Aberdeenshire Adult Protection Committee
Significant Case Review – Mrs B

Adult's Name:	**Mrs B**
Date of Birth:	**Age at death 65**
Gender:	**Female**

Introduction

In July 2019 a referral was made by Police Scotland under the Grampian Adult Protection Committee's Serious Case Review and Case Review Protocol.

The referral was made following the death of Mrs B, a 65-year-old female who resided alone in a council property. Mrs B had involvement with a number of adult protection partnership agencies including Social Work, Health and Police in the month prior to her death on 27 June 2019.

An initial case review (ICR) was undertaken to consider information from the agencies involved. A meeting of the Aberdeenshire Operational Practice Group in September 2019 determined that the case met criteria for further review based on the following points and recommended to the Aberdeenshire Adult Protection Committee that an internal Significant Case Review (SCR) be commissioned:

- Although not assessed at the time of input as an adult at risk of harm, based on the information reviewed it was believed that Mrs B would have been an adult at risk of harm
- Although the cause of death is unascertained the group felt that on the balance of probability self-neglect was likely to have been a significant factor in Mrs B's death
- The group believe the circumstances of the case would give potential for significant multi-agency learning
- The case is complex, with the involvement of several agencies

- Local recommendations are likely to be interagency rather than for a single agency

The Aberdeenshire Adult Protection Committee met on 6 November 2019 and agreed that further investigation was required to understand the root causes of where action was not taken or could not be taken to protect Mrs B. The Committee approved the recommendation for an SCR.

The purpose of the SCR was to establish whether there were corporate lessons to be learned about how better to protect adults. To that end, the review would be a process for learning and improving services and a means of recognising good practice.

The review would assess the agency and inter-agency decision making and involvement with the adult and others relevant to the case during the period 01/09/2017 – 27/06/2019.

Specific issues were identified to be considered:

- Support available to Mrs B following the death of her husband and the impact this death had on her ability to protect herself
- Barriers professionals encountered in recognising/sharing concerns as adult protection
- Assessment of current processes regarding police Vulnerable Person Database (VPD) reports, how these are shared with services and how they are responded to
- Perception and culture around difference between ASP and Care Management (CM) responses to concern and assessment of all partners recognising the differences.

The SCR Team was led by a Health and Social Care Location Manager with members from each of the relevant agencies: Care Management, Police Scotland, General Practice, District Nursing, Scottish Ambulance Service, Housing and the Adult Protection Network (APN).

The review team used the following methodology:

- Review the Terms of Reference
- Review agency notes
- Create timeline and identify areas for further investigation
- Interviews with professionals
- Audit the VPD reports by both Police Scotland and the Adult Protection Network
- Hold a workshop to develop conclusions

Mrs B had no contact with her family for a number of years. Inquiries were made to identify her next of kin to discuss their involvement in the review but it was established that her only relative passed away shortly after Mrs B.

The SCR Team was due to begin the review process in April 2020 but it was agreed with the APC to postpone due to the developing Covid-19 pandemic. The review began in July 2020 but due to ongoing operational priorities relating to the pandemic, it has taken some months to complete.

The facts

The events in this case took place over a relatively short timeframe. From the information gathered as part of this review, Mrs B had limited engagement with services. There were no family members to advocate for her although neighbours provided a lot of informal support in the weeks before her death.

Mrs B's husband passed away in **September 2017**.

Mrs B was registered at a medical practice but not well known by them: records show that she declined routine review appointments such as screening and diabetes reviews. Between 2017 and May 2019, Mrs B made contact with the practice by telephone on two occasions: in **October 2017** for diarrhoea and vomiting and **March 2019** for a 3 day history of coughing and vomiting.

2018:

Mrs B made contact with Housing and Police Scotland around **January 2018** with concerns about her personal safety at home. A window at her home was damaged

and Mrs B wished the height of her rear wall to be raised to prevent school children throwing items into her garden. It was agreed with Housing that the local voluntary organisation would arrange for her wall to be raised and Mrs B was encouraged to contact her GP to discuss any anxieties or bereavement issues affecting her.

Mrs B had a relationship with the local voluntary organisation through her husband's employment and the couple benefitted from grants twice a year. This ceased when he passed away but the Superintendent continued to support Mrs B informally. Mrs B regularly asked the Mission for assistance with household tasks in the months following her husband's death.

Mrs B telephoned the Aberdeenshire Council contact centre in **June 2018** to report drug dealing in her area and concern for her personal safety. Mrs B spoke to a Care Manager and was advised to report criminal activity to the Police and encouraged to seek support from her GP about her bereavement and the anxiety she felt about living alone.

May 2019:

On **24 May**, Scottish Ambulance Service (SAS) responded to a call from a supermarket following Mrs B having experienced a faint-like episode. On arrival, Mrs B was fully alert and responsive, stating she had not eaten that day. Mrs B refused admission to hospital: she was given fluids and taken home by the paramedics. Paramedics noted the house to be unkempt but not unduly so and had no safety concerns about leaving her alone. They did however, become concerned when Mrs B mentioned she was being pestered by a neighbour. The neighbour had asked to borrow money and jewellery and if Mrs B would go with her to a pub. The neighbour is known to paramedics and they were concerned they could be taking advantage of Mrs B and intimidating her.

Upon leaving Mrs B, paramedics visited the local Social Work office. They spoke to a Care Manager who advised the paramedic to make a direct referral into the Adult Protection Network (APN) to report their concern. No referral was subsequently made to the APN.

There was telephone contact between Mrs B & a GP on **30 May** where she reported that she felt fine since the incident at Morrison's and agreed to visit the practice for a review appointment when she could arrange transport.

June 2019:

Mrs B contacted Police Scotland on **2 June** to inform them of a fall from a taxi sometime during May and report the driver's 'bad attitude' toward her. Police attended Mrs B's home and became concerned about her living conditions.

Paramedics were called to attend Mrs B with reference to the fall. On arrival there was no answer at the door and no one could be seen inside the property.

Police Officers submitted a VPD report to Social Work and the health Single Point of Contact (SPOC), received on **13 June**, noting that Mrs B was not an adult at risk of harm.

Mrs B telephoned the medical practice on **4 June** to request a home visit with reference to the fall from a taxi; she then called back to cancel it. A GP telephoned Mrs B to query the cancellation and she reported that she did not need it and was walking normally. The GP agreed to cancel the visit and advised Mrs B to make an appointment at the practice if required.

Mrs B made several calls to Police Scotland on **5 June**. Upon arrival, Mrs B told Officers there was no real concern but she was lonely. Officers spoke to neighbours who said they supported Mrs B and had noted her health was deteriorating. Mrs B declined any medical assistance. Police submitted a further VPD report to Social Work received on **11 June**, noting that Mrs B was not an adult at risk of harm.

On **11 June** the VPD report relating to the Police visit on **5 June** was received by Social Work. As per the policy, the report was reviewed by an Adult Protection Network senior practitioner as Mrs B was not open to a Social Work team. The decision was taken that Mrs B did not appear to meet criteria for Adult Support and Protection but should be considered for Care Management assessment.

On the same day, Mrs B contacted Aberdeenshire Responders for Care at Home (ARCH) to make a care referral. Mrs B disclosed she had not eaten for 2 days so

Responders visited her at home, assisted her to change clothes and prepared a meal and a drink for her. Responders observed the house to be in disarray with mould growing in saucepans, clutter restricting movement around the house and soiled underwear left out. Responders fed back to their supervisor who completed a referral to the APN.

Care Management received reports from Police Scotland and ARCH on **11 June** and allocated Mrs B to a Care Manager who arranged to visit on **18 June**.

On **13 June**, Mrs B telephoned Police Scotland 3 times between 1615 and 1700 reporting she was starving. Officers attended and found Mrs B to be weak and confused. Out of Hours Social Work were contacted and it was arranged for Responders to attend. When they arrived, Responders found Mrs B eating a meal from a chip shop, having arranged a takeaway delivery, but they observed the house to be in the same, untidy condition.
Police submitted a further VPD report to Social Work and the health SPOC which was received **14 June**, noting that Mrs B was not an adult at risk of harm.
In light of this new information, Care Management arranged to bring forward their visit to **17 June**.

Care Management visited Mrs B at home on **17 June**. Observations were that the house was cluttered and unhygienic with a strong odour emanating from it. Mrs B advised she had help with shopping from neighbours and managed meal preparation: the Care Manager found food in the fridge plus prepared sandwiches and chocolate bars. Mrs B said she would like help from Care Management to clean and tidy the house.

Mrs B was discussed at the Virtual Community Ward on **18 June** and a request made for Community Nurses to visit Mrs B to undertake a continence assessment.

On **19 June**, Mrs B's neighbours cleaned her house. A manager for Mental Health heard about Mrs B from one of their service users and queried if she should be assessed for detention under Section 35 of the Mental Health Act. The Care Management Team Manager felt that was not appropriate at this stage.

Care Management made a second visit to Mrs B on **21 June**. They felt Mrs B's condition had deteriorated since their first visit: she was in bed and quite confused. There was little evidence of meals having been made or eaten in the intervening period. The house was tidier but her medication untouched. The Care Manager felt that Mrs B's deterioration could be due to an illness or infection and spoke to a Community Nurse following the visit. The nurses had not seen Mrs B and so a home visit from a GP was requested.

A GP visited Mrs B at home the same day: they noted that she was coherent and orientated to time, place and person. The GP felt there was a high probability of a significant underlying problem and explained this to her: including the severity of her condition and potential impact on her health of refusing admission to hospital. Mrs B refused but did agree to a Community Nurse visiting to take blood. The GP had no doubts about Mrs B's ability to make an informed decision about her medical treatment.

Police Scotland also attended Mrs B's home on **21 June**. Mrs B contacted them at 1652 to report her husband missing. Neighbours were in attendance when Officers arrived and stated concern about Mrs B not eating, drinking or taking her prescribed medication.

Police submitted a VPD report to Social Work and the health SPOC, noting that Mrs B was not an adult at risk of harm.

Police Scotland were contacted on **24 June** by a friend of Mrs B's who had not seen her for a while. Upon arrival, Mrs B was unable to rise from her chair to unlock the door so Officers arranged for her locks to be forced. Officers observed that Mrs B was very frail. The Care Management team were contacted and a member of staff attended and was given a spare key.

Police submitted a further VPD report to Social Work and the health SPOC, noting that Mrs B was not an adult at risk of harm.

Care Management contacted the medical practice to inform them of Mrs B's presenting condition and highlight concerns. The practice decided not to make a home visit that day and discuss Mrs B at the virtual community ward the following day.

Mrs B telephoned Police again at 1800 on **24 June** asking for help to remove her husband from the property. Upon arrival, they found Mrs B lying on the bedroom floor, very confused. Officers helped Mrs B into bed and contacted Out of Hours Social Work who relayed the recent Care Management notes including the decision by the medical practice not to make a home visit. Officers were advised to telephone NHS 24 if they felt medical assistance was required immediately.

SAS were contacted by Police and attended, helping Mrs B into clean clothes. Mrs B again refused admission to hospital.

Police submitted a further VPD report to Social Work and the health SPOC, noting that Mrs B was not an adult at risk of harm.

On **25 June**, a District Nurse visited Mrs B at home and found her slumped in a chair, very confused. Mrs B consented to admission to hospital which was arranged by a GP the same day.

Mrs B died in hospital on **27 June 2019**.

Analysis

Information gathered from the local voluntary organisation suggest Mrs B was a proud and independent woman who neither sought help or readily accepted it. They advised that Mrs B had always had a reluctance to engage with people and organisations and it was difficult for people to reach her. Mrs B had been estranged from her family and had a history of conflict with neighbours. Mrs B became more isolated after her husband died and found it hard to adjust to living alone. Her requests to the Mission for help related to practical household matters that would traditionally be considered male activities e.g. mending a vacuum cleaner or

changing a fuse. This implies that Mrs B struggled to take responsibility for these chores and that it was more acceptable to her to ask for this type of support than for help to manage feelings of loneliness and bereavement.

The contacts made to Housing, Social Work and Police Scotland in 2018 indicate a lack of confidence about living alone. Mrs B was encouraged to seek support from her GP but there is no indication that she attempted to do this.

The local voluntary organisation kept in touch with Mrs B but contacts became less regular as she was no longer a beneficiary of the organisation.

The incident at Morrison's was the first significant contact with Mrs B and the Paramedic spent some time encouraging her to go to hospital for assessment. The incident was comprehensively documented including that Mrs B was fully alert, responsive and appropriate, could retain and repeat information and understood the implications of not going to hospital. The Paramedic had no health or safety concerns about Mrs B in respect of her faint-like episode but he was concerned when Mrs B told him about a neighbour pestering her: SAS have knowledge of the neighbour as they frequently attend calls from them. Paramedics felt that Mrs B might be intimidated by the neighbour and someone should be notified. Their decision was to visit the Social Work office, in part because Paramedics do not have admin time to complete referrals so it would have to be done at the end of a shift, but also because they believed it would be more effective to speak to someone as opposed to submitting a form to a generic account: they had a distrust in that impersonal process.

On the face of it, this position does not sound unreasonable but demonstrates a lack of knowledge about the both the referral process and difference between Adult Protection and Care Management teams. The Care Manager advised the Paramedic to make a direct referral to the APN but there was a misunderstanding and it was not completed. The Paramedic believed they had done the right thing in speaking to the CM team and the matter would be followed up.

Unfortunately, the opposite occurred and the Paramedic's concerns were not documented specifically as they would have been if they had referred directly. It only came to light that the Paramedic's concerns stemmed from the neighbour when they were interviewed as part of this case review: it had been assumed their concern related to self-neglect and the condition of the property. Their concerns were not followed up because the CM advised the Paramedic to report them to the APN. Both parties believed they had discharged their duties and the other would take responsibility for action.

Mrs B started to contact Police Scotland regularly from the beginning of June. The calls appear to be 'cries for help' although most were presented by Mrs B as requiring genuine Police involvement: it was more acceptable to her to contact Police rather than health or social care services, reflecting the local voluntary organisation view of Mrs B that her proud character prevented her from seeking help.

The first two occasions: on 2 and 5 June were low level calls that did not give rise to particular concerns other than indicating Mrs B might benefit from social support. VPD reports were submitted for both occasions: they were marked 'not at risk' in terms of Adult Support and Protection and sent to Social Work as well as to the health SPOC who shared them with the relevant medical practice. The first concern report was received on 11 June and related to the second call (on 5 June). The report was reviewed by a Senior Practitioner and determined not to meet criteria for further investigation under ASP legislation, so it was passed to Care Management. The same day, Mrs B telephoned ARCH responders who visited and submitted an Adult Protection reporting form. Care Management progressed the referral and allocated it to a Care Manager, prioritising it over other cases on the waiting list. A decision to visit on 18 June was made based on the information available about Mrs B and the competing demands of the Care Management Team's workload and waiting list.

Mrs B next contacted Police Scotland on 13 June, making 3 calls in 45 minutes. Mrs B sounded confused and described herself as starving, having not eaten for 48 hours. The review team felt that this symbolised a 'tipping point' where concerns

became more serious and Mrs B may have met criteria for being an adult at risk. A VPD report was submitted, although again it was marked 'not at risk'. In line with the agreed process, reports are not reviewed by the APN if marked 'not at risk' and the case is open to an adult Social Work team. The report was passed to Care Management who assessed that the visit should be brought forward but as the report was received on Friday 14 June, the visit was brought forward to Monday 17 June.

The initial visit by Care Management on 17 June found that although Mrs B's home was in poor condition, she had adequate provisions and was able to converse appropriately. Mrs B admitted her home was 'in a guddle' and agreed to help to improve it: she felt this would help her get back on top of things. Mrs B said she managed her own meals, personal care and medication but agreed to consider a referral to Occupational Therapy for a functional assessment. The CM had reservations about Mrs B's level of ability and raised her at the Virtual Community Ward the following day where it was agreed that Community Nurses would do a continence assessment: it was assigned a low priority.

When Care Management visited Mrs B again on 21 June, neighbours had cleaned the house and the environment was much improved but there was a noticeable deterioration in her physical condition. Mrs B was in bed and quite confused, saying her husband was lying beside her but then that he was 'away out'. The GP that visited that day felt that she had a significant underlying medical problem that required admission to hospital. Mrs B refused and the GP was very clear with her about the severity of her condition, informing her that she may die if she did not consent to admission. The GP documented that he had no doubt about Mrs B's ability to make an informed decision about her treatment.

Mrs B's condition did not improve over the coming days, evidenced by continuing calls to Police to report her husband missing, then to have him removed from the property. Officers evidently felt frustrated by the circumstances: Mrs B was choosing to contact them but they were not equipped to manage her situation. They were passing on information and felt intervention was necessary but Mrs B did not wish to have medical input and was assessed as having the autonomy and

capability to make that decision. There was a reasonable amount of information held about Mrs B by partners at this stage that, had it been shared, could have helped agencies understand the bigger picture, but feedback between all the agencies was not shared.

The review team could not say for certain if Mrs B had been an adult at risk of harm but it could not be ruled out. Further inquiry should have taken place at the time to share information and decision making and ascertain if Mrs B was able to safeguard herself.

The outcome from an audit by Police Scotland into the VPD reports submitted in respect of Mrs B showed that she may have met adult at risk criteria following phone calls to them on 13 June. The review team felt this was a 'tipping point' when further inquiries should have been made under Adult Support and Protection and greater dialogue taken place between agencies to make decisions. None of the police concern reports were marked 'at risk' so, as per process, after the first one was reviewed by the APN they were forwarded onto Care Management. It was agreed by the review team that decisions should not be based on a 'tick in a box' but there are checks and balances in place i.e. Care Management can refer back to the APN if they feel the adult is or could be at risk from harm.

Police Scotland acknowledged there is a reliance from Officers to look back to previous reports to see if they were marked at risk or not and continue the pattern, reflecting history rather than circumstances.

General Practice acknowledged they are unlikely to flag up a VPD report to the APN as they would assume it had also gone to Social Work and be picked up by them: they would only take action if there was an obvious medical issue. There is significant variation as to how VPD reports are managed in General Practice.

The response to VPD reports from Social Work also varies across teams. Reports come into the APN for administrative reasons. If they are marked 'not at risk' they would only be reviewed by the APN if the individual is not known to a Social Work

team. All reports are shared with the relevant Social Work team and asked to inform the APN know if there are Adult Support and Protection issues.

Key issues

One of the key issues is that whilst the first concerns were noted by SAS on 24 May and Police Scotland had involvement on 2 and 5 June, no report was received by APN until 11 June, resulting in a maximum delay of 18 days. A reporting form to APN from SAS outlining potential harm from a perpetrator would have elicited a different response to the VPD report which detailed low level concern and did not indicate that Mrs B could be an adult at risk.

From review of the case notes and practitioner interviews, Adult Support and Protection concerns were not raised by any of the practitioners involved with Mrs B, with the exception of SAS, who did not make a referral and ARCH, who made a referral on 11 June. Police Scotland had concerns for Mrs B but did not mark concern reports 'at risk' so it is not clear if they believed that she may have been at risk of harm or not. Upon review, Police Scotland felt Mrs B could have met the criteria after the calls made to them on 13 June.

Neither Care Management nor the GP felt that Mrs B was an adult at risk of harm. The fact that Mrs B was not identified as potentially being at risk of harm is not the most significant factor: Mrs B was in need of support and this was evident in the frequency that she was being flagged up to agencies and the deterioration in her condition.

The discussion of a 'tipping point' in this case from 13 June implies there should have been something that was triggered or escalated at that point. The current system does not make allowance for that, relying on individual practitioners to flag it.

Agencies generally considered their input in isolation and whilst information was shared, it was primarily in the form of passing it to another agency for them to act or be responsible for deciding to act or not. This was evident through the VPD reports, the verbal report from SAS to Care Management and the contacts between

Care Management and the GP. Agencies all thought that another had, or should take, responsibility and there was a lack of multi-agency dialogue and shared decision making in this case. A lot of information was gathered by individual agencies about Mrs B over a short timeframe: had it been shared and considered as a group, it would have developed everyone's understanding of the case including what could be done and what could not be done. It may have reduced tensions by assuring partners that Mrs B was being assessed and action taken, within the available parameters, as well as providing an audit trail for decision making and defining roles and responsibilities.

The timescales in this case should be borne in mind as the first notification came into Social Work on 11 June, the Care Management assessment began on 17 June and Mrs B was admitted to hospital on 25 June. Typically, given Mrs B's reticence to seek or accept help, a service user would need time to build a trusting relationship with the Care Manager. Support for a practical task, such as house clearing, can feel less threatening and enable trust to be built so the service user will consider accepting more personal help. Time was not available given the rapid deterioration in Mrs B's health.

The process of reviewing VPD reports and determining what happened with them was overly reliant on a 'tick in the box'. The tick determines who looks at the report and what happens with it. There are other opportunities to identify a case that requires further inquiry but it requires agencies to be pro-active and take responsibility for highlighting them rather than assume someone else will.

Some agencies expressed that making an Adult Support and Protection referral could damage their relationship with an individual and recognise it as a Social Work role.

Throughout the review, opportunities were noted for making improvements to systems and processes so that in a similar situation, there could be a more robust and joined up, multi-agency response. It is important to state that, having evaluated the information, the review team did not think the outcome for Mrs B would have been any different. There is no evidence of practitioners not following systems and

processes although more could be done to raise awareness and reinforce areas of Adult Support and Protection policy.

The review team felt that Mrs B was representative of many people in the community living on their own, with potential for benefitting from support but not readily accepting it. An individual's right to choose, where they can, should be supported whilst we should assure ourselves that every effort is made to offer support in a way that is acceptable and non-threatening.

Learning points

One of the purposes of the review was to recognise strengths and good practice and there were many occasions when it was identified:

- Practitioners documented their interventions comprehensively. In particular, the recording by SAS on 24 May and the GP on 21 June detailed their discussions with Mrs B about hospital admission and recorded their assessment of whether she was able to make informed decisions about her medical care and treatment;
- The medical practice had a comprehensive system in place for managing VPD reports: patients have a named GP so reports go to the same GP for review and are saved in the patient's file so historical reports can be referred to;
- All agencies are busy with demand overtaking resources. Mrs B was prioritised by Care Management who had a waiting list for referrals;
- Mrs B had asked for a GP home visit on 4 June then cancelled the request. A GP called her to query it because it was recognised that Mrs B seldom contacted the practice and it was out of character for her to approach them;

Changes in practice and policy already implemented:

- Scottish Ambulance Service introduced a system for ambulance crew to telephone a national contact centre who make an onward referral to Adult Support and Protection in the relevant local authority area in real time;
- Guidance introduced by the Royal College of GPs recommends 8 hours of Adult Support and Protection training during each period of registration to be discussed with their appraiser;
- Aberdeenshire Adult Protection Network introduced an Initial Referral Discussion (IRD) process for referrals that require further inquiry or investigation.

The IRD is held within 2 days and involves an APN Senior Practitioner, Police Scotland (Public Protection Unit), the Social Work Team Manager and relevant health professional.

It is possible that if a similar situation occurred again today, an IRD may not be called because the first VPD report did not raise Adult Support and Protection concerns and subsequent reports went straight to Care Management.

The review was asked to address 4 specific points:

1. Support available to Mrs B following the death of her husband and the impact this death had on her ability to protect herself – Mrs B had limited involvement with services between the death of her husband in September 2017 and May 2019. She made calls to Housing, Police and Social Work during 2018 to raise issues about drug dealing, anti-social behaviour and litter and how they related to her personal safety. On reflection, those calls indicate she was struggling to adjust to living alone. Mrs B was given advice to contact Police Scotland about any criminality but also encouraged to make an appointment with her GP to discuss her anxiety and feelings following bereavement, it does not appear that Mrs B did this.

2. Barriers professional encountered in recognising/sharing concerns as adult protection – the findings of the SCR do not support this hypothesis. SAS recognised concerns but did not effectively pass them on due to lack of understanding of the process: they thought they had done. During the review, it became evident that some agencies are reticent about making an Adult Support and Protection referral due to concerns about relationships and confidentiality, but it was not an issue in this case.

3. Assessment of current processes regarding police VPD reports, how these are shared with services and how they are responded to – the audit identified an overreliance on whether the report was marked ‘at risk’ or not, then depending on individual practitioners to identify Adult Support and Protection concerns.

4. Perception and culture around difference between ASP and CM responses to concern and assessment of all partners recognising the differences – there remains an assumption amongst agencies that Social Work has primary responsibility for identifying and progressing Adult Support and Protection issues: some partners assume they do not need to make a referral directly to APN or are reluctant to. There was confusion for SAS between the role of Care Management and the APN with the Paramedic believing that speaking to a Care Manager meant that a direct Adult Support and Protection referral either was not necessary or the conversation with a Care Manager amounted to making a referral.

Recommendations

1. Review the VPD process from end to end by a multi-agency group and implement improvements to maximise the effectiveness of concern reports

2. Introduce a trigger point/escalation process for VPDs marked 'not at risk' received by Social Work and General Practice/health SPOC

3. Use existing multi agency forums to discuss cases at the earliest opportunity, share decision making about Adult Support & Protection and clarify roles and responsibilities

4. Reinforce individual responsibility for direct referral and address barriers including breaching confidentiality and/or damaging the therapeutic relationship with an adult at risk

5. The learning from this Serious Case Review should be shared across agencies