Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

EXTENDED ADULT PRACTICE REVIEW

ADULT W

1 Background

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. 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. On the 27/04/22 A multi-agency strategy meeting was held, but adjourned part way through after concerns were raised regarding the safety of Adult W and Adult X. Police used force to secure entry to the property.
Adult W was discovered deceased in bed, lying on soiled bedding wearing soiled clothing. It was identified that, Adult W had been deceased for some time.

2 Context

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). 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 was raised to social services by neighbours and the local pastor. A local shop delivered weekly food shopping to Adult W. It was evident that there were multiple agencies involved with Adult W, and her son, however, engagement with Adult W, and adult X proved extremely difficult for all agencies involved.

3 Key Learning Points

1: Professionals to undertake Mental Capacity Act refresher training.

2: 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.

4: All agencies to raise awareness of their professional standards and duties under their Codes or Practice in relation to the clarity of decision making, supervision, agreed actions and appropriate recording of information.

4 Key Learning Points

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

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

7: The GP Practice (identified in this review) 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 in and out of hours.

5 Key Learning Points

8: The Health Board lead for General Practitioners and the lead for the Ambulance Service to review the recording of the decision making and responsibility to identify a process where a patient decides not to be admitted to hospital, even though they are in need of urgent medical care.

9: GP and Ambulance Services to ensure there is clarity of decision making, agreed actions and recording with the patient notes / care plan.

10: Agencies to appreciate each other's roles and responsibilities and constraints of the legislation, with regards to Police Welfare Checks.

6 Effective practice:

Clear evidence of consistency in approach by social workers and evidence of good handover of information between social workers and teams.

Persistence in trying to develop a relationship with Adult W and her son to build on trust and confidence.

Innovative ways of working with the local community were identified and initiated.

There was evidence of professionals going the extra mile and displaying persistence when trying to engage with Adult W and X.

Social worker, used an escalation processes, due to concerns of lack of engagemen.t

7 Developing Systems and Practice

All professional to record detailed patient / case information that removes assumptions, checks, and challenges perceptions to find and agree facts with appropriate recording.

Professionals are to be encouraged to convene multi agency meetings, share information and view the case holistically.

A patient's mental capacity should be assessed where there is any doubt and where another person attempts to make decision on their behalf, there should be evidence of a Lasting Power of Attorney agreement being in place.