EXECUTIVE SUMMARY

OF A SERIOUS CASE REVIEW

IN RESPECT AN ADULT FEMALE

WHO DIED 12TH MARCH 2007
1. Introduction

1.1 This document is intended to provide an overview of the deliberations and recommendations of the Serious Case Review Panel instigated by the Safeguarding Adults Board relating to an adult female who died on 12th March 2007.

1.2 A Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adults in the future.

1.3 This review has been conducted with the provisions of the following documents in mind:

- ‘No Secrets’ – Guidance on implementing and developing multi agency policies and procedures to protect vulnerable adults from abuse – Department of Health 2000
- ‘Safeguarding Adults’ – A national framework of standards for good practice and outcomes in adult protection work – Association of Directors of Social Services 2005

2. Summary of the circumstances that led to a Serious Case Review being undertaken in this case.

2.1 On 1st March 2007 a 43 year old woman was admitted to hospital via an ambulance which she had called. She was found to have a fracture to the neck of her left femur and was referred for orthopaedic treatment.

2.2 Following surgery she was also treated for alcohol withdrawal but deteriorated and had a fit. She was transferred to the Intensive Therapy Unit where the diagnosis was:

- Hepato-Renal Failure
- Alcoholic Liver Disease
- Left fractured neck of femur - infected

2.3 She died on 12th March 2007 having never regained consciousness with the medical cause of death being established as liver failure, alcohol cirrhosis, renal failure and septicaemia in addition to the infected fracture.

2.4 A Police investigation resulted in a file being submitted to the Crown Prosecutor who decided that no proceedings could follow.

2.5 It is anticipated that HM Coroner will preside over an inquest in due course.
3. Terms of Reference

3.1 The terms of reference set by the APC, with a timescale requiring the review to report to their meeting of 6th March 2008, were:

- To review the circumstances of TS’s death and to establish if there are lessons to be learnt from how local professionals and agencies worked together in this case
- To consider events from 2003 to the 1st March 2007 with particular focus on involvement of agencies in 2006 and 2007
- To look at both individual agency and multi agency practice to identify any areas of weakness in current inter agency arrangements and to examine if and what other agencies should have been involved
- To consider what are the learning points from the situation (i.e. staff understanding of capability, the management of capability and the management of risk) and what, if any, steps could be taken to avoid a similar incident occurring in the future.

3.2 In working under these terms of reference the panel took cognisance of the fact that the safeguarding adults discipline is very much still under development and many of the events involved pre-dated such progress.

4. Process of the Serious Case Review

4.1 The review was undertaken by a Serious Case Review Panel, chaired by an Independent Person. The other panel members consisted of representatives from:

- Cornwall Partnership Trust
- The Multi-Agency Safeguarding Adults Unit
- Cornwall and Isles of Scilly Primary Care Trust
- Cornwall Department of Adult Social Care
- The District Authority Housing Department
- Devon and Cornwall Constabulary

4.2 Individual agency management reports were provided by these agencies (with the exception of the multi-agency unit). Further written submissions were considered from a general practitioner and the ambulance service and follow-up interviews took place in some cases.

4.3 The Chair of the Panel met with members of the family in order to identify and seek to address their concerns.
5. **Key issues**

5.1 The subject of this review moved to live in county in 2003 with her then partner, initially residing in private rented accommodation. She had been married but had no children. She had for many years been prone to drink to excess with information indicating that this could change her from “a lovely young woman, who everybody loved” to one who could become violent.

5.2 In 2003 she had a stroke but discharged herself from hospital after three days. As a consequence of this stroke she was left with speech difficulties restricting her capacity to express herself with ease.

5.3 Following the stroke she received help in the community and as an outpatient from health professionals (in particular a specialist nurse until 2006). She was referred to Social Care in June 2004 by this nurse but this was not followed through as she had moved address and it was agreed that she would re-contact the service if she wanted support.

5.4 A further referral was made by the specialist nurse for a mental health assessment which was conducted and concluded that she had no severe or enduring mental illness; as a consequence she was referred back to her primary care team.

5.5 The local authority provided support in respect of housing services leading to the occupation of social housing on a joint-tenancy basis with her then partner in December 2004. Prior to this accommodation being allocated Police had been involved in September 2004 when she made allegations of assault against her partner – counter allegations were made and Police warned both parties. Similar incidents occurred in October 2004, June and July 2005. Following this latter incident the partner was taken to court where he was bound over and ordered to pay compensation despite the victim withdrawing from the proceedings.

5.6 Also in July 2005 a tenancy support officer (TSO) referred the matter to Social Care but their assistance was declined. The TSO had predicted this would happen if she was telephoned rather than visited, which is what happened.

5.7 In August 2005 an emergency “lifeline” button was installed at the address by Housing, who also rendered other support.

5.8 In October and November 2005 the partner was subject to civil proceedings which resulted in a non-molestation order being made against him and an occupation order (meaning he lost joint-tenancy rights). He was arrested within days for failing to comply with the former but due to a misunderstanding the latter was not notified to the housing provider until early 2007. It does not appear that this was a systemic failure and as a consequence no remedy is proposed.
5.9 It is apparent that through 2006 both the Police and Social Care were not involved and there is clear evidence that the subject had addressed her drink problem and was abstaining “House immaculate and no sign of alcohol.”

5.10 Anecdotally it appears there was an incident at the home on Christmas day involving her former partner but what is certain is that on 31st January 2007 a neighbour reported to the GP surgery that she had fallen. Advice was given that she should attend the Minor Injury Unit and a visit was declined.

5.11 Police also attended on this day and found the house to be in a very poor state with faeces and urine on the floor. The ex-partner was present and although she did not want him to stay long-term she agreed to him remaining overnight. The Police concluded that she was clearly under the influence of alcohol. It has been suggested that her speech difficulties may have led the Police to make an error in drawing this conclusion. This is possible but considered to be unlikely in view of the later evidence of alcohol when she was admitted to hospital.

5.12 The Police made a referral to Social Care, recorded as an "adult referral" on 1st February 2007. Social Care spoke with her by telephone the following day (020207) but she did not wish them to attend but agreed to a visit on 5th February, 2007. Police had attended again on 3rd February 2007 to intervene in an argument with her former partner but on neither occasion did they take ownership of the situation, i.e. insist upon action or make a clear "Adult Protection Alert."

5.13 Social Care and Police made a formal assessment, took some steps to deal personally with the state of the premises and follow-up visits were made. Care Agency workers were allocated to assist in showering 3 times a week but help to properly clean the house was refused. (She later consented to a cleaning company being called in to remedy the situation, they provided an estimate but this had not been actioned before her hospital admission). Again no Adult Protection Alert was made, a matter of regret with hindsight by the workers involved.

5.14 Part of the ongoing care did involve a referral which resulted in the attendance of a district nurse to treat a skin condition. The nurse suspected a more serious injury to the hip and sought to persuade her patient to attend hospital or allow a doctor to examine her. She refused both.

5.15 The nurse later discussed this with a GP and it appears their recollection of the conversation differs. No notes are available as the nurse’s notes have not been located (they are routinely held by patients in their home) and none were made on her medical file (this has led to recommendation 1).
5.16 Various of the professionals involved, police, health and social care dealt with issues that presented themselves, sometimes cooperatively, within the constraints present when an adult declines consent. They did not, however, invoke the Adult Protection Procedures which were available to them which may well have resulted in a more holistic and coordinated approach being taken, involving all relevant agencies. As the Adult Protection Procedures involved are comparatively new this is likely to be linked to the need for more quality training (recommendations 2 and 3).

5.17 The panel sought to locate the nurse’s notes without success but this highlighted the need for Safeguarding Adults Serious Case Reviews to work effectively in partnership with HM Coroner, recognising the Coroner’s primacy (recommendation 4).

5.18 It became apparent to the panel that if an Adult Protection Alert had been made in early 2007 it is possible that agencies with a current involvement would have been involved but it was equally evident that other agencies, such as the Cornwall Partnership Trust, may well have been able to assist in tackling the issues effectively (recommendation 5).

5.19 The Cornwall Partnership Trust has recognised the need to ensure adult safeguarding is included in the core assessment in all cases and this is commended to other agencies involved (recommendation 6).

5.20 In support of recommendations 2 and 3 above it was considered that the Police may be in a position to lead in auditing compliance, once quality training can be assured, thus providing the SAB with valuable material to help drive up standards across agencies (recommendation 7).

5.21 There has long been a Police policy of positive action in respect of domestic violence but the facts of this case have indicated that this action is less obvious if the violence suspected is not recent. The Force is already reviewing it’s policy in this respect (recommendation 8).

5.22 Social Care have proposed system and structural changes which are intended to ensure that a more complete and properly coordinated response is given to issues of safeguarding adults (recommendations 9 – 11).
6. **Summary of Recommendations**

6.1 Recommendation 1 (Health)

It is recommended that the PCT review their contractual requirement for accurate and contemporaneous record keeping with all providers including General Practitioners. This review should address issues of adherence and information sharing, making agreements binding. These requirements should be subject to regular audit and review.

6.2 Recommendation 2 (Multi-agency)

It is recommended that in multi-disciplinary training across agencies that clear reference is made to the fact that every professional has a duty of care to an individual and that this duty cannot be discharged through another individual or agency without a formally recorded agreement.

6.3 Recommendation 3 (Multi-agency)

It is recommended that the Safeguarding Adults Board (formerly the APC) satisfies itself by ongoing audit as to the extent and efficacy of multi-disciplinary training across agencies including the PCT and in particular take up by General Practitioners.

6.4 Recommendation 4 (Safeguarding Adults Board)

It is recommended that the Safeguarding Adults Board negotiate with HM Coroners a protocol to permit timely access to relevant data, within the coroner's jurisdiction, for the purpose of progressing a Serious Case Review.

6.5 Recommendation 5 (Multi-agency)

It is recommended that agencies calling a multi-agency meeting in respect of a potentially vulnerable adult extend the invitation to all agencies whose expertise may provide a contribution to the outcome regardless of the agency’s prior or current involvement with the client and that all agencies have a responsibility to ensure they are represented.

6.6 Recommendation 6 (Multi-agency)

It is recommended that the work commenced by the Cornwall Partnership Trust to ensure adult protection is considered as part of the core assessment in all cases is replicated by all agencies and that senior managers monitor compliance by inclusion in audit processes and in performance measurement figures.
6.7 Recommendation 7 (Police)

It is recommended that the Police instigate an ongoing audit of compliance with Adult Protection procedures by frontline staff once satisfied that appropriate training has been delivered.

6.8 Recommendation 8 (Police)

It is recommended that Devon and Cornwall Police review and revise policy in respect of domestic violence so as to require staff to be vigorous in investigating information which may indicate historic incidents affecting vulnerable people.

6.9 Recommendation 9 (Adult Social Care)

It is acknowledged that DASC is currently developing a standard for assessment and care planning as part of a quality Assurance framework. It is recommended that this work is completed by June 2008

6.10 Recommendation 10 (Adult Social Care)

It is recommended that DASC continue to embed adult protection procedure in frontline practice by ensuring processes for management audit and oversight and through the current re-structuring process identify a smaller number of Care Managers (Team Managers) to take on the role of Adult Protection Coordinating Manager to facilitate a robust and consistent response.

6.11 Recommendation 11 (Multi-agency)

It is recommended that a domestic violence awareness programme is put in place for frontline staff ~ 25% of adult protection referrals are related to domestic violence therefore it is important that frontline staff have awareness and understanding of domestic violence issues.
7. **Conclusion**

7.1 The panel reviewed information provided by agencies and, where necessary, sought clarification so as to ensure as full a picture as possible was gained of how local professionals had engaged with the victim and each other.

7.2 As is evident above in several instances the immediate response was adequate or even commendable and that several individual professionals managed to strike up an effective relationship with the client. It is a matter of conjecture whether or not the involvement of these individuals during the significant first two months of 2007 could have altered the outcome. That said the gap between consensual and enforced treatment is large and the involvement of individuals with a history of effective interaction with a vulnerable adult is an opportunity worthy of exploration.

7.3 Had Adult Protection Procedures been formally instigated, particularly during the first two months of 2007, then decision-makers may have had an opportunity to take a more holistic view, potentially involving those professionals who had an established relationship with their client.

7.4 The background shows that there were other instances where a more joined-up approach would have been beneficial and the issue of owning a problem until it is formally dealt with, rather than assuming that others are doing what is necessary or making a referral to another agency was evident.

7.5 The agencies concerned and the reaction of individual professionals indicate a willingness to learn and an acceptance with hindsight that an alternative course of action may have been better, rather than being defensive. It is to be hoped that this attitude can be shared with colleagues so that the lessons learned out of this case can be of benefit to others.