City Of Edinburgh Adult Protection Committee

Learning Review – Adult A
Executive Summary

1. Introduction

1.1 Adult A had been known to services since birth and had a diagnosis of Crohn's disease and a Learning Disability.

1.2 In April 2023, Adult A died in hospital at the age of 24. The cause of death was stated to be sepsis and metastatic Crohn's Disease.

1.3 Adult A was considered under adult protection processes over 20 times during the 6 years of the review. There were nineteen hospital admissions and a substantial care package in place. Adult Protection concerns included:

- Self-neglect
- Neglect
- Physical harm
- Sexual harm
- Financial harm
- Psychological harm

1.4 A Learning Review notification was submitted to Edinburgh Adult Protection Committee in September 2023 and a decision was made to undertake a review based on the following:

- The adult was subject to adult support and protection processes.
- The adult at risk of harm died, and harm or neglect was known or suspected to be a factor in the adult's death.
- A referral from another organisation gave rise to reasonable cause for concern.
- The Adult Protection Committee determined that there may be learning to be gained though conducting a review.

2. Case Context

2.1 There were complexities managing self-care alongside considerations of self-determination and care arrangements with a family member who also had declining health.

2.2 There was a pattern of Adult A declining support for personal care and treatment which led, in part, to significant skin breakdown and infections. Adult A's ability to make decisions about care and treatment was the subject of, at times, almost daily discussion, especially while in hospital, where Section 47 of the Adults with Incapacity (Scotland) Act was invoked on several occasions to allow treatment to be carried out.

2.3 The reasons for hospital admissions varied and included specific surgical interventions, but the majority were to manage skin care, infections and sepsis.

2.4 The Review found that it was evident that those supporting Adult A took considerable time and effort to support Adult A's decision making on a day-to-day basis. It was noted that Adult A was vocal in choices and that Adult A had an advocate in place for over half of the time period covered by this review, with earlier consideration of a referral to advocacy being discussed with Adult A but declined.

3. The Process of the Review

3.1 A Review Team and Independent Reviewer were identified in 2023 but in 2024 a new Reviewer needed to be appointed. A new Reviewer was identified in September 2024. The timescale for the Review to take place was agreed to be October 2024 – February 2025.

3.2 The Review Team was chaired by the Chief Social Work Officer and had representatives from Health & Social Work Services and Police Scotland. The Review Team met on five occasions between December 2024 and March 2025.

3.3 A Terms of Reference had been compiled in 2023 and approved by the Adult Protection Committee. This was reconsidered by the 2024 Review Team and found to still be pertinent. It highlighted the following areas for consideration:

- Legal powers
- Application of informal measures of support
- Social work support
- Transitions from child to adult services
- Potential barriers to partnership working.
- Recognition of strengths and positive areas of practice

3.4 The review was to cover the period of 6 years prior to Adult A's death.

3.5 It was noted that some learning had already taken place, with action plans already in place, following the partnership's review of Through Care & After Care Services, Adult Protection processes and a separate report by an external body.

3.6 The External Reviewer was able to talk to a family member whose views have been considered. The family member agreed to extend an invitation to other family members to talk to the Reviewer should they wish to do so. No other family members were spoken with.

3.7 The Practitioners' Event was held in person in January 2025. Practitioners were asked to consider the timeline of events during the period of the review, their involvement with Adult A and key questions, namely:

- Who was responsible for Adult A's care and support?
- What might have made a difference for Adult A?
- What did make a difference?
- Are there policies, procedure, practice in place now, that were not when Adult A was alive, that might have made a difference, with specific thoughts about adult protection and risk assessment processes?
- What hindered practitioners doing what they wanted to do to support Adult A?
- What recommendations would they like to make?

3.8 The Senior Managers event took place in January 2025. The managers also considered the timeline of events and were provided with a summary of the points raised by the practitioners. Managers were asked to consider specific areas raised by practitioners:

- Chronologies
- Information governance (recording, information sharing, etc)
- Types of meetings held.
- Capacity decision making
- Recording, assessing, and managing risk (both within and out with adult protection processes)
- What is important to people as opposed to what is important to professionals.

4. Strengths and Positive Areas of Practice

4.1 Through Care and After Care was found to have shown commitment to Adult A, providing support throughout initial adult protection concerns, until an adult social worker was allocated.

4.2 The Liaison Learning Disability Service was found to have provided an essential link between professionals and Adult A, allowing some support to be provided and positive relationships to be built, showing how valuable this service is.

4.3 Hospital and community staff were found to have built positive relationships with Adult A and tried to value and understand Adult A's views.

5. Final Report and Learning Points

5.1 The Review findings were presented to the City of Edinburgh Adult Protection Committee on 8th April 2025 and the final report approved at the City of Edinburgh's Chief Officers' Group for Public Protection on 16th April 2025.

5.2 The Learning Review acknowledged improvement work already underway or completed had addresses some matters that arose during the review. The following Learning Points are accepted and being taken forward by the partnership:

Adult A – Independent Review Learning Points	
1. Expert Reference Panel	The use of an '***expert reference panel***' possibly consisting of a **psychiatrist, senior social work manager, solicitor,** and/or **Mental Health Officer (MHO)**, to support discussion around **capacity issues** for the **most complex of cases**. This would **not be a decision-making panel** but would allow an independent overview of these very challenging cases. It could **give support to practitioners** who are trying to provide care to those in these situations.

2. Adults with Incapacity Lead Role	The **identification of an MHO Team Leader** who would have a **role in supporting the application of AWI (Adults with Incapacity) legislation**. This manager should have sufficient **knowledge and experience to guide practitioners in complex situations** and provide a clear **link to adult support and protection**. Their role would sit between the current 'advice line' available for MHO's and other practitioners and the 'Expert Reference Group.'
3. Council Officer Role	**Clarifying the role of the Council Officer as lead professional,** especially in regard to **complex cases, including while the person is in hospital**, ensuring all aspects of their care, support and protection are coordinated.
4. Adult Protection when Adult Admitted to hospital	Confirming **the role of adult protection meetings while a person is in a hospital setting.** *(Note – this is derived from concerns over Adult Support & Protection related matters not being actively progressed when a relevant Adult is admitted to hospital on the basis of the notion that a hospital is a safe place, but perhaps not remaining focused on enduring risks that will often or likely prevail when the person is released from hospital.)*
5. Recording of Decision Making	**Reviewing the processes in place for recording decision making** in both adult protection and adults with incapacity cases **to ensure clarity.**
6. Recording & Sharing of High-Risk Information	Establishing a way of **highlighting and sharing key, high-risk issues for a person**, so that **all relevant professionals can see them**, even if this must be on paper e.g. capacity discussions, adult protection issues, DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation).
7. Escalation Policy	**Reviewing the current Escalation Policy** and how it fits with other policies and procedures. (Note - *Different from but* ***related to the partnership's ongoing Escalating Concerns Policy Review*** *given the background to that ongoing review included practitioners' conflation of Escalating Concerns and Escalation Policy in general terms.)*

8. Learning & Development	**Implementing the multiagency training group,** covering Adult Support and Protection, Adults with Incapacity and Mental Health Legislation, formed **following the completion of a training needs analysis** *(recommended to the partnership in a separate previous report).* The following is verbatim from the Learning Review but has been redacted: - the need for **multiagency training to focus on the principles of practice**, putting the **person at the centre of decision making** using case examples to promote discussion on the impact of legislation on those we support. - Training should also emphasise the **duty on professionals to voice their concerns regarding any part of process/system** and the **need for clear recording of decisions** made. - Consideration should be given to **including advocacy workers in both the delivery and participation of training** covering Adults with Incapacity legislation in particular. - Ensuring that scrutiny of **audits evaluating the improvement plans** includes a, **'So what?' question** at each stage, **to ensure the quantifiable outputs result in positive outcomes for people** at risk of harm.

6. Accountability and Monitoring

6.1 The Learning Review report has been shared with the Care Inspectorate.

6.2 This Executive Summary will also be shared with the National Adult Support & Protection Conveners' Forum to allow the learning to be considered by all areas across Scotland.

6.3 The Adult Protection Committee, its members and Independent Chair and the partnership in Edinburgh accept responsibility and accountability for making progress against the recommendations. Progress will be monitored by both the Care Inspectorate and Edinburgh's Chief Officers' Group.