Adult Practice Review Report

Adult Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review
Adult J

Re: CTMSB 01/2021

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 was commissioned by CTMSB in accordance with statutory legislation set out in Section 139 of the 2014[1] legislation and accompanying guidance[2]. The criteria for this review are met under Chapter 7, Extended Adult Practice Reviews.

A Safeguarding Board must undertake an Extended Adult Practice Review in any of the following cases where an adult at risk has, on any date during the six 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 be a local authority, and has:

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

The purpose of an Adult Practice Review is to identify learning for future practice. It involves practitioners, managers and senior officers in a collective endeavour, exploring the detail and context of agencies' work with the adult and their family. The output of the review

[1] *Social Services and Wellbeing (Wales) Act 2014*
[2] Welsh Government (2016) *Working Together to Safeguard People, Volume 3 Adult Practice Reviews*

is intended to generate professional and organisational learning and promote improvement in future interagency and adult protection practice. It should highlight effective practice as well as consider what needs to be done differently to improve future practice.

The terms of reference for this extended Adult Practice Review are included at Appendix 1

The timescale for this review is February 2019 to February 2020

Circumstances Resulting in the Review

Adult J, a young woman in her early thirties, had complex needs arising from past trauma, mental illness and polysubstance misuse. She had a diagnosis of Emotionally Unstable Personality Disorder and was dependent on alcohol and benzodiazepines. She was depressed, self-harmed and sometimes had suicidal thoughts. Her physical health was poor and, amongst other things, she suffered from asthma and non-epileptic seizures. She was known to be impulsive and could behave aggressively towards others at times, which she described as 'giving as good as she got'. Adult J had a son, who she had initially raised as a single parent but who, at the time of the review lived with his father and his father's partner. Adult J was supported by a network of agencies and services.

The year under review was a particularly turbulent one for Adult J. After a period of supervised and then unsupervised contact with her son, this ceased in June because Adult J was very unwell.

At some point early in the year Adult J began a relationship with G who also had mental health issues and misused substances. G was on probation at the time because of a conviction of Common Assault of an ex-partner. A condition of his probation was that he should disclose if he entered another intimate relationship. Adult J and G's relationship was characterised by serious domestic violence, and he was coercively controlling of her. In March 2019 a Clare's Law disclosure[3] was made by South Wales Police to Adult J about the history of G.

Over the year Adult J contacted NHS Direct on fifteen occasions. In nine of these contacts Adult J sought advice on her prescribed medications. This included reports she had run out of medications or forgotten to collect them and the pharmacy was closed, as well as citing professional errors why she had no medication on two occasions. Eleven 999 calls were also made to ambulance services either by Adult J, someone with her or further to contact with NHS Direct. Seven of these calls were due to physical health issues; two were because she attempted to take her own life and two because of domestic violence. She was conveyed to hospital by ambulance on nine occasions and on two occasions absconded in the middle of the night.

Adult J had financial problems and had been served with notice to leave her accommodation.

Tragically Adult J was found deceased in February 2020 in bed at her home address. Adult J's death was unexpected, and the cause of her death remains unclear as she was not

[3] **Clare's Law**, often known officially as a **Domestic Violence Disclosure Scheme**, designates several ways for police officers to disclose a person's history of abusive behaviour to those who may be at risk from such behaviour. It is intended to reduce intimate partner violence.

found for some time. In the weeks leading up to her death Adult J had been seriously assaulted by G, but she did not want an injunction taken out and had determined to go to court to speak up for G. She was also in contact with services and professionals via text.

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

Working with Someone who is Difficult to Engage

Adult J was difficult to engage and was also selective about which services she communicated with. For instance, she kept in contact with CMHT but did not respond to or missed pre-arranged appointments with Domestic Violence Services and the IDVA. Consequently, a lot of professional time and effort went in to trying to establish contact and set up face to face meetings.

When contact with her son ceased in June 2019, Adult J's situation deteriorated, and her life became increasingly chaotic. The professionals involved with her felt they were always 'fire-fighting', which meant interventions were about reacting to crises rather than working with clear and positive plans.

It is important to distinguish between contact and real engagement and in this situation, there did not seem to be meaningful engagement with services. Adult J looked to some of the professionals and services for support at particular times but seemed to lack any motivation or ability to change, especially after she lost contact with her son. However skillful professionals are, if the person they are working with lacks motivation, then positive change is not going to happen.

It is also difficult to engage in a therapeutic professional relationship with someone when they are not totally open about their circumstances. For instance, in this situation Adult J was initially secretive about her relationship with G, as well as not revealing the level of her dependence on street Diazepines. This had an impact on her emotional and physical health and led to more crises and increased the sense of 'fire-fighting' and crisis management.

Domestic Violence and Coercive Control

It is clear that G was physically abusive towards Adult J and also coercively controlling of her. He kept her away from support services and possible sources of help by such things as answering her phone and accompanying her to appointments. However, apart from

when he physically attacked her and she needed to seek immediate help, Adult J was in denial about G's behaviour, saying they were both as bad as each other and then describing him as her carer, and that she could not do without him.

Coercive control is insidious, powerful, far-reaching, and difficult to challenge. Even when relationships end the risks are still present. Victims of coercive control often do not realise that they are victims, even when there is clear evidence. The Clare's Law disclosure to Adult J about G's history early on in the relationship seemed to make little difference. His influence and constant presence exacerbated the difficulties that professionals had in trying to engage with her, increased the chaos in her life and impacted adversely on any motivation she may have had to make changes.

Inter-agency Collaboration and Communication

Although 'fire-fighting' and constantly having to react to crises can get in the way of multi-agency collaboration, on the whole communication and the exchange of information between services and agencies was good and systems were followed appropriately. For instance, Adult J was considered an adult at risk and so five PPNs (Public Protection Notices) were completed over the course of the year under review. On three occasions consent was overridden and the information was shared with partner agencies. With regard to the other two occasions, one was slightly different in that it was Adult J who attacked G and the other was not shared because health services already knew about the incident.

When the final PPN was submitted in January 2020 following a serious assault on Adult J by G, Adult J described G as her carer, saying there was no one else to look after her. It is important, therefore, to think about the wider implications and which agencies should be informed when a carer can no longer enter a house. It may be that other arrangements need to be made for someone's care.

It should also be noted, that electronic systems do not always facilitate communication and the exchange of information. For instance, the Community Mental Health Team (CMHT) is made up of personnel from Health and from the Local Authority. Each has a different system which do not link up.

Whilst there was oversight and supervision within each of the agencies and services involved, what was missing in this situation was an opportunity for all the professionals and services to come together to share information; to plan strategies and to co-ordinate actions. Adult J's case was discussed at the Multi-Agency Risk Assessment Conference (MARAC), but the focus here is on domestic abuse and thus some of the professionals working with Adult J would not have been in attendance. However, they knew Adult J and had a lot of useful information which would have increased understanding of her whole situation. Domestic abuse was only one aspect of the problems and difficulties that she faced.

Trauma Informed Practice

Adult J had been a bright young woman with a promising future, but her situation had gradually deteriorated. What led her to misuse substances; self-harm and become enmeshed in a violent and destructive relationship to the extent that her mental and physical health were adversely affected? Trauma informed practice is one approach that

could have been helpful here. It is a strengths-based approach which seeks to understand and respond to the impact of trauma on people's lives. The approach emphasises physical, psychological and emotional safety for everyone and aims to empower individuals to re-establish control of their lives.

Connecting with the Wider Family

Adult J had family within the area who were aware of her situation. They also had a lot of information about her history as well as the current situation and were very aware that she was vulnerable. The challenge for professionals is how to work in partnership with families whilst respecting Adult J's right to confidentiality and also remaining mindful of her views and wishes. She had capacity but she was also vulnerable and at risk.

Is there also something here about who is listened to and why? Research by Cardiff University[4] highlighted that there is a tendency for the views of professionals to be seen as being based on objective knowledge and therefore, superior to the 'subjective' judgements of family and community members. However, even if there is a difference of opinion, all of these pieces of information are parts of the whole and can help to build the bigger picture.

Was there delay in finding Adult J?

When Adult J was found in February 2020 she had been dead for some time. Could she have been found sooner? Throughout January her CMHT worker had been in contact with her via texts and some missed calls; either Adult J not answering her phone or the CMHT Worker missing the call. Housing Solutions were also trying to make contact to set up a meeting and again there were missed calls on both sides and messages left. The CMHT worker was on leave during this period but on her return, did make attempts to contact by phone and also visited the house. These difficulties in establishing contact with Adult J were not unusual and her elusiveness was not out of character.

The MARAC was held at the end of January 2020 at which Adult J's situation was discussed. What was omitted at this meeting was to establish when Adult J was last seen and by whom. Tragically she may have already been deceased by this time

Perhaps what would have alerted the professional network was the that Adult J had not collected her prescription for some time. In the past she had not always managed to collect her prescription on time, but her pattern then was to ring NHS Direct to say the pharmacy was closed and she had forgotten to collect her medication.

Effective Practice

In this situation there were some examples of effective practice including:

- On the whole communication and the exchange of information between services and agencies was good and systems were followed appropriately.
- South Wales Police did as much as they could. Specifically, they:
    - Made a Clare's Law disclosure as soon as it became clear that Adult J was in a relationship with G

[4] Cardiff University *'Findings from a thematic analysis of Child Practice Reviews in Wales'* February 2020

  - Commenced 'Police Watch' after an incident of domestic abuse. It was initially for a month but was extended after another incident.
  - Overrode Adult J's withholding of consent to share information when they submitted the PPN in January 2020, as they assessed the risk level as high; obtained a DVPO when faced with no criminal complaint and referred the situation into the MARAC process
- Adult J had altered a handwritten prescription, issued by the Home Treatment Team, to increase the dose. This was spotted by the pharmacy and dealt with promptly. It was agreed that no further prescriptions would be issued by CMHT services as they were handwritten. In future all prescriptions were to be issued by the GP as these were printed, thus removing the temptation to tamper with them.
- The professional network involved with Adult J were committed and persistent. They worked hard to maintain contact with her

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:-

1. In this situation professionals described their interventions as reactive and 'fire-fighting'. It was difficult to make any progress. It is suggested, therefore, that when working with complex cases professionals consider referrals to the Complex Case Partnership Panel. This provides a multi-agency opportunity to review individuals in the community who present with a significant level of risk to themselves or others. If a situation does not meet the criteria for this Panel then a professionals meeting should be convened. It is important to create multi-agency reflective spaces to share concerns and generate ideas for ways forward.

2. There are two recommended actions with regard to MARACs

    a. Review attendance to ensure that the appropriate people are present. In this situation mental health professionals, who had worked with Adult J for some time, were not present at the meeting However, they had a lot of useful information which would have greatly assisted discussions and the formulation of plans

    b. Chairs of MARACs to be reminded to routinely ascertain when a person who is the subject of discussion has last been sighted.

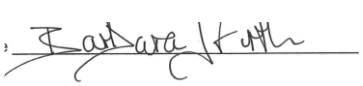
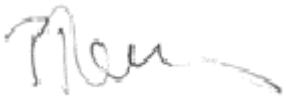
3. Setting up a protocol/arrangement for pharmacists to notify the relevant agency or professional when a prescription is not collected. This would need to be led by the treating team who would highlight those individuals where there were

safeguarding concerns and then notify the appropriate pharmacist who could add this information to their system.

4. Coercive control has been a theme of other reviews. It is recommended that a thematic feedback event is organised to both disseminate this learning from recent reviews, but also to consider ongoing multi-agency professional development in understanding and working with coercive control.

5. All agencies to review the training they currently provide to ensure it includes trauma informed practice. This is something which could be overseen and pulled together by the Multi-agency Training and Learning Group.

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, 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)*	Barbara Firth	**Name** *(Print)*	Phil Lewis
Date	02/02/2022	**Date**	02/02/2022

Chair of Review Panel (Signature)	S. M. Hurley
Name *(Print)*	Sue Hurley
Date	02/02/2022

Appendix 1: **Terms of reference**

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.

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.

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.

Adult 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.*

In accordance with the statutory guidance for Adult Practice Reviews, a multi-agency panel was convened to manage and steer the process. It was chaired by a Senior Police Staff member and made up of representatives from:

- CMHT
- South Wales Police
- Welsh Ambulance Service NHS Trust (WAST)
- Domestic Violence Services
- Adult Safeguarding
- Mental Health Nursing
- Probation
- Housing
- Representatives from CTMSB Business Unit

The Panel began the learning process by identifying significant issues and clarifying the questions and areas to explore. They also identified the participants to be invited to the Learning Event. Participants were asked to reflect on their involvement with Adult J, thinking specifically about:

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of effective practice
- Areas where there could have been some improvements

The Learning Event was held on 11th November 2021 from 9.30 until 4.00 and was facilitated by the Reviewer. Practitioners and Agencies represented at the event were from:

- CMHT
- Adult Services
- Welsh Ambulance Service NHS Trust (WAST)
- South Wales Police
- Domestic Violence Services
- WCADA (Welsh Centre for Action on Dependency and Addiction)
- Hospital Accident & Emergency Department
- IDVA
- Children's Services
- Probation
- Housing
- GP

During the first half of the event, participants explored four questions:

- What were the main challenges they faced in working with this family?
- What went well?
- What could have been done better?
- Were there any missed opportunities?

They then identified the key learning points that had emerged and went on to think about some suggested strategies for improving practice and systems.

The insights and reflections of the practitioners and managers involved in this review have informed the learning and recommendations detailed in this report.

During the course of this review the Reviewer and Panel Chair met with family members and their opinions and reflections are represented in this report.

☐ Family declined involvement

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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	☐	☐	

Appendix 2: Summary timeline

March 2019	DV incident between J and G. G Arrested, PPN submitted. Clare's Law disclosure to J by Police. DV Support agencies made significant attempts to both contact and engage with J. MH Services reported an improvement in Js Mental Health.
April 2019	Contact was due to J forgetting to collect medication from Pharmacy which was now closed.
May 2019	Deterioration in J's physical and mental health noted by services involved.
June 2019	Contact with son suspended. J started to self harm and increased her alcohol consumption
July 2019	Intentional overdose by J, admitted to hospital, absconded and was conveyed back by Police
August 2019	DV incident reported between J and G, which was referred and subject to MARAC process. Positive Police action taken in arresting G
September – November 2019	Several Incidents of self harm/attempted suicide by J
December 2019	Readmission to hospital for physical issues
January 2020	DV incident reported between J and G, which was referred and subject to MARAC process and a DVPN was served on W despite J not wishing for that action.
February 2020	J found deceased at home