Northamptonshire
SAFEGUARDING ADULTS

Independent Case Review

Overview Report

MC

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Northamptonshire Safeguarding Vulnerable Adults Board

MC Independent Overview Report

1 Introduction

1.1 MC died in Kettering General Hospital on 29 November 2009, whilst receiving in-patient treatment. He had learning disabilities and communication difficulties, in addition to the health issues being treated at the time of his death. MC had been living in residential care for some years and at the time of his death, was resident at a care facility within the county of Northamptonshire; his social care was funded through Hertfordshire County Council.

1.2 Following his death, Kettering General Hospital Trust (KGH) initiated an internal review, using 'Root Cause Analysis' (a standard methodology for KGH), and Hertfordshire County Council made a safeguarding referral to Northamptonshire County Council (NCC), raising questions and expressing concerns about aspects of MC's care, leading up to his death. As a result of the safeguarding referral, multiagency discussions took place and a safeguarding investigation was initiated. These two processes commenced within a few days of MC's death. The KGH internal review, through root cause analysis, was completed in February 2010 and the report finalised in April 2010. The safeguarding investigation commenced in December 2009 and was inactive by late summer 2010 but not formally signed off; it was re-opened in December 2010 and a case conference held in February 2011, but the investigation was not signed off, pending receipt of an independent medical report.

1.3 In addition to the KGH root cause analysis and the safeguarding investigation, AG lodged a formal complaint with KGH in April 2010, in relation to the care provided to her brother. In September 2010, KGH commissioned a report from an independent medical consultant, to review the care provided to MC prior to his death. This was completed in May 2011. AG lodged a second complaint in November 2010, in relation to delays in completing the investigation process and communication issues with Northamptonshire County Council. AG also lodged a complaint with Northampton General Hospital Trust in January and February 2011, regarding the appointment MC had attended for a PET scan. MENCAP provided support to AG through the complaint processes.

1.4 Under the terms of the Northamptonshire Safeguarding Vulnerable Adults Procedures, the decision as to whether or not to hold a Serious Case Review on any particular case, is the responsibility of the Northamptonshire Safeguarding Vulnerable Adults Board, and is exercised through their Serious Case Review sub-group. In February 2011, the Serious Case Review (SCR) sub-group of the Northamptonshire Safeguarding Vulnerable Adults Board (SOVA Board), received a referral from NCC, that a Serious Case Review be considered, as the safeguarding investigation had determined that allegations about the care of MC prior to his death, were partially substantiated and it was considered that there were lessons to be learned. At the time, the independent review commissioned by KGH, from an independent medical consultant, was not complete. The SCR sub-group were advised of the investigations and reviews which had already taken place, and in March 2011, the SCR sub-group requested individual management review reports (IMRs) from the relevant agencies, concentrating on the actions taken after MC's death; the IMR reports were to include lessons learned and a combined chronology of events for the period immediately following MC's death up to the date of the SCR sub-group in February 2011.

1.5 The SCR sub-group met again in May 2011, to consider the reports provided. At that point, the first report from the independent medical consultant was available but a supplementary report was not. The SCR sub-group concluded that an independently authored Overview Report should be commissioned and that the focus of that independent Overview Report should be on the multi-agency responses after MC's death. The main argument for this focus was that MC's death was primarily a matter related to KGH and they had already commissioned an independent medical review of the circumstances of MC's death in addition to conducting their own internal review, then devising and implementing an action plan to address the lessons learned. The SCR sub-group decided that the independent person should review the documentation already available to the SCR sub-group, and create an overarching report which would identify any lessons and potential actions for the SOVA Board to consider. This approach was recommended to the SOVA Board and agreed. The decision to adopt this approach was informed by the newly proposed regional framework for conducting SCRs; this model provides for four levels of review processes, representing different ways of reviewing cases, according to the circumstances of the case and varying levels of independence, as appropriate to the nature of the situation The independent Overview Report was then commissioned in July 2011.

Terms of Reference

1.6 The basis for commissioning this overview report is included in the minutes of the SCR Sub-Group of 23 May 2011 as follows

'Based upon the work taken place commissioned by SCR sub-group to date, we believe it is necessary to commission an independent report that will identify lessons learnt and actions for the SOVA Board and said lessons and actions can then be managed and monitored through the Board.

The decision to commission an independent report, rather than an SCR, was based upon three key principles:

i) That [MC's] death is primarily a matter related to KGH;

ii) That post his death materials produced confirmed that there are cross-agency issues and lessons that can be learnt pertinent to the work of the SOVA Board.

iii) That the recommendation builds on substantial work that has already taken place.'

Methodology

1.7 The Serious Case Review sub-group determined that this independent Overview Report should be a 'desk-top' analysis of various documents submitted to the SCR Sub-Group, focusing on the agency actions taken after MC's death. The assumption is made that the documents and points of clarification provided through drafting, provide an accurate and full account of each agency's actions in the period under review. The analysis has been based upon the content of the following documents.

- Kettering General Hospital Foundation Trust (KGH) management review report and associated action plan
- Independent review report and supplementary report commissioned by KGH, from Dr B
- Northampton General Hospital management review report
- Northamptonshire County Council (NCC) management review report
- Combined chronology report

Additional documentation supplied for reference comprised the following

- Northamptonshire Safeguarding Vulnerable Adults Board Inter-agency Safeguarding Adults Procedure v1 2007
- Northamptonshire Safeguarding Vulnerable Adults Board's Inter-agency Safeguarding Vulnerable Adults Procedure v2 November 2010
- Northamptonshire Inter-agency Serious Case Review Procedure
- Information about proposed new framework for case reviews within the East Midlands

The report is structured to provide the main report, summarising the key facts and providing analysis, conclusions and recommendations, together with three appendices. Appendix 1 provides the chronology, collated from the agency reports; Appendix 2 provides a shorter summary of key events; Appendix 3 provides a glossary of the abbreviations used.

The Author

1.8 The author has 35 years experience in social care and working in partnership with health agencies. This includes nine years at Chief Officer level in the statutory roles of Director of Social Services and Director of Adult Services and seven in the (then) Department of Health National Inspectorate – Social Services Inspectorate. She has previously undertaken case and performance reviews.

2.0 The Facts

2.1 MC was born on 31 May 1960. He had Down's Syndrome, a significant level of learning disability, complex needs and suffered from epilepsy. Key family for MC was his sister, who did not live in Northamptonshire.

2.2 MC had been living in residential care since 1994. At the time of his death, he resided in a residential care home in Northamptonshire and his daily care was, therefore, provided by the carers employed at the residential facility where he lived. MC had originally been a resident of Hertfordshire; Hertfordshire County Council placed MC in the residential home in Northamptonshire and also continued to be the responsible funding authority; Hertfordshire retained the care management responsibility for MC. This made Hertfordshire CC the 'placing authority' and NCC the 'host authority'. In addition to being resident in a care home, MC had attended an NCC day care centre since February 2006.

2.3 MC had contact with primary care services, outpatient contacts with KGH and a service commissioned by them from an external health provider (for a PET scan), and also three admissions to KGH over the course of October and November 2009. He died in Kettering General Hospital on 29 November 2009. (Note, the NCC report refers to the date of death as 30.11.09; the assumption made here is that the correct date is the one referenced by KGH).

2.4 The Chronology at Appendix 1, gives the detail of actions and events, as reported by the agencies. It shows that there were three processes running between December 2009 and February 2011. The first was the KGH internal review, undertaken using Root Cause Analysis (RCA), and which was initiated on 3 December 2009; the second was the safeguarding investigation which was led by NCC, prompted by the safeguarding alert sent to NCC by Hertfordshire County Council on 2 December 2009; the third was the complaint process as AG formally complained on 26 April 2010 about KGH's care of her brother and on 1 November 2010, about unacceptable delays in the process and lack of communication from NCC. AG made a third complaint in January/February 2011, to Northampton General Hospital (NGH), in relation to MC's PET scan appointment.

The following sections summarise the key aspects of these three processes.

KGH Internal Review

2.5 KGH initiated their internal review, to examine the unexpected death and consider whether reasonable adjustments had been made given MC's communication and mental capacity issues. The internal review included a review of medication (which was undertaken by the pharmacy department), the compilation of information from a range of staff interviews and a review of case notes. Their first draft of this report was released internally for comments on 8 February 2010. It was available for the KGH 'Lessons Learned' working group on 8 February and was also available for the case conference meeting held as part of the safeguarding process, on 12 February 2010. AG provided comments on this report – both amendments and also issues that she considered were not addressed. KGH provided a final version of the report to AG in April 2010 and met with her to discuss her outstanding concerns in 10 May 2010.

2.6 KGH undertook various follow up to their internal review, including a documentation audit, the results of which were considered in May 2010; discussion at their internal 'Lessons Learned' group in February and May 2010; an 'after actions review' (ie a review to check progress and what actions had been completed) in July 2010; and discussion at the surgical and medical Clinical Management Teams in September 2010. The implementation of

actions was monitored through the KGH Quality Governance Board during 2010. At the point where the agency report was prepared for this case review, all actions arising from the internal root cause analysis process had been completed, except for one relating to the Intensive Care Unit and that was underway.

2.7 The KGH Trust summarises the key findings from their internal process as improving staff knowledge for

- ensuring reasonable adjustments
- supporting MC
- communication with family and carers

Safeguarding process

2.8 The safeguarding process was prompted through the safeguarding alert made by Hertfordshire County Council, to NCC on 2 December 2009. The alert was followed up by a formal referral on 3 December. The concerns raised by Hertfordshire centred on MC's care in Kettering General Hospital and the alleged lack of 'Best Interest' assessment in relation to MC's mental capacity. NCC duly initiated the safeguarding process and were in contact with various people and agencies, from 3 December in preparation for, and up until, the Safeguarding Strategy Meeting which met on 16 December 2009. These contacts included representatives from Hertfordshire County Council, the community nursing learning disability service in Hertfordshire, various KGH staff, Nursing representatives from Northamptonshire NHS Provider Services and NCC's own learning disability service.

2.9 The Strategy Meeting received written reports from both attendees and others who did not attend. Attendees at the meeting were:

- NCC's Principal Care Manager (PCM) from the Safeguarding Adults Team (SAT).
- AG and her husband.
- Learning Disability Community Nurse, Watford.
- Assistant Team Manager Hertfordshire County Council.
- Manager and Deputy Manager of MC's care home.
- KGH Named Nurse for Safeguarding.
- NCC Care Manager (CM) from the Safeguarding Adults Team.

A number of issues and actions were recorded as follows:

- MC's care plan was available to KGH staff but was ignored.
- Staff from KGH were not available to give appropriate supervision.
- Staff from KGH did not consult the notes.
- Family were not contacted towards the end of MC's life.
- Did MC receive appropriate medical attention?
- Standards of customer care need to be looked at.
- Was a multi disciplinary discussion held as to how to best meet MC's medical needs?
- Was MC given the correct medication?
- Why were MC's family not told of his deteriorating condition?
- Named Nurse for Safeguarding Adults KGH to address the issues re KGH.
- Care Manager to speak to Care Quality Commission (CQC) re protocols that should have been in place.
- Care Manager to coordinate next meeting to enable all investigation information to be brought together and to agree next steps.

The minutes of this meeting of 16 December 2009, were provided to AG on 3 February 2010 (and presumably also at this point to all other attendees) and she replied with amendments.

2.10 On 13 January 2010, the CM and the KGH Named Nurse for Safeguarding, met to review the safeguarding investigation to date. They identified a number of outstanding concerns to be addressed.

2.11 On 5 February CM wrote to the GPs for information to contribute to the investigation.

2.12 A case conference was held on 12 February 2010, to review information and progress. The internal review report from KGH was circulated at the meeting and included in the deliberations. Attendance at this meeting was:

- PCM (who chaired the meeting).
- CM.
- AG and her husband.

- KGH Named Nurse for Safeguarding.
- KGH Head of Nursing for Surgery.
- A Representative from Hertfordshire County Council.
- A representative from the community learning disability nursing service in Watford.
- Manager and Deputy Manager from the care home.

The actions recorded were:

- Care Manager to stay in contact with AG and collate all issues.
- Named Nurse for Safeguarding Adults KGH to liaise with AG about finding a resolution.
- Head of Nursing for Surgery KGH to contact the General Medical Council about MC's hospital doctor.
- Safeguarding lead, KGH, to obtain list of all medication given to MC.

In the concluding note, the minutes state that the allegation of neglect could not as yet, be substantiated.

However, there was a considerable delay, of two months, in the initial circulation of these minutes; suggested amendments were provided but were never dealt with and the minutes were never agreed as an accurate record of the meeting, so remain on file as unapproved.

2.13 Between 14 February 2010 and 21 February 2010, there were several email exchanges between AG and CM, where AG raised issues about the KGH report. CM agreed to pass these forward to KGH, including her view of the need for independent medical advice. AG provided her detailed comments on the KGH report provided to the case conference on 12 February, in an email of 21 February to CM and this was forwarded to KGH, at a date not specified in the agency reports, but CM confirmed to AG that she had done so in an email of 8 March 2010. There is also a record that CM emailed KGH Head of Nursing for Surgery, on 26 March 2010, attaching a message from AG about her concerns regarding issues omitted from the KGH report.

2.14 CM continued to pursue and receive information from the GPs during February 2010.

2.15 On 30 March 2010, AG emailed CM, asking for a copy of the minutes from the case conference meeting of 12 February 2010. These were not yet ready for circulation at that point – CM indicated that they still needed to be checked for accuracy. The agency reports do not indicate when the minutes were distributed, but AG referred to them in an email of 11 April 2010 and it is now clear that the initial draft minutes were circulated some two months after the case conference but were never finalised or agreed as an accurate record of the meeting.

2.16 Further email exchanges took place between CM and AG during March through to 21 April 2010, where AG expressed her concern that the meeting between herself and KGH, agreed at the case conference on 12 February, had still not been arranged. She expressed particular frustration at an email of 9 April from CM, in which AG was asked whether she wanted to meet representatives from KGH, or receive a written response to the issues she had identified as missing from the KGH report; AG was clear that she was expecting a meeting, as agreed on 12 February 2010. As described above, it should be noted that there is no approved set of minutes from the case conference of 12 February and the unapproved minutes do not reference a meeting being arranged with AG. CM was apparently conveying a message from KGH in raising this question about the choice of a meeting or written response. On 21 April 2010 CM requested a discussion with her Principal Care Manager about making a response to AG on this matter. The agency report does not indicate whether this discussion took place or whether a response was made.

2.17 In these email exchanges, AG continued to raise concerns and ask for outstanding information eg the pharmacy review and information about medication from the GPs. CM recorded on 15 April 2010, that copies of the GP letters were sent to AG, along with the final version of the KGH report. CM also contacted the care home on 21 April, regarding medication prescribed by the GP and was advised that it had been administered as prescribed.

2.18 On 26 April 2010, CM finalised her safeguarding investigation report and passed it to her Principal Care Manager for consideration, prior to it being submitted to the Safeguarding Team Manager and Service Manager. On 17 May 2010, CM again emailed her Principal Care Manager, to ask whether he still had her investigation report. By 24 May 2010, the Safeguarding Team Manager had received the report and had reached the view that the allegations were 'partially substantiated' as there was no evidence of wilful neglect ('partially substantiated' is one of four possible categories of finding in a safeguarding investigation, under the Northamptonshire Inter-agency Safeguarding Procedures; the other categories are substantiated, not substantiated and not determined). The Team Manager also expressed the

opinion that the report should be submitted to senior managers, to consider whether a Serious Case Review (SCR) should be held, as he believed that there were lessons for local agencies to learn. CM conveyed this view about holding an SCR, to AG on 25 May 2010, although there had been no senior or multi-agency discussion on the matter at that stage. On 21 June 2010, CM updated her safeguarding report, to include the opinion of the Team Manager regarding consideration of holding a Serious Case Review. She also drafted a letter to AG, giving the outcomes of the investigation. This letter required approval from the Principal Care Manager. Before receiving that approval, CM emailed AG requesting her home address details so that the outcome letter could be sent to her. AG, having been advised to expect the letter, emailed CM on 5 July 2010, to say she had not received it. However, the letter to AG was never sent as it was never signed off by the Principal Care Manager, although CM did prompt on 12 July 2010.

2.19 On 10 June 2010, KGH asked NCC for an update on the safeguarding investigation. (Note the KGH report for the SCR sub-group refers to both June and July 2010, but it seems likely that June is the correct date). They were informed that the report had been passed through to the Service Manager for decision. They heard no more at this point and assumed that the matter was closed.

2.20 The agency reports do not refer to any further actions on the safeguarding process until prompted by AG's complaint of 1 November 2010. The NCC Service Manager and Safeguarding Adults Team Manager visited AG and her husband on 22 December 2010. They apologised for the delay and associated distress and also in prematurely leading them to believe that a Serious Case Review had been commissioned. AG, however, was clear that she wanted an SCR to take place. NCC confirmed that the safeguarding investigation would be re-opened from the point of the case conference in February 2010 and that a further case conference would be held on conclusion of the investigation.

2.21 Further discussions and document reviews took place between NCC and KGH during January and February 2011, with a view to update and completion of the investigation. A case conference was then held on 16 February 2011, at which AG was present. The issue of the un-amended and unapproved minutes of 12 February 2010 was discussed and it was agreed that the minutes could not be used as an accurate record of the meeting and that too much time had elapsed to now amend the minutes. AG continued to raise questions about her brother's final days in hospital, at the meeting. It was decided that the investigation should not be closed at this point as the (second) report from Dr B was not yet available. The meeting agreed to reconvene on 31 March, by which time, it was anticipated that Dr

B's report would be available. The meeting did not take place, however, as the report was still not available.

2.22 Although the safeguarding investigation was not fully completed, a referral was made to the SCR sub-group, to consider holding an SCR for MC's case and this was presented at the SCR sub-group meeting of 24 February. The ensuing discussion was the trigger for requesting, on 30 March 2011, that each of the relevant agencies prepare management reviews and that a combined chronology also be prepared.

Complaint Process

2.23 AG lodged her complaint against KGH on 26 April 2010 and this was acknowledged on 4 May 2010. Her complaint centred on aspects of her brother's treatment, whether KGH staff sufficiently understood how to respond to people with disabilities and also whether her brother's limited communication had impacted on his care and treatment. AG had expressed the view, in email exchanges following the February case conference, that an independent medical review was necessary. It is not clear from the agency reports, whether this was also discussed at the meeting between KGH and AG in May 2010, held to discuss the KGH review report. On 3 August 2010, KGH wrote to AG confirming that a review would be undertaken by an independent medical consultant. AG wrote to KGH on 27 August 2010 asking for an update on her complaint. The consultant undertaking the independent review was identified and terms of reference plus case information were sent to Dr B on 1 September 2010. On 22 September, KGH wrote to AG again confirming that an independent medical review was being commissioned. On 11 November 2010, KGH wrote to AG to update her on progress of this review. The KGH Trust Board considered Dr B's report on 26 November 2010 and a meeting was arranged with AG and her husband, to discuss the report on 21 December 2010. At this meeting, it was agreed that a second report would be commissioned from Dr B, focusing on the final week of MC's care. Also at this meeting, KGH acknowledged failings to make reasonable adjustments for MC and in assessing MC's mental capacity for decision making.

2.24 AG wrote to NHS Northamptonshire on 1 November 2010 with a further complaint about delays and lack of communication from the NCC Adults Safeguarding Team and also continuing issues regarding the KGH report. NHS Northamptonshire passed the complaint on to NCC on 12 November 2010. NCC decided to begin an investigation, on 19 November 2010. Following internal discussions on 3 and 7 December 2010 to consider a response to AG's complaint, NCC decided to suspend a member of staff and

this was effected on 8 December 2010. NCC met with AG and her husband on 22 December 2010. They apologised for the delays in concluding the safeguarding investigation and for any distress caused. They also apologised for prematurely leading AG to believe that a Serious Case Review (SCR) would be undertaken. They confirmed that the safeguarding investigation would be reopened from the point where the safeguarding meeting of 12 February 2010 took place. AG conveyed her view that she would still want a SCR to be undertaken.

2.25 On 23 December, KGH received a letter dated 20 December 2010, from MENCAP, on AG's behalf, welcoming the independent medical review and also asking for several additional points to be considered.

2.26 KGH wrote to AG on 4 February 2011, to give a further update and this included the KGH response to MENCAP's letter of 20 December 2010, with the exception that, as Dr B's second report had not yet been received, KGH did not respond to points related to his report. However, KGH did include:

- KGH's general action plan following Dr B's first report.
- KGH learning disabilities action plan.
- A letter from the Medical Director answering AG's questions.
- Response to MENCAP's questions.
- Notes of the meeting held 21 December 2010.
- Complaint update letter.

2.27 KGH summarise their conclusion of the complaints process as:

- The KGH Trust accepted that reasonable adjustments for MC were not consistently made and that mental capacity assessments were not always considered.
- The KGH Trust accepted that it did not investigate the issues raised by AG regarding a scan commissioned from another health provider.
- The KGH Trust accepted the findings of Dr B's first report.

KGH advises in its agency report, that the complaint was dealt with in line with the KGH Trust policy, although they acknowledge that they failed to connect with Northampton General Hospital Trust, regarding aspects of the complaints that concerned the PET scan appointment.

2.28 AG wrote to Northampton General Hospital Trust (NGH) in January and February 2011, regarding her questions and concerns in relation to the appointment MC attended for a PET scan. The PET scanner was sited at that hospital but contracted to an independent provider. This correspondence was treated as a formal complaint and the NGH Trust liaised with the scan provider, in order to respond to the complaint. The Trust wrote to AG on 24 March 2011, to extend the timeframe for responding to the complaint and a final written response was provided, dated 13 April 2011.

3. Analysis

3.1 This Overview Report is considering the period after MC's death and so there will be no discussion of the circumstances leading up to his death. Similarly, this report will not reproduce all of the commentary, analysis and recommendations produced through the individual agency reviews or the independent medical review. It is appropriate, however, to ask whether the agencies were right to make the decision to review the situation and also whether they then proceeded in an appropriate and timely manner. Reference will be made to safeguarding procedures current at the time and the new ones adopted in November 2010, as appropriate.

3.2 Given the nature of the concerns expressed about the circumstances of MC's death, the situation would fall within the principles and criteria for considering a safeguarding investigation, under the terms of the local Northamptonshire safeguarding vulnerable adults procedures. Considerations would have been under the definitions of neglect, acts of omission and also potentially under discriminatory abuse. Equally, the setting of a hospital is not excluded from considerations of safeguarding. It was therefore appropriate that the concerns over MC's death were treated as requiring examination both internally by KGH and through a safeguarding process. Thus the decision by Hertfordshire County Council to make the referral and by NCC to treat the referral as requiring a safeguarding response, were in keeping with the safeguarding expectations. Other organisations could potentially also have lodged an alert or initiated discussion about whether the situation warranted a safeguarding response, as discussed below.

3.3 KGH initiated internal consideration of MC's death very quickly, through notification internally and subsequent discussion over the next few days. There is no doubt that KGH were correct in initiating an internal review and to do so promptly. However, there is a question in this author's view, as to whether or not KGH should also have initiated a safeguarding referral to NCC. It might be argued that some level of investigation needed to occur before KGH were in a position to make such a referral; however, the decision to hold

a root cause analysis review, the inclusion of the KGH safeguarding lead in the discussion, and the fact that the question was raised in these discussion as to whether MC's mental capacity was appropriately considered, all indicate that there was some level of concern about MC's death which would be appropriate to at least discuss with NCC, as lead safeguarding agency, in terms of the possibility of it meeting local safeguarding criteria. This would be in addition to the internal review and the two processes would run simultaneously.

3.4 In similar vein, the NCC agency report does not address whether it would have been appropriate for the care home to raise a safeguarding alert with NCC. It is evident that the care home promptly and appropriately, contacted Hertfordshire County Council, as the placing and funding authority. The agency report indicates that the home conveyed their concerns about the circumstance of MC's death. Although it is not specifically referenced in the agency report, the home would also have had a duty to notify the Care Quality Commission (CQC) of the death, as required through regulation. Neither does the report say whether the NCC contracting service was notified by the home, of MC's death and their concerns, although this kind of information exchange would be dependent on the local contracting protocols to some extent. However, although Hertfordshire was the funding authority, it is clear that the lead responsibility for safeguarding lies with the host authority – NCC in this case. Local procedures refer to the responsibilities of care providers to raise safeguarding alerts to NCC as the 'host' authority. If the care home had concerns that amounted to possible safeguarding issues, they should have made a safeguarding alert themselves, directly to NCC, as soon after MC's death as possible, and in addition to notifying Hertfordshire County Council of their concerns and the death itself, CQC of the death (as regulator) and potentially also the contracting section of NCC, depending on local protocols and contracting arrangements.

3.5 There was not, apparently, an arrangement with Hertfordshire County Council, that NCC would handle any 'care management' issues on a day to day basis, on Hertfordshire's behalf, even though MC lived in Northamptonshire and was attending an NCC day centre, but it is evident that the NCC learning disability service had knowledge of MC and there was to be a review, which was scheduled for shortly after the date of his death, as a result of concerns raised by the day centre, with the NCC care management staff, about his health. The NCC learning disability service was (appropriately) involved in the initial safeguarding discussion, but again, the agency report does not indicate the point at which the NCC LD service knew of MC's death and whether they had concerns sufficient to have warranted them making a safeguarding alert themselves.

3.6 Had KGH, the care home or the NCC learning disability service made a safeguarding referral as discussed above, it would not have made significant difference to the timing of the commencement, or to the outcome, of the safeguarding investigation in this case, as Hertfordshire made the referral within a few days of MC's death. However, it is important that all agencies understand their responsibilities in identifying safeguarding concerns and taking them to the multiagency table, as well as addressing their own internal review and reporting processes.

3.7 It is possible that those involved in MC's situation were thrown off the normal approach to logging safeguarding concerns, as MC died in hospital following two months of health assessments and interventions, and also, not from an obviously deliberate or active form of abuse. The local safeguarding procedures do refer to safeguarding in the context of care settings, but hospitals are not specifically included and the sense is only of dealing with issues in social care settings. The SOVA Board may wish to consider whether the new procedures should contain specific reference to safeguarding in hospital settings. The independent medical review addresses the question of whether or not the medical treatment was appropriate and timely and will not be discussed here. The safeguarding issue was not about his medical care per se, but about the nature of how his care was determined and whether or not his capacity to participate in those decisions was ever, or properly assessed. There was also a second element to the safeguarding question, however, and that was whether there were any aspects of the approach to MC's care which, if applied to other people with learning and communication disabilities or capacity issues, would have an adverse impact on their health and wellbeing. The findings of the KGH internal review identified a number of improvements that should and (they report) have, been made, which will be of benefit to other patients – so this was not an issue just about MC's care. The agency reports do not describe this issue as being an active feature of discussion beyond the early referral stage, or beyond AG setting out this kind of concern in her various comments into the process. The potential impact for other patients seems to have been lost to the safeguarding process very early on. The potential for any safeguarding risks to apply to people other than the individual about whom safeguarding concerns are raised, is a standard aspect of safeguarding considerations and is referenced within the local procedures. This should have remained one of the explicit drivers for the pace and content of the investigation. (The importance of considering other vulnerable adults is specifically referenced in the new procedures at 11.7.4.VIII, as part of the strategy meeting considerations.)

3.8 Once the safeguarding process had been triggered, then strategy discussion was undertaken and a strategy meeting arranged. The Northamptonshire safeguarding procedures stated that a strategy discussion should take place within 24 hours of referral and a strategy meeting, if required, should take place as soon as possible; the text of the local procedures of the time, (paragraph A3.6.6) says that:

'The Strategy Meeting must be convened as soon as possible after the initial awareness of potential abuse, but no longer than ten working days after the referral was made.'

The flow chart in the procedures document, however, refers to the strategy meeting taking place within 5 working days. Local procedures should be consistent on this matter. (The new procedures, only seem to give a timescale in the flow chart and not in the text. The reference is to 5 working days from the referral.) The alert was made on 2 December, the formal referral on 3 December and the strategy meeting was held on 16 December 2009. There is then no set timescale for holding a follow on case conference, which in this case occurred on 12 February 2010. If the 10 day rule is used regarding the timing of the strategy meeting, then the safeguarding process broadly followed the requirements and timelines in the guidance, up to this point. (It would not comply however under the timescales set out in the new procedures.) Given that the KGH internal report was expected, at that stage, to be a significant contributor to the safeguarding investigation, it is not unreasonable that the case conference was arranged at a point when the internal review report was available.

3.9 The strategy meeting and the case conference are significant meetings in any safeguarding process and the expectation is for them to be properly minuted. Both procedures current at the time and the new ones, state that the minutes should be circulated to participants within 5 working days of the meeting. There were very significant delays in producing the minutes of these meetings and NCC's agency report appropriately identifies this as a failing. The minutes of these meetings were not available to this overview process, but it should be noted that the NCC management review identifies failings in the content of the meetings, as reported through the minutes, eg agenda not identified, dates for future meetings not identified, no version control of the minutes, which is important given the variation in the number of recommendations reported to have come out of one meeting as between different versions of the minutes, and apparently no written report submitted by the care manager to the case conference in February 2010. In addition to the two month gap between the meeting on 12 February and circulation of the draft minutes, it is also a significant failing that the minutes of the case conference on 12 February have never been reviewed in response to amendments suggested by attendees and never been agreed as an accurate

record of the meeting. At that time, NCC were apparently experiencing workload pressures due to an unprecedented high number of safeguarding referrals and NCC acknowledge that this impacted on communication with partners. The NCC management review appropriately identifies failings in the safeguarding process and discusses them in greater detail, together with recommending forward actions to resolve them. It is critical, however, that the importance of having prompt, accurate and agreed records of safeguarding discussions and actions, is recognised and upheld.

3.10 The delay in producing the minutes of the safeguarding meetings, is but one of a number of delays that have occurred through the locally initiated review, investigation and complaint processes. (Appendix 2, gives a simplified event history, which illustrates more clearly than the full chronology, the key events and the timescales.) The most notable delay is in the completion of the safeguarding investigation itself. There may be very complex cases, such as those which may involve many potential victims and criminal investigations, that might take longer than the norm, but this situation is not one of those. Whilst there was no firm timescale set in procedures, or apparently through the multiagency discussions, for completing the investigation, no-one would consider that a timeline from December 2009 to February 2011 is acceptable in this case. NCC have clearly identified failings in managerial oversight of the process, including allocating responsibility to someone who has no authority to influence or determine actions of others and considerations of inexperience. The new procedures specify that the safeguarding investigation is to be carried out within 28 days and this would clearly not have been achieved in this case.

3.11 It is not evident as to why the safeguarding investigation was not concluded soon after the case conference in February 2010. The conclusions of the meeting do not indicate significant and time consuming, outstanding safeguarding enquiries, although there were some actions which would seem to relate to continuing questions being raised by AG. The information provided for this review would indicate that most of those queries were about the medical aspects of MC's care, rather than the issues which were the focus of the safeguarding investigations. The Care Manager completed her safeguarding investigation report on 26 April 2010. Given that AG did not meet with KGH until 10 May 2010, this also suggests that the outstanding queries from AG, were not directly related to the matters which were the focus for the safeguarding investigation.

3.12 KGH enquired about the progress of the safeguarding investigation in a discussion of 10 June 2010 according to the NCC report, although the KGH agency report refers also to July as the point of this enquiry. Whichever date is correct, both agencies agree that KGH were advised that the Care Manager's report had been sent to a senior NCC manager for decision.

Under the Northamptonshire safeguarding procedures, the decision as to when a safeguarding investigation is concluded, lies with a manager within NCC. The procedures also require that the involved agencies be notified of the outcome of every safeguarding investigation. KGH heard no more, after the telephone conversation in June 2010 and apparently assumed that the matter was concluded – until being contacted and receiving a request for attendance at a case conference in January 2011. As referred to above, NCC were dealing at this time, with the impact of a high safeguarding workload and this adversely affected the communications with partners. Whilst responsibility for the failure to properly determine that the investigation was complete and to notify relevant agencies, lay with NCC, KGH would have been aware that they should have received a proper notification when the investigation had completed, under the terms of the local procedures. Without receipt of this notification, KGH should not have made the assumption that the investigation was concluded. It would also be reasonable to assume in this case, given the focus of the investigation, that KGH would have been part of a joint discussion to conclude the investigation. It should be noted that in the new procedures, (11.8 and 11.10), the requirement is set to hold a case conference to convey the outcome of the investigation, or to otherwise agree with the relevant partners, that the conference is unnecessary and how all relevant parties will be informed of the outcome. Para 11.10 of the new procedures, gives further guidance on concluding the overall intervention.

3.13 Another factor in the long time frames for completing various elements of the investigation and review processes, may be the fact that MC died – ie he was not in need of an active safeguarding plan to prevent further risk. Clearly there is no individual to safeguard when the person concerned has died, but as referred to above, the issue of risk to others remains a consideration in the safeguarding process. A loss of focus on this, coupled with the fact that MC did not require an active safeguarding plan, may have contributed to the loss of pace. The new procedures do not address this specific point but do consider who should lead investigations where there has been a death. The new procedures at section 12.6, includes a section on risk assessment and at section V, it states that where there is a death of a vulnerable adult and safeguarding concerns have been raised, then the police will take responsibility for the investigation and liaise with the Coroner's office. The information available on this case, does not suggest that it would have been appropriate for the police to lead the investigation, particularly as no criminal act is suggested at any point. There is no reported evidence that the fact that MC died, is a factor in the delays, but in reviewing local procedures, the Safeguarding Board may wish to consider whether guidance is clarified about how death of the person concerned does, or does not, affect pace of the safeguarding processes. The Board may also wish to review the new

procedures regarding the assumption that the police will always take the lead investigating role where the person concerned has died.

3.14 Under both the procedures current at the time and the new procedures, NCC must take on a co-ordinating role in safeguarding investigations, but do not always have to undertake the investigation themselves; there is allowance for another agency to take the lead on the investigation. It is not clear from the agency reports, why the NCC Care Manager was designated to undertake the investigation, as opposed to KGH leading, with supplementary contributions via the Care Manager, leaving her with the co-ordinating role. Equally, the internal review undertaken by KGH had a broader focus. KGH appropriately and promptly initiated their internal review and seem to have concluded it in a timely fashion. They then moved to implementing their recommendations and initiating learning processes. The external medical reviewer commends the KGH approach to initiating and learning from the review. It was also appropriate to initiate a safeguarding process. However, the focus of the two processes was not the same. It is not the role of a safeguarding investigation, to review the competence of the diagnostic and medical interventions carried out, per se. Nevertheless, the findings of such a review would be relevant if there was a suggestion that there was some form of wilful intent to harm (at which point it may also involves a criminal investigation), or where there is a concern about the impact of eg neglectful interventions, upon a wider group of patients. At no time was there ever a suggestion that there was wilful harm caused to MC by any of the hospital staff. In the case of MC, KGH did review the medical interventions in their own internal report and also considered the issues of making reasonable adjustments and capacity assessments for MC. (The independent medical review gave further consideration to the medical interventions at a later point in the timeline.) It was these latter two aspects which were the most directly relevant matters for the safeguarding investigation. The safeguarding process seems to have suffered from a lack of clarity about the precise focus of the safeguarding investigation and the KGH review, and how they did or did not relate to each other. In terms of the findings of the KGH review, KGH accepted that there were inconsistencies on these capacity and communication aspects, in the conclusion of their internal review. This information was therefore available in the February to April period when the safeguarding investigation was being completed by the Care Manager and this would have been an appropriate time to conclude the safeguarding process.

3.15 The external medical review commissioned to review the ‘technical’ side of the medical interventions was not commissioned as part of the original KGH review nor as part of the safeguarding investigation. It was initiated as a result of the complaints lodged by AG in April 2010, although she had raised the need for an independent medical review in February 2010. It was not,

therefore, available at the time that the safeguarding investigation was submitted to be 'signed off'. The findings of the independent medical review do add to the internal review of KGH, but do not change the substantive findings for the safeguarding investigation, as the points identified echo those acknowledged by KGH, prior to the external review being commissioned. This reinforces that the safeguarding investigation could have been concluded in Spring 2010. The safeguarding investigation was not, in fact, signed off in April 2010, as it potentially could have been and was reopened as a result of AG's complaint of November 2010. The re-opened process included a case conference on 16 February 2011; at this point, the first of the external medical review reports was available and the second was in train. As referred to above, the first independent medical review report did not identify any further substantive issues for the safeguarding investigation. The members of the case conference were not to know however, whether or not, any further issues would be identified in the second report. Given the considerable lapse of time since the investigation was begun, the draft report prepared, the work already undertaken by KGH to implement improvements in relevant aspects of patient care, and the apparent expectation of the imminent availability of the second report, it was not unreasonable for the case conference to consider the first report findings and to decide to await the second report, in order to be sure that no new information would emerge about the safeguarding issues. It is regrettable, however, that the second medical review was not available for the scheduled reconvened case conference of 31 March 2011. Once again, the safeguarding investigation could not be formally concluded.

3.16 The agency reports suggest that it was AG who persisted in prompting when minutes, reports and actions were not delivered, or to the expected timescale, rather than the agencies themselves. The question of whether AG was satisfied with the content of reports etc, is a separate issue, but the opportunity for AG to discuss her views on the content of the KGH review report, was tardily provided. The main body of the KGH internal report seems to have been completed in early February 2010, and the reports of the email exchanges between AG and the Care Manager during March and April 2010, indicate that AG was under the impression that there had been agreement at the meeting of 12 February, for a meeting to be arranged between herself and KGH. The reported email exchanges between the Care Manager and the KGH Head of Nursing for Surgery, in the same period, also raise the option of a face to face meeting (or a written response). However, the unapproved minutes do not refer to an agreement to meet and as the minutes were never amended or agreed, it is not now possible to conclude whether there was clarity amongst the parties, that this meeting would take place, nor when it would occur. This reinforces the importance of always having a clear, prompt and agreed record of the safeguarding meetings in all cases. The KGH report was finalised in April 2010 and sent to AG. A meeting did eventually take

place on 10 May and the agency reports would suggest that the driver for the meeting being held, was AG's persistence in wanting to meet, in order to discuss her views on her brother's care and the content of the KGH internal report.

3.17 Similarly, it was AG who persisted in asking for responses to complaints, copies of promised documents, and formal notification of the outcome of the safeguarding investigation. It is not appropriate that a family member, rather than the involved agencies, is the one to be identifying and pursuing process delays and to have to do so on so many occasions.

3.18 AG was making much of the contact for information and also providing comments and responses in relation to the KGH review, through the NCC Care Manager. The unapproved minutes of the case conference of 12 February 2010, record that the Care Manager was to 'stay in touch with AG and collate all issues' and that Named Nurse for Safeguarding at KGH would liaise with AG about 'finding a resolution'. As above, the minutes cannot be used as a reliable record of the agreed actions, but there does not seem to be disagreement that the prime direct contact with AG was the Care Manager and, the email exchanges between the Care Manager and the KGH Head of Nursing for Surgery, as referred to above, support the conclusion that the Care Manager was the prime point of contact with AG. The agency reports do not identify any direct contact from KGH to AG, until they acknowledged her complaint in May 2010 and met with her to discuss the review report, also in May 2010. Given that, as discussed above, many of her questions and issues, were related to the medical and hospital based care provided to her brother and so were not necessarily directly related to the safeguarding investigation, and also given that there may well have been a named contact at KGH identified in the February case conference, it seems unnecessarily circuitous, for AG to be providing her comments and issues to the Care Manager, who, in effect could only act as a messenger, as she had no direct involvement with the KGH review. Similarly, it is not clear why the Care Manager should have any responsibility for organising a meeting between KGH and AG. In addition, one of the issues that AG raised at an early stage, was about the lack of contact between the hospital and family, in the final and critical days of MC's care. It would have been more sensitive and more appropriate for AG to have an active point of contact directly with KGH, from the outset.

3.19 Given the delays and lack of responsiveness of the process, it is not surprising that AG resorted to lodging a formal complaint. Even this did not ensure prompt resolution however. For example, the external medical review was initiated as a result of the complaint made by AG on 26 April 2010, but was not finally procured until September 2010 and although the first report was completed in November 2010, the external reviewer was apparently not provided with all of the records and information needed to fully review the final

week or so of MC's care. In the meeting between the KGH Trust and AG on 21 December 2010, it was agreed that a second report would be commissioned to ensure coverage of this last period of MC's life. This second report was completed in May 2011. This means that the final report was available some 12 months after the decision to commission an independent report. It may be beneficial for KGH to assure themselves of the processes they have for commissioning such reviews, ensuring provision of all the appropriate information at the outset and setting timelines for the process to complete.

3.20 AG made her second complaint, to NHS Northamptonshire, on 1 November 2010. This complaint contained the issues about lack of communication from NCC Adult Safeguarding Team. When we bear in mind, that at this point, AG had still had no communication about the conclusion of the safeguarding investigation, it is not surprising that she lodged this issue as a complaint. Having received the complaint on 1 November 2010, NHS Northamptonshire forwarded it to NCC on 12 November and NCC decided to investigate the complaint on 19 November. The agency reports do not explain why this could not have been actioned sooner. These are longer timescales than is ideal and in the circumstances of the case, where delay has been a very significant factor, it would have been better and more sensitive, to move the complaint along more quickly.

3.21 The final aspect for comment is that of initiating a Serious Case Review. The decision as to whether or not to hold a Serious Case Review, is the responsibility of the Northamptonshire Safeguarding Vulnerable Adults Board, and is exercised through the Serious Case Review sub-group. AG was led to believe in May 2010, that a Serious Case Review would be held into her brother's death. This was inappropriate as there had been no senior discussion on the matter at that point and no multi-agency consideration of making the recommendation to the Safeguarding Board's sub-group. The safeguarding procedures however were worded in such a way as to suggest that an SCR would be automatic, so the potential for confusion was laid. Up until quite recently there was something of an 'all or nothing' approach to holding SCRs – ie a full SCR process was the only option open to the multi-agency Safeguarding Board. This was in common with other localities nationally and recent regional work has proposed a different approach, allowing for four levels of review. The advantage of this is that an approach can be agreed which is more in line with the nature and complexity of the case in question. Whilst this new approach had not been adopted formally at the time of the referral to the Sub-Group, to hold an SCR, the SCR Sub-Group was able to bear in mind the approach being proposed and the arguments behind the 'tier-ing' of the nature of review commissioned. As discussed earlier in this report, much of the concern about the care offered to MC, was

rooted in the medical interventions provided by KGH and was for KGH to investigate and resolve. Only the concerns meeting the safeguarding criteria were appropriate for the multi-agency safeguarding investigation. It is also evident that the handling of the various investigation processes subsequent to MC's death, have been fraught with inappropriate delay and less than adequate communication**.** The SCR sub-group is the representative group for the board which oversees how agencies work together on safeguarding issues. It is therefore appropriate that the SCR sub-group decided to focus this review as they did, on the multiagency work that took place after MC's death.

3.22 Summary of points identified in analysis

Paragraph reference	Point of analysis
3.2	It was appropriate that the concerns over MC's death were treated as requiring examination both by KGH and through a safeguarding process.
3.6	It is important that all agencies, including all health and social care providers, understand their responsibilities in identifying and alerting to safeguarding concerns, taking them to the multi-agency table, and to do so alongside addressing their own internal management review and reporting processes.
3.7	The SOVA Board may wish to consider whether the new procedures should contain specific reference to safeguarding in hospital settings.
3.7	The potential impact for other patients, of concerns about MC's care, seems to have been lost to the safeguarding process as it proceeded. The potential for any safeguarding risks to apply to people other than the individual about whom safeguarding concerns are raised, is a standard aspect of safeguarding considerations and is referenced within the local procedures. This should have remained one of the drivers for the pace and content of the investigation.
3.8	Local safeguarding procedures should be consistent in the timescales set down for holding the strategy meetings.

3.9	There were very significant delays in producing the minutes of the safeguarding meetings held in December 2009 and February 2010. It is critical, however, that the importance of having prompt, accurate and agreed records of safeguarding discussions and actions, is recognised and upheld.
3.10	Whilst there was no firm timescale for completing investigations, set in procedures, or apparently through the multi-agency discussions, for completing the investigation, no one would consider that a timeline from December 2009 to February 2011, is acceptable in MC's case.
3.12	Responsibility for the failure to properly determine that the investigation was complete and to notify relevant agencies, lay with NCC.
3.12	Without receiving formal notification that the safeguarding investigation had been concluded, KGH should not have made that assumption.
3.13	There is no reported evidence that the fact that MC had died, rather than was in need of an ongoing safeguarding plan, was a factor in the delays in the processes. However, the Northamptonshire Safeguarding Vulnerable Adults Board may wish to consider whether guidance is clarified about how the death of the person concerned does, or does not, affect the pace of safeguarding processes.
3.13	The Board may also wish to review the new procedures regarding the assumption that the police will always take the lead investigating role where the person concerned has died.
3.14	The safeguarding process seems to have suffered from a lack of clarity about the precise focus of the safeguarding investigation and the KGH review, and how they related to each other.
3.14	The information and conclusions relevant to the safeguarding investigation, from the KGH internal review, was available in the February to April period, when the Care Manager was completing her investigation report. The investigation could therefore have been concluded by April 2010.

3.15	The findings of the independent medical review, do add to the internal review of KGH, but do not change the substantive findings relevant to the safeguarding investigation, as the points identified echo those acknowledged by KGH, prior to the external review being commissioned. This further reinforces that the safeguarding investigation could have been concluded in Spring 2010.
3.15	Given the significant lapse of time, the work already undertaken by KGH to implement improvements in relevant aspects of patient care, and the apparent expectation of the imminent availability of the second report, it was not unreasonable for the case conference of February 2011, to consider the findings of the first independent medical review and to decide to await the second report, which was expected imminently, in order to be sure that no new information would emerge about the safeguarding issues.
3.17	It is not appropriate that a family member, rather than the involved agencies, is the one to be identifying and pursuing process delays and to have to do so on so many occasions.
3.18	It would have been more sensitive and more appropriate for AG to have a direct and active point of contact directly with KGH, from the outset of the review and safeguarding processes.
3.19	It may be beneficial for KGH to assure themselves of the processes they have for commissioning independent medical reviews, ensuring provision of all the appropriate information at the outset and setting timelines for the process to complete.
3.20	The passing forward of the complaint made in November 2010 and decision to investigate it, took longer than ideal and in the circumstances of the case where delay has been a very significant factor, it would have been better and more sensitive, to move it along more quickly.
3.21	It was inappropriate to lead AG to believe, in May 2010, that there would be a Serious Case Review, as there had been no senior discussion on the matter at that point and no multiagency consideration to the recommendation to the safeguarding board's SCR sub-group. The safeguarding procedures however were worded in such a way as to suggest that an SCR would be automatic, so the potential for confusion was laid.

3.21	The Serious Case Review sub-group is the representative group for the SOVA Board which oversees how agencies work together on safeguarding issues. It is therefore appropriate that the SCR sub-group recommended and the Board decided to focus this review as they did, on the multi-agency work that took place after MC's death.

4. Conclusion

4.1 It was entirely appropriate that Kettering General Hospital Trust initiated an internal review and also that Northamptonshire County Council initiated a safeguarding investigation. However, loss of pace and communication issues hampered successful and timely completion of both processes. Delay and communication issues emerge as themes throughout the period between December 2009 and February 2011. There are also issues of managerial oversight, clarity of focus and some issues of procedure.

4.2 Some of the procedural issues identified in this Overview Report, have been subsequently addressed or reinforced, in the updated version of the local multi-agency safeguarding procedures. However, there remains an issue of ensuring local compliance, as some of the issues were not about unclear procedures, but about their application.

4.3 As the momentum of the local process dissipated, AG became the person pressing for completion. The lack of direct and timely engagement with AG on the part of KGH, may well have extended the completion of their internal review processes. One can speculate that the need for AG to lodge her 3 complaints, may have been avoided, had the local agencies managed and co-ordinated local processes more effectively and communicated with her in a more timely fashion.

4.4 KGH have identified areas for improvement, accepted findings from their own initial review and from the independent medical review, and also implemented actions in response to the learning points.

4.5 Similarly, NCC have acknowledged the failings in their management of the safeguarding process and identified actions accordingly.

4.6 This overview has identified further issues which should be considered by the agencies involved both in this case and also those who are members of the wider Safeguarding Vulnerable Adults Board.

5. Recommendations

5.1 A number of recommendations arise from the analysis and conclusions from this overview. They are set out below.

Recommendation 1

The SOVA Board requires Kettering General Hospital Trust and Northamptonshire County Council, to report to the Board, the actions which they have taken in light of the investigation, both in terms of the procedures and how services have been revised to improve the outcomes for service users who may have impaired mental capacity.

Recommendation 2

The SOVA Board should review whether it is satisfied that local agencies, particularly health and social care providers, are aware of their responsibilities to raise safeguarding alerts, and whether any refresher training or guidance is needed.

Recommendation 3

The SOVA Board should review whether the local safeguarding procedures, need to include more specific guidance regarding identifying and raising safeguarding issues in regulated settings, including hospitals.

Recommendation 4

The SOVA Board should remind local safeguarding organisations that safeguarding investigations need to consider the risks posed to other vulnerable adults, in any given situation and not just risks for those who are the subject of the investigation.

Recommendation 5

The SOVA Board should consider how it can be assured that all local agencies are complying with the local procedures and whether there are sufficient routes for individual workers, to raise problems of compliance, within or across agencies, where their initial concerns are not acted upon.

Recommendation 6

The SOVA Board should review the local procedures, in terms of the guidance they provide about how safeguarding investigations apply where the individual has died. This should include issues of pace, considerations of other potential victims and the role of the police in investigating these situations.

Recommendation 7

The SOVA Board should review the current procedures (December 2010), to ensure that they provide sufficient guidance on setting and retaining the focus of safeguarding investigations, and how safeguarding investigations relate to any internal management/serious incident reviews associated with the case, ensuring that they run simultaneously. Included in this review by the SOVA Board, should be whether they provide sufficient guidance on identifying the lead investigating agency, as opposed to the coordination role, which will always sit with NCC. The initial strategy discussion/meeting should clearly identify a nominated Case Lead and consider whether any other roles are required, including family liaison and media leads, and also which is the most appropriate agency to act in that lead role.

Recommendation 8

All the individual agencies and the SOVA Board, should consider how they can routinely monitor and thus be regularly assured, that all safeguarding and associated complaint processes are being delivered in a timely manner.

Recommendation 9

The SOVA Board should progress the new regional framework for determining the level of review that is needed to consider lessons in safeguarding cases and adapt the local procedures accordingly.

Additional recommendation for KGH

Kettering General Hospital Trust should review whether it is satisfied that any future commissions of independent medical reviews, will include all the relevant records, at the outset and be clear about timescales for completion.

Sallyanne Johnson

October 2011

Glossary of abbreviations

MC Person who died and is the subject of the agency review and investigation processes

AG MC's sister

CM	Care Manager (with Northamptonshire County Council Adult Social Care Service)
CQC	Care Quality Commission – the regulatory body for health and social care providers of care
ICU	Intensive Care Unit
IMR	Independent management review
Herts CC	Hertfordshire County Council
KGH	Kettering General Hospital Trust
LD	Learning disability
NCC	Northamptonshire County Council
NGH	Northampton General Hospital Trust
PCM	Principal Care Manager (with NCC adult social care service)
RCA	Root Cause Analysis
SAT	Safeguarding Adults Team (NCC)
SCR	Serious Case Review
SOVA	Safeguarding of Vulnerable Adults
PET Scan	Positron Emission Tomography Scan
MENCAP	Royal Society for Mentally Handicapped Children & Adults