Adult/Child Practice Review Report

Adult Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review

Re: Adult V CTMSB 02/2022

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 review was commissioned by the Chair of the Cwm Taf Morgannwg Safeguarding Board (CTMSB) on the 6th December 2022 following a recommendation of the Joint Review Group, in accordance with the Guidance for Multi-Agency Adult Practice Reviews. The criteria for this review are met under:
Social Services and Well-being (Wales) Act 2014: Working Together to Safeguard People: Volume 3 – Adult Practice Reviews.

A Board must undertake an extended adult practice review 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.

Adult V was admitted to hospital in July 2020 from her home address. She was in poor physical condition, stating that she was experiencing pain to her shoulder, was significantly underweight, thought not to have had access to sufficient food and drink, had bilateral bruising to the back of both thighs, what appeared to be pressure damage and had recently missed her medication. Whilst in hospital she was diagnosed as having significant malnutrition, she did not wish to eat or drink and refused a nasogastric tube insertion to administer nutrition. She was aware that her condition could worsen without sufficient

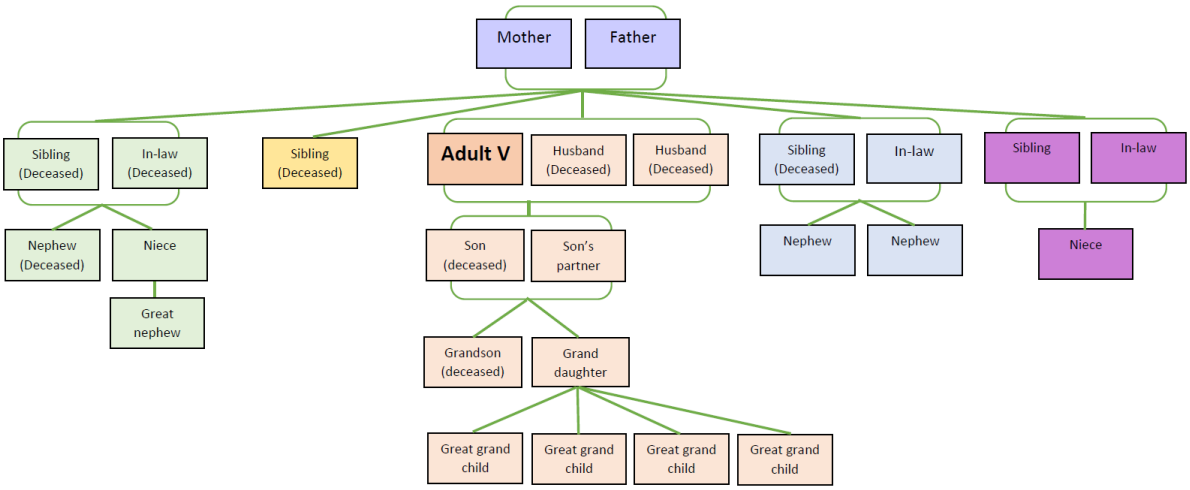
nutritional intake, but as a capacitated adult she was able to ~~take~~make decisions about her medical care.

In the few days prior to the hospital admission, safeguarding concerns were raised by her home care provider following Adult V disclosing to care workers that Adult A (family relation) who had been recently staying at Adults V's home, and their partner, had physically assaulted her. The Local Authority commenced enquiries and a criminal investigation was instigated by Police. The Local Authority took actions to safeguard Adult V, including protection of property and setting up respite care arrangements.

Sadly, Adult V, passed away 7 days after her admission to hospital, aged 87 years. The cause of death was recorded as pneumonia, frailty, heart disease and diabetes.

The timeline for the review was August 2019 to July 2020. There were no circumstances identified that warranted the review time period to be extended, significant events outside of the timeline are included as they provide relevant contextual information.

Adult V Genogram



Background information and context

Local Authority Adult Social Care Services were involved with Adult V from 2006, after she had the first cerebrovascular accident (stroke), with a second in 2009, leaving her with significant disabilities. She had lived alone since her husband died. Following a period of hospitalisation, she was able to return home on both occasions with a care package and additional support from family members (siblings). As well as the management of the care package, social workers supported Adult V in maintaining her independence, linking her in with social groups and assisting with practical matters such as accessing benefits.

In June 2009, after experiencing some issues with the Local Authority arranged care package, Adult V decided to make her own care arrangements and employed a private service. Her involvement with the Local Authority ceased at this point. Between 2015 and

2019, the Local Authority had engagement with Adult V, attempting to set up day opportunities and a supplementary package of home care; these were either declined or withdrawn at the request of Adult V and the case was closed in early 2019.

In August 2019, a relative made a referral to the Local Authority Social Services concerned that Adult V was not managing to care for herself at home. Her case was appropriately allocated, a care and support assessment completed, with the outcome for Adult V to receive support at home. Later that month, Adult V falls whilst at home, emergency services responded and she was admitted to hospital, there she received various therapy assessments and further social work assessment. ~~Whilst~~ In hospital Adult V signed a Lasting Power of Attorney (LPA) instigated by Adult B and listing them as attorney. A safeguarding ~~referra~~l report was made as there were concerns that this may have been done under duress.

The fall impacted on Adult V's confidence, having expressed worries about returning home, a residential placement was identified, and moved into a care home within her home area. Though Adult V had agreed to a residential care placement she now wished to return home. Adult B's family were in favour of her remaining at the care home, resulting in tensions within their relationship.

Soon after moving into the care home, Adult A contacted Adult V. It is believed that Adult A and Adult V were estranged. This was disputed by Adult V who has reported that they had kept in touch secretly. Adult A comes forward and wants to be involved in decision making about Adult V. Adult A supported V's wish to return home. There were concerns expressed by professionals about the suitability of a return home, as Adult V was in poor health, all her needs were currently being met by care staff and her home was not suitability equipped. A mental capacity assessment was completed and deemed that she had capacity to make decisions about her care. Adult A was a regular visitor to the care home, involving herself in aspects of Adult V's care, in wider health care and financial matters. Adult A was a vigorous supporter of a return home, where she would provide care for her. Concerns about the behaviours of Adult A and of potential influence she was having over Adult V's decision making were expressed by several agencies.

Adult V maintained that she wished to return home, professional advocacy involvement and further capacity assessments confirmed she had capacity to make this decision. Planning for a return home is expedited following the care home serving her with notice. Adult V returns home with a package of care and daily living aids in place. Adult A stays with her.

The following month coronavirus arrived in the UK. Even with Welsh Government restrictions in place, agencies maintained their involvement and the care package continued to be delivered. There was a good response by agencies when concerns were noted about Adults A's behaviour towards professionals, other family members and safeguarding risks to Adult V were made known. Culminating in a criminal investigation by Police and action taken to protect Adult V.

Engagement with family – For the protection of family members, this report has been anonymised.

For most of the review process, information on family members was limited. Following contact received from another family member, (not Adult A or B) the reviewers were able to compile a detailed family genogram. Some members of the family were not known to agencies during their involvement with Adult V.

The reviewers have spoken with three family members.

Adult E shared that they had not had contact or seen Adult V since 2011. Disagreements between Adult B and Adult C had escalated following the death of a family member resulting in accusations of threats and harassment between family members which involved the police.

Adult E shared details of several incidents between the extended family members which had taken place over many years, demonstrating a fractured and inconsistent relationship across most family members.

Adult E shared that they had a number of concerns around Adult V's care and contacted the police, and the coroner for information around their investigations and expressed they were unhappy with the outcomes, they felt they did not reflect the evidence presented in the reports.

Adults B and C had provided support to Adult V for several years. Adult C was firmly of the view that 'it was wrong to let her (Adult V) go home from the care home' and that Adult A had cut Adult V 'off from the family'. The family believed that she had motives for doing so, and that they had shared their concerns with professionals at the time.

Adult A conveyed to one of the reviewers that they considered themselves the only person advocating on behalf of Adult V that they 'tried to get her voice across'. Adult A stated that Adult V was 'put into a care home against her will'. They had little positive to say about any professionals / agencies involved and had submitted numerous complaints.

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

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

- **Understanding the adult in the context of their family.**

Professionals involved with Adult V did not have a full picture of the family context, whilst there was awareness of some family relationships and dynamics, there was not cross agency knowledge of the full family membership or which family members were considered close family relations and supportive.

At commencement of the review, no agency involved with the family could provide the reviewers with a full and accurate family genogram.

During the review process, information was acquired which revealed that Adult V was a member of a significant multi-generational extended family, including a son and grandchildren. With a total of 23 extended family members compared to the genogram including 8 extended family members shared by agencies. Of the 23 newly identified family members 8 were now deceased.

Sadly, it was also confirmed that Adult V's adult child had died while in prison in 2016 and Adult V had little contact with her 2 grandchildren in the years following this.

There were some immediate family members who did not seem to feature in agency records, indications are that they were at some point significant in Adult V's life and if known could have added context to agency assessments. Had further work been completed on the genogram at the time agencies were working with her, there may have been other opportunities to support Adult V and reconnect her with other extended family members.

- **The importance of Professional Independent Advocacy being available to individuals who have communication difficulties to support them to express their views.**

Independent advocacy is important in hearing the voice of the adult with care and support needs, supporting them to ensure that their views are listened to and fully considered and to make informed choices. Adult V, due to the effects of cerebrovascular accidents (strokes), had difficulties with communicating verbally.

When checking out Adult V's wishes regarding where she wanted to live, the social worker recognised that Adult V was susceptible to influence and had no appropriate adult relative available. As a result, the social worker, makes a referral for independent advocacy. The advocacy agency maintained contact with Adult V during Covid restrictions. Adult V had a good professional relationship with the advocate, it was to the advocate that she made the disclosure of abuse by Adult A.

It is not known if agencies considered a referral for advocacy services at the point of the LPA being drawn up. By the very nature of the family preparing an LPA in advance without consent, it is likely to have impacted on the relationship she had with these family members, leaving an absence of relations to advocate for her on this matter. Adult V would have been entitled to an advocate as set out in Part 10 of the Social Services and Well-being (Wales) Act 2014.

- **Mental capacity, coercive control, and safeguarding. Where there are safeguarding concerns, a capacitated refusal to engage with services may require on-going risk management, monitoring or changes to care and support plans.**

While all professionals were aware of disclosures made by Adult V it was widely known that she 'often changed her mind' with allegations made against family members not being upheld by Adult V.

With suspected abuse and coercive and controlling behaviour a feature in Adult V's relationships with family members, with no corroborated disclosure or clear evidence, agencies were placed in a difficult situation regarding legal intervention. The social worker had recognised indicators of domestic abuse and intended to submit a MARAC (Multi Agency Risk Assessment Conference) referral. After consultation with the Local Authority safeguarding team, they did not progress with the referral, believing there not to be sufficient hard evidence that would classify Adult V as high risk.

Social Services continued to work with Adult V and provision of care and support was not affected by this decision.

Whilst there was good communication agency-to-agency basis, convening a safeguarding strategy meeting at an earlier point in this case would have provided an opportunity for agencies to collectively share concerns and consider what actions may be required to protect Adult V. As there were accumulating reports of agencies not being able to gain access to Adult V's home or to speak with her without Adult A present, this may have prompted discussion around whether it would be appropriate to make an application for an APSO (Adult Protection and Support Order), which would have given a designated officer the authorisation to speak in private to a suspected adult at risk.

- **Multi Agency Risk Assessment Conference (MARAC) processes**

It is important to explore the individual's ability to make judgements about declining health and social care support within the context of an individual's mental capacity.

Where an allegation of abuse is withdrawn by a capacitated older adult, professionals should be mindful to any risks of influence on decision making due to the presence of coercive and controlling behaviour and take appropriate actions to mitigate risk.

Older persons may be isolated, have health issues that make it difficult for them to access support, and be in the position of being cared for by the perpetrator.

A MARAC risk assessment checklist provides a structure for judgement or risk and is not a definitive risk assessment. It cannot reflect all the aspects of an individual's situation.

In a review of evidence conducted by the Older People's Commissioner for Wales it was found that in 20% of cases, risk assessment work with older people resulted in lower scoring that might have been expected.

Where there is not 'concrete evidence' or a retraction of an allegation, a practitioner should still make a MARAC referral if in their professional judgement they consider an individual to be at high risk. Local domestic abuse services / Independent domestic violence advisor (IDVA's) have specialist knowledge and skills and can provide advice and guidance for professionals on identifying risks. A best practice response for an older person is likely to reflect an integrated approach which combines adult safeguarding and domestic abuse expertise and partner agencies.

- **Information sharing and electronic recording systems**

At the learning event practitioners gave examples of good communication and information sharing between agencies. This related mainly to direct communication between professionals. Gaps were highlighted regarding electronic recording systems both within and across agencies. Adult V's complex health condition meant that she was receiving healthcare from a number of different hospital departments and locality General Practice service. Within the Health Board region at the time there were 20 different electronic record systems in operation. Not all Department's records hold background information on the patient that would be as detailed on other hospital records. One example given at the learning event was that information received by one department only relates to the presenting health need. Representatives were of the view that having background information would be beneficial for both patient and healthcare professional.

- **Safeguarding and Lasting Power of Attorney (LPA)**

Most agencies have referred to changes in LPA as well as making mention to family members having LPA when documenting decisions on both health and care provisions. However, it is not clear why LPA was implemented as Adult V was deemed to have capacity, LPA would not have been relevant in these circumstances as LPA for health and

welfare can only be used when the adult is unable to make their own decisions (e.g. lacking capacity).

When engaging with agencies, various family members made reference to there being an LPA in place and that they were acting in the best interests of the individual. While the social worker did make enquiries with the Office of Public Guardian other agencies appear to have accepted this without seeking any formal confirmation.

As a result of changes made during the period of COVID restrictions health appointments took place with assessments completed by phone with Adult A, with no evidence of this being approved by Adult V. Information relating to safeguarding, communication needs and capacity assessment of the patient were not shared or available to all health care professionals.

- **Wills and legal representation**

In the weeks prior to Adult V's death a new solicitor visited Adult V in her home and a new will was written. While it is apparent the solicitor followed the correct process as per the Solicitors Regulation Authority (SRA) Code of Conduct. Solicitors would not ordinarily be aware of any ongoing safeguarding concerns for their clients and would only follow safeguarding procedures if they felt their duty of confidentiality was outweighed against the duty of care to protect the client in their best interests. There were no such reports made by the solicitor following contact with Adult V as they had no concerns at the time of the meeting.

Effective Practice

- Professionals respected Adults V's choice to live at home, her needs were comprehensibly assessed, with packages of care arranged.
- Mental capacity assessments were regularly carried out, with all practicable steps taken to enable Adult V to communicate her wishes and make informed choices about her care and support.
- Domiciliary care agency staff reported concerns when they felt the involvement of Adult A was adversely impacting on their ability to deliver consistently safe care to Adult V.
- When Adult V makes a disclosure and safeguarding concerns are raised, an adult at risk report is promptly submitted to the Local Authority. Agencies work together to ensure that Adult V is safeguarded and that her care and support needs continue to be met whilst having regard to her wishes and feelings. A criminal investigation is commenced by Police. Social Services take appropriate action to protection of Adult V's property.
- Police took prompt action when the adult at risk report is received and commenced a criminal investigation. Police, together with Social Services were able to speak to Adult V alone at her home, where she made disclosures around physical harm and coercion. Detailed enquires were undertaken by the Police. Following Adults V's death, without corroborative medical evidence neglect could not be proven. With

professionals involved with Adult V stating that she had capacity regarding to health, welfare and financial issues, there was insufficient evidence to progress the case. The outcome not to proceed with the criminal investigation was internally reviewed.

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:-

(What needs to be done differently in the future and how this will improve future practice and systems to support practice)

1. **Coercive Control, mental capacity and safeguarding. Older adults who have care and social care needs are especially vulnerable to coercive and controlling behaviour as a form of abuse. It is important that practitioners can appropriately recognise and respond to it.**

Action: Agencies to promote and facilitate access to information and where relevant to core training on domestic abuse, coercive control, mental capacity and safeguarding. To include the core training included within the National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence. (VAWDASV)

2. **Professionals understanding of MARAC processes**

Actions:

2.1 The Safeguarding Board to make available on the Safeguarding Board website resources for professionals which relate to older people and domestic abuse. To include guidance on older people's care / referral pathway.
2.2 Agencies operating within the Safeguarding Board region to support staff to access training for professionals on how to complete the Dash Risk Checklist.
2.3 Agencies operating within the Safeguarding Board region to ensure that they have sufficient staff trained to act as Champions within their organisation to support colleagues when working with adults affected by domestic abuse.

3. **Further professionals' and public understanding of Lasting Power of Attorney (LPA)**

Action: The Safeguarding Board to make available on the Board website information for Public and Professionals on Lasting Power of Attorney. To include the different types of power of attorney, mental capacity, choosing an attorney and how to report a concern about an attorney.

National recommendation

4. **Information sharing and recording**

The reviewers in the case of Adult V support the following recommendations:

4.1 'Risk, Response and Review: Multi-Agency Safeguarding. A Thematic Analysis of Child Practice Reviews in Wales 2023 McManus, Ball and Almond.

'This review has highlighted the key, but complex, nature of Health agencies within safeguarding. Whilst acknowledged as challenging, urgent work is required to further drive the facilitation of a unified health record.'

4.2 Child Practice Review Report CTMSB 04/2021 relating to Child T.

'The Review recommends that Welsh Government considers the commissioning of a full review of Health, Social Care, Education and Police recording, information gathering and sharing systems. There should be a clear focus on reducing the number of information systems, streamlining information sharing and enabling key agencies to have greater information at key points of decision making'.

The ability to exchange information electronically can help professionals to provide higher quality and safer care. Accurate and accessible records can help in the early identification of cause for concern. Although these recommendations are outputs from child practice reviews, they apply equally to this review.

References

Older People's Commissioner for Wales. 2016. Information and guidance on domestic abuse: Safeguarding older people in Wales. Available at: https://www.gov.wales/

McManus, Ball and Almond. 2023. '*Risk, Response and Review: Multi-Agency Safeguarding. A Thematic Analysis of Child Practice Reviews in Wales'.* Available at: https://safeguardingboard.wales

Cwm Taf Morganwwg Safeguarding Board. 2022 ' *Child Practice Review Child T*'. Available at: https://cwmtafmorgannwgsafeguardingboard.co.uk

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)*	Claire Holt	**Name** *(Print)*	Gail Biggs
Date	……	**Date**	……

Chair of Review Panel (Signature)	……
Name *(Print)*	Lisa Curtis-Jones
Date	……

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

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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

Extended Adult Practice Review Panel
Adult V – CTMSB 02/2022
Terms of Reference

Case Reference details
Adult V – CTMSB 02/2022

Circumstances leading to the APR
Adult V was known to adult services for a number for years and following returning home from a temporary placement. Adult V returned home with a package of care. Adult V previously had a stroke, resulting in additional needs which were being met by care staff. Adult V had mental capacity. When Adult V moved back home from the care home, Adult V's estranged family member who had limited involvement for a significant period of time, moved in with Adult V and started to support Adult V at home. It is a concern that the family member may have influenced Adult V's decision-making in returning home and subsequently influenced Adult V's decision to change the Will to the family member having power of attorney removing other family members despite them having consistent significant involvement with Adult V. There were concerns that Adult V was being controlled by the family member, a number of concerns raised by a care agency in relation to the care that was being provided by the family member which then led to the care package breaking down.

A previous carer for Adult V attended the home address and Adult V disclosed that "the family member is awful to Adult V, and that both the family member and their partner hit and push Adult V" It was also said that the house is cold and the family member won't put the heating on". There was also bruising to Adult V body. An urgent strategy discussion took and Adult V confirmed that the family member had hurt them.

Adult V began to deteriorate and was shortly admitted into hospital. Adult V had injuries on admission and appeared malnourished. On admission to hospital, Adult V presented as scared. Adult V sadly passed away several days later. Staff reported that Adult V presented as afraid and scared. A post-mortem was carried out, however the reports states the cause of death was linked to pneumonia, frailty, due to poor nutrition, heart disease and diabetes. Medic states that it was difficult to say how the bruising was caused or when it occurred, and he suggested a fall could be likely as an explanation. Medic quotes that were no markers to show that there had been any long-standing physical abuse. Social worker and care agency had no information to suggest Adult V had fallen.

This case has several different elements to it,

-older adult abuse

-coercion and control. High level of manipulation from the alleged care giver.

-an adult who has been deemed to have mental capacity and previously disclosed no abuse.

-A perpetrator who was challenging and argumentative to all professionals (uncooperative) during involvement.

-Police investigation that resulted in no conviction considering initial disclosure.

-Civil matters relating to an individual will and being changed under possible duress.

Delay in this case being formally submitted to the pandemic.

Agencies Involved

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

- South Wales Police
- Adult Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance Service Trust
- Serenity Support Services
- Cera Care
- Age Connect Cymru
- Oakwood Care Home

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
Lisa Curtis Jones	Independent Chair	Merthyr CBC
Gail Biggs	Independent Reviewer	Education BCBC
Claire Holt	Independent Reviewer	Social Services BCBC
Jackie Neale	Adult Safeguarding Service Manager	RCT Adult Social Care
Beth Aynsley	Vulnerable Persons Manager	South Wales Police
Janine Curtis	Public Protection Nurse	CTMUHB
Gwenan Jones-Parry	Safeguarding Specialist Paramedic	Welsh Ambulance Services NHS Trust
Helen Davies		Age Connect Morgannwg
Paul Davies		Cera Care
Barbara Jones/ Yvonne Powell		Contract and Commissioning (Oakwood Care Home representative)

Additional Areas of Focus
Nothing identified.

Any Parallel Reviews or Other Such Activity to be Noted
Consider the complaint raised by family member.

Timeframe for the APR

It was agreed that the panel would look at a timeframe July 2019 to July 2020.
This would incorporate time in hospital and the contact with WAST in August 2019.

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 November 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.

Appendix

Summary Timeline Adult V

Date	Significant Event
August 2019	Family member contacts the Local Authority concerned that Adult V is not managing at home. Adult V has health and communication difficulties following historical cerebrovascular accidents (CVA's). Care and Support assessment carried out, outcome package of care put in place.
September 2019	Adult V has a fall and is admitted to hospital. Whilst in hospital, she agrees to make a lasting power of attorney (LPA), appointing a relative. Safeguarding report is made as there were concerns that this may have been done under duress.
October 2019	Adult V is worried about returning home and expresses a wish to move into residential care. A residential care home place is secured, and Adult V moves from hospital into the care home.
November 2019	An assumed to be estranged relative re-establishes contact with Adult V.
December 2019	Adult V expresses wish to return home and for the relative to look after her. Health, occupational therapy, and social care assessments undertaken. A formal mental capacity assessment is carried out – Adult V is able to make decisions for herself.
January 2020	GP called by the residential care home as they had concerns for Adult V's health. She was not eating or drinking, had a chest infection and was refusing to take medication. At this time Adult V was deemed to lack capacity to decide on treatment. Admitted to hospital with a plan to return to the care home when well enough to do so.
January 2020	Care home serve notice to terminate the placement due to challenging behaviours from relatives of Adult V. Mental capacity assessment undertaken, she had capacity to make the decision to return home.
February 2020	Adult V returns home with a package of care.

March 2020	Coronavirus lockdown and measures commence. Package of care is maintained.
April 2020	Police called to a disturbance at Adult V's home. Concerns that there could be coercive control within Adult V's familial relationships.
May 2020	Concerns expressed by domiciliary care agency around access to property and of experiencing issues with the family carer.
May – June 2020	On-going issues with delivering the package of care. Adult V sometimes refusing care and to take her medication. Change in domiciliary care provider.
June 2020	Adult V discloses to an independent advocate that she had experienced abuse by a family member. Adult at risk safeguarding report submitted, safeguarding enquiry undertaken, action taken to safeguard Adult V. A criminal investigation commenced.
July 2020	Adult V's health in decline, and is admitted to hospital
July 2020	Death of Adult V.