



Adult Protection Committee

The Murder of Steven Hoskin

Serious Case Review

**Multi-agency and Single-agency Recommendations
and Action Plans**

December 2007

**NO TO
ABUSE**



Adult Protection Cornwall

Item 4

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Adult Protection Cornwall

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Section 1

Multi-agency Recommendations and Action Plan

Multi-agency recommendations and action plan in response to the Serious Care Review into the murder of Steven Hoskin

Introduction

Since its inauguration in December 2005, the APC for Cornwall has worked to embed best professional practice across all agencies working with vulnerable adults. We have implemented a clear business plan, revised pre-existing multi-agency procedures, implemented new and additional adult protection training, developed performance monitoring systems and introduced a Serious Case Review protocol. The level of funding available to implement adult protection across all agencies (just over £500k per annum) is far higher in Cornwall than many places elsewhere nationally and we have agreed that only the most senior officers from statutory agencies, as well as most senior representatives from the voluntary and independent sectors, sit as Members of the APC. Uniquely to our best knowledge, we have implemented a “local escalation policy” whereby any agency working with vulnerable adults judged by the independent Adult Protection Unit as not implementing its adult protection responsibilities sufficiently well is called to the APC to give evidence.

Despite all of these actions, the findings of this Serious Case Review into the murder of Steven Hoskin reveal weaknesses across each of the agencies in contact with him and those responsible for his abuse and murder.

The APC shares the public and personal sense of shock and abhorrence that has surrounded Mr Hoskin’s murder. It is the job of this Committee to ensure that the Serious Case Review’s findings are considered in full. It is our job to implement purposeful and positive action designed to minimise the likelihood of such an event from ever happening again.

Our recommendations and actions are devoted to the memory of Steven Hoskin. They reveal our determination to learn all of the lessons arising from the Serious Case Review and are underpinned by our collective resolve to deliver the very best multi-agency adult protection practice found anywhere.

Recommendations

A. Identifying vulnerable adults living in the community

Background

At the heart of this Serious Case Review are twin uncomfortable and haunting realities.

First, Mr Hoskin was regarded by several agencies not as a vulnerable adult to be protected from abuse and neglect but as a perpetrator of antisocial behaviour and worse. Mr Hoskin had been charged and convicted of assault. He was known to be



verbally abusive when drinking. There were complaints from neighbours about noise and worse emanating from his bedsit in St Austell. The fact that many agencies knew that Steven was a vulnerable adult with learning disabilities (including: Ocean Housing, the police, adult social care, the NHS and the Youth Service) was subjugated to their day to day experiences of responding to him. He was experienced as being at the heart of many and repeated social and health problems where he lived. There were the repeated complaints from neighbours and emergency calls to the police resulting in many visits to Steven's bedsit. There were the complaints to Steven's landlord, Ocean Housing, including a petition from his neighbours about noise and nuisance problems in the days before his murder. There were several emergency calls to the ambulance service to come to the bedsit to care for Steven and those later found guilty of his murder – with alcohol and violence often at the heart of the problems encountered when the ambulance crew arrived. Adult social care had "tagged" Steven's file because of the assault he had perpetrated against his mother and thus they also understood Steven not only in terms of his vulnerability – but also in terms of the risk he posed to others.

Second, Steven and Darren Stewart (one of his murderers) made extensive use of the emergency services after Steven had cancelled his services with adult social care. Yet at no point was any adult protection issue identified or adult protection alert made.

Our actions below are designed to ensure that frequent use of emergency and other services are analysed on a multi-agency basis – especially when a vulnerable adult is associated with this use. Our actions are also designed to ensure that there is better community awareness about vulnerable adults, as we recognise that local people, neighbours, provide a vital protective function for people with learning disabilities and other vulnerable adults living in the community (whether on their own or with their families).

1. Improving community safety: Multi agency conferences

1a. Actions:

- To review and improve multi-agency procedures for local multi agency conferences. In particular, to develop agreed single agency and multi agency "triggers" for when a multi-agency conference should be convened including: the number of emergency care episodes during a certain period in the NHS; the numbers and severity of complaints from neighbours and/or poor tenancy standards during a specified time frame for social landlords; repeated calls to the police over a specified period of time to any one address or for any one person; repeated referrals to adult social care during a period of time, including concerns about bullying. These procedures should provide each and every agency with their own flowchart as to what to do in specific circumstances – even when there is no evidence of adult protection concerns.
- For the APC to approve the policy and procedures for multi agency conferences - and for performance reports to be made available to the APC as part of the routine performance monitoring for adult protection
- To introduce training around multi agency conferences as an augmentation to existing adult protection training – ensuring that staff understand that such conferences should take place even when there is not necessarily previous evidence of any adult protection concerns. Such conferences could result in a



variety of outputs: adult protection, MAPPA, community safety plans and the provision of services

1b. Timeframe:

To implement new multi agency conferences procedures by 1/4/08 – and to audit its effectiveness and outcomes (including the extent to which adult protection procedures are invoked in response to such local conferences) after six months with a report coming to the September 2008 meeting of the APC as well as the next scheduled meeting of the Community Safety Partnership after that date.

1c. Responsible agencies

This work will be jointly led by the Adult Protection Unit and the adult protection leads for all statutory agencies comprising the working group.

1d. Resources

Additional funding necessary for training will be submitted to the APC meeting in March 2008. It is the expectation that each agency will ensure that the dissemination of the new procedure will occur in a comprehensive fashion throughout all relevant areas and that each agency will make available the funding necessary to embed the new procedures into practice.

2. Improved Information Sharing Across Statutory Agencies

2a. Actions:

- To audit the use of existing information sharing protocols across statutory agencies and to identify any gaps in such protocols
- To extend existing electronic information sharing systems across statutory agencies in order to ensure that operational staff and managers across the NHS, police and adult social care and children, young people and families can more easily alert each other about vulnerable adults and children in need/at risk

2b. Timeframe:

To complete the audit and make recommendations about any extensions to existing systems and procedures to the March 2008 meeting of the APC

2c. Responsible agencies

To be co-ordinated by the Senior Assistant Director in Adult Social Care with involvement from the IT and adult protection leads in all statutory agencies



2d. Resources

Within existing resources to undertake the audit and make any recommendations. (Although it should be noted that the specific recommendations that will arise about how to interface existing IT systems across agencies will inevitably have significant resource implications)

3. Raising the understanding of local communities about the identity and possible behaviours of vulnerable adults

3a. Actions:

- To undertake an annual multi-agency publicity campaign with the Community Safety Partnership designed to raise public awareness about vulnerable adults, who they are, the behaviours they may have and what people should do if they have any concerns. This will involve public meetings, media interviews, articles for the press and all agencies' internal newsletters/community newspapers
- To develop additional printed and electronic information about what members of the public should do if they are concerned about a vulnerable adult (keeping to the "Say no to abuse" brand and easy to access format) – and for all agencies to promote access to this information

3b. Timeframe:

To approve the details of the publicity campaign at the March 2008 meeting of the APC and to implement the campaign as specified in the detailed proposals during 2008 and thereafter

3c. Responsible agencies:

To be led by the Chair of the APC, the Chair of the Crime and Disorder Reduction Partnership and the APU

3d. Resources:

Within existing resources

B. Reviewing and embedding the effectiveness of existing adult protection arrangements

Background

Despite significant additional resources being devoted to adult protection arrangements in Cornwall, there were a number of "missed opportunities" which, if followed up, may have prevented Steven's murder. These missed opportunities include a failure to make adult protection alerts for Steven when there was a clear indication that it was appropriate to do. This means that the APC needs to obtain robust information about how confident and competent frontline staff and managers feel across all agencies working with vulnerable adults. With this information to hand, the APC will be able to review the adequacy of existing learning and development activities (which are already



evaluated for how good a learning experience they provide) and ensure that confidence with using adult protection procedures is matched by competency in doing so. The APC also needs to base its actions on known best practice nationally and ensure that there is systematic learning from child protection practice.

4a. Actions:

- To consider the results of the 2007 Adult Protection Training Audit
- To undertake an anonymous and representative sample survey of operational staff and managers across all APC member agencies measuring people's knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so. This survey will be repeated during 2008/09.
- To create additional capacity within APU to ensure that AP practice is of consistent high quality and informed by best practice from elsewhere. Specifically to create an additional adult protection co-ordinator (operations) post within APU
- For each agency member of the APC to continue to bring a report to the APC detailing how it has embedded adult protection policies and practices – and to provide evidence of the effectiveness of their adult protection work
- To convene an annual joint meeting of the Local Safeguarding Children's Board (LSCB) and the APC in order to share best practice, compare systems and approaches, identify issues of common concern and interest and agree joint areas of work
- To participate in the Knowledge Transfer Partnership of adult protection processes and practices – ensuring that best practice from elsewhere in the country feeds into the ongoing development of policy and practice in Cornwall.
- To convene a joint event between the APC and the Boards of NHS agencies in Cornwall, the portfolio holder for adult services, the Health and Adult Social Care Overview and Scrutiny Committee, the Police Management Board, and nominated portfolio holders in District Councils. This event will address the strategic issues facing all of the statutory agencies in respect of adult protection and will be used by the APC to inform the development of their service plan for 2009.
- To invite a representative from the Local Medical Committee to join the APC.

4b. Timeframe:

- Staff confidence and competence adult protection survey results to inform June 2008 meeting of APC.
- Proposal for additional AP co-ordinator to be submitted to December 2007 meeting of APC
- Agency reports – ongoing
- Joint APC/LSCB meeting to occur in late spring 2008
- Knowledge Transfer Partnership commences in early 2008
- Joint APC/Boards/Committee event to occur in July 2008
- Invitation to LMC – immediate



4c. Responsible agencies:

Staff Survey - Roger Indge/Corinne Leverton/Jon Dunicliff

Additional AP co-ordinator post – Carol Tozer and Jon Dunicliff

Agency reports – Jon Dunicliff

Joint APC/LSCB meeting – Carol Tozer and Dave Ellis

Knowledge Transfer Partnership – Roger Indge and Corinne Leverton

Joint APC/Boards/Committee meeting – Carol Tozer

Letter of invitation to LMC – Carol Tozer

4d. Resources:

Survey - £10k (first survey to be funded from adult social care)

Additional AP co-ordinator post – funded by Department of adult social care

Remaining actions - within existing resources

C. Ensuring that all vulnerable adults in Cornwall are well safeguarded

Background

From 1st April 2007, Cornwall County Council set its eligibility criteria for adult social care at meeting substantial and critical levels of needs only (as defined by the Government's Fair Access to Care Services guidance). This means that vulnerable adults with low or moderate levels of needs are no longer eligible for a service from the Department of Adult Social Care. This raises concerns about the support received by vulnerable adults with lower level needs. Should a reassessment have taken place of Steven's needs, from what is now known about him, it is possible that he would have been judged as having "moderate" levels of needs – meaning that he would have not been eligible for the weekly support from a community care assistant and regular support from a social work assistant.

As part of its Medium Term Financial Strategy, the Department of Adult Social Care has implemented its Preventative Strategy – being awarded an additional £500k per annum to invest (on top of its existing £3.5m expenditure) in services provided through the voluntary and community sector in order to meet low level needs and secure access to existing community services and resources for people no longer eligible for services from ASC. As a consequence, the voluntary and community sector will increasingly be the sector in contact with vulnerable adults with lower level needs and will thus be responsible for their identification and referral to adult protection procedures.

In addition, vulnerable adults with lower level needs living "independently" within the community – i.e., not with their families are, because of the prohibitive cost of owning one's own home or shortages in the private rented sector, are most likely to be living in social housing. In the mainpart, this is provided through registered social landlords and local councils. It is especially important, therefore, that housing officers within local



councils and staff working for SLs are knowledgeable about adult protection procedures and confident to use them.

5a. Actions:

- To ensure that senior members of all voluntary and community sector organisations in Cornwall who work with vulnerable adults have undergone adult protection training so that they can issue guidance to their staff and ensure best practice in identifying and responding to signs of abuse or neglect
- To audit the use of AP learning and development activities by the VCS, ensuring that they are given good access to, and make full use of, adult protection training places
- To ensure that the APU and Supporting People Team meets with all SLs in Cornwall, agreeing with them how they will each implement good adult protection practice across their organisations

5b. Timeframe:

- Delivery of dedicated adult protection training event for VCS senior managers by March 2008
- Meetings with all SLs completed by May 2008 and action plans for each RSL submitted to the June 2008 meeting of the APC

5c. Responsible agencies:

Voluntary and community sector training - Corinne Leverton and Roger Indge

Action planning with SLs – Jon Duniclif and Ann Hughes

5d. Resources:

Within existing resources

D. Restoring Public Confidence

Background

The APC recognises that public confidence in adult protection arrangements is severely dented by the circumstances of Steven's murder. External regulators have pointed towards "significant and commendable improvements" (CSCI, July 2007) in local adult protection arrangements – but this will count for little for vulnerable adults, their families and the public at large. Accordingly, the APC must work to restore public confidence, engender greater transparency in how adult protection works in Cornwall. To do so, the APC must engage more directly with vulnerable adults, their families and the public, including the media.



6a. Actions:

- To undertake a series of meetings between the APC and vulnerable adults, families and members of the public. These meetings should be held in different venues across Cornwall – and be in easy to access format. The meetings should allow people to ask their questions of the Committee as well as hear from the APC about its work, what is working well and the priorities for improvement
- To further develop the APC website to detail comprehensive data about the performance of adult protection procedures in Cornwall
- To work with the media in developing better public awareness in how adult protection works in Cornwall and to promote the good practice that occurs in safeguarding adults.

6b. Timeframe:

Three public meetings by the APC to take place during 2008 (and reviewed thereafter). Detailed proposal to be submitted to March 2008 meeting of APC (with first one planned for April 2008)

Media strategy to be developed in conjunction with these public meetings – and could involve inviting media representatives to learning and development events, meetings with members of the APU and APC etc

6c. Responsible agencies:

Public meetings – with proposal to be developed by Carol Tozer and Jon Duniclif and agreed at March 08 meeting of APC

Media campaign – To be submitted to March 08 APC – Carole Theobold and other communication leads throughout statutory agencies

6d. Resources:

To be determined

E. The national implications of lessons from this serious case review

The government is currently undertaking a review of the No Secrets guidance for adult protection. It is important that the lessons arising from this serious case review into Steven Hoskin's murder informs this national review.

As a result of this SCR, the APC considers that there are several weaknesses in current adult protection arrangements as established by the No Secrets guidance:

- the absence of a statutory duty to cooperate (as is the case in children's services)
- no statutory footing for local Adult Protection Committees or Safeguarding Boards (as is the case in children's services)
- the absence of any cross-inspectorate national review of the effectiveness of adult protection work (as has happened in children's services).



A statutory duty to cooperate

The No Secrets guidance establishes the local authority as having lead responsibility to co-ordinate and monitor multi-agency arrangements and ensure that vulnerable adults are safeguarded effectively by all agencies working with them. The primary task is to ensure that there is the right culture, policies and procedures in place across all agencies, thereby reducing the risk of abuse or neglect occurring and ensuring that effective action is taken when abuse or neglect has occurred. A large number of different agencies, at the right level of seniority, must be engaged in local multi-agency arrangements from across the statutory, voluntary and community and independent sectors if this is to occur. In the absence of a statutory duty to co-operate, the local authority has the responsibility to deliver effective adult protection arrangements without the necessary clout to do so.

With regards to those services it commissions or delivers, the local authority can take remedial measures necessary when there is any concern or evidence that vulnerable adults are at risk of abuse or neglect. But the lead “co-ordinating” and “monitoring” role accorded to the local authority provides it with no authority to either instigate enquires into another statutory agency (unless an adult protection referral has been received), or to insist that another statutory agency makes changes to its internal policies, procedures or practices when these are at variance with the agreed local multi-agency adult protection procedures.

In Cornwall, we have attempted to overcome these difficulties with the implementation of the APC “escalation policy” (whereby the Adult Protection Unit refers concerns about any one agency’s implementation of adult protection arrangements to the APC, the Chief executive of that organisation then gives evidence to the APC and the APC decides whether or not to formally report that agency to their regulatory body).

Statutory footing for local Adult Protection Committees or Safeguarding Boards

There is no statutory requirement for local multi-agency Adult Protection Committees to exist. Paragraph 3.4 of the No Secrets Guidance states “...agencies may consider there are merits in establishing a multi-agency management committee (adult protection) which is a standing committee of lead officers.”

This contrasts starkly with the requirement set out in the 2004 Children Act that each local authority with responsibility for social services establish Local Children’s Safeguarding Boards. In October 2005, the Association of Directors of Social Services published “Safeguarding Adults” setting out 11 good practice standards for adult protection work. Standard 1 states that each local authority should establish a multi-agency committee to lead adult protection work. Many local authorities, including Cornwall, have established such Adult Protection Committees. The statutory guidance that exists for children’s services ensures that people of the right seniority attend the Board, people who are able to take decisions and commit resources on behalf of their organisation. Many Adult Protection Committees struggle to get the same level of senior involvement and ownership as their counterparts in children’s services – and there are still some areas in the country where such Committees do not yet exist.



Cross-inspectorate national review of the effectiveness of adult protection work

The adequacy of child protection work has been the subject of cross-inspectorate national reviews. The published reports resulted in national recommendations about child protection being levied on all agencies involved including the police, probation, voluntary agencies, the NHS and the local authority. There has been no such equivalent national review into adult protection policies, processes, partnership working or practice. Consequently, there is no national knowledge about the level of adult protection work underway – we simply do not know how many adults are at risk and have been referred under multi-agency adult protection procedures. There is no national knowledge about the effectiveness of adult protection work subsequent to these referrals. There is no national knowledge about the effectiveness of partnership working in the adult protection arena.

There is an acknowledged lack of prevalence data about the level of adult abuse in the United Kingdom. The National Elder Abuse Study revealed significantly more elder abuse than was previously estimated to be the case and further studies are required. A cross inspectorate national review of adult protection work could usefully catalogue the numbers of adult protection referrals, investigations and plans that occur at any one time nationally – this would be highly complementary to the national study referred to above in giving an indication of whether or not abuse or neglect of vulnerable adults is being successfully responded to through the multi-agency arrangements.

There are a number of useful studies providing illuminating insight into the effectiveness of adult protection arrangements, but, in many ways, their results serve to reinforce, not obviate, the need for a cross-inspectorate national review. For instance, the 2002 Centre for Policy on Ageing report into local adult protection policies and procedures found: no evidence in 31% of cases that local procedures had been approved by chief officers, boards or elected members; 61% of codes failed to identify the designated adult protection lead officers across all organisations; 87% made no reference to the resource implications of local multi-agency procedures; 96% had no evidence of any reporting mechanisms to the public; and 96% had no summary versions of local procedures available for the public. There can be no more important an issue across all agencies working with vulnerable adults than the safety, dignity and wellbeing of those people – and yet, to date, there has been no cross-inspectorate national review. Such a national review is overdue.

F. Monitoring the implementation and effectiveness of all actions arising in response to this serious case review

The APC cannot change what happened to Steven. But it can ensure that everything is done, by all agencies, to ensure that the chance of this ever happening again is minimised. This will be our collective and sincere tribute to Steven's memory.

The SCR report contains the detailed action plans of all agencies involved. At each meeting of the APC in 2008, all of these agencies will submit a detailed progress report about the progress they have made. The APC will ensure that every agency fully implements the actions they said they would, in the timeframe they themselves have agreed.

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With regards to the actions of the APC set out in this document, we will build each action into our existing work plan and review their successful implementation at every meeting of the APC throughout 2008.

In this way, individual agencies are being held by the APC to account – and the APC is also demonstrating and monitoring its own collective responsibility.

Section 2

Single-agency Recommendations and Action Plans

The following information was abstracted from the Individual Agency Management Reviews:

Adult Protection Unit

- 1) *The Adult Protection Unit has an overarching role to provide advice and support to the Multi Agency Adult Protection Partnership.*
- 2) *The Adult Protection Committee will agree the multi agency recommendations and action plan in response to the Serious Case Review report. This plan will contain detailed actions for the Adult Protection Unit.*
- 3) *The Adult Protection Unit will support partner agencies in the implementation of their individual agency recommendations and action plans.*
- 4) *The Adult Protection Unit will support the Adult Protection Committee in monitoring the delivery of the single agency and multi agency recommendations and action plans.*

Cornwall and Isles of Scilly Primary Care Trust

- 1) *Cornwall and Isles of Scilly Primary Care Trust will strengthen its adult protection procedures/systems across its own directly provided services and with the organisations it commissions from.*
- 2) *Cornwall and Isles of Scilly Primary Care Trust will develop an anticipatory care management approach to identify and support the most vulnerable and needy in society. We intend to shift the emphasis away from crisis management towards anticipating people's needs and preventing crisis. In order to do this we will be introducing a predictive tool as part of the Whole System Demonstrator for assistive technology that Cornwall and Isles of Scilly Primary Care Trust is piloting. This is currently being procured by the Department of Health for Cornwall and Isles of Scilly Primary Care Trust. This tool will alert us to high intensity users of crisis services. This will include South Western Ambulance Service Trust, Accident and Emergency departments, Out of Hours GP Services, Minor Injury Units and Cornwall Partnership Trust crisis management services as well as our own services.*
- 3) *Cornwall and Isles of Scilly Primary Care Trust will establish an active Safeguarding Unit for adult protection that oversees responses of all serious cases within the NHS to include Cornwall & Isles of Scilly Primary Care Trust, Royal Cornwall Hospitals Trust, Cornwall Partnership Trust, South Western Ambulance Service Trust, Out of Hours GP Services and Primary Care. It will ensure there are appropriate links to both Plymouth and North Devon Services. This Unit will also be responsible for training and policy development.*



Specific actions that we will implement are:

- 4) *Cornwall and Isles of Scilly Primary Care Trust will appoint a named clinical professional for adult protection and appoint a named Doctor on a sessional basis with a focus on developing adult protection arrangements within the NHS in Cornwall and the Isles of Scilly. Job Descriptions will be agreed by the end December 2007 and the appointments panel in place by the end March 2008. £60,000 per annum will be invested in this position.*
- 5) *Adult protection training will be available and delivered to all staff including Primary Care. This will be delivered at induction and refresher training delivered every three years. Policies and procedures will be embedded in day to day practice as part of supervision. This will be ongoing, led by the Training Department and funded via existing resources.*
- 6) *Within contracts and service level agreements between Cornwall and Isles of Scilly Primary Care Trust and all providers of care, a requirement will be inbuilt for adult protection training for staff by March 2008. This will be led by the Primary Care Trust's Commissioning Department and funded within existing resources.*
- 7) *An electronic database will be developed in Minor Injury Units to ensure we are able to identify either vulnerable individuals or very regular users of services, ensuring that this complies with Human Rights legislation in relation to confidentiality and privacy. Existing arrangements will be reviewed by the end of March 2008 and will be led by the Director of Community Services. The cost of procuring appropriate systems remains to be determined.*
- 8) *We will develop a policy and guidelines to alert staff with appropriate 'flags' where vulnerable people are being cared for. This work will be undertaken by the new Safeguarding Unit within the Primary Care Trust. However, the existing arrangements already in place in the Ambulance Trust will be communicated to other agencies with immediate effect. The new Safeguarding Team will be in place by October 2008*
- 9) *The present Overarching Information Sharing Protocol will be reviewed and made more explicit, particularly in relation to South Western Ambulance Services Trust, GP's and Primary Care. The review will be led by the Caldicott Guardian and completed by March 2008.*
- 10) *Primary Care Liaison Nurses for Learning Disabilities within Cornwall and Isles of Scilly Primary Care Trust are now in post and will work closely with GP Practices to enable GP registers to be up-to-date flagging up learning disability clients. This ongoing work will be led by the Director of Community Services.*
- 11) *Within Primary Care, practices work through a Quality and Outcomes Framework. "The presence of an Intelligence Quotient below 70, should not, in isolation, be used in deciding whether someone has a learning disability." Through the Primary Care Liaison Nurses for Learning Disabilities, Cornwall and Isles of Scilly Primary Care Trust will ensure that this is applied consistently so that vulnerable adults are not excluded. This work will be led by the Primary Care Liaison Nurses*



- 12) *Cornwall and Isles of Scilly Primary Care Trust will introduce an electronic anticipatory care tool to alert us to high intensity users of crisis services. This will inform criteria for primary care monthly case conferences where risk assessments will be undertaken and used to initiate case management and appropriate care plans. It will be in place by October 2008 and led by the Safeguarding Unit, supported by the Assistive Technology Project. Resources for this have already been identified and allocated.*
- 13) *Health records within Primary Care are held by a number of different independent contractors. We will work with the Local Medical Committee to agree an information sharing protocol. This should be completed by the end of March 2008 and will be led by the Deputy Director of Primary Care. A procedure for accessing Primary Care records will also be introduced within the Primary Care Trust with immediate effect to ensure timely access to relevant health information. This should be completed by the end of November 2007 and will be led by the Director of Community Services*
- 14) *The Ambulance Trust have not been members of the Adult Protection Committee. They have identified a nominee and will attend regularly with immediate effect. The Chief Executive of South Western Ambulance Services Trust will lead this work.*

Cornwall Youth Service, Department of Children, Young People and Families

[It should be noted that as SHARE is a service in the process of being re-organised the following recommendations are proposed as considerations for the successor service.]

- 1) *Consideration is given to adding a category of Domestic Abuse/Domestic Violence to the SHARE enquiry classification system.*
- 2) *Consideration is given to making such a classification the subject of an automatic line management review process, including the examining of risks beyond those to the presenting client. In a similar manner to that accorded to child abuse and serious harm consideration for young people.*
- 3) *Consideration is given to supporting and training SHARE staff to provide an informed and structured response to clients where Domestic Abuse/Domestic Violence is disclosed and is a relevant issue.*
- 4) *Consideration be given to participating in robust community safety strategies, initiatives, structures and procedures related to Domestic Abuse/Domestic Violence and, where appropriate, the sharing of information to support agreed outcomes.*



Cornwall Youth Offending Team

- 1) *The Youth Offending Team is required to call and chair an inter-agency meeting when a young person is involved in a serious incident, in line with Youth Justice Board Policy. The Youth Offending Team manager will ensure that the Department of Adult Social Care are informed of all future inter-agency meetings called as a result of a serious incident.*
- 2) *The Youth Offending Team receives very few cold calls from concerned parties. However, unless anti social or offending behaviour is identified, it is unlikely the Youth Offending Team can formally respond. All such calls will be brought to the line manager's attention, who will ensure that appropriate agencies have been informed.*
- 3) *The Youth Offending Team will review its risk management policy and procedures.*

Cornwall Partnership Trust

- 1) *Where a threshold for risk is crossed, non-engagement and non-attendance should not be a barrier to internal multi-disciplinary discussion and wider multi-agency liaison and consultation. High risk cases amongst referrals should be highlighted for multi-disciplinary discussion at the weekly team meeting and with outside agencies where appropriate and legal.*
 - The forensic team have been offering referral and advice surgeries for Community Mental Health Teams to widen the influence of their expertise.
 - There is also now a mental health liaison forum which links mental health services with police at a level below the formal MAPPA processes and allows "intelligence" to be shared.
- 2) *To improve co-ordination of the referral pathway to mental health services for homeless people, especially where there are frequent changes of address, even if discussion takes place with relevant agencies without face to face contact with the client / patient. This can only take place if a risk assessment indicates that confidentiality and consent issues can be over-ridden in the interest of public protection.*
 - A psychiatric nurse, dedicated to mental health problems in homeless people has been appointed. Ideally, this role would include liaison with other agencies such as housing and voluntary or non-statutory homelessness services.
 - The Multi Agency Risk Assessment Conference (MARAC) process may offer a way to learn of incidents of domestic violence which can be cross referenced with mental health data to evaluate risk issues – a process of including this within Cornwall

Partnership Trust should be developed.

- A multi-agency forum to discuss complex problems would be helpful. This is relatively straightforward in inner cities, where most of the homeless population reside in a focused area and informal links are easy to maintain but more challenging in a rural/ small town environment.

- 3) *Training for adult protection, particularly the identification of vulnerable adults at risk runs alongside training for child protection and safeguarding children for all staff within Cornwall Partnership Trust. Multi-agency training may be of additional benefit and should be targeted at key professionals.*

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- Awareness of adult protection is included in CPT induction and mandatory training. A full matrix of essential training has now been devised to ensure that all staff receive the appropriate level for their role. The adult protection processes have developed significantly over the past year.
- 4) *A more co-ordinated approach to individuals presenting with personality disorders and requesting treatment should be agreed between Cornwall and Isles of Scilly Primary Care Trust and Cornwall Partnership Trust. This should then be explicitly commissioned using as its basis the NIMHE paper: "personality disorder: no longer a diagnosis of exclusion".*
- Cornwall Partnership Trust should take the lead in multi-agency training for other agencies in managing people who self harm or use maladaptive coping mechanisms when distressed.
 - A personality disorder steering group has started to meet to clarify commissioning for these disadvantaged people and a pilot day project is underway in one area of Cornwall.
 - Training for Accident and Emergency staff, including patients who self harm is already underway at RCHT –this could be extended to other agencies who work with people who self harm.
- 5) *Following arrest for an offence or detention under section 136 of the Mental Health Act, (at about 7-14 days) where there has been a mental health outcome, there should be a follow up review between police and psychiatrist (responsible clinician under the 2007 Act) to assess whether the outcome has achieved the correct goals of treatment or criminal responsibility and to re-assess risk management.*
- Follow up of arrests which lead to a mental health disposal between police and Cornwall Partnership Trust might go some way to identify where such diversion may have been inappropriate and the question of prosecution may need to be revisited in the interests of public protection. This may occur through sub-MAPPA processes. The high rates of section 136 in Cornwall are being audited through the Mentally Disordered Offenders group within the peninsula and further training for police staff is planned, with revision of existing procedures/protocols. Previous incidents associated with section 136 should be incorporated in that review.

Department of Adult Social Care

- 1) *Review the Risk Assessment/Review processes to ensure that key indicators of risk in the community are clearly identified and addressed.*
- There is a need to ensure that risk assessments and risk reviews for individuals are holistic and cover the whole person and situation alongside any specific risk that may have been initially identified. Key indicators of risk which need to be considered include a move away from a familiar location and family/friends; the absence of a familiar social support network; the absence of a daily routine and purpose (e.g. voluntary or paid work); a history of being teased/ taunted; a history of concerns about alcohol/ substance misuse; a history of aggressive or inappropriate behaviours which may put the person at risk if rumours persist in the community. The Review, resulting in written Guidance, will be completed by February 2008. Interim guidance will be issued immediately regarding the key indicators 1 and 2.
- 2) *Review of systems by which services are terminated so that it is clearly*



linked to the Risk Review

There is a need to ensure that when a person refuses/terminates services that the reasons for this are investigated and any possible risks are clearly identified and addressed against the indicators identified in 1 above. A Review of the Service Closure System will be completed by February 2008. Interim guidance will be issued immediately regarding risk assessment and case closure.

- 3) *Establishment of local inter-agency "Vulnerable Adults" meetings and include a focus on those ineligible for services. This will need to include Housing, Supporting People, the Police and Department of Adult Social Care. Forums for this sort of exchange of information already exist in some areas and these should be built upon.*
Different information-sharing groups already exist. By February 2008 Adult Social Care will undertake to review these groups, formalise their status and Determine protocols for information sharing.

- 4) *Establishment of protocols between Supporting People and Adult Social Care which ensure that referrals to Supporting People agencies are monitored and that systems are in place to highlight concerns (see Recommendation 3 above)*

There is a need to address how potentially vulnerable people, who are not eligible for services, or who refuse services, are signposted to other support services and how these support services monitor and report changes in situations which may be indicators of increased risk. By January 2008 there will be formal agreement on protocols. Interim guidance will be issued immediately regarding the referral process to Supporting People.

Since this Serious Case Review started, the Home Care Team Leaders have commenced a more rigorous monitoring of actual and abortive contacts with vulnerable adults i.e. cross checking visits to vulnerable adults against Time Sheets and the Community Care Assistants' Work Records. This means that if a vulnerable adult declines a service and/ or if someone in their residence declines the service on their behalf, the Team Leaders will ensure that this is reported to the Care Management Team.

Department of Children Young People and Families

- 1) *Where links are made by workers in Children Young People and Families and Department of Adult Social Care, these must be followed up by contacting the relevant individual social workers. Links will be highlighted on the 'Framework' system*
- 2) *A comprehensive information and management system which incorporates both adult and child files must be in place if the services are to share information.*
- 3) *Where persons are identified who present a risk or potential risk to children because of offences committed, or where there are reasonable grounds to be concerned, each district office should be informed. It is not reasonable to rely on the Joint Consultancy Team Adult Information database, as it is unreliable in terms of information offered by the courts, prisons and probation service.*



Devon and Cornwall Constabulary

- 1) *Adult Protection training is reviewed in line with this Serious Case Review, specifically aimed at the issues of identification and awareness of a vulnerable adult and procedures to instigate once the identification has been made. This will require rolling out to all operational staff with immediate effect.*
- 2) *That a list is forwarded to Police of all persons on within the Adult Protection process and that these named persons are all created as Nominal Records on the police computer and have an Adult Protection Flag placed on the nominal. That any person who has an Adult Protection Flag has a warning marker (SIG warning) put in place on the address where they reside. Any person coming into contact with police staff for any reason who has an Adult Protection marker against them or SIG warning on their address should have circumstances passed to either Adult Social Care or the Department of Children, Young People and Families (possible use of 121a form) and Neighbourhood Teams.*
- 3) *Any police staff coming into contact with a person deemed to be vulnerable/ in the Adult Protection process, and there is obvious concern regarding their welfare, or that of any other persons they have direct contact with, should take advice from the Adult Protection Officer.*
- 4) *That these incidents are monitored and prioritised by the Adult Protection Officers working within Basic Command Unit ensuring compliance with policy and concerns are shared and highlighted to Social Services i.e. either Adult Social Care or the Department of Children, Young People and Families.*
- 5) *That where an individual is identified as posing a threat to the community, consideration should be given to progress the individual within the MAPPA system. Thereby ensuring a multi agency review of the risk and action as deemed appropriate and managed by appropriate agency.*

Ocean Housing Ltd

- 1) *When the probationary tenancy of a vulnerable adult is extended, Ocean Housing Ltd. will inform the Care Manager in writing, outlining the reasons for the extension;*
- 2) *When the tenancies of vulnerable tenants are damaged e.g. windows are smashed, Ocean Housing Ltd. will inform the Police, the Care Manager and the Adult Protection Unit in writing and separately, will address this via the Anti-Social Behaviour Group (which Ocean Housing Ltd. chairs);*
- 3) *When a vulnerable tenant in a bed-sit has a lodger, the Care Manager will be informed in writing as a matter of urgency;*
- 4) *Ocean Housing Ltd will reflect the changes in 1-3 to practice in a review of our Vulnerable Tenants' Policy and Procedure and ensure that this is aligned with the County Council's multi agency policy;*
- 5) *Ocean Housing Ltd. will review its Rent Arrears Policy and Procedure with a view to ensuring that vulnerable tenants are supported to claim Housing Benefit;*



- 6) *Ocean Housing Ltd. will review its Complaints Policy in order to respond effectively to matters that do not hinge on repairs to our properties;*
- 7) *Ocean Housing Ltd. will collaborate with Restormel Borough Council to ensure that tenants who do not read are not sent letters and noise abatement notices for example;*
- 8) *Ocean Housing Ltd. will undertake a review of staff training provision, with particular emphasis on the needs of vulnerable tenants and widen its scope of training for Housing Management and Technical staff.*

Ocean Housing Ltd. will undertake to act on these recommendations by March 2008.