East Ayrshire Adult Protection Committee
Acting against harm

East Ayrshire Adult Protection Committee

Professional Learning Review Report – SCR ADULT L

June 2022

Introduction

A Significant Case Review (SCR) was commissioned by East Ayrshire Adult Protection Committee (APC) in September 2021 relating to an Adult (Adult L) who is a 53 year old woman with a learning disability. The SCR Report was undertaken by an Independent Lead Reviewer, supported by a Review Team drawn from the local services in East Ayrshire covering Social Work, Health and Housing who had no direct involvement in Adult L's care – this was to ensure independence and impartiality. The SCR Report addressed the matters outlined in the terms of reference approved by the Adult Protection Committee and consistent with the National Guidance on Conducting Significant Case Reviews which was the framework in place at the time of this Report. The purpose of a SCR is to better understand the full circumstances of the case where an adult has died or been subject to serious harm, to examine and assess the role of services and carers involved, identify and examine key practice issues and establish if there are areas for improvement, learning and development.

Due to the ongoing sensitivities surrounding Adult L's current circumstances and the potential for identifying the Adult and their family within the local community from the SCR Report; it was considered by the East Ayrshire Chief Officers Group (COG) that the Report could not be published in full and requested that the APC Chair prepare this high level Professional Learning Review Report, which could then be disseminated to support learning, improvement and development.

Background

Adult L currently lives independently in the community with a full package of support and now has an allocated Social Worker. Their casefile was reviewed by the Joint Inspection Team as a part of a sample of cases scrutinised during an inspection of Adult Support and Protection arrangements in East Ayrshire carried out in May 2021. The Inspection Team had concerns about the management of the case and immediately highlighted these to the East Ayrshire Health and Social Care Partnership (EAHSCP). In summary the key areas of concern were that:

- Adult L had not been allocated a Social Worker in their own right (rather there was a Social Worker supporting her whole family) and that no assessment of their needs, including a risk assessment, had been undertaken over a period of years;
- that Guardianship under the Adults with Incapacity legislation had not been identified as an appropriate legal measure earlier in their life;
- that a relative of Adult L's continuing status as their DWP Appointee was never reviewed despite the relative being deemed to lack capacity for financial decision making;
- that Social Work Services failed to respond to and use appropriate legal measures, in particular Adult Support and Protection, in relation to physical assault and emotional abuse allegations highlighted by Home Care and Housing staff.

Findings

In conducting the SCR the concerns above were considered to be well founded with further areas of concern being identified. In summary the SCR Report considered that Adult L is in all probability likely to have sustained emotional, financial and physical harm over a number of years within their home environment. Whilst some services, in particular Housing staff, attempted to respond to these issues, at significant points in Adult L's life, the SCR identified that Social Work Services did not act to protect and safeguard them. From a Social Work management point of view, the SCR Report identified a failure to prioritise the allocation of the case or

provide adequate support and supervision. From a Social Work practitioner point of view, the SCR Report identified a failure to assess Adult L's needs appropriately and to provide a coordinated care plan that supported and safeguarded them, including ensuring that appropriate statutory measures were in place. Other areas of concern were in relation to Adult L's health needs where it was identified in the SCR Report that her needs were neglected by her family but not followed up sufficiently by Health Services when they engaged with Adult L. These areas of concern will be progressed by EAHSCP and EAAPC through the relevant learning and improvement actions within the SCR Action Plan.

The SCR Report concluded that the accumulation of incidents over the Adult's life gave rise to serious concerns not only about professional practice but also about management oversight within Social Work Services. Given this, specific actions and improvements have been recommended within the Report and EAHSCP are currently addressing these within the SCR Action Plan. Actions include:

- action to ensure that an up to date comprehensive assessment of need is completed with all appropriate statutory measures required to support and safeguard Adult L being in place;
- a review of EAHSCP's policy and practice in relation to assessment, review and care coordination of adults within supported accommodation placements;
- action in relation to the identified areas of poor management practice highlighted in relation to this case but also a need to sense check this area of concern across the Social Work Service more widely.

It should be noted that the SCR Report also highlighted that some practitioners and services engaged in an appropriate, supportive and cooperative way in their efforts to support and safeguard Adult L, in particular Housing Staff, Social Work Staff within the hospital setting and Care at Home staff.

Learning

In terms of broader organisational learning the SCR Report highlighted key areas to consider which included:

1. Inadequate housing conditions impact on people's health. Health professionals carrying out duties in the homes of patients must be proactive in assessing the environment in which they are delivering care. When poor housing conditions are identified this should be included in the overall assessment and any subsequent care and treatment plan.

2. Significant periods of time without accessing a GP should be regarded as unusual and the reasons investigated as part of the holistic assessment of needs. This particularly applies to adults with a learning disability who will have been offered regular screening by their GP as well as other health screening programmes delivered in Scotland.

3. Reasonable adjustments to appointment letters and other written clinical communications to support people with a learning disability should be standard. In the event of frequent failure to engage with services, follow-up should not rely on further written communication.

4. Organisations responsible for Social Work Services need to ensure that at all times the fundamentals of good practice are in place. In this case the fundamentals of good practice broke down for periods of time. Within these fundamentals we would include the quality and clarity of assessments, the identification of risk and vulnerability, the supervision of staff, the challenging of poor performance, the adherence to procedures and timescales and the quality and clarity of managerial decision making.

5. Organisations and individuals who make referrals to Social Work Services regarding vulnerable people should be encouraged to escalate their concerns to more senior staff where they are not satisfied with the response to their

concerns. In an open and transparent system properly focussed on protecting vulnerable individuals, escalation should not be seen as a challenge but instead viewed as a clear statement of continuing concerns.

Conclusion

It is important to note that both the APC Chair and Lead Reviewer met with Adult L to inform them about the Significant Case Review. The Review process also sought to engage with Adult L in a way that was appropriate and supportive of them. This included East Ayrshire Advocacy Service engaging with them around 'life questions' provided by the Review Team to gain some insights into their life. Since the conclusion of the SCR, a meeting has taken place with Adult L attended by the Head of Service for Wellbeing and Recovery and the APC Chair to offer them an apology about the poor service they have received and to outline how things will be improved going forward.

A supportive Staff Briefing with those staff involved in the Review has taken place and their views will be taken into consideration by EAHSCP and EAAPC when taking forward the relevant improvements. A series of wider dissemination sessions will also be coordinated following agreement of this SCR Report by the Chief Officer Group.

Susan Maguire
Independent Chair
East Ayrshire Adult Protection Committee