Jeanette's GP described her as living a chaotic lifestyle, which was linked to her mental health diagnoses and alcohol use.

Jeanette had been in a relationship with Nishtar since around 2018.

7 Resources for Further Learning:

Identify 3 changes in your future practice influenced by the learning from this review.

Access the full published report here: ([Welcome | Trafford Safeguarding Adults Board](#))

3 Background (continued):

Nishtar had a history of violence against partners. He also had mental health conditions and is recorded as suffering from psychosis which was managed by medication which he often did not take.

From April 2021, until her death, Jeanette had been in and out of hospital due to the deterioration in her physical health. In October 2021, Jeanette discharged herself home, against advice of doctors.

Jeanette was found to have bruising to her body. Nishtar was present and professionals noted he was behaving strangely. He was arrested, however following confirmation that Jeanette's cause of death was due to her physical illnesses, no further action was taken.

6 Recommendations (continued):

4) ASC and NWAS to develop processes to ensure follow up is made with the referrer following a safeguarding referral.

5) The development of a carer support/resources page on the Trafford Strategic Safeguarding Partnership site.

6) L&Q to pursue DAHA accreditation in line with best practice.

7) TSSP will develop a multiagency/professional's meeting protocol to assist all agencies to coordinate and facilitate professional's meetings.

5 Recommendations:

1) A learning event to be held to highlight the following:

- The importance of record keeping
- The importance of effective information sharing
- Utilising the MARM protocol
- Awareness of the Escalation protocol

2) Professionals are reminded to not take matters at 'face value', especially when identifying coercive control alongside care and support needs.

3) Partners will be reminded of the availability of specialist domestic abuse services in Trafford.

4 Key Findings:

1: There was a lack of MDTs and professionals' meetings throughout the scoping period for Jeanette.

2: There does not appear to be any point throughout the scoping period for Jeanette, where every organisation involved, was fully aware of all the circumstances.

3: It is not clear that any of the services fully understood or acknowledged Nishtar's coercive and controlling behaviour.

4: Jeanette did not have a care package for much of the scoping period and Nishtar was never identified formally as a carer. It was recognised that Jeanette needed care, and if Nishtar was not her carer, it was not identified who was caring for Jeanette.