CTM
CARE TRAINING MATTERS

INDEPENDENT SIGNIFICANT CASE REVIEW REPORT (2019)
SHARON GREENOP
Commissioned by the South Ayrshire Chief Officers' Group for Public Protection

The following is taken from the above SCR. It aims to give the salient points to allow for analysis and also to pose questions on how Council Officers, in similar situations, might act. Quotes in italics are direct quotes from the report.

Full report can be accessed at: Accessed from - https://www.south-ayrshire.gov.uk/documents/independent%20scr%20report%20sharon%20greenop%2024%20april%202019.pdf

Sharon was 46 when she died. She had physical disabilities arising from a spinal injury and between 2009 and 2016 she received care at home. Sharon was found dead at home in Troon in November 2016. Due to decomposition her exact cause of death was not determined. However at the time of her death she had 19 rib fractures and a broken spine. Her sister Lynette and daughter Shayla were prosecuted for her murder. Her sister was found guilty whereas the verdict for her daughter was not proven. On conclusion of the criminal proceedings the Independent SCR was compiled.

Sharon had surgery in 2009 for spinal issues and then required crutches for walking and a wheelchair for longer distances. On discharge she received four times daily home support – mainly for personal care. This was in place from November 2009 until January 2016. An annual review in 2010 concluded the care was working well and Sharon's daughter Shayla was well supported by a young carer organisation

At some stage Sharon's sister Lynette moved in. In April 2011 Sharon told carers her sister Lynette was stealing from her. When reported to social work Sharon said she did not want action taken. There was a similar report in June 2011. The duty social worker called Sharon who said she was muddled about money. In October 2011 carers reported Shayla sleeping in a garden hut and this was investigated and the explanation she was playing in the hut was accepted. It was then noted that Sharon's sister Lynette was homeless and still living with the family. Annual reviews of Sharon's care in 2011 and 2012 revealed no apparent concerns.

In October 2013 care staff reported Sharon was "bullied" by her sister Lynette and daughter Shayla. A meeting was held and it was agreed Lynette would not be present when carers attended to Sharon (due to Lynette's abusiveness to carers). Then in November 2013 Sharon asked her care to be reduced and that her care package transfer to another provider. This happened in January 2014.

In July 2015 Sharon's case transferred from the Physical Disability Team to a locality team in Troon. The manner this was done was heavily criticised in the SCR. In Troon, a decision was made not to allocate Sharon's case but to hold it in the "review basket". In January 2016 her care provider advised that Sharon wanted their care to end. A phone call was made and the worker spoke with Lynette who said Sharon did not now need the care. A home visit was offered but refused. Sharon was spoken to on the phone and said both Lynette and Shayla would now provide her care. The care provider expressed concern about this. However the decision was taken that Sharon had capacity to decide these issues and the care package was cancelled and her case closed on 12th January 2016. Thereafter, there was no further social work contact with Sharon.

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 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 was the reason Lynette did not want the carers coming in to the house.

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".*

QUESTIONS:

a) If you had taken that call would you have acted differently?
b) Was Sharon's sister, consciously or otherwise, referring Sharon as an "adult at risk"?
c) In situations where the referrer is not using terms such as "adult protection" or "AP referral" or "abuse" – are we less likely to regard such a referral as an ASP matter?
d) In such a situation – what (if any) legal responsibilities do you have?
e) If this arose in your service in D&G would there be scrutiny of the duty workers decision?

In subsequent days there was no further contact from the family and the referral was marked "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.

Neither Diane nor her father referred these issues to the Police. No further social work contact took place until Sharon was found dead at home in November 2016.