Adult/Child Practice Review Report

Adult Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review

Re: CTMSB03/2022 Adult W

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

An Extended Adult Practice Review (APR) has been undertaken in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3". The guidance states that an Extended Review must be commissioned by the Safeguarding Board where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- Died; or
- Sustained potentially life-threatening injury; or
- Sustained serious and permanent impairment of health.

Key Code:

W	Person subject of the review
X	Son of adult W

Due to the nature of the event it was agreed at the Cwm Taf Morgannwg Safeguarding Board Joint Review Group that the criteria was met for the Extended Review. The circumstances of these are as follows:-

Background

Adult W was 96 years old, she resided in her own home with her 70-year-old son Adult X, who was her main carer.

Prior to August 2020 Adult W & Adult X were not known to social services and there had been no previous contact with them. There was no family involved, and concerns about their welfare were raised to social services by neighbours and the local pastor. Prior to Adult W being allocated a social worker in the long-term care and support team in June 2021, a number of contacts and visits had been made by social services. Support was discussed and offered to Adult W and Adult X during these contacts, but all was declined. Adult X personally found it difficult to engage with services and Adult W was very clear in her refusal of any support.

21/4/22 a local shop that delivered weekly food shopping to Adult W and Adult X contacted social services and the police with concerns for Adult X who usually telephones on a Thursday to place the food order. However, Adult X had not phoned, the last delivery of food was on 14/4/22 and there had not been any contact since. The caller explained that he had been told there was still post in the door and the curtains were shut and he was concerned for the safety of the occupants who were both elderly. Police commenced enquiries.

21/4/22 A social worker contacted the police requesting a welfare check. The social worker was told they would need to attend the address in the first instance and make attempts to check on their welfare. Later in the day the social worker phoned the police to say that they were unable to get an answer. They were informed that this was an ongoing incident, and Police would try to make contact that evening. When Police Officers attended the address, there was no post left in the door and the curtains were open. Neighbours stated that they had seen Adult X that day and that police had been out a few times over the past few weeks and Adult X just does not answer the door. There were no grounds for forced entry at that point and officers planned to reattend later to continue their attempt to obtain an answer at the address. Police eventually contacted Adult X via phone, and he stated they were safe and well and he had not answered the door because he was having trouble sleeping. Adult X requested further assistance with looking after his mother and consented to a PPN (Public Protection Notice) being submitted.

22/4/22 An unannounced visit was made by social services following receipt of the Public Protection Notice (PPN) from police, as Adult W had not been seen. Adult X initially refused entry stating he had fallen down the stairs on 18/4/22. The social worker persisted and gained entry. Adult W appeared physically unwell; she was conscious but unresponsive. The social worker contacted the GP and was advised to call an ambulance via 999.

22/4/22 Ambulance staff attended Adult W's address and confirmed that Adult W had a suspicion / working diagnosis of sepsis and that she lacked mental capacity and needed to go to hospital. Adult W was confused, deemed not to have capacity, though very adamant about not going to hospital and her son Adult X stated to ambulance staff that his mother was not going into hospital. Ambulance staff stated to Adult X that if his mother did not go into hospital then she would be at risk of dying. The social worker highlighted that Adult X did not have LPA (Lasting Power or Attorney) for Health and Welfare and therefore had no legal authority to make decisions on his mother's behalf. Ambulance staff expressed reluctance to transport Adult W to hospital when told she had previously stated she did not want to go to hospital but indicated that it was their wish to take her to hospital. Ambulance staff contacted the GP to explore alternative options to a hospital admission, the GP prescribed antibiotics for a chest infection (without seeing Adult W) via the telephone and stated he would try and visit, but would ask district nurses to visit over the weekend. Ambulance staff telephoned adult services who recorded the following in the notes advising Adult W *was advised* of the need to go into hospital but declined. Adult W presented as confused and had not been eating or drinking. Ambulance staff had passed to GP who will try and manage the situation over the weekend.

23/4/22 and 24/4/22 District nurses posted medications through the door and attempted to visit by knocking on the doors and windows and by telephone but received no answer.

26/4/22 The social worker visited Adult W and Adult X' at their address but could not gain access. An adult at risk referral was submitted to the local authority Safeguarding Team by the social worker and a strategy meeting was arranged for 27/4/2022.

26/4/22 District nurses received a telephone call from social services Safeguarding Team for them to visit due to health needs. District nurses explained they had made previous attempts to contact Adult W and Adult X to supply incontinence products, pressure relieving mattress etc. but these items had been declined by Adult X, although Adult W is more than happy for District nurses to visit and monitor her.

27/04/22 A multi-agency strategy meeting held, but adjourned part way through after concerns were raised regarding the safety of Adult W and Adult X, for an immediate welfare check to be conducted. District Nurses and Police Officers met outside the address, District Nurses had been at the address earlier in the morning trying to gain a response from the occupants without success, therefore Police used force to secure entry to the property.

Adult W was discovered deceased in bed, lying on soiled bedding on her left side and wearing soiled clothing, skirt, top, cardigan and with a blanket over her. The bed was saturated with urine, and she had been dead for some time as the effects of rigor mortis were evident.

27/4/22 District nurses stated it was their understanding that there had been no hot water or central heating in the house for the past 6 months and that the Adult X had

refused offers of support by the district nurses to bring in clean bedsheets and clothes.

Adult X was in his bedroom and was described as confused and disorientated and stated he had recently fallen down the stairs. He said he had checked on Adult W the day before and 'she was ok'.

Adult X was conveyed to the hospital, he was very unwell. He told professionals that he no longer wanted to live as his mother had died.

Engagement with others: -

Adult X did not wish to take part in this review due to his own health circumstances.

However there has been engagement with the local shop who delivered food to Adult W and Adult X and the Pastor who made a referral to social services the previous year and who had supported Adult W and Adult X through the early part of the Covid Pandemic.

Two multi-agency learning events were held for this review, the first learning event was with practitioners who were directly involved with Adult W and Adult X. The second learning event was with senior managers who had oversight of the case.

The time period reviewed was from June 2021 until the date of death in April 2022. This timeframe incorporated two periods of social work involvement from the Care and Support Team (June 2021 to November 2021 and January 2022 to the time of Adult W's death).

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

The first Learning Event was held on 27/2/2023. This Learning Event was conducted face to face, with a range of representatives from agencies in attendance who had involvement with Adult W and Adult X. The second learning event was held on 28/2/2023 via a virtual meeting on TEAMS with managers. A timeline of significant events in respect of Adult W was shared with practitioners, who had the opportunity to identify areas of effective practice and areas for improvement. There were limitations in identifying areas of learning with one agency, the GP Practice due to them being unable to attend the event but a discussion between the GP and the reviewers was held via a TEAMS meeting.

Social Worker – Effective Practice:-

Although the case was transferred between different social work teams, short-term team and longer-term team, there was a consistency in social workers and evidence of good handover of information between social workers and teams. The approach the social workers took with Adult X and Adult W was persistent in trying to develop a relationship with them built on trust and confidence. The social worker identified that grocery shopping was an issue and found innovative ways to arrange delivery of food and for its payment via a locally based grocery shop. The social worker was assertive and gained entry on several occasions to check on the wellbeing of Adult W, even though Adult X was often reluctant to allow entry.

The social worker went the 'extra mile,' undertaking numerous cold calls, drive bys, phone calls to the home and monitored the food deliveries through regular contact with the local shop. Also checking signs of movement in the property and liaison with neighbours. It is evident that the social worker had concerns regarding this case and escalated the case to their line manager and safeguarding and sought to involve other agencies in the management of this case.

Adult X was offered a Carers Assessment on 3 occasions between August and October 2020 but he declined on each occasion. He was offered and accepted a referral to the Sensory Team in October 2020. However, when attempts were made to arrange and complete an assessment visit these were unsuccessful.

Learning Points:-

There were several periods of time where the case was not progressed as would have been expected e.g., there was a nine-week period prior to allocating a social worker to the case, after the case had recently been closed with the agreement of the social worker and social work manager. However, a concerned neighbour had raised additional concerns which required a new referral.

At the time of this referral there were, and had been for some time, capacity issues within Care and Support Teams and waiting lists were in operation. There were significant numbers on the waiting lists and prioritisation guidance was being utilised. The waiting lists are regularly reviewed by the team managers and priority changed if there is new information to suggest this is needed. As the information on the new referral was not significantly different to the situation prior to the case closure this case would not have been a high priority for allocation and other referrals would have needed to be prioritised ahead of this one.

The social worker planned to visit within a two-week period, the timeline of events evidenced that this slipped to four weeks and there also appeared no oversight of the case whilst the social worker was on leave. The social worker planned cold calls to take place but because entry could not be gained this was moved onto the following week and then the following week. The social worker stated in the learning event that they did highlight their concerns regarding this case to the line manager and the

safeguarding team. The social worker discussed this case in supervision on 2/3/22. It was noted the social worker had liaised with safeguarding, there was ongoing work with DNs and Adult X to ensure Adult W gets the necessary support, and not intentional neglect from Adult X. There was no consideration of escalating of this case in line with the Self-neglect Policy, which had been developed but was a relatively new at the time.

Concerns were noted throughout the case by the social worker, support at home, district nurses etc. around Adult W mental capacity to consent to care and support. However no formal written capacity assessments were undertaken by any professional or agencies. This was crucial in this case as adult W was refusing support services. However, the social worker did request an audiology assessment because she was concerned that Adult W had a hearing impairment which may have impacted on her ability to take part in a formal capacity assessment. The two audiology appointments were cancelled by Adult X stating adult W was unwell and there was no follow up by the GP practice or to inform the social worker of this fact.

Following the initial referral by the Pastor and a referral being submitted to the safeguarding team, self-neglect of Adult W and Adult X was identified. Self-neglect differs from other safeguarding concerns and forms of neglect as there is no perpetrator of abuse. At this time, a self-neglect policy had been developed and a series of Awareness Training sessions were arranged by the Safeguarding Board commencing in September 2021. However there were numerous practitioners at the learning event from all agencies that were not aware of the Self-Neglect Policy and had not attended any of the training sessions.

GP Surgery

There appeared a lack of awareness by GP surgery regarding their patients wellbeing and regular timely reviews. Adult X was the main carer for Adult W but also experienced health issues specifically with his eyesight and had not attended his Ophthalmology appointments. There appeared to be no follow up by the GP considering there was a previous diagnosis of stage 4 cancer and there appears to be little awareness that Adult X had his own health issues and was the main carer for his mother. A carers assessment should have been offered.

There also appeared a lack of awareness of the frailty of their patients. Although there was evidence a frailty nurse was actively looking for cases that had not been seen by the GP for a number of years. The current leaflet drop system placed too much onus on the frail patient's ability to respond, and a frail person may be unable to in any event, e.g. because of a dementia or ill health, effectively acting as a closed loop.

When the reviewers spoke with the GP, because he could not attend the learning event. The GP thought by requesting the district nurses visit that weekend via the messaging service, they assumed that the district nurses would interpret this as urgent but this was not the case. District nurses who work with this GP practice do not have access on the weekend to patient notes, they only have access during surgery hours. There is disconnect between the services here as the district nursing

service is a seven-day a week service the GP Surgery is only a five-day service. It would appear from discussions in the learning event that access to patients notes have been declined out of office hours due to confidentiality/GDPR issues.

District nurses

1/3/2022 District Nurses tried to visit Adult W, as requested by the GP but Adult X refused access therefore no physical checks or bloods were undertaken. Police met the social worker and district nurses and access was gained via the police. The house was cold, damp but clean, full skin inspection was undertaken, skin was intact but heels and hip were red. Communication was difficult with Adult W due to her hearing loss but she was deemed to have capacity at this time for her care and support needs by the district nurse and social worker. District nurses stated there were no health concerns therefore district nurses discharged Adult W from their caseload on 8/3/2022. However, there would have been risks for pressure damage and malnutrition. Again there are a number of missed opportunities e.g. professional curiosity, not following process via escalation or reporting Adult W, as an Adult at Risk.

District nurses did try their best to get access to Adult W over the weekend of the 23/4/2022 & 24/4/2022 but district nurses were denied access by Adult X. District nurses do not have access to this practice's records on the weekend. Therefore district nurses could not see the details of the request to visit on a Saturday, and were not provided with accurate information by the GP practice and therefore district nurses were not able to comprehend the urgency of the visit requested. District nurses during the learning event highlighted that paper copies of notes are still held and are handwritten. Patient notes under the current system are written twice (once at the patient's house and once on return to the office) by the District Nurses.

Ambulance staff

On 22/4/2022 Adult W was seen by Ambulance staff, appeared physically unwell, conscious but confused, not eating and drinking since 18/4/2022, NEWS score 9, Paramedics were unable to convince Adult W and to go into hospital. Adult X refused for Adult W to go to hospital.

At this point ambulance staff present and the social worker agreed that Adult W did not have mental capacity to make a decision for a hospital admission. The social worker highlighted that Adult X did not have LPA (Lasting Power of Attorney) for health and welfare for adult W and therefore has no legal authority to make decisions on her behalf.

Ambulance records do not offer a full understanding of the capacity assessment undertaken and how the determination of Adult W lacking capacity was reached. One of the attending ambulance crew spoke with the GP but neither have made records of the discussion to determine next steps further to the belief Adult W lacked capacity in relation to the decision of ambulance conveyance at the material time.

The GP informed the ambulance crew a prescription of antibiotics for a chest infection would be arranged and that they would try and arrange a house call and / or districts

nurses to attend. Without re cords of the discussion between ambulance staff and the GP it is difficult to have understanding of what was considered to be in Adult W's best interest and the clinical plan at that time.

However Adult X was not a well man himself but Adult X's ability to care for his mother, Adult W at this time was not questioned. Also Adult X appeared more concerned about his mother's wishes than her health needs.

Police

On 6/10/2021 an initial e-mail to the police from the GP regarding Adult W and Adult X not being seen for some time either by the social worker or the GP who had tried to visit twice with no response. Although Police attendance was requested by the GP a full history and circumstances was not given, therefore the decision that was made by Police was based solely on what information was available to them.

At 12.48 hrs on 27/4/2022 District Nurses had asked for Police to undertake a welfare call as they had not been able to get an answer at the home of Adult X and Adult W. However the full history, circumstances and threat to life and limb were not explained.

At 13.00hrs later that day a multi-agency strategy meeting was called by the safeguarding team and during this meeting additional information was shared. The meeting was adjourned and the telephone call was upgraded during the strategy meeting by the police officer in attendance, to a priority call. At 15.08 hours Police then deployed and attended at 15.22 hours with district nurses in attendance at the address. Entry was forced by Police and Adult W was confirmed as deceased by an attending Paramedic and Ambulance staff. Further concerns existed for Adult X's health who was conveyed via ambulance to a local district general hospital.

Safeguarding

Four separate Safeguarding Reports were submitted to the safeguarding team. On three occasions it was decided that the reports did not meet the threshold to proceed through the safeguarding process and were concluded with advice given and closed to safeguarding.

On the fourth occasion an adult at risk report was submitted, a strategy meeting was convened, however this was adjourned part way into the meeting following information shared that Adult X and Adult W had not been seen and the district nurse could not obtain access over the weekend. It would have been beneficial in this case to have held a multi-agency meeting sooner to share information and co-ordinate a plan of action.

Covid Pandemic and Community Support

The initial lock down of the Covid Pandemic took place in March 2020 and the impact of Covid continued throughout this case. Adult W and Adult X had confined themselves to their home environment. Adult X acknowledged he had trust issues; he did not have confidence and was not leaving the house because of Covid.

Adult X was reluctant to let professionals in and expressed to the social worker that he did not like too many people visiting all at once. Adult X acknowledged they needed help with shopping and the local shop was engaged by the social worker to deliver food supplies. Adult X previously experienced underlying mental health issues this was possibly exacerbated by the pandemic.

It is evident in this case that Local Grocery, Pastor and social worker went the extra mile to try and support Adult W and Adult X through the Covid Pandemic. Social workers undertake work within the communities in which they work to develop social networks and develop supportive relationships and work with people to find solutions to their problems. This local care increases the eyes and ears on individuals and care is at the heart of the community.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes:-

Recommendations:-

1. Professionals to undertake Mental Capacity Act refresher training.

   a. Under the Mental Capacity Act 2005, it states that we must assume people have capacity, unless proved otherwise, however in the case of Adult W her capacity was questioned throughout the case, by different professionals, but no formal capacity assessments were documented by any of the professionals or agencies involved.

      Therefore refresher training needs to take place with all agencies and staff regarding the need to formally document Mental Capacity Assessments throughout a case where there is doubt if a person has capacity.

   b. The review found that adult X made decision on behalf of adult W and declined offers of welfare, treatment and a hospital admission for adult W even though he did not have Lasting Power of Attorney for Health and Welfare.

      Professionals should challenge and document if a friend or relative attempts to give their opinion on if treatment is in that person's best interest. This challenge should document if the individual has Lasting power of Attorney for Health and Welfare.

   c. WAST to complete an audit of documentation where patients are recorded as lacking capacity to review whether capacity assessments, best interests decisions and any

discussions with GPs, other professionals or family members are fully documented to ensure robust recording of all considerations, decisions and onward plans.

d. In line with the Mental Capacity Act 2005 professionals present had reasonable belief that Adult W did not have capacity to make a decision for a hospital admission to receive treatment. There was also no advance directive/decision in place. The importance of acknowledging peoples past and present wishes and feelings, beliefs and values and the views of other people who are close to the person is very important. However in this situation Adult X was not well himself, he had fallen down the stairs.

   A Best Interest Decision should have been documented involving all other professionals present and the GP who was spoken to on the phone and any challenge to decisions or differences of opinions noted. Therefore Agencies need to consider refresher training on the Mental Capacity Act, 2005 so they are clear regarding their roles and responsibilities at this time regarding Best Interest Decisions.

2. Staff at the learning event stated that they were not aware of the Self-neglect Policy developed by the Safeguarding Board or the awareness training. Research and guidance to support professionals when working with people who self-neglect highlights the importance of developing trusting relationships that accept the persons behaviours while at the same time working toward positive change.

   Therefore the Safeguarding Board need to consider additional awareness training on the Self-neglect Policy, the escalation process and the self-neglect panels held.

3. Managers should support staff to keep cases open where there are significant risks even if the person is reluctant to engage. We know that persistence and building trust over time are essential for any success with working with people who are suspicious of services & self-neglect rather than accept help. This is difficult, when there is such high demand and there are so many people asking for help.

4. All agencies are aware of their professional standards in relation to the recording of information and recording of supervision. All information should be recorded in line the standards outlined by GDPR legislation and departmental policy and procedures.

5. General Practitioners to look beyond the immediate health needs and approach their patient holistically, where there is evidence of frailty and unmet health needs.

a. The GP Practice should review how frail patients are identified, reviewed and monitored. Especially where they have not engaged with services for some time. Those most in need often don't seek help, so opt in services will miss them.

b. Nurse Frailty Service – The current leaflet drop system places too much onus on the frail patient's ability to respond, and a frail person may be unable to in any event, e.g.

because of a dementia or ill health, effectively acting as a closed loop. If the frail patient did not respond the case would be closed.

This is a missed opportunity around professional curiosity and understanding why the engagement did not take place prior to closing. Therefore this current process needs to be reviewed.

6. In providing clinical care GPs must prescribe drugs or treatment, including repeat prescriptions, only when they have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

   Adult W should have had a physical examination prior to medication being prescribed.

7. The GP Practice needs to have a formal policy where concerns and referrals from all agencies regarding a patient are recorded in the patients record and dealt with in a timely and appropriate manner.

   a. There was a lack of communication between the GP and the district nurses. There appears a lack of protocols in place to escalate urgent cases, instead of a message being left on the district nurses answer phone.

   b. The GP practice (identified in this review) needs to review the decision for the district nursing service having access to patients notes 7 days a week and how it fits in with the GDPR principles of data sharing to better serve members of the public who are registered with that surgery, especially as other surgeries in the same geographical area allow this

   c. District nurses need handheld devices that they can record information contemporaneously and be uploaded at the time. In the meantime devices that can be downloaded onto the main patient record on return to their office base. By district nurses having to record information twice (once at the patients house and once back at the office) this is valuable time that could be spent with patients and creating conflicts to accurate recording.

   d. When district nurses visited on the weekend following Adult W being prescribed antibiotics at the request of the GP, all methods were tried to get access e.g. cold calling, telephone, banging at the front and back door, trying Adult X mobile phone etc. This was reported back to the GP surgery on the Monday. As the District nurses did not have access to the notes and the GP had not spoken directly to a District Nurses the urgency of the request to call was not understood.

      There needs to be a process developed between the GP practice and District Nurses to ensuring there is a two-way flow of information and escalating concerns to those on duty.

8. The Health Board lead for General Practitioners and the Ambulance Service to each review the actions of their relevant professionals and staff involved in this case.

   The GP Practice and Ambulance staff appeared supportive of Adult W decision, but given a NEWS score of 9, the poor prognosis identified and the GP not making a home visit there appears to be a missed opportunity to establish a plan to support Adult W's death at home with end-of-life medication.

9. It is clear that record keeping was not appropriately completed by both GP and Ambulance staff and didn't provide clarity of decision making, with assumptions or beliefs left without clear appropriate professional challenge to confirm the exact agreed actions and care plan for the patient.

   In line with 'Good Medical Practice' and Paramedics 'Standards of Proficiency' guidelines and all staff must demonstrate, they work in line with the principles and values set out in this guidance / organisational policy.

10. When agencies are requesting welfare checks by the police information needs to be shared highlighting the risks and what has changed regarding the circumstances. Section 17(1)(e) of Police and Criminal Evidence Act 1984 gives the police the power to enter and search premises without a warrant, in order to **'save life or limb'** or prevent serious damage to property. Police must have more information than a general welfare concern about somebody, in order to evidence and use this power of entry, which may only be used in cases of emergency.

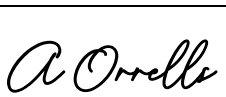
    Agencies to appreciate each other's roles and responsibilities and constraints of the legislation.

11. Safeguarding Referrals regarding an individual should not be seen as individual and unconnected events. In cases where multiple referrals from the same professional or professionals are making separate but connected referrals a strategy meeting to share the perspectives of all concerned professionals should be undertaken.

    Where a single agency has safeguarding concerns, professionals are to be encouraged to share information with other partners in order to develop and agree cohesive multi-agency action plans.

12. Social Services need to share the good work and practice identified within this review as a case study to be used in training and learning workshops.

    This case identified shared learning opportunities where the community and key individuals have been pivotal to supporting agencies to help safeguard people living in the community.

Statement by Reviewer(s)			
REVIEWER 1 Terri Warrilow		**REVIEWER 2** ***(as appropriate)***	Ann Orrells
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, or have 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, or have 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)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Terri K. Warrilow	**Name** *(Print)*	Anne Orrells
Date	13/03/2024	**Date**	13/03/2024

Chair of Review Panel (Signature)	
Name *(Print)*	Bryan Heard
Date	13/03/2024

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult/Child Practice Review process
To include here in brief: • *The process followed by the SAB 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.*
☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Terms of Reference

Case Reference details
Adult W – CTMSB 03/2022

Circumstances leading to the APR

On 27/04/22 SWP received a call from a District Nurse requesting police assistance. Officers attended and having forced entry to the address, which was secure, Adult W was discovered deceased in bed.

On 27/04/22 district nurses in attendance at the address disclosed to officers that paramedics attended Adult W's address on 22/04/22 after her son called due to Adult W having difficulty breathing. Paramedics have arrived and confirmed that Adult W had sepsis and that she did not have the capacity and needed to go to hospital. However, Adult W has stated that she did not want to go to hospital and her son stated to them that his mother was not going. Paramedics have the stated to Adult W's son that if his mother did not go then she would be at risk of dying.

He has still refused to let her go. Therefore, they left the house and Adult W has remained with her son at the property. It was then arranged by the paramedics/GP that a district nurse would attend the address.

Agencies Involved

The following agencies were involved with Adult W and will be completing a timeline and analysis of their involvement:

- South Wales Police
- Adult Services
- Cwm Taf Morgannwg University Health Board
- WAST
- Mental Health Services

Core Tasks

The Core Tasks of this Adult Practice Review Panel are to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

- To what extend the impact of the Covid Pandemic influenced decisions, actions and outcomes

Specific tasks of the Review Panel:

- Identify and commission a reviewer/s to work with the Review Panel in accordance with the guidance on APRs
- Agree the time frame
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken
- Produce a merged timeline, initial analysis and hypotheses
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the family members prior to the event.
- Receive and consider the draft adult/child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the CTMSB for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Panel Members

NAME	TITLE	ORGANISATION
Bryan Heard	Independent Chair	South Wales Police
Terri Warrilow	Independent Reviewer	BCBC
Ann Orrells	Independent Reviewer	CTMUHB
Christine Rogers	Team Manager	RCT Adult Social Care
Beth Aynsley	Vulnerable Persons Manager	South Wales Police
Julie Usher	Public Protection Nurse	CTMUHB
Dave Harris	Safeguarding Specialist	Welsh Ambulance Services NHS Trust

Stuart Hackwell	CTMUHB	Primary Care

Additional Areas of Focus

Any Parallel Reviews or Other Such Activity to be Noted

Timeframe for the APR

It was agreed that the panel would look at a timeframe 12 months prior to Adult W's death – 28th April 2021 to 27th April 2022.

Learning Event

The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

It is anticipated that the Learning Event will be held on 27th February 2023.

Completion Date

The completion date set for the Review is March 2024.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Send the report and action plan to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

SUMMARY TIMELINE

Date	Significant Event
June 2021	1st Referral to Adult Social Services by local Pastor due deterioration in living standards, cleanliness, needing food shopping
	Social Worker visited – Adult W and Adult X reluctant to engage. Identified Covid has reduced their confidence to leave the house
July 2021	Letter from social worker to GP requesting Eye test for Adult X and Hearing for Adult W.
	Adult X contacted Social Worker requesting help with food but reluctant for Social Worker to call at house
	Social Worker cold calls at house, persists and gains entry. Signs of weight loss and poor hygiene of Adult W. Evidently not managing and Adult X asks for help with food shopping, although both reluctant to accept help. Adult W ushers Social Worker out.
	Adult X admits to Social Worker he is reluctant to go outside and lack of trust of professionals. Social Worker makes arrangement for Pastor's wife to go shopping with the Adult X. When Pastor's wife attends, Adult X is rude and refuses to go.
August 2021	Social Worker cold calls. Adult X who although reluctant does answer front door, but refuses entry. Social Worker delivers food although Adult X reluctant to accept. Adult W seen at door appears ok. Local food store arranged to deliver food weekly.
	Social Worker contacted GP, informed both Adult X and Adult W haven't seen GP for 5 years. Last seen when Adult W was believed to have stage 4 bowel cancer.
	Social worker makes telephone calls no answer, cold call on 11/8/21 no answer. Cold Call on 13/8/21 Adult X answered complained about price of food. Social Worker had advised how to get new Debit Card but this had not been acted upon by Adult X. Entry refused by Adult X, Adult W not seen.
	Social Worker cold called 19/8/22 no answer. Case raised to Manager and the Safeguarding Team.
September 2021	Social Worker met with Manager, agreed to send letter to GP, to raise concerns / difficulties with case, requested to have professionals meeting although concern they are the only agency involved at this time.
	Cold Call no answer. Police welfare call considered but not made as Social Worker saw Mother in house window (no communication) confirmation with local store that food orders were being made.
October 2021	Social Worker spoke with GP and agreed if there is no response to a letter the GP had sent, then would make joint call.
	GP emails Police to request call as Adult W and Adult X were not answering door to GP. Police records of Jan 2021 show history of Adult W and Adult X not answering door and in absence of threat to life information, Police did not attend address.

	Audiologists state to social worker adult X cancelled 2 home visits for Adult W stating she was ill.
November 2021	Social Worker makes 2 drive by's no answer at door, blinds open in the afternoon. Food store confirms deliveries are being made weekly and increased spending. Adult W and Adult X not seen in person since 2/8/21
	Social Worker closed case due to lack of engagement, basic needs appear to being met.
December 2021	New referral received by social services.. A friend states Adult W and Adult X don't appear to be coping. Concern Adult W hasn't been seen.
January 2022	Frailty Nurse telephoned Adult W and Adult X - no answer, leaflet sent to patient for them to make contact.
	Case allocated to a social worker who a planned a joint visit with Team Manager 7/02/2022.
February 2022	7/2/22, 8/2/22 & 14/2/22 Cold Calls made – no answer. Social Worker contacted referrer, GP Surgery, District Nurse for more info & local shop who confirmed deliveries being made to Adult W and Adult X.
	Joint visit by social worker & GP. Home visit as Adult W has not been seen by professionals since August 2021. Entry gained Adult W very unkempt, dirty clothes and bedding, toenails very long and dirty, wounds to legs - bleeding. No obvious Pressure Ulcers, but wouldn't allow buttocks to be examined. Adult X was reluctant to accept help and Adult W has not been out of her room since December. No medical needs identified by GP asked District Nurses to visit to check pressure areas and take up to date bloods. Adult W adamant she does not want to go into hospital, very deaf, denies any pain.
	Local Store reports concerns to social services.
	Social Worker attended, concerned by Adult W presentation and request District Nurse to attend.
	Concerns of Self Neglect, mobile domiciliary service to call once a day to try and gain entry to assist with personal care of Adult W.
	24/2/22 District Nurse cold call – Adult X refuses access to Adult W. Adult X agreed to allow entry to district Nurses on 28/2/22.
	25/2/22 & 27/2/22 mobile domiciliary service called, refused entry by Adult X
	28/2/22 District Nurses refused entry by Adult X. Adult Safeguarding Team advise Joint Social Work and Health attendance and request Police Welfare Call if needed.
March 2022	1/3/22 Police received a request for Welfare check from District Nurses because Adult W and Adult X had not seen for 10 days. Police attend, Adult X was reluctant to allow Nurses in but Police persuade Adult X and he allowed entry. Nurses stated there was a care plan in place for Adult W to help Adult X with the care of his mother. No PPN submitted because Agencies already aware.
	8/3/22 District Nurse and Care Staff attend, Adult X refused entry, and for Adult W to be examined. Adult W had previously agreed to help. District Nurses state refusal will lead to

	off listing case. Adult X has a mistrust of professionals. Social Worker considers linking Adult X with local PCSO to build rapport. Care Staff to arrange future joint visit.
	17/3/22 Joint visit Care Staff and Social Worker, entry gained by persistence. Adult X stated Adult W had fall, Adult W examined no injuries evident, except bruised thumb. Adult W was able get out of bed, but refused support with personal care, her face was clean and she had clean bedding and underwear, but her feet and hands were dirty and unkempt in appearance. Agreed to call again in two weeks.
	21/3/22 Local Store informed Adult Services of concerns as Adult X not been seen, was advised to contact Police.
April 2022	11/4/22 Social Worker wrote a letter to GP as Adult X is refusing to engage and package of care had stopped. Last seen 17/3/22. Informed GP if any further concerns then another referral will need to be sent to Social Services.
April 2022	21/4/22 Local Store raise concerns as Adult W and Adult X not seen. Social Worker contacted Police requesting welfare call. Police advised social worker to attend first, no reply. Police state they will try over the evening and night. Emergency Duty Team informed of circumstances. Police made phone contact with Adult X after 6 minutes of calling, stated he was safe and well with Adult W, he said had trouble sleeping. Adult X intended to call for food at a future date and had not heard the door earlier. Adult X stated that his hearing and eyesight was not great and he was struggling to look after his elderly mother Adult W. Police requested assistance to look after his mother and a PPN was submitted for information / assistance of partner agencies.
	22/4/22 cold call by social worker at 2pm as mother not seen by Police. Adult X initially refused entry but stated he had fallen downstairs on 18/4/22. Social worker persisted and gained entry. Adult W appeared physically unwell; she was conscious but unresponsive. GP called who advised to call for an ambulance. Social Worker rang 999 for ambulance.
	22/4/22 One ambulance staff then two additional ambulance staff attended, recommend Adult W required admission to hospital due to infection or could die. Adult X refused Adult W hospital admission stating it's against her wishes. Adult W then stated she doesn't wish to go to hospital. Option for them both to go to hospital is also refused. All concerned that Adult W didn't present as having Capacity and social worker stated son didn't have LPA for mother. Paramedics contacted GP to discuss options if Adult W is not admitted to hospital. Emergency Duty Team informed by Paramedics that Adult W was not admitted to hospital but GP would try and visit to see Adult W and prescribe anti-biotics.
	23/4/22 District Nurse called at address at request of GP after Adult W declined hospital admission. All doors & windows closed and blinds closed. No answer after repeated knocking on door and trying to call mobile of Adult X. Note left through door.
	24/4/22 District Nurse visited again to try and gain access, no answer from knocking door or windows or from telephone calls.
	25/4/22 District Nurses repeated telephone calls to GP surgery. Message left with receptionist that nurses were unable to gain access to Adult W over weekend. What further action did GP want.

	25/4/22 Social Worker contacted pharmacy who confirm prescription was delivered to Adult X on 23/4 at front door, Visit to be made on 26/4/22.
	26/4/22 Social worker cold call – No answer / no response, spent 5-10 minutes knocking on doors and windows and rang the landline with no response. Adult Safeguarding referral completed.
	26/4/22 Adult Safeguarding email partners agencies to attend strategy meeting 1pm 27/4/22.
	27/4/22 District Nurse cold call – no response at address
	27/4/22 Police in attendance at Strategy meeting, due to immediate concerns Police rang Control room and requested immediate response to address.
	27/4/22 Police force entry Adult W found deceased, Adult X in bed for 2 days due to back pain, stated he tried to give Adult W anti-biotics, she had refused and last saw her alive a couple of days before when he had taken her water. Ambulance called for Adult X but declined hospital admission. District Nurses wanted assessment of his mental capacity to make this decision. Waiting for ambulance.