North Lanarkshire
Adult Protection
Committee

NORTH LANARKSHIRE ADULT PROTECTION COMMITTEE

SIGNIFICANT CASE REVIEW INTO

THE DEATH OF MISS A

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CONTENTS

1. INTRODUCTION

1.1 In October 2015 the North Lanarkshire Adult Protection Committee commissioned a Significant Case Review into the circumstances surrounding the death of Miss A.

1.2 Miss A was a 60-year-old single woman who had a learning disability. She lived in supported accommodation at an address in Motherwell, receiving individual daily support, funded by North Lanarkshire Council (NLC) and paid directly to Provider A, a local provider of supported living services for people with learning disabilities.

1.3 Miss A was in a relationship with a 49-year-old male from Uddingston, who also had a learning disability, and, on 19 May 2014, she failed to return home after going out to meet this male. She was reported missing to the Police and her body was found later that day in the River Clyde at Uddingston. Following a psychiatric assessment, the male was found to be unfit to plead to charges against him. He is currently detained at the State Hospital, Carstairs.

1.4 Following the conclusion of the criminal proceedings in the case, the Adult Protection Committee commissioned a Significant Case Review with a view to identifying any potential learning from the involvement of all of the statutory and voluntary sector agencies with Miss A. This Review focuses on the period from January 2006, when a request was received by the NLC Social Work Services for funding in respect of Miss A's care, until her death in May 2014. During that period, Social Work Services had care management responsibility for Miss A's care, were involved in reviewing her care and support package on an annual basis through Annual Reviews, liaising with Provider A staff and attending Provider A Reviews.

1.5 The significant case review commenced in October 2015 and an initial draft report was submitted to the Adult Protection Committee's Review Team in March 2016. Ownership of the Review Report, when concluded, lies with the North Lanarkshire Adult Protection Committee as the commissioner of the Review.

2. MISS A

2.1 Miss A had lived with her parents up until their deaths in 1991. She was an only child with no other relatives and she moved to a flat in Motherwell where she was supported by Provider A, a local provider of support services. She assumed the tenancy of the property in 2003 and this arrangement was financed by a trust fund administered by a local firm of Chartered Accountants who had financial guardianship for Miss A.

2.2 In 2006, Provider A contacted NLC Social Work Services advising that Miss A's funds were diminishing and in July 2008 an application was made for the discharge of financial guardianship.

2.3 In February 2006, a Community Care Assessment was completed by Social Work Services and this identified Miss A's learning disabilities and concluded that she did not fully understand the reason for the assessment. It confirmed that she could not live alone without support and advised that she required assistance with most daily tasks - cooking, planning shopping, managing correspondence and finances and budgeting. Notwithstanding that, Miss A expressed the wish to remain living in her flat in Motherwell, and to continue to be supported by Provider A.

2.4 There is no record of a formal assessment of capacity of Miss A's being undertaken at any time during the period under review.

3. MR B

3.1 Mr B was a 49-year-old man who had a learning disability and, despite being able in many ways, he experienced difficulties in his social interactions with others. He had been referred to NHS Lanarkshire Learning Disability Team in 2004 by his job coach and continued to receive this service until June 2013. Although he did not have a diagnosis of autism, the interventions focusing on his social interactions with others were considered to be "autism friendly".

3.2 The initial referral related to his behaviour at work, inappropriate comments to female colleagues and his failure to understand social norms. His psychological therapist advised the Lead Reviewer that he had a low IQ and experienced anxiety and depression. This manifested itself in social awkwardness, inappropriate language and behaviour in his work environment, some minor thefts and occasional

abuse of alcohol. It was reported that he was a physically imposing individual and, whilst he could be verbally aggressive, he was not physically aggressive. The verbal aggression was believed to be caused by his continual struggle with his emotions, frustration and irritability.

3.3 Mr B had had contact in the past with Strathclyde Police, the British Transport Police and Police Scotland but he did not have any criminal convictions. There was a pending case on his record for an allegation of a minor assault on a group of youths but this was not progressed as it was considered that he was being picked on by the youths because of his learning disability. Apart from that, there was nothing in his contact with the police that indicated that he represented a risk of violence.

3.4 Mr B was receiving support on a weekly basis from Provider B, primarily for respite for his parents as they became older but also for socialising, support and companionship. Originally referred in 2005, Provider B's Community Support Service assumed responsibility for Mr B in 2007. His original referral was made to and funded by South Lanarkshire Council Social Work Services.

4. REMIT OF THE REVIEW

4.1 The remit of the Significant Case Review was:

- To create a co-ordinated multi agency chronology based on the existing records of both parties, focusing on the period from January 2006, when a request was received by the local authority for funding in respect of Miss A's care, until her death in May 2014.
- To review individual and multi-agency assessment, risk assessment, planning, review and management arrangements for the period above and determine whether these were responsive to changing needs.
- To review individual and multi-agency practice, policies, procedures and processes to ensure compliance with local and national requirements, including joint governance arrangements.
- To consider agency compliance with statutory responsibilities, and in particular responsibilities that come within the NHS and Community Care Act 1990; Adults with Incapacity (Scotland) Act 2000; the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007.
- To review communication and co-operation both within and between Agencies, including public bodies and contracted service providers.

- To examine how differences were resolved or arbitration advice sought where appropriate.
- To identify where appropriate, any learning arising from the Review on an individual and/or multi agency basis, either locally or nationally.
- To identify any suggested amendments to legislation, or national/local policies.
- To make recommendations for any improvement action in respect of any matters identified as part of the review.

5. LEGISLATION

5.1 There are general principles applying to both the Adults with Incapacity (Scotland) Act 2000 Act and the Adult and Support and Protection (Scotland) Act 2007 which requires professionals working with an adult at risk or an adult with impaired capacity to balance the principles of least intervention, and benefit if intervening in the life of the adult, with the duties placed on them by the legislation to take action necessary to safeguard the person, involving that person in decisions as much as is possible in the circumstances.

5.2 Section 1 of the 2007 Act provides that a person may intervene, or authorise an intervention, in the life of an adult (in this case Miss A) only if they are satisfied that the intervention will provide benefit to the adult which could not reasonably be provided without intervening in their affairs and is the least restrictive to the adult's freedom. Section 3 of the Act defines an adult at risk.

Sections 4 and 5 of the Act outlines certain duties under the Act:

- the duty of a Council to make inquiries about a person's well-being if it knows or believes that the person is an adult at risk and that that it might need to intervene in order to protect the person's well-being, property or financial affairs; and
- the duty of a public body to report the facts and circumstances of the case to the Council where it knows or believes that a person is an adult at risk and that action needs to be taken.

5.3 There is a presumption in Scots law that adults are capable of making personal decisions for themselves and of managing their own affairs but, where there are questions of a lack of capacity, the Adults with Incapacity (Scotland) Act 2000 aims to protect those who lack the capacity to make particular decisions and to support their involvement in making decisions about their own lives as far as they are able to do so. The 2000 Act provides that there should be no intervention in an adult's affairs unless those responsible for authorising or effecting the intervention

are satisfied that the action will benefit the adult and that the benefit cannot reasonably be achieved without the intervention. As far as is possible, the wishes and feelings of the adult are required to be taken account of when intervening. However, Section 10(1)(d) of the Act places a duty on the local authority to investigate any circumstances made known to them in which the personal welfare of an adult seems to them to be at risk.

6. ADULT PROTECTION PROCEDURES

6.1 North Lanarkshire Council Social Work Services developed Practice Guidance and Procedures for Adults at Risk of Harm which:

- Recognises existing legislation;
- Focuses on the Adult Support & Protection (Scotland) Act 2007;
- Contains information on the definition of harm and common indicators;
- Outlines the procedures for intervention;
- Sets out guidance for, and emphasises the importance of, review of actions taken, indicators of good practice and final outcomes;
- Recognises existing systems to protect adults at risk, such as the national care standards, sound recruitment practices and appropriate training and support of staff; and
- Is consistent with the European Convention on Human Rights and the Human Rights Act 1998.

6.2 The aim is always to achieve a proper balance between working in partnership with adults and, if appropriate, their carers. Ensuring the adult's right to be protected from harm remains paramount.

6.3 Ensuring the protection and welfare of adults at risk is more important than rigid adherence to procedures. Where these responses involve departure from the normal procedures they should be defensible and recorded in the case file, showing why the decision not to follow procedures was taken, endorsed and approved by the supervisor or senior manager.

7 METHODOLOGY

7.1 The Lead Reviewer has reviewed this case using the *'Learning Together'* systems approach which was developed with the Social Care Institute for Excellence (SCIE). This approach seeks to understand the multi-agency professional practice with a view to moving beyond the specifics of the particular case – what happened and why – to identify the underlying issues that influence practice more generally. It is these generic patterns that are explored as 'findings' or 'lessons' from the case and the process attempts to look at the care system through the illustration of this specific case as a 'window on the system'.

7.2 The *Learning Together* approach seeks to involve the workers involved in analysing how and why practice unfolded in the way it did and identifying the broader organisational context. Information is gathered from a variety of sources including a review of existing documentation alongside that provided by front line practitioners and their managers.

7.3 The Review Team has comprised senior managers who did not have line management responsibility for the case, led by an independent Lead Reviewer. As Miss A had no surviving family there is no family perspective included in this Review.

8 CIRCUMSTANCES OF CASE

8.1 As reported above, Miss A lived in supported accommodation and received an individual budget, funded by North Lanarkshire Council Social Work Services, which was paid directly to Provider A for her daily support.

8.2 In July 2007, Miss A commenced a relationship with Mr B, who also had a learning disability. Mr B was a client of South Lanarkshire Council Social Work Services and NHS Lanarkshire Learning Disability Team and in receipt of commissioned services from Provider B. The senior managers and staff of North Lanarkshire Council Social Work Services appeared to be unaware that Mr B was a client of South Lanarkshire Council or Provider B.

8.3 Miss A's relationship with Mr B lasted from 2007 until her death in May 2014 but there were periods during those seven years when the couple were not seeing each other including a four-year period when they were not seeing each other at all. Whilst references are brief, there is an indication that the relationship went well in the first year and they became engaged in August 2008. However, by November

2008, Provider A staff recorded that Mr B was 'grumpy and unpleasant' and appeared to be taking money off Miss A.

8.4 On 3rd December 2008, Miss A took an overdose of prescribed medication following the breaking off of the engagement and she was hospitalised overnight feeling low and depressed. At this time, her support staff from Provider A recorded that Mr B had been verbally abusive and had struck her during an argument. It was also noted by Provider A staff that there was bruising on her face, lower back and thighs. These circumstances were reported to the Care Commission at this time.

8.5 Miss A's care was reviewed by Provider A and NLC Social Work Services staff after her overdose and she was subsequently referred to the NHS Lanarkshire Learning Disability Team. At this review it is recorded that she indicated that she was resuming her relationship with Mr B. In conversation with Provider A staff and recorded in the NLC Social Work Services case record, Miss A confirmed that she understood the risks of continuing what was an abusive relationship with Mr B but she had made her mind up that she wanted to be in a relationship with him. There is no record of a formal risk assessment having been undertaken and no record of any formal assessment of her capacity to understand this aspect of her life. However, an increase in Miss A's support package was negotiated with Social Work Services.

8.6 In late December 2008 Provider A referred Miss A to NHS Lanarkshire Learning Disability Team because of the overdose. Miss A disclosed the violent behaviour of Mr B and this was the subject of a number of discussions between Miss A, the NHS Learning Disability nurse and Provider A staff. It is recorded in both Provider A and the Learning Disability Team's case notes that Miss A satisfied those supporting her that she understood the unacceptability of Mr B's violence towards her and knew what she could do about it. Mr B's Psychological Therapist was also involved in some of these discussions during which the view was expressed that Mr B's violent behaviour was uncharacteristic and that he, Mr B, viewed the relationship positively.

8.7 At this time as part of their work with Miss A, a Sexuality Awareness Assessment of Miss A was undertaken by the NHS Lanarkshire Learning Disability Team. This assessment, which concluded that Miss A had an adequate understanding of her sexuality and what was involved in being in a healthy sexual relationship, was not copied to either Provider A or NLC Social Work but the results were discussed with her Provider A Project Manager. Miss A assured the Learning

Disability Nurse who completed the assessment that she understood what to do if someone was to be abusive in a relationship.

8.8 Between January and April 2009, discussions between staff from Provider A, NLC Social Work Services and NHS Lanarkshire Learning Disability Team with both Miss A and Mr B focused on strategies to manage Mr B's violence towards Miss A with a view to ensuring her safety. However, it appeared that Mr B's abusive behaviour continued and he continued to take money from her and break her spectacles. In this period there were three review meetings involving NLC Social Work, Miss A's support team Provider A and Miss A. On 16th March 2009 the NHS Learning Disability Nurse met with Mr B's Psychological Therapist to discuss *'..the negative aspects of the relationship'* and a joint meeting with Miss A and Mr B was suggested. A meeting took place at Motherwell Health Centre on 9th April between the NHS Learning Disability Nurse, Mr B's Psychological Therapist, the Provider A Project Manager for Miss A to discuss how best to resolve concerns raised in regards A and B's on-going relationship. NLC Social Work were not invited to this meeting as it was an internal NHS meeting, but they attended a Review meeting for Miss A on 20th April by which time the relationship between Miss A and Mr had ended.

8.9 In late April 2009 Miss A indicated that the relationship with Mr B had ended and there was no further contact between her and Mr B until August 2013. During that period of four years, Miss A appeared to have no contact with Mr B and her support package reverted to the pre-December 2008 level. She was initially reported to be in good spirits by Provider A and the Learning Disability Team and she was discharged from the Learning Disability Team in September 2009 with her physical and mental health assessed as stable.

8.10 In August 2013, Miss A advised her support team that she had met Mr B again and, whilst she initially indicated that she did not wish to see him because he was shouting at her and asking for money from her, the relationship was fully re-established in November 2013. Whilst there were indications that she was frightened of him, she continued to stress to her support team that she wished to continue with the relationship. At this time the previous history of abuse and violence is not referred to in the case notes of Provider A but NLC Social Work Services recorded that the relationship had been abusive in the past and it would be managed and monitored. There was no detail of what form this management and monitoring would take.

8.11 In late November 2013 her support team felt that she was hiding the relationship with Mr B from them because she realised that they were not happy

with it. In discussions between Provider A and NLC Social Work Services, it was considered that this rendered her more vulnerable and was causing concern and the submission of an Adult Protection referral was considered but not progressed. There were no reasons provided in the case files for this not being progressed. The relationship continued to be on and off over the November, December and January period but in late January 2014 she appeared happy with the relationship.

8.12 A review of Miss A's care took place on 18th February 2014 between staff from Provider A, NLC Social Work Services and herself at which there was some question that Mr B might be 'forcing himself' on her. It was recorded in Provider A's case notes that Miss A was 'unsure of terminology' but that she wished the intimate relationship between her and Mr B to continue. Further discussion took place between staff from both organisations about the submission of an Adult Protection referral to allow more detailed investigation to take place but this was not progressed at that time as further clarity was required. This query was followed up by Social Work Services on 28th March and they were advised by Provider A that Miss A had stated that the sexual relationship with Mr B was consensual and was a 'pleasurable side of the relationship which she consented to.' In light of this, Provider A and NLC Social Work concluded that there was no need for an Adult Protection referral.

8.13 On 26th March 2014 Miss A advised her support team that the relationship was off again and she was blocking calls from Mr B but on 29th April she advised them that the relationship had been re-established. Her contact with Mr B at her flat was being monitored by staff from Provider A within the supported accommodation (but not within Miss A's residence) and she was again advised to contact them if she was unhappy with his behaviour towards her.

8.14 On 18th May, Miss A travelled to Uddingston to meet with Mr B without any of her support staff being present. This was a significant departure from her normal practice as it was not believed by her support staff that she was capable of undertaking this type of journey without support. It was reported by Provider A that she was 'elated and happy with herself'.

8.15 On 19th May, Miss A advised Provider A staff that she intended to travel to Uddingston again that day to meet with Mr B and she was reminded to be back by 3.00pm for the regular meeting with her support team. She failed to return by the expected time and staff began searching for her. Mr B was contacted by Provider A staff by telephone and asked if he had seen Miss A and he reported that he had pushed her in the river. The police were contacted and Miss A's body was

recovered from the River Clyde later that evening. Mr B was subsequently arrested and charged with her murder.

9. IDENTIFIED CONCERNS

9.1 Abusive Behaviour in the Relationship

9.1.1 The relationship between Miss A and Mr B was abusive from the outset. This abuse comprised physical violence, verbal abuse and financial abuse including the destruction of property. Miss A took an overdose in December 2008 because the relationship between her and Mr B had been broken off and there was increased multi-agency support to her at this time. There were repeated references in the records to Mr B shouting at her and being verbally abusive and his psychological therapist advised that he had been working with Mr B to address, amongst other behaviours, Mr B's verbal aggression. The abuse and violence was continuous and repeated throughout the time of their relationship and it recommenced when their relationship resumed in 2013 after an interval of over four years. The chronic nature of this abuse must have had a significant cumulative emotional and psychological effect on Miss A.

9.1.2 There are repeated references to Mr B taking money from Miss A, possibly to purchase alcohol. There is no indication that this money was stolen but, whilst this may have been given of Miss A's own volition, it is possible that there was an element of coercion involved, either physical or emotional, which would have been exacerbated by the fact that she was not good at managing her finances. There is no reference to any discussion of this with Miss A in the case files. There were reports of Miss A's spectacles being broken by Mr B on seven occasions over the duration of their relationship and the financial costs of this would be in the region of at least £800. This regularly left Miss A short of money and, taken together, should have caused her support staff to question her capacity to understand the risks she was facing and her capacity to make decisions and understand them.

9.1.3 On 9th April 2009 NHS Nursing and Psychology staff held a therapeutic discussion at Motherwell Health Centre to consider the concerns about the ongoing relationship between Miss A and Mr B. The notes of this discussion do not describe the detail of what was discussed other than to record knowledge of Mr B breaking Miss A's spectacles and taking money from her. Miss A, accompanied by a member of her support team, Provider A, and Mr B attended the latter part of this discussion

but were not engaged in dialogue around the alleged physical violence. NLC Social Work were not included in this discussion and no consideration appeared to have been given to making an Adult Protection referral in respect of the violence and abuse in the relationship. In the event Miss A broke off the relationship shortly after this and potential follow-up meetings with Miss A and Mr B did not take place. Apart from this meeting there was no other contact between any of the services providing support to Miss A with any of the services providing support to Mr B.

9.2 Lack of Police Involvement

9.2.1 Miss A was involved in an on/off relationship with Mr B from July 2007 until her death in May 2014, albeit that there was a four-year period during which they were not seeing each other. The relationship was continually abusive and violent throughout the periods that the couple were seeing each other and it was regularly recorded that Mr B was violent towards her, verbally abusive, took money from her and broke her spectacles. In spite of the fact that this was evident on a very regular basis throughout, it seemed not to arise as a factor in the considerations by Provider A, Social Work Services or the Learning Disability Team that the Police might be able to offer alternative options or opinions on the approaches to be adopted to protect Miss A. While there is no guarantee that the Police would have become actively involved in the management of Miss A's case, the absence of any input from them meant that an enforcement and preventive perspective was absent from the discussions about her vulnerability.

9.3 Assumption of Capacity

9.3.1 In discussions with staff from Provider, it was assumed by them that Miss A had the capacity to make decisions about her relationship and understood the consequences of her decisions. It was reported to the Lead Reviewer that this assumption was based on their view that all clients have capacity unless otherwise indicated and their experience of working with individuals with learning disabilities. It was, thus, informal and was not supported by any formal assessment of Miss A's capacity. It was also assumed by her support team that she would follow the advice she received from her support workers about how to deal with the ongoing violence and abuse from Mr B. Again, this was an informal assumption and no formal assessment of risk was undertaken.

9.3.2. Miss A's wish to continue the relationship with Mr B, the constant abusive nature of the relationship and the later indications that she was 'hiding' this from her support team because of their perceived disapproval of the relationship should have raised serious questions in the minds of all of the professionals

supporting Miss A about her capacity in this respect and her proper understanding of the risks and consequences of continuing the relationship. It should have led to a formal assessment of her capacity, an assessment of the risks she was facing and a plan to manage and mitigate these risks and a referral under the local Adult Protection Procedures. However, it did not do so.

9.4 Referral under Adult Protection Procedures

9.4.1. Whilst it was considered on at least two occasions, a referral under the local Adult Protection Procedures in respect of Miss A as a vulnerable person in need of protection was never submitted.

9.4.2. An objective view, albeit with the benefit of hindsight and based on the information now available, is that Miss A was unable to safeguard her own well-being and property, was actually being harmed rather than being at risk of harm and, because of her learning disability, was more vulnerable to being harmed than an adult not so affected. When considered over the length of the couple's relationship and, in particular, in the period from when it resumed in August 2013 until her death in May 2014, the continuing abusive nature of the relationship, the regular reports from Miss A that she was being hit and verbally abused by Mr B and that he was continuing to take money from her, it would have been expected that a referral under the local adult protection procedures would have been made in respect of Miss A's vulnerability.

9.4.3. Had this been done, a more comprehensive and fully multi-agency assessment of her circumstances would have been undertaken with her protection as the focus and this would have involved the police. It is believed that the wider discussion that this would have generated would have included a criminal justice and domestic abuse focus that was not obviously present in any of the discussions that took place in respect of Miss A prior to her death.

10. PROFESSIONAL PRACTICE

10.1 Miss A's case illustrates the challenges facing professionals working with a vulnerable person with a learning disability and the risks associated with their right to make a decision to have a relationship with another individual. The fact that the other person also has a learning disability but who is in receipt of support from a different local authority adds a further complicating factor.

10.2 Miss A was regarded by all of the professionals supporting her as having the necessary capacity to make decisions in relation to her relationship with Mr B. They were of the view that her decisions needed to be respected and the staff from Provider A were of the view that she had the capacity to make properly informed decisions about entering into and continuing a relationship with Mr B.

10.3 Notwithstanding that there was continual physical violence towards Miss A and verbal and financial abuse of her by Mr B during the relationship, the staff were of the view that she, although recognising that his behaviour towards her was bad, wished the relationship to continue. In light of that, they advised the Lead Reviewer that they had made every effort to ensure that a member of staff was close by whilst Mr B was visiting her at her flat on agreed days and that she knew that staff were in the proximity and could be called on if required whilst respecting their dignity and privacy. She was briefed by them on what she should do if Mr B was violent or 'bad' towards her and they facilitated her blocking unwanted telephone calls from him at times when the relationship had broken down. These were the only risk management arrangements in place for her and there was no formal risk management strategy.

10.4 In deciding not to involve the police, her support workers advised the Lead Reviewer that she had a habit of being fanciful and telling stories, was reluctant for the police to be contacted and they, themselves, had concerns that she would not be a credible witness. They also expressed their concern that they would lose Miss A's co-operation as a client, something that they considered vital to the long-standing relationship they had developed with her. Notwithstanding these concerns, Provider A had a professional duty to safeguard Miss A and the overriding requirement was to take whatever action was necessary to achieve this and manage any subsequent difficulties or consequences in an appropriate manner and in consultation with NLC Social Work.

10.5 As a housing support and care service, Provider A were the subject of inspections, both scheduled and unannounced, by the Care Commission (from 2006

until 2010) or the Care Inspectorate (from 2012 until 2015). In the Inspection reports from 2006 until 2013 the assessment of the inspecting officer under the areas of support, staffing and management graded the organisation as either 'good' or 'very good'. In the inspection undertaken in August 2014, the grades for staffing and management were 'adequate'. Areas for improvement identified were stated – *"Although we saw some good examples of well-completed and comprehensive support plans and risk assessments, this standard was not consistent…."* The Inspection identified that *"…a number of staff had not completed their induction and mandatory training despite being employed for a number of years."* and *"There still remains a large number of staff who have not completed Adult Support and Protection training. This training is important as it gives staff information on identifying and responding to suspected or actual incidents of abuse."* *"We saw that there was scope for clearer information on incident forms regarding any management action including any required changes to risk assessments and support plans."* The Inspection Report of May 2015 reflected grades of 'good' for Quality of Care and Support, Quality of Staffing and Quality of Management and Leadership The Inspection Report noted in the summary that "*The service has made a lot of progress since the last inspection and we saw that work has been undertaken to improve systems and processes that were not working effectively. Much of this work is only just beginning to be implemented and it was not possible to evaluate its effectiveness…"*

10.6 The Care Commission/Care Inspectorate inspections of Provider A from 2006 through to 2013 graded the aspects of professional service that bore directly on the safety and well-being of clients as 'good' and 'very good' yet in August 2014, four months after the death of Miss A, the Service was graded only as 'adequate'. Whilst possible, it seems improbable that these areas of service declined so rapidly in the period of twelve months. The fact that this downgrading is recorded in an inspection only after the death of a client may call into question the quality of aspects of the previous inspections by the Care Inspectorate in the period prior to the death of Miss A.

10.7 In respect of North Lanarkshire Council Social Work Services' practice, the Lead Reviewer was not able to speak with any of the social workers who had handled Miss A's case. However, he was provided with excellent support from their senior managers and access to the relevant files, including an account of subsequent disciplinary action against a member of staff.

10.8 The disciplinary action following an internal investigation concluded that there were a number of concerns around professional practice that overlooked the appropriate consideration of Adult Support & Protection procedures. Allegations made by Miss A at her case review in February 2014 were not investigated properly

and procedures were not followed. Provider A staff, commissioned officers for the client, would appear to have been left with the responsibility to clarify further with Miss A the concerns raised at the meeting rather than social work submitting an Adult Protection Referral and investigating further.

10.9 The member of staff admitted that, as an experienced and qualified worker, she had missed signs that she should have responded to. It was clear that other partnership agencies and Social Work Services staff had made similar errors throughout the time that they had worked with Miss A in terms of failing to properly assess and manage risk of abuse towards her.

10.10 Case notes were not always clear or up-to-date and did not properly and unambiguously record information pertaining to repeated allegations of abuse and the risk that represented. It was noted that the recording by partnership agencies was not always clear and, although there is reference to risk, it was not always recorded in the appropriate format or highlighted, therefore it did not give immediate cause for concern.

10.11 There appeared to be no evidence of the consideration of protective action, despite the concerns about the relationship with Mr B being raised repeatedly in review minutes over a period of time. There appeared to be an assumption that Miss A had the capacity to make decisions regarding the relationship and, in the event, when Miss A was advised to report any abusive behaviour to staff and did not do so, no protective action was taken.

10.12 NHS Lanarkshire's Learning Disability Team staff were aware that Miss A was being physically and verbally abused by Mr B and her property was being damaged. They liaised with Mr B's Psychological Therapist and discussed concerns about the negative aspects of the relationship and proposed a joint meeting with Miss A and Mr B to provide support around developing positive relationships. An initial meeting was convened with Provider A staff and both Miss A and Mr B and covered how best to resolve concerns about the relationship and about Mr B having broken Miss A's spectacles and taken money from her. No discussion took place about the physical violence, it being intended to be raised at a future meeting. However, as the relationship was broken off shortly after that meeting, there was no further opportunity to discuss this with them together and Miss A was discharged from the Learning Disability Team before the relationship resumed.

10.13 An objective assessment of the information available to the Learning Disability Team when taken together with the information possessed by Provider A

staff, was more than sufficient to justify a referral under local Adult Protection Procedures but this was not done.

11. CONCLUSIONS

11.1 Section 10(1)(d) of the Adults with Incapacity (Scotland) Act 2000 places a duty on the local authority to investigate any circumstances made known to them in which the personal welfare of an adult seems to them to be at risk. In the case of Miss A, there was ample evidence available to all of the professionals involved in supporting her that her relationship with Mr B was an abusive one.

11.2 Given the extent of this evidence, had the management of the care of Miss A been properly exercised, it should have been sufficient to justify an investigation and further protective and safeguarding activity. However, in spite of that, there was no formal assessment of the capacity of Miss A to make an informed decision in respect of her safety at any time in the period under review; there was no involvement of the police in what was a criminal matter; and, in not referring the matter to the police, there was a decision made by her support team without any formal basis that Miss A would not be a credible witness.

11.3 Whilst there were discussions about the nature of the relationship between Miss A and Mr B, at no time was a formal assessment carried out of the risks that Miss A faced in continuing her relationship with Mr B given the verbal abuse and physical violence he perpetrated on her.

11.4 Miss A was a woman with learning disability and, whilst she had capacity to make decisions about many things in her life, she required support on a daily basis for a number of key aspects of her life. An objective assessment of the Adult and Support and Protection (Scotland) Act 2007 should have concluded that she comfortably met the definition of an adult at risk of harm under Section 3 of the Act.

11.5 The staff in the services working with Miss A were aware that she was in a relationship with Mr B which was abusive and violent. Whilst it was discussed on at least two occasions, the submission of a referral under the local Adult Protection Procedures was not progressed. Increasingly throughout the relationship, an objective assessment of Miss A's treatment at the hands of Mr B and the evidence that was available at the time was of such a nature as to justify a referral under local Adult Protection Procedures.

11.6 The case records show that Miss A had contact with Mr B in August 2013 and that *'he was shouting at her, asking for money and appeared to have been drinking – A told him and her staff that she does not want to see him again.'* This was advised to Mr B by

Provider A staff when he called but he continued to attempt contact throughout August 2013.

11.7 Miss A re-established her relationship with Mr B in November 2013. Given the previous violent nature of the relationship recorded in the files of both Provider A and NLC Social Work over the period from December 2008 to April 2009 and the concerns recorded in August 2013, it would have been expected that immediate concerns would have been raised and action taken to consider and manage any risk to her safety in the re-establishment of the relationship. However, there is no record of multi-agency discussions about the risks of further violence and abuse, additional protective measures or the possibility of a referral under Adult Support and Protection processes.

11.8 Throughout the periods in which Miss A was receiving care from Provider A, NLC Social Work Services and NHS Lanarkshire Learning Disability Services, there were a significant number of opportunities to put in place measures that would, in all probability, have protected Miss A and enabled the relationship to be managed. All of these opportunities were missed by the various services and, whilst this may not have prevented the fatal outcome that transpired, a fuller discussion about the risks may have offered alternative strategies that, if introduced, might well have.

11.9 There was clear and continuing evidence of violence and abuse within the relationship between Miss A and Mr B. This violence was continuous throughout the length of the relationship and it recommenced in 2013 when the couple resumed their relationship after the break of nearly four years. Regardless of this, the police were never involved and, as a result, a police perspective with potential additional strategies to address and counter violent and abusive behaviour were never given the opportunity to be considered.

11.10 Mr B had a learning disability and he, too, was in receipt of services, albeit to a more limited extent, from South Lanarkshire Council Social Work Services, NHS Lanarkshire Learning Disability Team and Provider B. He had had previous contact with Strathclyde Police, British Transport Police and Police Scotland but did not have any criminal convictions. Apart from an allegation of a minor assault on a group of youths explained at 3.3 above, he had no history of violence other than in this relationship. The Provider A staff working with Miss A were unaware that Mr B was a client of South Lanarkshire Council Social Work Services and in receipt of support from Provider B until shortly before Miss A's death. There was no real contact between the services in the two local authority areas at any time prior to Miss A's death and there is little doubt that this was a missed opportunity.

11.11 Carers, in this case staff in NLC Social Work Services and Provider A, are presented with the daily and unenviable task of striking the right balance between respecting a person's decision-making whilst also ensuring they are fulfilling their 'duty of care' to their client. That balance was not always properly struck in this case.

11.12 There was no history of Mr B being violent, he had no criminal history of violence of any sort and his psychological assessment did not identify that as a risk. However, it was clear that Mr B was abusive and violent towards Miss A and, had the relationship continued, it was likely that the abuse and violence would have continued. Notwithstanding that, there was no indication that the relationship would lead to her death and, as such, her death was not foreseeable.

11.13 Had there been formal assessments of her capacity or of the risks that she faced in continuing the relationship with Mr B and had the case been referred under local Adult Protection Procedures it is likely that alternative action would have been taken that may have provided greater safeguards for Miss A.

11.14 In reviewing this case, a number of issues have been identified that have caused concern:

- The absence of a formal assessment of Miss A's capacity to make informed decisions given that she required support in a number of other areas of her day-to-day living;
- The absence of a formal assessment of the ongoing risks to Miss A in continuing in and resuming a relationship with Mr B that was abusive and violent;
- The assumptions made about and the casual dismissal of Miss A's credibility as a witness to the violence and abuse perpetrated by Mr B;
- An absence of involvement of the police as a possible additional partner agency;
- The absence of the effective escalation of concerns about Miss A's safety when they became evident to staff;
- The apparent absence of the understanding of the duty to safeguard Miss A as opposed to merely providing her with care and support

These are, of themselves, separate issues but a different approach to any one or all of them might have strengthened the safeguards for Miss A.

11.15 In reaching these conclusions, the Lead Reviewer has no doubt that the professionals involved in the care of Miss A were committed to achieving the best outcomes for their client and they have been deeply affected by her death.

12. RECOMMENDATIONS FOR PROVIDERS, PUBLIC AGENCIES AND THE ADULT PROTECTION COMMITTEE

12.1 It is recommended that all services undertake and publish an annual review of the quality and frequency of training in adult support and protection to ensure the full understanding of and compliance with local procedures; an adequacy of staff knowledge of the early identification of situations in which there is a need for a referral in terms of the Procedures; and the progressing of adult support and protection referrals timeously.

12.2 It is recommended that the training for both staff and managers in relation to the understanding and management of both capacity and risk in respect of vulnerable clients is reviewed and, where necessary, updated.

12.3 It is recommended that, in all cases where an individual is identified as being in a situation or relationship where abuse or violence are suspected, the police are informed at the earliest opportunity and are actively involved in the multi-agency assessment and management of the risks existing within the relationship.

12.4 It is recommended that, in cases involving the delivery of support services to a person with a learning disability:

- where there is a question or a concern as to that person's capacity to make informed decisions about their care, or
- where there is a question or concern about the risks they face in their day-to-day life, including in their relationships with others,

a formal assessment of their capacity and a formal assessment of risks should inform the development of any support plan.

12.5 It is recommended that, in reviewing and updating training, emphasis is placed on the importance of recording an appropriate level of detail in case notes as good record keeping helps to improve accountability and shows how decisions related to an individual's care and support needs were made. All staff are accountable and responsible for case recording and for ensuring that the management and quality of that record is in line with the standards set out within their own agency. This should also assist in any retrospective review by providing a clear and defensible reasoning for actions (both taken and not taken) in respect of the care of a vulnerable person.

12.6 It is recommended that North Lanarkshire Council conduct a comprehensive review of its current arrangements for commissioning services to ensure that commissioned services have a proper understanding of how to escalate concerns to

ensure that the needs of clients are met and care management responsibilities are properly coordinated and delivered by commissioned organisations. This recommendation will have a wider applicability and other local authorities may wish to consider their own arrangements in this respect.

12.7 It is recommended that the concerns about the quality of the Care Inspectorate's scrutiny of service providers is raised with both the Care Inspectorate and the Scottish Government.

APPENDIX 1: METHODOLOGY AND PROCESS

A 'Learning Together' review process is based on several key principles:

- Avoid hindsight bias – by seeking to understand the situation for the workers at the time, exploring their understanding of the case and the contributory factors that influenced their practice at the time.
- Provide adequate explanations – appraise and explain decisions, actions and inactions by the professionals who were working on the case. A systems approach understands performance as the result of interactions between the context of the case and what the individual brings to it. The review will gain an understanding of what happened and why.
- Move from the individual case to find learning that has a general significance – the process moves beyond understanding the specifics of the particular case to identify the 'deeper', underlying systemic issues that are influencing practice more generally.
- Produce findings and questions for the Board to consider – the process recognises the generic patterns (findings) allowing the Board to consider those issues and establish the actions they think are required to improve the local functioning of the safeguarding system.

The three main phases of the Review process are:

- Reconstructing what happened – unearthing the 'view from the tunnel' from talking with the practitioners involved and understanding their 'local rationality'. to avoid hindsight bias and to learn how people saw things at the time
- Appraising their practice and explaining why it happened through the identification and analysis of Key Practice Episodes (KPE's). Then to understand the way that things happened and explore the contributory factors that were influencing the services' working practices. This is known as the 'local rationality'.
- Assessing the underlying relevance and understanding what the implications are for wider practice – using the particular case as a 'window on the system' to develop generic findings.

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings. The review followed the process and meeting structures as outlined by SCIE.

APPENDIX 2 - THE REVIEW TEAM

The SCR was carried out by a Review Team led by independent reviewer Donald Urquhart. The Lead Reviewer did not have any direct involvement with the case prior to the review.

The Review Team provide a source of high level strategic information about their own agencies as well as professional expertise in their fields. Together with the Lead Reviewer they collected data about this case and contributed to the analysis of practice and to the development of the findings from the Review and produced and agreed this report. No members of the Review Team had any direct case management responsibility in relation to the services offered at the time of the incidents that were being reviewed. The Review Team was made up as follows:

- The Independent Chair of North Lanarkshire Adult Protection Committee
- A senior manager from North Lanarkshire Council Social Work Services
- A senior manager from South Lanarkshire Council Social Work Services
- A senior manager from NHS Lanarkshire
- A Detective Inspector from Police Scotland

APPENDIX 3 – SOURCES OF DATA

In total 14 practitioners were involved in individual face to face conversations with the Lead Reviewer representing:

- North Lanarkshire Council Social Work Services
- Provider A
- NHS Lanarkshire
- South Lanarkshire Council Social Work Services
- Provider B
- Police Scotland

Six of these were directly involved with Miss A and four were directly involved with Mr B.

DATA FROM DOCUMENTATION

In the course of the review the Review Team members had access to key documentation including:

- The chronology submitted by Provider A
- The chronology submitted by NLC Social Work Services
- The chronology submitted by NHS Lanarkshire Learning Disability Team
- The chronology submitted by Police Scotland
- Provider A Essential Lifestyle Plan and Personal Outcomes Plan for Miss A
- The chronology submitted by SLC Social Work Services
- NHS Lanarkshire Mental Health and Learning Disabilities Internal Reflective Review
- NHS Lanarkshire Community Nursing Assessment of Miss A
- NHS Lanarkshire Sexuality Assessment of Miss A
- SLC Social Work Services Review of Mr B
- Provider B Personal Plan for Mr B
- Police Scotland statements relating to the death of Miss A
- NLC Adult Support and Protection Procedures (December 2012)
- Generic Contract between Provider A and NLC for Provision of Individualised Support Arrangements (not specific to Miss A)
- NHS Lanarkshire Adult Support and Protection Policy and supporting guidelines
- Care Inspectorate Reports in relation to Provider A 2006 to 2015

LIMITATIONS IN RELATION TO DATA

During the review the following limitations on access to data were identified:

- During the Review it was not possible to speak to the NLC Social Workers or SW Assistants who dealt directly with Miss A. However, the Lead Reviewer was provided with full access to NLC SW's case files in relation to Miss A and with a detailed account of disciplinary action in relation to one of the social workers who provided direct service to Miss A.
- It was also not possible to speak with Provider B's worker who provided support to Mr B but full support was provided by the Director of Adult Care and the Team Leader of Provider B.