**BOURNEMOUTH & POOLE SAFEGUARDING ADULT BOARD**

# EXECUTIVE SUMMARY

**Regarding the Serious Case Review**
**In respect of Mrs. A**

**Author:** Elizabeth Whatley
**Date:** 4 November 2010

## 1. INTRODUCTION

1.1 MRS. A was an elderly, widowed lady of 83. She was murdered by her son-in-law in her house and found on 06.05.2008. Prior to her murder she lived independently in her own house in Bournemouth, where she had been resident for some years.

1.2 MRS. A's daughter, MS. B was diagnosed as having a serious mental health problem. In addition, she drank heavily at times. MS. B was married, divorced and married again to MR C. MR. C was an alcoholic with a diagnosis of anti-social personality disorder. The couple had an on/off, violent relationship. MS. B and MR C's children had all been taken into care.

1.3 MS. B and MR. C moved in and out of MRS. A's house over a number of years and were, at times, violent and abusive to her. MRS. A is said to have been afraid of MR. C and MS. B and frequently consulted her GP about the stress caused by both MS. B and MR. C.

1.4 MS. B, MR. C and MRS. A were known to a number of agencies, including the police and considerable support was provided to MS. B and MR. C by mental health services and probation. In 2008, some support was offered to MRS. A by Bournemouth Community Care Services but she declined this.

1.5 MRS. A had a niece, MS. D, who lived outside the area and who raised concerns about her aunt on a number of occasions with the police, the GP and Community Mental Health Services. Neighbours also raised concerns, with the same agencies about the way MS. B and MR. C treated MRS. A.

1.6 Whilst a number of agencies highlighted, in their records, concerns for MRS. A, information, with one exception, does not appear to have been shared. As a result this Serious Case Review has been undertaken to ascertain if lessons can be learned and practice improved as a result of the findings.

1.7 A formal decision to conduct a Serious Case Review (SCR) was made by the SCR Panel of Bournemouth & Poole Safeguarding Adults Board on 25.06.2009, in view of concerns about the apparent lack of communication between agencies and, in accordance with the protocol for undertaking Serious Case Reviews agreed by Bournemouth & Poole Safeguarding Adult's Board and Dorset Safeguarding Adult's Board in November 2009. The SCR Panel met again on 09.02.10, 09.04.10, 05.05.10, 04.06.10 and 28.07.10.

1.8 Agencies contributing to the SCR were:

Bournemouth and Poole Teaching Primary Care Trust
Bournemouth and Poole Community Health Service
Dorset HealthCare NHS Foundation Trust
South West Ambulance NHS Trust

Bournemouth Borough Council Adult Social Services
Bournemouth Borough Council Children's Services
Dorset Police
Dorset Probation Service
Bournemouth Drug and Alcohol Action Team
Borough of Poole Social Services Out of Hours Service

## 2. Findings from the Review

2.1 The main issues emerging from this Review are as follows:

a) Identification and recording of safeguarding adult issues, especially when working with different members of the family on related issues such as Domestic Violence.
b) Sharing information across agencies and/or convening a multi-agency meeting, and recording what has been done.
c) Raising a safeguarding adult alert once concerns have been identified.
d) Not leaving a scene of potential violence until all are safe and the appropriate organizations have been called and are responding, at the same time as keeping oneself safe.
e) Following up received alerts promptly.
f) Continuing to be aware of safeguarding issues and potential changing needs when services have been refused or eligibility criteria not met.
g) Being familiar with and following Policy and Procedures.

2.2 The majority of Independent Management Reviews (IMR) prepared by individual agencies, have highlighted a catalogue of missed opportunities when action could and should have been taken to liaise with other agencies and to provide support and protection for MRS. A.

The following findings relate to these areas:

**a), b) and c) Identification of safeguarding adult issues, sharing information and raising an alert.**

2.3 The IMRs show that a number of agencies and organisations had a great deal of information in relation to MRS. A, MS B and MR. C but each agency concentrated only on the person or problem they were dealing with.

2.4 The Dorset Probation Service was the exception to this and looked at the impact MR. C had upon people other than MS. B and the risks to MRS. A.

2.5 The GP saw MRS. A in the surgery and on home visits. Despite concerns for MRS. A's safety expressed, in writing, by her niece and telephone calls from her neighbours, plus MRS. A's own medical history of stress

related to fear of MS. B and MR. C and injuries caused by them, the GP Practice made no referral to Adult Social Services in relation to MRS. A being a vulnerable adult nor did they record having had any discussions about the possibility of such action.

2.6 The majority of incidents recorded by the police involving MS. B, MR. C and MRS. A were treated separately and no overview was created nor was the impact of the violence around MRS. A, an elderly lady, considered. On each occasion, advice was given about what MRS. A should do if she felt threatened ie: to call 999 and also how to apply for an injunction. There is no evidence that contact was made with other agencies with a view to sharing information in a multi-agency meeting and looking at how best she could be protected.

2.7 Had any of the agencies, particularly the Police, the GP, Dorset HealthCare NHS Trust, Children's Services or Adult Social Services considered a multi-agency meeting at any time, a considerable amount of information could have been pooled to provide a clearer picture of what was happening in MRS. A's life.

2.8 Dorset HealthCare NHS Trust, Children's Services and Dorset Police recorded information provided by MS. B and MR. C about violent and abusive incidents either at the home of, or in front of MRS. A, but little if any consideration was given to the impact upon MRS. A. The GP recorded MRS. A's own worries and fears about her situation but did not pass this information on. The Community Mental Health Team, (CMHT) MRS. A's GP and the police took little or no notice at the time that they were received, of letters from MRS. A's niece detailing her concerns for MRS. A's safety and wellbeing.

**d) Ensuring all at a scene of potential violence are safe and appropriate organizations are called and responding.**

2.9 On 04.05.07, ambulance staff, called to a violent domestic incident, call the Police and do manage to remove MR. C from MRS. A's house. However, when no treatment is required by MR. C, they leave before the police arrive, with MR. C free to return to the house from the back garden, where he was subsequently found by police officers.

2.10 In October 2007, despite the police having to break into MRS. A's house where she had been locked by MS. B who also disconnected the telephone, and finding MRS. A confused and disorientated, no action other than contacting MRS. A's niece was considered.

**e) Following up safeguarding adult alerts promptly and ensuring those affected are safe.**

2.11 On 25.04.08 Adult Social Services received an allegation of financial abuse from a private Domiciliary Care Agency. This stated that Mrs. A's bank card had been allegedly stolen by Ms. B, so Mrs. A's account was frozen and she was unable to pay their bill. Mr. C had also told them that Ms. B had physically assaulted Mrs. A the previous week. No immediate action was taken.

2.12 On 30.04.08 the Community Mental Health (CMH) Nurse for Ms. B referred Mrs. A as she had nothing to live on that week. Adult Social Services then discussed Vulnerable Adult concerns, attempted to contact Mrs. A by telephone and appointed an Adult Protection Investigator. The Domiciliary Care Agency were telephoned and said Mrs. A had cleared her debt on 28.04.08, appeared well and had cancelled future service. The CMH Nurse was telephoned but was not available. It was decided to write to MRS. A inviting her to contact Adult Social Services to discuss her care needs. The GP surgery was telephoned and said MRS. A had had an appointment on the 29.04.08, which she had not kept. In view of the vulnerable adult concerns, an unannounced visit was planned for later that day on the 30th.

2.13 When the visit took place, there was no response and milk was noted on the doorstep, and through the front door, post was seen on the doormat. A neighbour confirmed that lots of arguments had been heard between MRS. A and her daughter in the past and they had not seen MRS. A for 2 days. However, no attempt to gain access to the house or efforts to try to ascertain where MRS. A was, were made. There is no record of whether the neighbour was asked if they had a key or knew who did have.

2.14 The case was discussed the following day, on 01.05.08 and an Adult Protection initial investigation initiated but a visit was not planned until 07.05.08. The CMH Nurse telephoned the Adult Protection Investigator back on 02.05.08 and faxed a copy of the letter from MRS A's niece dated October 2007. This contained details of MS. B's behaviour and MR. C's violence. No contact was considered with the niece or other agencies including the police, bearing in mind the mention of violence. On 06.05.08 the faxed letter was discussed by a Senior Practitioner and the Investigator, who considered whether there were concerns for MRS. A. The record states, 'Given that she did not have care visits and that no appointment had been made and not kept, this was not treated as an Immediate Response'. However, a worker agreed to visit on the way home. On arrival, the Police were present as a body had been found.

2.15 None of the contacts from Dorset Probation; a referral on 13.12.07, the telephone call in support of the referral on 20.12.07 and a letter on 10.01.08, were dealt with appropriately. An alert was not raised nor

were any of these contacts filed on MRS. A's file. Whilst it is acknowledged that on occasions a letter or a record of a telephone call may be mislaid but the loss of all three items calls in to question how incoming mail and telephone calls are recorded and passed on.

**f) Continuing to be aware of safeguarding issues and potential changing needs when services have been refused or eligibility criteria not met.**

On 07.02.2008, the Community Mental Health Team (CMHT) referred MRS. A to Adult Social Services for social work support. On 14.03.08 an assessment of MRS. A was started and 3 visits made. MRS. A declined support but expressed concerns about MR. C and said she had good neighbours who would keep an eye on her. 26.03.08 an Age Concern worker visited MRS. A, who continued to refuse support but agreed the worker could visit to keep her informed about day services. 28.03.08 Adult Social Services closed the case as MRS. A did not need support.

**g) Being familiar with and following Policies, Procedures and Guidelines.**

The existing Adult Protection Policy & Procedures was based on government guidance called 'No Secrets' and updated in October 2007. All agencies have agreed to follow them.

There is sufficient evidence in the Policy & Procedures that MRS. A met the criteria for a vulnerable adult and was being subjected to abuse of varying kinds.

2.16 The policy also makes it clear in section 6 that all staff have a responsibility to report allegations of adult abuse to their line manager. In addition all agencies who are signatories to the policy '…have an absolute and unequivocal duty to report any allegations or suspicions of abuse or potential abuse of a vulnerable person to their immediate line manager.'

2.17 Sadly, despite this detailed guidance and subsequent training, the policy and procedures do not appear to have been followed and staff from many agencies failed in their duty of care to MRS. A.

2.18 Whilst it is acknowledged that multi-agency meetings and information sharing might not have prevented MRS. A's death, they might have done. By the same token, gaining access to MRS. A's house during the visit on 30.04.08 might still have resulted in finding her dead. However, she may well have been alive and at least some suffering, for her and the family, could have been eased bearing in mind the Pathologist's findings that MRS. A, despite her very severe injuries, took at least three days to die and she was last seen alive on the afternoon of 28.04.08.

## 3. RECOMMENDATIONS FROM THE OVERVIEW AUTHOR

**In relation to procedures and training to ensure Safeguarding Adults issues are identified and responded to it is recommended that:**

3.1 To ensure it is embedded within the culture of the organization, all agencies and front line staff must undertake, on a regular basis, compulsory joint Vulnerable Adult/Safeguarding training. This training must be supported with compulsory refresher courses, easily accessible information and flow charts and regular discussion at team meetings and during supervision sessions.

3.2 Appropriately experienced and qualified workers manage and respond to all adult abuse referrals.

3.3 Clearer protocols and guidance are produced for working with people who refuse services.

3.4 Much greater support and guidance is available to the police to ensure that they identify vulnerable adults and make appropriate referrals to safeguarding teams and other services, such as domestic abuse support.

3.5 Local interagency procedures and guidance are reviewed to find a definition of 'vulnerable adult', which is more suited to and understood by all partners.

3.6 Training is provided to ensure that staff from all agencies are aware of their responsibilities under the Data Protection Act and their duty of care to Service users.

**In relation to recording all information, management discussions and decisions following Safeguarding Adults referrals and follow up work it is recommended that:**

3.7 From the time a Vulnerable Adult referral is received all management discussions and decisions are recorded to form a clear audit trail.

3.8 Greater emphasis is placed on the correct maintenance of records to ensure that detailed, relevant and up to date information is available to staff.

3.9 The Social Services Out of Hours Service maintain accurate records to ensure that when undertaking Individual Management Reviews they provide details of all relevant contacts.

3.10 An overview/database of all vulnerable adult and adult abuse alerts is created and maintained.

3.11 All records, whether hand written or computerized are legible, dated and the author clearly identified.

**In relation to Inter-agency working with carers and whole families it is recommended that:**

3.12 All agencies work to develop closer links when several services are working with different members of one family/extended family.

3.13 Closer links and working partnerships are maintained between the Integrated Mental Health Team and Adult Social Services Services, of which they are part.

3.14 When a Carers Assessment is undertaken much greater consideration be given to the carers' own needs and circumstances.

3.15 Closer links and working partnerships are maintained between Children's Services and Adult Social Services .

**In relation to inter-agency responses to potentially violent situations it is recommended that:**

3.16 Consideration be given to the feasibility of establishing inter-agency protocols for responding to the circumstances found on the visit to MRS. A's house on 30.04.08.

3.17 A similar reporting system in relation to domestic violence situations when a vulnerable adult is present, is set up between the Police Domestic Violence Unit and Adult Social Services as that which already exists with Children's Services when a child is present.

3.18 When responding to violent situations, all staff have a responsibility to assess and manage the risk to themselves and others until the situation is resolved.

**In relation to Individual Management Reviews it is recommended that:**

3.19 A common format for Individual Management Reviews be agreed and followed with the process, outcome, recommendation and author clearly identified as a minimum.

3.20 When preparing Individual Management Reviews dates and titles of staff are checked and agreed between different agencies.

**Elizabeth Whatley**