



# **South Lanarkshire Adult Protection Committee**

## **Learning Review Report Adult 0060**

**HIGHLY CONFIDENTIAL**  
**Executive Summary**

## **Adult 0060**

### **Executive Summary**

Adult 0060 was a 26 year old woman who lived in the South Lanarkshire Health and Social Care Partnership area. Adult 0060 had a traumatic childhood and complex and challenging family dynamics. Adult 0060 had lived in a number of Local Authority areas in Scotland before settling in South Lanarkshire.

The Adult Protection Committee were advised of Adult 0060's death and received an Adult Support and Protection Learning Review request from the social work team. The Significant Case Review Task Group agreed a terms of reference and a Review Team. The review focused on the period January 2019 to January 2022 when adult 0060 died. Her previous life history was acknowledged, however, the Learning Review did not explore in any detail the history prior to the review timeline.

The review was conducted in line with the national guidance for Adult Support and Protection Learning Reviews as set out in South Lanarkshire's Adult Protection Committee local guidance.

### **Practice and organisational learning**

The Review Team considered the detail of the information gathered over the process of the Learning Review and in particular the reflections through each key episode of care. There were some aspects that were circumstance and context specific and others that appeared to bridge each episode.

### **Effective Practice**

The Review Team wished to highlight the following:

- The Police Officer who dealt with Adult 0060 in January 2019 demonstrated the level of professional curiosity, compassion and concern when dealing with this case. The desire to ensure follow through of the Adult at Risk IVPD referral was commendable.
- The Review Team noted that the Social Work team made connections between two referrals, one of which the referral did not identify themselves. They also pushed forward to an ASP case conference even when the investigation was incomplete because of the previous history and level of concern.
- The Review Team commend the DN team for their understanding of the importance of ASP and their recognition of the urgency when such requests for support are made by social work.
- The Review Team were advised that DN team Huddles had been introduced in this area, to the community nursing service, the staff felt that this now meant that a case such as Adult 0060 would be more readily discussed with coordinated efforts to provide support.

## **Reflections for consideration**

- The Review Team were not aware of a transfer protocol for vulnerable adults between local authority areas. The team could not identify any available formal protocol across Scotland or in South Lanarkshire. This is a national issue which requires discussion across Scotland.
- The Review Team were concerned that none of the partners, at the time, considered a referral to the Scottish Fire and Rescue Service despite there being indicators that the home was a potential fire risk. This has already been taken forward and the number of referrals has significantly increased. This is positive progress and needs continued effort.
- The Review Team noted that, on a number of occasions within Social Work Resources, escalation processes had been applied, the outcome of such escalation was not clear. This is reflected in the approach to risk assessment, record keeping and governance standards. The partners should consider further testing this issue to determine if this is a common or significant reflection across Social Work Service.
- Over the period of the review there had been a number of contacts with the family, by Police Scotland, that were not specific to Adult 0060. There is no mention of Adult 0060 from the records of these contacts. The Review Team have therefore identified a specific action for Police Scotland on the awareness of ASP by Police Officers even when making inquiries not specific to ASP.
- The Review Team noted that public awareness of the ASP requires further energy to increase the profile of ASP. The Review Team were aware that at certain periods in the year there were increased national efforts for publicising ASP but were of the view that it does not have the required reach. It was noted that the referrals of concern by members of the public about Adult 0060, were significant in triggering intervention and efforts to support Adult 0060.

***The Improvement recommendations from the Learning Review are noted below and the associated improvement plan developed by the Adult Protection Committee should be read alongside these recommendations.***

## **Person Centred Care**

- A refresh of the values-based approach to care should be undertaken, perhaps exploring an Ethics of Care framework.
- The principles of trauma informed practice and care should be embedded across agencies. It is acknowledged that considerable work has been undertaken by the partnership already and this will continue.

- There should be a refresh of the Complex Case Escalation Policy ensuring it has clear pathways for services to follow. The awareness of this policy and how it influences practice and decision making also requires audit.
- Staff should be further supported to understand the concept of neglect in adults and managing resistance and should be supported to access SLAPC training, support, and professional guidance in this area of practice.

### **Effective Communication and Record Keeping**

- Standards and systems for information sharing should be reviewed including embracing informal case discussion across the professions and services.
- The “Huddles” introduced by the DN Team should be reviewed and considered for roll out across the system.
- A review of the models of risk assessment used by Social Work and how these are recorded should be completed.
- Partners should explore a common understanding of a police officer led “Welfare Check” and underpin this with appropriate risk assessment, record keeping and training.
- NHSL District Nursing service should ensure that standards of record keeping are maintained and that entries of nursing input are completed timeously and accurately.
- Social Work record keeping standards and practice should be reviewed to ensure the importance of defensible decision making is embedded in practice and evidenced through record keeping.
- The completion of IVPD referral by Police Scotland should be standard where risk exists even when the request for a Welfare Check comes from social work.
- Social Work should explore with CLDT the opportunity to create an appropriate urgent referral pathway to assist in ASP assessment and investigations.
- A single source multi-agency chronology recording pathway should be explored and implemented.

### **Understanding and coping with difficult to engage people**

- Awareness should be enhanced, and available guidance and training further embedded for staff, across the Partnership, on how to provide support and care to and with difficult to engage individuals. It is acknowledged that there has been considerable progress made in this area of practice and this will continue to be reviewed and adapted.

- Further awareness of recognising and coping with coercive behaviour, including undue pressure and or influence, should be developed across the agencies. This should include reference to the full range of powers and support options expressed in the Adult Support and Protection Act 2007.

### **Awareness of Adult Support and Protection- its true purpose**

- SLAPC should review its training, development, and awareness plan to ensure it has the required reach to support staff, managers, and professional leads. This should include measuring the impact of training on practice, services and on the wellbeing of the people receiving care. Mixed models of education and training delivery should be extended.
- SLAPC should refresh its ASP decision making pathways to ensure clear guidance is in place for robust assessment, risk appraisal and outcome decision context.
- SLAPC should encourage the establishment of a network of ASP advisors across the main agencies to ensure that staff have ready access to guidance and support wherever they work.