WEST GLAMORGAN SAFEGUARDING BOARD
Adult Practice Review Report

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West Glamorgan Safeguarding Adults Board

Concise Adult Practice Review

Re: WGA S14 2019

Brief Outline Of Circumstances Resulting In The Review

A Concise Adult Practice Review was commissioned by the West Glamorgan Safeguarding Board on the recommendation of the Practice Review Management Group (PRMG) in accordance with the Guidance for Adult Practice Reviews. The criteria for this review are met under the Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People: Volume 3, Section 6.1:

"A concise adult practice review will be commissioned where an adult at risk who has not on any date during the 6 months preceding the date of the event, been a person in respect of whom the local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, has :

Died; or
Sustained potentially life threatening injury; or
Sustained serious permanent impairment of health"

Circumstances resulting in the review

Adult A was an elderly female from an ethnic minority background; she did not speak English. In June 2019 she was brought by ambulance to the Emergency Department (ED) 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.

Due to Adult A's presentation, 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.

During the timeline, Adult A was seen at the GP Practice for investigations due to leg swelling. She was also seen at home on two occasions by an Assistant Practitioner[1] from the Occupational Therapy service, part of the Common Access Point (CAP) multi-disciplinary team, following a referral by Adult A's daughter, on the advice of the GP, for a wheelchair to assist with her decreasing mobility. These visits generated a referral to District Nursing for considerations around incontinence, nutritional supplements and swelling to the foot.

This Concise Review covers the period from the 22nd of October 2018 to the 14th of June 2019. It begins with Adult A's first visit to the GP in two years due to the symptoms of leg swelling and ends when Adult A passes away in hospital.

Practice And Organisational Learning

Screening and Prioritisation

Adult A's daughter made a referral to CAP in December 2018 on the advice of the GP. She had seen the GP that day and disclosed that due to her mother's decreasing mobility she was struggling to get her to appointments. The referral was screened and a decision made that an occupational therapy assessment would be required. A conversation was undertaken with Adult A's daughter and the case was allocated to an Occupational Therapy Assistant Practitioner to visit Adult A at home.

Discussions at the learning event highlighted that the notes 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 wasn't 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.

It was encouraging to hear that since this time there has been some education within CAP for those with responsibility for screening referrals to ensure a more robust screening process is in place and that cases are allocated appropriately.

Referrals

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

Due to Adult A's very small stature and low weight, a narrow wheelchair was requested by the Assistant Practitioner. Documents provided to the review show that Adult A's weight

[1] Occupational Therapy Assistant Practitioners work in support roles alongside qualified healthcare professionals and assess people's need for aids and equipment at home.

had decreased from 38.8 kg in 2016 to 34.4 kg at the end of 2018. Such a request should have raised questions about the requirement for Dietician input however no such questions were raised and this was therefore a missed opportunity to refer to the Dietician. It was confirmed that practitioners within CAP have received training on the Malnutrition Universal Screening Tool (MUST)**2** and so the importance of utilising this tool needs to be reiterated.

In January 2019 Adult A was added on to the continence register by the District Nurse administration team following a discussion between the District Nurse and the Assistant Practitioner who had visited Adult A at home. This register was no longer in use and Adult A should instead have been signposted to the continence service. In March 2019, there is an entry in the District Nursing notes that Adult A's daughter had not heard anything with regards to a continence assessment; there is no record that this was followed up. It appears that this referral became 'lost' and Adult A was never assessed with regards to continence issues.

During the learning event, the District Nursing Service shared that some deficiencies had been noted in terms of how the information provided by the Assistant Practitioner was triaged and how the action taken as a result was recorded. In response the method of collating information and triaging within a Single Point of Contact (SPOC) has now been updated and paper forms have been replaced with an electronic system.

Wales Ambulance Service Trust (WAST) attended Adult A's address in June 2019 in response to the 999 call made by Adult A's son. The attending Paramedic submitted a Safeguarding referral to the WAST Safeguarding Team due to concerns about bruising and skin tears observed to Adult A's body, the condition of her property and a number of weapons located within the room in which she had been sleeping. A report was also made to police in relation to the weapons who attended and confirmed that these were replicas. The WAST Safeguarding Team have been unable to locate the Safeguarding referral and it was not received by the Local Authority Safeguarding Team.

At the learning event, the WAST representative explained that a situation such as this is no longer able to occur as the internal process for submitting Safeguarding referrals within WAST has now changed and all clinicians are provided with IPads from which they are able to make reports directly to the Local Authority.

Adult A was visited at home in December 2018 following a referral to the Care of the Elderly Consultant, made by the GP to support Adult A and her family with advice around weight loss and reduced appetite. This visit was recorded as unsuccessful and a follow up appointment was made for Adult A at the clinic in January 2019.

It was not documented in Health records why this visit was unsuccessful. It was established by the Health panel representative, following a conversation with the Consultant that attended the address, that Adult A's son had refused her entry as she did not have any professional identification with her, as she was between roles at the time. This was also confirmed by Adult A's family. It is expected practice for all professionals to carry appropriate identification and this was acknowledged by the Consultant.

The follow up appointment to the failed visit was cancelled by Adult A's son and a letter sent to the GP notifying them that Adult A did not attend. The reviewers were advised that there is a process within the surgery whereby all incoming letters are screened by a GP. On this occasion the GP screening the letter was not the same GP that had seen Adult A the previous month and the letter was filed for 'no further action'. During a conversation with the reviewers the GP confirmed that this is standard practice and that they would not normally

2 The MUST tool is a five step screening/assessment tool to identify adults who are malnourished or obese. It includes management guidelines which can be used in the development of a care plan and next steps.

act on a ‘did not attend’, unless there were concerns already highlighted.

The GP did share that if they had screened the letter, given their knowledge of Adult A’s previous presentation, they would have likely requested a further appointment to re-review her weight and other ongoing issues and this would have included a referral to the Dietician. The reviewers were advised that due to capacity issues, continuity of GP is a challenge and not practically possible.

Consent, Capacity and the Use of Interpreters

When a referral is received by Social Services or Health, consideration should always be given to whether the person being referred has consented to the referral and is aware that their personal information will be shared in order to assess what intervention is required. If the person is deemed to lack capacity to make decisions, a Best Interest consideration is needed and this should be documented in the person’s record. The Mental Capacity Act (2005) identifies professional responsibilities when working with people for whom the Act applies.

Within the timeline, Adult A was supported to GP appointments by her daughter. From the documented information provided to the review, the reviewers were unable to identify whether Adult A consented to her daughter being present and to her medical information being shared with her.

It was unfortunate that the GP was unable to attend the learning event to reflect on their involvement and participate in the multi-agency discussions, however the reviewers were able to speak with them after the event to gain their views. During this meeting the GP reported a “good rapport” between mother and daughter at appointments and no concerns were documented on GP records. Therefore consent was presumed in these circumstances. The GP shared that this is not uncommon and highlighted that they have a high number of patients who are supported by family members. Unless the surgery has concerns, this is common practice. For people whose first language is not English, there is the option of Language Line (telephone interpreter), but this is only usually used where there are concerns.

At the learning event, it was identified that, at the point of referral to CAP, capacity was presumed and it was assumed that Adult A was in agreement for her daughter to make contact for the purposes of making a referral for a wheelchair. There were no concerns identified at point of referral that would indicate that Adult A’s daughter was not acting in her mother’s best interests.

During the learning event there was a discussion about the use of an interpreter, as Adult A’s first language was not English and Adult A could not converse in English. Social Services staff reported that it is not expected practice for them to use an interpreter unless there are concerns that the person advocating is not doing so in that person’s best interests. However, Health staff attending the learning event reported that there would be an expectation on them to consider the use of Language Line at the point of referral.

As the referral was received by a Social Services representative within CAP, there was no recorded consideration of using an interpreter and this is in line with current organisational practice and policy.

The review has identified that there are conflicting processes in relation to the use of interpreters within the integrated team and it is recommended that this be reviewed to ensure consistency for service users, regardless of the allocation within CAP.

Through the ongoing support being offered there was evidence of numerous referrals being made for additional support and assessment. Consent for these referrals and interventions was sought via Adult A's son and daughter. When consenting, there were no concerns being raised in regards to Adult A's children acting in their mother's best interests and therefore this consent was accepted by Health and Social Care professionals.

In January 2019 Adult A's daughter declined a GP review offered by the District Nurse and a referral for a Social Worker offered by the Assistant Practitioner. Her son also declined support from the Care of the Elderly Consultant.

Following the visit to Adult A in January 2019, the Assistant Practitioner documented inappropriate manual handling techniques being used by the family to support Adult A into the bath, poor home conditions, poor nutritional intake, very low weight, poor fluid intake and continence issues. Given these concerns, consideration could have been given to a Mental Capacity Assessment and Best Interest Decision in relation to the family declining interventions. It is not documented that her children held Lasting Power of Attorney in relation to Health and Welfare, and neither was it clear whether they were acting in their mother's best interests by declining this support as there was no evidence available to the reviewers that suggested professionals had explored with the family their reasons for declining the same.

Adult A was presumed to have capacity throughout the timeline and the reviewers have found no evidence that anyone had assessed Adult A's capacity.

It was evident that there were opportunities to access advocacy and interpreter services in order to ascertain Adult A's wishes and views and through this work, capacity could then have been assessed.

It is not clear whether Adult A was provided with information to make an informed decision about her care. The reviewers were not provided with any documentation to suggest that the potential risks around decisions being made were shared with Adult A or her family. If this was shared, it would not have been possible for professionals working with Adult A to establish whether the information translated by Adult A's daughter encompassed these risks. Family members may not always fully explain risks due to the potential impact this could have on the person. Therefore, without advocacy and the use of an interpreter, it would not have been possible for professionals working with Adult A to be sure that she understood the risks associated with inappropriate manual handling transfers and declining medical appointments and interventions.

Safeguarding Thresholding

The concerns documented by the Assistant Practitioner 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 also have been requested as part of the Safeguarding process to fully assess Adult A's level of understanding and whether she was consenting to her care arrangements.

By submitting a Safeguarding report, there would have been opportunities for all professionals to share information and consider what support was needed in terms of reducing risks to Adult A and whether a Best Interest Meeting/Decision was needed to consider accommodation, care and treatment.

There were indicators of potential risk throughout the timeline. The Safeguarding process would have been an 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.

Views of Adult A's Daughter

As part of the review process one of the reviewers spoke with Adult A's daughter. During this conversation she said she felt that her mother had been 'forgotten' when a professional who had attended the address without ID and was refused entry, did not return. She stated she assumed that this meant that her mother's situation was not a priority and that other people who were more ill and more in need of a service would now be seen before her.

Adult A's daughter said the family were shocked when her mother's condition deteriorated as they had not understood that she was so unwell. For them this was compounded by the fact that, in their eyes, the GP had been unable to provide an answer as to why her mother's legs were swollen or offer an alternative to the care that the family were providing, and so they had continued doing what they had always done.

When the reviewers spoke with the GP they confirmed that the investigations undertaken had not raised any medical concerns and therefore they had referred Adult A to the Care of the Elderly Consultant to support the family with advice and assistance around weight loss and nutrition. This support was later declined by Adult A's son.

Professionals need to ensure that family members fully understand the outcomes of medical investigations and supportive interventions, including potential outcomes when these are declined, and that understanding is checked so that family are not left to make assumptions about the needs of those they are caring for. This is all the more important where family are being used as interpreters.

Improving Systems and Practice

(What needs to be done differently in the future and how this will improve future practice and systems to support practice)

Recommendation 1
All agencies need to ensure that screening processes to determine allocation of resources are thorough and documented accurately and in detail to ensure the correct allocation at the earliest opportunity.

Recommendation 2
Health and Social Care practitioners should use the Malnutrition Universal Screening Tool (MUST) when concerns are raised about low weight or poor nutritional intake to ensure appropriate support is provided to those who are malnourished or at risk of becoming malnourished.

Recommendation 3
The Safeguarding Board should be assured that there is consistency in the use of interpreters within multi-disciplinary teams to ensure that all service users' wishes and feelings are captured and consent and capacity can be explored at the point of referral if a person does not understand or speak English.

Recommendation 4
The Safeguarding Board should be assured that where concerns arise that a family member is not acting in a person's best interests, staff are aware that advocacy support and/or translation should be sought to ensure the person is providing informed consent to the way their support is being provided.

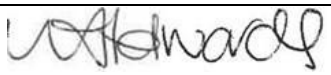
Reminders of practice

- The importance of accurate and up to date record keeping including details of telephone conversations and actions taken.

- Professionals need to ensure that family members fully understand the outcomes of medical investigations and supportive interventions, including potential outcomes when these are declined, and that understanding is checked so that family are not left to make assumptions about the needs of their loved ones. This is all the more important where family are being used as interpreters.

- All professionals should be aware of their duty to report an Adult at Risk in line with the Wales Safeguarding Procedures 2019.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)*	B.Aynsley	**Reviewer 2** *(Signature)*	
Name *(Print)*	Beth Aynsley	**Name** *(Print)*	Paul Cotgias
Date	12.03.21	**Date**	12.03.21

Chair of Review Panel *(Signature)*	
Name *(Print)*	Nicola Edwards
Date	12.03.21

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review Process *To include here in brief:* • *The process followed by the Board and the services represented on the Review Panel.* • *A learning event was held and the services that attended.* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
The Chair of the West Glamorgan Practice Review Management Group (PRMG) made a recommendation to the Chair of the West Glamorgan Safeguarding Board on the 21st October 2019 that a concise APR should be undertaken in respect of WGA S14 2019. The services represented on the panel consisted of: - Swansea Bay UHB - Swansea Local Authority Adult Services WAST and South Wales Police provided timelines but were not required as panel members. A virtual learning event was held using Microsoft Teams on the 23rd of September 2020 due to Covid restrictions in place at the time. Practitioners from the following agencies attended: - Swansea Bay UHB - Swansea Local Authority Adult Services - WAST The Reviewers spoke separately with the District Nurse, the GP and the Care of the Elderly Consultant as they were unable to attend the learning event. Comments and feedback from these discussions have informed the report. In line with Welsh Government guidance, Adult A's sons and daughter were notified in writing of the decision to undertake the Adult Practice Review and Adult A's daughter accepted the opportunity to speak with the reviewers. This took place over the phone due to Covid restrictions in place at the time. The family will be provided the opportunity to view the final report.
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	