# 7 Minute Briefing

## Adult Practice Review: WGA S13 2019

### 1. Background

The West Glamorgan Safeguarding Adult Board (WGSAB) commissioned an Adult Practice Review on 7th August 2019 on the recommendation of the Practice Review Management Group (PRMG) 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 PRMG felt that this review could generate multi-agency learning around self-neglect.

The subject of the review is an 83yr old male who was in receipt of Care & Support from the Local Authority for just over 2yrs prior to his death. The subject lived independently in the community and maintained capacity throughout.

### 2. Context

The subject had chronic obstructive pulmonary disease and arthritis, he relied on a walking stick and zimmer frame due to poor mobility and had an electric scooter. He lived on the ground floor of his property, which had a hospital bed, commode and adaptations to raise his chair.

The home was described by family and professionals as being in an appalling condition such so that the LA were unable to identify carers through brokerage to attend the home to provide the package of care identified to meet his health and social needs. The family and social worker suspected a family friend who was supposedly supporting the subject with shopping, cooking and cleaning was financially exploiting him. As he maintained capacity and refused any involvement with Police this was unable to be investigated further.

### 3. Context continued

The subject declined all offers of support/ services to improve home conditions and quality of life. As a consequence of health concerns he was taken to hospital by ambulance on nine separate occasions. Three safeguarding referrals were submitted highlighting neglect and poor home conditions, as well as one referral by the hospital. He was deemed to have capacity on each hospital admission and subsequently on the numerous occasions he discharged himself from hospital against medical advice. Following the Police attending the family home three PPN's were submitted concerning neglect and poor home conditions.

### 4. Key Themes / Discussions

**Self-Neglect:**

It was evident, and agreed by all agencies who had worked with the subject, that he had capacity and as such felt their hands were tied and out of their control when he consistently refused services/support.

**Multi-agency working:**

It was clarified at the learning event by the Local Authority, that there is no requirement or expectation for social services to hold multi agency meetings on Care and Support cases. The Care and Support Plan is reviewed on a regular basis however there is no multi agency working other than when a service is inputted.

Local Authority Social Services Management at the Learning Event shared that the process has since changed when it comes to sharing responsibility, and as a team going forward have started to bring back the process of multi-agency case conferences, and sharing risks with partner agencies.

### 5. Key Themes & Discussions continued

**Communications between Health Board & Social Services:**
Health are unable to access Social Services IT system other than through the hospital Social worker, Hospital shared can take up to 1hr in their absence to obtain the relevant information required. Hospital and Community OT were not familiar with their internal IT and how to access all areas, whereby the hospital could have been aware of the involvement with Community OT.

**Mental Capacity:**
The common theme throughout the event highlighted by all agencies, was that despite services being offered, the subject was deemed by professionals to make unwise decisions as he constantly refused services and support. The Subject was assessed on each occasion as having capacity when he made these choices.

**Safeguarding Reports:**
The Social Worker shared that any safeguarding reports received by the department are dealt with by management. It was not clear whether a certain number of reports received within a period of time would be a trigger point for escalation or not or how these would be dealt with.

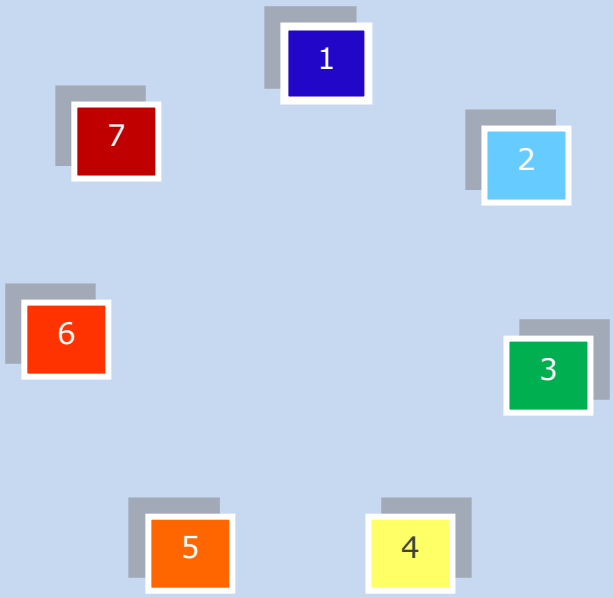
### 6. Improving Systems & Practice

The Board should develop a multi-agency self-neglect tool. This will inform and enrich practice going forward, to share wider with partner agencies.
Health should consider their current IT system and any adaptions required to provide other parts of their internal service access.
Since July 2020 all WAST emergency and non- emergency staff have been issued with iPads. This has enabled the organization to introduce an electronic safeguard reporting system. This ensures that a completed safeguarding report is automatically emailed to the relevant Local Authority. Making the process easier to use, more robust and information shared in a timely manner

Social Care and the Health Board should consider how communication can improve in the absence of a universal IT system.

To improve communication and information sharing:

- the Local Authority (regional) to consider how care and support cases are reviewed through a multi-agency lens, which will provide a far more holistic approach and better outcomes for the individual.
- The Safeguarding Board to review how Mental Capacity is assessed across the region to ensure best practice and consistency.




### 7. Learning Points

Professionals are reminded that capacity should not be a barrier to raising safeguarding concerns.

In line with Handling Individual Cases Volume 6, outcomes of safeguarding reports should be fed back in line with the Wales Safeguarding Procedures

All practitioners included in the timeline need to take responsibility and attend the learning event, this will afford everyone the opportunity to understand why individuals did what they did and to make changes where appropriate to do so.