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The purpose of the Significant Case Review was to:

- Identify lessons to be learnt from the circumstances of the case
- Improve future practice by acting on that learning
- Inform and improve multi-agency working.



Circumstances

- Miss G had physical disabilities from an injury in 2009
- Care at Home was delivered until 2016
- Sister co-habitant cancelled Care at Home to self-care for Miss G
- November 2016 Miss G found murdered in her home. 19 rib fractures & broken neck
- April 2018 sister convicted of murder

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Reviewing our HSCP Practices

- Closure of care packages
- Record keeping & chronologies
- Case reviews
- Management oversight
- Capacity for reviews
- ASP identification & reaction
- Duty System – effectiveness
- Use of audits-how do we monitor practice?
- Professional decision making
- Individual responsibilities



Opportunities for Agency Involvement through concern reports

- Financial harm
- Bullying by the sister
- Disputes between the sister and carers
- Child Protection
- Familial relationships

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Recommendations

- Formal review of care packages prior to closing/transfer & need for direct client contact
- Review care packages annually
- Scrutiny of Duty System to ensure effectiveness
- Robust IT recording
- Disciplinary processes

Conclusions

- Intervention opportunities missed
- Ending care exposed Miss G to abuse which killed her
- Knowledge of ASP
- Failings in Duty System
- Deterioration in management of the case
- Review of community care cases inadequate

Issues

Critical

- Closure of Care Package
- Duty phone call

Contributory

- Community care reviews
- Duty system
- Case handover
- Recording & Information
- Management practice

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**Questions to Consider?**

How to we apply this learning within the service?  
Will these actions and recommendations work?

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