Adult Practice Review Report

Adult Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Adult Practice Review

Re: Adult R – CTMSB 03/2021

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*

A Concise Review was commissioned by the Cwm Taf Morgannwg Safeguarding Board (*CTMSB)* in October 2021 following a recommendation of the Joint Review Sub-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 a concise adult practice review where an adult at risk who*

*has **not**, 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.'*

NB The pseudonym Adult R is used throughout the report to represent the person who is the subject of the Review

An adult at risk is defined within the Social Services and Wellbeing (Wales) Act as an adult who:

1. Is experiencing or is at risk of abuse or neglect
2. Has needs for care and support (whether or not the authority is meeting any of those needs), and
3. As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Adult R met the criteria for an Adult Practice Review as she was identified as an adult at risk, there were a number of agencies involved at the time of her death and there was a potential for multi-agency learning to be identified. Adult R was deemed by practitioners who worked with her to have capacity to make decisions for her own treatment, to engage in support on the basis of understanding the information given and the ability to communicate her wishes and feelings on her care. This was based on the principles of the Mental Capacity Act (MCA). However, it has been considered throughout the timeline of this review that her mental health may have fluctuated, affecting her ability to understand information, make informed decisions and access advice or support.

The MCA says:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who does not have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms

Adult R died in the summer of 2021, she was in her sixties, her cause of death is considered to be from suspected completed suicide, a cause of death will be confirmed by the coroner. She was found at the family home with a ligature around her neck. The date of her passing was a year to the date of the death of a close family member and was during the COVID pandemic.

In the year prior to her death, Adult R had suffered significantly with poor mental health, with a diagnosis of Generalised Anxiety Disorder (GAD). GAD is described by the NHS website as a long-term condition that causes a person to feel anxious about a wide range of situations and issues. A person with GAD feels anxious most days and often struggles to remember the last time they felt relaxed (NHS 2022). She subsequently had extensive contacts and treatment with Cwm Taf Morgannwg University Health Board (CTMUHB) mental health services. These were through the

means of home visits, hospital admissions and telephone contacts. Adult R continued to receive mental health services up until the time of her death.

Adult R was a wife, mother and grandmother. She was a Registered Nurse for many years, until she retired at the age of 50. Adult R was described by her husband as a very proud lady, who took pride in her appearance and home. She enjoyed reading and annual holidays with her husband. In the final year of Adult R's life, she had suffered two significant bereavements, her mother and brother both passed away in 2020, which had a significant impact on Adult R's emotional wellbeing.

Adult R had experienced a voluntary period of admission as an inpatient at a mental health unit. This was following significant concerns raised by her family, as she was presenting as physically and verbally aggressive, agitated and anxious, which was not the usual presentation of Adult R.

In the days following discharge from hospital, Adult R attended the emergency department on four occasions following an overdose or self-harming behaviours. On each occasion, she was discharged on the same day as attending, despite family members reportedly voicing their concerns to practitioners.

Family members tried to support Adult R and her husband, with Adult R's son offering respite on one occasion at his family home. However, Adult R was described within her records as having behaviours that were controlling and sometimes difficult to manage by both practitioners and her family.

The relationship between Adult R and her husband was one of concern for professionals. During the year prior to her death, there were nine contacts with South Wales Police (SWP) by Adult R, her husband and son, primarily in respect of domestic related incidents or concerns for her mental health; the two were often linked. This resulted in them being discussed at Multi Agency Risk Assessment Conference (MARAC) as both victims and perpetrators of domestic abuse. The couple had reportedly expressed to professionals that they did not want support, despite both recognising they had difficulties within their relationship.

Adult R's husband did not recognise the presence of domestic abuse within their relationship. It is considered that the complexity of Adult R's mental health and the role of her husband as a carer appeared to have changed the dynamics of the couple's relationship, putting strain on them both.

Within the last 5 weeks of her life, there were four emergency department attendances and six calls to the Welsh Ambulance Service NHS Trust (WAST). Incidents of self-harming and suicidal ideation had increased significantly over the weeks prior to death. Prior to this, Adult R had not used WAST or attended A&E.

It is documented that there had also been a referral made to the Local Authority for Adult R's husband and son to receive a carer's assessment, as it was recognised by practitioners that due to the changes and deterioration in Adult R's mental health that caring for Adult R may have had an impact on her husband's wellbeing. Although,

whilst agency records confirm that Adult R's husband was offered support, this was not his perceived understanding.

Learning and recommendations for this APR have been concluded from a review of multi-agency timelines, a practitioner learning event and the views of Adult R's husband.

It is acknowledged by the Reviewers that the Health Board have undertaken a Route Cause Analysis, that has been shared with Adult R's husband. It is important to clarify that this review is independent from the RCA and focusses on learning for multi-agency practice.

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

A Learning Event was held on the 10th of May 2022. This Learning Event was conducted face to face, with a range of representatives from agencies who had worked with Adult R in attendance, as well as those who were able to contribute to learning and any recommendations and actions moving forward. A timeline of significant events in respect of Adult R was shared with practitioners, who had the opportunity to identify areas of effective practice and areas for improvement. There were limitations in identifying areas of learning due to some agencies being unable to attend the event and contribute. It should be noted that all agencies, however minimal their involvement, can make a valuable contribution to the overall process of learning. This learning can be shared and implemented within their relevant service area to ensure improvements are made in practice.

Through the course of the review the following themes were identified;

1. **The importance in recognising the impact of deterioration or change in the presentation of a person with long term mental and/or physical health.**

   Leading up to Adult R's death there appeared to be a notable increase in her self-harming behaviours, whereby either WAST were contacted and/or she attended the emergency department (ED). There had been four attendances within 5 weeks and two of those within 48 hours preceding her death. At each attendance, she was seen in the emergency department by ED staff and mental health practitioners. Mental health practitioners assessed Adult R on

each occasion, following assessment they did not feel that she met the criteria for being detained under the Mental Health Act. Adult R had previously been admitted on a voluntary basis and had not consented to another admission. She was under the care of the community mental health team, and it was felt that care could be continued in the community from this team and her family.

Adult R's husband felt that there was a perceived lack of appropriate inpatient facilities available to Adult R, due to her only having an option of admission to a 20-bed local NHS provision. Adult R had previously been a voluntary inpatient within a mental health ward, however, she was very reluctant for re-admission when her mental health continued to decline. She had previously worked within the area, which may have influenced her decision making. It was felt that she may have reconsidered an inpatient setting if an alternative provision was available. Whilst it was acknowledged that she would benefit from a therapeutic inpatient environment, their understanding was that any private settings would incur a cost to Adult R. It is considered that this may have been a barrier to her agreeing to another voluntary admission.

Adult R had not previously accessed emergency services for care. It does not appear that health practitioners within the emergency department recognised the implications of her decline in presentation and the escalation of her self-harming behaviour. There was a lack of professional curiosity in respect of Adult R's repeated attendance, and it is considered that practitioners may not have recognised the risk factors in Adult R's condition. Consideration of why Adult R was attending the emergency department repeatedly in this short period was not evident in practitioners' records.

The Welsh Government 'Talk to Me 2' strategy recognises that emergency departments have an important role in managing people who self-harm or engage in suicidal behaviours. The Suicide Information Database (SID) Cymru has demonstrated this is the most common place of last contact with health services in the year prior to suicide. It is important that needs and risks are assessed appropriately in order to inform longer-term care.

Adult R's husband reported that there was a marked deterioration in the presentation of Adult R and that previously she had been very well groomed, but now was described as neglecting her appearance. It is important that practitioners who are working closely with patients are attuned to a person's change in physical presentation as well as their mental wellbeing.

2. **Understanding and assessing the impact of significant change in a person's life and the possible consequences for mental health and well-being.**

Adult R had grieved the death of two immediate family members in the space of a year, in addition, she had experienced relationship changes, it is considered that these may have contributed to a loss of her personal identity. This was due to having previously undertaken a caring role of her mother. Adult R died exactly one year to the date after her brother's death.

It is also acknowledged that the death of Adult R occurred during the COVID pandemic, following significant periods of lockdown and isolation from friends and extended family. It is not clear what impact this had on Adult R's emotional wellbeing and relationships or her husbands, although Adult R's husband's opinion was that COVID had not contributed to further impacts on her mental health.

Whilst Adult R had received a diagnosis for GAD, it is not clear how the additional risk factors such as bereavement and change in behaviours were incorporated into her risk assessment and care and treatment plan. Whilst she was offered a bereavement counselling referral, which she refused, it was not evident that this was ever revisited.

Mental Health practitioners need to consider the impact of life events on people with pre-existing mental health needs. This will ensure a more holistic view of the risks to individuals and their families/carers. It is also important to recognise changes in people's behaviour over time that might indicate elevated risk, e.g. although Adult R had experienced mental health difficulties for some time, she had never presented in the way she did in the last few months of her life.

Agencies need awareness of what services are available to support people and ensure these are offered on multiple occasions to enable people to access support at times when they feel ready. It is acknowledged that during periods whereby a person is experiencing poor mental health and feeling low they may not at that time have the capacity to access services. It is therefore vital that the offer of support is revisited, making every contact count.

Since the start of this review, the Health Board have implemented a Risk Formulation and Management Plan across all inpatient and community mental health services. This is a more in-depth assessment tool that supports the facilitation of assessment, formulation and analysis of information, and is a holistic approach to highlight measures that are required to manage identified risks. This is seen as a positive approach to improving assessments for those people presenting with risk factors associated with self-harming and suicidal ideations.

3. Sharing information is essential to enable each organisation to play their part in identifying, supporting, and safeguarding adults with care and support needs or at risk

While Adult R was an inpatient, a multi-agency meeting was held prior to discharge. It is important to ensure that all appropriate agencies are invited to attend meetings to share information. The Independent Domestic Violence Advisor (IDVA) was not invited to the meeting, despite there being ongoing concerns for the couple's relationship. The IDVA's attendance may have provided opportunities to explore what support could be offered to Adult R in respect of her relationship on discharge. In addition, it could have facilitated consultation between health and the IDVA service. It is important to acknowledge that this was during the COVID pandemic, when there were restrictions in place, which would have prevented the IDVA from attending the ward in person. It is documented that Adult R had declined to engage with this service, it is not known why Adult R declined this service.

The importance of domestic abuse services and the IDVA role was acknowledged by all health practitioners, albeit there was a lack of awareness of how to access advice and support from the service.

All practitioners attending the learning event acknowledged the advantages and benefits of access to a health IDVA, which is a specialised IDVA working within a health setting. This was not a service that was available at this hospital site, however, was considered a recognised service that would allow face-to-face contact within the hospital setting, thus providing opportunities for an IDVA to explain their role and detail how they can support an individual.

Minutes of the MARAC meeting had not been shared with all those practitioners working with Adult R. Agencies need a robust process in place to ensure information is shared in a timely and appropriate manner within their agency. This will enable practitioners to understand and analyse risk, adequately informing their care plans.

It was noted throughout the review that effective information-sharing and communication was affected by the numerous differing IT systems used by agencies. Even practitioners within the same agency were unable to access information saved in respect of Adult R. When emergency services attended calls, they were not equipped with information of Adult R's condition or details of the escalating self-harming behaviours.

WAST had been called on six occasions during a 32-day period. Three of those contacts were within two days of her death. When called out in an emergency, WAST did not have access to records that contained a history of Adult R's mental health condition, therefore they were reliant on the information provided by both Adult R and her husband. On the day Adult R died, she had denied any suicidal thoughts to attending paramedics and there was no information or observations to indicate that Adult R was at risk of suicide at this time. Since this time, WAST have moved to an electronic patient care record that will allow an attending ambulance crew to access information recorded during previous contacts. This is a positive step forward in providing information to support ambulance crews in exercising professional curiosity.

The repeated contacts to WAST suggest that Adult R's condition was unstable at that time. It is important that all agencies demonstrate professional curiosity and challenge when a person is repeatedly contacting their service. In addition, they should have access to relevant information to appropriately conduct a holistic assessment.

4. **The importance of agencies having adequate knowledge and skills with regards to domestic abuse and the MARAC process to enable them to appropriately signpost and support those suffering or perpetrating any aspect of domestic abuse.**

   There had been two MARAC meetings, that included representation from all key agencies including, police, health, domestic abuse services and adult services. The MARAC process worked well in identifying risk factors and developing a safety plan for this couple. Following these meetings, police were persistent in trying to engage Adult R, through phone calls and joint visits. It is acknowledged that this effective practice should be encouraged through all agencies. Where possible, joint visits should take place to allow for effective information sharing and a collaborative response to those who may be suffering from domestic abuse.

   Agencies need to ensure that practitioners have adequate training in Domestic Abuse and a clear understanding of the referral pathways. This should include an understanding of the MARAC/Daily Discussions process and an awareness of what support services are available to victims and perpetrators.

   Practitioners felt that the difficulties in Adult R's relationship were further affecting her mental health. However, it was difficult to engage Adult R in any support services. Both Adult R and her husband had been seen as both victims and perpetrators at different times, there were contributory factors that caused increased stress and pressure in their relationship. It is documented within

South Wales Police records that the first contact from Adult R's husband to police was regarding concerns for Adult R's mental health and worrying presentation.

It is recognised that there is a lack of known services available that can work with couples experiencing domestic abuse who wish to continue their relationship.

Effective Practice

- There were many examples of good and effective practice throughout this review. Agencies demonstrated vigilance and determination in their attempts to engage Adult R in therapies and support services.

- Mental Health services had worked intensively with Adult R and held regular multi-disciplinary meetings to coordinate her care. Several treatments and therapies were tried in an attempt to improve her mental health. Throughout the COVID pandemic there continued to be regular face to face meetings to offer support.

- The MARAC had good representation from all statutory agencies on both occasions, with representation from mental health services, including Adult R's care coordinator. This ensured effective communication and information sharing between agencies, resulting in a personalised approach.

- The Domestic Abuse Unit within South Wales Police attempted to engage Adult R on numerous occasions and did not give up until they were able to have a meaningful conversation about what support services were available. This included collaborative working with other agencies.

- Emergency services responded quickly to 999 calls despite this being during the COVID pandemic when services were under increased pressure. They were persistent in trying to contact and engage Adult R in assessments during the call out on the day she died.

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. Health practitioners need to have access to bespoke domestic abuse training, to enable them to appropriately respond to concerns of abuse in the older person. In particular, they should have a good understanding of the complexities associated with the older person's relationship. This should include awareness of the referral pathways to MARAC and IDVA services. Joint training between health and IDVA services would encourage collaborative working. This will present further opportunities to provide advice and support to both men and women who may be experiencing domestic abuse

2. All practitioners who represent their agency at MARAC need to have access to specific training that helps them understand their role in the multi-agency response to safeguarding adults at risk of domestic abuse. This should include guidance on information sharing within their organisations.

3. Whilst there is invaluable support for those who are victims of domestic abuse, practitioners within Cwm Taf Morgannwg were not aware of any services that will work with couples who wish to remain within a relationship. Considering the complexities of domestic abuse within older people, there needs to be appropriate support available to assist in developing plans that will increase resilience and reduce risks.

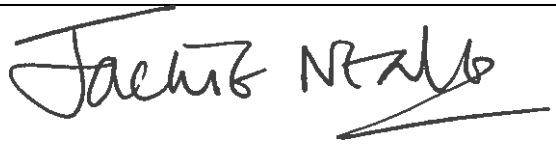
4. All agencies need to encourage professional curiosity and embed it within practice. Practitioners need to exhibit confidence in discussing feelings of suicide and respectfully challenge those at risk of self-harm or suicide. Suicide prevention awareness training should be delivered to organisations across the Cwm Taf Morgannwg region, in particular to emergency departments. Training should be delivered on early intervention for those presenting with self-harming behaviours. This needs to enable practitioners to recognise risk factors, escalations in a person's behaviour or deterioration in their mental health condition and ensure that they have confidence to ask the pertinent direct questions around a person's intent to complete suicide.

5. When a person presents in crisis with a mental health condition, agencies including emergency services, need to have access to relevant background information that enables them to consider risk factors during their assessment to formulate safe decisions.

6. Whilst it is acknowledged, that those suffering with mental health are entitled to confidentiality in respect of their care and treatment, it is important that practitioners recognise the effect a person's condition may have on family members and their relationships. Effective communication with families and carers will ensure that they are able to access support for themselves and the person for who they are caring, taking a systemic approach to working with families and couples. It is important that families understand the rationale for decisions made by mental health practitioners. The Health Board need to utilise resources that support effective communication between families and practitioners. It is essential for families to understand the criteria and reasons for decisions about the need for hospital admission.

Statement by Reviewer(s)			
REVIEWER 1	**Claire O'Keefe**	**REVIEWER 2**	**Anneliese Donovan**
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)*	C O'K eefe	**Reviewer 2** *(Signature)*	....
Name *(Print)*	Claire O'Keefe	**Name** *(Print)*	Anneliese Donovan
Date	24/11/2022	**Date**	24/11/2022

Chair of Review Panel
(Signature)



Name
(Print) Jackie Neale

Date 24/11/2022

Appendix 1: Terms of reference –

CONCISE ADULT PRACTICE REVIEW PANEL
Adult R - CTMSB 03/2021

Terms of Reference

Case Reference details
Adult R – CTMSB 03/2021

Circumstances leading to the APR
Adult R was found deceased following her suspected suicide. Adult R had a history of mental health issues for which she was prescribed medication and had been under the care of her local Community Mental Health Team (CMHT). Adult R had been discharged from her local acute mental health unit around two weeks prior to the incident, where she had been a voluntary patient and there had been a number of mental health episodes leading up to the day.

Adult R was reviewed in the CMHT clinic in the month before her death. She had been noted to be anxious on the ward initially but did settle. She did not wish to leave the ward on discharge. There appeared to be issues in the relationship with her husband and she made repeated references to self-harming.

Adult R's mental health had been deteriorating prior to her death. There were multiple professionals involved but she often declined advice offered by them.

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

- South Wales Police
- Adult Services
- Cwm Taf Morgannwg University Health Board – Safeguarding and Mental Health
- Domestic Abuse Services
- Welsh Ambulance Service Trust
- Carers Trust

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 individually focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.

- Determine if the Coronavirus pandemic had any impact on the care, treatment and safeguarding arrangements for Adult R.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify any 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 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.
- Prepare a 7-minute briefing
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Additional Areas of Focus
None noted.

Any Parallel Reviews or Other Such Activity to be Noted
Root Cause Analysis review being undertaken by Cwm Taf Morgannwg University Health Board.

Coroner's Inquest planned for November 2022

Timeframe for the APR
20th May 2020 – 4th June 2021, rationale for this being, to be inclusive of a PPN that was received in relation to a domestic incident and the date of Adult R's death.

Learning Event
Scheduled for the 10th May 2022

Completion Date

Target is 16th September 2022

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, action plan and summary timeline 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 2

Summary Timeline

Summary Timeline

Date	Significant Event
May-20	Adult R's husband reports concerns to Police with regards her mental health and his ability to care for her. PPN completed but not shared in relation to Adult R due to lack of consent.
Jun-20	Adult R suffers a family bereavement
Sep-20	Adult R's husband attends Police station with reports for her mental health. Advice given and no PPN submitted.
Feb-21	999 call made to Police, husband reports that he is scared that he is going to assault Adult R. Referral to MARAC, assessed as medium risk, no further input
Mar-21	referral to MARAC, Adult R as victim, IDVA support offered but declined
May-21	hospital admission following a number of emergency calls – discharged after 2 weeks
May-21	June 2021 – multiple incidents and calls to emergency services
Jun-21	Death of Adult R