Adult Social Care and Health Overview and Scrutiny Committee

7 December 2011

Agenda

A meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on WEDNESDAY, 7 DECEMBER 2011 at 10:00 a.m.**

The agenda will be: -

1. General

(1) Apologies

(2) Members' Disclosures of Personal and Prejudicial Interests.

Members are reminded that they should disclose the existence and nature of their personal interests at the commencement of the relevant item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

'Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration'.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 25 October 2011

(4) Chair's Announcements

2. Public Question Time (Standing Order 34)

Up to 30 minutes of the meeting is available for members of the public to ask questions on any matters relevant to the business of the Adult Social Care and Health Overview and Scrutiny Committee.

Questioners may ask two questions and can speak for up to three minutes each.

For further information about public question time, please contact Ann Mawdsley on 01926 418079 or e-mail ***annmawdsley@warwickshire.gov.uk***.

3. Questions to the Portfolio Holders

Up to 30 minutes of the meeting is available for Members of the Committee to put questions to the Portfolio Holders (Councillor Izzi Seccombe (Adult Social Care) and Councillor Bob Stevens (Health) on any matters relevant to the Adult Social Care and Health Overview and Scrutiny Committee's remit and for the Portfolio Holders to update the Committee on relevant issues.

4. Performance Management

Phil Evans, Head of Service Improvement and Change Management, will give a verbal update on effective performance management and links to the overview and scrutiny process.

For further information please contact Phil Evans, Head of Service Improvement and Change Management, Tel: 01926 412293 email ***philevans@warwickshire.gov.uk***.

5. Shaping Local Healthwatch in Warwickshire – Progress Report

This report sets out the current position and plans around the development of a local HealthWatch in Warwickshire as would be required by the Health and Social Care Bill.

Recommendations

The Adult Social Care and Health Overview & Scrutiny Committee is requested to:

(1) Note the current position and plans around the development of local HealthWatch in Warwickshire

(2) Comment on the proposed timescales for the development of local HealthWatch in Warwickshire

(3) Comment on the stakeholders' feedback in relation to the role of local HealthWatch in Warwickshire

(4) Give further consideration to the arrangements for establishing local HealthWatch at its meeting on 15 February 2012

For further information please contact Monika Rozanski, Senior Projects Manager, Tel: 01926 412439 email ***monikarozanski@warwickshire.gov.uk***.

6. Protocol between Adult Social Care and Health Overview and Scrutiny Committee and Warwickshire LINk

This report sets out a protocol for the Adult Social Care and Health Overview and Scrutiny Committee and Warwickshire LINk for the remainder of the time until LINks is replaced by Local Healthwatch.

Recommendations

That the Committee agree the protocol.

For further information please contact Ann Mawdsley, Senior Democratic Services Officer, Tel: 01926 418079 E-mail ***annmawdsley@warwickshire.gov.uk***.

7. Quarter Two (July - September) 2011-12 Performance Report for Adult, Health and Community Services

This report provides an analysis of the Adult, Health and Community Services Directorate's performance for quarter two of 2011/12. It reports on performance against the key performance indicators as set out in the Directorate Report Card

Recommendation

That the Adult Social Care and Health Overview & Scrutiny Committee:

- Consider both the summary and detail of the performance indicators within the Directorate Report Card for the quarter two of 2011/12 (Appendix 1)
- Consider and comment on areas where performance is falling short of target, and where remedial action is being taken.

For further information please contact Wendy Fabbro, Strategic Director of Peoples Group, Tel: 01926 742967 email ***wendyfabbro@warwickshire.gov.uk*** or Ben Larard, Business Intelligence Team Manager, Tel: 01926 745616 email ***benlarard@warwickshire.gov.uk.***

8. Progress in Adult Safeguarding Report

This report provides an update for Members on Adult Safeguarding.

Recommendation

It is recommended that Members consider and comment on the information presented on performance in safeguarding vulnerable adults in Warwickshire over the last 12 months, and future plans for continual improvement.

For further information please contact Wendy Fabbro, Strategic Director of Peoples Group, Tel: 01926 742967 email ***wendyfabbro@warwickshire.gov.uk***.

9. Adult Safeguarding – Serious Case Review

This report provides an update on the recent serious case review.

Recommendation

In response to members' request for more information, this report brings forward the public summary of the serious case review (SCR) into the death of GH published on 14th November. Members are asked to consider and comment on the report that has now been accepted by the Warwickshire Safeguarding Adults Board.

For further information please contact Wendy Fabbro, Strategic Director of Peoples Group, Tel: 01926 742967 email ***wendyfabbro@warwickshire.gov.uk***.

10. Work Programme

This report contains the Work Programme for the Adult Social Care and Health Overview and Scrutiny Committee.

Recommendations

The Committee is recommended to agree the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year

For further information please contact Ann Mawdsley, Senior Democratic Services Officer, Tel: 01926 418079 E-mail ***annmawdsley@warwickshire.gov.uk***.

11. Any Urgent Items

Agreed by the Chair.

EXEMPT ITEMS FOR DISCUSSION IN PRIVATE (PURPLE PAPERS)

12. Reports Containing Confidential or Exempt Information

To consider passing the following resolution:

'That members of the public be excluded from the meeting for the item mentioned below on the grounds that their presence would involve the disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972'.

13. Effectiveness of the Learning Disability Strategy – *A Good Life for Everyone 2011-2014*

This report considers the effectiveness of the Learning Disability Strategy – *A Good Life for Everyone 2011-2014*.

Recommendation

For the Learning Disability Strategy:
To comment the change management approach taken for the implementation of the learning disability strategy.

To agree that quarterly monitoring reports are presented to O & S with a profile on key areas eg; Accommodation (April '12), Safeguarding (July '12) and Supporting Family Carers (Oct '12).

For Day Services:
To note the progression of the Day Opportunities Transformation Programme.

For further information please contact Chris Lewington, Service Manager – Learning Disability, Mental Health, Carers and Customer Engagement, Tel: 01926 743259 email ***chrislewington@warwickshire.gov.uk.***

JIM GRAHAM
Chief Executive

Adult Social Care and Health Overview and Scrutiny Committee Membership

Councillors Martyn Ashford, Penny Bould, Les Caborn (Chair), Jose Compton, Richard Dodd, Kate Rolfe (S), Dave Shilton (Vice Chair), Sid Tooth (S), Angela Warner and Claire Watson.

District and Borough Councillors (5-voting on health matters) One Member from each district/borough in Warwickshire. Each must be a member of an Overview and Scrutiny Committee of their authority:

North Warwickshire Borough Council:	Councillor Derek Pickard
Nuneaton and Bedworth Borough Council:	Councillor John Haynes
Rugby Borough Council	Councillor Sally Bragg
Stratford-on-Avon District Council	Councillor George Mattheou
Warwick District Council:	Councillor Michael Kinson OBE

Portfolio Holders:- Councillor Izzi Seccombe (Adult Social Care)
Councillor Bob Stevens (Health)

The reports referred to are available in large print if requested

General Enquiries: Please contact Ann Mawdsley on 01926 418079
E-mail: annmawdsley@warwickshire.gov.uk.

Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 25 October 2011 at Shire Hall, Warwick

Present:

Members of the Committee	Councillor Les Caborn (Chair) " Jose Compton " Richard Dodd " Jim Foster (replacing Cllr Angela Warner for this meeting) " Kate Rolfe " Dave Shilton " Sid Tooth " Carolyn Robbins (replace Cllr Claire Watson for this meeting)
District/Borough Councillors	Michael Kinson OBE (Warwick District Council) George Mattheou (Stratford-on-Avon District Council) Derek Pickard (North Warwickshire Borough Council)
Other County Councillors	Councillor Izzi Seccombe (Portfolio Holder for Adult Social Care)
Officers	Wendy Fabbro, Strategic Director of Adult Services Paul Hooper, Group Manager Community Safety and Substance Misuse Will Johnston, Joint Commissioning Manager (Adult Treatment and Care) Di King, Service Manager, Locality North Ann Mawdsley, Principal Committee Administrator Ron Williamson, Head of Communities and Wellbeing/Resources
Also Present:	Roger Copping, Warwickshire LINks David Gee, Warwickshire LINks Roy Green, Warwickshire LINks Jane Ives, South Warwickshire NHS Foundation Trust Hugh Jobber, Addaction Alison Kennerdell, George Eliot Hospital NHS Trust Quentin Marris, Addaction Jerry Penn-Ashman, West Midlands Ambulance Service Sue Roberts, Arden NHS Cluster Paul Wells, Coventry and Warwickshire Partnership Trust Caron Williams, Arden NHS Cluster

1. General

(1) Apologies for absence

Apologies for absence were received on behalf of Nigel Barton, Councillor Sally Bragg (Rugby Borough Council), Councillor Martyn Ashford, Councillor Penny Bould, Councillor John Haynes (Nuneaton and Bedworth Borough Council), Heather Norgrove, Councillor Bob Stevens, Councillor Angela Warner (replaced by Councillor Jim Foster for this meeting) and Councillor Claire Watson (replaced by Councillor Carolyn Robbins for this meeting.

(2) Members Declarations of Personal and Prejudicial Interests

Councillor Richard Dodd declared a personal interest in item 3 as an employee of the West Midlands Ambulance Service NHS Trust.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 7 September 2011

The minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 7 September 2011 were agreed as an accurate record and signed by the Chair.

Matters Arising

None.

(4) Chair's Announcements

Members were reminded that the meeting on 7 December would be a full day meeting, with the scheduled meeting in the morning, lunch and a workshop on commissioning in the afternoon (led by Wendy Fabbro and Claire Saul, Head of Strategic Commissioning). All members have been invited to the afternoon session, which will not be open to the public.

2. Public Question Time

None.

3. Improving Trauma Care in the West Midlands

Sue Roberts, Transformation Programme Director, Arden NHS Cluster, spoke to the Committee on Improving Trauma Care in the West Midlands,

setting out the case for change and the expected outcomes for patients in Warwickshire.

Sue Roberts and Jerry Penn-Ashman, West Midlands Ambulance Service, answered questions from the Committee. It was noted that patient flows in Coventry and Warwickshire had already been remapped, so no further changes to patient flows were expected. The following points were noted:

1. A&E departments faced different seasonal pressures, but the small number of trauma cases that would be taken directly to the specialist trauma centre were not expected to impact on patient flows.
2. Blue light paediatric cases were already sent directly to UHCW. Work was being undertaken with UHCW to better understand the needs for specialised paediatrics.
3. Ambulance teams had experienced problems accessing the hospital during the business works, but there was no evidence of access issues locally at this time. Jerry Penn-Ashman undertook to confirm this, but also pointed out that any serious case alerts for major trauma were accepted by all hospitals.
4. Members welcomed the move towards triage at the scene of an accident, which was based on lessons learned in the Gulf War, but questioned the capacity within the ambulance service to manage. Sue Roberts responded that each of the proposed models had workforce implications, and included proposals for investment to deliver against these implications. Jerry Penn-Ashman pointed out that central to this programme was the ability of paramedics to identify the extent of injury quickly, what was needed and where the patient needed to go. All paramedics would be trained appropriately. Councillor Richard Dodd added that one of the dangers was staying too long at the scene of the accident and key to training was the 'golden hour', focussing on early identification of the patient's condition and transport to a trauma centre.
5. Guidance for paramedics was to get patients to major trauma centres within 45 minutes. In rural areas where this was not possible, patients would be transported to a trauma unit to be sedated and stabilised before being moved to specialist trauma centres.
6. Sue Roberts undertook to provide to the Committee comparative information on numbers of cases per day and whether other regions were looking the implement the same changes.
7. Air ambulances borrowed road paramedics, as well as recruiting their own full time paramedics and having doctors on board. Jerry Penn-Ashman confirmed that St Johns ambulances were used on full blue calls, and that their staff were trained and adhered to full governance arrangements managed by their own clinical departments. Sue Roberts agreed to provide a briefing note for the

committee on the co-ordination between air ambulance and charities.

8. The final approval on the preferred option (Option 1 for three trauma networks) would be made by the West Midlands Strategic Commissioning Group on 31 October 2011, and as agreed by the West Midlands Regional Health Scrutiny Chairs and Officers Group, a programme of community engagement would then take place.
9. Once agreed, implementation would commence in February 2012 with phased plans, but it was noted that the Arden NHS Cluster were already well advanced with this.

The Adult Social Care and Health Overview and Scrutiny Committee agreed that:

- there had been adequate consultation and the committee were content with the explanations given
- they supported Option 1, which was the best option for Warwickshire
- the committee should receive an update on the implementation plan once this was ready to move forward, and a further report 12 months later.

4. Discussion on Improvements for Frail Elderly Care

Jane Ives, Director of Operations at South Warwickshire Foundation Trust gave a presentation on the Proposal for South Warwickshire Community Emergency response team, asking the Committee to consider whether the proposal to reconfigure care pathways represented a significant service change requiring a full public consultation. She was supported by Caron Williams, Associate Director of Commissioning Community Services, Arden NHS Cluster and Di King, Service Manager, Warwickshire County Council.

During the discussion that ensued the following points were raised:

1. The options for the NHS were to either engage with the public in consultation with the ASC&H O&S, or to hold a full public consultation. These proposals were about moving a facility to a different location rather than any closures.
2. Wendy Fabbro noted that there had been a high volume of consultations carried out recently along these same principles, with similar discussions on issues such as extra care housing and reablement being held in a number of different settings. The NHS and the Council had fewer resources to meet need and had to do things differently in the future, and in this case it was delivering changes that residents had asked for.

2. The problem for the NHS was moving patients through the pathways, not the number of patients entering the system. A recent survey of patients at South Warwickshire Foundation Trust had identified 70 patients not requiring acute care.
3. Patients lost their confidence quickly in a hospital setting, and the longer they were in hospital, the less likely it was that they could be reabled or enabled. These proposals were about putting services in the right place to the benefit of patients.
4. In order to ensure safe implementation, the beds would not be taken out this winter, and the ward at the Royal Leamington Spa Rehabilitation Hospital would only close once the community facilities were in place.
5. In response to a query about whether the loss of eight beds was sufficient to achieve the savings being sought, it was noted that on average, five people could be supported in the community from the resource tied up in one hospital bed.
6. Social care staff would not take on clinical tasks, and the key to the success of this process was in partnership and joint working.
7. There would not be a reduction in the number of community staff, but the changes would increase productivity and less time would be spent travelling to offices.

The Chair invited Roy Green, Warwickshire LINks, to put forward a question.

"I was a member of the North Warwickshire Community Board, and in that role attended the Quality Assurance Committee, the Health Safety and Risk Committee and the Fall and Bed Sores Committee. All of these committees ceased to operate in March 2011 on the transfer of community services to South Warwickshire Foundation Trust.

The Mid Staffordshire Management report identified a number of issues including:

- *the Trust lacked effective Clinical Governance*
- *the Board was distanced from reality*
- *the Board should review audit processes and outcomes on a regular basis.*

Their final recommendation was that 'ALL NHS Trusts and Foundation Trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report'.

Since March I have not been aware of any such Community Governance in the North of the County. However, I have been assured it is all covered at the NHS Warwickshire Board Meeting

which to me is not fully in accord with the above. Have standards, governance and performance been satisfactorily reviewed in the North?"

Jane Ives responded that governance structures of clinical and community services had been brought together and good practice in areas of monitoring and auditing had been established. She agreed to discuss Mr Green's issues with him, outside the meeting.

Members thanked Jane Ives, Caron Williams and Di King for their contributions and agreed that they had been adequately consulted, that this proposal did fit entirely within the views of Warwickshire County Council and their agreed direction of travel and requested:

- an update report six months after implementation
- a post event analysis of the winter pressures in the late spring.

5. Reablement: Data on Demand for the Service

The Committee considered the report providing the data and narrative on customer demand and eligibility for reablement, including:

- how many customers accessed the service
- how many customers bypassed reablement
- how many customers who were eligible for reablement did not receive a service upon their hospital discharge.

During the discussion that followed the following points were raised:

1. There was no restriction to the number of times a person could have reablement, and each case was decided on an assessment and the best outcomes for the person.
2. When money was transferred from Health to Social Care, a reablement audit had been requested, including the number of repeats. It was generally accepted that two years was the recovery period for people benefitting from reablement, and it was not yet two years since it had been introduced.
3. In response to a question about the low numbers in Rugby, Di King noted that it had taken time to get the resources in place to transfer into reablement services and to transfer users into the service.
4. The Committee commended the report and the work done in this area.

The Overview and Scrutiny committee are asked to:

1. Consider and comment on the information presented on demand for the reablement service
2. Recognise the report on the Evaluation of the Home Care Reablement Service (Cabinet 8th September 2011) for context and further information

3. Continue to support the development of Reablement

6. Commissioning for Recovery: Drug and Alcohol Service Modernisation Update

Will Johnston, Joint Commissioning Manager (Adult Treatment and Care) presented the report providing Committee Members with background information to the new drug and alcohol treatment provision. He then introduced Hugh Jobber and Quentin Marris from Addaction, the new providers of a recovery-orientated drug and alcohol treatment system for Coventry and Warwickshire. They gave a PowerPoint presentation on 'The Recovery Partnership: An Implementation Update'.

The Chair drew Members' attention to the letter they had received from the Coventry and Warwickshire Partnership Trust on this change.

During the ensuring discussion the following points were noted:

1. Members welcomed the positive report and presentation and the shift in treatment away from the methadone programme.
2. The scope for this treatment system covered treatment and recovery, and the Substance Misuse Team were responsible for the wider aspects of drug and alcohol abuse, including education. It was noted however that while Addaction would be providing treatment services and not preventative services, they would commission approximately 1,000 training places for people such as PCSOs and foster carers.
3. Within a short space of time Addaction were taking on the care of hundreds of service users and the transfer of 160 staff from CWPT. They would also be setting up five bases, satellite services and linking into community-based services that were already in place. This all involved the transfer of data, particularly prescribing data, IT system, telecoms and services and suppliers. Risk assessments had been carried out for each of these aspects.
4. Local GPs would work within the service and in some cases primary care and Drug and Alcohol services would be delivered from the same premises. Addaction were in contact with all local medical communities and GPs.
5. A referral process and one focussed contact number would be available from early November 2011.
6. Addaction staff would be working in police cells at the point of arrest and with criminal justice staff in justice centres and on all local bodies dealing with criminal justice.
7. Included in the contract is access for family and friends, and the initial assessment of people would include getting an awareness of the needs of the person and those affected.

8. While the service was not set up to deliver services in people's homes, people who could genuinely not access services in their communities would not be excluded.
9. After the end of November 2011, people could be referred to a number of different providers of inpatient services. These would be as close to Warwickshire as possible, depending on the needs of the person.
10. Organisations such as Alcoholics Anonymous and Narcotics Anonymous were recognised as being essential for people moving through treatment and recovery.
11. Success rates would be measured against people's ability to lead normal lives, in terms of employment, maintaining housing and relationships and participating in society. This was however a new way of working, and in the future it was hoped there would be a clear way of measuring success.
12. Having investment, treatment and preventative services in place, would not only impact positively on individuals, but would help to support work in lots of other services across the county. The overall aim of the County Council was to focus on prevention, but this contract ensured that treatment services were available if needed.
13. Members requested contact details as soon as they were available.
14. The placement of satellite centres would be based on needs assessments, in communities with the greatest need.

Hugh Jobber and Quentin Marris thanked Paul Wells and the staff at Coventry and Warwickshire Partnership Trust for their co-operation in mitigating the risk to patients during the transfer.

The Committee thanked Hugh Jobber and Quentin Marris, as well as the staff at Coventry and Warwickshire Partnership Trust for this work and requested a report back in June 2012 giving an update on the transition, what had gone well or not during the implementation, and the way forward.

7. Questions to the Portfolio Holder

Councillor Izzi Seccombe

1. Councillor Michael Kinson OBE asked for an update in relation to the disposal of care homes, particularly in the Warwick District Council area. Councillor Izzi Seccombe responded that the expression of interest for a social enterprise takeover of the Lawns in Whitnash had not progressed. The Council was still trying to sell the care home as a going concern, and this did not materialize, further discussions would be held with the community group. The

Chair added that the work of the Committee evidenced the focus on taking care of older people and ensuring that the quality of care was as good as it could be. Councillor Seccombe added that the Alex in Redditch had not had a good outcome report and this situation needed to be monitored.

2. David Gee, Warwickshire LINks noted that a new integrated model of health and social care in Herefordshire, with an integrated care organization under one management structure combining community, acute and adult social care had enabled them to cut administrative costs by two thirds, with an aim to achieve a 90% savings. He asked whether Warwickshire County Council were looking at anything similar. Councillor Seccombe responded that Warwickshire were already progressing down that route, as exampled in earlier items. She added that future plans were for more integration of frontline teams and the delivery of better community services to people.

3. David Gee, Warwickshire LINks stated that he was concerned about the consultation in regard to maternity arrangements at George Eliot, which had not been meaningful. The Chair undertook to pass this concern to the Paediatric and Maternity Task and Finish Group.

4. Roger Copping, Warwickshire LINks was saddened at the closure of Helen Lay on 31 January 2011. He asked Councillor Seccombe for a report on the 10 residents currently at the Helen Lay. Ron Williamson undertook to provide a briefing note to the Committee on this.

8. Update on the Peoples Group

Wendy Fabbro outlined the structure that the new Peoples Group would take from 1 November, made up of the following six business units:

- Social Care and Support Services
- Safeguarding
- Business Management
- Strategic Commissioning
- Early Intervention and Family Support
- Learning and Achievement.

She added the following:

1. There would be five themes that ran through the new Group:
   - intervention would be evidence-based
   - a commissioning approach would be taken
   - work would be done in partnership

- officers would be accountable
- staff needed to be innovative and do things differently, taking risks if necessary.

2. Current plans and performance indicators would remain in place for the next year.
3. A Risk Management Planning Conference would be held to consider current risks and additional risks the Peoples Group would bring.
4. There would be an Ofsted and a Care Quality Commission (CQC) inspection the first week in November.
5. The results of the serious case review from Rugby that was carried out in the summer would shortly be published. This was expected to receive a significant amount of media interest and Members were reminded that any queries must be redirected to the Directorate or to Communications.

The Chair thanked Wendy Fabbro and offered the full support of the Committee in her new role.

9. Fairer Charges and Contributions – Impact of Changes

In October 2010, following a three month consultation, Cabinet approved a series of increases in charges for community care under the Fairer Charging guidelines aimed at eliminating subsidy other than by way of means testing. The Committee considered the report, the first annual monitoring report on charging in response to concerns about the effect of these changes, looking at whether the success of the policy in achieving its objectives could be measured against the impact on customers.

During the ensuing discussion the following points were raised:

1. In the savings plan it had been presumed that what was lost due to increased charging would be saved on the cost of the service. There was no estimate on numbers, but it was anticipated that there would be some people who would stop using the service, and some of these would move to personal assistants and personal budgets.
2. Concern was raised that older people may become more isolated because of costs. Councillor Seccombe undertook to ensure that the Committee were provided with information on respite care and any changes to the use of service hours. She added that it was important that service users understood the options available to them to mitigate the impact of any increase in charges.
3. The efforts made by staff during the consultation period were commended.

4. Social work teams had a duty to ensure that peoples' needs were met. Where there were issues of real concern the teams were required to follow these up.
5. Changes to charges had been challenging from an IT perspective. The Directorate were looking to more integration of their systems in the future.

The Committee noted the contents of this first annual monitoring report on Charging and urged officers to sort out any computer problems as soon as possible. A further report was requested in twelve months time.

10. Work Programme

The Work Programme was agreed, including the additional items requested at this meeting.

11. Any Urgent Items

Councillor Dave Shilton asked that a letter be written raising concern about the capacity for A&E Services at UHCW to cope with demand.

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Chair of Committee

The Committee rose at 12:45 p.m.

Item 5

Agenda Item No 5

Adult Social Care and Health Overview and Scrutiny Committee

7 December 2011

Shaping Local HealthWatch in Warwickshire – Progress Report

Recommendations

The Adult Social Care and Health Overview & Scrutiny Committee is requested to:

(1) Note the current position and plans around the development of local HealthWatch in Warwickshire

(2) Comment on the proposed timescales for the development of local HealthWatch in Warwickshire

(3) Comment on the stakeholders' feedback in relation to the role of local HealthWatch in Warwickshire

(4) Give further consideration to the arrangements for establishing local HealthWatch at its meeting on 15 February 2012

1.0 Background

1.1 The Health and Social Care Bill currently making its way through Parliament, makes provisions for the establishment of HealthWatch England and subsequent local HealthWatch organisations. Both establishments will be a "consumer champion" for care users and promote better outcomes in health for all and in social care for adults – locally and nationally.

1.2 At the national level, the Bill proposes HealthWatch England to be a statutory committee within the Care Quality Commission, which will:

- Be independent of Government through being a committee of CQC
- Provide leadership, guidance and support to local HealthWatch organisations
- Be able to escalate concerns about health and social care services raised by local HealthWatch organisations
- Provide advice and information to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities
- Present an annual report to Parliament

1.3 Local HealthWatch will act as a point of contact for individuals, community groups and voluntary organisations around their experiences of health and

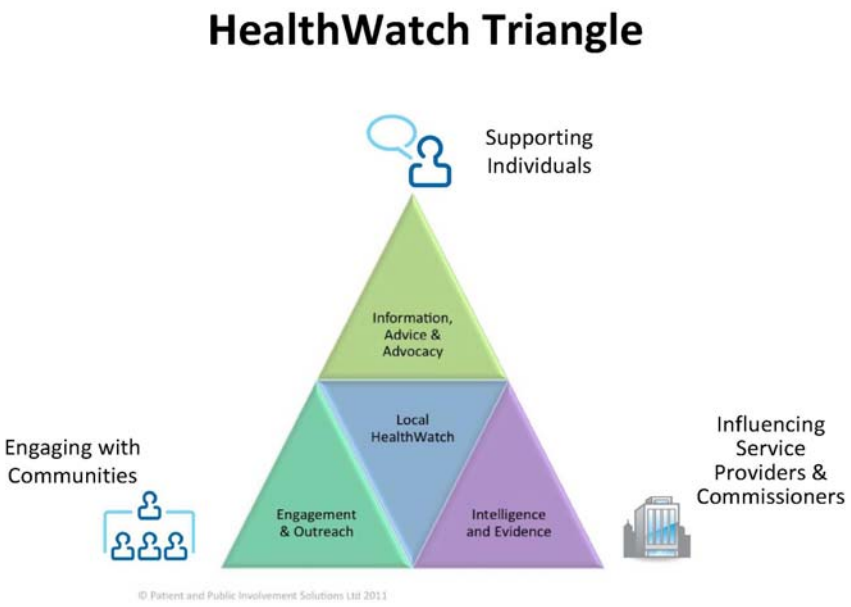
social care. It will influence local commissioning decisions by representing the views of local stakeholders at the Health and Wellbeing Board and influence national policies by informing HealthWatch England about the views and experiences of local people. The specific role of the new service will be to:

- Collect and analyse consumer feedback on local health and social care
- Give consumers a chance to suggest ideas to care professionals that may help improve services
- Investigate specific issues and concerns and make recommendations to care professionals
- Provide information and support to individuals to help them make choices
- From April 2013, provide independent support to people who wish to make an NHS complaint

2.0 Current Position and Plans

2.1 Department of Health Guidance highlights the importance of continuity in service provision and thus a smooth transition between the current Warwickshire Local Involvement Network (LINk) contract and new local HealthWatch arrangements is expected. However, local HealthWatch organisations are required to fulfil additional functions, roles and responsibilities that are not currently provided by Local Involvement Networks. Additionally, local HealthWatch will be a body corporate, able to employ its own staff. This means that unlike LINks it will need to be appropriately established in order to have its own legal identity. Therefore, a different model has to be considered to deliver local HealthWatch functions effectively.

2.2 There are three main functions of a local HealthWatch, and they can be summarised in the form of a triangle.



2.3 Warwickshire County Council will have the responsibility to make sure Warwickshire has an effective Local HealthWatch organisation from October 2012. A transition project, leading to the development of viable options for the new service, has been led by the Localities and Partnerships Team which since May 2011 has made significant progress and has been successfully engaging with what is known as the Warwickshire HealthWatch Transition Team, a group of representatives of key stakeholder organisations and groups in the county, including NHS Warwickshire, Local Involvement Network (LINk) members, voluntary and community sector, Adult Social Care services and care users. The outcome of this work is a robust transition plan and communication strategy which in July 2011 received pathfinder status from the Department of Health. The aspiration is that through the Pathfinder Scheme Warwickshire residents will be able to benefit from the new service in its shadow form earlier than in other areas prior to its statutory delivery date in October 2012.

2.4 In order to deliver on this ambition, an extensive and thorough engagement process with all stakeholder groups and the public has been undertaken since May 2011. The engagement activities included a number of meetings, 2 surveys launched back in June, 4 focus groups with LINk members, voluntary and community sector representatives, front line social care and NHS staff and care users. We also held a very successful stakeholder event on 7 October 2011, during which the future shape of Warwickshire HealthWatch was discussed in more detail.

2.5 As a result of these activities, the following core principles of the future shape and function of Warwickshire HealthWatch (WHW) have been identified:

(1) WHW should be impartial and trusted in the local community. It will be commissioned and performance managed by the Local Authority in such a way as to preserve its ability to independently carry out its functions, and the County Council as the funder will support its development as an independent organisation which is able to add real value to the decisions that are made about health and social care services on behalf of local residents.

(2) The structure of WHW must be simple and its activities focussed. WHW will be able to demonstrate high quality prioritising and decision-making through the use of clear processes and an evidence base not influenced by the vested interests of other organisations, groups or individuals.

(3) WHW must be a well-managed high quality organisation with knowledge and integrity at its core. It must have a strong, visible and respected leadership. Those involved in its leadership will have clearly defined roles and responsibilities and be held to account for their performance. They will have appropriate skills, knowledge and experience to ensure WHW is able to reflect and meet the needs of all residents across the areas it covers.

(4) WHW must be well-known. It will have a high profile supported by a clear brand and identity that makes it as easy as possible for people to find it and access its services. The name HealthWatch will be recognised as having a national identity, but locally it will be made clear that social care is within its remit.

(5) WHW should be inclusive of all sections of the community, it should be a representative voice of the population it will serve. It will champion and support local patient and user groups and it will avoid structures that make it harder for people to become involved.

(6) WHW must be recognised as a single point of access to information and support to access health and social care services, the statutory route for the public, patients, service users and carers to express views and/ or seek advice about health and care.

(7) WHW will work effectively with other statutory organisations, supporting and influencing them in their decision making in relation to planning, improving, or commissioning care services. It will have consistent representation on partnerships influencing policy and service change locally. It will be a recognised part of the Health and Wellbeing Board with a significant contribution to the Joint Strategic Needs Assessment (JSNA) and will do this through the presentation of intelligent and robust data and evidence.

(8) WHW will have a good understanding of local voluntary and community groups and organisations, with whom it will cooperate to improve care and health outcomes for Warwickshire residents.

(9) WHW must reach out to those groups and individuals who want to contribute and allow them to express their aspirations and views.

(10) WHW should effectively coordinate engagement activities around care services, so that it is able to provide robust, accurate and timely information in relation to its performance, good and bad practices and the needs of the local population.

(11) WHW will have a robust recruitment process in place for its staff and volunteers, it will provide robust training to them and will manage their activities effectively which will enable care users have their voices heard and make appropriate choices in relation to their care needs.

(12) From April 2013, WHW will provide quality advocacy services and will be clear about the level and type of support it will provide to ensure best outcomes for care users.

2.6 Those who responded to the engagement discussion around the future shape of Warwickshire HealthWatch have clearly described aspirations for the new organisation as one that could co-ordinate the provision of advice, support, information, engagement and advocacy. Its services would be locally accessible, free and impartial. It will have effective governance to ensure it can deliver services of the highest quality. It will develop a strong sense of corporate identity and have a clear and sustainable business model that will enable it to deliver work that goes beyond the proposed immediate HealthWatch functions.

2.7 To achieve these aspirations a contract specification is being created in such a way as to encourage partnerships and creativity. As the commissioner of Local HealthWatch, Warwickshire County Council will need to stimulate the market by further engagement with potential providers and support them in the establishment of a shadow form of Warwickshire HealthWatch. Overleaf is the proposed timetable for the implementation of the shadow HealthWatch.

ACTIONS	TIMESCALES
Possible legal and procurement structures/ models for WHW determined	December 2011
Draft service and contract specification	December 2011
Finalised service and contract specification	January 2012
Procurement commencement	February 2012
Shadow HealthWatch established	July 2012

The above is an indicative timeline; dates are subject to potential delays in democratic and procurement processes as well as confirmation of funding from central Government.

2.8 As it is expected that Warwickshire HealthWatch will deliver on a number of functions, it has been necessary to explore various models for this new corporate body. The fact that it must be a corporate body in itself suggests a wide variety of structures each of which has its advantages and disadvantages. It appears that the most suitable format due to its object being for the public benefit will be either a charitable company limited by guarantee, or a community interest company, or a social enterprise. However, in addition to the actual legal organisational model, a partnership arrangement has to be considered in relation to the delivery of the multiple services Warwickshire HealthWatch will be required to provide via as many access routes as possible. It is unlikely that there is currently a single supplier who could meet all of these requirements. Further time is needed to consider The range of models that might be available and appropriate, and advice will then be sought from the County Council's Legal and Procurement Services, with a view to a comprehensive proposition report being considered by the Cabinet in early 2012.

3 Key risks and issues for consideration

3.1 Funding for local HealthWatch will be provided for local authorities in the same way as for LINks, i.e. as part of a Government formula grant, to enable them to tender for the service. Although there are indications that there will be extra funding provided additionally to that currently available to LINks, the level of it is yet to be determined. The Department of Health has conducted a consultation to determine the level of additional funding allocation to be made available to local authorities, outcomes of which should be known early next year.

3.2 There is also an issue of transfer of funds from the existing Primary Care Trust's Patients Advice and Liaison Service (PALS) to cover for the signposting and advice element of HealthWatch's service. This is being currently considered in conjunction with the Health Transition Strategic and Delivery Teams, led by the Health Transition Finance Manager.

3.3 Another issue which relates to the actual function and remit of Warwickshire HealthWatch is that current proposals risk ignoring the voice of child social care users. The Health and Social Care Bill sets out plans to establish local and national HealthWatch organisations to gather views of patients and use their feedback to promote better outcomes in health for all and in social care for adults only. Similarly to the above, the Bill does not include provision of advocacy support services to social care users, but requires local HealthWatch organisations to provide advocacy services only to patients of the NHS.

3.4 It has been made clear throughout the engagement process and a high level Equality Impact Assessment that there is a need to ensure close coherence with advice, information and advocacy arrangements secured through adult social care.

3.5 Finally, it is uncertain how the local market will respond to the commissioning process, and whether it will establish an appropriate local HealthWatch provider for Warwickshire. Therefore, it is imperative that the Localities and Partnerships Team produces a quality service and contract specification and works closely with stakeholders to ensure its sound development and performance.

4 Conclusions and Next Steps

4.1 There is a clear desire among all stakeholders, including the public, for a high quality local HealthWatch provider which will have an influential role of a **coordinator** of the care engagement activity, an **assessor** of local needs, an **arbiter** who provides a robust and accurate argument and data and a **conduit** between the local population and the local and national decision and policy makers.

4.2 In order to achieve this ambition and ensure best outcomes in health and social care for all in Warwickshire, the Committee is asked to gives its views on the approach to establish Warwickshire HealthWatch, as specified above, and to consider the above recommendations and proposals.

Background Papers

1. HealthWatch Transition Plan – Department of Health. March 2011: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126325.pdf

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Item 6

Item No 6

Adult Social Care and Health Overview and Scrutiny Committee

07 December 2011

Protocol between Adult Social Care and Health Overview and Scrutiny Committee and Warwickshire LINks

Recommendations

That the Committee agree the protocol attached as Appendix A.

Key Issues

HealthWatch is to be the new consumer champion for health and social care services that will replace Local Involvement Networks in 2012. In order to ensure that Warwickshire LINk are able to complete their work programme before this happens, the Adult Social Care and Health Overview and Scrutiny Committee and the Warwickshire LINks Board have been asked to agree a working protocol. This is attached as Appendix A.

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Appendix A

Warwickshire County Council

Draft Protocol between the Adult Social Care and Health Overview and Scrutiny Committee and the Warwickshire Local Involvement Network (LINks)

This Protocol will be in place until such time as the Warwickshire LINk ceases to operate.

KEY ELEMENTS OF THE PROTOCOL

- The Chair of the Adult Social Care and Health O&S Committee and the Chair of Warwickshire LINks will hold regular informal meetings

- A nominated LINk representative will be invited to attend all Adult Social Care and Health Overview and Scrutiny Committee meetings. Where the nominated representative is not available, a substitute will be nominated by LINk to attend for that meeting only. In accordance with the Warwickshire County Council Constitution, LINk members will not be able to vote on matters.

- LINk to formally report on their activity and their performance twice a year (once in support of their final annual report)

- All referrals from the LINk to scrutiny shall be co-coordinated through the administration arrangements for the LINk and referred via Democratic Services. Individual LINk members will not be able to make a referral without going through the LINk Host Organisation

- The Adult Social Care and Health O&S Committee and LINks will take collective responsibility for demonstrating that they have worked collaboratively and avoided duplication.

- The Adult Social Care and Health O&S Committee will make every effort to support LINk to carry out their agreed work programme

Item 7

Agenda No 7

Adult Social Care and Health Overview & Scrutiny Committee – 7th December 2011

Quarter Two (July– September) 2011-12 Performance Report for Adult, Health and Community Services

Recommendations

That the Adult Social Care and Health Overview & Scrutiny Committee:

- Consider both the summary and detail of the performance indicators within the Directorate Report Card for the quarter two of 2011/12 (Appendix 1)
- Consider and comment on areas where performance is falling short of target, and where remedial action is being taken.

1. Background

1.1 This report presents the Adult Social Care & Health Overview & Scrutiny Committee with the 2011/12 quarter two report on the performance of the Adult, Health and Community Services Directorate. This is set out in detail in Appendix 1.

1.2 The Directorate Report Card is made up of measures from the new national Adult Social Care Outcomes Framework and local measures developed by the Directorate to measure the effectiveness of both its transformation programme and core service delivery. Some of the transformation measures are still in development so are not included in this paper but will be considered in future reports.

1.3 The majority of the indictors against which the Directorate is now measured are new and and as a result baseline and benchmarking data is not available in all cases but where measures are comparable to those that have existed in previous years this analysis is included within the report. Due to the lack of baseline and benchmarking data, at this stage we have only set provisional targets at this stage, which will be revised once more data is available to inform our position.

2. Performance and Key Messages

2.1 The table below summarises the forecast full year performance outturn for 2011/12. Of the Directorate's 20 performance measures 14 (70%) are forecast to either met or exceeded target. Two indicators are significantly behind target. A summary of all indicators can be found in appendix one.

Performance	Number	Percentage
 Target has been achieved or exceeded	14	70%
 Performance is behind target but within acceptable limits (10%)	4	20%
 Performance is significantly behind target and is below an acceptable predefined minimum	2	10%

2.2 The two indicators missing target are **'Proportion of adults with a learning disability in settled accommodation' and 'Proportion of adults with a learning disability in employment'**

The Directorate is forecast to continue to miss targets related to the measures assessing the proportion of customers with a Learning Disability in 'settled' accommodation and in employment. These indicators although not new in nature have only formed part of the national indicator set for a short period of time and have presented a data collection challenge to most local authorities. Part of the lower than anticipated performance against these measures is as a result of the calculation definition requiring customers to be reviewed and for the outcome of a move to settled accommodation or employment being recorded.

Although we are not meeting our targets in relation to these two measures our performance does continue to improve but the pace of change does need to increase. Benchmarking data for these measures shows that we perform close to the level of our comparator group of similar authorities in relation to supporting customers to access settled accommodation and at a higher level than our comparators with regard to supporting people into employment.

Clearly there is more work to do in delivering an increased pace of change for the services that are measured by these indicators and this is being addressed positively through our recently developed Learning Disability Strategy. Key elements to this revised strategic approach are projects around a "place to live" and a "fulfilled life" which seek amongst other things to increase access to appropriate accommodation and life chances through employment.

As part of these projects work is underway to identify customers who are able to move out of residential care and provide suitable alternatives for them and any other customers who may have required residential care. As an outcome of this the number of people with a Learning Disability in residential care will reduce by 20% (70 people) before the end of March 2014. Based on the 2010/11 outturn this would increase the outturn of the indicator by seven percentage points from 57% to 64%. Further increases can be achieved through data quality as the definition of the indicator requires this information to be captured at the customers review. Currently 69% of customers with learning disability are receiving community services, this figure would increase to 76% following the 20% reduction of numbers in residential care by March 2014.

From an employment perspective we are currently developing a service specification to commission a revised support structure for customers with a

disability (LD & PD) aimed at improving access opportunities. Although this service will not be in place in time to impact upon current year performance it will form a key component part of our approach for the future and should result in a significant increase in our performance in supporting customers into work.

3. Additional Performance Considerations

3.1 Market Development

3.1.1 A critical facet of our revised strategic commissioning approach and mechanisms for strategic development is to ensure that the Directorate is actively working with providers to develop services that meet the aims of personalisation. At the end of August AHCS hosted a 'meet the buyer' event attended by around 160 delegates representing approximately 80 care providers to explain our commissioning intentions and the direction of travel for care services in Warwickshire. Our engagement with the provider sector has been enhanced further following the meet the buyer session through the use of provider forums, launched in September, acting as a mechanism for on-going communication and interaction with the market.

3.1.2 Following on from the meet the buyer event we have now hosted a range of provider forums across the county designed to continue a positive dialogue with the market to help support development of services to meet the personalisation agenda. The forums have been well attended with a total of 175 providers being represented at the 5 forums. Over the course of the coming months we will be hosting further forums with the topic for January's round of forums focussing on extra care and assistive technology. A third round of forums will be hosted in March and these will be focussed on service developments to meet the needs of customers with disabilities in a more personalised way. Providers have welcomed the forums and given positive feedback to reinforce that this revised approach to working with the market is seen as a positive development in Warwickshire.

3.2 Local Account

3.2.1 As part of the commitment to reduce the burden of national bureaucracy the regulatory framework for adult social care previously administered through the Care Quality Commission was brought to an end in 2010. The Department of Health (DH) have produced a framework for local assessment which sets a range of performance measures against which activity will be measured. As part of this framework the DH reiterated its commitment to the use of sector led improvement and within this the need for all local authorities with adult social care responsibilities to produce "local accounts" which provide the communities that they serve with an assessment of service quality and performance improvement.

3.2.2 To support the production of local accounts the Association of Directors of Adult Social Services (ADASS) have developed a guidance methodology for Councils in the region to work towards. The ADASS guidance suggest that local accounts should:

1. Report performance against the national outcomes framework

2. Include a meaningful range of locally developed measures of performance
3. Be supported by and signed off by partner agencies including Healthwatch
4. Include assessments of performance based on customer experience and or feedback
5. Benchmark performance across the region wherever possible

3.2.3 There is a clear expectation that local accounts will be published and made available to local communities and that they should be used to inform and drive improvement in service quality and delivery. In addition to this the content of local accounts will be used to inform peer assessment and sector led improvement interventions although the mechanisms and approach for this are yet to be defined and agreed. The local account for Warwickshire is currently under development with a final version to be brought to this committee for comment and approval in January prior to publication.

4. Recommendations

4.1 That the Adult Social Care and Health Overview & Scrutiny Committee:

Consider both the summary and detail of the performance indicators within the Directorate Report Card for the quarter two of 2011/12 (Appendix 1)

Consider and comment on areas where performance is falling short of target, and where remedial action is being taken.

Report Author: Ben Larard – Business Intelligence Team Manager

Head(s) of Service: Claire Saul, Head of Strategic Commissioning

Strategic Director(s): Wendy Fabbro, Strategic Director of People Group

Portfolio Holder(s): Cllr Izzi Seccombe

Appendix One: Adult Health and Community Service Report Card, Quarter Two 2011/12

Theme	Title	Definition	2010/11 Outturn	Quarter 2 Actual	2011/12 Forecast	2011/12 Target	Performance Against Target	2010/11 Benchmarking
Warwickshire's residents have more choice & control	Ensuring a safe environment for people with learning disabilities	Proportion of adults in with a learning disability in settled accommodation (high is good)	56%	21.8%	58%	70%	▲	Comparitor: 60.2% (●) England: 61.0% (●)
	Enhancing quality of life for people with learning disabilities	Proportion of adults with a learning disability in employment (high is good)	5.9%	2.1%	6.5%	11%	▲	Comparitor: 5.3% (★) England: 7.2% (●)
	Ensuring a safe environment for people with mental illness	Proportion of adults in contact with secondary mental health services in settled accommodation (high is good)	76.7%	74.6%	80%	80%	★	-
	Enhancing quality of life for people with mental illness	Proportion of adults in contact with secondary mental health services in employment (high is good)	19.4%	17.5%	20%	20%	★	-
On-going home care packages are decreasing	Helping older people to recover independence	Proportion of older people (65+) who are still at home after 91 days following discharge from hospital into rehabilitation services (high is good)	86.3%	-	88%	85%	★	Comparitor: 81.1% (★) England: 83.1% (★)
	Regular reviewing of packages	Proportion of customers receiving a review	77%	51%	80%	85%	●	-
	Customers outcomes are met	Proportion of people whose outcome measures are fully or partially achieved at completion of reablement	60%	52%	70%	70%	★	-

Theme	Title	Definition	2010/11 Outturn	Quarter 2 Actual	2011/12 Forecast	2011/12 Target	Performance Against Target	2010/11 Benchmarking
	Reducing home care	Total weekly value of homecare packages	£635,493	£623,349	£590,000	£600,000	★	-
	Reducing home care	Total weekly homecare hours being delivered	55,245	54,644	48,000	50,000	★	-
Warwickshire's vulnerable residents are supported at home	Admissions to residential care	Admissions to residential care homes per 10,000 population (low is good)	14.1	5.5	13.5	14	★	-
	Promoting personalisation	Proportion of people using social care who receive self-directed support (high is good)	29.3%	33.0%	45%	45%	★	Comparitor: 27.5% (★) England: 30.1 (★)
	Supporting carers	Number of carers receiving an assessment in their own right	929	522	1250	1100	★	-
	Supporting carers	Number of carers receiving services provided as an outcome of an assessment or review	2079	879	1500	1500	★	-
	Delivering efficient services which prevent dependency	Proportion of Council spend on residential care (low is good)	51.4%	-	51%	49%	●	-
	Maintaining customer's independence	Proportion of adults receiving on-going social care support who are in residential care	30%	29%	29%	28%	●	-
	Supporting recovery at the most appropriate place	Number of older people entering residential care direct from hospital as a percentage of all admissions to residential care	43%	45%	43%	40%	●	-

Theme	Title	Definition	2010/11 Outturn	Quarter 2 Actual	2011/12 Forecast	2011/12 Target	Performance Against Target	2010/11 Benchmarking
	Customers have an alternative to residential care	The number of extra care housing units available for use by customers eligible for Warwickshire County Council Adult Social Care	46	101	107	107	★	-
	Supporting recovery at the most appropriate place	Delayed transfers of care (low is good)	18.8	15.9	16	17	★	-
Residents of Warwickshire have greater access to specialist residential care	Access to specialist residential care	Admissions to specialist residential care as a proportion of all residential & nursing care	18.5%	20%	19%	19%	★	-
	Access to specialist residential care	Cost of specialist residential care as a proportion of all residential & nursing care	17.5%	17.8%	18%	18%	★	-

Item 8

Item No 8

Adult Social Care and Health O&S Committee

07 December 2011

Progress in Adult Safeguarding Report

Recommendation

It is recommended that Members consider and comment on the information presented on performance in safeguarding vulnerable adults in Warwickshire over the last 12 months, and future plans for continual improvement.

1. Background

1.1 A "Vulnerable Adult" is defined as a person aged 18 or over :

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm".

(*No Secrets*, DoH 2000)

1.2 Warwickshire Safeguarding Adults Board (WSAB) brings together the agencies accountable for safeguarding vulnerable people to agree how they will work together, and to assess how effective they are in safeguarding vulnerable people.

1.3 WCC is accountable for safeguarding people, and leads the Board, provides the single point of contact, co-ordinates investigations and case work and produces reports of activity.

2. Activity

2.1 Serious case reviews

The purpose of a serious case review is to establish whether lessons can be learnt from the circumstances of a case that may improve practice, or the way in which agencies and professionals work together to safeguard vulnerable adults. It is not to re investigate or apportion blame. The SCR is commissioned from an independent chair, and makes recommendations based on lessons learnt. The WSAB receiving the report then creates an action plan, and monitors progress until completion of all agreed improvements Over the last 12 months the WSAB has commissioned 2 serious case reviews (SCR), Mrs L who died in hospital and GH (young woman with learning disabilities who was murdered in August 2010). The SCR relating to Mrs L has been largely completed, but the Board is awaiting

confirmation from SWFT that priority actions have been completed. The SCR relating to GH was agreed on 19th October and published on 14th November to much media interest. An action plan is being developed based on achieving all of the recommendations, subject of a separate report to Scrutiny

2.2 **Performance report**

Appendix A covers the latest performance report. A key finding is that despite the fourfold increase in safeguarding referrals over the last 2 years, Warwickshire is still slightly under the national average volume of referrals. While this may be related to areas of multiple deprivation, there are other indicators that suggest we may still see further increases in demand. In particular WSAB has expressed serious concern that the central point for collating referrals (WCC Safeguarding team) has received no referrals from GP's in this financial year, and 8 (of 862) in the previous financial year. This is now a priority action for the board to deliver training to each practice, to attend the CCG plenary session, and to work with PCT colleagues to embed safeguarding in the operational contracts.

2.3 Elizabeth Phillips, Chief Executive of Age UK in Warwickshire has convened and set up an additional sub group this year to focus on communications and conveying to the public that safeguarding vulnerable adults is *'Everybody's business'.* A conference has been arranged for January 2012 to pursue this objective.

3. Future plans

3.1 **Impact of the People Group and sharing expertise**

The launch of the People Group of services has brought expertise from Safeguarding children to the WSAB. Phil Sawbridge has now assumed managerial responsibility for the WSAB strategy, framework and procedures and will be bringing these in line with the children's work, which has had significantly more attention over the past decades. The subgroups will also be aligned, bringing greater focus from district councils, maintaining a Health sub group, performance and quality, training for all staff.

3.2 **National implications – likelihood of statutory status**

In the Adult Social Care White Paper now anticipated to be published in April 2012, we are expecting that there will be proposals to establish Adult Safeguarding Boards on a statutory footing, matching those for children's safeguarding. This would include something like the Children's Act section 11 duty to co operate.

3.3 **Issues**

Most professionals have welcomed and applaud the Mental Capacity Act and its requirement to assess mental capacity to recognise an adults right to determine their own life choices. However, where an individual is not FACs eligible, and has mental capacity to make decisions for themselves, yet is still

seen as a vulnerable adult and is making risky decisions, we are faced with extremely difficult problems. This is a national issue, but has sharp resonance through a recent SCR.

Looking forward, our systems need to be simple and easy to follow, yet comprehensive, rigorous and robust. Staff are asked to focus and target resources, but also to collate low level concerns to be able to quickly identify when multiple concerns should attract the attention of agencies.

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Safeguarding Adults

Report to Safeguarding Adults Board

November 2011

Data for the period 1 April 2010 – 30 September 2011

Contents

For further information please contact the Business Intelligence Team

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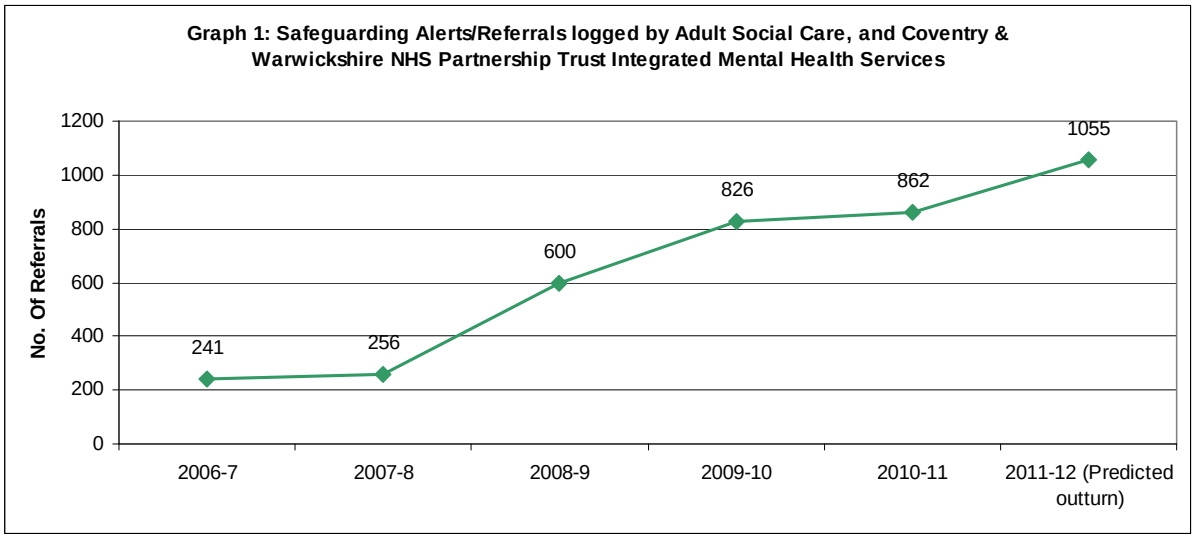
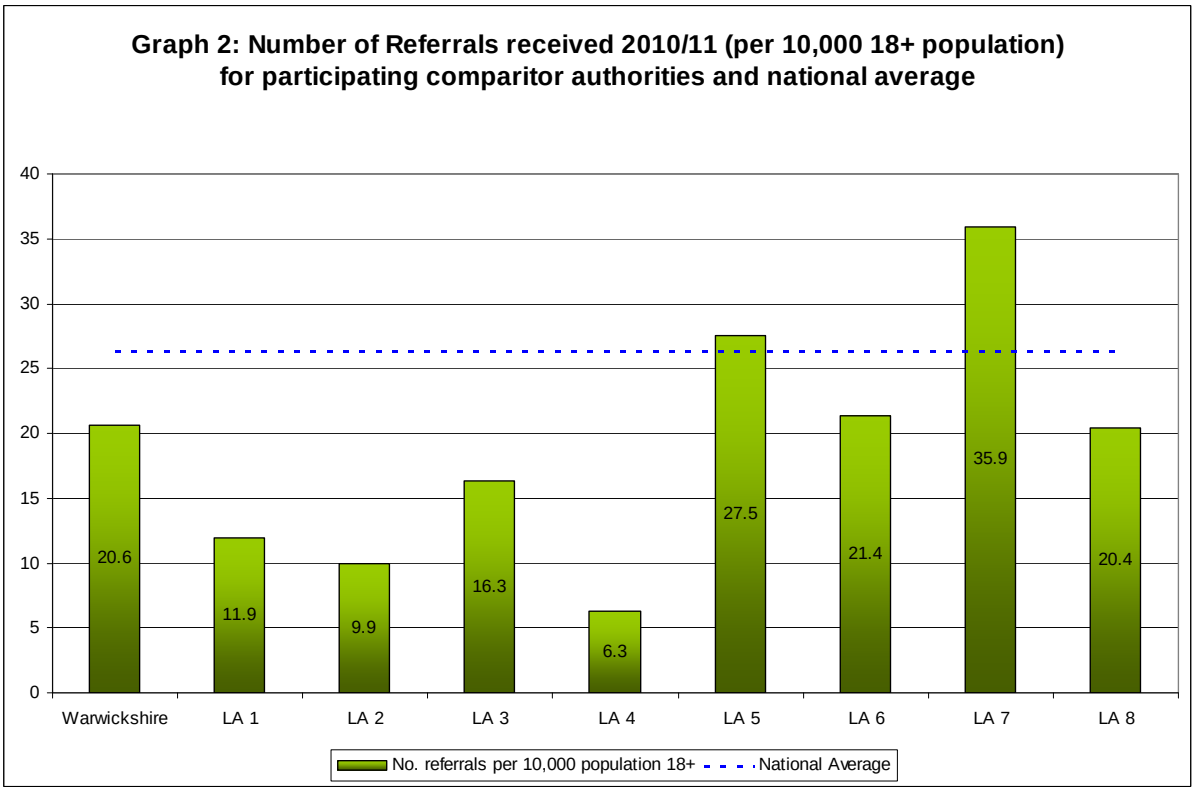
1.1 Annual Safeguarding Referrals Received since 2006

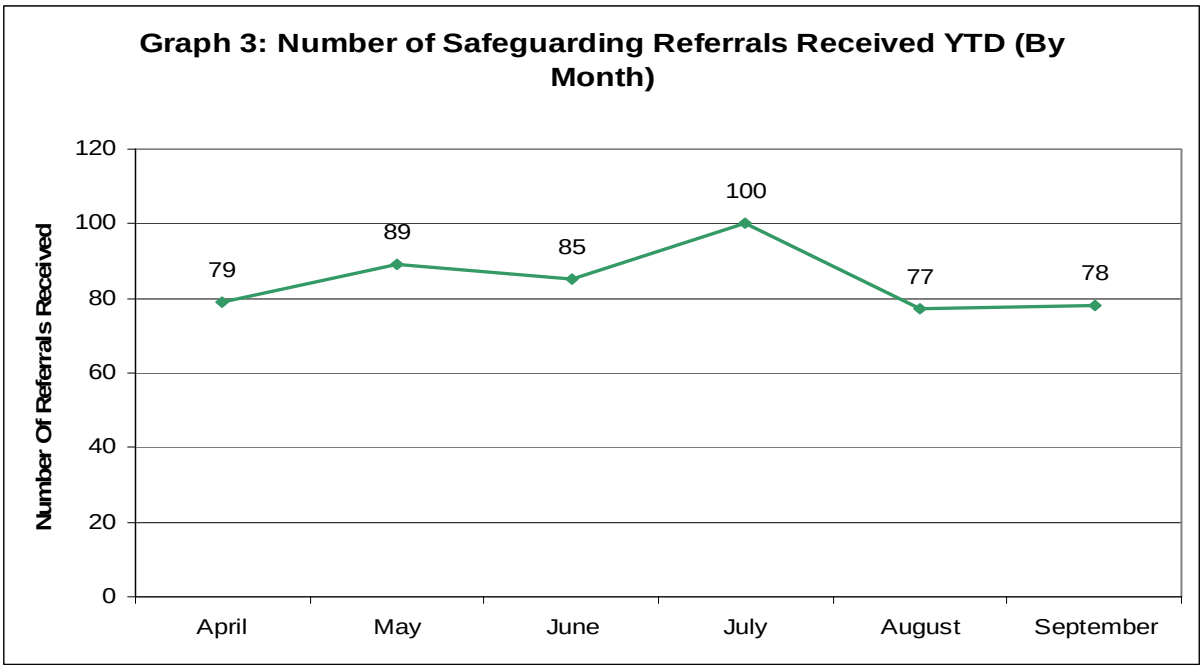


As reporting processes have been refined and improved the number of safeguarding referrals received continues to rise. With the introduction of a more robust reporting process in 2011 it is anticipated that the annual referrals will show a more consistent year on year trend than has previously been evident.



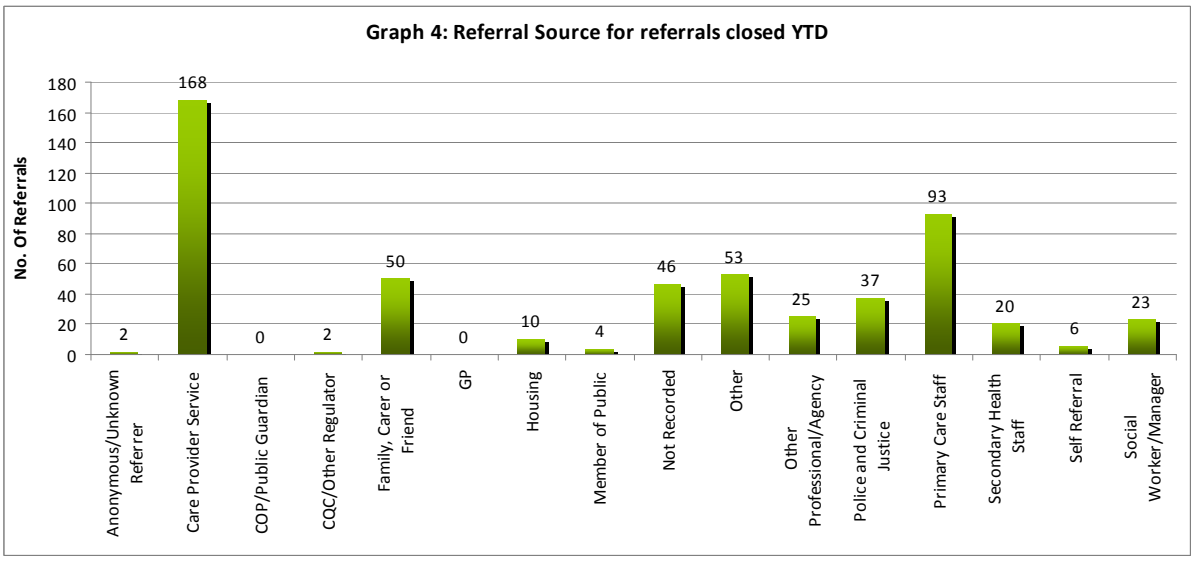
Graph 2 (data from voluntary benchmarking group) shows the number of referrals received in 2010/11 for Warwickshire, nationally and for other Shire Counties who participated. Under the terms of the agreement these counties have been anonymised. Warwickshire is roughly in the middle of the pack, but received fewer referrals per 10,000 than the national average of 26.3.

1.2 Number of referrals received Year To Date



The number of referrals received by month so far in 2011/12 remains steady, with 510 referrals received and 502 closed since 1 April. If this trend continues the total number received during the financial year will exceed 2010/11's total of 862, reaching 1037 in 2011/12. The number of closures will also exceed 2010/11 (946) but by a smaller margin than the referrals received, estimated to be 1019 by the March 2012.

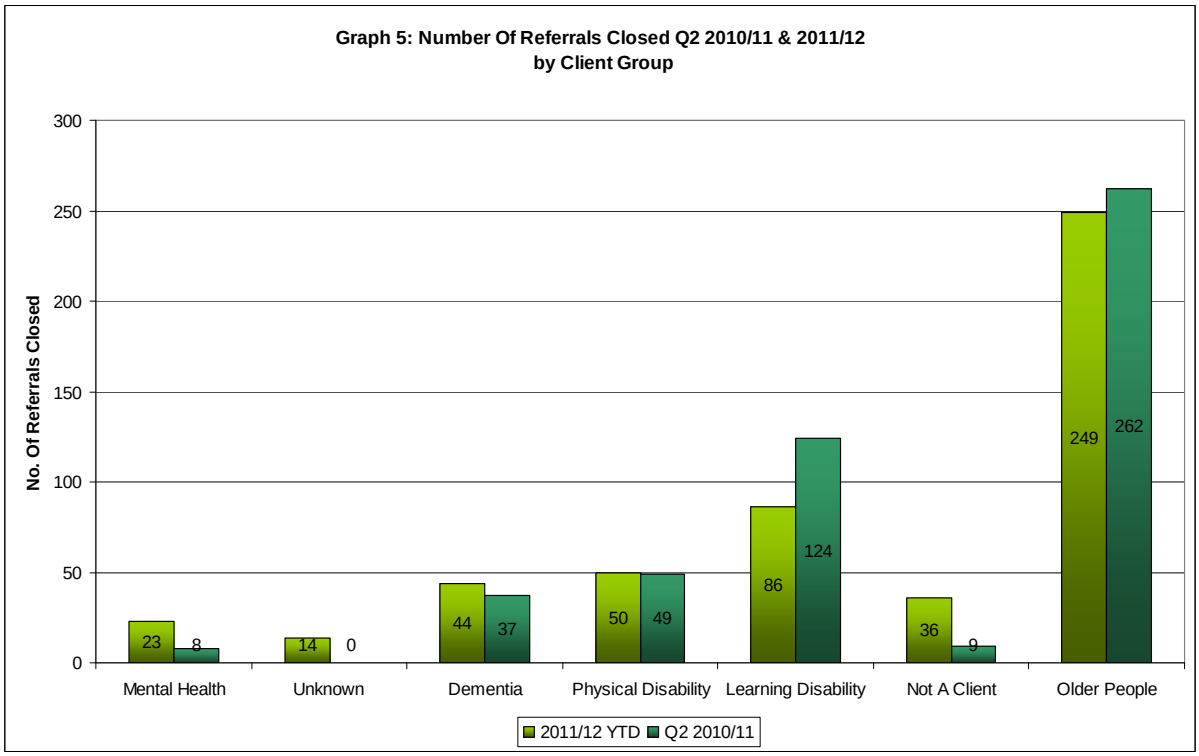
1.3 Referral Source



NB – Referrals may have more than one referral source (e.g. concerns referred by both a family member and a GP would be counted twice in this graph, under each referral source heading).

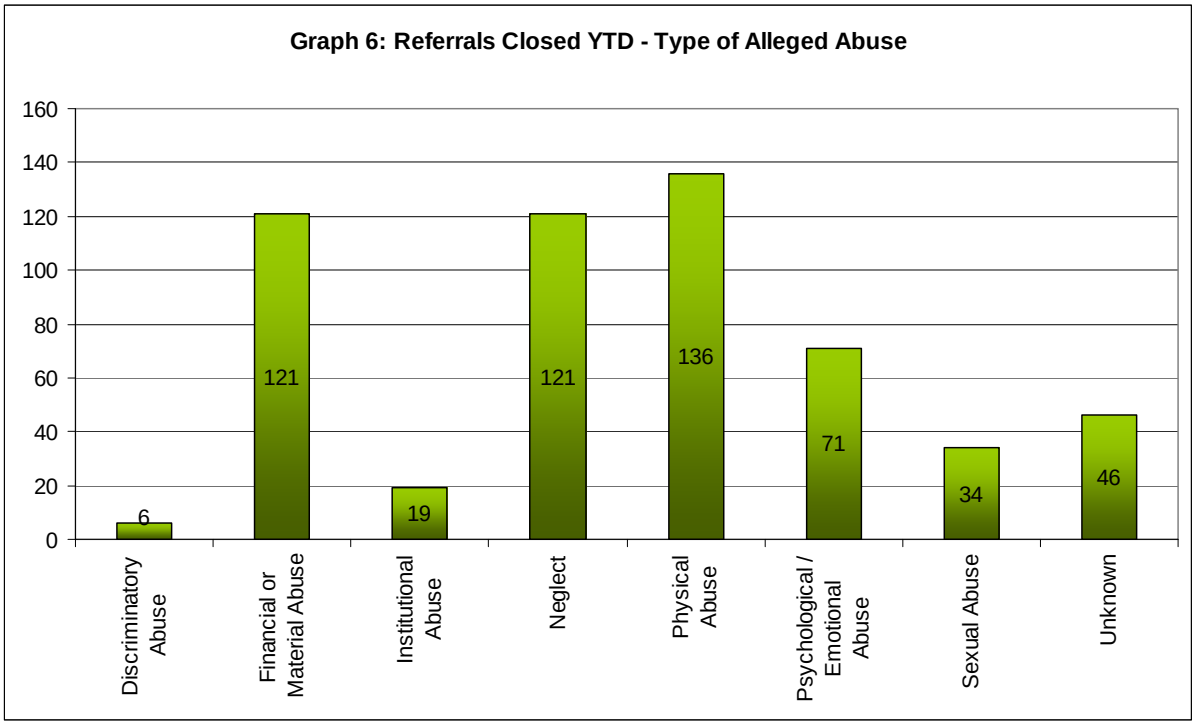
Care provider services made up the majority of referral sources closed YTD. Primary Health Care staff, Friends and Family and other sources providing the bulk of the remainder.

1.4 Victims of alleged abuse



Service users with a client group of older people are most likely to be the subject of a safeguarding referral, making up 50% of the referrals closed YTD. Service users with a Learning Disability form the next highest group, with a comparatively similiar distribution between the remaining client groups. At the same point in 2010/11 the proportion of older people and service users with a physical disability (18-64) were very similar, but substantially fewer referrals were received for service users with Learning Disabilities. There was an overall increase in the number of referrals received at this point in the year (489 by the end of Q2 in 2010/11, 502 at the same point in 2011/12), with service users with client groups of Mental Health and Dementia also seeing increases on the previous year. The number of 'unknown' client groups is higher in 2011/12 as 2010/11 data has been through the annual tidy up process, whereas the 2011/12 has not. There has also been an increase in the number of service users who did not have a package prior to their safeguarding referral ('Not a client').

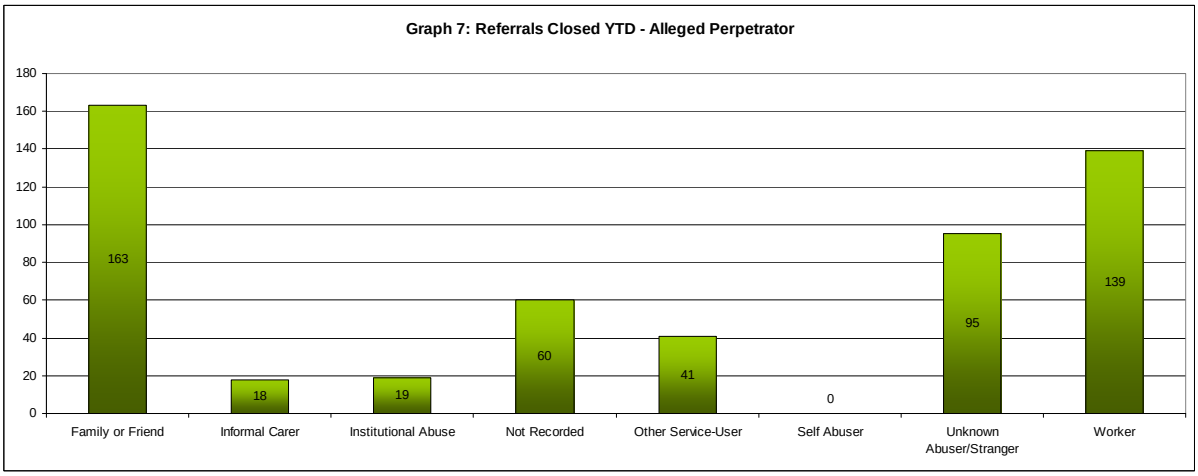
1.5 Type of alleged abuse



NB – Service users may be victim to more than one type of alleged abuse

Physical abuse, financial abuse and neglect provide the bulk of referral types for closed cases year to date. This follows the trend of referrals in 2010/11, with the same three categories forming the majority of referral categorisations.

1.6 Alleged Perpetrator

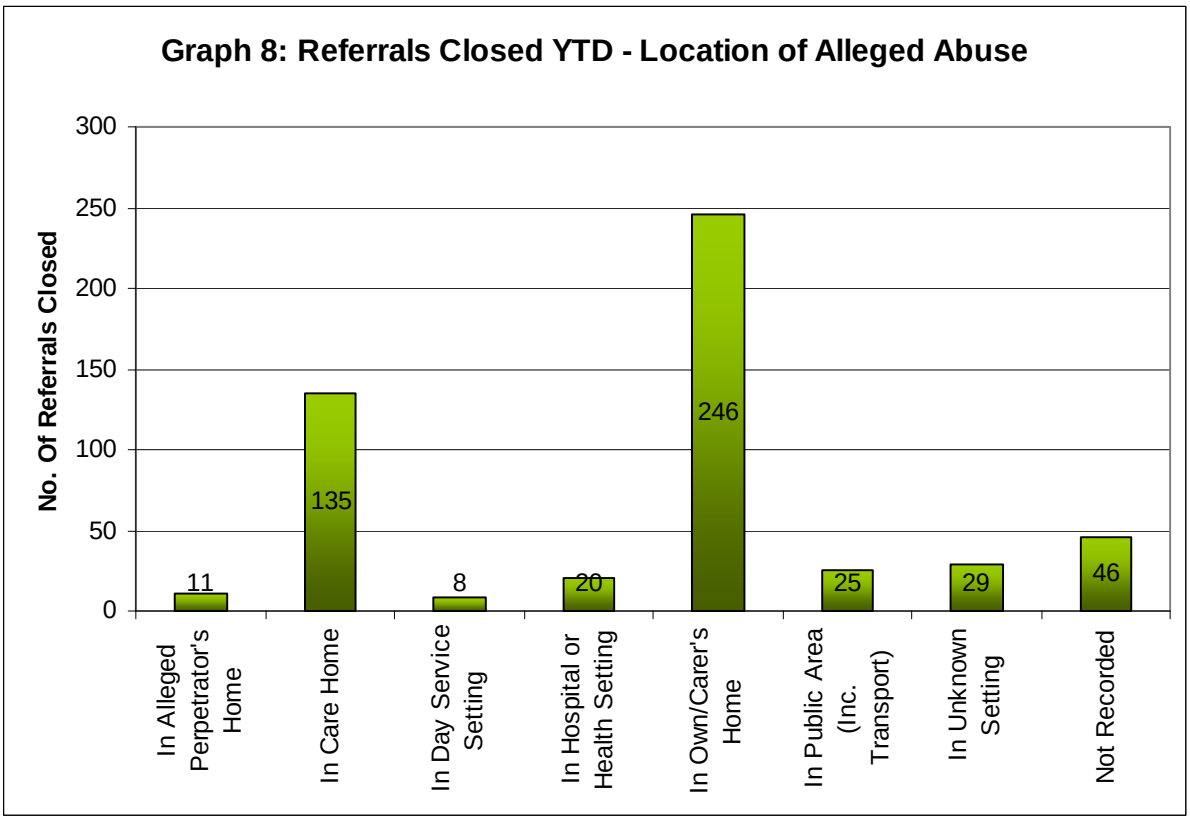


NB – A service user may suffer abuse from multiple perpetrators

Family and Friends continues to make up the greatest number of alleged perpetrators, followed by care workers. The number of referrals in which a care worker is named as an alleged perpetrator may appear high, but referrals may have multiple alleged perpetrators and allegations involving workers may appear to be double counted if more than one worker of a different type (eg a Home

carer and a Daycare center worker) is accused, in accordance with the guidelines for the completion of the AVA submission.

1.7 Location of Alleged Abuse



NB – Service users may be the victim of alleged abuse in more than one location.

A service user's own home is the most common location of abuse, followed by care homes. However, tables 1 and 2 below show the conclusion of referrals by their location and shows the majority of allegations in care homes were unsubstantiated. Despite this, the greatest percentages of substantiated allegations took place in care homes of the victim's (or their carer's) own home.

1.8 Location of Abuse by Conclusion of Referral

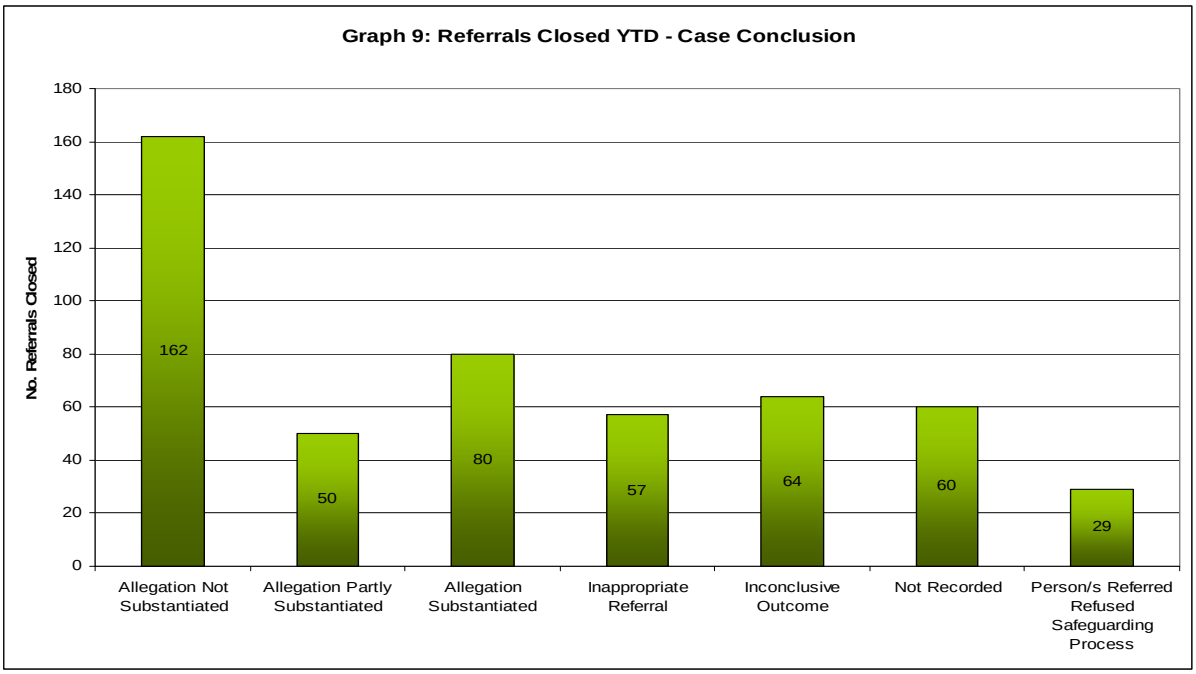
Table 1 & 2: Referrals closed YTD but conclusion and referral, by proportion of both locations and conclusions

Referrals Closed YTD by Location and Conclusion of Referral (by % referrals by conclusion)	Allegation Not Substantiated (%)	Allegation Partly Substantiated(%)	Allegation Substantiated (%)	Inappropriate Referral (%)	Inconclusive Outcome (%)	Not Recorded (%)	Person/s Referred Refused Safeguarding Process (%)
In Alleged Perpetrator's Home	2.3	3.7	0.0	1.8	4.4	1.7	3.2
In Care Home	32.0	22.2	52.9	19.3	14.7	13.6	0.0
In Day Service Setting	1.1	0.0	2.3	1.8	5.9	0.0	0.0
In Hospital or Health Setting	2.3	5.6	3.4	7.0	0.0	6.8	6.5
In Own/Carer's Home	53.7	59.3	33.3	50.9	51.5	11.9	80.6
In Public Area (Inc. Transport)	2.9	0.0	3.4	5.3	13.2	1.7	3.2
In Unknown Setting	4.0	5.6	3.4	12.3	7.4	1.7	6.5
Not Recorded	1.7	3.7	1.1	1.8	2.9	62.7	0.0
Total %	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

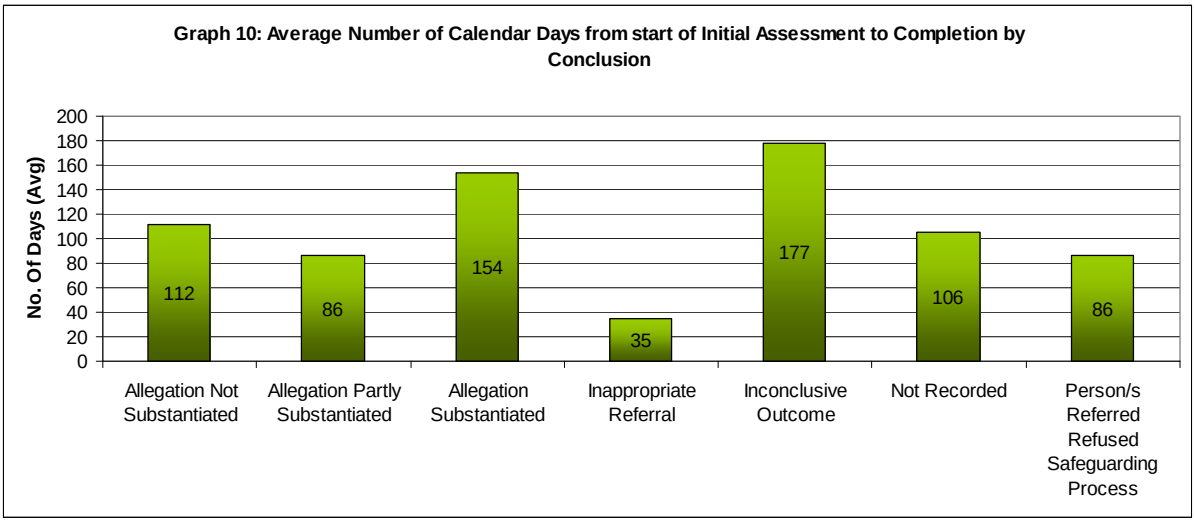
Referrals Closed YTD by Location and Conclusion of Referral (by % referrals by location)	Allegation Not Substantiated	Allegation Partly Substantiated	Allegation Substantiated	Inappropriate Referral	Inconclusive Outcome	Not Recorded	Person/s Referred Refused Safeguarding Process	Total (%)
In Alleged Perpetrator's Home (%)	33.3	16.7	0.0	8.3	25.0	8.3	8.3	**100.0**
In Care Home (%)	39.2	8.4	32.2	7.7	7.0	5.6	0.0	**100.0**
In Day Service Setting (%)	22.2	0.0	22.2	11.1	44.4	0.0	0.0	**100.0**
In Hospital or Health Setting (%)	20.0	15.0	15.0	20.0	0.0	20.0	10.0	**100.0**
In Own/Carer's Home (%)	37.5	12.7	11.6	11.6	13.9	2.8	10.0	**100.0**
In Public Area (Inc. Transport) (%)	22.7	0.0	13.6	13.6	40.9	4.5	4.5	**100.0**
In Unknown Setting (%)	25.0	10.7	10.7	25.0	17.9	3.6	7.1	**100.0**
Not Recorded (%)	6.5	4.3	2.2	2.2	4.3	80.4	0.0	**100.0**

Table 1 shows that substantiated allegations are most likely to occur in a care home or in the victim or their carer's own home, however, the greatest proportion of allegations received about abuse in the victim or their carer's own home are likely to be unsubstantiated. In care homes an almost equal number of allegations were fully or partly substantiated as those which were not substantiated, suggesting a greater prevelance of genuine cases in care homes over any other location. The distribution of conclusions amongst other locations was generally consistent, with 'inconclusive outcome' the most likely conclusion to an allegation located in a public area, where investigating allegations may be more difficult.

1.9 Conclusion and Outcome of Referrals



The greatest proportion of referrals closed were not substantiated (162 referrals - 33%), with 25% referrals (130) being either fully or partially substantiated.



Graph 10 shows that, as might be expected, referrals with an inconclusive outcome take the longest from start to conclusion. As shown in graph 10, referrals with an inconclusive outcome made up 13% of referrals closed YTD. Substantiated allegations took an average of 154 days but inappropriate referrals were identified and closed within an average of 35 days.

1.10 Deprivation of Liberty Safeguards (DOLS)

Referrals 1st April 2011 – 30th September 2011

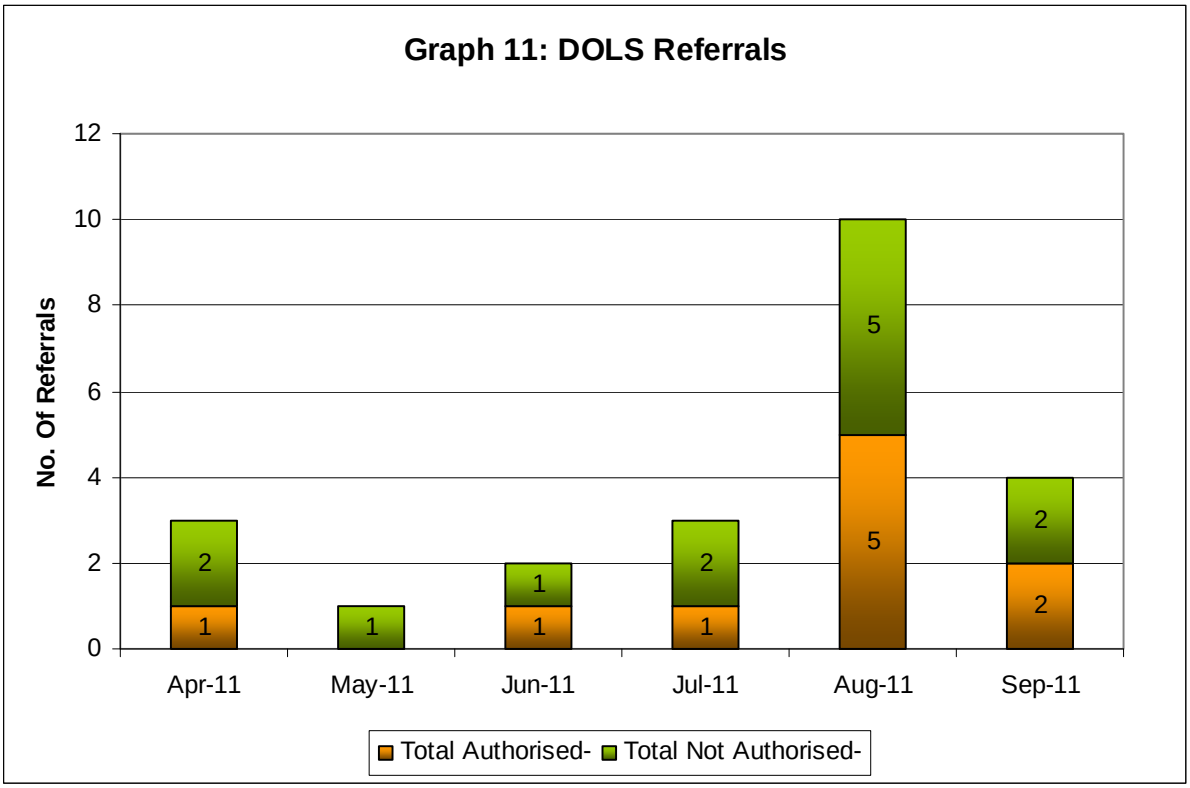
The report gives headline information regarding DOLS operational activity. This information is taken from the details DOLS dataset that is reported to the DoH on a quarterly basis.

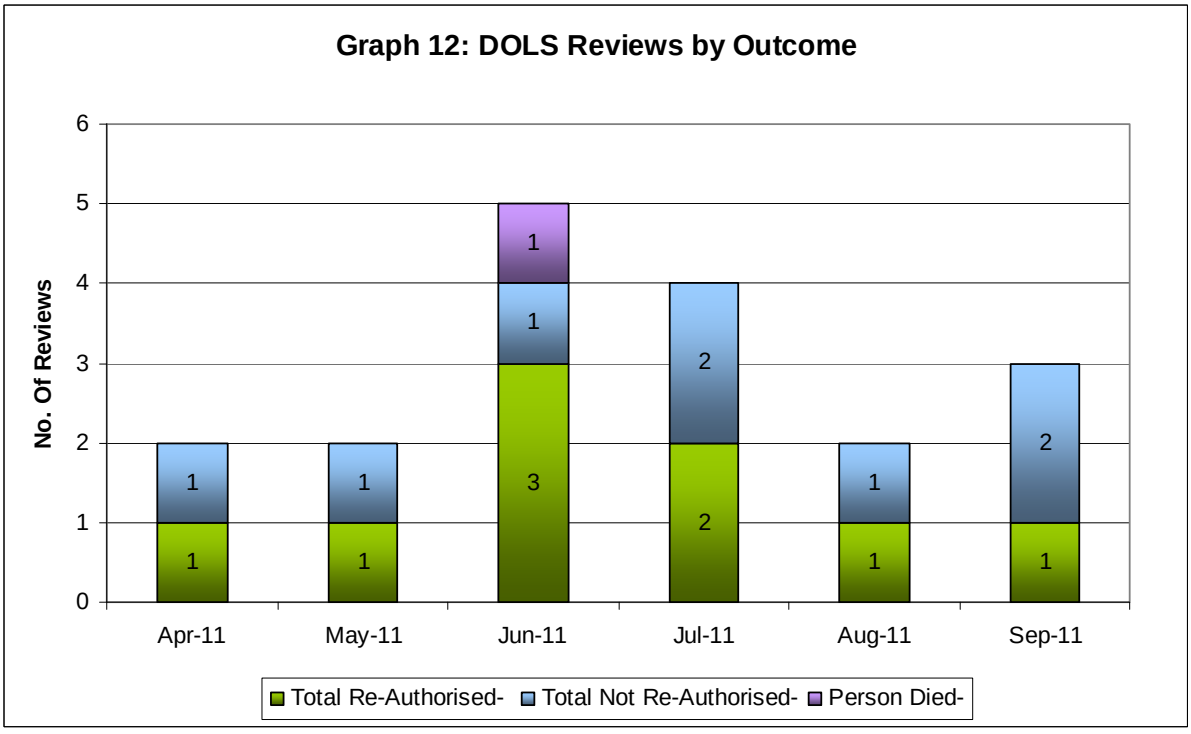
When DOLS cases are referred to the team they are either Authorised for DOLS monitoring or not and are agreed for a set length of time. The maximum monitoring period is 365 days, at the end of which the service user will be reviewed. Graph X shows the number of new referrals to the team YTD, with graph X showing the number reaching the review stage YTD by outcome. Those re-authorised begin the process again, those not re-authorised leave the DOLS monitoring process. There are currently 10 referrals authorised for DOLS monitoring.

Total Referrals 1st April 2011 – 30th September 2011: 23

Outcomes: - Referrals Authorised for DOLS 10

- Referrals Not Authorised for DOLS 13





Graph 11 shows August saw the greatest number of new referrals in the year with 10 new referrals received, half of which were authorised for the DOLS monitoring process. September saw a return to a more consistent number of new referrals with 4 received. Throughout the year there has been an overall 50/50 split between the number of new referrals authorised for DOLS and those not authorised. That trend is generally reflected in the number of cases (graph 12) reauthorized after review, with a roughly equal split each month.

Item 9

Item No 9

Adult Social Care and Health Overview and Scrutiny Committee

07 December 2011

Serious Case Review - Lessons Learnt

Recommendations

In response to members' request for more information, this report brings forward the public summary of the serious case review (SCR) into the death of GH published on 14th November. Members are asked to consider and comment on the report that has now been accepted by the Warwickshire Safeguarding Adults Board.

1. Background

1.1 The SCR was commissioned to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

1.2 The SCR on GH was commissioned in December 2010, and chaired by an independent expert.

1.3 The case was subject to significant media interest through the trial held in summer 2011, and so a large volume of personal data is already in the public arena. We have tried to ensure that we do not re expose personal data, and only use those facts that pertain to judgements about agencies effectiveness in working together.

2. Lessons Learnt

2.1 Appendix A contains the lessons learnt and recommendations, information from the public summary to be found in full on the website

2.2 All recommendations have been accepted by WSAB who commissioned and own the report, and an action plan has been drafted to set out how we will address the recommendations. WSAB will monitor completion of actions at each meeting

3. Issues to Note

3.1 The key finding was that agencies could not have predicted or prevented GH's murder, though we could have improved the quality of her life.

3.2 A key finding is that previous systems relied on a medical diagnosis of learning disability, which was usually not confirmed. The last diagnosis was

that GH had a conduct disorder. Current systems rely on assessments of vulnerability, but there are two areas of risk that are hard to evaluate

3.3 Referrals could come through from multiple sources, each separately may fail to reach FACS eligibility or appear to be significant in themselves. There is a need to record centrally and collate / log all contacts so that patterns and trends can be identified should there be (as with GH) many concerns that would not prompt an assessment, investigation, or service delivery.

Big Society (Adult safeguarding is 'Everybody's business') also needs to play a part.

Clear records are now kept of mental capacity assessments carried out for all such referrals, but there remains a 'judgement of Solomon' to be made when vulnerable adults with mental capacity actively choose a risky lifestyle.

	Name	**Contact Information**
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Portfolio Holder	Cllr Mrs Izzi Seccombe	

SERIOUS CASE REVIEW

THE MURDER OF GEMMA HAYTER

9th August 2010

PUBLIC SUMMARY

This Report is the Public Summary of a Serious Case Review conducted in 2011 in relation to the murder of Gemma Hayter on 9th August 2010.

The Serious Case Review Panel consisted of eleven people none of whom had prior involvement with this case. The review was led by an independent chair:

- Independent Social Care Consultant (Former Director of Adult Social Care) **[Independent Chair]**
- Lay Member [Advocacy organisation]
- DCI, Protecting Vulnerable People Unit, Warwickshire Police
- Assistant Chief Probation Officer, Warwickshire Probation Trust
- Service Manager Child Protection, Children's Services, Warwickshire County Council
- Service Manager, Adult Services, Warwickshire County Council
- Manager, Warwickshire Youth Justice Service
- Lead Nurse, Safeguarding Vulnerable Adults, NHS Warwickshire
- Lead Nurse, Safeguarding Vulnerable Adults, Coventry & Warwickshire NHS Partnership Trust
- Lead Nurse, Safeguarding Vulnerable Adults, University Hospitals Coventry & Warwickshire NHS Trust
- Head of Safeguarding, West Midlands Ambulance Service.

In addition, the following two representatives attended specific meetings only:

- Head of Housing, Rugby Borough Council Housing Service
- Senior Solicitor, Legal Services, Warwickshire County Council

Acknowledgements

This independent review under Warwickshire's Multi-Agency Policy and Procedure for the Protection of Vulnerable Adults [Serious Case Review Policy and Procedure] would not have been possible but for the ready co-operation and information supplied to the Panel by those invited to contribute to its thinking and the administrative and professional support provided by the County Council's Adult Protection Co-ordinator. The input of agencies and services involved with Gemma throughout her short life, as well as those with knowledge of the lives of the alleged perpetrators and the environment in which these tragic circumstances were played out, has been invaluable. The assistance of the family and their willingness to provide evidence during what has been a harrowing and traumatic time has also been invaluable. This report reflects the views of the Review Panel whose hard work, commitment and expertise have been invaluable throughout the process.

The key findings

The overall findings of the Serious Case Review are that:

- There was no evidence that Gemma's murder could have been predicted or prevented but if she had received and accepted better support, she may have lived a better life and been less likely to fall into the company of people who presented her with serious risks.

- There was no evidence that it was known or suspected that any of the five perpetrators presented a serious risk of harm to Gemma or other vulnerable adults; the relationship of the group with Gemma was not known to the agencies involved with them.

- There was clear evidence that Gemma was vulnerable to the risk of abuse and that she had been a victim of "mate crime" on a regular basis over a period of time, by a number of people who were known to her. None of these people were, however, the perpetrators.

- No single agency had a full picture of what was happening in Gemma's life: there were a number of missed opportunities for initiating safeguarding procedures, assessments or other interventions and for agencies to share information.

- The panel identified a number of lessons to be learnt including:
    - The system for accessing specialist health services and social care services by people with lifelong disabilities who do not have a clear diagnosis was inadequate.
    - Risk assessments were not routinely or systematically undertaken or used by agencies to underpin decision making in relation to undertaking reassessments and the closure of cases.
    - Mental capacity assessments were not completed. Decisions were made on the assumption of capacity that were not tested out.
    - The adult safeguarding process and threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where evidence is through a larger number of low level triggers.
    - There was no prevention strategy that gives people who are living in the community, and may be vulnerable to mate crime, the skills to keep themselves safe.
    - There was no systematic approach by agencies to give or request feedback following referrals or contacts to report concerns.

It should be noted that the Panel examined agency contacts and input over a long time period, and that it needs to be acknowledged that there have been changes to how services are delivered throughout this time period.

Finally, this case raises wider issues about community safety for single adults who may be vulnerable to disability based harassment, hate or mate crime and exploitation. This case sets out evidence of the sub-culture that continues to prevail within some groups of people where drug and alcohol abuse is endemic, there is a lack of respect for others, and where violence and mate crime is normalised.

Kathy McAteer,
Independent Chair.

CONTENTS

GLOSSARY

Warwickshire Safeguarding Adults Board (WSAB): multi agency management committee for safeguarding adults.

Warwickshire County Council (WCC): the local authority responsible for provision of adult social services, education and children's social care services to the residents of Warwickshire.

Transition Services/Team: staff responsible for the effective transition of young people from children's health and social care services to adult health and social care services.

Rugby Borough Council (RBC): responsible for the provision of housing and other local council services for the residents of Rugby.

Supported Housing: a funding stream used by Warwickshire County Council to fund providers – often voluntary organisations or housing associations – to provide low level, preventative services to support vulnerable adults to manage their tenancy.

Coventry & Warwickshire NHS Partnership Trust (CWPT): The statutory organisation providing specialist learning disability and mental health services to the population of Warwickshire and Coventry. (Prior to 2006 this was North Warwickshire PCT).

University Hospital Coventry & Warwickshire (UHCW): NHS Trust providing acute and secondary health care services to the local population.

Primary Care Trust (PCT): the NHS body responsible for the commissioning and procurement of health services for the local GP population.

GP Consortia: A group of GPs who will replace PCTs as the new commissioning bodies following the implementation of the NHS White Paper "Equity and Excellence: Liberating the NHS".

CAMHS: Child and Adolescent Mental Health Service.

Fair Access to Care Services (FACS): national framework setting out the eligibility criteria for adult social care services. Based on 4 levels of risk and need (Low, Moderate, Substantial and Critical), local authorities have discretion to set local eligibility based on resources. Warwickshire County Council is set at substantial and critical.

MARAC: Multi Agency Risk Assessment Conference: a co-ordinated community response to domestic abuse.

1. INTRODUCTION

1.1 Purpose of a Serious Case Review

The purpose of a Serious Case Review is not to reinvestigate or apportion blame but to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults. The focus of serious case reviews, in line with both multi-agency policy[1] and national guidance[2], is to:

- Learn from past experience and the specific event examined;
- Improve future practice and outcomes by acting on learning identified by the review;
- Improve multi-agency working and compliance with any other multi-agency or single agency procedures; including, regulated care services.
- Review relevant aspects of multi-agency policies and procedures to help ensure effectiveness in safeguarding adults at risk and more vulnerable to harm.

1.2 Reasons for this Serious Case Review

1.2.1. Warwickshire Safeguarding Adults Board (WSAB) commissioned a panel to undertake a Serious Case Review (SCR) following the murder of Gemma Hayter, a young woman with learning disabilities, on 9th August 2010.

1.2.2. A referral for a serious case review was made by Warwickshire County Council Adult Health and Community Services on 1st September 2010. It was considered by a multi-agency meeting chaired by the Chair of the Partnership and accepted on 28th September 2010. The grounds for doing so were based on the information available at the time:

- A vulnerable adult had died and abuse or neglect is known or suspected to be a factor in the death
- The case gives rise to concerns about the way in which local professionals and/or services work together to safeguard vulnerable adults.

[1] The Warwickshire Safeguarding Adults Partnership [Board] is a multi-agency partnership
[2] Vulnerable Adult Serious Case Review Guidance – Developing a Local Protocol, ADASS 2006

1.3. Terms of Reference

1.3.1. The terms of reference for the review were agreed and approved as follows:

a. To establish how effective agencies and the various assessment and support processes were in identifying Gemma's vulnerability and support needs, both as a child/young person and as an adult.

b. To review the effectiveness of the transition procedures from Children's Services to Adult Services, and establish whether any lessons can be learnt about how this can be improved.

c. To establish how well agencies work together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults.

d. To establish whether it was known, or could have been suspected, that the five perpetrators posed a serious risk to Gemma or other vulnerable people

e. To establish whether Gemma was targeted for abuse or exploitation as a direct result of her disability and if so, to determine the lessons that can be learnt to identify early warning signs of possible hate crime.

2. WHAT WE LOOKED AT

2.1 The Key Lines of Enquiry

2.1.1. **Information:** How was information about Gemma and the perpetrators received and addressed by each agency and how was this information shared between agencies?

2.1.2. **Assessments and Diagnosis:** What assessments did Gemma receive, from which agencies, and when? What were the outcomes of assessments and what were the decisions about her eligibility for support? Which of these were completed by a single agency and which were multi agency?

2.1.3. **Contact with and Support from agencies:** What contact did each agency have with Gemma and the perpetrators? What support did Gemma receive and from whom? Was there any history or evidence of bullying or harassment as a child or an adult?

2.1.4. **Transition:** What was the process for transition to adult services and what was the outcome of this?

2.1.5. **Housing:** Where has Gemma lived and for how long? What were the reasons for housing moves including any periods of homelessness? What support or interventions were initiated to support Gemma in managing her tenancies?

2.1.6. **Anti-Social Behaviour:** What is the history of any anti-social behaviour at Gemma's addresses and at those of the perpetrators? Was any crime reduction activity initiated as a result of this, and if so what?

2.1.7. **Choice and Control:** Was there any formal assessment of Gemma's mental capacity? What choices was Gemma perceived to have made and how did this influence decision making regarding intervention by agencies?

2.1.8. **Relationship between Gemma, the perpetrators, and other members of the community:** What was known by agencies about the relationships between Gemma and the five perpetrators? Were there any warning signs that Gemma was being abused, exploited, harassed or bullied by any of the perpetrators or by anyone else in the community? Were there any indications that Gemma was being targeted by anyone because of her disability or vulnerability? Was Gemma caught up in the domestic abuse between Daniel Newstead & Chantelle Booth?

2.2. The process for collecting and analysing information

2.2.1. The report is based on information from Chronologies and Individual Management Reviews submitted by the following agencies:

- Warwickshire County Council Children's Social Care.
- Warwickshire County Council Education Services.
- Warwickshire County Council Adult Health and Community Services.
- Rugby Borough Council Housing Services.
- Orbit, Heart of England Housing Association.
- Warwickshire Police.
- Warwickshire Probation Trust.
- Warwickshire Community Services, South Warwickshire NHS Foundation Trust.
- Coventry & Warwickshire NHS Partnership Trust.
- University Hospital Coventry & Warwickshire NHS Trust.
- West Midlands Ambulance Service.
- Warwickshire Youth Justice Service.
- Enfield Youth Offending Service.
- Pengwern College.

2.2.2. Additional information was submitted by:

- Mayday Trust.
- Westside Medical Centre submitted computer print-outs of medical records for Gemma only, including copies of some correspondence.
- Gemma's family.

2.2.3. In addition, the Panel considered the additional evidence that became available following the murder trial. Following the verdict on 28th July 2011, the Panel received a copy of the Case Summary from Warwickshire Police which outlined the circumstances of the murder and a summary of the witness statements.

3. WHAT WE FOUND OUT

3.1 Summary of Events

3.1.1. The full details regarding Gemma's murder were elicited from the trial.

3.1.2. Chantelle Booth had known Gemma for some years and it is evident that Gemma perceived Chantelle to be her friend. At the trial it was reported by witnesses that Chantelle Booth had previously mistreated Gemma, calling her names, referring to her as having Down's Syndrome, and on one occasion shaving Gemma's hair off.

3.1.3. On Saturday 7th August 2010, Gemma was drinking with the 5 perpetrators in Rugby town centre. Gemma started telling doormen and bar staff that Chantelle was only 15 years old, with this information being shared via the pub watch scheme, resulting in the group being refused entry into a number of pubs and being ejected from others. This caused some anger and an assault against Gemma who "had spoiled their night".

3.1.4. On Sunday 8th August, Chantelle Booth and Daniel Newstead invited Joe Boyer and Jessica Lynas to join them at about 4-5pm at their flat for Sunday lunch. Joe Boyer took along his friend Duncan Edwards. The group are said to have been drinking lager and smoking weed throughout the afternoon and evening. Following an exchange of texts between Gemma and Chantelle, Gemma joined them at their flat a couple of hours later. During the course of the evening, Gemma was subjected to prolonged and serious assaults over a period of 4 hours. Perpetrator witness statements suggest this was motivated by the alleged theft of £800 from Chantelle Booth and the fact that Gemma had failed to pay it back, however, the true motivation for the assaults is debateable. The assaults included sustained physical assaults and being head butted, resulting in several fractures to her nose, being hit with a mop, being forced to drink urine out of a lager can, and being locked in the en-suite bathroom. Her phone was taken from her and the battery flushed down the toilet. All 5 perpetrators were found guilty of assault, though each attempted to blame the others and minimise their own part in it.

3.1.5. At just past midnight on 9th August, Gemma and the 5 perpetrators were captured on CCTV leaving the flat. Gemma had asked to go home, and the group decided that they would all walk her home. The group, however, took a route in the opposite direction to Gemma's flat and subsequently took her onto the disused railway line. Here, Gemma was subject to further physical assaults resulting in her death. She was stripped of her clothes which were set on fire along with her other belongings, had a black bin bag put over her head and was also (superficially) stabbed in the back of the neck.

3.1.6. The 5 perpetrators were captured on CCTV walking back to their flats between 1.09 and 1.30am. Gemma's badly beaten body was found by a jogger at approximately 5.30am.

3.1.7. Chantelle Booth, Daniel Newstead and Joe Boyer were found guilty of murder; Jessica Lynas and Duncan Edwards were found guilty of manslaughter. All were found guilty of assault.

3.2 Gemma's Life Story

3.2.1. Gemma was the youngest child in a family with 2 older siblings and during her childhood and adolescence lived with her mother and step-father., her birth father having left the family home when she was 9. Gemma had a number of life-long health difficulties and development issues, though there was never any clear diagnosis of a specific medical condition underpinning this. There are conflicting diagnoses regarding Learning Disability and Autistic Spectrum Disorder. As a child she was diagnosed as having a learning disability with differing reports about severity, from mild to severe, and at 18 was diagnosed as being on the Autistic Spectrum. When tested as an adult the diagnosis was that she did not have a learning disability or Autistic Spectrum Disorder, and in 2008 she was diagnosed with Conduct Disorder.

3.2.2. Gemma received additional support within mainstream education throughout her primary school years and transferred to a special school for her secondary education, and subsequently to a local residential school and then to a residential college in Wales for the final years of her education.

3.2.3. Throughout Gemma's childhood her mother consistently raised concerns relating to her behaviour at home and though these problems were not initially experienced by her primary schools, these difficulties became more apparent as she got older. The difficulties escalated to the point that social care services were subsequently provided during her adolescence.

3.2.4. As well as several incidents of concern that highlighted Gemma's vulnerability, a common theme throughout her life was about her difficulties in making friends and she was perceived as being at risk of being abused or exploited. It was stated that Gemma would "never tell on people" - "she would accept abuse as long as the abuser acknowledged her as a friend".

3.2.5. There is no evidence of a planned transition from children's to adult social care services although an adult social care assessment was completed to plan for her leaving College and returning to her home area. Gemma was

assessed as meeting High (Critical) Fair Access to Care Services (FACS) eligibility for adult social care services due to her needs around managing risks, diet & nourishment, social support networks, housing, money management, shopping and home cleanliness.

3.2.6. Gemma returned to Rugby in July 2004 at the age of 21, and moved into shared supported housing with Mayday Trust, a specialist supported housing provider, living in two tenancies during this period. Her tenancy broke down within two years as a result of Gemma's behaviours related to her difficulties in social communication and her strong desire for independence - "not to be treated as a child". There were worrying examples of Gemma's behaviour putting her at risk.

3.2.7. Adult Social Care closed Gemma's case shortly after her return to Rugby, though continued to have intermittent contact, which increased when her tenancy became at risk in late 2005. In early 2006 Gemma was referred briefly to mental health services. Throughout this period Gemma's behaviour towards professional support is described as aggressive and unco-operative and she refused assessments. Following this episode, though several re-referrals were made to Adult Social Care, she was deemed ineligible for services on the grounds that she did not have a diagnosis of a learning disability and had previously failed to engage.

3.2.8. After her eviction from the Mayday tenancy in September 2006, Gemma lived in a private shared tenancy. In December 2007 Gemma was again referred to mental health services and an assessment commenced, including psychiatric, psychological and OT assessments and she was allocated to a community psychiatric nurse (CPN) for community nursing support, though she was not referred for a social work assessment. The mental health assessments, which included psychology, psychiatry and Occupational Therapy (OT), took an extended period of time to complete due to Gemma's sporadic engagement.

3.2.9. Whilst undergoing the range of mental health assessments throughout 2008, Gemma's lifestyle was becoming more risky and chaotic and she was again in crisis with her tenancy. There was a high level of contact with the police during this 12 month period (2-4 contacts per month) mostly around Gemma being the victim of thefts and concerns about her being subject to extortion. In February 2008, the police made a safeguarding referral to Adult Social Care, which was not investigated, with the police advised to contact mental health services.

3.2.10 Whilst the OT assessment identified that Gemma needed a more structured living environment and supervision, the overall assessment concluded that Gemma did not have a learning disability or autism. Following this

assessment process the intention was to convene a vulnerable adults meeting to consider the findings of the assessments and appropriate action; this meeting did not take place. Subsequently, following eviction from her private tenancy, Gemma was accepted as homeless and moved to her final tenancy with Rugby Borough Council (RBC) housing department in August 2008, and from this time onwards until her death received floating support from Orbit, a voluntary organisation funded by Supporting People money to provide low level, preventative support to people who need help to maintain their tenancies, pay bills etc.

3.2.11. Throughout 2009, Orbit and RBC had continuing concerns about Gemma's vulnerability and potential for exploitation, and her inability to cope with her tenancy. Gemma's living conditions continued to deteriorate with evidence of self-neglect, a chaotic lifestyle, debts and inability to manage her finance, with a pattern of intermittent engagement with support workers. Further unsuccessful attempts were made to refer her to Adult Social Care, and the CPN, being unaware of the full circumstances, closed the case on the grounds that she seemed to be coping. By this time police contact had reduced significantly until Gemma was assaulted in May 2010. Following this assault, which was not by or linked to any of the perpetrators, and until her murder on 9th August, Gemma was continuing to fail to engage with support workers and was subsequently facing eviction from her tenancy, being distressed about this on the day of her murder.

3.2.12. In summary, the pen picture of Gemma prior to her death is of a young woman of 27, whose physical appearance is described as being similar to that of a congenital disorder, despite all medical tests being negative. She was of small stature and it can be speculated that her physical appearance would become more distinctive as she got older, and many people who had contact with her describe her as "looking different". Despite the lack of a learning disability diagnosis, she was generally seen as someone who did have difficulties and vulnerabilities associated with a learning disability. Gemma was in debt and unable to cope with paying her bills and was considered at risk of extortion or exploitation by others. Her lack of social skills and her behaviour towards others put her personal safety at risk. Over a period of 6 years between leaving college and her murder, Gemma's lifestyle had become increasingly chaotic and risky. She was not attending college or working, and she was associating with other young people living in her local community who also had chaotic lifestyles, who were immature, were not working or in college, and who tended to be both the victims and perpetrators of violence and petty crimes. She mixed with a community of young people where violence was considered a normal part of life and where drug and alcohol abuse was a significant factor. Gemma would have been vulnerable in

situations where she came into contact with people who did not have her best interests at heart and her social circumstances made this inevitable.

3.3 The lives of the perpetrators

3.3.1. The perpetrators consist of 2 couples and a single man, these being Daniel Newstead & Chantelle Booth, Joe Boyer & Jessica Lynas, and Duncan Edwards. The 2 couples were neighbours in privately rented tenancies and lived approximately 2 miles from Gemma's flat. Duncan Edwards lived nearby with his mother, having recently returned to the area after some time away. Daniel Newstead, Chantelle Booth and Joe Boyer were all found guilty of murder, Jessica Lynas and Duncan Edwards were found guilty of manslaughter. All five were convicted of assault occasioning actual bodily harm.

3.3.2. Chantelle Booth is believed to have been known to Gemma, and perceived by Gemma to be a friend, for at least 18 months prior to her murder. Chantelle Booth's relationship with Daniel Newstead was known to have started around October 2008. It is not known how long Chantelle Booth & Jessica Lynas had been friends but it is alleged that they were both involved in bullying and assaulting a vulnerable young woman who was living in a hostel in June 2010 (this was not Gemma and this allegation has not been corroborated by other agencies). Jessica Lynas had only recently developed a relationship with Joe Boyer, who she appears to have met in supported accommodation in May 2010 and she moved into his private tenancy in July 2010.

3.3.3. **Daniel Newstead:**

3.3.3.1. Daniel Newstead was 19 at the time of the murder and was living with his girlfriend, Chantelle Booth, 21. He had been known to both the Warwickshire Youth Justice Service, and Warwickshire Probation Trust. His contact with Youth Justice service was between January 2008 and February 2009, when he was transferred to Probation supervision. He was convicted of a number of offences between 2004 and 2008, including an offence of affray when he was in possession of a metal bar and a knife, and was known to the anti-social behaviour group. Daniel was known for his violence towards women having a history of domestic abuse against his mother, sister, previous girlfriends and Chantelle.

3.3.3.2. Daniel is described as having a chaotic lifestyle that featured emotional immaturity, and persistent substance misuse.

3.3.3.3. Daniel was identified as both a perpetrator and a victim of violence and a key feature seems to be the normalisation of violence – the evidence

suggests that he appears not see violence as anything unusual and accepts it as a normal part of everyday life.

3.3.3.4. Daniel Newstead was known to mental health services for his substance misuse and anger management issues. The mental health assessments found no evidence of mental illness or active suicidal thoughts. There was no knowledge of his relationship or contact with Gemma and no evidence that he presented a risk to others because of these incidents.

3.3.4. **Chantelle Booth:**

3.3.4.1. Chantelle Booth was 21 at the time of the murder and living in a private tenancy with Daniel Newstead. She lived a chaotic lifestyle, appeared emotionally immature, and was subject to regular episodes of domestic abuse and violent altercations with other individuals.

3.3.4.2. Chantelle was known to Probation following an offence of Grievous Bodily Harm resulting in a Community Order with a supervision requirement, curfew requirement and education, training and employment requirement. Chantelle maintained regular contact with her supervising Probation Officer throughout the period of supervision.

3.3.4.3. Both Chantelle Booth and Daniel Newstead were subject to on-going concerns of anti-social behaviour involving abusive, aggressive and violent behaviour, and Chantelle was identified as both a perpetrator and victim of this behaviour. Chantelle however received only one further conviction, this being for common assault of a female in May 2010. Though this took place at Chantelle Booth's home, the victim was not known to Probation and was not linked to this review.

3.3.4.4. One agency stated that Chantelle was involved in an incident with Jessica Lynas in June 2010 when they allegedly bullied and assaulted a vulnerable young woman living in a hostel (this was not Gemma). This incident was not corroborated by other agencies.

3.3.4.5. Though there was some knowledge of Chantelle's links with Gemma, this was at a very general and infrequent level and there was no evidence that this was of concern.

3.3.5. **Jessica Lynas:**

3.3.5.1. Jessica Lynas was 18 at the time of the murder and living in a private tenancy with Joe Boyer, 17 years. Jessica had previously lived in shared, supported accommodation which rapidly broke down and she subsequently

moved into Joe Boyer's tenancy, with whom she had recently started a relationship.

3.3.5.2. Jessica was known to the police as both a perpetrator and victim of crime, being both the subject of and perpetrator of various assaults, the latter for which she was cautioned. Though there was some knowledge of her friendship with Chantelle Booth, there was no knowledge of her contact with Gemma.

3.3.6. **Joe Boyer:**

3.3.6.1. Joe Boyer was 17 at the time of the murder and he had been living with Jessica Lynas for a short time in his private tenancy, where they were neighbours of Daniel Newstead & Chantelle Booth. Joe was made subject to a 4 month Referral Order in August 2009 for possession of cannabis, and a further order in June 2010 for the same offence. He was in breach of the order and in the process of being returned to court at the time of the murder. He was not, however, known for any violent offences and was considered low risk of harm to others, and was known to the police as a victim of crime.

3.3.7. **Duncan Edwards:**

3.3.7.1. Duncan Edwards was 19 at the time of the murder and had recently moved back to Rugby to live with his mother, close to the flats where the 2 couples lived. Previously living in Enfield, Duncan Edwards was known to Enfield Youth Offending Service (EYOS) from 2003 onwards and between 2001 and 2010 he had been convicted of nine offences, and investigated for a further nine.

3.3.7.2. There was no knowledge of Duncan having any contact with Gemma or of his friendship with the other 4 perpetrators.

3.4 Contacts with Gemma.

3.4.1. Adult Social Care Interventions:

3.4.1.1. Gemma had 11 separate assessment events open to Adult Social Care between July 2001 and February 2008 and had 6 allocated workers plus regular contact with duty social workers/duty managers. The reasons for case closure of these episodes are not always clear.

3.4.2. Health Interventions:

3.4.2.1. From the age of 11 years until her death, Gemma attended Walsgrave/Rugby Hospital and subsequently University Hospital Coventry & Warwickshire on 18 occasions. As an adult, between 2000 and January 2010 she was under the care of 5 adult consultant teams including General Medicine & Endocrinology, ENT, Orthodontics, Rheumatology and Opthalmology. She attended outpatient clinics on 10 occasions and had 2 failures to attend. In May 2010 she attended Rugby Urgent Care Centre with injuries due to an alleged assault.

3.4.2.2. As a child Gemma had contact with North Warwickshire PCT (now Coventry & Warwickshire Partnership Trust) children's learning disability services and was initially assessed as having learning difficulties with an IQ of 62-65. Between 1995 and 1998 there were a total of 14 contacts. As an adult she had 5 contacts in 2000 and 10 contacts in 2001 with adult Learning Disability services, with tests indicating that she did not have a significant learning disability, plus one additional contact in 2004 when the police were seeking judgement about her capacity to consent to sexual intercourse, following an alleged rape.

3.4.3. Mental Health Interventions

3.4.3.1. Between 2006 and December 2008, Gemma had 64 contacts with Coventry & Warwickshire Partnership Trust mental health services plus a number of appointments in 2009, of which she attended one and failed to attend at least 4. The majority of the contacts – 41 – were in relation to the Psychiatric, OT and Psychology assessments that were completed during 2008.

3.4.4. Police Contacts

3.4.4.1. There were 20 contacts with Gemma between September 2004 and her death. However, the majority of contacts – 14 in total - were between February and December 2008.

3.4.5. **Housing and Floating Support**

3.4.5.1. From when Gemma moved into her Rugby Borough Council tenancy in August 2008 there was regular contact between Gemma and Rugby Borough Council Housing and Orbit floating support service up until her death. Rugby Borough Council housing service had at least 67 contacts of which 27 were face to face and 40 by phone or text. There are 6 recorded instances of Gemma's failure to attend appointments with RBC. Orbit had 30 face to face contacts and 13 recorded contacts by phone. Gemma failed to attend 18 appointments and records suggest that many of the phone calls were related to unsuccessful attempts to book appointments.

3.5 Timeline

DATE	KEY EVENTS	ADULT SOCIALCARE (ASC)	MENTAL HEALTH (MH)	LANDLORD & HOUSING SUPPORT	POLICE
Sept 02- July 04	Placed at Residential College, Wales				
May 2004		Assessed for leaving college: HIGH Fair Access to Care Services eligibility			
July 2004	Returns to Rugby			Shared tenancy with Mayday Trust	
Aug 2004		Case allocated to new social worker			
Sept 04	Alleged rape		Contacted re capacity to consent	Remains at Mayday tenancy with new contract	Police contact
Feb 05		Review: "going well"			
17th July 2005		Case closed			
22nd July 2005		Request for social worker to attend review		Has moved to new address (shared tenancy) with Mayday	
Sept – Nov 05	Deteriorating situation – bills/money; stopped college and work placements	Requests for social worker to attend reviews		Tenancy at risk;	
December 2005		Case re-allocated			
Feb 06	Behaviour – aggressive & unco-operative throughout this period – refusing assessments but clear risks		Referral to Psychiatrist – behavioural		
April 06			Mental Capacity assessment re managing money (at outpatients appointment with Psychiatrist and support workers)		

June 06				Notice to quit served by Mayday	
July 06		ASC decision to offer one accommodation and to close case if this is refused (it was refused as out of Rugby)		Alleged refusal to offer housing due to Learning Disability (social care records)	1st record of police contact
August 06		Case closed (recorded May 07)			
Sept 06				Evicted from Mayday tenancy. Moves to private tenancy	
October 2006			Decision re: no input from Learning Disability or MH services but may benefit from counselling re relationships		
August 2007		Re-referred to ASC – reassessment refused due to no learning disability diagnosis		At risk of losing private tenancy	
Oct 2007		Re-referral to ASC – reassessment refused on same grounds			
December 2007			MH assessment offered and commences		
Feb 2008	deteriorating		Full assessments recommended and vulnerable adult meeting		Police contact begins and continues on a regular basis throughout 2008 (2-4 contacts each month)
Feb/Mar 08	Concerns regarding extortion etc.	Police refer to ASC re risks – Adult Safeguarding referral declined	MH still actively involved	Clear crisis with tenancy and other people potentially exploiting her	
May 2008			MH still actively involved; OT recommends structured environment	In crisis with tenancy	

			with more supervision		
July 2008				Accepted by Rugby Borough Council (RBC) as homeless	
August 2008	Moves to RBC tenancy			Moves to RBC tenancy and referred to Orbit for support to maintain tenancy	
Dec 2008			MH assessment being completed		
Jan 09				Support Plan with Orbit	
Mar - April 09	Evidence of not coping with tenancy		Some contact with RBC & Orbit	Concerns about vulnerability	
May 2009					Police contact x1 (drunk)
Sept 09			"seems to be coping"	"not engaging"	
Oct 09	Concerns re extortion				Police contact
Nov 09		Attempts to re-refer – refused on ground of no diagnosis of learning disability or mental illness	CPN to close case	In crisis and not engaging: decision to take recovery action	
Feb 2010				Taken off support as not co-operating	
March 2010	Flat dirty, hygiene, self-neglect; rubbish;			Support re-starts & Crossroads input to help with cleaning	
April 2010	Bills & debts			Support plan for bills & debts	
May 2010	Assault				Police contact
April – Aug 2010	Generally not engaging, debts and not paying bills, up to death on 9th August.			Generally failing to engage	
July 2010	Daniel Newstead & Chantelle			Threat of eviction; report of fall & injuries	Police contact x 1 (theft)

	Booth split up but back together by 29th.			29th July	
9th August 2010	Gemma murdered			Distressed re eviction	

3.6 Contact with the perpetrators

3.6.1. There are only three contacts that have linked Gemma to any of the five perpetrators, this being only with Chantelle Booth. Two of these contacts were when Gemma contacted the police regarding the theft of her friend Chantelle's purse. The only other contact was with Rugby Borough Council housing when Chantelle accompanied Gemma to her meeting to discuss her eviction on the day before her murder. On each of these occasions there was nothing to cause concern about their relationship.

3.6.2. The majority of police contact with Gemma was during 2008 and during this period there were 7 police contacts with Daniel Newstead and 6 with Chantelle Booth, with 4 joint contacts due to their domestic abuse, these being after October when their relationship began. Between January 2009 and August 2010, there were 17 contacts due to their domestic abuse and 6 separate contacts with each of them. On none of these occasions was Gemma involved.

3.6.3. There were no contacts with any agency that linked the two couples with each other except the one reported incident when Chantelle Booth and Jessica Lynas allegedly bullied and assaulted the young woman in the hostel. There were no contacts that linked Duncan Edwards with the two couples.

3.7 Analysis and Findings

3.7.1. **(a) To establish how effective agencies and the various assessment and support processes were in identifying Gemma's vulnerability and support needs, both as a child/young person and as an adult.**

3.7.1.1. Gemma's vulnerability and support needs were apparent from early childhood and all agencies that came into contact with her as an adult generally recognised her as being vulnerable. However, agencies use different definitions of vulnerable, often based on specific legislation relating to the type of service offered (for example "vulnerable" in terms of the Housing Act in relation to homelessness is different to the definition of "vulnerable" in

No Secrets). Overall, Gemma's vulnerability and support needs relate to a combination of her disability and her behaviours.

3.7.1.2. A key difficulty for professionals involved with Gemma has been a lack of an agreed diagnosis that explains succinctly her difficulties and needs. She was diagnosed as a child as having learning difficulties variously described as ranging from a mild learning difficulty to a moderate or significant learning disability. As a teenager she was diagnosed as being on the Autistic Spectrum. As a young adult she was diagnosed as *not* having a learning disability or Autism and has also been described as having a borderline learning disability and her most recent diagnosis being that of Conduct Disorder, this being a recognised mental disorder. She did not have a diagnosed mental illness. Gemma also suffered from a range of physical health conditions and her appearance has been described as being suggestive of a congenital disorder, genetic syndrome or birth defect, though all clinical tests for such conditions have been negative.

3.7.1.3. There is much evidence that despite the lack of diagnosis, professionals often recognised her difficulties and tried hard to identify her needs and how these could best be met. However, the issue of a lack of diagnosis was a key factor in preventing Gemma from receiving timely and effective social care support when she needed it. For adults with social care needs, eligibility to access specialist services in many local authorities has generally tended to be based on diagnosis. The system of accessing specialist support from the learning disability service with Warwickshire requires a diagnosis of a learning disability, and access to mental health social care services has required a diagnosis of severe and enduring mental illness (though it needs to be noted that the new CMHT draft specification would not now exclude someone with a Conduct Disorder). However, Valuing People (2001) states clearly that IQ level alone should not be the main determinant of a learning disability and that other factors, including for example social functioning, should be taken into account.

3.7.1.4. A community care assessment is the only way a person can access provision of community care services. The duty to assess as set out in the NHS and Community Care Act (1990) does not replace assessment duties in earlier legislation such as the Chronically Sick and Disabled Person's Act (1970) and it is clear that the local authority had a duty to assess Gemma's needs on the basis of her disability – the fact that the diagnosis changed over time isn't relevant and in more recent years she had a diagnosis of a Conduct Disorder, a recognised mental health condition within the legislative framework. For Gemma, there were two prospective routes for accessing an assessment – via the learning disability team or the community mental health team.

3.7.1.5. Gemma did receive a community care assessment in 2004 from the learning disability team when she left the college in Wales to return to Rugby (the residential college being a specialist placement for people with a learning disability). She was assessed as meeting the high (critical) level of Fair Access to Care Services (FACS) criteria and identified with the following needs:

- Risk management
- Diet & nourishment
- Social networks
- Housing needs
- Money management
- Shopping
- Home cleanliness

3.7.1.6. Fair Access to Care Services (FACS) eligibility criteria are set out in 4 tiers of risk/need – low, moderate, substantial and critical – and those assessed as substantial or critical are eligible to receive services in Warwickshire. It is important to note that FACS criteria only applies to the provision of services – it does not determine eligibility for an assessment (as clearly a person needs an assessment to determine eligibility). However, the Adult Social Care case records regularly state that Gemma was not eligible for an *assessment* because she "did not meet FACS criteria". Not only is this an inaccurate interpretation of FACS but Gemma already had an "active" FACS assessment that stated that she met Critical needs, and this had not been reassessed or up-dated.

3.7.1.7. Following her initial assessment and the provision of a supported tenancy on her return to Rugby, Gemma's case was quickly closed. Though she received some further input at various times, generally her lack of a diagnosis become the focus of decision making and a barrier to accessing effective support, and the evidence identifies that:

- a system based on diagnosis was the key deciding factor (rather than vulnerability or risk) that prevented Gemma from receiving effective and timely assessments and/or provision of support – the fact that Gemma received *some* support from Adult Social Care "despite her not meeting criteria" illustrates the inconsistency and inequity of the policy.
- the use of diagnosis as a criteria for accessing specialist learning disability services is used by many local authority learning disability teams to control referrals and workload and is not in line with a personalised approach to risk, need and vulnerability.
- the use of a system that is based on diagnosis rather than risk or vulnerability is likely to result in staff losing sight of Gemma as a person – and it is clear from the evidence that the team "had developed a

cultural need for a diagnosis" and that "despite Gemma's diagnosis and support needs being established in 2001, from 2006 onwards social care practitioners/management focus seems to have been around whether there was an official diagnosis".

- the issue of not being eligible for social care support from the learning disability team in itself should not deny someone access to an assessment and support from a different part of the adult social care system, had there been alternative means of accessing services. There was no system in place to signpost Gemma to other adult social care services that could offer her an assessment and support, and though she was receiving support from Mental Health health professionals she was not referred for social work support from within the mental health team and there was no process for joint working across mental health and learning disability services.
- the requirement for a diagnosis, combined with assumptions about her mental capacity to make her own choices, also denied Gemma access to adult safeguarding investigations at those times when there was clear evidence that she was at risk of significant harm.
- the focus on a lack of diagnosis resulted in outcomes whereby other agencies making referrals and raising concerns about Gemma were given advice (about her not having a learning disability and having capacity to make her own choices) that influenced their own decisions and reduced their ability as single agencies to support her adequately.

3.7.1.8. As she was deemed ineligible for learning disability psychiatric services, Gemma was referred on several occasions to Coventry & Warwickshire Partnership Trust (CWPT) adult psychiatric service in relation to her behavioural difficulties. In October 2007, following a re-referral from Gemma's sister to the CWPT learning disability service, the Learning Disability Consultant Psychiatrist wrote to the learning disability social work team requesting a joint reassessment of Gemma, but social care input was declined based on his earlier diagnosis in 2001. The outcome of this was a referral to the adult psychiatric service resulting in the completion of psychiatric, occupational therapy (OT) and psychology assessments during 2008, as well as support from a community psychiatric nurse (CPN). A carer's assessment was also offered but declined by her family.

3.7.1.9. Though Gemma did not present with a mental illness, her difficulties were recognised and the assessment process was an attempt to identify her needs and how these could be met. The assessment did not follow the usual multi-disciplinary team process (for example a social care assessment from a mental health social worker was not requested), the assessments were not effectively co-ordinated, and though there was a stated intention to convene a vulnerable adult meeting, this didn't happen and the case was subsequently

closed on the grounds that she was not eligible for services due her lack of a diagnosed mental illness, with no support plan being proposed. It should be noted that, at this time, the adult mental health service was an integrated team, with social work input to the multi-disciplinary team, though this was prior to the more formal Partnership Agreement that is now in place with the Council to fully integrate health and social care services.

3.7.1.10. A key feature of Gemma's contact with health and social care services is regarding decisions to close cases and terminate input. On occasions, this appears to have been because of her lack of engagement and in one episode of assessment, her aggressive behaviour and refusal to complete the community care assessment process. The pattern of contact with Adult Social Care shows a lack of consistency due to regular changes of worker (due to staff leaving or structural changes, case closure and contact with duty when she did not have an allocated worker). The evidence suggests a tendency to close her case too early – on many occasions there were re-referrals and concerns raised within days or weeks of the case being closed. The evidence suggests that there was no systematic assessment of risks at the point of closing her case, as well as arbitrary decision making regarding "eligibility" that was not based on the outcome of any reassessment of her needs.

3.7.1.11. Finally, a key factor in decision-making, regarding the refusal to offer assessments/re-assessments and support, has been assumptions regarding Gemma's mental capacity and her right to choose her own lifestyle, neglect herself and make decisions that put herself at risk. There has been no assessment of Gemma's Mental Capacity in line with the Mental Capacity Act (2005) to underpin these decisions. On one occasion a psychiatric opinion was taken regarding her capacity to manage her money – this was prior to the Mental Capacity Act being implemented and was completed at a psychiatric outpatients appointment rather than via a multi-disciplinary meeting.

3.7.1.12. The issue of choice and control over her life was also a key factor in some decision making by agencies regarding the adult safeguarding processes, especially when Gemma denied that she was being exploited and stated that she wanted no further action. This raises questions about whether the right systems are in place to enable professionals to discuss concerns about adults deemed to be vulnerable without their explicit consent – such a system would have ensured that information about the extent of the risks was better shared between agencies and would have enabled a more accurate assessment of the risks of harm or abuse.

3.7.1.13. Valuing People (2001) sets out a key principle of Independence but states very clearly the role of the public sector to support people to achieve this – "*independence in this context does not mean doing everything unaided*".

There is clear evidence that agencies, whilst often recognising her vulnerability, were over reliant on the belief that Gemma "chose" to put herself at risk and that it was her right to do so. In 2006 a letter from a psychiatrist to her GP stated that "Gemma has the ability to make her own decisions about contact with the services (but) she is perhaps poor at judging some risks". There was a failure to adequately investigate, or explore with Gemma, the impact of her vulnerability. This is not to suggest that agencies should be risk averse and should not take into account Gemma's views and wishes, but "choice" should not be used as a rationale to ignore the duty of care or stop providing a service. Though Gemma had periods of disengagement and on a minority of occasions had been aggressive towards workers, she would usually quickly come back to ask for help. Supporting people who are difficult to engage is a particular skill and is not uncommon, with specialist learning disability and mental health services having considerable experience and expertise in working with people whose behaviour places them at risk.

3.7.1.14. The chronology sets out clearly the support Gemma received from housing services, and she was appropriately referred for floating housing support services to help her maintain her tenancy and manage her debts. Gemma's engagement was spasmodic, and intervention tended to focus on the latest crisis relating to rent arrears and threat of eviction. It is clear that RBC housing services and Orbit worked hard to engage Gemma and to provide assistance, that in the case of RBC went beyond the norm, to ensure that she paid her rent, including enabling access to additional housing benefit on an exception basis to help her out of her backlog of debt. This cycle of crisis intervention, however, meant that Gemma's situation was never sufficiently stable to work with her on other aspects of her life, such as college and employment, or to explore her social needs and contacts.

3.7.2. **(b) To review the effectiveness of the transition procedures from Children's Services to Adult Services, and establish whether any lessons can be learnt about how this can be improved.**

3.7.2.1. It is important to note that Gemma's transition to adult service was 10 years ago and that there have been significant changes in procedures and practice since that time. However, the lack of an effective transition process for Gemma *at that time* potentially had a significant impact on the future response from adult services and influenced longer term decision making that subsequently reduced her ability to access timely and effective support.

3.7.2.2. It is clear from the evidence that Children's services held a large amount of knowledge about Gemma's needs and her family circumstances. This included a wealth of information about her health needs and attempts to

diagnose a condition that could explain her needs and vulnerability. The evidence from Children's Services records indicate that transitional issues were considered and it was believed that a Transition Plan was put in place. However, there are no records of this in either Children's Services or Adult Social Care. The evidence from Adult Social Care suggests that there was no formal transition plan or process.

3.7.2.3. The first recorded contact with Adult Social Care was in July 2001 and was initiated by Gemma's mother, whilst Gemma was attending Exhall Grange school and due to her recent diagnosis of Autism. There is no evidence that information was sought at that time from Children's Services to inform the adult assessment, establish her history or undertake any joint working. A multi-disciplinary assessment was completed, the outcome of which determined that Gemma did not have a learning disability or Autism but that her behaviour indicated a conduct disorder. Gemma was informed that she did not have a learning disability or autism a few days before it was recorded that the case was to be subsequently closed. The transfer summary states that the Gemma had applied for a place at a residential college in Wales and that if she was successful, the case would be closed, otherwise she would be given advice on housing and employment options.

3.7.2.4. The evidence from the residential college in Wales shows that Gemma was still open to Children's Services when she commenced her placement and notes that the case was subsequently transferred to Adult Services in December 2002. The chronology shows that both Children's Services and Adult Social Care were involved with Gemma at the same time between July 2001 and December 2002, but there is no evidence of communication or joint working during this period, other than a note in the adult records to state that the "review of education and care plans" was received and filed in March 2003.

3.7.2.5. It is disquieting that there are stark differences in diagnosis between Children's Services and Adult Health and Community Services during such a short period of time given that diagnosis was such a significant determinant of eligibility for accessing adult services. However, the type and level of services available to adults with disabilities are different to those available to children with disabilities, and this issue is not just pertinent to this case but is a cause of concern and anxiety to many families at this time of their lives. Throughout her contact with Children's psychiatrists & psychologists there was general agreement that Gemma had a learning disability, though this in itself is a very broad definition that encompasses a diverse range of conditions and needs. The independent assessment commissioned by Gemma's mother and its findings regarding Autism were accepted by Children's Services and were not challenged. A more formal transition process would have enabled a more

rounded and realistic assessment of her vulnerabilities and the opportunity for a more personalised approach but this would have only been effective if it was not so heavily biased towards the need for a confirmed diagnosis as the main criteria for accessing services.

3.7.3. **(c) To establish how well agencies work together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults.**

3.7.3.1. As a generalisation, the evidence suggests that in the main agencies tended to deal with the issues pertaining to their own remit and, despite efforts to make referrals to Adult Social Care, the links were not made that are a pre-requisite to the effective protection of vulnerable adults. This was evident as early as the transition process outlined above, with a lack of joint working across Children's and Adult services. There was also little attempt to complete an assessment regarding suitability of the proposed placement at the residential college in Wales. It would appear that Gemma's parents identified and arranged this placement independently of any agency input. Adult Social Care records suggest that the placement was to be funded by health, but this is not corroborated and is unlikely. It has not been possible to identify how this was funded (presumably via Further Education funding). The decision to move away from home should not be taken lightly given the risk, for someone with Gemma's poor social skills, of being unable to maintain or develop local friendships or the support networks that will be so important in adulthood.

3.7.3.2. At no time during Gemma's adult life did one agency have a full overview about what was happening in her life and a full understanding of the risks to which she was exposed. However, there is evidence that some agencies not only tried hard to make appropriate referrals and engage other agencies in supporting Gemma, but also went further than the norm in trying to support her as a single agency.

3.7.3.3. Some of the earlier decisions about eligibility based on diagnosis clearly had an impact on agencies attempts to flag concerns with Adult Social Care about Gemma's well-being. For example, the police made attempts to refer Gemma under the safeguarding procedures, but the referral was not accepted. RBC Housing Services made repeated attempts to refer to Adult Social Care and to seek clarity and advice on Gemma's disability and needs, but were told that she did not have a learning disability and had capacity to make her own choices. Decisions about whether to make a vulnerable adults referral under safeguarding procedures were considered by agencies in isolation, largely based on single agency evidence, and Gemma's word that she was not being exploited.

3.7.3.4. There is little evidence of effective multi-disciplinary working – often the focus of any multi-disciplinary working that did happen appeared to be about whether or not she had a diagnosis of a learning disability, rather than to develop a care plan that brought together the various services and agencies in any structured way to provide on-going support to Gemma. The mental health assessment that was carried out was ineffectively co-ordinated and did not include social care input. Opportunities to convene a multi-agency vulnerable adult meeting were missed.

3.7.3.5. Agencies often did not have access to information that was known to other agencies. There is clear evidence during 2008 that RBC Housing and Orbit worked closely together to support Gemma in maintaining her tenancy. There was awareness that mental health services were involved (specifically a CPN). However, although there were some joint visits and some evidence of communication, the evidence points to this being ad hoc and occasional rather than systematic. The decision to close the CPN input to the case is first set out in August 2009 based on Gemma's failure to keep appointments, then in September 2009 that "she appears to be coping with living independently". This is in stark contrast to the crisis that was known to Orbit and RBC Housing Services during this period in relation to her tenancy and debts and evidence that she was vulnerable to exploitation.

3.7.3.6. A key learning point that emerges is the importance of follow up and feedback. There are many examples of information being passed on to agencies, but with no follow up. There is a lack of a systematic approach to either give feedback to agencies following a referral or receipt of information, or to proactively seek feedback – this needs to be a two way process with an obligation to both give and ask for feedback.

3.7.4. **(d) To establish whether it was known, or could have been suspected, that the five perpetrators posed a serious risk to Gemma or other vulnerable people.**

3.7.4.1. There is no substantial evidence from any agency that the five perpetrators posed any risk of harm to Gemma or other vulnerable people. All five were well known to a range of agencies, and a key feature of their lives was the normalisation of violence with their being both the victims and perpetrators of assaults. Daniel Newstead was a known risk (categorised Medium) in relation to domestic abuse and his partner Chantelle Booth was considered vulnerable within the police definition (that is in relation to domestic abuse, not the No Secrets definition). Drugs and alcohol, anger management issues, loss and bereavement were all a key feature of their chaotic lifestyles.

3.7.4.2. There was one alleged incident of Chantelle Booth & Jessica Lynas harassing and bullying a vulnerable woman (not Gemma) in a hostel, this being in the June prior to Gemma's murder. However, this was not corroborated through either the adult social care or police records and other than this, there were no indicators, triggers or escalating factors that could have led to a prediction of the events which took place in August 2010.

3.7.4.3. Though the police had investigated various allegations made by Gemma, including an assault on her by a male during May 2010, none of these incidents were related to any of the alleged perpetrators. There was no knowledge of Gemma's relationship or contact with Joe Boyer & Jessica Lynas, Duncan Edwards, or Daniel Newstead and only limited knowledge of her perceived friendship with Chantelle Booth. The police were aware of her contact with Chantelle Booth when Gemma contacted them on Chantelle's behalf regarding a stolen purse in September 2009. The day before her death, Gemma attended a meeting with the RBC Housing officer accompanied by a friend who was later identified as Chantelle Booth. On none of these occasions were there any issues that triggered concern about this relationship.

3.7.5. **(e) To establish whether Gemma was targeted for abuse or exploitation as a direct result of her disability and if so, to determine the lessons that can be learnt to identify early warning signs of possible hate crime.**

3.7.5.1. Gemma's vulnerability to exploitation is well documented, with anecdotal evidence of her willingness as a child to accept abuse for the sake of being acknowledged as a friend, and clear evidence of her potential sexual vulnerability both as a teenager and an adult.

3.7.5.2. As an adult there is evidence that Gemma was subject to exploitation by people who knew her (but not by the alleged perpetrators). The first indication was during her first supported tenancy with Mayday when she was allegedly asked to look after drugs by the landlord of a local pub and being subsequently charged with possession. There were clear concerns identified by Orbit and RBC Housing Services about extortion and/or exploitation during early 2008 and subsequently in October 2009. These incidents included having possessions taken from her and not expecting to get them back and suspicions that she was giving people money on a regular basis. The police were involved on each occasion. A safeguarding referral was made to adult services by the police as a result of the first incident but was closed by adult services without being investigated. On the second occasion Orbit and RBC discussed making a POVA referral but did not proceed due to Gemma stating

that she was not being extorted but was “spending her money on rubbish”. However, these concerns continued to be recorded regularly after this decision, which was not reviewed or revisited in the light of additional evidence mounting.

3.7.5.3. Though there is no concrete evidence that Gemma was targeted for abuse or exploitation as a direct result of her disability, she was living in a social environment where young people were regularly perpetrating crimes against each other. There is evidence that she was the victim of “mate crime” based on her allegations to the police against people she associated with (though these were not the alleged perpetrators, there were repeated complaints about named individuals who she was known to be associating with at different times). Gemma presented as someone who “looked different” and her behaviours and lack of social and communication skills placed her at high risk of being targeted for abuse or exploitation. She would find it particularly difficult to protect herself and her need for social contact and friendship to combat loneliness and isolation would lead her into situations where she did not have the skills to recognise the dangers.

3.8 The known facts

3.8.1. It is important to establish fact from supposition or assumption and to ensure that the findings are reflective of the evidence.

Issue	Factual evidence	Assumption	Agency
Gemma had delayed development as a child	Statement of Special Education Needs, 1987		Local Education Authority
Behavioural difficulties at home (as a child)	Family reporting and various assessments		Coventry & Warwickshire Partnership Trust (CWPT) Children’s services
Diagnosis of borderline Autistic Spectrum or Asperger’s Syndrome	a) Psychology assessments 1997 b) Private Psychology assessment		a) CWPT – children’s learning disability service
Diagnosis that Gemma had a learning disability	**a)** IQ tests of 62 and 65 **b)** Private		a) CWPT – children’s learning disability service

	psychology assessment		
Diagnosis that Gemma did not have a learning disability or Autism	IQ and psychological tests 2001		CWPT – adult learning disability Psychiatric Service
Diagnosis that Gemma had borderline learning disability and behavioural difficulties	Mental Health assessments 2008		CWPT – adult Mental Health psychiatric service
Gemma had a diagnosis of Conduct Disorder	Assessment Summary. Letter from MH Adult Psychiatrist to GP, refers to LD Psychiatric diagnosis (2001)		CWPT
Gemma did not have a mental illness	Psychiatric assessments 2008		CWPT
Gemma was perceived by agencies that came into contact with her as someone who had a learning disability or a mental health condition		Observations of staff based on Gemma's appearance, behaviour and social communication	Police RBC Housing Services UHCW Schools & Colleges
Gemma was vulnerable and at risk of exploitation	Recorded contact with agencies relating to the allegations made against others, her inability to manage money, poor personal hygiene and self-neglect, suspicions/evidence of exploitation; family evidence; episodes showing sexual vulnerability.		All agencies that came into contact with her- Police RBC Housing Orbit Mayday CWPT – children's and adult services Adult Social Care Children's Services UHCW Residential College Schools attended

Gemma was considered to have the mental capacity to make choices about lifestyle and to take risks	No factual basis as no Mental Capacity Assessment undertaken	Psychiatric opinion sought by RBC re her ability to manage money; Police sought advice re her mental capacity to consent to sex following alleged rape	Adult social care CWPT adult services
Gemma's perceived friendship with Chantelle Booth	Phone call to police and attendance at RBC offices		Police RBC
Though Gemma's contact with Chantelle Booth was known, there was no knowledge of her relationship with the other parties	Case records from all agencies show no links except the 2 contacts with Chantelle Booth referred to above		All agencies
There was no evidence that Gemma was at risk from the alleged perpetrators.	Case records from all agencies show no incidents or warnings		All agencies
Chantelle Booth and Jessica Lynas harassed and bullied a vulnerable adult (not Gemma) in June 2010	Orbit IMR	No record of adult safeguarding referral or action; no police records.	Orbit RBC Housing Service
Gemma failed to engage with services, was aggressive to staff and refused to co-operate with assessments	Engagement with floating support services was inconsistent and she failed to attend 18 appointments out of 48; with RBC she failed to attend 6 out of 33 possible face to face appointments; Gemma kept 10 out of 11 OPD	Though the facts show that Gemma's engagement was spasmodic, the evidence does not indicate a significant or sustained refusal to co-operate. There are 2 records only of her aggressive	Orbit RBC Housing Services Adult Services CWPT UHCW

	appointments. Out of 11 separate assessment events with ASC, Gemma refused to co-operate with one.	behaviour towards staff – these being Mayday and one specific social worker.	

3.9 Missed opportunities

3.9.1. There is no evidence that Gemma's murder could have been predicted and, other than one alleged but uncorroborated incident of harassment involving Chantelle Booth & Jessica Lynas, there is no evidence that any of the perpetrators presented a risk of serious harm to vulnerable adults. However, there is clear evidence that Gemma was vulnerable to the risk of abuse and she had been a victim of "mate crime" on a regular basis over a sustained period of time, by a number of people who were known to her. None of these people were however the perpetrators. The panel have found some evidence of inadequate systems, poor professional practice and decision making, and of weak multi-agency working.

3.9.2. The threshold for initiating an adult safeguarding assessment is currently defined by the risk of "significant harm" (the recent Law Commission[3] consultation paper proposes changing this to "harm"). The obligation for agencies to take reasonable steps to safeguard a vulnerable adult from abuse is set out in Articles 2 and 3 of the European Convention on Human Rights and the requirement is to take action if a person is *believed* to be at risk of harm, not when there is demonstrable evidence that abuse has actually happened. There were a number of incidents that indicated that Gemma was believed to be at risk of significant harm due to financial exploitation and these were missed opportunities to assess under the Adult Safeguarding procedures.

3.9.3. There were other incidents that indicated that Gemma was at risk due to a lack of daily living skills and self-neglect, and was repeatedly making decisions that put herself at risk, that did not meet the adult safeguarding threshold of significant harm, but were missed opportunities to complete a community care assessment, risk assessment, and to consider or offer the provision of additional support.

3.9.4. Whilst there is no guarantee that Gemma would accept help, there is clear evidence that she did develop and maintain good relationships with the police and would contact them regularly, and though she often refused to engage

[3] The Law Commission (LAW COM No 326): Adult Social Care; May 2011

with agencies, she always contacted agencies when she perceived herself to be in crisis. This led to a repetitive pattern of Gemma asking for help when in crisis but being unwilling to engage in any follow up on the occasions that it was offered.

3.9.5. Given the lack of knowledge about Gemma's relationship with the perpetrators, and her strong desire to protect her independence (and anecdotal evidence that she may cover up abuse if she perceived the abusers to be friends) it is probably unlikely that intervention could have predicted or have prevented the tragedy that happened to her – the evidence set out in the missed opportunities relates mainly to financial exploitation, sexual vulnerability and self-neglect and, with the exception of the assault in May 2010, does not suggest a high risk of physical abuse. However, it may be that timely and effective intervention could have resulted in better outcomes for Gemma in terms of managing her finances, finding more meaningful day time occupation (such as college or employment) and finding alternative social contacts that would have avoided her becoming sucked into the company of people who were leading such chaotic lifestyles and who were not going to be mindful of her welfare.

3.9.6. The missed opportunities - for initiating safeguarding procedures, assessment or other interventions, and for multi-agency communication and sharing of information - are set out in the following table:

Missed Opportunity	**Agency actions**	**Comment**
Completion of adult assessment in 2001 that Gemma did not have a learning disability or autism but her behaviour is indicative of a conduct disorder	Assessment completed by December 2001 – Gemma informed of outcome. Adult Social Care decision to transfer case for monitoring by a community care worker until she left school and to close case in the event of securing place at residential college out of area – date of closure unclear, recorded as May 2003, but chronology suggests limited input during 2002.	Though this occurred 10 years before her murder, this early focus on a diagnosis of a learning disability by adult services had a long term impact on future decisions regarding intervention and support. Case was also open to Children's services until December 2002, but there was no joint working between Children's and Adult services for a planned handover.
Alleged rape in supported accommodation with Mayday in September 2004.	Meeting convened with Adult Social Care and Mayday Trust to discuss whether Gemma should live elsewhere whilst perpetrator	No adult safeguarding investigation, and no formal assessment of mental capacity to consent to sexual intercourse was completed.

	bailed. Police asked Psychiatrist for judgement about mental capacity to consent to sexual intercourse – advised that she does not have a learning disability. Risk assessment completed in October 2004 that Gemma was contractually required to adhere to (by Mayday) and moved accommodation. Decision to close case was recorded by Adult Social Care in December 2004, a review was subsequently held in February 2005 and then no further contact until case formally closed 17th July 2005.	
Breakdown of placement at Mayday with deterioration from late 2005 through to her eviction in September 2006. Included evidence of exploitation by pub landlord (when Gemma was asked to look after drugs) and arrested for possession.	Adult Social Care had allocated the case during this period. Social worker stating that Gemma doesn't meet Fair Access to Care Services (FACS) criteria – this is not based on a re-assessment as Gemma is refusing to co-operate. RBC Housing Services allegedly refuse to re-house her due to her learning disability and need for support. Adult Social Care management decision to make one offer of accommodation and to close case if Gemma refuses it. Gemma refuses the offer because the property is in Bedworth and she does not want to move out of her local area. The closure summary is dated August 2006 and formally closed in September 2006.	No adult safeguarding investigation completed. No Mental Capacity Assessment completed. No review of FACS eligibility - previous FACS assessment of critical is still therefore in place. Decision appears to be on the grounds that Gemma does not have a diagnosis of a learning disability and assumptions that she has capacity to make this choice - the social worker states clearly in the notes that Gemma has a choice between accepting the offer or of being homeless. This episode of intervention is a critical turning point in Gemma's life and her ability to access support. There was significant evidence of Gemma's vulnerability and difficult behaviours - this required skilled social work intervention to engage her. However, the records indicate that relationships

		became strained – the tone of the case recording is emotive and decisions are heavily reliant on assumptions about Gemma's right to make choices about her life, even if this places her at risk. No risk assessment was completed and no vulnerable adults meeting was convened prior to closing the case. It is after this episode that referrals about Gemma were dealt with by duty workers and Adult Social Care consistently declined to become involved on the grounds of her lack of a diagnosis and failure to co-operate.
New referral from Gemma's mother in August 2007 as Gemma at risk of losing another tenancy "because of her behaviours related to her learning disability", and that she is "living in a pigsty".	Adult Social Care advise her mother that Gemma does not have a learning disability and to contact her GP.	It is by this point over a year since the case was last allocated and there was a duty of care to re-assess given the on-going concerns.
New referral from LD Psychiatrist in October 2007 requesting a joint health & social care assessment as she is still experiencing difficulties.	Adult Social Care decline to do a joint visit on the grounds that Gemma does not have a learning disability. Learning Disability Psychiatrist refers to Adult Psychiatrist for assessment – Mental Health services allocate for psychiatric, psychology and OT assessments and family are offered a Carers Assessment which was declined. It is recommended that a	This was the opportunity for a full multi-disciplinary assessment, including a community care and social work assessment, that cut across Learning Disability and Mental Health services. The planned Vulnerable Adult meeting did not take place, which would have brought together all agencies to share information and identify risks.

	Vulnerable Adults meeting is convened once assessments are completed. Assessments are completed by December 2008, but no further action is taken to convene a Vulnerable Adults meeting or arrange support on the grounds she is not eligible for CWPT services. CPN involvement continues into 2009 until case closed due to Gemma not attending appointments and a belief that she is successfully living independently. No risk assessment completed to check that this was the case.	
Police refer concerns regarding the condition of the accommodation and Gemma's vulnerability to Adult Social Care on 27th & 28th February 2008	Though logged as a Safeguarding referral, Adult Social Care decision is to close the case without investigation on the grounds that Gemma does not meet criteria, despite acknowledging her vulnerability. Police are advised that Gemma has not been diagnosed with mental illness, has capacity to make decisions and does not need support to ask Housing to re-house her. Police are informed that "every assistance has been offered to Gemma in the past and she has refused all support".	An adult safeguarding investigation should have been completed at this stage. The statement that "every assistance has been offered to Gemma in the past and she has refused all support". is incorrect as there is clear evidence that Gemma has not rejected all support in the past and in fact the previous decision to "offer one accommodation only" had not taken into account Gemma's wishes to stay in the Rugby area and could not be described as "every assistance". Gemma is still assessed as meeting critical FACS criteria at this time, as this has never been reassessed. There is no assessment of her Mental Capacity to support the statements made.
Letter from Financial Company to CPN in March 2008 regarding debts and	CWPT actions unclear, case closed April 2008.	No adult safeguarding referral or investigation.

allegations that Gemma is being manipulated and duped.		
OT assessment started in April 2008 and completed in May 2008 states that Gemma requires an environment that provides on-going supervision and support with all activities of daily living. It is also stated that she would benefit from a structured daily routine in order to increase her motivation and increase her confidence with life skills.	There is no record of the outcome of the assessment being discussed in the CWPT SPA meeting. Notice to quit was served a week after the completion of the assessment and she was accepted as homeless by RBC in July. RBC speak to CPN and are sent a copy of the OT report. CWPT informed of her housing move.	There is no evidence of multi-agency working to agree a care plan or agree housing provision (mainstream tenancy offered by RBC and referral for floating support).
On 27th May 2008 the police were involved following Gemma reporting a theft of money from her room by Stan[4] and Sam[5]. Gemma's mother also rings the police to state that "the males knew how to take advantage of her because of her learning difficulties". Gemma rings again to say she has no money for food and describes herself as vulnerable due to her disability. Further 999 call on 29th May regarding another	Police investigate the crime and arrange to see Gemma with her mother. Police records state that they would up-date her mental health worker as they feel she doesn't understand advice given. Following further 999 calls 2 days later, also linked to Sam, police records note that Gemma is being assessed by Mental Health services.	No safeguarding referral or investigation or evidence of this leading to a multi-agency discussion to share information and agree plans.

[4] pseudonym
[5] pseudonym

male.		
Further 999 call on 22nd July 2008 regarding stolen purse, linked to Sam and his friend - Gemma described as very distressed.	Police noted that due to Gemma's autism, need to involve mother, but mother not available for a further week. Gemma and her parents spoken to and her vulnerability re Sam and his friend noted.	No safeguarding referral made. 2nd incident linked to Sam.
Further 999 calls on 11th August and 14th August 2008 when Gemma says that Sam and 2 others have threatened to assault her (11th) and banging on her door (14th).	Police Officers attended – Sam and the other 2 people were visiting someone else at the bedsits. No offences committed. On second occasion Gemma was seen on 24th August and requested no further action.	A total of 4 incidents linked to Sam, all linked to similar theme . No safeguarding referral made.
Gemma makes further complaints of theft against Sam, on 9th September 2008, and on 11th September when she claims Sam has stolen her friend Chantelle Booth's purse and states that Chantelle Booth is frightened of Sam who keeps harassing her and asking for sex.	After the first complaint, Gemma is issued with an harassment warning because of repeated unproven allegations against Sam. On the 2nd occasion police tried to contact Chantelle Booth but unable to do so.	This period – from May to September is starting to show a repetitive pattern of complaints that indicated that all is not well in Gemma's life. As her allegations against Sam are unproven, Gemma is issued with an harassment warning – which in itself is indicative of her difficulties and potential vulnerability and should have been used as an opportunity for a vulnerable adults meeting.
On 8th December 2008 the concierge calls police as he is monitoring Bill[6] who has been bothering Gemma.	Police make telephone contact with Gemma and give advice. .	During the same time period, issues regarding non-payment of rent have been escalating with RBC and Gemma has been consistently failing to keep appointments. On 9th December 2008 CWPT records suggestion to make

[6] pseudonym

		social care referral and to hold a professionals meeting. Clear lack of communication between housing, mental health and police
On 13th March 2009, Orbit support worker concerned about Gemma's behaviour (hanging around the flats, looking "shifty").	Reported to RBC, who also witness same behaviour on 16th March 2009. No communication with MH team - CPN records dated 16th March state "remains very stable. To consider discharge". RBC & Orbit joint visit on 25th March 2009 and discuss their concerns with Gemma, who insists she is fine and no-one taking advantage of her or taking her money off her.	Repeated concerns about financial exploitation combined with Gemma behaviours would have warranted better inter agency communication to share concerns.
Orbit raise concerns on 16th April 2009 regarding debts, personal hygiene, housekeeping, and that people may be taking advantage of her. RBC identify Gemma is hanging around a known drug dealers flat and may be taken advantage of sexually. Gemma has said she is "smoking weed and drinking".	Orbit report to RBC and consider POVA referral. RBC discuss with Gemma who insists she is not having money taken off her "just spends it on rubbish" and thus decide not to make a safeguarding referral. RBC ring and inform CPN and arrange a joint visit (RBC, Orbit and CPN) for 1st May 2009. Gemma was not in on 1st May so joint visit didn't happen but RBC worker saw her later the same day. Gemma inferred someone owed her money and she did not expect to get it back – was advised not to lend people money or visit people taking advantage of her. Next record from CWPT is decision on 12th May 2009 to discharge Gemma. Followed	Though 3 agencies involved at this stage, and aware of current concerns, no safeguarding referral was made due to Gemma's response. At the very least, a multi-agency meeting, involving Mental Health services, should have been arranged to share information and concerns.

	by record on 8th June that there are “some concerns”.	
On 1st May 2009, Gemma tells RBC that Colin[7] has sold her X box and she won’t get her money back.	This was during a joint visit between RBC and Orbit to discuss rent arrears and state of the flat. Gemma advised not to visit people who take advantage of her.	The focus was on de-fumigation of the flat and living conditions. The decision not to make a POVA referral should have been re-visited in view of the continuing evidence of vulnerability.
In the early hours of 20th May 2009, Gemma drunk and causing a disturbance with 2 other females.	Police take Gemma home and state displaying signs of possible Mental Health issues. No further action.	
Following Gemma failing to keep appointments earlier in the year, face to face contact by CPN during early August.	CWPT - closed as an episode on EPEX (the electronic database system).	No summary and unclear whether risk assessment completed prior to discharge
Gemma tells RBC in October 2009 that Colin is taking £50 a week off her and she doesn’t know how to say “no” to him.	RBC report it to Police who request social services to attend interview with Gemma. RBC attempted to involve Victim Support or family and friends. Gemma did not keep the appointment. Orbit had followed up with Gemma, who said she was seeing the police with her sister, but then Gemma avoids meeting with Orbit for several months. RBC make referral to Victim Support	This is the same person who sold her X box and who RBC had advised her not to visit. No evidence of any further follow-up by any agency. No adult safeguarding referral made. No link made between the episodes with Colin and earlier history of episodes with Sam.
By mid November 2009, Gemma has failed to keep appointments with Orbit or Victim	Rugby Borough Council contact Adult Social Care Learning Disability team who advise them to speak to a health professional for advice	No Mental Capacity assessment is carried out to support the advice given to RBC. The advice that she does not meet eligibility of

[7] pseudonym

Support and has built up rent arrears and debts.	about a referral for Mental Health support or a capacity test. Both Adult Social Care and the health professional tell Rugby Borough Council that Gemma doesn't have a learning disability and has refused all support in the past. RBC are advised that as Gemma does not have a learning disability, does not meet criteria for services, and has the capacity to understand her actions, it is recommended RBC take recovery action.	services is 10 days after CPN had closed the case. The record states that "(health professional) felt she may continue her behaviour and that perhaps recovery action was the only way forward in order to get her to engage". Though at this point RBC and Orbit are consistently attempting to engage Gemma, there is no referral accepted for a social care assessment and advice to try and make her engage by carrying out recovery action is not based on any multi agency assessment or planning meeting. However, it should be noted that after court action is taken, Gemma does start to re-engage with Orbit and RBC.
In May 2010 Gemma is assaulted by a male – Tom[8] – who denies the charge. Gemma has bruising and pain for which she requests medical treatment.	Police arrest Tom but no corroboration so no further action taken. Gemma attended Rugby urgent care centre (UHCW). Bruising observed by RBC and Orbit and both are told by Gemma that she was assaulted at a friend's house and police are dealing with it.	This is the first and only report of an assault and, based on Gemma's account, by someone she knows and took place at a friend's house. Though she is seen by 4 agencies on 4 separate occasions, no adult safeguarding referral is made even though Gemma is recognised as vulnerable within No Secrets definition.
Engagement of Gemma's parents and family	Police had regular contact with Gemma's mother, with local police holding her contact details. CWPT offered a Carers Assessment which was declined. Adult Social Care had some contact with Gemma's mother and sister at various times, usually when they rang	Once Gemma reached adulthood the main contact between health and social care agencies and the family was when Gemma's mother or sister contacted to make a referral or ask for help. On only one such occasion was a Carers Assessment offered (which was declined).

[8] pseudonym

	to make a referral, or relating to a specific incident.	

4. LESSONS FROM THIS REVIEW

4.0.1. The lessons learnt by each individual agency have been set out within the agency reports (IMRs) along with individual agency recommendations for improving multi-agency working. This section summarises the overarching lessons that have been learnt from the Serious Case Review.

4.1 The system for accessing specialist health and social services by people with lifelong disabilities and/or vulnerabilities, who do not have clear diagnosis, was inadequate.

4.1.1. The review has identified critical issues about people who are vulnerable and are at various levels of risk, but who don't meet the "eligibility criteria" to access specialist support. Many people, like Gemma, are often described as "borderline" in such cases. Based on IQ levels and to a lesser extent other psychological functioning tests, as an adult, Gemma was not diagnosed as having a learning disability. Valuing People states that "*This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need.*

4.1.2. As the term learning disability is so broad, and encompasses such a diverse range of needs, using diagnosis alone is not an appropriate determinant for accessing services. Valuing People is clear that the term learning disability "*does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation"*. The term *learning difficulty* refers to a problem related to learning, such as dyslexia, and is understood by most people to be something slight, or a set back, that can be overcome. It is very different to a learning disability that is always a recognisable life-long condition with life-long support needs.

4.1.3. The panel found that there was clear evidence that Gemma had a life-long condition that included significant difficulties relating to social functioning and communication, and risks related to her behaviour. Gemma did not have a diagnosed mental illness though she was diagnosed with a recognised mental disorder, that of Conduct Disorder.

4.1.4. Fundamentally, the evidence shows that professionals recognised her life-long difficulties but felt restrained by the systems and protocols around diagnosis to offer her support – so there was confusion about who was ultimately responsible for offering that support. If health and social care agencies are going to put into practice the personalisation agenda, as set out in Putting People First, there needs to be a significant culture change that moves away from determining eligibility based on diagnosis or IQ levels

towards an approach that is based on vulnerability, need and risk and takes into account the whole person.

4.1.5. In cases where people appear to have cross cutting needs and issues relating to a mild or borderline learning disability and what is often described as a behavioural, conduct or personality disorder, there needs to be effective joint working across mental health and learning disability services to identify the appropriate support.

4.2 Risk Assessments were not routinely or systematically undertaken or used to underpin decision-making in relation to undertaking reassessments and the closure of cases. This is especially important when someone is reluctant to engage with services, refuses support or cancels services. Some professional practice was too heavily weighted towards the "right to choose" rather than the duty of care.

4.2.1. The Review identified a number of issues relating to reluctance or failure to engage with services, or noncompliance with follow up actions that have been agreed. This applied to Gemma and to the alleged perpetrators who had also failed to attend therapeutic appointments or take advantage of support to address issues relating to substance abuse. It is a reality that there are people who will always choose to reject support, and in Gemma's case it is clear that she valued her independence, often telling people that she was an adult with the right to do what she wanted. Furthermore, though someone may have a diagnosis of a mental disorder, they cannot be forced to accept treatment without a Treatment Order.

4.2.2. Working with people who are difficult to engage requires skill and expertise, and this requires cases to be allocated to staff who possess the appropriate skills and experience. Sometimes it does involve people having to face the consequences of their decisions (such as understanding that not paying your rent leads to court action and losing your home) but this needs to be done as part of a planned approach and in a structured way that ensures that the support mechanism is ready to be activated once the person re-engages.

4.2.3. It has to be recognised that the willingness to accept help often fluctuates. Gemma always came back to ask for help, and always when she perceived herself to be in crisis, and yet her reputation as someone who "failed to engage or co-operate" was constantly used as a reason to reject re-referrals or to refuse to reassess her changed circumstances and current level of vulnerability.

4.2.4. Whilst recognising the realities that some people will always exert their right to refuse support, it is important that the risks are fully understood and documented – and this requires ensuring that all information is gathered to ensure that an appropriate decision is made. It is essential that the "right to choose" to disengage is not used as an excuse to ignore the duty of care. Gemma's choice to disengage with services increased her vulnerability. She became more and more in debt and at risk of losing her home, but she also

became more and more isolated and dependent on a community of perceived friends and acquaintances who were living chaotic lifestyles and were frequently both the victims and perpetrators of crime. Though there was no evidence of Gemma's relationship with the alleged perpetrators, there was evidence of her vulnerability to exploitation or financial abuse by the people around her.

4.2.5. The new social care model of personalisation, based on self-directed support, provides opportunities for people to decide what support they need and how they want to be supported. However, it needs to be recognised that some people, like Gemma, are unaware of the risks presented by their lifestyle and repeatedly make decisions that place themselves at risk of harm. It is essential that the procedures for accessing community care assessments and services via self-directed care are based on robust risk assessments and do not further dilute the duty of care. This is not to suggest that services should become risk averse and ignore choice and self-direction, but that a balanced approach is taken based on positive risk taking that is underpinned by appropriate safeguards.

4.3 Mental Capacity Assessments were not completed. Decisions were made on an assumption of capacity that was not tested out through a professional assessment.

4.3.1. There are numerous occasions when professionals stated that Gemma had the capacity to make her own decisions and choices. This was applied to her difficulties in managing her money, her personal hygiene, her living conditions, her ability to consent to a sexual relationship and her lifestyle. On none of these occasions was it recorded that a Mental Capacity Assessment had been completed.

4.3.2. Principle 1 of the Mental Capacity Act (2005) starts with a presumption of capacity – "*every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability".* One of the factors in assessing whether someone can make a decision is whether they can weigh up information about the decision and understand the consequences. If someone "repeatedly makes decisions that put them at risk or result in harm to them or someone else" this could indicate that they do not understand the risk or are unable to weigh up the information about a decision.

4.3.3. However, a person should not be treated as unable to make a decision just because they make an "unwise decision". This is covered in Principle 3 of the Act that states "*people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people."*

4.3.4. A pattern of behaviour that puts a person at risk – such as losing their accommodation – indicates a need to question their capacity and to consider requesting a mental capacity assessment. Rugby Borough Council housing service and the Police did request an opinion about capacity early on in their contacts with Gemma (this pre-dated the Mental Capacity Act and the opinion of a Consultant Psychiatrist was sought). However, on the other occasions when professionals stated that Gemma had capacity, no consideration was given to the repetitive pattern of behaviour, and no Mental Capacity Assessment was completed.

4.3.5. It is highly likely that a Mental Capacity Assessment would have found that Gemma did have the mental capacity to make decisions and manage these elements of her life, but this was never properly tested. Her history of failing to manage her money and suspicions of financial extortion certainly suggest that her inability to manage her money may have been deeper than her own statement that she "just spent her money on rubbish". Completing a Mental Capacity assessment would not necessarily have resulted in a decision that she lacked capacity but it would have brought the agencies together and enabled a proper assessment of her level of functioning and identification of the risks to which she was being exposed, especially as her Community Care Assessment in 2004 identified her as meeting the High (Critical) needs because of some of these issues, that had now become part of the pattern of her life.

4.4 The Adult Safeguarding process and the threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where the evidence is through a larger number of low level triggers.

4.4.1. The review raises issues regarding the threshold for adult safeguarding and the trigger processes used. The Chronology identified a significant number of incidents that taken on their own indicated a risk of "harm" but didn't meet the threshold of "significant harm". In some cases several incidents considered together by a single agency would also have been insufficient to indicate a risk of significant harm. (To note that the Law Commission report on Social Care does recommend lowering the adult safeguarding threshold to "harm"). The current system does not easily identify people in the community who may be at risk when there are a lot of low level triggers rather than one bigger incident.

4.4.2. In Gemma's case, no single agency had the full picture of what was happening in her life and the current safeguarding processes do not provide a means of identifying cases with many low level triggers, or of pulling all of the intelligence together to provide an accurate assessment of risk to harm. To address this, it would be worth exploring a new approach, for example through the use of Multi Agency Integrated Safeguarding Hubs.

4.4.3. A further issue identified was the fact that some detailed information about Gemma's day to day life was held by front line support staff, who rarely have

the opportunity to share that information. Current systems are often targeted at public sector procedures when in fact direct support staff from smaller voluntary organisations are often the ones who will pick up the low level triggers.

4.5 There was no prevention strategy that gives people who are living in the community, and may be vulnerable to mate crime, the skills to keep themselves safe

4.5.1. Gemma was involved with a group of young people who were often the perpetrators of crimes against each other, with these behaviours being normalised and therefore an expected part of their lives. For people who are vulnerable (in the No Secrets definition) this is a real risk, as they will be less able to protect themselves and will be seen by their contemporaries as an easy target. People with lifelong disabilities and vulnerabilities, like everyone else, want friends and a social life, but may be unable to judge when the motivation of a perceived friendship is based on a desire to exploit.

4.5.2. There needs to be increased awareness of “mate crime” and consideration of how to reach people who may be in Gemma’s position. It was noted that often police recorded “advice given” and Rugby Borough Council also advised Gemma to “keep away from people” but there is no formal multi-agency approach to giving people the skills to “keep safe”.

4.6 There was no systematic approach by agencies to give or request feedback following referrals or contacts to report concerns.

4.6.1. A key theme across agencies was the regularity with which concerns were reported back to agencies – for example, the police actions almost always included notification of Adult Social Care or mental health services, and Rugby Borough Council frequently made contact with those services. However, there were no systems in place to follow up such contacts and seek feedback on actions taken.

4.6.2. The responsibility for feedback does not just lie with the referring agency, but highlights a lack of procedural process to ensure that referrers are given information on what action has been taken. In some cases assumptions were made that follow up actions would be taken – for example the correspondence between the Adult Psychiatrist and the GP when the GP assumed that the Mental Health team would take action based on being copied into the letter, rather than making a direct approach to the team to request this.

4.7 There was a lack of oversight or clear co-ordination between housing support services and other adult social care services.

4.7.1. Central to Gemma's adult life were decisions about her access to housing and housing related support. The link between Supporting People funded floating support services and Adult Social Care is unclear. Whilst recognising that some people only need a low level preventative service of this nature, it is unclear how additional support can be accessed when there are clear indicators that someone like Gemma needs a higher level of support. This raises issues about how housing support is managed and the level of oversight. The evidence shows that the housing support provider was arranged by Rugby Borough Council, and though the front line support workers probably knew Gemma better than anyone else, there is no evidence of other health and social care agencies seeing them as playing a key role (other than some apparently ad hoc joint visits with a CPN).

4.7.2. The principles set out in Valuing People about people with learning disabilities having the right to access an ordinary life and having the same right as anyone else to access mainstream social housing should not be a barrier to receiving the sort of structured support identified in the OT assessment. It was only when Gemma was faced with her final eviction that consideration was given to her needing a higher level of support than could be offered by a floating support service, and the records imply that this could only be achieved by Gemma being referred to a building based supported living service. People with support needs should not have to move house or move into shared accommodation to access the level of support needed in their own home.

4.7.3. It is also important that people who are vulnerable are not allocated tenancies in areas, or properties, where it could be reasonably predicted that they may be subject to targeted anti-social behaviour or abuse. It is essential that a range of accommodation and support options are available that provide greater flexibility and choice – for example, Shared Lives Schemes and Key Ring type schemes. Supporting People services that are available in Warwickshire tend to be very specific, with little flexibility to offer a more bespoke service.

4.8 Panel Recommendations

4.8.1 Specific Actions

Warwickshire Safeguarding Adults Board

1. That the Warwickshire Safeguarding Adults Board develops procedures and/or issues guidance to:

a) ensure that multiple low level concerns/referrals are escalated. This should enable agencies to identify, monitor and report multiple low level concerns over a period of time, and to request escalation to a multi-agency meeting.

b) put in place a mechanism for ensuring that the guidance on the feedback process is implemented when safeguarding referrals are received.

c) remind all agencies of their responsibilities to protect and safeguard vulnerable adults, that this is based on concerns that a person may be at risk of being abused rather than the need to demonstrably prove that abuse has already happened, and reviews the operational procedures to ensure that this is adequately reflected.

d) ensure that when multi-agency meetings are arranged to discuss a particular individual, it is important that housing managers and housing support staff are included. On many occasions housing support providers are missed out or their views are not taken as seriously, yet they more often than not spend the most time in someone's property and will have detailed information that may not seem significant in isolation.

2. That the Warwickshire Safeguarding Adults Board works with the relevant partners to develop a strategy on mate crime as part of a wider Prevention Strategy. This must include an awareness raising exercise to raise awareness of mate crime across all agencies and the development of advice for people who are vulnerable on how to "keep safe".

3. The Board should review the multi-agency training plan to ensure that staff working in housing, and other District and Borough council services, receive mandatory safeguarding awareness training and are aware of the procedures.

4. The Board should review housing representation and, jointly with housing services, put in place an action plan to identify how the arrangements can be improved. There is a need to involve housing services, districts and boroughs

(county-wide) in a review of inter-agency safeguarding vulnerable adults procedures and that this should happen as soon as possible.

5. The Board will put in place arrangements to independently review and evidence progress against the recommendations 12 months after publication of the public summary.

Warwickshire County Council Adult Health and Community Services

6. That Warwickshire County Council adult services takes the following action to improve procedures and issue guidance as follows:

a) To set quality standards and issue guidance to improve case recording to ensure that all key decisions and the rationale behind them are recorded and easily identified, ensuring a robust framework is established that ensures a consistent approach to case recording across all services.

b) To ensure that the Adult Social Care screening process is compliant with the duty to assess, and does not focus on eligibility for provision. To develop a policy that ensures people who do not meet the criteria for accessing specialist services (whether learning disability, mental health or other) can easily access a needs and risk assessment at the first point of contact with the department. The policy must be subject to an Equality Impact Assessment to ensure that people with a mild or moderate Learning Disabilities/Learning Difficulties or who do not have a specific diagnosis, are not denied access to an assessment.

c) To review operational procedures for Adult Social Care and implement a process to ensure that agencies making referrals for community care assessments, or to raise concerns about the welfare of people living in the community, are given feedback on the outcome.

d) To issue guidance to all staff to remind them of the statutory duty to make an assessment and that clarifies the role of Fair Access to Care Services (FACS) – i.e. that FACS eligibility is determined as part of a community care assessment to determine council funding, not to determine eligibility for an assessment. The guidance should ensure that all staff check existing FACS eligibility and ensure that this is only changed following a review or reassessment.

e) To issue guidance that sets out the expectations of managers in overseeing and supporting staff with casework and ensure consistent management oversight.

f) To put in place operational procedures that ensure that the personal safety of people receiving self-directed care is effectively monitored

7. To revisit the remit of the Learning Disability Team. There is a need for a clearer definition of customers who are entitled to support and to ensure the team has an appropriate response framework for people with needs that do not meet the definition, to ensure they are enabled to get the service they need from the right place.

8. That Warwickshire County Council puts in place formal links between housing support services (funded by Supported People funding) and community care services and develops procedures and/or protocols that ensure that there is a timely review when additional support needs are identified by the supported housing provider.

9. That Warwickshire County Council ensures that electronic recording systems readily flag the existing or active FACS assessment so that re-referrals and concerns are linked to known levels of risks.

10. That adult services conducts a management review of the learning disability team's professional practice in relation to this case and takes appropriate management action to address shortcomings. This review should be carried by a senior manager not connected to the team, to afford transparency

11. That adult services complete an audit of safeguarding process and practices in the Learning Disability Service to ensure the Team provides a consistent service to all vulnerable customers.

12. That Warwickshire County Council reviews the current Transitions process against the findings of the serious case review to provide assurance that all young people moving from Children's Services receive a Transition Plan.

Warwickshire County Council Adult Health and Community Services, and Coventry & Warwickshire NHS Partnership Trust

13. That Warwickshire County Council and Coventry & Warwickshire NHS Partnership Trust (CWPT) issue guidance to their adult learning disability services that:

a) decisions to accept referrals for assessment are based on risk, vulnerability and need and not on diagnosis/IQ levels alone, and put in place clear protocols for determining diagnosis based on the guidance set out in Valuing People (2001). This must ensure that all adults who clearly have a lifelong condition are recognised as disabled and eligible for assessment for services.

b) risk assessments will be routinely completed when a case is closed for the reason of a failure to co-operate or engage, or repeated failure to keep clinical appointments. This must include the requirement to actively check with other agencies that are known to be in contact with the person

c) that staff undertake Mental Capacity Assessments and ensure that this is recorded.

14. That Warwickshire County Council Adult Services and CWPT adult services put in place written protocols to enable a structured approach for MH and LD services to work jointly in cases where there is a lack of clarity regarding which service should take lead responsibility and where a bespoke commissioned service can by agreed and coordinated.

15. Both agencies should review and appropriately amend operational procedures to ensure that assessments of young people being transferred from Children's Services to Adult Services includes an assessment of their social communication skills and their ability to understand the consequences of behaviour.

Coventry & Warwickshire NHS Partnership Trust

16. That Coventry & Warwickshire NHS Partnership Trust (CWPT) implement their agency action plan to ensure effective case co-ordination, effective clinical supervision and management, and that documentation is kept up to date.

17. That CWPT issue guidance to ensure that all staff follow the multi-disciplinary team approach and case co-ordination procedures when completing assessments.

18. That CWPT approve the draft service specification and operational policy and formally implement it with immediate effect.

Local Medical Council, GP Consortia and Warwickshire Safeguarding Adults Board

19. That there is a discussion between the Local Medical Council, GP Consortia and the Chair of the Warwickshire Safeguarding Adults Board to identify appropriate GP representation on the Warwickshire Safeguarding Adults Board.

20. That the Local Medical Council, GP Consortia and the Warwickshire Safeguarding Adults Board jointly develop a protocol that sets out clear expectations and duties of GPs in adult safeguarding procedures and that this includes clear advice on the involvement of GPs in Serious Case Reviews.

21. That the Local Medical Council and GP Consortia write to all GPs to remind them of the importance of following up recommendations and actions, rather than assuming that other agencies will do so.

22. The process of removing people from GP lists inappropriately when complex issues arise needs to be addressed, as identified in the closure of Chantelle Booth from her G.P.'s caseload at the time she was in custody

Rugby Borough Council Housing Services

23. Rugby Borough Council implement their agency action plan to embed the principles of safeguarding across all front line services, review the way front line services share knowledge of vulnerable adults, signpost or refer vulnerable adults for support, develop procedures for the implementation of the Domestic Abuse Policy, and share the action plan with other districts and boroughs.

Warwickshire Police

24. Warwickshire Police to issue guidance that details of the advice given to people involved in incidents, when there is no substantive offence recorded and no other type of police intervention, should be recorded.

25. Where referrals are made to other agencies, the feedback on the outcome of this referral should be sought so there is a complete picture of the support/work being undertaken with an individual by all agencies.

Warwickshire Probation Trust

26. Warwickshire Probation Trust to further highlight and develop awareness of Safeguarding Vulnerable Adults procedures as part of current risk assessment and risk management processes. This must include ensuring that attention is given to both potential perpetrators and victims, as well as those already known to the Trust.

4.8.2 Broader Issues that need to be explored

1. That Warwickshire Safeguarding Adults Board explore the feasibility of setting up a Multi-Agency Safeguarding Hub (MASH). This is a model that can be used to gather intelligence that may act as an alert that someone living in the community is vulnerable and is especially useful in pulling together a pattern of individual events that on their own may not appear significant. This should include a proactive trigger plan system that flags address and regular callers/users to the various services/agencies so a multi-agency approach could be put into place far earlier. This would enable improved communication networks to be put into place between the various agencies to allow for easier information sharing.

2. That Warwickshire Adult Social Care commissioners explore the development of alternative housing options for people who need greater levels of support, such as a Shared Lives Scheme and Key Ring type schemes.

3. There needs to be multi agency exploration of strategies that can be employed to encourage active compliance/engagement with therapeutic interventions offered across the multi agencies and to develop better understanding and expertise in working with people who are hard to engage.

4. When young people receive residential further education out of the Council area, it is important to ensure that such decisions are well thought through and take into account longer term plans to return to the area so as to ensure the maintenance of strong social networks. This should include risk assessments around proposed placements and advice for young people on keeping safe.

5. There is a need to consider a mechanism for early intervention similar to the Common Assessment Framework (CAF) as used for children. The adults CAF is not as comprehensive as children's but could be a useful link to preventing people falling through the net. This could have been used at the time a POVA was considered for Gemma. This was also suggested by housing in respect of Daniel Newstead but did not go ahead as he had entered the criminal justice system.

6. Warwickshire consists of five districts with five different District and Borough councils providing housing. Joint working between housing services and

Warwickshire County Council Adult Social Care needs to be strengthened to identify:

a. How information about the needs of vulnerable tenants/potential tenants (as in the No Secrets definition) can be better shared between agencies.

b. How housing providers can be better involved in the assessment and risk assessment process.

c. Ensuring that Support Plans are clear about the support people will receive to manage their tenancy

d. A clear escalation policy for reporting concerns about tenants who are vulnerable and appear to be at risk.

4.8.3 National Issues

4.8.3.1. This case raises a wider issue about community safety, and the accessibility of social housing for single adults who may be vulnerable to harassment, mate crime or exploitation. The chronology demonstrates that Gemma's circumstances deteriorated significantly following her being re-housed after becoming homeless. It was during this tenancy that contacts with the police increased significantly and that there were increasing concerns about her vulnerability to exploitation and "mate crime". This is no criticism of Rugby Borough Council Housing Services who gave Gemma high priority for social housing on the basis of her needs and who made many attempts to refer her for a community care assessment. The case does highlight however a national issue regarding the shortage of suitable social housing that is available as general needs housing. People who are vulnerable (in terms of the No Secrets definition) have the same rights as everyone else to access general housing options that are available from the public sector and registered housing providers. Social Housing is let through choice-based lettings schemes where people 'bid' for advertised properties (often on-line), where high priority banding is determined by medical or welfare needs. The 'homelessness route' as covered by housing law (the Housing Act 1996 Part VII as amended by the Homelessness Act 2002), is essentially a fast-track route for those who are on the extreme end of the housing needs spectrum: the homeless or about-to-be-homeless. Case law provides that the test for vulnerability is whether a person, if street homeless, would, due to that special reason, be less able to fend for him or herself than another homeless person, so that injury or detriment would result (known as the Pereira test).

4.8.3.2. Whilst it is important that each case is treated individually and the priority determined under both homelessness and allocations and it is essential that all agencies involved with vulnerable people work together to keep partners informed and assist at an earlier stage the reality is that in Rugby, as in many parts of the UK, the housing options for single people are primarily in multi-

storey blocks and other blocks of flats, sometimes designated as “hard to let”, and inevitably place people in neighbourhoods where the risks of mate crime, hate crime, harassment and exploitation are higher. Though the OT assessment completed whilst her private tenancy was breaking down was not shared with housing providers, there appear to be few alternative housing options available.

4.8.3.3. As stated by the Department for Communities and Local Government[9] “*A home should help people be independent and give them the security to be active members of their communities*”. This goes much further than housing stock and allocations policies – a home will only be a safe haven if the neighbourhood and community is also a safe place to live. Despite national policy initiatives to combat anti-social behaviour, hate crime and to create safer communities, this case, like many before it, highlights the challenges facing local agencies Finally, this case raises wider issues about community safety for single adults who may be vulnerable to disability based harassment, hate or mate crime and exploitation. This case sets out evidence of the sub-culture that continues to prevail within some groups of people where drug and alcohol abuse is endemic, there is a lack of respect for others, and where violence and mate crime is normalised.

[9] www.communities.gov.uk/housing

5. NEXT STEPS IN THE SERIOUS CASE REVIEW PROCESS

5.1. Completion of this review will be evidenced by the Independent Chair signing the overview report, together with the summary report. Both were presented to the Serious Case Review Sub-Group of the Warwickshire Safeguarding Adults Board on 30th September 2011. It's role was to:

- ensure contributing agencies are satisfied their information is fully and fairly represented in this report,
- ensure that a draft public summary report has been prepared for the consideration of the multi-agency adult safeguarding board,
- translate recommendations from the report into the action plan for endorsement at a senior level within each agency,
- ensure the public summary report, recommendation and action plans are sent to individual agencies and sub groups of the partnership for action,
- ensure that the Care Quality Commission receive a copy of the final report and actions.

5.2. There was a formal presentation of the report to the Warwickshire Safeguarding Adults Partnership Board on 19th October 2011 for approval, sign off and action to take forward its learning points and recommendations. The resulting action plan will remain on the Board agenda until it is confirmed all the actions within it are completed. The Board considered and approved the Public Summary report for publication.

5.3. The Chair of the Board will ensure the Statutory Director of Adult Social Services is informed on progression and outcomes of this review.

5.4. Additionally, there may be potential learning points about the serious case review process itself. These are matters for the Partnership Board and its Serious Case Review Sub-Group to consider as part of the normal process of learning and review around local policy and practice that should occur following each review.

5.5. The Family were given a copy of the "draft public summary for consideration" and offered the opportunity to discuss the findings and raise any questions with the chair of the panel. The family chose to discuss the report with the Adult Protection Coordinator and submitted their written views to the SCR sub group. The family will be given a copy of the final Public Summary report. The family will also be included in the 12 month review, although this is not at present a formal requirement of the multi-agency policy.

Signed by,

Kathy McAteer
Independent Chair, Adult Safeguarding Serious Case Review Panel

[Signed copy held by Warwickshire County Council]

Appendix

Sources and References

Warwickshire County Council: Warwickshire Safeguarding Adults Serious Case Review Policy and Procedure, [Inter- Agency], , November 2009.

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Item 10

Item No 10

Adult Social Care and Health Overview and Scrutiny Committee

7 December 2011

Work Programme Report of the Chair

Recommendation

The Committee is recommended to agree the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year

1. Work Programme

The Committee's Work Programme is attached as Appendix A. The Work Programme will be reviewed and reprioritised throughout the year so that the Committee can adopt a flexible approach and respond to issues as they emerge.

2. Task and Finish Groups

The Committee may wish to consider any potential future Task and Finish Groups.

Background Papers

None.

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Appendix A

DRAFT Work Programme for Adult Social Care and Health Overview and Scrutiny Committee 2011/2012

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes
COMMITTEE										
7 Dec 2011 (on the rise of the scheduled meeting)	Workshop on Commissioning – Wendy Fabbro/Claire Saul	- Commissioning Intention document - Directorate use of evidence and commissioning arrangements (to review commissioning arrangements in the Adult, Health and Community Services Directorate (how evidence is used to guide commissioning practices) - ASCH progress towards corporate objective of being a strategic commissioning organisation (To assess use of evidence in commissioning practice - To assess the appropriateness and robustness of Needs Assessments in relation to a specific Corporate Strategies, for example the Dementia Strategy and Learning Disability Strategy. - Briefing on key themes in the draft JSNA								
16 Dec 2011 – 2pm	Special Meeting to consider closure of Birch Ward, Rugby St Cross	The committee will hold a special meeting to consider the processes undertaken by the UHCW in the decision to close Birch Ward, Rugby St Cross. This will include presentations from the Chief Executive of UHCW and Jenny Wood (WCC), who will make a verbal presentation on our strategic and operational position			✓		✓			
15 Feb 2012 (all day mtg)	Update from Chief Executive, George Eliot Hospital	Kevin McGee will give the committee on update on developments at George Eliot Hospital			✓		✓			

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes
	Coventry and Warwickshire Foundation Trust – Elaine Rackham	Presentation to the Committee on CWPTs application for foundation status. (The consultation is available on the CWPT website now)			✓		✓			
	West Midlands Ambulance Service -Anthony Marsh, WMAS	Update on re-modernisation programme (reported to the Committee on 12 October 2010), the Regional Make Ready System and the NHS Pathways and CMS DOS			✓		✓			
	Improving Trauma Care in the West Midlands -Sue Roberts, Arden NHS Cluster	Update report on the implementation – requested by the Committee on 25 October 2011			✓		✓			
	Review waiting times for CAMHS – Jo Dillon and Loraine Roberts	To review waiting times for Child and Adolescent Mental Health Services.			✓		✓			
	Warwickshire LINk – Nick Gower-Johnson	Update report			✓		✓			
	AHCS Staffing and Staffing reductions – Wendy Fabbro	To consider AHCS Directorate Staffing and Staffing reductions (further progress from Sept Committee)	✓		✓					
	Dementia Strategy and Mental Health Strategy – Chris Lewington *	Update on the Dementia Strategy Update on the Mental Health Strategy, including concerns raised on Anti-Social Behaviour and Mental Health	✓		✓		✓			
	Older Adult Mental Health Services – Task and Finish Group – Cllr Jerry Roodhouse/Dave Abbott*	Update report from the TFG responding to the consultation on Older Adult Mental Health Services			✓		✓			
	Physical Disability and Sensory Impairment (PDSI) Strategy – Wendy Fabbro/William Campbell	To consider the PDSI Strategy			✓		✓			

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes
	Charging – Annual Review – Ron Williamson	To give Members an annual update in relation to Charging	✓		✓		✓			
11 April 2012	Virtual Wards	To consider progress made in implementing virtual wards and outcomes achieved			✓		✓			
	The Concordat - Update Wendy Fabbro & Rachel Pearce	To review partnership working between WCC and Arden Cluster			✓		✓			
	Joint Strategic Needs Assessment – Wendy Fabbro and John Linnane	To consider the Joint Strategic Needs Assessment		✓	✓		✓			
	Personalisation, Jenny Wood	To consider progress made in the implementing the personalisation agenda			✓		✓			
	Effectiveness of The Learning Disability Strategy - *A Good Life for Everyone 2011-2014* – Chris Lewington	To consider the effectiveness of the Learning Disability Strategy in relation to Residential Accommodation.			✓	✓				
	Proposed Changes to Community Meals Service	The Committee requested a further update on developments at their meeting on 07-09-11	✓		✓		✓			
20 June 2012	South Warwickshire Community Response Team	Update report 6 months after implementation. Requested by the Committee at their meeting on 25 October 2011 (Proposal for South Warwickshire Community Emergency Team)			✓		✓			
	Care and Choice Accommodation Programme – Ron Williamson	The Committee requested a further report based on 2.4 of the 7 September 2011 report	✓		✓		✓			
5 Sept 2012	Crisis House Provision - Nigel Barton, CWPT	An update report (requested by the Committee on 07-09-11), including occupancy rates, access and an update on the outcomes of service reforms.			✓		✓			

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes
24 Oct 2012	Fairer Charges and Contributions – Impact of Changes – Ron Williamson	Annual monitoring report on charging. Requested by the Committee on 25 October 2011	✓		✓		✓			
6 March 2013	Improving Trauma Care in the West Midlands - Sue Roberts, Arden NHS Cluster	Update report on the implementation – requested by the Committee on 25 October 2011			✓		✓			

SUBJECT OF BRIEFING NOTE	OBJECTIVE OF BRIEFING NOTE	COMMENT / FURTHER INFORMATION
Current waiting lists for Disabled Facilities Grant – Wendy Fabbro	To assess waiting lists for Disabled Facilities Grant with particular focus on joint working by / between Borough & District authorities.	*Briefing Note requested from Wendy Fabbro on 11/10/11*
Access to WCC properties for people with disabilities – Steve Smith	To assess the suitability of access to WCC properties for people with disabilities, referencing the Corporate Asset Management plan and wider property rationalisation	*Briefing Note requested on 11/10/11*
Coordination between Air Ambulance and Charities – Sue Roberts	To brief the Committee on the relationship between Air Ambulances and Charities. Requested by the Committee on 25 October 2011	*Briefing Note requested on 03/11/11*
Closure of Helen Lay – Ron Williamson	To brief the Committee on the support being provided for the remaining 10 residents at Helen Lay following the closure of the centre on 31 January 2011. Requested by the Committee on 25 October 2011	*Briefing Note requested on 03/11/11*

Fairer Charges and Contributions – Ron Williamson	To brief the Committee on take up of respite care and any changes to demand resulting from increased charges. Requested by the Committee on 25 October 2011	*Briefing Note requested on 03/11/11*
Quality and Standards in Personalisation – Wendy Fabbro	To review mechanisms and processes in place to ensure quality and standards in services provided through Personalised Budgets	*Briefing Note requested on 03/11/11*
Post Event Analysis on Winter Pressures – Jane Ives	Post Event Analysis on Winter Pressures	*Briefing Note to be requested in late spring*
Local Accounts – Wendy Fabbro	As part of the commitment to reduce the burden of national bureaucracy the regulatory framework for adult social care previously administered through the Care Quality Commission was brought to an end in 2010. The Department of Health (DH) have now released the new framework for local assessment "Transparency in Outcomes" which sets a range of performance measures against which activity will be measured. As part of this framework the DH reiterated its commitment to the use of sector led improvement and within this the need for all local authorities with adult social care responsibilities to produce "local accounts" which provide the communities that they serve with an assessment of service quality and performance improvement. This briefing note will address the approach Warwickshire has taken in producing the Local Account, with the intention of deciding an appropriate time to formally report to the Committee	*Briefing Note requested 24/11/11*
Care and Choice Accommodation Programme – Ron Williamson	The Directorate have been asked to provide a briefing note in April updating the Committee on the process in April, in preparation for the report to the Committee on 20 June (requested a further report based on 2.4 of the 7 September 2011 report)	*Briefing Note to be requested for April 2012*
Community Choices Framework for Older People – Andy Sharp	The Directorate has been asked to provide a briefing note setting out Day Opportunity Proposals	*Briefing Note expected in early December 2011*

ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	MEMBERS / COMMENT
Paediatric and Maternity Services Cllrs Peter Balaam (Chair), Carolyn Robbins, Barry Longden, Sonja Wilson, Lesley Hill (LINks)	A public consultation is scheduled to begin on 5 December, seeking views on proposed future model(s) of service delivery. The role of the T&F Group is not only to formulate a response to the consultation, but also to scrutinise the pre-consultation phase - looking at the process by which the Cluster has established its proposals and determining whether appropriate engagement with stakeholders and service users has taken place.	Expected to report to the Committee in February 2012	
Older Adult Dementia Review (formerly the Older Adult Mental Health Services) Cllrs Jerry Roodhouse (Chair), Peter Fowler, Sid Tooth	To review the CWPT consultation process regarding older adult mental health services	Expected to report to the Committee in April 2012	