WEST GLAMORGAN SAFEGUARDING BOARD

Adult Practice Review Report

Extended Adult Practice Review

Re: WGA S13 2019 Board 1/17

Brief Outline Of Circumstances Resulting In The Review

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 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.

Reviews that meet the criteria for an Adult Practice Review should follow the principles, approach and process outlined in chapters 1 - 7 of Part 7 of the Social Services and Wellbeing (Wales) Act 2014, Volume 3.

The purpose of a review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the context and detail of agencies' work with an individual and their family. The outcome of reviews intend to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice.

The Practice Review Management Group felt that this review could generate multi-agency learning around self-neglect. As such the Group agreed that Mr A's case met the criteria for an Extended Adult Practice Review.

Methodology and Scope of the review.

The scope of the review was from the 1st February 2017 to 15th March 2019. Following the decision to carry out this Review an Adult Practice Review Panel was formed comprising of the following;

Chair: Chris Frey-Davies– Neath Port Talbot CBC

Independent Reviewers: Ali Davies - Neath Port Talbot CBC

Helen Sinclair - Neath Port Talbot CBC

West Glamorgan Safeguarding Board management Unit.

Panel Members:

- South Wales Police
- Local Authority Adult Social Services
- Probation
- Health Board
- Local Authority Housing
- Welsh Ambulance Service Trust (WAST)

The panel met on four occasions prior to the Learning Event.

As part of the preparatory work the Reviewers met with the family to ensure that their wishes and views were represented at the Learning Event and within this report.

- All attendees were sent the chronology in advance of the Learning Event in order to be afforded the time to consider the following :

- What did you know
- What didn't you know
- What concerns did or didn't you have

- There was a delay in convening the Learning Event due to the unprecedented times of Covid 19 and working restrictions. The Learning Event was eventually held on 8th September 2020 with representation by professionals both managers and practitioners from the following partner agencies:

- WAST
- Local Authority Social Services
- Health Board representatives

- Local Authority Housing Department
- South Wales Police

- The Panel combined the learning event [Managers and Practitioners] to ensure effective use of time given the challenges associated in convening the learning event virtually as well as the small number of attendees.
- There was no representation from the GP Surgery.
- In order to remind participants of the context for the Adult Practice Review, they were each sent the timeline in advance of the Learning Event. Participants were asked to consider the entries specific to their respective agencies and to share what they did and why they did it against the background of their physical and psychological working environment.
- It was stressed at the outset by the Chair the point of the review is not to assign blame or responsibility, but to learn how to improve, and therefore the event should be seen as a learning opportunity.
- The Learning Event adopted a systems approach to help participants reflect, think and learn together in a safe environment. Managers and practitioners at the event were afforded the opportunity to identify key single and interagency learning points.

- The outcome of the event was positive with managers and practitioners from partner agencies working together. All participants were reflective and were prepared to review their individual and organisational working practices and procedures.
- Following the Learning Event, the GP's were written to on 2 separate occasions, followed up by a telephone call to offer them the opportunity to meet with the Reviewers and feed into the review process. The Reviewers spoke to the Practice Manager who confirmed that after reading the Chronology and reviewing the patient records there was nothing to add on the part of the GP Practice.
- While it is appreciated that GP's are very busy professionals, their lack of availability and their understanding of the requirement for them to attend the Learning Event as outlined in Part 7 of the Social Services and Wellbeing (Wales) Act 2014 will be escalated as a recommendation from this report.

Circumstances Resulting in the Review

The referral for the Adult Practice Review was made following an investigation by South Wales Police.

- On 7th March 2019 Mr A was found semi-conscious on the floor in his home and an ambulance was called when it was believed he had fallen.
- Upon admission to hospital Mr A was in poor health. Mr A was emaciated, de-hydrated and had bruises over his body, including trauma to the right side of his head.
- Mr A later died in hospital as a combination of his overall condition.
- Medical cause of death 1a) Acute exacerbation of Chronic Pulmonary Disease 1b) Traumatic Right-Sided Subdural Haemorrhage.
- The coroner reported Mr A died in hospital from an acute exacerbation of chronic obstructive pulmonary disease which was a complication of the head injury that he sustained in an unwitnessed fall at home.
- A criminal investigation was undertaken and no offences were identified.

Background to the Adult Practice Review

- It was agreed by the panel to conduct the review over a 2 year timeline between 01.02.17 – 15.03.19 during which time Mr A was in receipt of a Care and Support Plan by the Local Authority.

- Mr A resided at a council owned property where he had been for the majority of his years and was listed as a sole occupant.

- Mr A had mobility issues that made him rely on a walking stick and zimmer frame as well as a mobility scooter. There was also a stair lift fitted within the property.

- Mr A had additional health concerns namely, chronic obstructive pulmonary disease and arthritis, that resulted in him having a hospital bed, adaptations to raise his sofa and a commode to the ground floor of his property.

Subject of the Review

- The review relates to Mr A an 83 year old, who according to information provided to the Local Authority Housing Department, lived alone.

- However it was evident from professionals who saw and worked with Mr A that his son unofficially lived at the property which transpired as, Mr A living on the ground floor and his son occupying the first floor.

- Consultation by the Reviewers with the family provided an insight into Mr A who tragically lost his two sons.

- Mr A refused to sleep upstairs following the death of his son in 2015.

- Mr A was the father to 4 boys. Mr A was married to the mother of his first born son, however this soon resulted in divorce and he lost all contact with his first born. Mr A went on to have 3 further sons from subsequent relationships.

- It was reported by his son B who lived with him, that Mr A 'hobbled' as a car mechanic and scaffolder for years before his health deteriorated.

- His son B shared that they had a 'love/hate relationship' and would often call the police on one another, however knew his father 'loved him and he was his favourite son'.

- Mr A liked to go out however was confined to the home following the battery of his mobility scooter being stolen and having insufficient funds to replace it. At home, Mr A liked to watch television and described his only other pleasure as smoking.

- Son B described the home conditions as 'filthy' resulting in carers refusing to attend the property, he also shared it was infested with rats. His son went on to say he was used to the home conditions as they were similar to what they were when he was a child.

- Son B described his father as 'stubborn, argumentative and distrusting of females and professionals'. He said 'everyone was ripping him off' (financially) to include one person in particular who was supposedly doing his shopping and cleaning, which he informed the social worker of.

- Son B spoke highly of the social worker describing her as the only one that did anything for his father. He said 'she tried to get services in but each time they closed the door in her face'. Granddaughter C also spoke positively of the social worker and her attempts to get services in place.

- Further conversations with Mr. A's granddaughter C said her grandfather was a very private man and didn't like people touching him. Granddaughter C suspected the family friend who was assisting Mr A with shopping, cooking and cleaning was mis-using his money which she reported to the social worker.

- Granddaughter C said she didn't really know her grandfather as the family had no contact with Mr A when she was growing up and only visited the home on a number of occasions in the last few years. C described the home as 'filthy'.

Practice And Organisational Learning

Multi-agency working

- Effective communication between partner agencies is an important tool that is fundamental to ensure that relevant information is shared and to enable the implementation of appropriate measures where there are practice and / or safeguarding concerns.

- Mr A's social worker described him as a character, fiercely independent and it took a while for him to trust professionals. She was confident that Mr A was constantly assessed and was deemed to have capacity throughout her

involvement. She described home conditions as unfit, there was clutter everywhere, the settee was soaked in urine and the flooring was dirty throughout, as well as the front garden strewn with rubbish yet Mr A did not have funds to pay for a cleaner.

- Mr A was assessed as needing a package of care, brokerage explored all avenues however due to the poor home conditions and the risk assessment highlighting the need for the calls to be double staffed, no agencies were prepared to accept the work.

- Mr A was offered the opportunity to access respite in order for the house to be cleared and housing works to take place however Mr A refused to access respite as there was a top up fee to be paid which he could not afford.

- On the one occasion Mr A did agree to go into a residential home for a short period the acute clinical team made the decision that they could not support this as his needs could not be met as a consequence of his poor health and he needed to be admitted to hospital instead.

- The social worker shared she had a good working relationship with the community occupational therapist (OT) who provided aids to assist Mr A within his home.

- The social worker confirmed Mr A had a multi-agency outcome focused plan. The plan identified the need for a package of care, with Mr A's outcome being he wished to remain at home. Social worker shared she was very worried about Mr A's nutrition and hydration and took the initiative to arrange for the GP to prescribe nutrition drinks.

- Social worker raised concerns with her seniors in supervision that she felt a family friend was financially exploiting Mr A. The social worker had sight of bank statements evidencing what the friend was withdrawing however was told by Mr A that he was only receiving half the funds. Family members also raised their concerns with the social worker in relation to this matter. It was deemed as Mr A had capacity and chose to deal with the matter himself, in the absence of the police being notified there was nothing else that could have been done.

- This could have been a missed opportunity as Mr A appeared to be a vulnerable adult who potentially was being financially exploited. Had safeguarding been considered at this point Mr A might have been in a different place financially which could have supported his need to pay for a cleaner and other items that were required to improve home conditions and his quality of life.

- The social worker also had concerns in relation to his son's (B) ability to care for him, however Mr A wanted his son (B) to stay and care for him.

- From the reading of the timeline, it was shared at the event by the Community OT that she was not aware of the number of times Mr A had presented at the Hospital Emergency Department, furthermore the Hospital OT was not aware that there had been a service provided by the Community OT. It appears the NHS has several different recording systems which is

dominated by the part of the service the individual works.

- Both Community OT and the Hospital OT suggested that they did not have access to the Clinical Systems. Further enquiries with the Health Board confirmed that any Health Board employee can access the Clinical Systems as required.

- The Emergency Department shared that they do not have access to the IT system that is used by Local Authority Social Services. Fortunately during normal working hours there is a social worker based within the Emergency Department and depending on his availability he is able to access the system and relay relevant information to his colleagues in the Emergency Department.

- However in his absence it was shared it can take anything from 45-60 minutes to obtain the relevant information required. Access to the system has been requested on numerous occasions to no avail.

- The Community OT shared that she had a very good working relationship with the social worker and undertook all her visits jointly. She reported Mr A declined additional support that could have been offered from the physiotherapist, each offer of support Mr A would say he did not need it as his son B would assist him.

- The Social Worker based in the Hospital Emergency Department felt he had really good working relationships with Mr A's Social Worker and his colleagues within the hospital department as well as having access to the various IT systems. He felt Mr A's social worker did everything she could however her hands were tied as Mr A had capacity.

- Similarly Housing were not aware of the number of hospital admissions or indeed the full extent of the work on the part of the Social Worker and the Community OT. Housing were also unaware of the partner agency concerns with regard the home conditions.

- Over the years Housing had undertaken repairs at the property and on one occasion at Mr A's request offered to support him with a move to another area. More recently contractors refused to enter the property to undertake much needed renovation works to the kitchen and bathroom as the unacceptable conditions within the property were deemed as a health and safety concern.

- Housing could have reported the matter to Environmental Health who would have most likely condemned the property. However this would have been counter-productive to the cause of Mr A as he refused the offer of alternative accommodation. Housing reinforced they would not take any action against the tenancy as the outcome would not be proportionate to the offences. The Reviewers felt this was clearly a pragmatic decision not to prosecute.

- Mr A would greet Housing Officers with abuse and refuse them entry into his home and when offered support to rectify the home conditions would turn all help of support down. Mr A was deemed to have capacity each time he interacted with Housing and made the choice not to engage with their

services.

- WAST attended the home on 12 separate incidents, 1 was from a paramedic discharging duties on behalf of the GP and 2 instances related to Mr A's son B. Of the 9 attendances they submitted 3 safeguarding referrals relating to the appalling living conditions, frailty, older person care needs, emaciated condition as well as highlighting a fire hazard on 1 occasion.

- Other than these referrals and the paramedics updating the Emergency Department on arrival at hospital it felt that they effectively worked in isolation of the other agencies involved with Mr A.

- The Practitioner from WAST felt the home conditions were unacceptable saying 'home was appalling, it was not cluttered just extremely dirty ', however there is no direct mechanism between WAST and housing where these issues can be raised directly between the two agencies.
  From discussions at the event Housing shared the processes already in place with the Fire Service and Police whereby they regularly update Housing on visits they have undertaken to their properties.

- The event evidenced how agencies are already clearly thinking how they can take things forward with WAST and Housing agreeing to speak to their respective senior managers to develop a reporting mechanism going forward similar to that of the other emergency services.

- The Police representatives at the event shared similarly to other agencies that they were unaware of partner agency involvement and the amount of admissions Mr A had to the Hospital Emergency Department.

- They too described the home conditions as dirty and noted on one occasion that Mr A had no food. Mr A was described as looking malnourished, with serious concerns about his health. On three occasions Police attended the home concerns were such that Public Protection Notifications (PPNs) were submitted by attending officers and shared with Adult Services.

- It was clarified at the 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 Case Conferences and sharing risks with partner agencies.

Mental Capacity

- 'Mental capacity is the ability to make specific decisions at specific time-points. Everyone is assumed to have it until proven otherwise. Unfortunately, when an injury, illness or difficulty with the mind or brain occurs, we can lose the capacity to make certain decisions. Laws have been put in place to

ensure that people without mental capacity will be supported and their rights protected' (Mackenzie and Wilkinson, 2020: xii)

- The common theme throughout the event by all agencies was that despite services being offered Mr A was deemed by professionals to make unwise decisions as he constantly refused services and support. Mr A was assessed on each occasion as having capacity when he made these choices.

- The Social Worker was very clear in that each time she met Mr A she would informally assess Mr A's capacity and enter a note in her recordings to this effect. The Social Worker confirmed at the Learning Event that there was never a need to formally assess Mr A as he was always deemed to have capacity when she visited.

- Had the Social Worker deemed Mr A to have lacked capacity then she would have completed a formal assessment and attached the paperwork to her recording.

- Of the 9 incidents that WAST attended Mr A's home address. He was deemed to lack capacity on only one occasion. This was in relation to an acute clinical presentation which he recovered from, following conveyance to Hospital.

- The Emergency Department Consultant confirmed that Mr A attended their Emergency Department on 8 occasions and on each occasion he was deemed to have capacity.

- Similarly on the occasions Mr A refused medical intervention and discharged himself against medical advice, the relevant form was completed by the medical staff treating Mr A which evidenced he knew what he was doing and was deemed to have capacity on each occasion.

- The hospital Social Worker shared that capacity is always considered when a patient is admitted to the Emergency Department. Details from the paramedics would be factored into any capacity assessment be that formally or informally.

Safeguarding concerns:

As Reviewers the safeguarding concerns have been listed numerically.

1) WAST and the hospital submitted safeguarding reports at various points in time. The referrers did not receive any feedback from the referrals which poses the question what if they did not agree with the outcome.

2) The WAST practitioner provided an explanation as to why not all incidents resulted in a safeguarding report, despite colleagues entering the same

home conditions mentioned previously. Anecdotally, some staff have become reluctant to raise safeguarding reports, due to not receiving feedback when they have raised concerns in the past. The practitioner advised that they were recently made aware that report makers can request feedback following the submission of a safeguarding report.

3) During this timeline the WAST referral system was a paper report, which was faxed (later emailed) to WAST control room for the Duty Control Manager to facilitate the process of sharing the form to Local Authority. Fax machines or printers did not often work at locality stations so staff felt that the task became onerous, so could be deterred from making a referral due to these issues.

4) The Chair stressed, whereas good practice is feedback should be provided to the referrer, should this not be the case and if there is no response within 7 days then it is incumbent on the referrer to chase this up.

5) 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 or not and how these would be dealt with.

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)**

Again for the purpose of transparency and ease of reading all suggestions and recommendations have been set out numerically:

1) The absence of representation on the part of the GP surgery to be raised with the Board. 3 GP's, 1 GP paramedic and the practice manager were invited to the learning event however, apologies were only received from 1 invitee.

2) The Board should develop a multi-agency self-neglect tool. This will inform and enrich practice going forward, to share wider with partner agencies.

3) Health Board staff being aware that they can access the different systems, the process of requesting access via the Portal, and in particular for community staff, how widely the Mobilisation project is now rolled out that staff can access systems remotely.

4) 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.

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

6) 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.

7) The Safeguarding Board to review how Mental Capacity is assessed across the region to ensure best practice and consistency.

Reminders of Practice

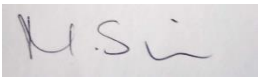
Professionals are reminded that capacity should not be a barrier to raising safeguarding concerns.

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

Where a report is made to social services by telephone, the person making the report should confirm the report in writing within 24 hours. Once the written report

has been received by social services, the person making the report should receive an acknowledgement within 7 working days. If they do not receive this, they should always contact social services again.
https://safeguarding.wales/adu/a3pt1/a3pt1.p4.html.

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.

Statement by Reviewer(s)			
REVIEWER 1	Ali Davies	**REVIEWER 2** ***(as appropriate)***	Helen Sinclair
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)*	AJDavies	**Reviewer 2** *(Signature)*	
Name *(Print)*	Ali Davies	**Name** *(Print)*	Helen Sinclair
Date	12.03.21	**Date**	12.03.21

Chair of Review Panel *(Signature)*	C.Frey Davies
Name *(Print)*	Chris Frey-Davies
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 West Glamorgan Safeguarding Adult Board (WGSAB) commissioned an Adult Practice Review on 7th August 2019 on the recommendation of the Practice Review Management Group 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 Practice Review Management Group felt that this review could generate multi-agency learning around self-neglect. As such the Group agreed that Mr A's case met the criteria for an Extended Adult Practice Review.

The scope of the review was from the 1st February 2017 to 15th March 2019. Following the decision to carry out this Review an Adult Practice Review Panel was formed comprising of the following;

Chair: Chris Frey-Davies– Neath Port Talbot CBC

Independent Reviewers: Ali Davies - Neath Port Talbot CBC

Helen Sinclair - Neath Port Talbot CBC

West Glamorgan Safeguarding Board management Unit.

Panel Members:

- South Wales Police
- Local Authority Adult Social Services
- Probation
- Health Board
- Local Authority Housing
- Welsh Ambulance Service Trust (WAST)

- There was a delay in convening the Learning Event due to the unprecedented times of Covid 19 and working restrictions. The Learning Event was eventually held on 8th September 2020 with representation by professionals both managers and practitioners from the following partner agencies:

- WAST

- Local Authority Social Services

- Health Board representatives

- Local Authority Housing Department

- South Wales Police

The Reviewers met with the family to ensure that their wishes and views were represented at the Learning Event and within this report.

- Following the Learning Event the GP's were written to on 2 separate occasions followed up by a telephone call to offer them the opportunity to meet with the Reviewers and feed into the review process. The Reviewers spoke to the Practice Manager who confirmed that after reading the Chronology and reviewing the patient records there was nothing to add on the part of the GP Practice.

- While it is appreciated that GP's are very busy professionals their lack of availability and their understanding of the requirement for them to attend the Learning Event as outlined in Part 7 of the Social Services and Wellbeing (Wales) Act 2014 will be escalated as a recommendation from this report.

☐ Family declined involvement

For Welsh Government use only

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	☐	☐	