Independent Significant Case Review (SCR) Report

Sharon Greenop

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EXECUTIVE SUMMARY

Background

This Significant Case Review relates to the circumstances of the death of Sharon Greenop, a 46-year-old woman who was found dead in her home in Troon in November 2016. Following a trial at Glasgow High Court in April 2018, her sister, Lynette Greenop, was convicted of her murder.

Sharon had physical disabilities arising from a spinal injury and was in receipt of a care at home service from 2009 until 2016. Sharon had the care of her daughter, Shayla, throughout this period. Shayla was charged with the murder of her mother but the charges were found to be “not proven”. When she was found, Sharon’s body was in an advanced state of decomposition and the exact time and cause of her death cannot be confirmed. She had 19 rib fractures of different ages and a broken neck.

During the years when the care package was being provided, there were several issues including:

1) Concerns expressed on three occasions that Lynette may be financially exploiting Sharon
2) Concerns that Lynette was bullying Sharon
3) Disputes between Lynette and the carers who looked after Sharon
4) Concerns about the care of Shayla
5) Concerns about the relationship between Shayla and Lynette.

The care package was terminated in January 2016 at the request of Lynette and following a telephone conversation with Sharon. It was agreed that Lynette and Shayla would now look after Sharon, with no input from professional carers.

In August 2016 another sister, Diane Hogg, called the Duty Social Work system and told a worker that her father had seen Sharon with a black eye on two occasions in recent weeks. Despite the nature of the information provided, the call was not identified as an Adult Protection referral and Diane Hogg was told to call the police if she thought that Sharon had been assaulted.

Critical issues

Using the process of Root Cause Analysis, the review group identified two critical issues.

1. Closure of the care package

The decision to allow the care package to be closed was flawed and allowed the circumstances to develop which led ultimately to Sharon’s death.

A number of factors contributed to this decision including:

• Poor record keeping over several years and major gaps in recording.
• Poor use of chronologies, which should be a cornerstone of recording and would have allowed patterns of concern to be identified.
• Lack of case reviews, which were supposed to be done at least annually but hadn’t been done in this case for four years.
• Poor case reviews which did not address current issues or properly identify Sharon’s needs.
• Poor management practice in transferring the responsibility for Sharon’s case from an authority-wide disability team to the Troon locality team.
• Lack of staffing in Troon to allow reviews to be undertaken.
Ultimately, the decision to allow the care package to be withdrawn did not reflect an appropriately questioning approach to the circumstances of a vulnerable adult. A significantly less passive approach would have helped the managers to question the wisdom of leaving Sharon’s care to Lynette and Shayla.

2. The duty phone call
The failure to identify the duty call as raising adult protection concerns and to then respond appropriately meant that a crucial opportunity to intervene to stop the abuse of Sharon was missed. There is a personal and inescapable responsibility for the worker who dealt with the call but, as with the decision to allow the closure of the care package, there were system issues that contributed to the mistake. The duty system was known to be problematic and at times overloaded. The individual worker’s role and workload were not well defined or well managed and there was no managerial oversight of the actions taken by frontline workers operating the duty system.

Contributory issues
The Root Cause Analysis process identified four system issues that contributed to the development of the critical issues identified above.

1. The review system for community care cases
Sharon’s case had not been formally reviewed since 2012 and the quality of that review was poor. We have confirmed that Sharon’s was one of hundreds of cases that had not been reviewed over a number of years despite both a statutory obligation and a current local policy that reviews should be done annually.

2. The duty system
Failings in the duty system had been identified in a previous Significant Case Review, which also related to the death of a vulnerable adult and an improvement plan had been put in place. An independent review of the duty system was commissioned in response to this case and described the system as “creaking at its seams”.

3. Recording and information systems
There are major gaps in the case records and years where there are no records at all. The use of chronologies is neither systematic nor comprehensive and this made it difficult to identify patterns of concerns, particularly when the case was transferred to a new team and became the responsibility of a group of staff with no personal knowledge of Sharon. The impact of the deficits in recording are exacerbated by the outdated information system, which is still in use and which does not give frontline staff the modern tools to promote good recording and case planning.

4. The quality of management practice
In the course of the review, we identified a number of examples of poor practice, which had both managerial and professional components.

These included:
- The circumstances surrounding the transfer of Sharon’s case to the Troon team.
- The failure to record and follow up on the child care concerns in respect of Shayla.
- The failure to respond to the concerns around the bullying and financial exploitation of Sharon by Lynette and to consider whether these concerns pointed to a pattern of abuse.
- The decision to defer a decision on disciplinary proceedings in relation to two members of staff for nearly two years.
- The absence of a systematic approach to the use of operational performance information, which would assist middle managers and provide assurance to senior managers that key systems are operating effectively.
Recent improvements

In the period since Sharon’s death, and in response to the issues identified at an early stage, a number of improvement actions have been put in place.

These include:

• Increased levels of review activity
• Major changes to the duty system
• The introduction of the nominated worker system, which aims to divert a large amount of work away from the duty system
• The introduction of a system of local management audits.

Individually and collectively, these changes have the potential to bring about major improvements in the system of health and social care in South Ayrshire. Considerable effort has gone into the introduction of these changes, which have been adopted within existing resources. To be successful these initiatives need to be sustained and then developed over the long-term. An indication of the distance which has still to be travelled is that in October 2018, almost two years after Sharon’s death, there are still 74 cases which have not had a review in more than three years.

The conclusions and recommendations of the report are outlined below in sections 5 and 6.

The improvement action plan developed by the South Ayrshire Health and Social Care Partnership in response to the conclusions and recommendations is set out in appendix 1.
Section 1 – INTRODUCTION AND SIGNIFICANT CASE REVIEW PROCESS

This Significant Case Review was commissioned by South Ayrshire Chief Officers’ Group in May 2017. The Terms of Reference, which are laid out in full in Appendix 2, relate to the circumstances of the death of Sharon Greenop, a 46-year-old woman who was found dead in her home in Troon in November 2016. Sharon’s sister, Lynette, and her daughter Shayla, were subsequently charged with her murder.

The review group was established in November 2017 and membership was drawn from the relevant agencies. David Crawford, a former Director of Social Work, was appointed as the independent chair of the group. The full group membership is attached at Appendix 3.

At the time that the report was commissioned, the criminal trial was still to take place and the review was able to progress with the caveat that the review group would not be permitted to have contact with any member of staff, or relative of Sharon’s, who might be a witness in the criminal trial. The trial took place at the High Court in Glasgow in April 2018 and Lynette Greenop was convicted of her murder. The case against Shayla Greenop was “not proven”.

In the period before the trial, the review group were able to scrutinise the case record and a large amount of related documentation. This included the report and interview transcripts from the disciplinary investigation undertaken in early 2017 and the report into the operation of the duty system prepared in June 2017. Elements of this report are drawn directly from this earlier work. In February 2018, the review group met with the then Chief Social Work Officer (CSWO) who was able to provide details on the changes being made as a result of the issues identified at an early stage in the review of this case. Updated information on the impact of the changes was given to us in October 2018 and this is commented on in section 4 of the report.

Sharon Greenop received a social work service over a period of seven years. This was initially under the auspices of South Ayrshire Council and subsequently the South Ayrshire Health and Social Care Partnership (HSCP). Over the period, there were significant staff changes and some people who had involvement with Sharon had left the employment of the Council before this review began. The direct provision of the care service was done by an independent company and the provider company changed at Sharon’s request in January 2014. The disciplinary investigation interviewed eight members of staff and this review had access to the records of those interviews. Staff were re-interviewed for the purpose of this report only where we felt that it was absolutely necessary. We also interviewed some members of staff who had not been interviewed as a part of the disciplinary investigation. We appreciate that such interviews are stressful for all concerned and we are grateful to everyone we saw for their honesty and cooperation.

After the end of the criminal trial, contact was established with Sharon’s family through her sister, Diane Hogg. The review process was explained and Diane outlined to us the key question for the family, which was to understand why the decision was made to stop the care package in January 2016. Contact was maintained with Diane until the end of the review and we hope that this report answers her questions. The subsequent sections of this report will lay out a factual account of the social work involvement with Sharon, an analysis of the key issues and an analysis of the impact of the changes made in response to this case.

Before we do this, there are three key points which should be made:

1) The responsibility for the death of Sharon Greenop lies with the person convicted of her murder. This report will bring scrutiny on the staff who were involved with her and on the organisations responsible for public protection in South Ayrshire. While the public scrutiny of the social work practice and the decision-making of individual staff may be very difficult for them, this needs to be set against an acknowledgement that Sharon Greenop lost her life having suffered an extended period of physical abuse. Such scrutiny is essential for learning and future improvement.
A Significant Case Review is about learning and improvement. It is not a disciplinary investigation or a search for the guilty. It is conducted with the benefit of time and hindsight. Time to methodically review all the information, and to arrive at considered conclusions, is seldom available to frontline operational managers. Many things which can appear clear and obvious with hindsight look very different in real time and when operating with limited information, limited resources and multiple demands. In undertaking our work, the review group have been acutely aware of these issues.

No system or organisation has ever succeeded in eliminating human error. However, the literature on safety systems* emphasises that people make fewer mistakes in high functioning systems which are properly resourced, properly managed and have safeguards and “checks and balances” built in to their operating procedures. In considering the issues laid out in the rest of this report, it is crucial that there is a focus on “the system” and not just on the individuals within it.

* Source - Sidney Decker “Drift in to Failure; From Hunting Broken Components to Understanding Complex Systems”

The Significant Case Review process

The procedures which have governed the conduct of this review are the Pan Ayrshire Procedures for a Significant Case Review (SCR). These were agreed by the three Ayrshire councils in October 2013 and remain in force. There are no current national procedures covering significant case reviews for adults. A national consultation exercise on SCR procedures was started in October 2016 but, to date, the outcomes of that consultation have not been published and no new national guidance has been circulated.

The review group met on eight occasions between November 2017 and October 2018.

In reviewing the case, we have:

- Met with Diane Hogg, as the representative of Sharon’s family
- Reviewed all available elements of the case record including paper and electronic records
- Reviewed the relevant procedures
- Reviewed the performance information provided by South Ayrshire HSCP
- Reviewed all relevant documents including the disciplinary investigation report and the transcripts of the interviews undertaken with eight members of staff as a part of this process
- Interviewed relevant staff, including re-interviewing some staff who had been interviewed in the disciplinary investigation, and seeing both those directly concerned and those who could provide relevant history and contextual information
- Met with the consultant who led the disciplinary investigation
- Met with the independent consultant who undertook the review of the duty system
- Met with the CSWO who provided a report on the changes made in response to the issues in this case
- Conducted an analysis of the key issues using the Root Cause Analysis tool.

In undertaking this work, we have sought to be comprehensive in our approach and sensitive to the issues for Sharon’s family and for the staff directly involved.

The conclusions and recommendations presented at the end of the report represent the unanimous view of the review group.
Section 2 – THE FACTS

Sharon Greenop was found dead in her home in Troon on 11th November 2016. She was 46 years old and had been dead for some time. Her sister Lynette Greenop and her daughter Shayla Greenop were subsequently charged with her murder. At the trial at Glasgow High Court in April 2018, Lynette was convicted of her murder and the charges against Shayla were found to be “not proven”.

The evidence presented at the trial indicated that, due to the decomposition of the body, it was not possible to establish either a precise time of death or a precise cause of death. It was, however, identified that Sharon had 19 rib fractures of different ages, believed to be caused by blunt force trauma, and also fractures to her neck.

In April 2009, Sharon had been admitted to hospital in Ayr as a result of a disc prolapse. She was transferred to the Southern General Hospital in Glasgow for surgery and subsequent rehabilitation. Following the surgery, she required elbow crutches for short journeys and a wheelchair for longer journeys. To support her discharge from hospital, a number of mobility aids were installed in her home and a home care service was initiated to provide assistance with personal care and with meal preparation. The home care service was in place continuously from her discharge in November 2009 until January 2016.

A social worker from South Ayrshire Council was allocated to work with Sharon before and after her discharge from hospital.

In January 2010, the case record summarises events since Sharon’s discharge from hospital and in March 2010, the records indicate that the worker discussed the case with their line manager in supervision. An Annual Review took place in December 2010. The record of this review indicates that the homecare service was working well and would continue; appropriate aids and adaptations had been installed in the house and had made a big difference to Sharon; Shayla was being supported by the South Ayrshire Young Carers’ Centre; and that both Sharon and Shayla were happy with the current level of support being provided.

On 12th April 2011, the care provider advised Sharon’s social worker that Sharon had told one of the carers that Lynette had been stealing money from her purse. The record in the case file indicates that: “There had been some concerns in the past regarding Sharon accusing her sister of taking £25 or £30 from her but did not want to take any further action against her sister and did not want further investigations”. It was noted that Sharon did not wish any further action to be taken. On 6th June that year, the same service provider passed information to the Social Work Duty Officer that Sharon had again reported to them her suspicions that Lynette was stealing from her. The SWIS (Social Work Information System) case-file record shows: “The Duty worker spoke to Sharon on the phone to make further enquiries but Sharon advised that she had got mixed up about her money and was muddled because her mother had been taken into hospital. Sharon advised that she did not want to take it any further and that it had been resolved. Sharon did not want to discuss it further”.

In October 2011 Diane Hogg, sister of Sharon, reported concerns that Shayla was sleeping in the garden hut. The case record indicated a discussion about these concerns and the need to liaise with Children and Families Social Work staff. A home visit was undertaken and an explanation that Shayla was simply playing in the hut was accepted. No child care referral was created and no records exist in relation to Shayla. There is no evidence of these concerns being considered as potential child protection issues and no assessment of Shayla’s needs or circumstances was undertaken. The failure to follow up this referral is considered further at Section 3 of this report.

On 2nd October 2012, the manager of the care service telephoned Sharon’s social worker to pass on a carer’s potential child care concerns relating to Shayla following a visit to the house. The manager had asked the carer to provide a written record of her concerns (and, specifically, any child protection concerns) and the SWIS record notes that this was to be investigated further. However, there is no record of a written statement regarding this having been received and there is no evidence of the concerns being followed up or investigated. The social worker carried out a home visit the following day but this seemed to have focussed on concerns about Lynette living in the house and having been made homeless. Lynette was
provided with information and support to enable her to secure alternative accommodation as a homeless person. There are no further case-file records until 14th October 2013.

There is no indication in the records that the original allegation which prompted the visit was actually discussed.

Annual reviews were undertaken in 2011 and 2012. Thereafter, there is no evidence of there being further reviews before the case was closed and the care package withdrawn in January 2016. The issues of case recording and of annual reviews will be commented on in detail in Section 3 of this report.

In October 2013, the care provider raised concerns that Lynette Greenop was being rude to their staff and may be financially exploiting Sharon. In a further discussion, the care provider raised concerns that Sharon was being bullied by Lynette and Shayla and that there were also concerns that she was being financially abused. These issues were identified as potential Adult Protection concerns and a home visit was organised. The allocated social worker was off sick, so two other qualified social workers undertook the visit. During the visit and subsequent discussions, Sharon again made no further complaints regarding any allegation of theft or financial abuse. The record of these discussions also point to very difficult and tense relationships between Lynette (and to an extent Shayla) and the carers going into the house. Both Lynette and Shayla are described as routinely being rude, verbally abusive and intimidating towards the carers (at this point in time, Lynette had her own tenancy in Ayr). These discussions resulted in a set of protocols being put in place, including (with Sharon’s agreement) that Lynette should not be in Sharon’s home when the carers were there.

On 8th November 2013, a meeting was held at Sharon’s home with her social worker to discuss the failure to keep to the agreed protocol, resulting in further issues for the carers. That same day, Sharon contacted the care provider to advise that she wanted her care package reduced. This was agreed to and subsequently arranged. On 17th December, Sharon and Lynette had requested that Sharon’s care be provided by a different care provider. An alternative care provider was arranged, commencing January 2014, with the reduced care package being continued.

In July 2015, the responsibility for Sharon’s case was transferred from the Physical Disability Team, which covered all of the local authority area, to the locality team based in Troon, which covered Sharon’s home area. In the report prepared as a part of the disciplinary investigation, it states: “There were a significant number of physical disability cases which were not being managed and as a result of changes to the structure, a decision was taken to transfer all of the cases held centrally out to the 5 geographical older people’s teams. There was no formal transfer undertaken and files were simply boxed and sent out to the 5 teams”. When Sharon’s case-file arrived in Troon, a decision was made not to allocate the case but to hold it in the “review basket”. The circumstances surrounding the transfer of the case are discussed further in Section 3.

In January 2016, the care provider contacted the Troon social work team and said that the family wanted to cancel the care package Sharon was receiving. Lynette later followed this up with a phone call to the Troon social work team advising the duty worker that Sharon wanted the care package to be cancelled and that she (Lynette) and Shayla would provide the required care for Sharon. The duty worker also contacted the care provider regarding this request and the care provider expressed their own concerns at such a proposal. Recent records were checked and a discussion took place involving the team leader and service manager. An attempt was made to arrange a home visit, but this was refused by Lynette. Sharon was subsequently spoken to on the phone and indicated that she wished her sister Lynette and Shayla to provide her care. The view was taken that Sharon had “capacity” (i.e. was able to make her own decisions and was not impaired by mental health, learning disability or dementia) and was therefore entitled to decide to stop the care package. The care package was therefore stopped and the case closed on 12th January. Thereafter, there was no further social work contact with Sharon.

In August 2016 Diane Hogg, sister of Sharon, made a phone call to the duty social worker in Troon. The reason for her call was to establish whether Sharon was still receiving a care package. In the course of the call she said that when her father had last seen Sharon she had a black eye. She had also been seen to have a black eye in June of that year.
The case file records that: “There was also an overpowering odour in the property which Diane said her father described as urine / faeces.”

The duty worker advised Diane “that if she felt there was physical assault then this was a police matter”. This call was not identified as an Adult Protection referral and no further action was taken.

On 10th November 2016, Police Scotland were contacted by a neighbour and Sharon’s body was found in her bedroom in an emaciated state and in a state of decomposition indicating that she had been dead for a period of time. Police Scotland submitted an Initial Case Review report to South Ayrshire Adult Protection Committee on 15th November 2016 and, in accordance with the relevant procedure, an Initial Case Review was convened. The outcome of the Initial Case Review was that a Significant Case Review be conducted into the circumstances around the death of Sharon Greenop.
Section 3 – ANALYSIS OF KEY ISSUES

The previous section outlined a factual account of social work involvement with Sharon. In this section, the report will comment on the key issues identified by the review group. These issues were identified using a process called Root Cause Analysis which is in common use in the NHS and which is identified in the Pan-Ayrshire Significant Case Review guidance as a relevant tool for the analysis of issues in adult protection cases.

The review group has identified two CRITICAL ISSUES which we believe were significantly responsible for allowing the circumstances which led to Sharon’s murder to develop.

The group also identified four CONTRIBUTORY ISSUES which we believe need to be explained in order to fully describe the circumstances.

Critical issues

1. The decision to close the care package
Sharon had a care package to help her to live safely at home from the time of her hospital discharge in 2009 until January 2016 when the package was stopped. Although the levels of care changed over time, there had been daily contact with Sharon for seven years. The current criteria used by the HSCP indicates that such a care package should be provided where there is “critical or substantial need”. While the eligibility criteria may not have been as explicit in the early years that the package was provided, it seems clear that Sharon had a significant level of disability as a consequence of her spinal injury. She also had the care of her daughter throughout this period. There was no input from a social worker after 2013 and the daily visits by care staff represented the totality of the external support which Sharon received.

The first indication that the package might be ended came in a phone call from the care provider to the social work department in January 2016 and this was then quickly followed by a phone call from Lynette Greenop. From the available records, it is clear that the initial handling of this call was of a very good standard and that the worker concerned was thorough and diligent both in the approach she took and in the recording she made.

It is clear that the managers involved did not simply accede to the closure of the case. Recent records were reviewed, advice was taken from a more senior manager, a home visit was offered and refused, and finally Sharon was spoken to on the phone. As is often the case, frontline operational managers had to make a decision based on partial information, with no personal knowledge of the case and with the family resistant to further contact. There were a number of factors which contributed to what was ultimately a decision which did not reflect good social work principles and practice.

The case records were of little assistance. There were big gaps in the recording caused in part by the allocated worker being on sick leave for extended periods of time. There is no evidence of any management of the case during the periods when the allocated worker was absent. The chronology is incomplete and was substantially out of date when the case was transferred to the locality team, with the most recent entry being on 24th December 2013. No further additions were made to the chronology following the case transfer. A comprehensive review of the case file would have required the team leader to read the paper record and review the electronic record. When this was done for the purpose of the SCR, it was identified that there were gaps and inconsistencies between the two elements of the records.

There had been no annual reviews since 2012 and the quality of these was poor. The report for the 2012 review was extensively “cut and paste” from the 2011 report and the section on carers issues, which related to Shayla, are identical in both reports. There had been a significant number of family issues in the run up to the 2012 review, but these do not feature in the review report.

There was, therefore, little useful historical information which would have helped those faced with the decision about closing the care package to identify issues of concern. Previous concerns, especially those around potential financial exploitation by Lynette, which had been raised on three separate occasions, had
not been systematically followed up and there is no indication that these were ever considered as potential Adult Protection concerns.

The case was transferred to the Troon team from the Physical Disability Team in July 2015 without a proper handover process and without a transfer summary, which would have highlighted the history of the case and any issues of concern for the receiving team. In the disciplinary investigation, these issues were rightly identified and that investigation was told that the transfer of cases arose from a restructuring of services. However, in the process of this review, we were given additional information which more fully explains the context of the case transfer.

We were told that the decision to transfer the cases to the locality teams, at short notice, and without reviews or transfer summaries, was taken because the Physical Disability Team had “ceased to exist”. Staff had left and not been replaced, the team leader then left and the team was reduced to one worker. The caseload, however, was still there and many clients, like Sharon, were receiving care packages from care providers funded by the Council. A senior manager was then told that they now had responsibility for the cases and the budget. In the absence of any staff to manage the workload, the manager took the decision to allocate the cases to the locality teams and a memo dated 30th July 2015 asked them “to be vigilant in how they allocate as the cases may need a bit of work”. This appears to be the sole piece of advice given to the receiving teams and no feedback was requested.

It is clear that the locality managers got responsibility for a caseload in completely unsatisfactory circumstances, but also that the senior manager was trying to manage an untenable arrangement. The detail of the way the cases were transferred does not reflect well on the management of the service.

When the case was passed to the Troon team, a decision was made not to allocate the case to a named worker but rather to hold the case in a “review basket”. It was noted in the case-notes at the time of transfer that the case required to be reviewed, with the last review having been completed in October 2012, but no review took place before the case was closed.

At that time, this case was one of many which had no active caseworker and we were told that the staffing capacity simply did not exist to actively review all of the cases on a regular basis. Since these events, changes have been made in order to enhance the review capacity. These changes will be commented on in Section 4.

The understanding of the significance of “capacity” in relation to Sharon’s decision to end the care package was flawed. While it may well be the case that Sharon had mental capacity – indeed there is nothing to suggest that she did not – that does not mean that she was not a vulnerable adult and susceptible to abuse. Consideration of potential vulnerability in the absence of the care package should have been a central consideration in the decision to end the care package, but this was not the case. A great many adults who would be seen as being at risk of harm in terms of the Adult Support and Protection definition would, nonetheless, have mental capacity.

The managers who took the decision to end the care package could, and should, have taken a much more questioning approach. The report into the death of Victoria Climbie suggests that social workers approach their work with a questioning attitude and a “healthy scepticism”. Taking a questioning approach would have challenged the wisdom of taking the decision at the time and with the information they had. Had the managers considering the closure of Sharon’s care package taken a more questioning approach, they might reasonably have asked some of the following questions:

- If Sharon has needed a significant care package for the past seven years, why would she no longer need one now?
- If there hasn’t been a review in years, should we not have one before we agree to close the case?
- What do the carers who see Sharon every day think about the plan that Lynette and Shayla provide the care?
- Have there ever been any concerns about Lynette or Shayla looking after Sharon?
- Why is the family so hostile to a visit before we close the case?
• Are there any other family members we should talk to before we make a decision?
• If we agree to close the case, should we check in a few weeks that the new arrangement is working?

Although there were various issues over the years, it would seem Sharon was generally kept safe and well throughout the years when the care package was operating. Within nine months of the ending of the care package, she had suffered repeated abuse and was ultimately murdered. There is no evidence that the physical abuse of Sharon was happening while the care package was in operation. It is therefore highly likely that daily visits from professional carers provided Sharon with a very substantial degree of protection.

It is our conclusion that the decision to end the care package exposed Sharon to the abuse which ultimately ended her life. This is a very difficult conclusion especially for the members of staff who made the decision and who have been profoundly affected by these events.

It needs to be acknowledged that, at the point where the decision was made to close the case, there was no known history of violence toward Sharon. The managers involved could not have foreseen the violent death which Sharon would suffer – but this does not mean that it was a good or well thought out decision.

Frontline managers have to make difficult decisions, and potentially life and death decisions, on a regular basis. They seldom have access to all the facts. They will seldom feel that they have all the resources they need. They can be helped to make good decisions in difficult circumstances if they have good systems and good work practices. The systems of record keeping, case review, and case transfer in this case were inadequate and left the managers exposed. The lack of rigorous follow up of previous issues compounded the problem. Had these systems been in place and had there been a much more rigorous management culture then they may have been helped to make a different decision.

2. The duty phone call

On 15th August 2016 Diane Hogg, Sharon’s sister, called the duty system at the Troon team. She spoke to the duty social worker, who was an experienced qualified worker, and asked whether a care package was still being provided to Sharon. The worker checked the record system and identified that the case had been closed. In the course of the subsequent conversation, Diane Hogg outlined a number of concerns including:

- That Sharon had been seen by her father the previous day and had a black eye which Sharon had said was the result of a fall
- That she had also had a black eye when seen on a previous visit by her father in June
- That there was a strong odour in the house, believed to be urine and faeces
- That Diane believed Sharon had a fear of Lynette and that Lynette had “a hold over Sharon”, and that this was the reason that Lynette didn’t want the carers coming in to the house.

According to the record of the interview undertaken as part of the disciplinary investigation, the duty social worker then advised that “if she felt there was physical assault then this was a police matter”. The call concluded with Diane saying “I may go and visit myself tomorrow – I am going to speak to dad and I may go and see her tomorrow’ and the worker saying “fine, but come back to me and let me know and we can look at it”. In subsequent days there was no further contact from the family and the referral was marked for “no further action”. The way the duty system operated at that time, there was no managerial oversight of referrals so there was no opportunity to question the worker’s response.

When information is received that a person may be an “adult at risk of harm” as defined in the Adult Support and Protection (Scotland) Act 2007, the local authority has a duty to make enquiries regarding the safety and protection of that individual. The information received from Diane Hogg should have triggered an Adult Support and Protection inquiry which should have been initiated by the duty worker recognising that the information required an adult protection response. This would have resulted in Sharon’s situation being inquired into that day, and, unless the inquiry (essentially a desk-top exercise, gathering information from existing records) ruled out Sharon being an “adult at risk of harm”, the duty to investigate would have resulted in two workers visiting Sharon at home. They would want to interview her about her situation and her safety and protection needs. They would also want to interview relevant others, for instance Sharon’s father who had witnessed the black eyes; Diane Hogg; the carers who visited the house on a daily basis; Lynette and Shayla. Any concerns about Sharon’s safety and protection needs could have resulted
in immediate steps being taken to protect her and the calling of a case-conference to enable a wider discussion around any issues that were felt to be putting her at risk and to develop a protection plan to deal with these. The investigation would also have had regard to any support needs which the informal role might have had and considered how services could support them in their role as carers.

If the referral had been correctly identified as an Adult Protection matter, then it is almost certain a decision would have been made to initiate an urgent inquiry. The failure to do this resulted in a key opportunity to protect Sharon being missed. The worker who took the call was an experienced, qualified worker who had received all of the relevant training in relation to adult protection.

The worker who took the call had previously received a service excellence award from the Council and was viewed by her line manager as “a meticulous worker”.

As a part of the disciplinary investigation, she provided a detailed written account of the circumstances in which she was working.

She had been based in Troon and was asked to take on a three-year secondment to a hospital-based post aimed at facilitating hospital discharge. She says that she was never given a formal job description but was told that she would not be involved in the duty system. Around the point where she took up the secondment, her team leader left and there was a gap until the new team leader appointed. Due to staff shortages, she had to go back on to the duty rota and then had other work (not related to her hospital role) allocated to her.

The detail of events outlined below is taken directly from the worker’s statement to the disciplinary investigation:

- I felt extremely under pressure and other members of the team were commenting on the amount of work that was coming in for me and that they didn’t know how I would cope with it all. I broke down a few times in front of staff saying I wasn’t coping and was stressed.

- I went to my team leader’s office and told her I wasn’t coping and was very stressed for me to tell her that I had reached crisis point and as a result I wanted to return to my original post. I was told that this is what I’ve to do (continue with the duties already allocated).

- Duty is overwhelming for one person – concerns raised to (Team Leader) for fear of missing important information due to the pressure and volume of calls. This was discussed at team meetings and all staff in agreement.

It needs to be acknowledged that this is a highly personalised account of the circumstances provided by a worker whose practice was being investigated as part of a disciplinary process. It does, however, provide a significant insight in to the context in which the worker was operating.

Following the disciplinary investigation, the Council took disciplinary action against the social worker for “A lapse in professional judgement around the criteria for Adult Support and Protection resulting in a failure to follow Adult Support and Protection procedures”. The worker did not appeal against the action taken.

Further comments on the operation of the duty system are outlined at section 4 of this report.

It is clear that a social worker made a critical error in not recognising the adult protection issues when dealing with the duty call. While there is an inescapable personal responsibility for the worker concerned, it also needs to be recognised that there were major issues with the wider operation of the duty system which had been highlighted by a previous Significant Case Review and are addressed in greater detail in section 4.
Contributory issues

The previous sections have focussed on the decision to close the care package and on the response to the duty phone call. These issues focus on the actions and decisions of individual workers and managers. It is crucial that equal focus is given to the systems within which staff were operating and to consider the extent to which these assisted and promoted good practice. Using the Root Cause Analysis tool, we have identified four system issues, the operation of which impacted on the quality of the response to Sharon’s circumstances.

1. The review system for community care cases.

The standard set by the Partnership, consistent with the statutory guidance * is that each community care case should be reviewed at least once a year. In Sharon’s case, reviews were held in 2010, 2011 and 2012. Thereafter, there were no further reviews prior to the closure of the case in 2016. As a consequence, there was little up to date information available to the managers faced with the decision on case closure. It also means that there was no view on whether Sharon’s ability to care for herself had improved, deteriorated or changed over the years.

*Source – National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care Of Older People – Guidance (Scottish Government 2009)

Care at home services deal with around 1,600 cases in South Ayrshire at any given point and ensuring the regular review of service users’ needs is a major challenge. We know that Sharon’s was one of a large number of cases which were overdue for review. In South Ayrshire, more than 70% of care at home is provided by independent providers. With this “balance of care”, it is imperative that sufficient resource is available to review cases. Without this, the Partnership cannot be sure that service users’ needs are being properly met or that resources committed to external suppliers are being spent effectively and efficiently.

Unfortunately in Sharon’s case, even in the years where reviews did take place, these were not of a good standard. Given the scale of the task, there needs to be an audit process which ensures that the quality of reviews is of an acceptable standard.

The Partnership has been aware of these issues for some time and action has been taken over the last year to improve on past performance. Section 4 will comment in more detail on the impact of these

2. Duty system

In response to the issues highlighted by this case, the Council Chief Executive initiated an external review of the duty system in adult services. The review was undertaken by a highly experienced social work manager with a background in service inspections. She met with relevant staff, read relevant policies and procedures, and examined a sample of 50 recent records of contact made to the duty system.

The summary of findings is outlined in full opposite, together with the strengths and areas for improvement identified by the report.
Summary of findings

• Social work staff involved in the duty system understand their statutory responsibilities.

• Staff appear to recognise when issues are raised which indicate that an individual might be at risk.

• Electronic case records include an obvious flag to indicate if there are current or historical adult protection issues.

• Most duty contacts relate to individuals who have existing care packages, subject to annual review, but who do not currently have an allocated worker.

• Staff are conscientious at completing case records in circumstances where the individual has a current care package in place.

• Where the individual does not have a current care package and staff are completing a new referral form, they are not doing so fully or consistently. Staff are not clear about the organisation’s expectations.

• Team leaders provide staff with supervision and are accessible for advice.

• Team leaders have sight on a daily basis of all forms regarding new referrals and copies of any case records on unallocated cases where the duty worker considers that further action is needed.

• Team leaders are not fully recording the reasons for the decisions they make.

• There is no quality assurance framework for the duty system setting out expectations about what checks should be made, by whom, and with what frequency.

• Statistical performance information about the level of demand on the duty system is unreliable as it reflects only new referrals. There is no consistent understanding of what constitutes a new referral and no guidance about what duty activities staff should log.

• Staff and their first and second tier managers describe a system experiencing high demand, extremely so in two of the three areas. Staff describe a system at breaking point and express their fear of “missing something” due to the level of demand.

• Senior managers are aware that there are concerns about the duty system. They have planned new initiatives to reduce the overall level of demand on the system and, as the next stage, aim to consider what form a new operational model might take.

• The lack of robust statistical data is likely to impact on planning for improvements or major changes to service delivery and hinder evaluation of the difference such changes make.
Strengths and areas for improvement

Strengths
Although many duty staff report working under extreme pressure, they appear committed to providing a good service, grasp their statutory responsibilities, and are supported by their line managers.

Areas for improvement
The current duty system impresses as one that is still working but creaking at its seams. There are weaknesses that could be addressed quickly. These include:

- emphasising the importance of recording analyses and decisions
- setting criteria on what constitutes a new referral and should be recorded as such
- providing duty workers with guidance on when to pass matters to the team leader for allocation
- establishing operational procedures for the duty system, and
- developing a quality assurance framework.

However, other issues, in particular the amount and range of activity carried out by duty workers and the importance of prioritising referrals, signal that, in addition to addressing these issues, a more fundamental change to the duty system is required. Senior managers have already begun to consider the matter.

Different duty system models apply across Scotland – including those staffed by centrally-based dedicated trained duty staff; those operated locally (variously defined as local team level or larger locality area) by dedicated duty staff; and those operated locally by staff holding responsibility for caseloads as well as duty. It will be a matter for South Ayrshire Council to determine, in consultation with partners and stakeholders, what model best meets the needs of its area and to determine what should fall within the remit of this system and what should not.

As a first step in planning a future model, it is essential that the local authority obtains accurate data on current activity. Only by doing so can it determine how it might appropriately resource both the system and any elements it might decide to move from its remit, and evaluate the impact of any changes it chooses to make*

*Source – Review Of Duty System in Adult Services – June 2017
In response to this report, a significant reform of the duty system was initiated. The impact of the changes made will be commented on in Section 4.

It requires to be acknowledged that shortcomings in the duty system had been highlighted in a previous Significant Case Review in relation to the death of an adult in June 2015. The issues highlighted in the independent review of the duty system in 2017 were therefore identified despite the previous SCR and subsequent action plan.

3. Information systems
The case record for Sharon Greenop has three elements – a paper-based social work file; an electronic record, compiled and stored on SWIS; and, separately, there should be a care log kept in the client’s home that records the daily contact with care staff. We understand that these daily records were provided by the care provider to the police as a part of the criminal investigation, but we were not able to gain access to these records.

We comprehensively reviewed the paper file and the electronic record. In the early years of the care package being in place, the records are of an acceptable standard; but in later years the quality of the recording is poor and there are very large gaps in the recording (e.g. there are no recordings at all for 2014). It is not known if this is because there was no contact with Sharon, or whether there was contact that was not recorded. There are inconsistencies between the paper and electronic records and important issues that appear in one file but not the other.

Individual workers are accountable for the quality of their recording, but this is assisted by modern user-friendly information systems. The system still in use in South Ayrshire is a variant of a system developed in the 1990s. A decision was taken three years ago to buy a replacement system, but this is not yet in use in Adult Services or Children & Families services. The recording systems are therefore substantially out of date and do not give either frontline workers or their managers the benefits of modern software systems.

4. Management practice
In the course of the review, we have identified multiple examples of management practices which could not be described as representing good practice and which raise questions about the prevailing management culture.

4.1. Case transfer
The circumstances which led to the transfer of Sharon’s case to the Troon team are a clear example of these failings. The Physical Disability Team which Sharon’s social worker was a member of was variously described as “disintegrating”, “disappearing” and “ceasing to exist”. Workers left and were not replaced, the caseloads of workers on long term sick leave were not covered and ultimately the team Leader left and was not replaced. The team appears to have been disbanded without any obvious strategy and the decision to hastily allocate the remaining caseload to the area-based teams solved one problem and added to another.

4.2 Child care concerns
As noted in section 2 of the report, there were two occasions when clear child care concerns were raised in relation to Shayla. The records show no details of these incidents being followed up or of them being referred to Children & Families services. In the absence of any recorded follow-up, the significance of these incidents is unknown. The wider concern would be that this may be reflective of a lack of communication between Adult Services community care staff and Children & Families care staff, which resulted in protection concerns not being properly and thoroughly investigated assessed.
4.3 Adult protection concerns
A thorough review of the case file reveals that concerns about Lynette financially exploiting Sharon were raised on at least three occasions. Concerns were raised about Lynette bullying Sharon and Lynette had a poor and, at times, abusive relationship with the carers who came to the house. The failure to use a proper chronology made it difficult to identify these individual issues. One of the values of a good chronology is that it allows repeated concerns and patterns of abuse to be identified. There were sufficient concerns to warrant further consideration in terms of adult support and protection, but the failure to thoroughly pursue the individual concerns and the failure to use a chronology meant that the pattern around alleged financial exploitation was not identified.

4.4 Disciplinary proceedings
While the day-to-day management of the service is undertaken by the South Ayrshire Health and Social Care Partnership, the staff involved in this case were employed by South Ayrshire Council. The Disciplinary Procedures which apply are those of the Council. In this section, we therefore refer to the Council rather than the Partnership.

The use of the Council’s Disciplinary Procedures in this case is problematic. While the decision to take disciplinary action against a social worker for their failure to deal properly with the duty call from Diane Hogg is considered appropriate, we do not consider that it was fair to have two other workers left in a position where disciplinary proceedings are still pending nearly two years later. These workers were issued with letters in 2017 which indicated that the Council would consider further the issue of disciplinary action against them after the conclusion of this review. We consider this approach both to be unfair to the workers concerned and to indicate a lack of understanding of the role of this review. If the SCR process is to genuinely be about “Learning Together”, then the outcome of an SCR should not be linked directly to disciplinary proceedings. The disciplinary investigation which was undertaken was thorough and extensive. In our opinion, it provided sufficient information for the Council to make a decision on the use of disciplinary proceedings for all of the staff involved. If this was not considered to be the case, then the disciplinary investigation should have been extended and those matters concluded prior to the commissioning of the SCR.

In a complex and emotive case like this, the taking of disciplinary action against members of staff requires much consideration. By taking the decision to put disciplinary action against two members of staff on hold for an extended period of time, the Council has created a major dilemma for itself. If, at the end of its consideration of this review, the only person against whom disciplinary action is taken is a basic grade social worker then the feeling among frontline staff that they are the scapegoats for systemic failings will be substantially reinforced. Equally, to now progress with disciplinary action after nearly two years may be procedurally and practically problematic.

4.5 Management information
In the course of the review, we received a huge amount of management information and performance data. Much of this is “high level” data used to review the performance of the Partnership on major strategic issues, both local and national. We heard from numerous sources that information on routine operational performance, which was used by middle managers to monitor service delivery on a month-to-month basis, was no longer available to them and that the resources available to generate and analyse data had been severely reduced in recent years. We also heard that planning and strategy capacity had been similarly reduced. While we understand the wish to prioritise frontline services, the Partnership needs to ensure that it has both sufficient capacity and adequate systems to develop a genuine performance culture within the organisation. As an example, the Review of the Duty System stressed the need for improved data quality. This will not happen without sufficient resources and the Partnership will be vulnerable to repeating its previous mistakes.
Section 4 – RECENT CHANGES AND IMPROVEMENTS

In response to the issues identified at an early stage in this review process, the Health and Social Care Partnership has already initiated a number of changes.

Many of these changes are very new and it will take time to fully assess their impact. Outlined below are details of a number of the key changes together with an assessment of their impact to date based on the available data.

1. Review of the duty system
The review of the duty system gave rise to a number of changes including:

• Improved administrative processes aimed at improving the screening of calls and giving better information to duty workers before they took calls.
• The redirection of enquiries about current cases away from the duty process through the introduction of a “nominated cases” system.
• The introduction of rigorous standards for oversight of duty referrals.
• The re-designation of staff and an increased focus on review activity.
• The introduction of a “nominated worker” system aimed at giving current clients a clear point of contact and thus directing calls away from the duty system.

The review group were given a report in April, which summarised the impact of the changes over a three-month period (November 2017 to January 2018). The data provided was based on an analysis of 911 referrals and indicated a high level of compliance with the new standards (in excess of 90%) for all but one standard. The standard which was not being complied with was the reviewing of duty referrals by team leaders within 24 hours (one working day) of completion by the duty worker. Compliance with this standard was at 43%.

2. Reviews
The report provided data on review activity and compared the three-month period November 2016 to January 2017 with the period November 2017 to January 2018. The data showed a threefold increase in reviews being undertaken. This data was updated to provide details of reviews undertaken from July to September 2018.

Reviews undertaken

<table>
<thead>
<tr>
<th>Dates</th>
<th>Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2016 to January 2017</td>
<td>119</td>
</tr>
<tr>
<td>November 2017 to January 2018</td>
<td>354</td>
</tr>
<tr>
<td>July 2018 to September 2018</td>
<td>457</td>
</tr>
</tbody>
</table>

While the increased review activity appears to be being maintained, it is of great concern that there are still many cases, like that of Sharon Greenop, where the statutory obligation to review is not being met.

Information provided in October 2018 showed that 373 cases are currently outside the statutory deadline.

Reviews outstanding

<table>
<thead>
<tr>
<th>Review timelines</th>
<th>Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases which have not been reviewed in 18 months</td>
<td>212</td>
</tr>
<tr>
<td>Cases which have not been reviewed between 18 months and 3 years</td>
<td>87</td>
</tr>
<tr>
<td>Cases which have not been reviewed in more than 3 years</td>
<td>74</td>
</tr>
</tbody>
</table>

It also needs to be acknowledged that the increased review activity is not consistent across the geographical teams and that some teams appear to be performing much better than others.
3. Guidance on case recording
The HSCP re-issued every team leader with guidance on the practice and expectations around case recording. This guidance was all previously available via the intranet. The intention in re-issuing it in paper form, and on an individual basis, to first line managers was to re-emphasise the importance of recording and to ensure that each manager was absolutely clear about what they should be demanding of their staff.

The impact of this action can only be judged by the regular auditing of individual case files. The data provided from the audits carried out in 2018 does not include case recording data.

4. Audit and quality assurance process
The HSCP has introduced a Quality Assurance Framework and a series of Adult Services audits. These audits are to be carried out at three levels, team leader, service manager and operational group. The audits cover the following areas of work:

- The duty process
- The review process
- Self-directed support
- Adults with Incapacity
- Adult Support and Protection.

A series of audits were completed in September/October 2018. The introduction of these audit processes represents a substantial modernisation of the approach to quality assurance. To have a measurable impact on the quality of service delivery, these audits must be sustained over time and comprehensively implemented across the various elements of the service. The outputs of the audits require to be aggregated across the HSCP and performance reported and monitored by senior managers and the Integrated Joint Board on a regular basis. The review of the nominated worker system has not yet taken place and this needs to be prioritised in order to create a more comprehensive view of the effectiveness of the recent changes.
Section 5 – CONCLUSIONS

The review group have concluded:

5.1 That more could and should have been done to identify Sharon Greenop as a vulnerable adult and to intervene to ensure her protection from harm.

5.2 That the decision to end the care package exposed Sharon to the abuse which ultimately ended her life.

5.3 That although the managers involved could not have foreseen the violent death which Sharon would suffer, the decision to end the care package was not one which reflects a good standard of social work practice.

5.4 That the response to the duty call represented a critical error of judgement on the part of the social worker who should have identified the matters being raised as Adult Protection concerns and then followed the appropriate procedures.

5.5 That the management of Sharon’s case deteriorated over time and the failure to review the case contravened both national and local standards.

5.6 That frontline workers were working with a number of poorly operating systems (the duty system, the review system, the IT and recording system) which did not encourage best practice and led to increased stress and increased vulnerability for staff at the “coalface”.

5.7 That the actions taken to improve the duty system in response to the concerns raised in a previous SCR involving the death of a vulnerable adult were evidently insufficient to resolve the problems in the duty system.

5.8 That significant work has now been done to improve the duty system and to increase review activity; however this needs to be maintained and improved upon before the HSCP can be assured that this system is operating safely and effectively.

5.9 That the review arrangements for community care cases are still inadequate and it is extremely unlikely that a comprehensive review system can be implemented within existing resources.

5.10 That the progress made to date on introducing a new IT and recording system is not adequate and requires urgent attention.
Section 6 – RECOMMENDATIONS

6.1 Action to ensure proper steps are taken before the closure of a care package and before the transfer of cases between teams
It is recommended that the South Ayrshire HSCP takes urgent action to ensure that in future no care package is closed without a formal review and without direct contact with the client. It should further ensure that in future the process of case transfer meets acceptable professional standards.

6.2. Comprehensive review process
The South Ayrshire HSCP needs to ensure that it has comprehensive arrangements in place to review care packages on at least an annual basis. The Adult Protection Committee should receive regular reports on compliance with this standard until such times as the standard is routinely adhered to and the Chief Officers’ Group must ensure that adequate resources are in place to ensure compliance with statutory obligations.

6.3 Carefirst roll-out
The South Ayrshire HSCP must take urgent steps to ensure the roll-out of the Carefirst system across all its services within the shortest achievable timescale. It must devote the necessary staff and other resources required to ensure the implementation of this recommendation and they should report regularly on progress to the Adult Protection Committee and the Chief Officers’ Group.

6.4 Continued scrutiny of duty system
The South Ayrshire HSCP must continue to rigorously monitor the effectiveness of the duty system in adult services and should report to the Adult Protection Committee on a regular basis on the operation of this key element of the public protection system.

6.5 Discipline decisions
The South Ayrshire HSCP should make an immediate decision in relation to the outstanding disciplinary issues resulting from this case.
Section 7 – APPENDICES

Appendix 1 – South Ayrshire Health and Social Care Partnership improvement action plan
Appendix 2 – Terms of Reference
Appendix 3 – List of Review Team Members
6.1 **Action to ensure proper steps are taken before the closure of a care package and before the transfer of cases between teams.**

It is recommended that the South Ayrshire HSCP takes urgent action to ensure that in future no care package is closed without a formal review and direct contact with the client. It should further ensure that in future the process of case transfer meets acceptable professional standards.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions taken by South Ayrshire HSCP</th>
<th>Status</th>
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<tbody>
<tr>
<td></td>
<td>• Clear and comprehensive guidance has been introduced, following approval by the Partnership’s Health and Care Governance Committee. This ensures that care packages will only be closed after a formal review is completed and following face-to-face contact with the service user affected, and their family, as appropriate.</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>• The new guidance has been issued to all staff and is readily available on shared drives.</td>
<td>Complete</td>
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<tr>
<td></td>
<td>• New regular training and development programme introduced for staff.</td>
<td>Ongoing</td>
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<td></td>
<td>• Audit activity has shown evidence of improved case recording and clearer information on decision-making.</td>
<td>Ongoing</td>
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<td></td>
<td>• Due to the small number of case closures/transfers within adult social work services, a meaningful audit of case closures/transfers against the new guidance has not been undertaken at this time, but will be progressed as part of annual audit activity.</td>
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<td></td>
<td>• Audit activity will be reported to the Adult Protection Committee to ensure oversight and governance in relation to the required improvements.</td>
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### 6.2. Comprehensive Review Process

The South Ayrshire HSCP needs to ensure that it has comprehensive arrangements in place to review care packages on at least an annual basis. The Adult Protection Committee should receive regular reports on compliance with this standard until such times as the standard is routinely adhered to and the Chief Officers Group must ensure that adequate resources are in place to ensure compliance with statutory obligations.

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<tr>
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<tbody>
<tr>
<td></td>
<td>• A new documented procedure for care package reviews has been introduced to ensure clarity and consistency in relation to reviewing care packages within the statutory timescales.</td>
<td>Complete</td>
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<td></td>
<td>• As at 17 April 2019, almost 1,750 of the 1,800 current community care packages in place have now been reviewed – through visits with service users – at least once within the last year. The small number of outstanding cases reflects the fluid and changing nature of community care service users’ needs and circumstances – for example, a review may not have been completed if someone is in hospital or respite care; or family members need to attend before we can confirm current care needs. All of the outstanding cases have been reviewed within the last 18 months.</td>
<td>Partially complete</td>
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<td></td>
<td>• Teams have implemented a monthly programme for reviews to ensure the schedule of reviews is maintained on an ongoing basis.</td>
<td>Ongoing</td>
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<td></td>
<td>• Review activity is reported on a weekly basis to the senior leadership team to identify any anomalies at the earliest opportunity.</td>
<td>Ongoing</td>
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<td></td>
<td>• Quarterly reporting of review activity to the Adult Protection Committee to ensure oversight and governance in relation to the required improvements.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• New regular training and development programme introduced for staff.</td>
<td>Ongoing</td>
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<td></td>
<td>• A review of the current workforce model – including staff numbers and gradings of staff as well as associated work processes – is underway to ensure that review activity remains robust and sustainable in the long-term.</td>
<td>In progress</td>
</tr>
</tbody>
</table>
### Recommendation

**6.3 Carefirst Roll Out**
The South Ayrshire HSCP must take urgent steps to ensure the roll out of the Carefirst system across all its services within the shortest achievable timescale. It must devote the necessary staff and other resources required to ensure the implementation of this recommendation and they should report regularly on progress to the Adult Protection Committee and the Chief Officers Group.

<table>
<thead>
<tr>
<th>Actions taken by South Ayrshire HSCP</th>
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<tr>
<td>- The Carefirst social work management information system is being rolled-out across all social work services on a phased basis, with the first phase beginning in July 2018. The second phase went live on 1 April 2019.</td>
<td>Partially complete. On track for completion by 31 December 2019.</td>
</tr>
<tr>
<td>- A phased approach ensures the safe transfer of case files and personal information and identifies any potential issues to be addressed with the minimum impact.</td>
<td></td>
</tr>
<tr>
<td>- Carefirst is scheduled to be in use across the Health and Social Care Partnership by the end of 2019.</td>
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<tr>
<td>- Once embedded within the Partnership, the new modern system can offer additional functionality to further support performance management and improvement.</td>
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<tr>
<td>- Quarterly reporting of implementation activity to the Adult Protection Committee to ensure oversight and governance in relation to the required improvements.</td>
<td>Ongoing</td>
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</table>

• The Carefirst social work management information system is being rolled-out across all social work services on a phased basis, with the first phase beginning in July 2018. The second phase went live on 1 April 2019.

• A phased approach ensures the safe transfer of case files and personal information and identifies any potential issues to be addressed with the minimum impact.

• Carefirst is scheduled to be in use across the Health and Social Care Partnership by the end of 2019.

• Once embedded within the Partnership, the new modern system can offer additional functionality to further support performance management and improvement.

• Quarterly reporting of implementation activity to the Adult Protection Committee to ensure oversight and governance in relation to the required improvements.
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<th>Recommendation</th>
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<th>Status</th>
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| **6.4 Continued Scrutiny Of Duty System**  
The South Ayrshire HSCP must continue to rigorously monitor the effectiveness of the duty system in adult services and should report to the Adult Protection Committee on a regular basis on the operation of this key element of the public protection system. | - Independent review of the duty system undertaken in 2017.  
- Significant changes have been made to the duty system in terms of initial call-handling and decision-making. This ensures better information is available for duty social workers when considering how best to respond to calls, improves team leader oversight and accountability, brings in new rigorous standards for oversight and governance, and ensures every case has an allocated or nominated worker.  
- Clear and comprehensive guidance on the new way of working has been introduced, following approval by the Partnership’s Health and Care Governance Committee.  
- The new guidance has been issued to all staff and is readily available on shared drives.  
- Audit activity has shown evidence of improved case recording, clearer information on decision-making, and high levels of compliance with the new system.  
- Quarterly reporting of review activity to the Adult Protection Committee to ensure oversight and governance in relation to the required improvements.  
- New regular training and development programme introduced for staff. | Complete  
Complete  
Complete  
Ongoing  
Ongoing |
| **6.5 Discipline Decisions**  
The South Ayrshire HSCP should make an immediate decision in relation to the outstanding disciplinary issues resulting from this case. | - No further disciplinary action will be taken in relation to current employees working within the Health and Social Care Partnership who were involved in Ms Greenop’s case. | Complete |
Terms of Reference

1. Initial Case Review

An Initial Case Review (ICR) meeting into the circumstances around the death of Sharon Greenop was held on 10 March 2017. The minutes of the meeting are appended. The ICR concluded that there were grounds to progress to a Significant Case Review (SCR).

The decisions of the ICR were reported to the Chief Officers’ Group (COG) by the Chair of the Adult Protection Committee on 15 March 2017. At this meeting the Chief Officers agreed to proceed to an SCR on receipt of the full Minute of the ICR Panel. This was completed and forwarded on 5th May 2017 and confirmed by Chief Officers on 16th May to progress to a Significant Case Review.

2. Purpose of a Significant Case Review

The purpose of an SCR as defined by the current Pan Ayrshire Guidance(2013) on conducting an SCR in relation to Adult Support and Protection is to provide a systematic and transparent approach to the review process and:

- Establish whether there are lessons to be learned about how better to protect adults at risk. Reviews should be understood as a process for learning and improving service delivery as well as a means of recognising good practice;
- Make recommendations for changes in practice/policy/procedures where such changes will improve services to adults at risk.
- Consider how any recommended actions will be implemented;
- Ensure transparency and accountability in the review process;
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about an adult at risk;
- Identify national issues where appropriate including good practice.
- Undertake the review at the level that is necessary, reasonable and proportionate;
- Adopt a consistent, transparent and structured approach;
- Identify the skills, experience and knowledge that are needed in the review process and consider how these might be obtained;
- Address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome; and
- Take account of the evidence bases.
Further guidance and information around the role and purpose of SCRs is contained within the Pan Ayrshire Guidance.

3. Remit for the Review

The review should consider two broad areas of practice with a view to identifying lessons learned and opportunities for improvement:

1. The conclusions of the ICR focus on the issues surrounding the closure of a care package. The SCR should therefore review the circumstances around the decision-making including any wider issues of case management, including:
   • Current guidelines on annual review of cases and how these guidelines were followed and monitored by managers?
   • Expectations around completion of chronologies and to what extent these are followed across the service?
   • Actions taken within the service to clarify expectations around recording in case files?
   • Current quality assurance processes in place within adult services? Assess if these are effective and leading to appropriate service standards and quality of service.
   • The extent to which staffing concerns are being addressed at a senior level within the service and evidence of discussions and management action being taken.
   • Numbers of unallocated cases and the number of those cases which have not been reviewed. Clarify what plans are in place to address the situation?

2. There is reference in the ICR to the referral to Social Work on 16 August 2016 where concerns were raised that Ms Greenop had a black eye. The SCR should consider the circumstances surrounding this incident including the following:
   • Call handling
   • Initial assessment approaches by social work staff
   • Attitudes to and recognition of risk
   • Understanding of key statutory responsibilities
   • The ability to identify and act on situations where there may be public protection risks including those associated with adult or child protection.
   • Supervisory roles and linkages between front-line staff and team managers and service managers
   • Record keeping and evidence for decision-making
   • Where concerns are identified in relation to adult or child protection for example are these adequately flagged within the system to alert practitioners involved at a later date that a concern was raised?
   • How satisfied are managers that current duty arrangements are appropriate. Has the performance of the duty system been addressed at Directorate management level within the H&SC Partnership?

4. SCR Process

The Remit for the SCR is as outlined in Section 3 above and follows the processes and workplan identified in the Pan Ayrshire SCR Guidance(2013). The Lead Reviewer will also require to take into account any parallel procedures undertaken by NHS Ayrshire and Arran for reporting of Adverse Events, as updated at February 2017.

5. SCR Team

The appointment of a Lead Reviewer will be confirmed by the Chief Officers’ Group. This appointment will take into account all relevant professional knowledge and skills in evaluating and testing evidence. The Lead Reviewer will be supported by a SCR Panel to be appointed from agencies comprising the Adult Protection Committee. Membership of the Panel will not involve anyone who was substantially involved in service provision directly with the individual whose case is being reviewed. The Panel will act as a sub-group of the Adult Protection Committee.
6. Interim Reporting Arrangements

The Lead Reviewer will report to the SCR Panel at regular intervals. Interim reports will be made in writing to the Adult Protection Committee and Chief Officers’ Group, consistent with agreed milestones and elements of the SCR process.

7. Review Methodology

The review team will use established practice for conducting a SCR, including such methods as they deem necessary to answer key questions posed under the Remit for the Review. Partner agencies will be expected to cooperate fully with the Lead Reviewer who will have unrestricted access to policies, protocol’s, procedures and case records. Access to either staff or family members will require to be cleared in advance with the Crown Office and Procurator Fiscal Service (COPFS).

Any contacts with General Practitioners must recognise their status as independent contractors, whose cooperation will be facilitated by NHS Ayrshire and Arran.

The work of the Significant Case Review will at all time take into account any areas of potential overlap with any ongoing criminal investigation and will advise the COPFS of progress and seek advice on any areas of the SCR which could affect the criminal procedures led by COPFS.

Any significant risks identified by the Lead Reviewer during the SCR process will be reported immediately to the relevant Chief Officer from the agency/service involved. Administrative support for the Lead Reviewer will be provided through South Ayrshire Council (SAC) and the South Ayrshire Health and Social Care Partnership SAHSCP)

8. Final Report

The Lead Reviewer will draft both an interim report and a final report. The report will be considered and agreed by all members of the SCR Panel. Where there is disagreement this will be noted in the report.

The structure of the report will follow the agreed format for Pan Ayrshire SCR reports:-
  > an introduction which summarises circumstances leading to the Review
  > Executive Summary and list of recommendations and/or learning points
  > Chronology of agencies professional involvement, including listed contacts with the individual at risk and extended family in eliciting views and wishes of the former.
  > Extent of carer involvement-by agencies and family.
  > Analysis of evidence
  > Conclusions

1. Report Dissemination

The Final Report will be submitted to the Chief Officers’ Group who will have responsibility for deciding what elements of the report and timing may be put into the public domain. This will include any media contacts necessary during or at the conclusion of the SCR process. A single point of contact for all media enquiries will be agreed in consultation with Chief Officers.

2. Process and timescales

> Appointment of Lead Reviewer and SCR Panel by June 2017.
> The first meeting of the Lead Reviewer will scope and agree the process of the Review and agree an outline of the workplan and timeline.
> The Lead Reviewer will submit a written progress report regularly to the COG
> The final report, executive summary and action plan will be submitted to The Chief Officers’ Group.

Tim Eltringham and David Cumming - 1/6/17.
## LIST OF REVIEW TEAM MEMBERS

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION</th>
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<tbody>
<tr>
<td>David Crawford</td>
<td>Independent Chair – Significant Case Review</td>
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<tr>
<td>Mark Taylor</td>
<td>ASP Co-ordinator</td>
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<tr>
<td>Karen Briggs</td>
<td>Service Lead, Legal &amp; Licensing</td>
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<tr>
<td>Angela O’Neill</td>
<td>Associate Nurse Director, Acute Services</td>
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<td>Caroline Dickson</td>
<td>Clinical Nurse Manager, Acute Services, NHS A&amp;A</td>
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<tr>
<td>D.C.I. John Hogg</td>
<td>Police Scotland</td>
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Independent
Significant Case Review (SCR) Report
Sharon Greenop