Summary and Recommendations of a Significant Case Review (B)

December 2014

Glasgow City Council Significant Case Review – Ms A

1.0 Context

1.1 This significant case review was commissioned by the Glasgow Adult Protection Committee in the context of the Glasgow Adult Protection Significant Case Review Protocol. The purpose of the significant case review was to establish the following under the auspices of adult support and protection inter agency responsibilities:

- Whether lessons could be learned about the way local practitioners and agencies worked together, in the light of a situation where an adult who had been part of the adult protection and/or other welfare systems, experienced significant harm.

- To identify what key lessons learned were, to recommend how best they be acted upon and what outcomes may be expected through change as a result.

- To provide a framework for improvement in inter-agency working towards the better support and protection for adults seen to be at risk of harm within Glasgow City.

2.0 Summary of the case

2.1 Ms A was admitted for a two week respite stay to an independent provider's unit within Glasgow. When she returned to her usual day centre service directly from the respite unit she was noticed to be in pain and discomfort with some bruising evident on her body. Day centre staff informed her family and offered to take Ms A to hospital but her family chose to do this themselves. The Provider had recorded a "bruising" injury in their Incident Log book but no medical intervention had been sought. Ms A and her family attended her local A&E department where she was diagnosed with a fracture. At the A&E department scratching and bruising were noted. It would not have been possible for Ms A to inflict any of these injuries to herself due to her particular condition. Ms A's father then informed Glasgow City Council Social Work Services that his daughter had sustained an injury whilst in respite care.

2.2 The Provider was asked to carry out an initial investigation of the incident but was unable to ascertain where, when and how Ms A had sustained her injuries. Subsequently an anonymous whistle blowing email was sent to the Care Inspectorate stating that Ms A had sustained an alleged injury at the unit she had attended for respite care. There was a further allegation of financial irregularities in relation to staff purchasing an item from Ms A's personal monies.

2.3 This led to a series of further investigations and case discussions by various agencies, the lead one being the Care Inspectorate. At the conclusion of

these investigations no charges were brought against anyone. The family were not in agreement with this decision and believe that there has been no resolution to the incident.

3.0 Recommendations

3.1 The significant case review concluded that lessons could be learned by all of the agencies involved in relation to the application of Adult Support and Protection procedures and joint working practices. The recommendations for consideration on a single and multi-agency basis were as follows:

4.0 Care Inspectorate recommendations

4.1 The Care Inspectorate must ensure that any concerns of an Adult Support and Protection nature are identified quickly and the appropriate action taken. In this instance it took the Care Inspectorate 12 days to notify Glasgow City Council of this incident. The Care Inspectorate has since introduced a new system which should expedite the whole process.

4.2 The Care Inspectorate investigation led to the conclusion that there was “collusion” between members of staff within the respite unit who made attempts to “cover up” the incident. This raises an issue over personal and professional responsibility and accountability in relation to senior management at the unit. Additionally it highlights the need for training in the processes for Adult Support and Protection and whistle-blowing especially for provider organisations.

5.0 Social Work Services recommendations

5.1 It is clear that there is a lack of clarity for some social work staff about the use of the Multi-agency Adult Support and Protection Procedures and the use of the Deficits in Care Protocol. Both documents require to be reviewed in terms of clarity and briefings then take place so that there is clarity amongst its managers as to when to instigate them.

5.2 The Provider organisation should be given the opportunity to establish the circumstances of any incident and report back on it to the appropriate agency. However the managing agency must set a timescale to the Provider organisation for the completion of the report. Five working days for an incident involving Adult Support and Protection is suggested as practical and feasible. It would also be of benefit to provider agencies if the managing agency provides a draft template on the reporting criteria and what the initial report should contain in relation to when, circumstances, staffing, dates and times and any other pertinent information that will be required. For the purposes of any incident relating to Adult Support and Protection the lead managing agency must always be Social Work.

5.3 The correct procedures must always be followed in relation to all incidents of Adult Support and Protection.

6.0 Joint Working recommendation

6.1 This incident has highlighted the need for closer working relationships between different agencies particularly in relation to Adult Support and Protection issues. There is a need to strengthen inter-agency working relationships principally in relation to communication and information sharing. With this in mind it was agreed that it would be beneficial to establish a formal group of professionals including social work and the police which would meet quarterly and would review existing cases and unresolved cases of adult support and protection whereby multi agency discussion may improve outcomes.

7.0 Police Scotland recommendations

7.1 With regards to the Police investigation, the incident should have immediately been processed as an Adult Support and Protection issue. The information received from Glasgow City Council Police Liaison Officer appears to conflict with that of the Police' Adult Support and Protection Team. There needs to be clarity of information provided, to ensure that the correct procedural routes are followed regarding complaints of this nature. This has highlighted the need for additional training and education on the correct processes to use when investigating issues of Adult Support and Protection

7.2 A number of agencies and Ms A's family raised the issue of a prosecution against the Provider on "Neglect of Care". The Police officers who attended the family, on the conclusion of their investigation, intimated that there was no case to answer and that it was a matter for Adult Support and Protection. There needs to be a greater emphasis placed on liaison between different agencies and the Police to minimise confusion and conflicting opinions and outcomes.