# 7 Minute Briefing

## Adult Practice Review: WGA S14 2019

### 1. Background

A Concise Adult Practice Review was undertaken on the recommendation of the Practice Review Management Group (PRMG) of the West Glamorgan Safeguarding Adults Board (WGSAB) in accordance with Part 7 of the Social Services and Wellbeing (Wales) Act 2014 and the underpinning Practice Guidance for Multi-Agency Adult Practice Reviews.

The subject of the review is a female (Adult A) from a minority ethnic background who resided in her own home with her adult son.

### 2. Context

In June 2019 Adult A was brought by ambulance to the Emergency Department following a 999 call made by one of her sons due to a deterioration in her condition and difficulty breathing; another of her sons had been living with and caring for her at her home address.
Health staff suspected neglect and made a report to Police. Adult A was reported to be dehydrated, malnourished and compared physically to a skeleton. Fresh and old bruising, pressure sores, broken skin on her hands and feet and an abrasion to her face were noted. Adult A's son was arrested and an investigation was undertaken which resulted in no further action being taken.
Adult A died three days after her admission to hospital. The cause of death was recorded to be severe general deterioration, malnutrition and dehydration.

### 3. Key Learning Themes

**Screening & Prioritisation**
The notes made within the Common Access Point (CAP) detailing the conversation with Adult A's daughter to screen and identify the issues that Adult A was experiencing were limited. It was felt that the screening was focused on the original request for a wheelchair for external use and did not consider Adult A's needs within the home and what she was and was not able to do. If the initial screening had been more thorough, a more appropriate allocation would likely have been made, given what was later established about Adult A's circumstances and needs. It was also noted that the screening could have had more focus on support requirements for the family and that a carer's assessment should have been offered at this point.

### 4. Referrals

The review identified a number of instances during the timeline when opportunities for referrals were missed, or referrals were made but became 'lost' in the system.

- Despite a request for a narrow wheelchair due to Adult A's small stature, no MUST was completed and no referral was made to the Dietician.
- Adult A's details were added to a continence register that was no longer in use; she therefore never received a continence assessment. When family raised that Adult A had not been assessed it was not followed up.
- A professional from the Care of the Elderly clinic was declined entry to the address by Adult A's son, as they did not have ID with them.
- A Safeguarding referral sent to the WAST Safeguarding Team by the ambulance crew was never received.
- The GP who made the referral to the Care of the Elderly Clinic did not see the letter sent to the practice outlining an unsuccessful visit and that an appointment was declined and therefore Adult A was not invited back for review.

**The review noted that a number of changes had already been made to practice to address some of the above.**

### 5. Consent, Capacity & Use of Interpreters

Adult A was initially referred to CAP by her daughter due to difficulties with mobilising and accessing GP appointments. It was presumed that she consented to the referral as her daughter was acting in her best interests.

- As Adult A was not able to communicate in English, interpretation services should have been explored in order to determine if Adult A was able to provide informed consent / refusal.
- When support and professional involvement was declined by son and daughter, a mental capacity assessment and if appropriate, a Best Interest Consideration should have been made in regards to ongoing support and professional involvement to support and assess care and support needs.
- Independent Advocacy was not explored when son and daughter declined support for Adult A.

### 6. Safeguarding Thresholds

The concerns documented by the Professional following the visit to Adult A in January 2019, combined with the family declining interventions on their mother's behalf, would have met the threshold for a Safeguarding report.

- The Wales Safeguarding Procedures would have supported access to advocacy and interpreter services in order to ascertain Adult A's views and wishes.
- Capacity Assessments could have been requested through the Safeguarding Process to fully assess Adult A's level of understanding and whether she was consenting to her care arrangements.
- This was a missed opportunity for professionals to share their concerns with Adult A and her family to try to engage with them to provide the appropriate levels of support.

### 7. What to do Learning Opportunity

**Reflect** on the case discussed and think of how this situation could have presented in your work with vulnerable individuals?
**Ask** are there any similarities in cases you have worked or situations you have encountered?
**What** would you have done in a similar situation when working with vulnerable individuals? And what are the barriers to practice in your organisation?
**Identify** key support for yourself in your team.