Serious Case Reviews – "Olivia" and "Yasmine"
Safeguarding Adult Review – "Carol"

Executive Summary and Board Response

Background

"Carol" was a vulnerable adult who was killed in December 2014.

"Olivia" and "Yasmine" – then aged 13 and 14 – were found guilty of her murder and in April 2016 were sentenced to 15 years in custody.

Two Serious Case Reviews were commissioned by the Hartlepool Local Safeguarding Children Board (Hartlepool LSCB) and a Safeguarding Adult Review was commissioned by the Teeswide Safeguarding Adults Board (TSAB).

The reviews were carried out by two experienced independent reviewers following the Learning Together model, a nationally recognised method of undertaking these types of reviews. The method looks at what happened in a particular case and also considers the wider implications for local and national learning.

There was some delay in the review proceedings because of criminal processes which took 16 months to complete. This did not prevent early data collection, or key agencies reviewing their existing services to see what immediate action might need to be taken.

All members of each board wish to express their deepest condolences to Carol's family for their loss.

Summary

All three reviews found that no professional or agency could have foreseen that Carol would be murdered, or predicted the actions of the young people.

However, both boards are determined that the learning arising from all three reviews will be implemented to seek to reduce the risk of a similar tragedy occurring in the future.

It was decided it would be most useful to carry out the two Serious Case Reviews at the same time as the Safeguarding Adult Review to capture any shared themes or learning.

Each review sets out how it was undertaken and who was involved. The life experiences of Carol, Yasmine and Olivia are summarised and the reports then focus on the three years period before Carol's death.

The Safeguarding Adult Review shows that Carol lived a chaotic life as a result of a long history of addiction to alcohol and a personality disorder. She was well known locally and had frequent contact with workers in the mental health and alcohol services, ambulance and hospital services and the police.

Carol's Review highlights the challenges of trying to help someone with lots of complex needs, and how the committed and hard working professionals who worked directly with Carol did their very best to support her. The findings show that mental health and alcohol services need to work together closely when someone has a dual diagnosis, and that there can be confusion between frontline workers and those that commission specialist services. Workers need to be able to assess someone's capacity to make their own decisions when their capacity keeps changing as a result of their problems. The systems that keep vulnerable people safe require all organisations to work together to the same thresholds and procedures.

The Serious Case Reviews of both Olivia and Yasmine were commissioned by Hartlepool LSCB because of the serious nature of the offence and at the time it was committed, both girls were in care and had a high level of contact with local services. Hartlepool LSCB decided that although the circumstances did not meet the criteria for undertaking Serious Case Reviews, this approach provided the best framework to capture learning, and improve systems and professional practice for the future.

Individual reviews were undertaken for both Olivia and Yasmine; however the reviews are very similar in their findings for both girls.

There is no evidence that Olivia and Yasmine knew each other well until shortly before the murder.

Yasmine and Olivia's Serious Case Reviews state that: "Although we have learnt lessons about how we understand adolescent neglect more broadly, and the likely trauma it creates, we cannot predict how this will manifest itself on a daily basis or how it might interact negatively with other factors. These issues are beyond professional control."

In section two of each report there are details of the work that was being undertaken with the girls and their parents from 2012 for Olivia and 2013 for Yasmine. Both families received a great deal of support and guidance from a consistent, caring and hard working group of professionals. Neither girl had any history of violent offences although they were angry, abusive and hostile to those around them. There is considerable evidence that both Olivia and Yasmine experienced abuse and neglect which had an impact on their well being and behaviour. This resulted in the need for them to be taken into care, Olivia in September 2013 and Yasmine in October 2014.

There are five shared findings in relation to Olivia and Yasmine which revolve around the issues of adolescent neglect, the impact this has on young people and the challenges professionals face in correctly identifying and responding to this complex issue. Whilst these findings are aimed at helping workers to respond to this issue in a better way, there is also recognition of the essential role of parents and the dangers that arise when children experience neglect.

There is an additional finding, specific to Yasmine's Serious Case Review, which looks at how to identify 'fixed thinking' when working with young people and to challenge information that is received.

A shared finding - common to all three reports - highlights that those who work with adults, children and in community safety services must work more closely to share information about individuals and the community. Since 2014 there have been considerable changes in the way services work together to help vulnerable people.
All partner organisations have joined together to develop Action Plans in response to the findings and questions asked of the Boards in each review. The implementation of these plans will be monitored by the Hartlepool Local Safeguarding Children Board and the Tees-wide Safeguarding Adults Board.

Findings and Board Response

Finding 1: The care pathway in Hartlepool for people with a dual diagnosis, including personality disorder, has insufficient appropriate senior clinical oversight, early specialist input, close clinical case management and multi agency understanding.

Summary

Individuals suffering from mental illness and a drug or alcohol problem need a high level of support which includes supervision from senior and specialist professionals in psychology from an early stage in their treatment programme. Senior professionals need to provide management and supervision of the work completed with complex individuals to support the operational team.

Questions for the Board

How will the Board gain assurance that commissioners and providers of mental health services in Hartlepool provide an effective service that is complaint with national guidance?
How will the Board seek assurance that mental health and alcohol services are working together in an optimal way to meet the needs of those with a dual diagnosis?

TSAB Response

Mental health services in Hartlepool are commissioned in accordance with the NHS Standard Contract and this is in line with national guidance. The delivery of mental health services is monitored and quality assured through the contract. In addition, the Care Quality Commission, the independent regulator of all health and social care services in England, inspects the delivery of mental health services through its inspection programme. Going forward, we will require all inspection reports to be considered and discussed at the TSAB Performance and Quality Sub group for assurance that action is being taken to address any identified areas for improvement. Where any significant concerns are highlighted the inspection reports will be escalated to the Board.

At a local level, in 2016 TSAB introduced a Quality Assurance Framework which requires all partner organisations that make up the Board to complete a self evaluation of how they meet their safeguarding duties and this is audited by an independent group made up of other Board members. The Quality Assurance Framework helps the Board to be assured of the effectiveness of local arrangements for vulnerable people. In 2017/18, we will review our Quality Assurance Framework to make sure it includes arrangements for partner organisations to demonstrate how they meet national guidance and prioritise completion by those organisations who were involved in this case.

In the last year, a revised pathway has been developed for individuals with mental illness and a drug or alcohol problem which has improved how people can access support and joint working between services. In addition a multi agency network is being established. However, we know that there is more work to be done to improve the understanding of those who work with vulnerable adults about how to best help and support individuals with mental illness and drug or alcohol problems. In 2017/18, we will make sure that those who work in mental health and substance misuse services receive education and training to improve

their understanding of the work of each other's organisation and best practice in working together to support an individual. The newly established multi agency network provides these organisations with a forum to discuss their work and improve communication.

Finding 2: There is confusion between frontline efforts and the commissioning system which risks unreliable information being given to individuals which may have a negative impact.

Summary

Health services are commissioned and provided by different organisations. When those who are working with a vulnerable individual identify a specific service that may help the person, they must follow a process to secure agreement to arrange that service. This is known as an 'Individual Funding Request'. When this process does not work properly, there is a risk that the individual receives inaccurate information as to what is available or achievable. This is not helpful and may have a negative impact on the vulnerable person.

Questions for the Board

How will the Board seek assurance from the commissioners that they have robust systems and processes to consider the needs of complex individuals like Carol?
Is the Board satisfied that the provisions of the Care Act will be met when assessing the needs and risks of complex individuals like Carol?

TSAB Response

Services are commissioned according to strict criteria and there is a process for arranging additional services outside of those commissioned via the 'Individual Funding Request'. Commissioners have reviewed the process for agreeing and managing requests for specialist treatment and are now working more closely with providers to make sure that decision making is appropriate and timely to meet the needs of the individual.

It is crucial that the process is fully understood by operational staff working with vulnerable people and we expect that the partner organisations that make up TSAB will review the practice within their organisation to be confident that staff know what is required of them and provide training and education as appropriate. TSAB will measure the effectiveness of this through the Quality Assurance Framework.

This Safeguarding Adults Review highlights the need to make sure that all staff have the necessary knowledge and skills to support vulnerable adults with complex needs. We will ask the TSAB Learning and Development Subgroup to review the annual training programme and identify any additional training needs across the partner organisations that are required to strengthen the support and services provided.

The Care Act came into force in April 2015, since this time, all TSAB policies and procedures have been updated to make sure they comply with the Care Act requirements and the Board has received assurance that partner agencies have also updated their documents and practices. Training on the Care Act has been delivered by the Board and within partner agencies. There have been two annual conferences, one on self neglect and one on domestic abuse.

Through the Quality Assurance Framework, we will check that all partner organisations provide Care Act training to their workforce. In 2017/18, we will undertake a sample audit of multi agency practice where an individual has complex needs to be assured that the lessons from this Safeguarding Adults Review are embedded in practice and make recommendations for improvement where required.

Finding 3: Amongst professionals, the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases that are complex; limiting the risk assessment and professional response.

Summary

In order to decide whether an individual has capacity to make decisions about their lives, professionals must assess their mental capacity and there is a framework in place to help them to do this. Where a person does not have mental capacity they may need help and support from those working with them to make decisions. If professionals working with a person do not properly understand their mental capacity or have the skills to properly assess this, it can lead to incorrect judgments being made about a person's mental capacity. This, in turn, can affect the professional response.

Questions for the Board

How is the Board assured that staff are competent in fully assessing mental capacity and receive appropriate training?
In what way can the Board further test the quality of mental capacity assessments across the agencies?

TSAB Response

Compliance with the Mental Capacity Act is a priority for TSAB. Health and social care organisations provide regular training to their staff in relation the Act and the assessment process. Mental health services and adult social care services have named staff that can provide advice and support to the workforce when assessing mental capacity. In the light of the findings from this review, we will require partner organisations to provide evidence of their compliance with the Mental Capacity Act including the policies, procedures and documentation used by the organisation and training requirements.

Each member organisation of the TSAB has arrangements in place to review the quality of the work undertaken within their individual organisations. An audit of practice evaluating the compliance of partner agencies with the Mental Capacity Act requirements will be carried out and the Board will receive a report on the findings and oversee the implementation of any recommendations arising from this.

Further, through our Performance, Audit and Quality subgroup, we will examine the staff supervision arrangements that are in place within partner organisations and how effective these are in ensuring that Mental Capacity Act assessments are in place, appropriate and regularly reviewed. The Board will receive a report on the findings from this piece of work and have oversight of the implementation of any identified areas for improvement.

Finding 4: There is a lack of clarity on thresholds, inconsistent process and ownership for multi agency adult safeguarding leaving some frontline professionals managing complex and high risk cases and hindering vital information sharing and effective responses.

Summary

Safeguarding arrangements provide a framework in which all multi agency professionals work to a shared set of procedures to safeguard vulnerable adults. This requires organisations to share information, assess risk and take action to safeguard an adult at risk. The danger of an informal or inconsistent safeguarding system is that professionals become unclear who is leading the process, where roles and responsibilities lie and the adult at risk may not be afforded the protection they require or should be able to expect.

Questions for the Board

How can the Board seek to bring independent challenge to the adult safeguarding system?
Is the Board satisfied that all agencies understand the TSAB thresholds of when to make a referral to adult safeguarding?
How can the Board evaluate how agencies understand high indicators and self neglect?
How can the Board be assured that the duties and responsibilities of the Care Act are being met in terms of safeguarding adults at risk?
Will the Board consider the views expressed by Carol's family on home invasion?
How can the Board best strengthen the links between adult and children's safeguarding systems?

TSAB Response

TSAB is chaired by an experienced and qualified individual who is independent of the organisations that make up the Board. The Board has established audit systems which provide independent challenge to organisations on implementation of the adult safeguarding system, this includes the Quality Assurance Framework and peer challenges. We will further strengthen these arrangements by seeking an independent peer review of the local safeguarding arrangements in Hartlepool and make recommendations for improvements where these are identified.

We will explore how we can strengthen local arrangements in safeguarding practice. This will include ensuring there is a formal professional challenge/dispute resolution procedure to make sure that where there is a disagreement about assessment or decision making in individual cases, this can be followed and concerns escalated. We will ask our Policies, Procedure and Practice Guidance Group to develop a procedure for ratification by the Board.

Individual agencies have mandatory training for staff and this is complemented by the multiagency training commissioned by TSAB. TSAB will require all partner organisations to report to the Board on the implementation of this training, including the impact on practice. We will undertake a survey of the adults safeguarding workforce to establish how well workers understand the thresholds for safeguarding intervention and what to do if they are concerned about an individual. We will take action to strengthen these arrangements in light of the findings.

We will review our policies and procedures to make sure that the issue of self neglect is appropriately incorporated and supports all staff in their practice when working with this issue.

We know that Carol's family feel very strongly about the issue of home invasion and would like to see national changes to the law which supports vulnerable people who experience their home being taken over by others. The TSAB Independent Chair will liaise with members of Carol's family.

The Board is aware of the need for practitioners in adult services to engage with colleagues in children's services to make sure that information about vulnerable people is shared to safeguard both vulnerable adults and children. Regular meetings take place between the chairs of both of the Safeguarding Boards and Directors of Child and Adult Services to work strategically across all age ranges. We will arrange a joint meeting of the TSAB and HSCB to discuss opportunities for closer working relationships.

Finding 5: There is a disjoint between both children's and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.

Summary

The reviews found that the sharing of information between organisations with responsibility to safeguard children and vulnerable adults and organisations responsible for community safety was not as effective as it could have been. Not all of the information available was known to those working to protect children and the community. This is important in the context of the amount of time young people spend with their peers in the community without the supervision of adults.

Question for the Board

How can TSAB work in partnership with HSCB and the Community Safety Partnership to ensure that the development work currently being undertaken by the Community Safety Strategic Partnership strengthens the links for both adults and children?

TSAB response

This finding is shared across the three reviews and challenges the three partnership bodies to strengthen the links between their work. Within Hartlepool, a Vulnerable Victims Group is now well established where professionals from across the partnership including local authority, police, health and voluntary sector come together to consider concerns raised by any agency. Anti social behaviour risk assessment conferences are held and shared action plans are developed regarding high risk victims.

An electronic information system (E-CINS) has been implemented in the local area where professionals who are working with an individual involved in anti social behaviour can share information. This system is used for individuals who are referred to the Vulnerable Victims Group and has improved multi agency information sharing and putting in place timely actions to support vulnerable individuals. Going forward we will roll out the use of E-CINS across the adults safeguarding workforce to make sure that all those working with vulnerable adults have access to the information recorded on the system.

Parallel to the use of E-CINS, across the partnership in Hartlepool, a 'Team Around the Individual' approach has been recently established where those working with vulnerable adults with complex needs in contact with a number of organisations come together to coordinate the plan of intervention and support. This approach is still in its early stages and needs fully embedding. In one year, we will require a report to be presented to TSAB on the effectiveness of this approach and the improvements this brings to multi agency working with complex individuals.

We are currently developing a Joint Protocol between TSAB, HSCB and the Community Safety Partnership. This protocol will set out how these strategic boards work together to tackle shared agendas and avoid duplication and overlap. Through the Community Safety Partnership, work has started on creating a Community Protection Team integrating neighbourhood policing and community safety. As this develops, we will identify how this team will work with safeguarding professionals to improve the sharing of information.