# Child Practice Review – Adult G

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board


## 1) Family Background

Adult G lived with Adult H. Adult G had two close family members nearby. Adult H had a diagnosis of dementia. Adult G had health issues. Adult G was reluctant to have support from outside the family. Two family members visited daily to provide support. Adult H was open to adult services, Adult G was not.

## 2) Circumstances that led to the Adult Practice Review

Following an escalation of need a number of safeguarding referrals were received, resulting in a s.126 enquiry being undertaken for adult H&G. Adult G disclosed that she was frightened of a family member but later denied this. However Adult G accepted the need for an assessment in her own right. A social worker was allocated shortly afterwards. The assessment did not start due to Adult G being admitted to hospital in a critical condition with two fractured ankles, a perforated bowel and other health issues. Whilst in hospital Adult G reiterated a family member had been 'horrible' but would not speak without a family member present. Adult G sadly passed away before this was arranged. A police investigation and inquest commenced.

## 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

Two family members living close by engaged with the reviewers at an early stage. Other family members overcame some initial reluctance and met with the reviewers but not until after the learning event had taken place. It was clear that the two groups of family members held strong opposing views.

## 5) Notable Effective Practice

Social Workers worked well with the family to develop a working relationship.

A good handover of information was achieved when there was a change of social worker

When MASH was asked for support, the response was timely and good advice was provided

## 6) Practice and organisational learning

- Carers assessments were not re-offered periodically
- Increased professional curiosity may have led to insight into appearances of need and levels of family support being provided. This may have led to an earlier assessment.
- Evidence was not recorded to show why professionals believed Adult G had capacity.
- Advice to family members to apply for Deputyship was not followed up to ensure fully informed decision making
- Issues of self-neglect were not explored across a multi-agency basis.
- Clear evidence of a safeguarding concern was not escalated to the line manager and the MASH.
- A GP did not look beyond immediate health concerns and consider holistic needs.
- Police did not make enquiries with another agency despite being aware of their involvement
- Records were not kept on the file of the individual in line with GDPR obligations

## 7) Improving Systems and Practice

- Regular Carer assessments should be offered and declined offers should be reviewed.
- Professional curiosity and management oversight should inform analysis of risks and strengths before deciding on any actions.
- A multi-agency self-neglect policy to be developed.
- General Practitioners should consider immediate and holistic health needs.
- Where there is potential risk wider multi agency information to be sought to inform decision making.
- All agencies should have in place their own policies and mechanisms for clear and accurate record keeping, in line with GDPR.