Significant Case Review

Adult Support and Protection Committee

In respect of Adult B

HIGHLY CONFIDENTIAL

Lead Reviewers:

[redacted] NHS Greater Glasgow & Clyde

[redacted] Glasgow City HSCP

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Please note – no attempt should be made to identify the individuals in this report

Introduction

1. Why this case was chosen to be reviewed?

1.1 The case was referred to Glasgow City's Adult Support and Protection Committee following the death of Adult B from sepsis. At the time of her death Adult B was the subject of an Adult Support & Protection investigation in response to concerns raised by hospital staff who had noted indicators of neglect on admission.

Significant case reviews are important for those individuals, families and agencies in involved in critical incidents and to promote learning across agencies.

2. Succinct summary of case

2.1 Adult B was a 36 years old lady who lived with her parents and boyfriend at her parents' home in Glasgow. Adult B, who had capacity, had numerous long term health issues including immature personality disorder, agoraphobia, panic disorder, dermatitis and morbid obesity.

2.2 In December 2015 Adult B was admitted to hospital with abdominal pain and 6-7 weeks history of vomiting. Despite her morbid obesity, she was admitted in a malnourished condition with evidence of neglect and poor personal hygiene. She had a prolonged and complicated stay in hospital before being discharged to her family home in March 2016.

2.3 In June 2016 Adult B was re-admitted to hospital with infected leg ulcers and anaemia, and following extensive clinical investigations a diagnosis was made of non-Hodgkin's lymphoma. After a prolonged stay in hospital she went home in October 2016 to the care of her family and her General Practitioner. Community nurses were denied access to Adult B's home and specialist input from tissue viability was also declined. Nursing staff were concerned about her vulnerability in this environment and made an adult support & protection referral which was quickly closed down; the issues of Adult B and her mother refusing care and assistance were longstanding and it was felt that a support needs assessment was required, not adult support and protection. The family remained unwilling to engage with social work and subsequently the case was closed mid February 2017.

2.4 Towards the end of February 2017 Adult B was admitted to hospital from squalid living conditions at home with sepsis and acute kidney injury. Such was the seriousness of her condition she was admitted to the high dependency unit and required haemodialysis; her social issues were not investigated with her or her family. There was no new package of care arranged to support her discharge home however specific district nurses were granted permission from Adult B to access the home for select treatment interventions only.

2.5 Adult B had a further hospital admission in April 2018 with acute kidney injury and sepsis; her condition was extremely poor and her family was advised that she may not recover from this acute episode. However by the end of April Adult B was well enough to go home, but as before Adult B and her mother were very selective in whom they allowed to care for Adult B's complex physical needs in her home.

2.6 In July 2018 Adult B was re-admitted to hospital with septic shock. She was in a poor state of neglect with multiple infected skin wounds and ulcers. Nursing staff made an adult support & protection referral but Adult B's mother prevented social work staff speaking to Adult B alone. As Adult B was critically unwell and thought not to benefit from ventilation and/or renal replacement therapy, following discussions with her family, a DNACPR (do not attempt cardiopulmonary resuscitation) decision was made. Adult B died mid July 2018 and the adult support & protection investigation was closed.

3. Methodology

3.1 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the "deeper", underlying issues that are influencing practice more generally. It is these generic patterns that count as "findings" from a case and changing them will contribute to improving practice more widely.

3.2 At the analytic heart of the Learning Together model are three key questions;

- **What happened?** Reconstructing the case and surrounding context as experience by the professionals involved;
- **Why did it happen?** Analysing practice in detail appraising individual practice and looking at individual, local and national influences on practice; and
- **What are the implications for wider practice?** Exploring whether issues identified in the case apply more widely and their relevance to achieving better safeguarding.

3.3 Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour.

The key tasks are data collection and analysis. Data comes from semi-structured conversations with involved professionals, case files and contextual documentation from organisations.

3.4 The fact that family members were unwilling to participate in the review process was a significant limitation on this review. The absence of the perspectives of family members regarding their experience of working with services, what they had found helpful and what they found created barriers and challenges to

working together with agencies to keep Adult B safe, has made it difficult to address questions focused on whole family approaches to assessment and service delivery.

Review Team and Case Group

3.5 The learning review was undertaken by two lead reviewers who have been trained in using the SCIE's (Social Care Institute for Excellence) Learning Together methodology. The reviewers were supported by a Supervisor and Review Team whose membership were drawn from across agencies involved in the case and had not held any decision-making responsibility in relation to the case. Collectively, their role was to contribute to the analysis of data and inform the final report. SCIE supervisor, provided methodological oversight and quality assurance. Ownership of the final report lies with the Glasgow City Adult Protection Committee as commissioner of the case review.

3.6 The SCIE model involves gathering and making sense of information about a case through meetings with the Review Team and a Case Group of practitioners who had been directly involved in the case. Draft research questions were shared and refined in consultation with the Review Team and Case Group, and the conversations with individual practitioners were reconstructed and shared with the Review Team and Case Group. Both groups were involved in the analysis of practice on the specific case and in discussions to identify the wider systemic findings. Attendance at all meetings. Attendance at all meetings was requested but not always possible.

3.7 The Lead Reviewers met the Case Group and Review Team on 14 occasions (Appendix 3).

3.8 12 conversations were held with 35 staff – some were individual conversations and some were in small groups of two, three or four professionals (Appendix 2).

Research question

3.9 The research question identified for this review was;

What can we learn about the manner in which the quality of care for service users living at home is assessed and responded to by professionals, with particular reference to;

- The professional interface with the carers, and
- The needs of others in the household

Methodological comment and limitations

3.10 The focus of the review was the period from December 2015 to April 2018. There is information that came to light during the investigation that is not presented in this report, that is because the issues were unable to be verified by Adult B or because the issues relate to practice out with the timescale of the SCR.

3.11 Due to sickness absences and holidays, it was not always possible that all members of the Review Team and Case Group could meet together on all occasions however every effort was made to seek the views of colleagues.

3.12 The review process was very protracted, which is not the norm for this model; this was initially due to the conflicting demands of both Lead Reviewers and latterly due to the changes in Lead Reviewers' roles in response to COVID-19. In addition, one Lead Reviewer took up a new position with a different health board. Undertaking a significant case review using this model needs protected time away from operational demands. Furthermore, endeavours to engage the family in the review delayed the start of this work.

4. Sources of data

Conversations and case group

4.1 The Lead Reviewers conducted semi-structures conversations with staff in a variety of roles, which together formed the Case Group for the review (Appendix 2).

4.2 The review was also informed by the following documents;

- Electronic patient record for Adult B
- Multi-agency chronologies
- Initial Case Review Report for SCR panel from Acute Health
- Initial Case Review Report for SCR panel from Police Scotland
- Initial Case Review Report for SCR panel from Education
- Initial Case Review Report for SCR panel from HSCP (South)
- Critical Incident Report

Perspectives of the family members

4.3 A significant effort was made to engage with the family at the start of the SCR process and after initial agreement they ultimately declined to participate in the process.

5. Structure of the report

5.1 Guidance (Scottish Government, 2015) for those producing SCR reports suggests a consistent structure to make it easier for people to read. The report structure and content of the SCIE Learning Together model is outlined in full in Annex 5 of Scottish Government Guidance and, in line with that, this reports includes;

- A contextual introduction
- A succinct summary of practice
- An appraisal of practice on the specific case
- Findings, categorised using a systems typology
- Considerations for the APC to help reach decisions about solutions and changes required

Findings

6. Introduction

6.1 A case review plays an important part in efforts to achieve a safer adult protection system, one that is more effective in its efforts to safeguard and protect adults. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the adult protection system. The particular case acts as "a window on the system" (Vincent, 2004).

6.2 Case review findings therefore need to say something about the Adult Protection Committee or about agencies and their usual patterns of working. They exist in the present and potentially impact the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of adults and families; these may not be the issues that appeared most critical in the context of a particular case, however they may present the most risk to the system if left unaddressed. In this review the prioritisation of findings is a matter for the Adult Protection Committee.

6.3 In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of underlying patterns, each of which relates to different aspects of multi-agency adult support and protection work:

- Tools
- Management systems
- Professional norms and culture – incidents
- Professional norms and culture – longer term work
- Family- professional interaction
- Innate human biases (cognitive and emotional)

7. Appraisal of practice

Period 1 Prompt identification of an adult at risk but subsequent necessary actions delayed (December 2015 – February 2016)

7.1 In December 2015, Adult B was admitted to hospital. During initial assessment Adult B was appropriately identified as a vulnerable adult by the admitting Trainee Nurse Practitioner which was good practice. An AP1 (Adult Protection) referral to social work was considered at the time, but a decision was made to defer this until she was medically fit; would have been better had the AP1 referral been made as it would have been in the system and followed up as per normal processes. **The impact of this is examined in Finding 1.**

7.2 It was evident that the admitting Trainee Nurse Practitioner (TNP) knew what was required but delayed acting on this because of the belief that Adult B was in a safe place and her clinical condition was more of a priority. This was annotated in the case notes however it raises questions about the extent to which entries in patients' case notes can be relied on as a mode of communication between

health care professionals. There was no clear instruction as to when and who should complete the AP1 and ultimately no-one took responsibility for doing this. The timing of this case meant the impact of reduced staffing in social work during public holidays was taken into account by acute health staff, but they did not take sufficient account of the seriousness of the signs of neglect and complex social circumstances.

7.3 Over the subsequent 24 hours Adult B was reviewed by eight doctors from a range of specialities and grades, all of whom acknowledged Adult B was an adult at risk; they made reference to referring Adult B to social work but not in the respect of adult support and protection. Local policies were not adhered to and none of their concerns were escalated.

7.4 Their judgement was not to progress an AP1 but to refer to social work thinking this was the correct course of action. Whilst there is a well established process for acute health care staff to make an adult support and protection referral, the staff failed to differentiate between social work and AP1 referrals. From a medical staff perspective social work referral and AP1 are one and the same.

7.5 The process of AP1 referral was, and remains electronic via the staff intranet though it is not easy to find; it sits within the Nursing, Midwifery and Allied Health Professionals pages, under Public Protection. The general culture within the acute health medical staff is that it is the responsibility of the nursing staff to make the social work and AP1 referrals. In addition, the referral template does not allow for comprehensive information sharing but it prompts the referrer to include details of concern; however the quality of this information is dependent on the referrer.

Period 2 Suitability of mum as a carer (December 2015 – February 2016)

7.6 From the moment Adult B was admitted to hospital the family presented with aggressive behaviour; in particular Adult B's mother came across as controlling and intimidating. The family appeared only to co-operate with health care professionals in order to allay concerns and stop professional engagement.

7.7 Following a referral to the carer's team, a social care worker visited the family home to carry out an assessment. Significant Adult Support and Protection concerns were noted at the time of the visit and were presented to, but not shared by, the social worker. Consequently the assessment was disregarded and the case closed.

7.8 Past experience of a poorly managed similar situation influenced the social care worker's decision not to go above the social worker when she felt brushed off. Whilst there may have been a process for supervision in place it was not used and applied properly in this situation.

7.9 There is limited evidence from the case file or from conversations with key staff to suggest that, in terms of the relevant national legislation and local guidance there was a comprehensive assessment of Adult B's mother's needs as a carer.

7.10 This case highlights the challenges of working with families who do not want to be involved with services, particularly social work. Decision-making in this case was based more on the medical treatment and interventions. However, the role of other factors such as the family dynamics and the needs of others in the household were less clear. **The challenges for professionals working in these circumstances are explored in Finding 2.**

Period 3 Pathway from acute health care to GP and Community Services (February 2016 – March 2016)

7.11 A multidisciplinary (MDT) case conference was held, at which professionals clearly identified both risk and protective factors to allow Adult B to return home, and a trial of discharge was agreed based on four conditions of discharge. There was, however, no evidence that the social worker who agreed to coordinate plans with community social work saw his actions through to completion. However this did not delay the discharge of Adult B because it did not come to light until the GP wrote to the acute health physician several weeks later.

7.12 It is unclear why there was no health professional to coordinate Adult B's discharge, or why the plan agreed at MDT meeting was not included on the immediate discharge letter; it focused solely on medical interventions and treatment with no consideration given to the impact of this most recent hospital admission given Adult B's vulnerabilities.

7.13 The four conditions of discharge agreed at the MDT meeting was a good example of professionals coming together and supporting Adult B and her family across a range of identified needs with the primary focus of minimising risk to Adult B. However there should have been a representative from the community nursing team and a hospital discharge coordinator to improve the sharing of information between all relevant disciplines. The discharge plan identified the contribution of different professionals, but there was no consistent process to record and share the plan with all the professionals involved, including those who could not or would not necessarily attend the MDT meeting.

7.14 Information sharing between acute health and GP and community services was inadequate. **The interface between the discharge MDT, GP and community services is explored in Finding 4.**

Period 4 Inexperienced nursing staff inappropriately protected from the family (July 2016 – October 2016)

7.15 There was insufficient understanding of the complex social circumstances and previous adult support and protection concerns by staff, although a review of her notes on clinical portal would have provided this information.

7.16 Junior nurses were discouraged from helping Adult B's mother with Adult B's

care; only one senior nurse could do this. Junior staff were also advised that they should not use clinical portal to read previous notes, though the reason for this was unclear. One senior nurse wanted to control the situation to prevent any negative feedback or complaints about the staff or care in the ward, and to avoid staff time being taken up by the family. Consequently, there were missed opportunities for other staff to become involved with Adult B and her family, and earlier intervention may have been missed. **The consequence of this practice is further explored in Finding 4.**

Period 5 General case management (November 2017 – March 2018)

7.17 There were various issues identified in respect of all services which attributed to a lack of coordination and seamless ongoing care and support. There were no adult support and protection processes underway and when an AP1 was submitted, social work closed it down, with no provision of any feedback.

7.18 Racial and verbal abuse from Adult B and her mother towards community nurses was not always reported and staff felt there was nowhere to take their concerns.

7.19 The GPs involved in this case felt that any referrals to social work under adult support and protection would cause a breakdown of their relationship with the family. One GP in particular believed he had a good relationship with the family and could manage them.

8. Good practice: what worked well?

8.1 Although good practice is acknowledged throughout the appraisal of practice, the Lead Reviewers wanted to highlight some aspects in particular.

- Good, early identification of an adult at risk by the Trainee Nurse Practitioner; initial clinical examination was comprehensive and accompanying record keeping was detailed and clear. Experience and professional clinical judgement clearly influenced the way in which the TNP took time to listen and thoroughly assess Adult B.
- Multidisciplinary Team discharge planning for an adult with complex needs was good. There was good representation from most disciplines, but this could have been better if the GP and/or community nurse had been invited to attend.
- Whilst the practice of community nurses visiting in pairs was resource intensive this was considered to be safe practice.

9. In what ways does this case provide a useful window on our systems?

9.1 This case provides a useful window on the system because much of the learning is in relation to adults who have capacity with whom professionals are working with on a regular basis. There are processes for protecting adults when

the risk of significant harm is clear. There are also services, which can be offered when families/carers need to be supported rather than those they care for needing to be protected. This case highlights the challenges practitioners face in identifying and assessing risk and need in cases of neglect and how well systems in Glasgow support this.

10. Summary of findings

10.1 This significant case review has identified four system findings that have emerged from the review. The findings explain why professional practice was not more effective in protecting Adult B;

Finding 1 **Professional norms and culture**
Within acute health there is a tendency for acute care professionals to focus only on clinical matters and not address social issues, but failure to do so can impact on the analysis of risk of future harm.

Finding 2 **Family - professional interaction**
Within health and social care professionals there is a natural inclination to carry out business to a professional minimum if families are known to be challenging and aggressive which can compromise the safety and wellbeing of vulnerable adults.

Finding 3 **Management systems**
Within health and social care there is evidence that some staff lack the confidence and competence to challenge professional decision-making and direction, with the result that some adults can be inadequately protected.

Finding 4 **Management systems**
The culture in healthcare does not allow professionals to pay sufficient attention to useful historical information and professional curiosity which can result in misleading assessments of risk.

11. Findings in detail

Finding 1

11.1.1 **Within acute health there is a tendency for health care professionals to focus only on clinical matters and not address social issues, but failure to do so can impact on the analysis of risk of future harm.**

Acute healthcare professionals need to make judgements about vulnerability and social care needs, as well as treating a clinical condition, which if not included in their assessment, impacts on decision-making and the understanding of the level of risks to an adult and how this is managed.

How did it manifest in this case?

11.1.2 There are repeated examples of where senior medical professionals, nurses and Scottish Ambulance Service personnel recognised that Adult B was at

risk but made conscious decisions not to get involved with the social needs of Adult B and her family, or they made assumptions that someone else would do this, or that a general referral to social work was sufficient. This was particularly apparent in the clinical notes where the health professionals had acknowledged “multiple social issues”, “complex social issues”, “brought in from squalid house”, “I think she may be a vulnerable adult and I am concerned about the comment of squalid home….I think we should undertake a social work assessment”, “needs a social work referral and psych assessment at some point”, which is reiterated a few days later, but “her medical issues 1) anaemia and 2) infection are priorities right now”.

11.1.3 Throughout this case hospital staff continued to recognise and document that she was an adult at risk but there was a lack of understanding of the difference between referrals to social work, and adult support and protection referrals which resulted in delays in prompt intervention. There was a tendency for acute health staff to rely on social work colleagues to interpret social work referrals and make onward AP1 referrals, where appropriate.

How do we know it’s an underlying issue and not unique to this case?

11.1.4 It is unlikely to be unique to this case because medical staff told the Lead Reviewers during conversations that they did not know there was a separate reporting process for adults at risk.

11.1.5 In conversations with staff, they expressed a view that an AP1 referral form is not easy to find on the staff intranet and completion of Datix is not straightforward.

11.1.6 Professionals’ interpretation of current legislation, policy and operational practices did not fully recognise and meet the long-term needs of Adult B, leaving her open to exploitation.

How widespread and prevalent is this issue?

11.1.7 The Case Group and Review Team were clear that there was often confusion about when to refer to Adult Support and Protection. In addition, more often than not this is left to nursing staff even though it is the responsibility of all staff that have contact with patients in NHS Greater Glasgow & Clyde.

11.1.8 In 2018/19, a total of 197 AP1 referrals were made by acute health and in 2019/20 the number of referrals was up by one to 198. These figures are low given the number of patients served across the organisation therefore the lack of understanding about referrals to social work versus AP1s is unlikely to be unique to this case.

Why does it matter?

11.1.9 A safe system relies on accurate information being recorded and shared. It is a statutory duty of co-operation for certain groups of staff, including NHS staff therefore referral processes should help professionals when they need to

make immediate judgements about potential risk to adults and take any necessary action to keep them safe.

Finding 1

Within acute health there is a tendency for health care professionals to focus only on clinical matters and not address social issues, but failure to do so can impact on the analysis of risk of future harm.

In cases of adult neglect, medical treatment is a significant part of the intervention however it is only part of the jigsaw; social, family and environmental factors must be included in the assessment and management of the adult where there is risk of further harm.

Questions for the Adult Protection Committee to consider:

- Is the APC confident that professionals working across the boundaries of adult support and protection networks understand each other's roles and responsibilities?
- Is the role of acute health services understood by all agencies particularly where there are adult support and protection concerns?
- Is awareness training in respect of adult support and protection fit for purpose, and is the impact of this training evaluated?
- What strategies can be taken to ensure the Adult Support and Protection lead makes herself more visible and known to acute health care professionals?

11.2 Finding 2

11.2.1 **Within health and social care professionals there is a natural inclination to carry out business to a professional minimum if families are known to be challenging and aggressive which can compromise the safety and wellbeing of vulnerable adults.**

Those working in health and social care with cases such as this will, at times, be involved with adults and families for whom they have concerns that are difficult to manage. Situations where professionals are subjected to repeated abuse and intimidation can hinder professional intervention.

How did it manifest in this case?

11.2.2 Repeated admissions to hospital with indicators of severe neglect did not trigger a comprehensive assessment or appropriate action under Adult Support and Protection legislation and protocols.

11.2.3 From the moment Adult B was admitted to hospital the family presented with aggressive behaviour; in particular Adult B's mother came across as controlling and intimidating. The family appeared only to co-operate with health care professionals in order to allay concerns and stop professional

engagement.

11.2.4 A number of professionals accepted reassurances at face value despite there being signals to the contrary. Essentially, professionals gave too much weight to what Adult B's mother was telling them, thereby allowing the right to self-determination - to override the right to protection.

11.2.5 All professionals involved in this case recognised the complex relationship between Adult B and her mother, but believed they did not have the skills to challenge the co-dependency, which was a barrier to intervention.

11.2.6 Adult B's mother discredited care and constantly complained about everything, which was draining on the nursing staff. She regularly phoned the ward in the middle of the night to make enquiries about her daughter and insisted on speaking to medical staff there and then. Her language was threatening, she was demanding and did not take no for an answer. The family took up a lot of one senior nurse's time; she missed breaks and worked late to prevent getting complaints from the family, and to avoid other nurses' time being consumed by the family.

11.2.7 Concern was expressed by nurses about the suitability of mum to provide care for Adult B as she herself had health problems. She used every opportunity to discuss her own health issues during conversations with medical staff, which were meant to be about Adult B. The social care worker did not think she was a suitable carer; "she was only interested in benefits".

11.2.8 There was inadequate sharing of information between acute health professionals and the GP that had a significant bearing on the care and management in this case. From the case note review it would seem that the doctor who wrote the discharge letter had no knowledge of her social circumstances or did not think it was relevant.

11.2.9 In a discharge letter to her GP following another in-patient stay in hospital the consultant noted that concerns were raised about her care at home. Similar concerns were expressed previously however "we didn't investigate this issue with her or her family during this admission".

11.2.10 Concerns were raised about bullying and abusive relationships with professionals who came to the house, for example, a community nurse was denied access to Adult B's home because of the colour of her skin. Others, when they did gain access, were only allowed to provide certain elements of care. During a house call by one of the GPs as per the discharge plan, Adult B's mother looked away and refused to engage whilst Adult B's partner said "nothing and continued to play computer games". The subsequent failure to report these incidents made it difficult to address.

How do we know it's an underlying issue and not unique to this case?

11.2.11 Legislation, policy and practice have emphasised self-determination; adults with capacity being able and supported to make choices. However there

remains widespread confusion in health and social care professionals around legislative intervention in relation to a vulnerable adult with capacity.

How widespread and prevalent is the issue?

11.2.12 The Case Group and Review Team were clear that staff have limited knowledge of Adult Support and Protection, particularly in this case where the adult has capacity, partly explained by the myriad of overlapping complex legislation.

Why does it matter?

11.2.13 Professionals should have the knowledge and confidence to make judgements about vulnerability factors, unmet needs, adversity and challenges within a family to keep an adult safe. If staff are not confident in their own skills there is a risk that shortcuts will be taken in terms of the rigour of the assessment and analysis, e.g., information will not be recorded, hunches will not be followed, and ultimately this prevents the adult protection system from effectively working together.

Finding 2

Within health and social care professionals there is a natural inclination to carry out business to a professional minimum if families are known to be challenging and aggressive which can compromise the safety and wellbeing of vulnerable adults.

Those working in health and social care with cases such as this will, at times, be involved with adults and families for whom they have concerns that are difficult to manage. Situations where professionals are subjected to repeated abuse and intimidation increases the likelihood of their concerns not being taken forward.

Questions for the Adult Protection Committee to consider:

- How confident is the APC that acute health professionals recognise and respond to behaviour that includes non-engagement or undue influence?
- In situations where the carers are hostile and intimidating, how can health and social care professionals be enabled to ensure that their assessments adequately consider both risks and protective factors?
- How can the APC be assured that in all complex family situations where adult protection is a concern there is a robust process to ensure a family risk assessment has been completed?

11.3 Finding 3

11.3.1 **Within health and social care there is evidence that some staff lack the confidence and competence to challenge professional decision-making**

and direction, with the result that some adults can be inadequately protected.

Some health and social care professionals with limited knowledge and experience of adult protection find it difficult to question decisions without feeling that they might be imposing their own values, thus potentially placing adults and families at risk.

How did it manifest in this case?

11.3.2 Throughout this case there were examples where the response to adult support and protection concerns were delayed and procedures were not followed, for example, a social worker discussed a risk assessment with her Team Leader who closed the case down with no explanation, other than "they will keep an eye on the situation".

11.3.3 In response to information being escalated there was a tendency for lead professionals to minimise this and/or consider in isolation, or allow innate bias to influence their decision-making, consequently some staff felt powerless to raise their concerns, for example during a supervision session at which the social care worker described her concerns, these were dismissed by the supervisor because he felt Adult B's mother's "heart was in the right place". Consequently the staff member felt her assessment was not valuable.

How do we know it's an underlying issue and not unique to this case?

11.3.4 Some Case Group members gave examples of not being heard and/or not being involved in decision-making, leaving them feeling unable to question decisions; some due to their inexperience and limited knowledge, but also as a consequence of poor quality and impact of clinical supervision in the past.

How widespread and prevalent is the issue?

11.3.5 The Case Group was clear that whilst there is a process in place for clinical supervision there are significant variations across the city and teams depending on the individuals involved.

Why does it matter?

11.3.6 Statutory vulnerable adult and family social work is all about managing risks and making good-quality decisions. To do this successfully, information about risks and how they are being managed needs to be shared between social workers and their managers at all levels.

11.3.7 Good, reflective supervision must enable and support staff to build effective professional relationships, develop good practice and exercise both professional judgement and discretion in decision making. Even more, it is likely to have a direct positive impact on vulnerable adults and families.

Finding 3
Within health and social care there is evidence that some staff lack the confidence and competence to challenge professional decision-making and direction, with the result that some adults can be inadequately protected.
Where there are variable arrangements in place for supervision some staff lack the confidence to question professional decisions because of their limited knowledge and/or previous experience, which can impact on the management of adults at risk of harm. **Questions for the Adult Protection Committee to consider**: • How confident is the APC that professionals working across Glasgow City HSCP have easy access to reflective meaningful supervision that encourages them to develop professionally and personally through trust, honesty and empathy? • How can supervision for all staff groups be developed and supported? • How can the APC support acute health professionals in their understanding of evidence and the analysis of risk of future harm, and how this contributes to physical health concerns?

11.4 Finding 4

11.4.1 **The culture in healthcare means professionals do not pay sufficient attention to useful historical information and professional curiosity which can result in misleading assessments of risk.**

A number of factors influence the culture within an acute hospital; demanding workload, high turnover of patients and constantly managing patients in crisis. However it is vital that professionals do not discount the need for professional curiosity and available historical information because it may not be seen as relevant to the clinical problem.

How did it manifest in this case?

11.4.2 The complex nature of Adult B's family history did not appear to be known to the acute hospital teams. Concerns around Adult B's vulnerability were not adequately considered or effectively communicated between and across the various health services.

11.4.3 Some nursing staff were discouraged from accessing Adult B' previous notes on clinical portal though the reasons for this are not known.

11.4.4 One GP in the practice suspected that Adult B's mother was not allowing Adult B to make her own choices and she was selective about which medication she gave to Adult B. An AP1 referral was considered however, based on the primary GP's relationship with the family a letter to social work was submitted instead and headed "Adult Vulnerability". Social work teams discussed this and

it was deemed not an adult protection issue rather a duty visit would be suitable. During this duty visit Adult B's mother advised the social worker that things will "settle down, they usually did".

11.4.4 Throughout this case there is little evidence that professionals approached their work with a questioning attitude, instead they gave undue weight to Adult B's mother who was adept at keeping them at arm's length.

11.4.5 Within acute health there is no evidence that professionals talked to each other about their experiences with Adult B and her family.

11.4.6 In the course of reviewing this case it occurred to the Review Team that the GP was committed to maintaining a positive relationship with Adult B's family members. However, this ultimately became a barrier to progressing necessary actions when further risk to Adult B was identified by fellow colleagues.

11.4.7 Professionals' concerns took the form of uncertainties, perceptions and "a gut feeling", which was difficult for them to articulate as factual evidence and they did not know whether they should or how to escalate those feelings.

How do we know it's an underlying issue and not unique to this case?

11.4.8 In an acute setting with a high volume and turnover of acutely unwell patients there is limited time for acute healthcare professionals to access and review past records relating to previous admissions and social issues. Some Case Group members advised that they had just moved into a new hospital and were getting to know their surroundings and were coming together as a new team; they did not have time to review historical information. In another ward junior staff were deterred from reading notes on clinical portal, though they were unable to explain the reasons for this, other than they should not do this.

11.4.9 The Case Group acknowledged that they have worked with many families where carers are ambivalent to professionals, but appear or are adept at manipulating contact with professionals.

11.4.10 Professional curiosity is not always easy and straightforward, especially with those families, parents and carers who demonstrate disguised compliance or coercive control.

How widespread and prevalent is the issue?

11.4.11 This information is not recorded however the Review Team reported that it is common and professionals can often be over-optimistic in working with complex families and want to maintain as far as possible positive working relationships with them. However the positives in a given situation need to be balanced with careful consideration that compliance is often temporary.

Why does it matter?

11.4.12 This finding predominantly concerns non-social work staff who are likely to be involved in greater numbers more of the time with vulnerable adults. If they are

not confident in their own skills then, ultimately it prevents the adult protection system from working effectively.

11.4.13 This pattern of behaviour can make it very difficult for professionals who are involved with a family to maintain an objective view of progress in protecting the welfare of a vulnerable adult. Previous history is often the best indicator of future behaviour.

11.4.14 The team leaders and health care professionals who took decisions to close down AP1 referrals, or not to make an AP1 referral could, and should, have taken a much more questioning approach; this would have challenged the wisdom of taking the decision at the time and with the information they had.

Finding 4

The culture in healthcare does not allow professionals to pay sufficient attention to useful historical information and professional curiosity which can result in misleading assessments of risk.

The importance of taking time to explore and understand what is happening by asking questions and seeking clarity, rather than making assumptions is vital. These interactions provide crucial opportunities for protection but a lack of professional curiosity can lead to poor assessments and intervention measures that can fail to support those at risk.

Questions for the Adult Protection Committee to consider:

- How can the APC be assured that there is an appropriate balance between the focus on the assessment and management of an acute medical condition and assessment of an adult at risk?
- Are there any ways to assist acute healthcare staff understand professional curiosity in complex social cases and its importance for the safety and wellbeing of vulnerable adults?

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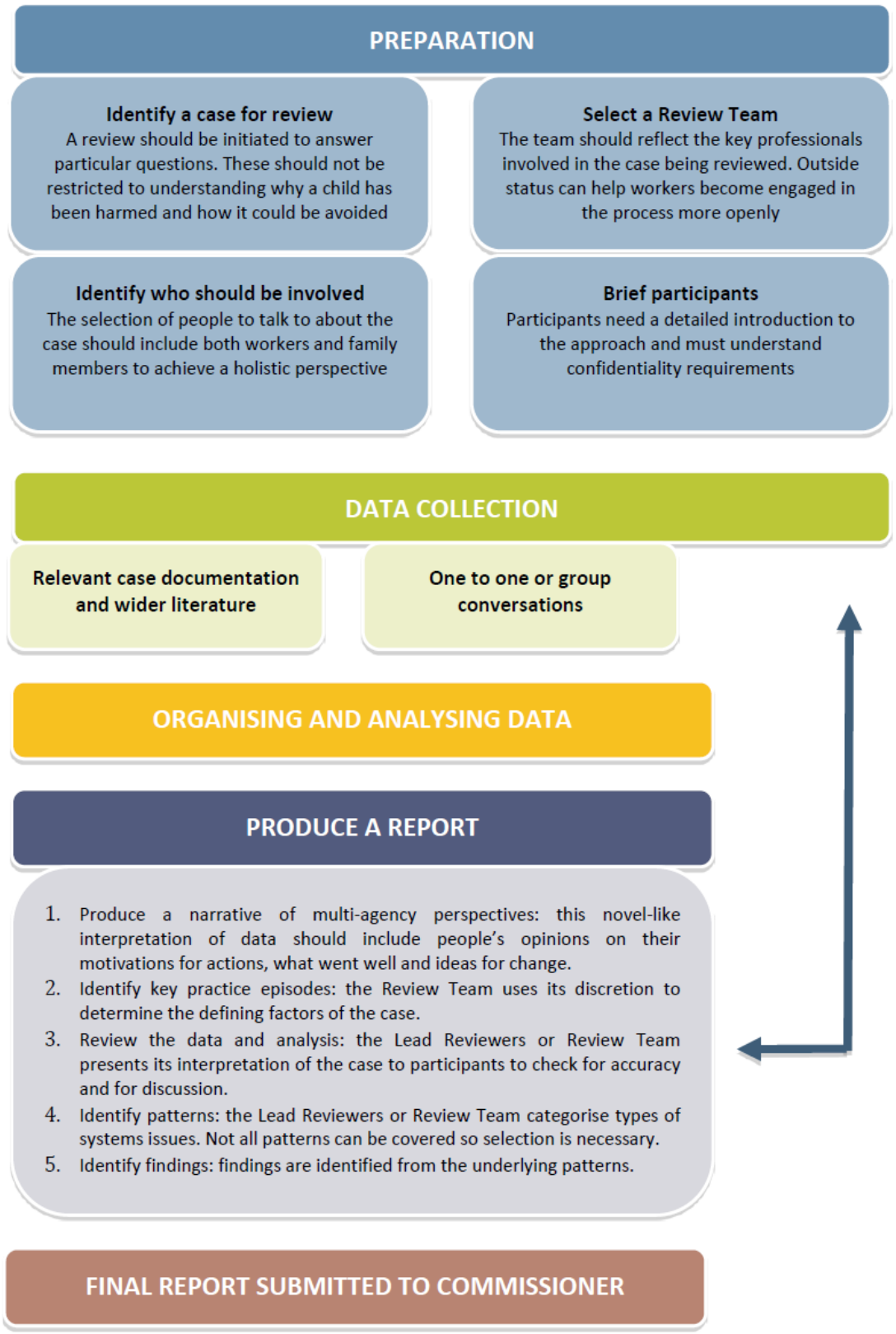
How the SCIE Model Works



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Appendix 2

Membership of Review Team

Associate Chief Nurse	NHS Greater Glasgow & Clyde
Service Manager	Glasgow City Health & Social Care Partnership
Service Manager	Glasgow City Health & Social Care Partnership
Detective Inspector	Police Scotland

Membership of Case Group

Team Leader	NHS Greater Glasgow & Clyde
Community Nurse	NHS Greater Glasgow & Clyde
Community Nurse	NHS Greater Glasgow & Clyde
Specialist Nurse Bowel & Bladder Service	NHS Greater Glasgow & Clyde
Staff Nurse	NHS Greater Glasgow & Clyde
Staff Nurse	NHS Greater Glasgow & Clyde
Tissue Viability Nurse Specialist	NHS Greater Glasgow & Clyde
Occupational Therapist	NHS Greater Glasgow & Clyde
Specialist Physiotherapist	NHS Greater Glasgow & Clyde
General Practitioner	NHS Greater Glasgow & Clyde
General Practitioner	NHS Greater Glasgow & Clyde
Charge Nurse	NHS Greater Glasgow & Clyde
Charge Nurse	NHS Greater Glasgow & Clyde
Consultant Liaison Psychiatrist	NHS Greater Glasgow & Clyde
Consultant Renal Physician	NHS Greater Glasgow & Clyde
Consultant Physician/Endocrinologist	NHS Greater Glasgow & Clyde
Consultant Endocrinologist	NHS Greater Glasgow & Clyde
Consultant Cardiologist	NHS Greater Glasgow & Clyde
Carers Development Worker	Glasgow City Health & Social Care Partnership
Social Worker 2	Glasgow City Health & Social Care Partnership

Social Worker	Glasgow City Health & Social Care Partnership
Care Manager, Social Work	Glasgow City Health & Social Care Partnership
Team Leader, Intermediate Care	Glasgow City Health & Social Care Partnership

Conversation only

Specialist Nurse Bowel & Bladder Service	NHS Greater Glasgow & Clyde
Trainee Surgical Nurse Practitioner	NHS Greater Glasgow & Clyde
Staff Nurse	NHS Greater Glasgow & Clyde
Staff Nurse	NHS Greater Glasgow & Clyde
Senior Charge Nurse	NHS Greater Glasgow & Clyde
Charge Nurse	NHS Greater Glasgow & Clyde
Charge Nurse	NHS Greater Glasgow & Clyde
Consultant General Psychiatrist	NHS Greater Glasgow & Clyde
Carers Development Worker	Glasgow City Health & Social Care Partnership
Social Worker 2	Glasgow City Health & Social Care Partnership
Care Manager, Social Work	Glasgow City Health & Social Care Partnership
Team Leader, Intermediate Care	Glasgow City Health & Social Care Partnership

Appendix 3

Dates of meetings

5th July	2018	Lead Reviewers information session
6th August	2018	Review Group information session
1st November	2018	Review Group scoping exercise
20th November	2018	Case Group information session
26th November	2018	Case Group information session
10th January	2019	Review Group
31st January	2019	Family session – cancelled by family
14th February	2019	Case Group information session
23rd April	2019	Case Group information session
30th April	2019	Case Group information session
1st August	2019	Review Group – feedback from conversations/share reconstruction
7th August	2019	Case Group – feedback from conversations/share reconstruction
13th December	2019	Review Group – draft findings
4th February	2019	Review Group – draft findings
		(Postponed from 8th January)
5th March	2020	Case Group draft findings