Confidential

Southend Safeguarding Adults Board

Serious Case Review

Executive Summary

04 September 2011

Mr and Mrs A

1. Executive Summary

This review was commissioned on the 29th November 2010 by Chris Doorly, Independent Chair of the Southend on Sea Safeguarding Vulnerable Adults Board (SVAB), in relation to the involvement of all agencies with Mrs A and her husband Mr A. Mrs A died on 30th October 2010 aged 81 following her emergency admission to Southend Hospital, earlier the same day, with her husband who was investigated in connection with her death. He is now living back at his home address.

It was known that that Mrs A had had considerable contact with Southend agencies, Essex Police, Southend Adult Social Care, her GP and others, in relation to domestic abuse from her husband who, at the time of the incident, was aged 88. Mr A had been admitted to Southend General Hospital on 28 October 2010, where he had alleged domestic abuse by his wife and was discharged home on the 29th, a few hours before the fatal incident.

Essex Police initiated a manslaughter investigation and presented an evidence file to the Crown Prosecution Service. On 22 March 2010 the CPS decided that there was insufficient evidence to substantiate a prosecution.

The Safeguarding Adult Board intention in commissioning this review was to discover whether there was learning to be gained from these circumstances which could improve practice in future.

Subjects of review

Mrs A **D.O.B** 20.05.1929 **D.O.D** 30.10.2010
Mr A **D.O.B** 11.02.1923

An independent consultant in social care and health and a former Director of Social Services was appointed at the end of February 2011 as the independent author to oversee the review and write the Overview report. This person had experience of undertaking previous serious case reviews and was a panel member for a major domestic homicide review.

Draft terms of reference were considered and agreed at the initial meeting of the Serious Case Review Panel on 17 March 2011. The Terms of Reference, scope and brief for Internal Management Reviews drew heavily on those adopted by the Southend Essex and Thurrock (SET) consortia of Safeguarding Boards.

Clear terms of reference were set up and this can be seen in the full report.

The Purpose of the review was agreed as

To establish the facts and examine the circumstances leading up to the death of Mrs A in October 2010.

To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies worked together to safeguard Mr and Mrs A.

To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

To review the effectiveness of procedures (both multi-agency and those of individual organisations) and to inform and improve local inter-agency practice.

To identify whether as a result of this review, there is a need for changes in single agency or inter agency policy, procedures or practice in Southend on Sea.

To improve practice by acting on learning from the review (developing best practice).

To make recommendations for future action by bringing together the findings and analysis from of the various reports from agencies in a single overview report.

The review is not an enquiry into how the Vulnerable Adult died or who is responsible for her death. These are matters for Coroners and Criminal Courts respectively to determine as appropriate.

The review is not part of any disciplinary inquiry or process. However Information that emerges in the course of the review may indicate that disciplinary action should be taken under established agency procedures.

The scope of the review was to consider several aspects, which is highlighted in the full report that latter in the report formulated the conclusions and recommendations.

Each agency completed its own IMR Individual Management Review that was then signed of by each agencies senior manager/s.

Analysis of the Chronology

In the full report there is a full analysis of each agency involvement.

2. Findings

General Background - Physical and mental health

2.1 Mr A and Mrs A had been married for 56 years when Mrs A died in October 2010.

2.2 Apart from community health service input to Mrs A following a Road Traffic Accident they managed without assistance other than from primary care until August 2006 when Mr A suffered a fall. Their General Practitioners were from different practices.

2.3 Mrs A was considered to have capacity to make her own decisions by those in contact with her, including her daughter. Some specific incidents could be misconstrued. The ambulance service on one occasion noted that she appeared confused and queried a Urinary Tract Infection which could have that effect in the short term. When her husband was admitted to hospital on 28 October 2010 she appeared to ward staff to be confused when she telephoned the ward but it was also the case that there was some real confusion in the arrangements. On the night of 30 October she was again thought by ambulance to be somewhat confused. However she had just experienced a blow to her head. This was never able to be formally assessed as Mrs A became unconscious and died later. There is no other suggestion that she did not have full mental capacity

2.4 In relation to her physical health she had a number of health issues which were managed by her primary care team but she was mobile and able to get out of the home and to self care. She was prescribed Warfarin and used a walking stick to aid her mobility.

2.5 In relation to Mr A, the professionals involved with Mr A considered him to have capacity and this was independently confirmed on his admission to hospital and after Mrs A's death. The exception to this were the attending police officers who, in discussion with Mrs A, formed an impression that Mr A had old age mental health problems but without undertaking a mental health assessment. Their impression was inaccurate. Mr A's GP's judgment about Mr A's mental health was confirmed by the assessments done after Mrs A's death.

2.6 In relation to Mr A's physical health, he was increasingly limited in his mobility and experienced more falls in 2010, but he was still able to get around his home and was found upstairs in his bedroom on the night of the 30 October.

2.7 Recording of professionals giving consideration to Mr and Mrs A's mental capacity to make specific decisions is generally good throughout the period under review.

2.8 There is also good evidence that professionals sought the views of both Mr and Mrs A about their needs and wishes and sought the follow them.

2.9 To some extent this led to the problem behind this review: that Mr and Mrs A were both clear prior to the 29 October that they did not want or need any help from social care, and apart from in a crisis did not want other possible interventions. It is not possible to say to what extent Mr A's views may have been formed in the knowledge of his wife's wishes but he had capacity to make his own decisions.

Appropriateness of service responses

2.10 Community health and social care services provided between August 2006 and December 2007 after Mr A's emergency operation for a fractured neck of femur and then a hip replacement operation were appropriate. In 2008 only health care interventions for Mr and Mrs A are recorded. These were appropriate.

2.11 In 2009 social care did not respond to one request for a carer's assessment by Mrs A's GP who continued to provide primary care support. On the other occasions social care offered an assessment but it was turned down. Social care could have sought to do a full assessment with Mr A but this is unlikely to have been accepted. The GPs did not refer the abuse to any outside agency.

Mrs A

2.12 Between August 2006 and January 2010, there were six recorded references to domestic violence all except one about verbal abuse, four to Mrs A's GP and two to social services, who also observed one incident of verbal abuse by Mrs A to her husband in 2006. Mrs A referred to historical physical abuse. It is likely that she meant the 2003 incident, rather than a lengthy history of physical abuse.

2.13 In 2010 Mrs A reported a total of nine separate incidents of physical abuse by Mr A, prior to 30 October, some to more than one agency and over a period of time. For some/most of these there was corroborating evidence of injury to Mrs A. These were all responded to promptly and considerately by agencies, who were concerned for her safety. There were also referrals were no immediate physical abuse was reported. She was regularly given advice about her options, with the exception of advice about her legal rights (which was planned be included in the abortive visit in May 2010) but it was clear throughout that she would not leave her husband. She was also given advice about sources of emotional support but there is no information that she followed these up and indeed no real expectation by agencies that she would.

2.14 She was also unwilling to let social services talk to her son or daughter, although she allowed the police and the ambulance service on some occasions to contact her son who lived locally.

2.15 In 2010 she also told agencies other than social care that she needed help caring for her husband. This sometimes formed part of her reports of Mr A's physical abuse, and on other occasions was separate to that but when Social Care followed this up with her she did not want any help and said that she and her husband were managing their care needs. She did not contact social care directly on any occasion in 2010. She referred to care being expensive and that her husband would not spend his attendance allowance on help.

2.16 As a result of this pattern of asking for help but not accepting it professionals were concerned but also felt powerless to help.

2.17 On the occasions when Mrs A called the police using 999 because of Mr A's abuse each incident was responded to as if it were a stand alone incident. Despite the need for each incident of domestic violence to be responded to in manner which supports the reduction of repeat offending and risk of escalation it appears that first response officers responding to 999 calls did not have any information about previous calls to the address. As a result each officer responded as if each call were a first call.

2.18 On each occasion they decided to refer the matter to social services. They were influenced by Mrs A who appears to have down played the abuse and described Mr A as having deteriorating mental health or Alzheimer's disease as an explanation for his behaviour. The officers engaged with apparent mental ill health with Mr A's evident age and frailty and did not follow Force policy in relation to domestic abuse or seek a mental health assessment.

2.19 On two occasions this was identified by a more senior officer and Mr A was arrested interviewed and cautioned, the officer having clarified his mental health status.

2.20 Despite this, the officers did not pick up the significance of Mr A's statement that his wife sometimes abused him, including with her nails and did not pass this information to anyone else.

2.21 They also did not follow through on a joint plan with social services which would have enabled social workers to visit Mrs A at home whilst Mrs A was at the station. This was the most obvious missed opportunity for interagency working within the events under review.

2.22 Following this failed opportunity Social care raised what had happened with the sergeant of the unit and also asked for the case to be discussed at the multiagency MARAC meeting, which considers high

risk Domestic Violence case. This was a good initiative but the short discussion at this meeting appears to have focused more on the limitations of agency powers than on making a plan about what could be done collectively or with the wider family when the next incident occurred. It did not have the information from the police interview of Mr A on 25 May.

2.23 There a number of occasions when both the police and social care could have called an interagency safeguarding strategy meeting in response to the combination of worrying reported incidents and Mrs A's unwillingness to engage with services. In addition to the missed opportunity described above, social care could have taken this action in January and the police could have done so in September and October but neither did.

2.24 There was reasonably good contact between social care and the police Domestic Abuse Hate Crime Unit over the reported incidents but underpinning this was police officers' assumption that this needed to be dealt with as a welfare matter by social care whilst social care, although they followed up each incident with Mrs A became increasingly concerned about their inability to do anything to help without Mrs A's consent.

2.25 Apart from the good practice example given above oversight of the oversight by the Domestic Abuse Hate Crime Unit of the pattern of calls and the responses to them appears to have been inconsistent.

2.26 Mrs A's GP practice appears to have provided Mrs A with a good service and tried to provide her with knowledgeable advice and support whilst respecting Mrs A's privacy and confidentiality and recognising that she would not leave her husband.

2.27 Ambulance service officers responded appropriately to call outs to Mrs A. On two occasions the 28 and 30 October they should also have sent safeguarding referrals to social care. They did not have access to information about previous calls but the service is working to resolve this.

2.28 The officers who attended on the night of 30 October did not assess Mrs A's injury as life threatening and have reported that they did not spend any longer at the scene than was necessary in the circumstances, a lapsed time of approximately 1.5 hours. The observations recorded by the officers at the scene on arrival at hospital suggest that there was no deterioration in Mrs A's mental function during this period. This has been reviewed by senior officers and the Trust's review concluded that the officers acted within the agreed protocol, meaning that the service provided was appropriate in the circumstances.

2.29 SUH appears to have provided Mrs A with appropriate service over the period. In relation to the specific events of the 30 October 2010, the

delay at the Emergency Department at SUH before Mrs A was seen by the Emergency Department doctor is documented within the IMR. It is noted that Mrs A's condition was observed, albeit distantly, throughout and between 03.00hrs and at 04.20hrs Mrs A was reported to have been seen sitting up and talking. Her condition deteriorated suddenly so that by around 05.00hrs (noting the Intensive Treatment Unit registrar was bleeped at 04.56hrs) she was found to be unresponsive.

Mr A

2.30 Prior to 28 October 2010 when Mr A was admitted to hospital he had received time limited support from Community Nursing and from the Social Care Collaborative Care team and emergency assistance from the Ambulance. He did not directly seek assistance and was reluctant to respond to opportunities to convey his point of view.

2.31 However the review reports show good evidence that he was given opportunities by social care and the ambulance service to have his views heard or to receive care.

2.32 He was spoken to in 2006 by the social care worker who observed Mrs A's verbal abuse, and again in January 2010 about Mrs A's allegations about him, and on both occasions he declined to engage. He was spoken to twice in 2007 when he ended the community care services and again in hospital at the end of 2007and again in August 2010 when he refused care. He was seen by the ambulance service and declined opportunities to be taken to hospital. In October he was seen when Mrs A was out of the house and was asked about marks to his ear but said that this was an accident.

2.33 Community Care assistance was provided where there were opportunities to do so. Mr A was seen at home by social care in August 2010 and offered daily help which he declined, but he did accept a weekly session of rehabilitation for his stair mobility for six weeks.

2.34 Although this intervention was not co-ordinated with the social worker who was concerned with Mrs A's safety it is an occasion only a few months before Mrs A's death when Mr A was seen and his needs discussed with him in person. Nothing untoward was reported from the stair mobility visits.

2.35 Had this been coordinated it might have been possible for the social worker to engage in more discussion with Mr and Mrs A about the reasons for refusing help with care, and whether the issue of the cost of care was insurmountable. During 2010 social care were never able to get to the position of having undertaken an assessment of need showing what care was required, and hence never reached the point where they might have given exceptional consideration to waiving charges on grounds of safety and risk management. This is a power they report that they have exercised in other cases.

2.36 Mr A was seen by visiting police officers but his views were not elicited because of the belief that he had dementia or Alzheimer's. The interview at the police station obtained relevant information but this was not passed on. This was a missed opportunity to obtain an account or probe more deeply into what was happening in the household.

2.37 There is limited information about the care provided by Mr A's GP as he kept few written records and was not been interviewed for this review. It can be concluded from the available information that he had good knowledge of Mr A's marital difficulties and of Mr A's mental health, and Mr A had appropriate community health services arranged for him when required. There appear to be concerns about how medication reviews were managed. He did not respond to social care in January 2010 and although his practice manager acted positively in making a SETSAF1 referral to social care, the information was not shared within the practice or with Mrs A's GP. However, despite the lack of written evidence there is nothing that suggests that Mr A's GP's presence or absence affected the outcome in this case. The absence of records does mean that there is no information from this source about Mr A's weight or general appearance. Mr A's practice is now part of a larger practice and the matters raised are for the PCT and his new practice to address.

2.38 On 28 October 2010, when Mr A was admitted to hospital, his report that his wife was abusing him was taken seriously by ambulance, hospital and social work staff. The interviewing social workers obtained a full account from Mr A and took his report seriously. However, they informed but did not involve the police and no one interviewed Mrs A about the injuries. Mr A wanted to go home and his wife wanted him home, and he was considered to have capacity to make this decision. Care support at home, with his son handling the financial assessment was set up and was seen as the way of managing this risk and enabling a better picture to be gained of how the household was functioning.

2.39 However, there was no contingency plan in the event of the care being quickly cancelled. Given the previous refusals of care and his ambivalence whilst in hospital, rapid cancellation of the care package must have been a likely outcome. The police should have been more involved at this point and an interagency meeting involving the family would have been a better way of managing the risks. This was a missed opportunity.

2.40 However, if Mr A was insistent on going home, as he is reported to have been, given that he had the capacity to make this decision, no one had any legal powers to prevent him from doing so. The most that could have been done would have been a short delay, citing his medical condition.

2.41 The second issue for this period of hospitalisation was whether hospital staff and social work staff responded appropriately to Mr A's physical

appearance. Both ward and social work staff noted that he was thin, and was hungry and his clothes were observed to be too big for him. However, he had just spent time on the floor at home unable to get up and was expected to be hungry. He ate well during the time he was in hospital. The hospital was able to identify that Mr A's weight had dropped from 65.5 to 55.7kg between 2002 and 2007 but he was not weighed and a nutrition assessment was not undertaken on this admission. Routine nutrition review has now been introduced to this admission unit. The house was well stocked with food on discharge. Mr A told staff that he usually got his own lunch and that Mrs A cooked for him. His daughter who had very recently spent time with her parents told the Independent Author that she was not concerned about his nutrition. The arrangements for his discharge were for a community care package which would have taken care of this need.

3. Conclusions

3.1 Agencies responded promptly to referrals and requests for assistance for Mrs A both in relation to domestic abuse and her concerns about her inability to care for her husband, and for help for Mr A in moments of crisis. They took her concerns seriously but were unable to reach beyond Mrs and Mrs A's refusal of services other than emergency or very short term assistance.

3.2 There were however some shortcomings in how the police investigated Mrs A's allegations of abuse by Mr A and how they liaised with social care, and in how social care responded to Mr A's allegation of abuse by Mrs A on the 29 October. Both of these may have affected the outcome.

3.3 The fatal incident of 30 October could not have been predicted by anyone. However, a breakdown in the couple's capacity to care for one another or in the care package set up on the 29 October to facilitate discharge from hospital was highly predictable, as were further incident(s) of domestic abuse, any one of which could have been fatal.

3.4 It is possible the specific incident of the 30 October may well have been prevented if there had been adequate investigation at the time by Essex Police and Southend Borough Council social care of Mr A's allegations of abuse by Mrs A, however this is by no means certain. The risks to both should have analysed and explained to both parties, the family (both son and daughter) should have been invited to become involved in understanding the risks and Mrs A's consent to the care package clearly obtained. A slightly longer period in hospital to allow for a multi-agency strategy meeting and joint planning would have removed the point of crisis just after midnight on the 30 October . This could only have happened if the MDT agreed it was unsafe to discharge him. There would have been little or no evidence to reach that conclusion. As it was the police did not become involved, there was no strategy discussion or meeting and although Mr A's son was involved by telephone and agreed

to look after the financial assessment there was no case conference or strategy meeting.

3.5 In addition, had Essex police investigated the four previous incidents of domestic abuse in line with Force policy, having ensured that a mental health assessment of Mr A was in place; they would have been in a better position to accurately assess the risks to both. On each occasion when the police attended they did not appear to have accessed any previous information and treated each call as if it were a first call, and were side-tracked by Mrs A's inaccurate descriptions of her husband as having mental illness.

3.6 As it was, two of these occasions (in May 2010) were corrected by effective supervision by the Domestic Abuse Hate Crime Unit supervisor but the other two were not. However, when Mr A was interviewed in response to the supervisor's instruction the officers did not recognise the importance of Mr A's statement that Mrs A would shout at him and sometimes scratched him with her nails and did not pass this on either to the Domestic Abuse Hate Crime Unit or to social care or to the MARAC meeting. Poor communication within the service meant a planned liaison with social care did not happen and a further opportunity was missed to better understand the situation. As a result the mindset with which this case was considered was that of abuse by Mr to Mrs A and not a more complex situation with risks to both.

3.7 The reasons behind this appear to be poor understanding of the Mental Capacity Act and the requirements for a mental health assessment before making decisions on a person's ability to form intent, poor appreciation of the risks of domestic abuse in old age, and too great a willingness to be swayed by Mrs A's definition of the situation and to see the situation as one requiring a welfare response. Consistent oversight by the Domestic Abuse Hate Crime Unit appears to have been lacking, and there did not appear to have been an expectation or an efficient way for first response officers to have ready access to the pattern of call outs in relation to abuse. These are essential for effective management of domestic abuse whether in old age or otherwise.

3.8 Officers were aware of and influenced by the risks as well as the undesirability of bringing a frail elderly man into custody and would have wanted to be victim focused and respond sympathetically to his wife. This is understandable. Clearly this was not a case which could be solved by the police alone and a joint response with social services was needed.

3.9 Although there was a good level of liaison in this case between social services and the police service it did not translate into effective joint working and although either the police or social services could have called a safeguarding strategy meeting neither did. No reason for this has emerged in the review but it suggests that effective joint working in safeguarding adults cases was not very well embedded. The MARAC

discussion did not appear to be outcome focused and arrangements for ensuring that agreed actions were undertaken were not effective.

3.10 Despite these shortcomings in the police and social care response to the abuse allegations, Mr and Mrs A, throughout the period under review, were adults with full capacity to make their own decisions. The abusive events which social care and the police service were asked to respond to did not pose the level of serious risk of harm to have warranted interference with any other fundamental human right, including the right to family life.

3.11 Ultimately Mr A could not have been prevented from discharging himself home on the 29 October and clearly had the capacity and desire to make this decision. Mrs A could not be forced to accept services she did not want even if professionals thought this was in her best interests. However a more rounded multi agency intervention involving both son and daughter might have made a difference to the immediate sequence of events and to the longer term.

3.12 With the exceptions above, Mr and Mrs A received a good standard of services from the statutory agencies which was timely and responsive to their wishes.

3.13 Each agency has documented occasions when communication with others could have been better, or procedures could have been tighter or better implemented and these are reflected in their action plans. However, having taken an overview of events my conclusion is that with the exception of those discussed above, these did not make any difference to how the case was handled by any agency. Nevertheless they need to be addressed within each agency with urgency as similar lapses in slightly different circumstances could have serious consequences.

3.14 Decisions about the cause of death and the responsibilities of the parties involved are outside the remit of this review.

4. Lessons Learnt

4.1 This domestic violence review has highlighted issues about domestic violence in old age, especially in older old age and where older people have community care needs, which need to be incorporated in the training and development of staff. As the population ages the incidence of domestic abuse in older age will grow.

4.2 Most agencies showed good awareness of the Mental Capacity Act. This awareness needs to be extended within the police service so officers do not make assumptions about mental capacity, or mental health issues or make decisions based on those assumptions without a mental capacity or a mental health assessment.

4.3 This was a difficult and intractable situation which agencies had separately assessed as high risk; it would have been better managed if agencies had focused on what they could do together rather than on their single agency responsibilities. Agreed interagency processes for safeguarding strategy meetings should have been used and the family, both son and daughter, engaged if at all possible

4.4 Whilst working closely together agencies should also have role clarity; police officers need to keep their focus on an "effective and proactive investigation" while social services need to keep theirs on their community care responsibilities whilst both have a responsibility for ensuring the safety of the vulnerable adult(s). Revisiting Safeguarding adult procedures to clarify respective responsibilities in domestic abuse cases where the person also has community care needs would be useful.

4.5 As far as they could, professionals tried to respect Mrs A's expressed wishes about who should be informed, and to seek her consent to information sharing. In practice as Mrs A gave different consents to different people and the risks to Mr A were not highlighted this left professionals out of control of the situation; they would have benefited from stepping back and considering data sharing in the context of the risk of harm.

4.6 The SET Safeguarding vulnerable adults' process appears to have become well established, with referrals being made appropriately on most occasions. Risk assessments were also completed. However, what is less clear is whether the whole process operated with an outcome focus.

4.7 The MARAC did not serve as useful function in this case. The quality of discussion was poor and actions were not implemented. Questions were raised about whether it has sufficient administrative resources to effectively progress chase actions.

4.8 Only Mr and Mrs A's son was involved by agencies who had permission to contact him. It might have been useful if they had sought information about Mrs A's daughter who lived further away and contacted her. However most of the contacts were made in moments of crisis when an urgent response was needed.

5. Recommendations

5.1 Each agency has produced recommendations for their own agency. These are presented as an appendix to the main report using their original format. The following recommendations in this section are strategic recommendations or cover matters not covered in the agency IMRs.

5.2 It is recommended that:

1) Essex Police should act to promote police officers' understanding of the impact of domestic violence in older age, reinforce that Force Domestic violence policy applies in these cases and emphasise that where there are community care needs they should work jointly with social care rather than seeing social care as an alternative disposal and recognise that that social care has no additional powers to intervene if the victim refuses help.

2) Essex Police should act to improve the awareness of the Mental Capacity Act among their officers and ensure that decisions are not made about adults' capacity without a mental capacity or mental health assessment.

3) Essex Police should review its recommendations in the light of this review.

4) Southend Adult Social care should reinforce in social care that although the agency has a leadership role in safeguarding vulnerable adults that this is not an alternative to the police lead role in investigating allegations of domestic violence or other allegations of crime and that the police should be involved when there are allegations of crime, provided that consent has been obtained or appropriate judgements made about the level of risk where consent is not forthcoming.

5) The LSP Safer Board should review the Safeguarding Adults process and how it interacts with Domestic Violence where there are community care needs and reinforce with referrers that where an offence appears to have been committed they should refer this to the police as currently agreed within SET policies for safeguarding vulnerable adults.

6) The Board should reinforce the need for multi-agency responses in situations which are not amendable to single agency intervention, where the vulnerable adult(s) is hard to engage or are refusing offers of assistance to the extent that they are putting themselves at risk.

7) The LSP Safer Board should accept the recommendation from the Southend Safeguarding Board that the Board should analyse the prevalence of domestic abuse in disabled adults and frail older people within the locality and to devise a local multi-agency strategy within the context of professional and legislative responsibilities. The strategy promotes the effective co-ordination of, delivery and evaluation of multi-agency responses to domestic violence in the borough.

8) Each agency should help staff to understand the features and risks in domestic violence in older age, for example that pre-existing frailty, limited mobility and existing medication can increase the impact of smaller amounts of physical force and lead to unexpected and unintended consequences.

9) Each agency should raise staff knowledge and awareness of the range of factors to be taken into account situations where there are mutual allegations of domestic abuse to ensure that the risks to both parties re fully explored and understood and the safety plan is appropriate to both parties.

10) The responsible partnership for the MARAC should satisfy itself that it has adequate administrative support and effective quality assurance processes in place.

11) Each agency should ensure that it acts on its own recommendations, and report this back the safeguarding board within six months of this report being heard.

12) The Board should put arrangements in place to monitor the implementation of agency action plans.