Final Report

North Tyneside Safeguarding Adults Board

The Death of Adult A
(1951 – 2010)

A Serious Case Review
(Overview Report)

Tom Wood
April 2011

Contents

1. Introduction

1.1 The Serious Case Review

On 26 February 2010 the North Tyneside Safeguarding Adults Board agreed that it was necessary to carry out a serious case review as the result of the death of Adult A and to commission an independent person as its Chair and a further independent person as the overview report writer.

The Serious Case Review was undertaken because "an adult had died and abuse or neglect is known or suspected to be a factor in the death."

The purpose of a Serious Case Review is:

1. To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.
2. To review the effectiveness of procedures, both multi-agency and those of individual organisations.
3. To inform and improve inter-agency practice.
4. To improve practice by acting on learning.
5. To commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

1.2 Serious Review Group

Dr Sue Ross accepted the position of Independent Chair of the Review and Mr Tom Wood that of Independent Overview Report Writer. Dr Sue Ross is currently Independent Chair of Newcastle upon Tyne and Manchester Safeguarding Adults Boards. She is a qualified and respected social worker and has served as a Director of Social Work in Scotland and Wales. She has also served as Chief Executive of a large PCT in England. Tom Wood is currently Independent Chair of both Adult and Child Protection Committees in two Scottish Local Authority areas. He was the Deputy Chief Constable and Director of Operations of a large police force in Scotland and subsequently served as a Special Adviser on Alcohol and Drug Policy in Scotland.

The other members of the Serious Review Group are:

Mr Richard Booth – Northumbria Probation Trust
Mr Ian Smallman – Northumbria Healthcare NHS Foundation Trust
Ms Vida Morris – NHS North of Tyne
Ms Sheila Watson – North Tyneside Council
Mr Chris Piercy – NHS Newcastle and North Tyneside Community Health
Ms Jacqui Old – North Tyneside Council
DI Neil Brotherton – Public Protection Unit
Ms Moira West – North Tyneside Council
Mr Robert Clark – Minute Taker
Mr Roy Marston – North Tyneside Homes
Mr Paul Courtney – Northumberland, Tyne & Wear NHS Foundation Trust

Ms Michelle Garrod – Legal Representative, Serious Case Review Group, North Tyneside Council

1.3 **Basis of review**

This review is based on individual agency reviews submitted by

- North East Ambulance Service
- Northumbria Police
- North Tyneside Homes, North Tyneside Council
- Northumbria Healthcare and Northumbria NHS Foundation Trust
- Jobcentreplus
- NHS Newcastle and North Tyneside Community Health
- Northumberland Tyne and Wear NHS Trust
- Independent GP Practice

and on the information offered by family members of Adult A and a number of expert witnesses (see Appendices)

1.4 **The Death of Adult A**

The circumstances surrounding the death of Adult A were given extensive media coverage in February 2010 (see Appendix).

Following a police investigation, a criminal prosecution was instigated against Adult A's brother JB, with whom she shared the tenancy of her home. In December 2010 JB pled guilty to the charge of Manslaughter – gross negligence.

This common law offence may be committed where a person causes the death of another through extreme carelessness or incompetence. Four things must be proved:

1. The defendant owed a duty of care to the deceased.
2. The defendant breached this duty.
3. The breach caused the death of the deceased.
4. The defendant's negligence was gross, that is it showed a disregard for the life and safety of another as to amount to a crime and deserve punishment.

In January 2011 JB was convicted and sentenced to a term of imprisonment for the Manslaughter of Adult A by gross negligence.

In light of the finding of Criminal Responsibility this report focuses on what lessons can be learned from this difficult case where Adult A, a reclusive and 'hard to reach' individual with learning difficulties, apparently refused to seek help or medical care and her brother, the only person in contact with her and able to raise the alarm, failed to do so.

1.5 **Summary**

The circumstances of Adult A's death:

At 1640 hours on 9 February 2010 a 999 emergency call was made by JB to report that his sister Adult A required medical attention at the home they shared in North Shields, Tyne and Wear. As the patient was described as unconscious the call was prioritised and a rapid response crew attended some four minutes later.

On arrival it was found that the house was so heavily cluttered with rubbish, furniture and rotting food that access was both difficult and hazardous for hygiene reasons. There was a pervading smell of faeces and urine and the house was very cold. The toilet was blocked and the bath full of rubbish. Such was the condition of the house that the ambulance crew had to wear protective clothing and masks before entering.

Adult A was found in her upstairs bedroom lying on the floor on her left side. She was partially clothed and there was fresh and old excrement throughout the sparsely furnished room, on the floor where she lay and on Adult A. She was barely conscious and gave the impression of having been lying in the position she was found for some time. With difficulty, Adult A was removed from the house and taken to the North Tyneside General Hospital where she was admitted a short time later.

On arrival at Accident and Emergency, Adult A's condition was judged critical. She was suffering from severe hypothermia and showed evidence of severe neglect and numerous soft tissue injuries. She was suffering from an infestation of lice and maggots were present. What appeared to be pressure sores were observed, indicating that she had been lying for some time in the position she was found. During examination it was seen that Adult A's feet were blue/black in colour indicating lack of circulation, subsequently identified as gangrene.

Adult A's temperature was extremely low and as a priority she was given emergency treatment for the life threatening condition of hypothermia.
Later that evening, however, her condition deteriorated and she suffered a number of cardiac arrests. Despite advanced resuscitation Adult A died at 0240 hours on 10 February 2010.

Following post mortem examination the cause of death was determined as "Hypothermia".

1.6 **Terms of Reference**

At the time of admission to hospital a "Safeguarding Alert" had been issued for Adult A and this instigated an assessment of the circumstances surrounding her death. Whilst a criminal investigation was immediately undertaken, the Serious Case Review Sub Group of the North Tyneside Safeguarding Adults Board considered a number of specific issues and questions that the case had raised at that time. To answer these they required a Serious Case Review to provide answers to the following and any other matters thought relevant.

1. Adult A's mother died in 2004 and whilst it is recorded that Adult A had a learning difficulty the review needs to determine whether agencies were aware of this and if they were, whether the actions taken were appropriate. Were there any gaps in multi-agency working? Was there an intentional concealment of learning difficulties?

2. Child to Adult transition, considering how people transfer across services.

3. What processes and procedures were in place at the GP practice? We are aware that Adult A had type 2 diabetes but was not in receipt of medication. Should the District Nursing Service have been involved to monitor this?

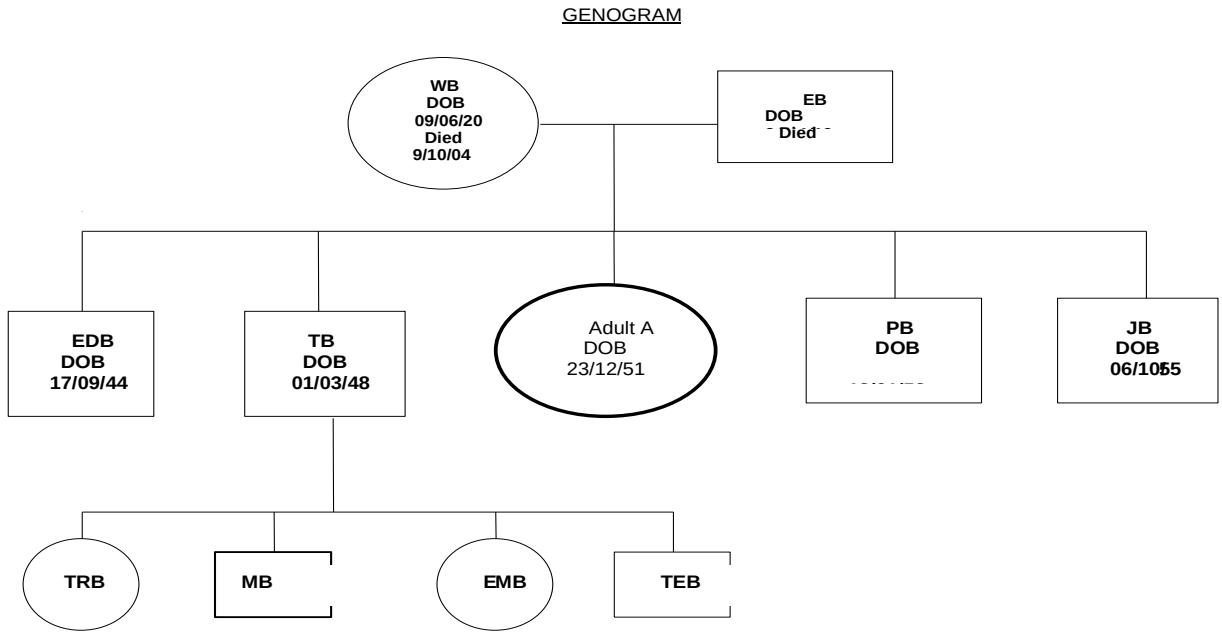
4. From a housing perspective, there has been significant involvement by North Tyneside Homes; however, none of this became a formal safeguarding concern. We need to understand why and how systems, processes and practices can be improved to flag up vulnerability.

1.7 **Timescale**

In order to fulfil the requirements of the Serious Case Review Sub Group a plan was agreed with timescale for reporting by 30 September 2010 (see Appendix).

2. **Family Information**

2.1 **Family composition and genogram**



2.2 **Summary of family background and circumstances**

The following family background has been drawn together from Adult A's siblings and from the police and court reports.

Adult A was born on 23.12.51, the third child of WB (d c1979) and EJB (d 2004). She had two elder brothers EB (b 1944) and TB (b 1948) and two younger brothers PB (b 1953) and JB (b 1955).

The B family have lived in North Shields for several generations and while the elder brother EDB is long estranged, TB and PB live within a mile of the family home in North Shields, until her death occupied by Adult A and her younger brother JB.

Following the death of the father EB in 1979 the mother WB moved with Adult A and JB to the recently "revitalised" mid terrace, three bedroom house in North Shields, the property of North Tyneside Council. By this time the three older brothers EDB, TB and PB had left the family home to live independently but both TB and PB and their families remained infrequent visitors until after the death of their mother in 2004.

Adult A is described by her brothers TB and PB as being shy and awkward as a child but not in their view as having a mental incapacity. Accordingly she passed through normal schooling, took a keen interest in reading and crossword puzzles and had a job immediately after leaving school. Even in later years (1990s) she was a competent babysitter for her brothers' young children. The family believe that whereas Adult A needed encouragement and stimulation to overcome her introverted and awkward nature, her mother WB dominated and controlled both Adult A and JB and may have prevented them from becoming independent or capable adults.

The family describe their mother WB as reclusive, controlling and antisocial, who dominated Adult A to the extent that she would not let her pick her own clothes, go out with friends or go on holiday on her own. By all accounts Adult A, described as pretty when she was young, had no friends outside the family and no relationships during her adult life. It appears that Adult A did start a job as a shop assistant immediately after she left school but was removed from work by her mother after a few months after it was alleged Adult A had been bullied. The family believe this was about 1969-70, at about the time Adult A was first identified as having a mild learning difficulty. Accordingly Adult A never worked again and quickly became lazy, neglected her personal hygiene and care and became obese.

JB, described as weak and lazy by his brothers was similarly dominated by his mother but managed to gain casual work, develop friendships outwith the home and even move away from the family home for a period when he worked with his father EB in Gloucestershire.

Towards the end of her life (1990s) it seems that Adult A's mother, WB developed a form of dementia which made her even more reclusive but also aggressive to neighbours and to children playing in the vicinity of their house. This in turn made her a target for children in the neighbourhood. It was during this period that the family believe Adult A was driven into further isolation, developing the reclusive nature that marked her final years.

WB died in 2004 in what must have been a traumatic event for Adult A. It appears that having found her mother collapsed in the toilet of the house, Adult A dragged her to the front door in an effort to get help. On arrival at the house the Ambulance Service found Adult A with the body of her mother. JB having called the ambulance immediately absented himself from the house, an indication perhaps of how he coped with stress.

Adult A did not attend her mother's funeral and from that time the family saw her slowly slide into isolation and seclusion. They believe that both Adult A and JB, while being dominated by her, had become totally dependent on their mother and consequently were unable to look after themselves following her death. Sensing this, members of the family tried to help and from 2004 to 2006 this seemed to work. Members of the family visited the house from time to time and would see Adult A out shopping albeit infrequently. It was noted that the house was cluttered and dirty but still liveable. After 2006, however, contact became more difficult. Adult A was not seen even on her infrequent shopping trips and family members could not get her to answer the door of the house even though they were certain she was in. Thereafter, the only contact the family had was via JB who they would still meet regularly in the street. When asked about Adult A he would simply say she was "fine" and give no further detail. This reassurance satisfied the family who assuming Adult A was like her mother simply reclusive eventually stopped calling at the family home and since there was no telephone landline in the house all direct contact with Adult A ceased in 2006.

From 2006 to the time of her death, Adult A had no contact with her family and was not seen by neighbours. JB was, however, frequently seen in the neighbourhood and entering and leaving the family home. Always smartly dressed and well-presented JB would always report Adult A as "fine". From time to time he would contact his brother TB by mobile phone but at no time did he indicate a problem with Adult A or ask for help.

In the description of Adult A's life, a picture emerges of a shy and awkward girl with learning difficulties, but who may have had the potential to develop given treatment, positive support and development. Instead she was dominated and controlled, prevented from any development as an independent adult and ultimately descended into complete isolation. It is also clear that Adult A's life began to slide after her mother's death with 2006 as the pivotal year. That was the year that she withdrew from her family and the outside world, the year she ceased her medication, and the gas was capped off in her house, following identification of an unsafe appliance.

While JB's account of Adult A's life is still vague, even after extensive police interviews, it now seems certain that from 2006 to the date of her death Adult A's life slid into a state of neglect, squalor, isolation and failing health in which she died.

3. **Agency Involvement Summary**

3.1 A number of agencies were involved with Adult A and her family. Individual agency reports were received from the following:

The North East Ambulance Service
Northumbria Healthcare NHS Foundation Trust
Jobcentreplus
Northumbria Police

Northumberland Tyne and Wear NHS Trust
NHS Newcastle and North Tyneside Community Health
North Tyneside Homes – the housing service department of North Tyneside Council

Within these agencies the involvement with Adult A and the B family differed greatly.

3.2 **The North East Ambulance Service** report of two incidents relating to the B family, the first on 9 October 2004 when an ambulance attended WB's sudden death, the second on 9 February 2010 when Adult A was found collapsed and unconscious in her home. In both cases the record shows that the Ambulance Service attended speedily and carried out their duties to a high standard. No other issues arise from their involvement.

3.3 **Northumbria Healthcare NHS Foundation Trust** record two periods of contact with Adult A, the first in 2004 and the second in 2010 when she was admitted shortly before she died. In the first contact the record shows that from 2.2.04 to 23.2.04 Adult A attended for outpatient podiatry treatment at the Diabetic Resource Centre. In four appointments within a three-week period she received treatment described as "wound management". On the date of the fifth appointment (27.2.04) she did not attend and was referred back to the GP. Whilst detailed records are missing, this profile appears fairly normal in the management of diabetes and it is clear that during the period (before the death of her mother) Adult A was organised and motivated enough to seek and accept help.

In the second contact the record shows the Accident and Emergency Service's vigorous attempts to save Adult A's life from the 9th to 10th February 2010. It is clear that in very difficult circumstances they did their utmost.

Given that the broken appointment in February 2004 was referred back to the GP, no other issues arise from their involvement.

3.4 **Jobcentreplus** record their relationship with Adult A from 1991 to the time of her death. Since evidence from her family indicates she only worked briefly in 1970 there may have been contact prior to 1991. If so this is not recorded.

In 1991 Adult A is recorded as being in receipt of Invalidity Benefit on the grounds of "learning difficulties and obesity" and this is confirmed in 2005 when Adult A is recorded as "passing" a personal capability assessment, thus confirming her status as unfit to work.

In 2005 three appointments were made to visit Adult A but for reasons unrecorded these visits did not take place.

In February 2006 Adult A's benefit was suspended for reasons of non-communication, but on 26 June an officer from Jobcentreplus visited Adult A in her home and completed the necessary paperwork confirming her invalidity. Whilst information on this visit is scant and the officer who conducted it has since retired and is unavailable, this interview with Adult A is significant as the last recorded interaction between Adult A and the outside world until the time of her death over three years later. The meeting is significant for having happened at all and perhaps indicates that in certain

circumstances a combination of both a determined approach and use of official sanctions that would directly affect Adult A, it was possible to coax Adult A to a face-to-face meeting.

The records of Jobcentreplus show that though infrequent, contact with Adult A continued to persuade them of her incapacity to work and accordingly no other issues arise from their involvement.

3.5 **Northumbria Police**

Following Adult A's death, Northumbria Police carried out an extensive criminal investigation, this leading to the successful prosecution of Adult A's brother JB for the Manslaughter – gross negligence of Adult A.

Prior to the death of Adult A records show a number of police calls to the B household apart from the sudden death of Adult A's mother WB in 2004 and the discovery of Adult A in February 2010. The police record five calls to the B household between December 1998 and 2001, these calls relating to youth disorder, a dispute with neighbours and damage. These incidents coincide with the family's description of WB's declining mental state, her behaviour and the consequential disturbances in the neighbourhood in the years before her death.

The homicide investigation carried out by Northumbria Police was thorough and extensive. All relevant witnesses, neighbours, family members, friends of JB and the professionals who had contact with the B family were interviewed and statements obtained. Relevant information from these statements is included within the text of this report.

JB was interviewed by police six times prior to being charged with the Manslaughter of Adult A.

JB presented as pleasant and relaxed during interviews, his concentration was good and his self care appeared reasonable. Most noticeable, however, was his emotional, superficiality, the minimisation of any abnormality regarding the state of his living conditions, even in the face of clear descriptions of what they were like and the lack of detail in his account of his family.

In his account of his family life, JB appears to have had only limited dealings with his mother WB and his sister Adult A. He was vague about the other members of his family, had no knowledge of his elder brother EDB and limited contact with his other brothers TB and PB.

JB has never had long term employment and describes his life as being mainly concerned with domestic chores within the family home. He says that he cooked the meals, did the shopping and paid the bills with money his mother WB gave him, while she and Adult A "looked after the house" although in later years his mother found it difficult to stand or walk because of phlebitis. He states that he had occasional arguments with his mother but did not consider her particularly difficult. Her behaviour did apparently prevent him from bringing friends to the house, however, as his mother WB was by that time "cantankerous" and "in her later years got a bit unfriendly."

According to JB he was rarely home during the day, and at night he spent his time alone in his room reading or listening to the radio.

Following the death of his mother WB in 2004 JB speaks of things going "downhill" and this is confirmed by his attendance at his GP with symptoms of low mood, tearfulness and "not wanting to get up." These symptoms persisted during 2005-2006 during which time JB states he "couldn't be bothered to do anything" and in his own words "I let myself go a little."

Records confirm that JB attended the GP practice and requested bereavement counselling which was arranged. He had an appointment for October 2005 which he rang and cancelled. On return to his GP in November 2005 he was unwilling to speak about his mother and had stopped taking earlier prescribed anti-depressants because of side effects.

During this time JB believes Adult A may also have been affected by their mother's death. Whereas previously she went to local shops and attended the GP, he says she became more withdrawn and stopped going out altogether, spending much of her time in her room or watching television. About this time Adult A stopped washing, stayed in bed all morning and did nothing round the house. This account is verified by family members who saw Adult A become isolated and unkempt following the death of her mother and by neighbours who noted her disappearance from sight around 2006/7.

By JB's account he tried to get her up and out of the house, even suggesting a trip to York in 2006, but these attempts failed and after a period JB reverted to his previous lifestyle, having little to do with Adult A and spending most of the day out of the house. He continued to shop and do the cooking but otherwise he appears to have left Adult A to fend for herself.

In regard to Adult A's medical condition, JB claims that he tried to get Adult A to keep her medical appointments, but on her refusal he does not appear to have made much effort to encourage her or attempt to seek any outside help.

According to JB the state of the house began to deteriorate in 2005. As Adult A refused to help in the house, JB decided only to cook and do nothing else. By his own account JB lost all interest in the house during 2007-8 and in 2009 stopped using the bathroom within the house, using public toilets or facilities within the homes of friends and acquaintances. Regarding the lack of heat JB blamed Adult A for not letting engineers into the house claiming he had to go out during the time of the arranged visits. When challenged over this he could not explain his part in the failure to allow gas engineers to visit the house.

Throughout his interviews JB gave the impression of being overwhelmed by the problems of caring for Adult A. In summary he says:

> "I gave up doing everything and anything. I would feed her, do a little shopping for her, cook, that was it. She wouldn't help us, she would say no – you can't do that. She was not an easy person to get on with."

When asked about his living conditions, JB said:

> "Once out of the front door, I didn't think about it. When I returned I would say something's got to be done. Many a time I'd say to C that we had to do something. She wouldn't do anything….. she wouldn't pick up the rubbish and I certainly wasn't going to do it."

In his account of Adult A's fall in her bedroom and her final days JB gives contradictory versions to the police and in his psychiatric assessment. Unlike his account to police in which he claims she was not in any pain, during a psychiatric assessment he states that Adult A complained of pain to the leg, stomach and back, but "did not want to see a doctor." JB further claimed that she was "fine" while lying in her bedroom and was only "in a bit of a state" a short time before he called the ambulance. When questioned about the general condition of Adult A's room, JB states that it "did smell a bit" but was not littered with faeces.

Given the condition of Adult A's bedroom when she was found, JB's detachment from reality is clear to see.

This detachment is further illustrated when JB was questioned by police about a text message he sent a friend in the early afternoon of the day Adult A was found in her home. While the text message indicates that Adult A was unwell, it was much later in the evening that he actually raised the alarm.

To paraphrase a psychiatric report made available to the police:

> "While JB presented as pleasant and relaxed with good concentration and no sign of depression or other mental illness, most noticeable was his emotional superficiality, the minimisation of any abnormality regarding the state of his living conditions over the past few years even in the face of clear descriptions of what they were like and the lack of detail in his account of his family."

In summary while the extensive police investigation raises concerns over North Tyneside Homes and GP involvement with Adult A, the police report concludes that ultimately only JB had a duty of care and was in a position to help Adult A.

The police view that JB was criminally responsible was supported by the Crown Prosecution Service, leading to his court appearance and subsequent plea of guilty to the charge of Manslaughter – Gross Negligence.

3.6 **Northumberland Tyne & Wear NHS Foundation Trust (NTW)** –
NTW maintains statutory responsibility for the provision of specialist mental health and learning disability services in North Tyneside. North Tyneside Primary Care Trust and North Tyneside Council provide community learning disabilities services in North Tyneside. NTW record only that GP records show Adult A as having been a patient at a day unit at St George's Hospital, Morpeth between August and October 1980. This day unit would offer a treatment service for people with mental health issues and would then not be part of the learning disability service provision. GP records indicate that she was seen at the day unit for treatment of some form of phobia. The background information to this was that Adult A suffered a panic attack on a train prior to her GP referring her to the day unit.

At that time Adult A underwent an examination during which reference is made to her mother describing Adult A as "intellectually subnormal". The conclusion reached was that Adult A would not have "the intellectual equipment to respond to supportive psychotherapy and relaxation therapy".

A subsequent assessment later in 1980 concludes that "there is little we can do for her (to deal with her phobia) as she is of limited intelligence."

With that conclusion it appears that no further attempt was made to address Adult A's mental health or fear phobia, conditions that undoubtedly contributed significantly to her subsequent seclusion and isolation.

No further information is available from NTW and no other issues arise.

3.7 **NHS Newcastle and North Tyneside Community Health** – Provides Community Learning Disability Services. There is no record of Adult A accessing these services.

3.8 **Independent GP Practice** – As expected, the general practice in North Shields where Adult A and other members of her family were registered had regular contact with Adult A from 1973 to 2006 (although her records begin in 1970) after which having not requested any further prescriptions, she was neither seen nor prescribed for – her last prescription was issued on 27.4.06.

Although Adult A was diagnosed with a "learning difficulty" in 1970 this being variously described as "mentally handicapped", "intellectually subnormal" and "learning difficulties" no treatment was considered appropriate. The true extent of Adult A's learning difficulty is to a large extent unknown. Initially described as a "mild" condition, where some employment was possible (1970) this status was reviewed following a panic attack in 1980 when she was assessed as "not intellectually equipped to benefit from therapy" and classed as mentally handicapped and incapable of work by the Consultant. This 1980 assessment was verified annually from 1989 when she was examined in order to obtain her yearly learning disability sick note. During these examinations phrases such as "subnormal intelligence" and "learning difficulties" were noted in records. The final reference on 17/8/06 refers to learning difficulties.

As previously noted in 3.6 it was accepted that Adult A was unlikely to respond to treatment and consequently despite long diagnosis and changed behaviour there is no record of contact with the local learning disability team or the local district nurse.

Adult A also suffered from a number of physical conditions for which she was prescribed a variety of medications:

- Obesity first noted in 1990
- Type 2 diabetes and hypertension diagnosed in 2001
- In 2002 and 2004 respectively she was prescribed Metformin and Gliciazide for her diabetic condition
- In 2003 she received treatment for an eye disease resulting from her diabetes

Throughout the period 1970s – 2005 Adult A attended medical appointments regularly and demonstrated the ability to follow medical directions and manage her medication.

Consequently despite her documented learning difficulties and her ongoing chronic medical conditions, she was not considered vulnerable and information was not shared with partner agencies.

Adult A was last seen within the GP practice in 2005 for her annual diabetic review by the practice nurse and by her GP late in 2004.

About this time (mid 2005) it is recorded that Adult A began to fail to attend medical appointments regularly. While she attended her GP's practice as late as November 2005, she had already broken several appointments at hospital and from August 2005 a number of letters highlighting this were sent to her home address.

In April 2006, Adult A stopped requesting medication and while a repeat prescription was in place until April 2007 no further medication was accessed by Adult A after 2006.

While further treatment would have been made available to Adult A on request and after medical examination, the request was never made and since Adult A was not seen as vulnerable, no attempts were made to contact her other than by letter.

It is the procedure in GP practices that "exception reports" are routinely completed to highlight patients who have failed to attend appointments. These cases are reviewed annually. In the case of Adult A three or four such reviews should have been undertaken but there is no record of any review being held.

There was no further contact between Adult A and her GP's practice after this time. Since she was not assessed as vulnerable and suffering from only mild learning difficulties, no further action was taken and no attempt was made to contact her via a district nurse. At the time (2006/7) there was no policy regarding safeguarding adults in place at the GP practice in question. More recently all GPs and their staff receive bi-annual Safeguarding Supervision linked to a training programme. The practice in question had safeguarding supervision in March 2010. There are 4 GPs in the practice.

Two further points of information may be relevant:

- 3.8.1 In 2005, Adult A's brother JB attended his GP in the same practice and complained of depression following the death of his mother (WB). At that time he also spoke of the difficulty he had caring for his sister (Adult A). While a note was made referring to "social services" it was left to JB, as a capable adult, to contact them.

- 3.8.2 In the period around 2006/2007 Adult A's brother PB attended his GP in the same practice for a routine matter when a nurse asked if he was related to Adult A. When PB confirmed that he was the nurse asked that a message be passed to Adult A to get her to attend for diabetic check ups. PB thereafter attempted to pass the message directly and via JB but it is not known whether the message was received.

3.9 **North Tyneside Council** is the landlord of the house in North Shields, the house occupied by Adult A and her brother JB at the time of her death. The housing service is delivered through the Council's service department – known as North Tyneside Homes.

The house occupied by Adult A and JB is described as a three bedroom mid terrace house situated in a well-kept area where most of the properties are owner/occupied.

As landlords North Tyneside Council is responsible for the repair and upkeep of the property including the safety and servicing of the gas and electricity supply. For their part the tenants have responsibility for promptly reporting damage and repairs.

Records show that the B family first took the tenancy of the house in North Shields in 1975 and following the death of WB the tenancy was held by WB with Adult A and JB recorded as resident at the property.

Following the death of WB in 2004, JB and Adult A were granted successor joint tenancy of the house and in November 2004 attended the local housing office to sign the appropriate documents. This is the only recorded time that Adult A was seen by North Tyneside Homes staff.

Following the transfer of the tenancy to JB and Adult A problems arose over a period of time, these falling into three distinct categories, rent arrears, gas servicing and garden maintenance.

The rent arrears issue arose soon after JB and Adult A took the tenancy. Following a number of letters, missed appointments and non-compliance, a notice seeking possession was issued. This and pending court action appears to have stimulated JB to action and the situation was rectified via the housing benefit system.

It is significant that during this incident, as early as 2004, extreme difficulty was found in communicating with JB and Adult A.

The issue of garden maintenance arose late in the tenancy (July 2009) but bore similarities to the rent arrears incident. Following a report of an overgrown and unkempt garden, several attempts were made to contact the B family without success. Only when a formal notice was issued seeking possession on the grounds of breach of tenancy did JB make contact and resolve the matter.

By far the most important interaction between North Tyneside Homes and the B family arose in connection with the gas supply at their house in North Shields. North Tyneside Homes are responsible for the safety of gas and electricity installations in their properties and in the case of the house occupied by the B family no record of inspection exists for the early part of the B family's tenancy. In March 2006 access was gained to the house, where in the presence of JB the gas system was inspected, the boiler, seen to be out of use, was found unsafe and the gas supply disconnected (capped off). It was noted on the gas fitter's report that the boiler was not used and that a new boiler was required.

No record was taken of alternative heating or of an alternative hot water source within the house at that time although there was a hot water cylinder with electric immersion heater in the house. It was assumed that the tenant(s) would quickly move to rectify the

situation. Housing officials made initial follow up visits to prepare a specification for the boiler replacement when they left calling cards but on getting no response their efforts tailed off on the assumption that eventually the tenants would make contact.

The visit to the B family's house in North Tyneside in March 2006 was the only recorded visit to the house by an official from North Tyneside Homes when entry was gained during the joint tenancy of Adult A and JB. It is significant that during the visit JB was present and apparently raised no concerns when the gas was capped off. It was noted on the gas fitter's report that he was advised by JB that the boiler was not used.

Throughout 2007 and 2008 a number of letters were sent and attempts made to contact the B family without success. In June 2007 formal proceedings were started to gain access to the house but these faltered possibly due to sickness/absence of the official responsible.

By the time of her death there had been no principal heat source in the house occupied by the B family in North Shields for three years and ten months. The police investigation identifies only one small electric heater working in the house at the time of Adult A's death.

It is worthy of note that except for the signing of the initial tenancy agreement in 2004, all contact between North Tyneside Homes and the B family was with JB. While always leaving actions till the last possible moment, JB was always well presented and appeared able, articulate and literate. Consequently he was not viewed as vulnerable and Adult A although recorded as a co-tenant was not seen or known to be vulnerable by North Tyneside Homes officials.

3.10 **Adult Social Care** – No individual agency review was prepared from North Tyneside Adult Social Care as there was no record of Adult A held by that service. However, a statement to that effect was submitted. The fact that Adult A was not known to Adult Social Care is in itself cause for concern. This issue will be examined in more detail in the analysis.

4. Analysis

4.1 Before analysing the role of the various agencies involved two strong caveats must be recorded.

First, we now know that JB has pled and been found guilty of the Manslaughter – Gross Negligence of Adult A. All considerations of the roles – strengths and weaknesses of the agencies involved must be seen in the light of JB's culpability. In the words of the prosecutions submission:

> "JB was his sister's carer. He assumed that role. She was so dependent on him that he owed her a duty of care in law. On his own account for at least two and a half weeks before he called the emergency services he must have known of the cold weather, the inadequate heat in the house, her lack of mobility, her deterioration and need of medical attention. He was the only person who could have alerted the authorities to her condition. His negligence in failing to provide for her basic needs, warmth, clothing and basic care, and to summon assistance

when her condition deteriorated was gross negligence. This was a breach of duty which exposed Adult A to a risk of death and caused her premature death. On this basis he is guilty of Manslaughter."

4.1.2 Secondly, we must recognise that Adult A was a difficult person to help. Her learning difficulties, reclusive nature, her avoidance of contact, even with her family made her extremely hard to reach and easy to overlook. Following the death of her mother in 2004 this facet of her character became more extreme and after 2006 she seems to have retreated into a completely private and isolated world. From that time she seems never to have answered her door or left the house. Without a working telephone or other means of communication she was therefore totally isolated. From 2006 callers to the house including family members were unable to gain access. Only two people apart from JB are recorded to have been in the house after that time, the gas engineer who capped off the gas supply and the Jobcentreplus benefits official who was the last person to have face to face contact with Adult A before the events in February 2010.

4.1.3 Accepting the extremely difficult circumstances surrounding Adult A there were a number of weak and strong "warning signals" that all was not well with Adult A. Despite this none of these involved the Adult Protection Procedures. Information was not shared by agencies and throughout Adult A was not seen as vulnerable despite her questionable mental and deteriorating physical health.

4.1.4 As with all tragic events, the context has to be taken into account in understanding the circumstances. Many of the agencies involved had little contact with Adult A or her family and some like the Ambulance Service and the Accident and Emergency Unit carried out their work to a high standard, meriting no further analysis. Likewise the contact with Jobcentreplus, the police, NHS Newcastle and North Tyneside Community Health and Northumberland Tyne and Wear NHS Trust (Mental Health Services) was slight and merits little further analysis.

Apart from her brother JB – her carer, now convicted of her manslaughter, by far the greatest impact on Adult A's life was through her relationship with North Tyneside Homes and her GP. These relationships presented the greatest opportunity for intervention and accordingly they merit more detailed scrutiny.

4.2 **North Tyneside Homes** – The house occupied by the B family in North Shields.

As landlords North Tyneside Homes have a duty of care to their tenants and a responsibility for the upkeep of their property including gas and electricity services. Records show that routine repairs were carried out to the house at occupied by the B family in North Shields during the period of the tenancy. These repairs included the mending of broken windows, the clearing of gullies, unblocking of drains and the repairing of a gas leak. During the 10 years from 2000 to 2010, however, no routine inspections were made and the only time an official representing the landlord gained entry to the premises while the tenancy was held by JB and Adult A was to inspect and subsequently "cap off" the gas supply in 2006. It appears that North Tyneside Homes did respond to the issues of rent arrears and the garden in line with their procedures at the time. While their response during this period was mainly reactive, North Tyneside Homes made a number of attempts to gain access to service the central heating system, but to some extent were reassured by the demeanour and appearance of the

joint tenant (JB) who appeared capable. Since no profile of tenants was available at that time there was no knowledge of Adult A, her health or her vulnerabilities.

The overall impression of North Tyneside Homes' relationship to the tenancy of the B family is one of reactivity rather than a proactive approach to the maintenance and improvement of the property. While it is true that repairs, such as broken windows and blocked drains were dealt with promptly, no system existed at that time to profile tenants to identify Adult A's vulnerabilities or to deal effectively with the complex circumstances of the 'B' family. It is clear that JB's actions allayed concerns while the lack of co-ordination and information sharing meant that North Tyneside Homes were unaware that their tenant Adult 'A' was vulnerable.

During the police investigation an independent Environmental Health Consultant was asked to examine and give a view on the house occupied by the B family in North Shields. Within the report a number of deficiencies were assessed under the Housing, Health and Safety ratings system which evaluates potential risks to Health and Safety from housing conditions. It looks at twenty-nine possible hazards and produces a hazard score that determines the appropriate enforcement. In the case of the house occupied by the B family in North Shields the assessment produced the following hazards:

Damp and mould growth	-	Category 1 hazard
Excess cold	-	Category 1 hazard
Personal hygiene, sanitation and drainage	-	Category 1 hazard
Food safety	-	Category 2 hazard

The local authority has a duty to act on Category 1 hazards and discretionary powers to deal with Category 2 hazards. These assessments are seen as part of the Decent Homes standards which places an obligation on local authorities and other social landlords to deal with all non-decent homes by 2010.

While the house occupied by the B family failed the Decent Homes standards, in 2010, North Tyneside Homes' capital programme for 2010/2011 includes funding for the refurbishment of non-decent homes including the B family's house.

4.2.1 **The Gas Supply to the B family's house in North Shields**

North Tyneside Homes have a duty to regularly inspect gas and electricity supplies in their properties. In the case of the B family's house, while there were obviously numerous attempts to gain access, with one exception, there is no record of this being achieved after the year 2000 and certainly not in the tenancy of JB and Adult A. The exception was of course the visit in 2006 when a gas engineer employed by North Tyneside Homes inspected, found unsafe and in the presence of JB, capped off the gas supply to the house.

What appears to follow was a series of omissions and issues:

- There is no evidence to suggest that consideration was given to alternative heating although there was an electric immersion heater/hot water boiler in the house

- There is no evidence to suggest that the profile of the tenants was known and that therefore adequate consideration was given to their welfare. In fairness tenant JB's deceptive behaviour did much to cause this failure
- There is no evidence that any robust follow up was made
- As no information was held regarding Adult A's vulnerability there was no opportunity to intervene
- The evidence available tends to suggest that an extremely reactive position was taken, assuming that the tenants would eventually make contact
- The evidence available suggests that the system to ensure subsequent follow up checks on the gas supply failed, meaning no action was taken after the disconnection in 2006.

Though key staff absences and legal questions over right of entry have been cited as mitigating factors it is clear that the systems in place at North Tyneside Homes at the time were inadequate to deal with the complex situation at the B family's house. As aforesaid the actions of JB contributed significantly to this situation.

Routine repairs were carried out at the house up to 2007 including external pointing, replacement of tiles etc. but little proactive effort was made to improve or enhance the property. Major improvements were scheduled for 2010/11 but at the time of Adult A's death the house of the B family in North Shields failed all the main Decent Homes standards. While North Tyneside Homes had systems for safeguarding vulnerable adults, these systems failed to identify Adult A as such a person.

4.3 **Independent GP practice**

4.3.1 Adult A attended a local GP in North Tyneside throughout her life. Her records span 1973 to 2006 when all contact ceased. From 2001 to 2006 she was registered at a North Tyneside medical practice.

Adult A suffered from poor mental health and two long term physical conditions, Type 2 diabetes mellitus and hypertension, in addition to obesity. These deserve separate scrutiny.

4.3.2 **Mental Health**

While it is questionable whether Adult A was ever formally assessed or diagnosed she was first recorded as having "learning disability" categorised as mild, in 1970 following a request from DHSS questioning her fitness to work. At that time she was found to have a low IQ but to be fit for some employment.

In 1980, this assessment changed following a panic attack and thereafter she was seen as mentally handicapped and unfit for work.

Following the 1980 diagnosis, no further medical assessment of her mental health was carried out, no treatment or therapy was offered and North Tyneside Learning Disability Team had no involvement with her. The only other assessment of Adult A's mental health was by a Jobcentreplus officer who assessed her fitness for work in 2006.

From the limited information provided, it is difficult to assess Adult A's mental capacity. On one hand we have the family's account of a shy girl who passed through normal

school and briefly moved into employment, who read avidly, who enjoyed crosswords and who competently cared for young children. At the same time we know that Adult A's mother WB dominated her, controlled her day-to-day life and in the family's view hindered any chance of her normal development.

What seems certain is that following the death of her mother in 2004, Adult A slid into seclusion eventually cutting off all outside contact in 2006 after which she depended on her brother JB for the basics of life.

In summary, whatever Adult A's mental state as a young woman, it seems to have deteriorated sharply after her mother's death. This change was not observed by her GP, nor perhaps would it have been detectable during routine diabetic reviews.

4.3.3 **Physical Health**

Adult A was first recorded as having physical health issues in 1990 when during a routine check she was found to be obese. Accordingly she responded well to treatment but in 2001 was diagnosed with Type 2 diabetes. From that time to 2006 she was treated for her diabetic condition and for associated eye disease and podiatry issues.

Within a year of her mother's death, Adult A's attendance at diabetic clinics and appointments began to slip. Despite many letters she failed to attend and did not request any further medication.

4.3.4 The cessation of diabetic care is a serious matter. Type 2 diabetes is a chronic ongoing condition that requires careful clinical management in order to slow the progress of the disease. While there is a risk in continuing to prescribe some drugs, particularly Metformin, not to continue treatment is certain to hasten the progress of the disease. Adult A had already developed a diabetic eye condition, suggesting poor management of the disease. To allow her to withdraw from treatment without robust follow-up is in the opinion of an expert witness, Consultant A, questionable. She states:-

> "The discontinuation of treatment meant there is the reasonable acceptance that blood sugar control would worsen and the likely complications of that would be the progression of the diabetic eye disease already present in this patient and possibly diabetic kidney and nerve damage as well."

4.3.5 GP practices regard the treatment of diabetes as a priority. Despite this following her withdrawal from treatment no robust attempts were made to contact Adult A. While Adult A appears not to have met the criteria for District Nurse involvement this seems anomalous in the treatment of such a serious and chronic condition.

4.3.6 At the same time, as is the norm, the GP practice continued to automatically issue certification to the effect that Adult A was unfit for work.

4.3.7 At the heart of Adult A's treatment by her GP's practice is the simple fact that they did not view her as vulnerable and no procedure for the identification and treatment of vulnerable adults was in place in the practice.

It would seem that despite all the indications present –

- A history of learning difficulty albeit documented as mild and of questionable authenticity
- Long term chronic medical conditions
- A change in patterns of behaviour

no re-assessment was made of Adult A's capacity and she was not judged vulnerable.

4.4 Taking all these factors into account it would appear that the GP practice responsible for caring for Adult A failed to identify her as vulnerable and to connect her recorded mental health issues with her chronic physical ailments. Consequently this resulted in a failing to take appropriate steps to engage with her and to attempt to maintain the treatment of what they knew was a deteriorating condition.

4.4.1 Whilst it is the function of this review to identify lessons to be learned, and we are now aware of JB's culpability, it is impossible to analyse agencies' involvement in Adult A's life and death without acknowledging the omissions of two of the agencies involved.

5. What are we to learn?

5.1 At the heart of this case lies the fact that Adult A was largely hidden from view throughout her adult life. Her family circumstances, her mental health and her reclusive nature all combined to make her problems difficult to see, recognise and deal with.

In addition, her brother and carer JB has been found criminally responsible for her death through gross negligence, part of which was failure to seek help for Adult A.

5.1.2 Notwithstanding the extreme difficulty in reaching Adult A, however, it is clear that a number of systems designed to act as a safety net in such cases failed or were not in place.

5.2 In the case of Adult A's GP, no system to identify and protect vulnerable adults was in place in the practice concerned at the time. Had such a system been in place and been effective, the links between Adult A's questionable mental health, her chronic physical condition, the changes in her personal life and her behaviour would have been collated. Together with JB's report of difficulties with Adult A these strands of information should have triggered a response and clearly identified Adult A as vulnerable and in need of help.

5.3 In the case of North Tyneside Homes, it seems that while Adult A was recorded as a co-tenant, North Tyneside Homes were not aware of her vulnerability. At that time no effective system existed to establish tenant profiles or vulnerability and no warning systems were in place to alert Social Services to potential problems due to the actions of North Tyneside Homes. Had such systems been in place the warning signals of the early rent difficulties would have been added to the overgrown garden and the stronger signals of the capping of gas supply to trigger a response.

Within the framework of an efficient and integrated housing management framework such a system should have identified the B household, post 2004 as in need of help.

5.4 Adult A lived the last period of her life in squalor, cold, with probably failing eyesight and extremely restricted mobility. The person closest to her failed her, but she was also failed by the systems that were either not in place, or that were operated in isolation and in such a manner as to be ineffective.

6. Conclusions and Recommendations

6.1 It is questionable whether Adult A was capable of an independent life. She was first observed as having a 'mild' mental incapacity in 1970, then in 1980 was assessed regarding a travel phobia with the clear outcome that she would not benefit from any therapies and had no disorder that required medication. Following this her capacity was not considered again and no further treatment or support was offered.

The issue of "capacity" and Adult A's ability subsequently played a major part in the way she was seen and treated by agencies. Several opportunities to intervene were missed by Adult A's GP because they failed to recognise her vulnerability and deemed her independent with capacity. North Tyneside Homes, while aware of her presence, were not aware of her vulnerability.

That said, it is clear that Adult A was both hard to reach and easy to overlook. She was reclusive and following the death of her mother in 2004 she became extremely difficult to reach. There is no evidence that she left her house after 2006 and from that time refused to respond to callers at her house, or to mail sent to her by her GP practice. While several inoperative mobile phones were found in her house after her death there is no evidence to suggest she used them or was capable of doing so. Consequently Adult A presented the toughest of challenges to services in North Tyneside.

6.2 All agencies have legal responsibilities not only to prevent harm caused by their own agents, but to safeguard vulnerable people against the harmful actions of third parties. It is striking that in Adult A's case each agency focused on single issues within their own narrow sectional remit and did not make the connections necessary to recognise and protect Adult A as a vulnerable person. Consequently despite a record of mental and physical incapacity throughout her life, Adult A was unknown to Adult Social Care Services in North Tyneside.

6.3 Whilst Adult A's mother heavily dominated her early life, she appears to have lived a safe if reclusive life in her family home. Following her mother's death in 2004, however, Adult A's life deteriorated quickly and this was marked by significant changes in behaviour. Both Adult A's GP and her landlords (North Tyneside Homes) had the opportunity to spot these changes, connect the issues and act.

Due to the absence of effective systems and procedures to safeguard vulnerable adults these opportunities were missed.

6.4 We now know that Adult A's brother JB has been found criminally responsible for her death by gross negligence. In addition to neglecting her failing health and the condition in which she lived, he also effectively obstructed agencies, particularly North Tyneside Homes in what may have been positive interventions that changed events and alerted services to Adult A's condition.

We also know that by his own admission JB's attempts to get medical help were minimal and restricted to his visit to his GP in 2005. Even so, Adult A's questionable mental capacity and the increasing irregularity of her attendance for diabetic treatment should have triggered an intervention and influenced the response to her withdrawal from treatment in 2006. The absence of robust safeguarding procedures within Adult A's GP practice at the time, undoubtedly contributed to this significant missed opportunity.

6.5 The disconnection of the gas supply to Adult A's home is directly linked to her cause of death – Hypothermia. It is evident that a fundamental breakdown in the Duty of Care took place following the disconnection of gas supply to the house at Central Avenue in 2006. JB's conduct in what followed was certainly highly significant but even so the failure of systems to ensure a follow up to the disconnection, to insist on a home visit and to alert and engage social services meant that no co-ordinated or adequate response was triggered.

6.6 With the understandable delays caused by the criminal case against JB, Serious Case Review contributors have been willing to explain and amplify the weaknesses of their own agencies. This does not imply that these agencies are without strengths; for indeed attention to safeguarding people at risk of harm from abuse was apparent through the SAB multi-agency policy and training. The acknowledgement of the individual agencies conveys where there were failings and of their determination to learn lessons. In that regard much has already changed. North Tyneside Homes have undergone significant organisational restructuring since 2008, improving both their internal and external communications, as well as their "Gas Servicing" procedures (see Appendix). In addition they have set procedures in place to ensure regular home visits to tenants and are making good progress in developing a comprehensive database of client profiles in order that they can identify vulnerable tenants. The Principles of Adult Safeguarding are now included in all procedures and staff training. The GP practice has already put measures into place to: ensure better co-ordination and the introduction of a comprehensive case review system so that all known factors can be considered in making clinical decisions.

7. Review Recommendations

7.1 The following recommendations for improvement are made bearing these developments in mind and are at two levels, for the Adult Protection community and individual.

7.2 Agency Recommendations

7.2.1 **That the North Tyneside Safeguarding Adults Board raises with partner agencies the issue of the monitoring of changing or deteriorating capacity of adults with learning difficulties and/or mental health issues**

Central to Adult A's case was the uncertainty as to her true mental capacity and the failure to note the gradual change in her ability to cope after her mother's death. While her physical health was monitored, her mental health was not, nor were changing social factors considered in judging her capacity or her vulnerability.

The routine monitoring of a patient's mental health is surely as important as their physical health and should be considered as part of their overall treatment and wellbeing.

That the North Tyneside Safeguarding Adults Board raise with their Community the issue of ensuring Carers can and do access support

No carer of a vulnerable adult should ever feel isolated and unaware of where they can go to get the help they or their loved ones need. Every Carer should know they and the person they care for has the right to help and support. Multi-agency partners should set up systems to ensure a listening and acting stance ensures requests for support are not viewed as a sign of failure.

7.2.2 **That the North Tyneside Safeguarding Adults Board raise with other strategic partners the issue of practices and procedures relating to "Hard to Reach" and easy to overlook clients and patients and produce partnership guidelines based on best practice**

The differing approach taken by agencies in this case illustrates very different standards. Adult A was undoubtedly very hard to reach and became more so as time went on. Nevertheless, some agencies persisted while others adopted an entirely reactive position. Clearer guidelines, as to responsibility together with techniques and best practice advice would be beneficial in this difficult and time-consuming area.

7.2.3 **That the North Tyneside Safeguarding Adults Board raise with partners the continuing need for clear risk criteria and thresholds with respect to safeguarding vulnerable adults corresponding to those for the protection of children**

Identified in Serious Case Reviews in other areas, Adult A's case once again illustrates the need for clearer guidance of what comprises vulnerability. Despite all the clues and markers – learning difficulties, poor mental health, chronic physical ill health, hard to reach - easy to overlook and missed appointments – none of the agencies in this case saw Adult A as vulnerable or alerted partners. This failure to recognise vulnerability continues to pose a significant threat to effective safeguarding of vulnerable people.

7.2.4 **That the North Tyneside Safeguarding Adults Board continue to embed the principles of safeguarding adults within all partner agencies, and ensure the guidelines and the lessons from this case are given due prominence in the working of all partner agencies**

While most of the agencies involved with Adult A had received training and had safeguarding procedures in place, the process between the theory and the practice were ineffective in protecting her. Only systematic embedding and testing of safeguarding procedures will protect against future failures. All partners to commit themselves to share safeguarding vulnerable adults priorities and procedures. The ethos of Safeguarding Vulnerable Adults must be adopted as a high priority in the corporate governance of partners.

7.2.5 **That the North Tyneside Safeguarding Adults Board revisit and test the application of recommendation 7.2.4 annually to ensure compliance and firm embedding of the principles of Safeguarding Vulnerable Adults**

It is the unfortunate experience of Serious Case Reviews, both in child and adult protection cases that recommendations made and accepted are then not firmly embedded and valuable lessons are forgotten. To ensure this does not happen it is recommended that an annual review be established so that systems can be tested by a selective scrutiny of a small number of case files. This could be facilitated by an independent "critical friend" or internally, and serves not only as a useful "health check" but also as a point of focus for partners.

7.2.6 **Independent GP Practices**

All GP practices to ensure they have robust systems in place to assess the capacity and question the circumstances of patients who withdraw from the treatment of serious illness. Whether by a review mechanism or outreach by the Community Nursing Service these interventions should form part of robust safeguarding adults procedures to be developed by the GP practices with education sessions for GPs and their staff to familiarise them with the procedures.

7.3 **Individual Recommendations**

That Adult A's brothers, TB and PB along with their families, are invited by the Independent Chair of the Serious Case Review to engage with and comment on the findings of this review.

JB has been approached on behalf of the SCR to establish whether he would be willing to contribute to this report. He has declined stating he has made his feelings known to the police during his interviews.

8. Terms of Reference

8.1 Lastly, in specific response to the terms of reference set out in 1.6 of this report:

8.1.1 Adult A's learning disability was known and recorded by her GP, Jobcentreplus and Northumberland Healthcare NHS Foundation Trust. Throughout her life, however,

Adult A received no treatment for this disability and at no time was referred to the local disability team. Following the death of her mother WB in 2004, her decline and all the warning signals associated with it was missed and at no time was she considered vulnerable. The absence of a Safeguarding Vulnerable Adults framework is relevant and this area is covered in recommendation 7.2.5. There is no evidence to hand of intentional concealment of learning difficulties.

8.1.2 In relation to the management of Adult A's diabetes, recommendation 7.2.5 also relates. The cessation of medication for what is known to be a long-term chronic condition without robust follow-up is highly questionable. Certainly a considered assessment and attempts at outreach via a district nurse should have been made whether Adult A was recognised as vulnerable or not. The fact that she was clearly vulnerable compounds this decision.

8.1.3 As regards North Tyneside Homes, it is clear that their actions in relation to the tenancy at 31 Central Avenue were uncoordinated and in the case of the gas supply highly questionable. Much has since changed and current procedures appear to have set in place a high standard of safeguarding.

This area is covered by recommendations 7.2.5 and 7.2.6.

8.1.4 With relation to child to adult transition:

In this case Adult A first came to notice at the age of 19 (in 1970) when already a young adult. The problem in this case lies in the fact that after initial recognition of mental incapacity she was offered no treatment, help or therapy. Following the death of her mother in 2004, her ability to cope apparently deteriorated sharply but this decline in capacity and changes in her behaviour were not recognised. This area is covered in recommendation 7.2.1.