Adult Practice Review – CTMSB 02 -2021

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

1) Background

Aaron had a learning disability; he lived independently in sheltered accommodation, which has a peripatetic scheme co-ordinator, & received a package of care and support, including specialist domiciliary care. Aaron had been well-known to Adult Services; he had been subject to annual reviews of his Care & Support Plan by the Community

2) Circumstances that led to the Adult Practice Review

Aaron died in the summer of 2020, age 74, having been struck by a train. In the months prior to his death, Aaron had become increasingly confused, he had been referred by his GP to the Cwm Taf Morgannwg University Health Board (CTMUHB) Older Person's Mental Health Team. He was assessed at his home in June 2020 and had a 'highly probable' diagnosis of dementia.

There were 8 incidents between February 2020 and his death, where Aaron was reported to South Wales Police having been found lost and/or confused at different locations, often in the late evening or early hours of the day. These incidents had increased in frequency over the weeks prior to this death.

3) The Review Process

A Review Panel was set up, two independent reviewers appointed and a multi-agency learning event was held to consider a timeline of involvements with agencies.

4) Family Engagement in the Process

At the start of the Review, it was not possible to identify family members of Aaron to contribute. However, following the Learning Event, two family members were identified via the probate process, who had not had any contact with Aaron for 25 years.

5) Notable Effective Practice

Joint visit Social Worker/Domiciliary Care Provider in February 2020, Case summary to transfer to new Social Worker

Domiciliary Care Provider arranging and accompanying Aaron to GP appointment when his functioning/memory began to deteriorate

Joint visit -Consultant Old Age Psychiatry and Domiciliary Care Provider appointment had been brought forward as concerns raised by Domiciliary Care Provider which the Social Worker acted upon

Domiciliary Care Provider tried to provide consistent staff for Aaron during the pandemic

6) Practice and organisational learning

The importance of an Independent Advocate being available when individuals have no family or friends to speak up for them and support them to express or represent their views and best interests.

The importance in recognising the impact of deterioration in people, both with regards to mental and physical health and therefore re-evaluating the response or action planned and the urgency of that action. Practitioners at the learning event considered this a 'safety first approach'

Understanding and assessing the impact of significant change in a person's life and the possible consequences for mental health and well-being. In this case the impact of coronavirus pandemic.

Processes should be in place to risk assess each new incident (PPN) of concern for a person's safety and wellbeing in the context of previous concerns (PPNs submitted) to inform safeguarding actions, and decision making.

Technical options can be useful tools in safeguarding people with dementia who are at risk of going missing.

7) Improving Systems and Practice

1.Adult Social Services (ASS) to review the arrangements for offering individuals timely Independent Professional Advocacy, & be satisfied they address the learning identified in this APR.

2.ASS to review the arrangements for risk assessments for those with developing dementia to ensure there is an understanding of the potential harm & emerging risks.

3.CTMSB should be assured that partners organisations have escalation processes which are clear, timely, transparent and utilised effectively.

4.SWP to review the process for risk assessing PPNs and escalating risk to ensure appropriate safeguarding responses are made.

5.CTMSB to raise awareness about the Herbert protocol & Keep Safe Cymru across all agencies.

6.ASS should review the recently implemented arrangements for risk assessment and escalation when repeat PPNs are received to be satisfied they address the learning identified in this APR

7.CTMSB should ensure that partner agencies are aware of the digital/technical tools available to assist in safeguarding people, including those without family members or close friends.

8 Adult Social Services should build the learning from this review into existing case management processes to ensure assessments and plans are informed by a multi-agency perspective, in order that agencies are able to work together collectively to safeguard people and meet their care and support needs.

9.CTMUHB should review the arrangements in place for Mental Health Clinical Services to comply with the National Reportable Incidents process, to ensure that they are aware of Nationally and Locally reportable incidents and comply with the agreed timescales