Executive Summary of the

Serious Case Review

in respect of

Adult A

Contents:

1. Introduction

Adult A was a 41 year old man with learning disabilities. In December 2009, he was found dead and the cause of death was multiple stab wounds.

A proposal was made to Bury's Multi-Agency Safeguarding Adult Partnership for a Serious Case Review (SCR) to be undertaken.

The Board considered this proposal at an Extra-Ordinary Meeting held on 16th December 2009. It was agreed that the victim was a vulnerable adult who had been receiving services from several of its partner agencies and that there might be important safeguarding lessons to learn. The agencies present felt that as the case was an open criminal investigation that the agreement of the Coroner, the Crown Prosecution Service (CPS) and Greater Manchester Police (GMP) should be sought before commencing the review.

At a second Extra-Ordinary Meeting, on 26th January 2010, it was confirmed that the Coroner's Office, CPS and GMP's Murder Investigation Unit had given their approval for a SCR to proceed.

2. Background

Adult A was a man with mild learning disabilities, who was born on 6th November 1968 at Fairfield General Hospital in Bury. As a young adult he expressed a wish to live independently. This independence was achieved in 1994, when he moved into a rented ground-floor flat.

In 1999, he moved to his second home and in 2006, he made what was to be his last move to a flat half a mile from Bury town centre. From 1994 until 2009 his accommodation was provided by Six Town Housing (Bury Council's Arms Length Management Organisation or ALMO) and his personal support came from the Bury Council's Adult Care Services (ACS). His primary care was provided by GP practices, first in Radcliffe and then in Bury and Rossendale Hospital, Bury General Hospital and, subsequently, Fairfield General Hospital provided secondary health care.

Adult A was single minded in his wish to not allow his disabilities or health care problems to limit his opportunities and his independence. He knew what he wanted and he realised he needed others to help him understand the world – his world, and to help him in the successful pursuit of his chosen activities and interests and enable him to live a successful, independent life.

3. Serious Case Review Purpose and Methodology

a. The decision to establish an SCR

The request for a SCR following the death of Adult A was made by GMP, who hoped that they and their partner agencies might learn important lessons about:

- Vulnerability to crime and safeguarding of adults with learning disabilities who live independently;
- Lifestyle issues/ behaviour of someone with learning disabilities that might increase risk; and
- Lifestyle issues and vulnerability in relationship to other vulnerable tenants also living in that community.

At an Extraordinary Meeting held on 16th December 2009, the Safeguarding Adults Board agreed:

- The victim was a vulnerable adult covered under the Safeguarding Adults Multi-Agency procedure;
- A SCR should be commissioned "to identify any learning and whether safeguarding alerts should have been triggered at any stage";
- Agreement to this course of action should be sought from the Coroner, GMP and the CPS; and
- All relevant files and records should be kept secure.

At a second Extraordinary Meeting of the Board held on 26th January 2010 it was confirmed that the CPS, Coroner's Office and GMP's Murder Investigation Unit had given approval to proceed with an SCR.

It was also agreed that an Independent Chair should be appointed and that the SCR would cover a two year period from 1st January 2007 up to and including the post murder period leading up to the request for a SCR at the Board Meeting on 16th December 2009.

b. Commissioning the Serious Case Review

A working group was then convened to establish terms of reference for the SCR and a job specification and contract for the Independent Chair of the

SCR Panel/ Overview Writer. An Independent Chair was subsequently appointed with a contract commencing on 5th May 2010.

The commissioning of an Independent Chair and Overview Writer were remitted to the Independent Chair of the Safeguarding Adults Board and a Senior Manager from Bury ACS. It was they who were also given responsibility to set in place a contract, agree the administrative support that would be available for the SCR and a timetable within which the report would be prepared.

c. Terms of Reference

Appendix I provides information about the terms of reference and purposes agreed by the Serious Case Review Panel.

In preparing the terms of reference for the SCR, the Overview Writer took into account:

- The reasons that GMP requested this inter-agency review; and
- The statement of scope prepared by the Safeguarding Adults Board.

d. Timeframe of the review 2007-2009

The agencies that had a primary involvement with Adult A during this period were those who had previously been involved in providing his housing, his personal support and his health care, although his exchange of accommodation and the emergence of skin problems meant he would come into contact with some different practitioners within Six Town Housing and at Fairfield General Hospital.

Early in 2007 the improvement in his epilepsy meant that he no longer needed his hospital specialist reviews but these were replaced early in 2007 with contact with dermatology specialists – first at Rossendale Hospital, then later in July 2009 at Fairfield General Hospital.

In this period Adult A had just one contact with the Police, with a desk clerk, when he went on 28th May 2008 to report that his telephone wire had been cut.

The report provides analysis of the way each agency discharged their roles and responsibilities. It will consider joint working, communication and information sharing issues.

Bury ACS had sustained continuous contact with Adult A since the 1990s they held a collective memory of his life, his personality, his social network and his limitations. Its Learning Disabilities Support Team (LDST) service had been working effectively across agency boundaries and was knowledgeable about the capacity of their colleagues in partner agencies, particularly Six Town Housing and the NHS to work with Adult A as an individual.

During this period the LDST workers provided Adult A with the practical advice and reassurance he needed, through regular one-on-one contacts, through meeting with him and through regular telephone conversations. The LDST workers also accompanied him to some outpatient clinics.

The Overview Writer identified from the interviews with practitioners involved with Adult A's care that Adult A had flourished and had gained greater independence during this period. The Overview Writer felt that all of this would not have been possible without a support team and a service that really knew and understood him as an individual, and respected his wish and right to direct his own life. One example of good practice at this time was when his Senior Support Worker took personal responsibility for trying to tackle the problem of psoriasis on his scalp and was positively pushing the boundaries of 'floating support' by assisting him at with the correct application of ointments.

The willingness of the LDST to work collaboratively with health care professionals and with Anti-Social Behaviour (ASB) Caseworkers from housing was evident from the logs and records. These arrangements were thought by the Overview Writer as more informal than formal.

Six Town Housing continued to discharge both its responsibilities to provide decent, affordable housing. Without this, Adult A would not have been able to enjoy his home life – which was so important to him.

A noise dispute illustrates how home life can be disrupted and spoiled by people who are not prepared to show consideration to others. There is evidence that Six Town Housing understood the importance of a peaceful home life for all tenants, and the problems of social mix and the complexity of successful work with tenants who have disabilities.

Six Town Housing's ASB Caseworker played a central role in investigating complaints, in working with all the parties in the dispute, in seeking advice from colleagues in other statutory and independent sector agencies and in co-ordinating important meetings with colleagues. The ASB Caseworker's interaction with all the tenants was focused but flexible. She showed good

awareness of individual differences. There were several people whom she correctly recognised as vulnerable adults and she actively sought advice from colleagues in partner agencies who knew them better than her. She worked persistently over a long period of time as the Individual Management Review (IMR) writer put it "in an efficient and professional manner to resolve problems", and she succeeded.

The agency's good record keeping demonstrated sensitivity to the individual needs of Adult A.

GMP, as their IMR notes show, had just one opportunity to demonstrate their recognition that they might be dealing with a vulnerable adult.

The Police IMR indicates that no Police intelligence was held on Adult A or his address that would give cause for concern that they were dealing with a possible vulnerable adult.

The IMR writer believed that "appropriate actions were taken in the circumstances". The Overview Writer believes that the policies, procedures and training GMP now have in place in relation to the assessment of vulnerability and action on reports of anti-social behaviour may have assisted the desk clerk, Police Officers and other colleagues in their decisions about follow up on this crime incident and strengthened safeguarding practice. The training now being provided to call handling staff is intended to help them in recognising vulnerable victims of anti-social behaviour and domestic abuse. It should lead to better prioritising of incidents where the victim's vulnerability is viewed as a key consideration or an important influencing factor.

The GP, colleagues in the primary care practice and hospital base specialists were working together with Adult A on a treatment package for his psoriasis.

In general, both the primary care staff and the hospital staff showed real sensitivity in responding to the confusion and the distress he sometimes showed. They communicated this distress to his Support Workers and followed up on delayed hospital appointments.

In Six Town Housing's log, dated 26th June 2008, the IMR writer recorded that Adult A's Support Worker had mentioned to the ASB Caseworker, in the course of a face-to-face discussion about an earlier noise nuisance problem, that someone had written graffiti on Adult A's windows. Adult A subsequently accused a particular neighbour for the graffiti and an earlier incident where his telephone lines had been cut. The earlier incident was reported to the Police.

Around this time, Bury ACS log show that it was Adult A who had alerted his support team to the fact that someone had put graffiti on his windows and was deliberately closing his windows from outside.

In Six Town Housing's log, dated 11th August 2008, one of Adult A's Support Workers advised the ASB Caseworker that Adult A had made several (non-specific) allegations about children in the area. The Support Worker stated he did not feel the complaints were justified.

The Overview Writer has been assured by GMP that no other evidence of hostility toward Adult A by his assailant was reported.

Adult A did not report, to those agencies who were only occasionally working with him, that he was being subjected to anti-social behaviour i.e. the Police, the hospital staff and the primary care practitioners and their staff. Nor were there any third party reports from friends, family or neighbours during this period that he was being abused or showing any signs of distress. NHS staff and GMP consequently had absolutely no reason to know or suspect that he was at risk of any kind of abuse either during the focal period for the SCR.

4. Conclusion

On the basis of the information available to the SCR Panel the review concludes that Adult A's murder by his assailant was neither predictable nor preventable by any of the people directly involved with him.

Adult A's assailant was not a party to the noise nuisance dispute and played no direct part in the complaints. In the weeks and days immediately prior to his death, Adult A was going about his life in the same way as usual. The only concern he was expressing related to his psoriasis, and the impact regular visits to the hospital were likely to have on his daily activities. He was also planning a range of activities with his family and friends for the Christmas period.

The Overview Writer wishes to add weight to the view that the murder investigation was a success, justice was done and seen to be done. The joint working designed to coordinate and inform the investigation manage communication and reassure the local community demonstrated effective Police leadership and how well Bury's agencies were able to work together.

5. Recommendations

5.1 Six Town Housing should:

5.1.1 Be commended for quality of its record keeping, which has, inter-alia enabled the review to fully understand the nature of the noise-dispute and the context to Adult A's tenancy moves.

5.1.2 Commend their ASB Caseworker for her leadership and professionalism in dealing with a prolonged neighbour dispute involving several vulnerable tenants in close collaboration colleagues in partner agencies.

5.1.3 Continue to roll out its safeguarding adults training to all relevant staff.

5.1.4 Review its ASB performance management arrangements to ensure low level, ongoing ASB cases involving vulnerable people are flagged up and reviewed on a regular basis

5.1.5 Engage with the Council's review of the data sharing arrangements in place with themselves to ensure relevant information is captured and shared in a timely and appropriate manner.

5.1.6 Engage with Bury Council (ACS) as they review its allocation policy, exploring the feasibility for allowing local letting policies to be introduced in defined areas.

5.2 Greater Manchester Police should:

5.2.1 Commend the Murder Investigation Team for the success of its enquiry into Adult A's death and their leadership and coordination of effective multi-agency action demonstrated throughout "Operation Eager".

5.2.2 Commend the Police Officer who liaised with Adult A's family for his sensitive relationship building and the quality of various background and witness reports he prepared and subsequently made available to the SCR.

5.2.3 Ensure that knowledge and skills now being developed by call handling staff in the recognition, assessment of and response to vulnerable victims becomes firmly embedded in the practice of all officers and staff. This should include assistance and support in managing the expectations of vulnerable citizens and helping to facilitate their

integration into local communities as well as improving their safety and sense of security.

5.2.4 Build on the priority and progress now being made in relation to ASB and hate incidents directed at vulnerable citizens by identifying with partner agencies the improvements needed in communication, information-sharing, referral and joint working that can maximise the impact of new Police and community safety policies and practice.

5.2.5 Consider with its partners, the formalising of Multi Agency Risk Assessment Conference (MARAC) style joint reviews designed to assess and manage risk with a view to minimising or preventing serious harm to adults at risk.

5.2.6 Ensure that its recording mechanisms are developed to capture the management of vulnerable cases.

5.3 Bury Council Adult Care Services should:

5.3.1 Be commended for consistently high level of personalised support and continuity of service provided to Adult A over a fifteen year period. This was a major key to his successful independent life.

5.3.2 Consider in the light of this review the actions needed to promote increased awareness of anti-social behaviour towards people with learning disabilities, including actively enquiring, for example in both intra and inter agency reviews whether clients are experiencing any such problems, in order that appropriate risk assessment and management plans can be made and their implementation monitored.

5.3.3 Note and commend the action taken by Adult A's Support Workers in assisting him to report an earlier property crime to the Police.

5.3.4 Consider what action needs to be taken to ensure that this standard of support is available to all service users who are the victims of crime or anti-social behaviour and who wish to report this to GMP, Community Safety Team or the Safeguarding Adults Service.

5.3.5 Note and commend the good practice of his Support Workers in advising and supporting Adult A in making informed choices about his house moves.

5.3.6 Consider what action ACS could take in a wider context in order to promote closer working jointly with Six Town Housing and other housing providers, and information sharing with housing partners in

5.3.7 Carry out a review of its allocation policy with all housing providers especially Six Town Housing and whilst doing so Bury Council (ACS) should explore the feasibility for allowing local letting policies to be introduced in defined areas.

5.3.8 Undertake a review of the data sharing arrangements it has in place with Six Town Housing and other housing providers to ensure relevant information is captured and shared in a timely and appropriate manner.

5.4 Bury Primary Care Trust (NHS Bury) should:

5.4.1 Commend the GP in the light of the positive comments made in the Pennine Acute Hospitals NHS Trust's IMR about the various occasions on which the GP took initiatives and advocated on behalf of his patient in communications with Neurology colleagues.

5.5 Pennine Acute Hospitals NHS Trust should:

5.5.1 Confirm that the treatment of his epilepsy was consistent with NICE guidelines, taking into account the advice offered by the GP at various times for improved communication with a view to identifying any improvements that might be made in joint primary/ specialist NHS care working.

5.6 Bury Safeguarding Adults Partnership should:

5.6.1 The partnership should develop an action plan that identifies key partnership issues relating to safeguarding that have been identified within this report or have emerged as part of discussion and debate within this SCR to ensure integrated planning and action. The action plan should also include:

- Monitor the implementation of the individual action plans developed by partner agencies on the basis of this SCR; and
- Communicate directly with Adult A's immediate family, about the lessons learnt and the way the review has highlighted Adult A's

Appendix 1 -Terms of reference and purposes

1. The SCR Panel wishes to explore and examine with the partner agencies:

- Whether their practitioners and managers understood Adult A's needs and both, individually and jointly worked to provide the advice and support he needed; and

- More specifically, whether their understanding of safeguarding enabled them to:

    - Identify risks relating to his disabilities, behaviour, personality and his home-life circumstances and take appropriate action to reduce these risks and protect his health and well being;

    - Notice at an early stage potential indicators of abuse or escalating risks;

    - Act promptly on their concerns with the framework of established safeguarding policy, procedures; and

    - Communicate and share information with other agencies and with significant other people in his family or social network.

2. The SCR Panel also wishes to establish:

- Whether partner agencies had safeguarding policies and procedures in place that were up to date, fit for purpose, and well understood by their staff. Whether Bury's multi-agency policies and procedures were well understood and embedded in the safeguarding practice of partner agencies;

- Whether commissioning and contracting processes were robust, and likely to strengthen safeguarding practice. Whether there was any equality, diversity cultural or reputation issues that had a significant influence in this case; and

- Also whether there are safeguarding policy issues that relate to support arrangements for adults with learning disabilities, and the congregation of vulnerable adults in a particular community. If

3. The SCR Panel will review and amend its agreed terms of reference, as required, during the course of the review in consultation with the Independent Chair of the Safeguarding Adults Board.

4. Purposes

4.1 The primary purpose of this SCR it was agreed was to establish whether there are important lessons to be learned about the ways in which statutory and independent sector agencies worked individually and together to protect to health, well being and, ultimately, life of Adult A, and therefore other vulnerable people within the locality.

4.2 The SCR would focus on how learning from this particular tragedy will be acted upon by the individual agencies, and how better inter-agency practice and policy on adult safeguarding might be developed by the Safeguarding Adults Board.

4.3 This was the first SCR commissioned by the Bury Safeguarding Adults Board since its inception. The Board hope that the SCR would help its own learning about how to commission, support and conduct SCR's in the future.

Appendix 2 - The SCR Panel

1. The SCR Panel appointed by the Safeguarding Adults Partnership was as follows:

   - Independent Chair and Overview Writer
   - Bury Primary Care Trust (NHS Bury)
   - Bury Adult Care Services
   - NHS Community Services Bury
   - Greater Manchester Police
   - Care Quality Commission (CQC)
   - Pennine Acute Hospitals NHS Trust
   - Six Town Housing

2. The SCR Panel will invite other expert advice if it believes this would assist its enquiry.

3. It was agreed the representative from the CQC would not be a member, but would attend the first meeting of the SCR Panel.

Appendix 3 - Glossary

ACS	**Adult Care Services**
ALMO	**Arms Length Management Organisation**
ASB	**Anti Social Behaviour**
CPS	**Crown Prosecution Service**
CQC	**Care Quality Commission**
GMP	**Greater Manchester Police**
GP	**General Practitioner**
IMR	**Individual Management Review**
LDST	**Learning Disabilities Support Team**
MARAC	**Multi Agency Risk Assessment Conference**
NICE	**National Institute for Health and Clinical Excellence**
NHS	**National Health Service**
SCR	**Serious Case Review**