Adult Practice Review Report

Cardiff and Vale Safeguarding Adults Board
Adult Practice Review

Re: *APR 01/2021*

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*

Circumstances Leading to Review:

A concise adult practice review was commissioned by the Cardiff & Vale Safeguarding Board in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. A concise adult practice review is commissioned where an adult 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

The adult at risk has been identified as Adult A, for the purpose of this report.

Adult A passed away in hospital in June 2021. Welsh Ambulance Services University NHS Trust (WAST) had conveyed her there following a 999-call made by her daughter stating that her mother had fallen out of bed 2 months ago and was on the floor of their home delirious and not eating. Adult A's two adult daughters are referred to in this report as Daughter 1 and Daughter 2. They had been caring for her at home on the floor for approximately 8 weeks.

Upon admission to hospital Adult A was covered in urine and faeces with full thickness infected pressure sores to her sacrum, buttocks, spine, lower back, hips, and heels. She was only able to respond to pain and could not be fully examined as she was too unwell to roll.

Adult A was a 77-year-old woman who was born and brought up in Cardiff. She was the middle child of 3 siblings, having a brother who was 6 years older and 1 sister who was 5 years younger. Adult A and her husband divorced when their children were still in school. Adult A's youngest daughter has a learning disability.

Adult A and her daughters led a very quiet life. Adult A's sister provided a statement to the coroner following her death which identified that Adult A was devoted to her daughters and made all decisions for the family. The family appear not to have had any visitors to their home for many years other than the care and support provider who supported Adult A's youngest daughter (Daughter 2). District Nursing staff during the learning event provided information that the door knocker to the family home was covered with a tea towel to prevent any loud noise. Her sister also stated that loud sounds were a problem for Adult A, and this included the telephone. It was known by services that Adult A did not like to answer the telephone. Adult A often communicated by letter, and we have seen letters to her GP and to her youngest daughter's care and support provider while undertaking this Review.

Adult A's brother died in January 2019 and her sister believed that she did not leave the family home after this. Adult A had a hospital admission in January 2020 after a fall at her home where she remained on the floor for several weeks being cared for by her daughters, declining treatment until WAST and the Police intervened transferring her to hospital for treatment. Following her discharge from hospital in January 2020 she would not accept support from her sister other than giving her daughter handwritten notes to give to her sister detailing items to purchase. Sadly, Adult A's sister has also now passed away, so we have been unable to establish if she had seen Adult A following hospital discharge in early 2020.

Adult A was described as a private and independent woman who did not want people including family visiting her home or telephoning the family home. Professionals raised concerns that Adult A made decisions on behalf of them all and that her daughters deferred to their mother. Adult A was not in receipt of care and support and declined this when it was offered by professionals in the community and to support hospital discharge in 2020.

Adult A described herself as the carer for her daughters during a hospital admission in 2020. At the time of her death her eldest daughter was 55 and the youngest was 51. Her older daughter was believed to have had mental health issues but was not open to any Mental Health Services; it is not within the remit of the Review to consider her medical records. Her younger daughter had a learning disability and is in receipt of a care and support package commissioned by Adult Social Services. Both daughters were caring for Adult A at home following her hospital discharge in 2020 and this was noted by both District Nursing staff and Adult A's sister.

In April 2021 the family cat died. Her sister spoke with Adult A to offer condolences, and she described Adult A as hysterical and grieving and telling her that the family simply wanted to be left alone.

Timeframe Agreed for Review:

The timeframe for the Adult Practice Review was agreed as January 2020 to June 2021 to include the hospital admission and subsequent discharge back to the family home in 2020 with significant support from District Nursing services who visited Adult A at the family home regularly. The incident in 2020 provided some parallels to the fall in 2021.

Learning Event:

A Learning Event took place on 14th March 2024 with professionals from Adult Social Services Learning Disability Team, Adult Services Safeguarding Team, Cardiff and Vale UHB, WAST and Daughter 2's Care and Support Provider. Unfortunately, the Police were unable to attend due to other work commitments. The GPs views have been gathered by convening a separate meeting following the learning event.

Contact with Family:

The Review Chairperson and the Reviewers agreed to approach Adult A's daughters via the Manager of Daughter 2's Care and Support Provider who has a good relationship with the sisters. It was agreed that the Manager of the Care and Support Provider would give Daughter 1 a leaflet about the Adult Practice Review process and explain what that meant and offer to arrange for us to get in touch with her. Daughter 1 has declined this offer on behalf of the family. Daughter 1 was offered the opportunity to read the review prior to publication, again via the Manager of the Care and Support Provider, however she declined the offer and has requested to receive a copy of the report on publication. The information to date that we have regarding Adult A has been obtained from the participants at the Learning Event who met Adult A and her daughters, the family GP and the letter sent to the Coroner by Adult A's sister during the Coronial process.

A summary of the chronology of events within the review timeframe can be found in the appendix to this report.

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

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

Learning Point – Self Neglect:

As detailed above, Adult A was a private person, living in isolation with her two daughters. There was minimal involvement from agencies prior to the review period and throughout as Adult A preferred a very independent private life, limiting all contact with others.

Adult A was admitted to hospital in early 2020 after the Police and WAST were contacted by Adult A's GP to gain entry to the house. Concerns had been raised by the Learning Disability Team and the care and support provider working with Daughter 2. Upon assessment, Adult A's physical condition had significantly deteriorated from wounds acquired after a period of weeks being cared for lying on the floor. There was evidence of self-neglect, alcohol misuse and underlying mental health issues noted by WAST. Adult A was discharged in April 2020, after she demonstrated improved ability to self-care, had increased mobility and was assessed to be medically fit for discharge by health practitioners.

Upon discharge, Adult A received ongoing support by District Nurses for wound care but had refused any other support services. Considering Adult A's presentation and improvement at the point of discharge, the Adult Services safeguarding assessment was closed as Adult A was assessed as having mental capacity and improved self-care. Therefore, a strategy meeting was not required. By June 2020, Adult A's presentation had begun to deteriorate, with the District Nurses concerned for Adult A's self-care, alcohol use, suspected depression and reduced mobility. The District Nurses demonstrated positive practice identifying Adult A as a potential adult at risk and made a report to the Local Authority Safeguarding Team and requested an escalation to the GP for a mental capacity assessment. Although the report did not progress to an adult at risk at outcome, actions were set of a further mental capacity assessment to be requested from the GP. Additionally, for the Adult Learning Disability Team to be notified of the adult safeguarding report considering their involvement with Daughter 2 and a further report made, if necessary, upon completion of the actions. (*additional details are contained within the Safeguarding learning section*)

The District Nurses raised further concerns in Sept 2020 to the GP on Adult A's self-care, ability to use toilet facilities, reduced mobility from not leaving the bed and continued alcohol use. The GP attempted to visit Adult A and complete a further mental capacity assessment, Adult A refused a face-to-face visit, only engaging over the phone. During the meeting with the reviewers, the GP advised that they do not undertake unannounced house calls unless there is someone at a property to meet them. Daughter 1 was assessed as an additional adult presence in the home and Adult A's mental capacity was presumed. Adult A had presented competently over a telephone conversation and the GP was aware Daughter 1 was present and able. District Nursing services were removed in Feb 2021 upon Adult A's wound having healed.

The learning event found, Adult A presented with a reluctance to engage with agencies throughout the period under review and was resistant with all referrals raised to support with her presenting behaviours and care and support needs; specifically, those linked to self-neglect. It was identified there was a lack of awareness by professionals as to what constitutes self-neglect and how agencies can be confident in assessing self-neglect. When self-neglect behaviours such as an

unwillingness to care for health needs, hygiene, home or substance use are presented by an individual who is deemed or assessed to have mental capacity, this places additional challenge on practitioners. Practitioners questioned how and when they intervene: balancing the rights of a private life for Adult A, with their professional assessment of Adult A not meeting her care needs, alongside an assessment of Adult A with presumed mental capacity.

The review found there was positive practice in the escalation of concerns to the GP and the report to Adult Safeguarding in response to the presentation of self-neglect behaviours. There were opportunities for additional safeguarding reports to be made after Adult A's health continued to deteriorate and the GP had been unable to complete a face-to-face new mental capacity assessment. The GP was aware that Daughter 1 was also in the household and deemed an appropriate adult but was not aware of the family dynamics and care arrangements. Reporting back the challenge of being unable to complete a new mental capacity assessment would have improved a multi-agency awareness of all circumstances and safeguarding concerns. All agencies reflected the opportunity a multi-agency approach would have afforded them working with the family to have improved their knowledge and a joint approach to implement interventions around self-neglect.

The learning event evidenced the requirement for guidance to all agencies working with individuals presenting with self-neglect behaviours, complex mental capacity and unwise decision-making. The Cardiff and Vale Safeguarding Board has developed a practitioner tool kit on self-neglect since the Review was undertaken. This will support professional understanding of expectations and practice development around working with self-neglect.

Learning Point – Mental Capacity:

Adult A was deemed to have mental capacity for care and support decisions after her initial admission to hospital and at the point of discharge. WAST had queried Adult A's mental capacity due to her presentation and a Public Protection Notice was submitted by the Police. Appropriate professional curiosity was taken by District Nurses to question this assessment prior to discharge based on the circumstances of Adult A's admission to hospital, her presentation and police intervention to gain access to the home. As detailed earlier, the Adult Safeguarding report was closed by Adults Services with actions for a re-referral, if necessary, after reconsideration of a mental capacity assessment. Adult A engaged in occupational therapy and physical therapy, demonstrating appropriate decision making around her care needs, within an environment restricting her control over alcohol consumption and reclusiveness.

There were occasions when Adult A's presentation and self-neglect behaviours resurfaced and the District Nurses working with Adult A questioned Adult A's mental capacity for care and support throughout 2020. There was some uncertainty by practitioners on the role and ability of all professionals working with individuals, to undertake a mental capacity assessment. District Nurses had a reliance on the GP in completing mental capacity assessments.

When questions on mental capacity were raised and escalated, the guidance and support provided to health care professionals should have been based on robust decision making, considerate of consent and intervention.

The impact of the COVID pandemic on operations and Adults A's reluctance to engage in support when at home, resulted in District Nurses being the only agency accessing Adult A's home. There were two occasions when her mental capacity was questioned, based on Adult A's self-care, alcohol use, health and her caring responsibilities for her youngest daughter. District Nurses questioned Adult A's continuous refusal to consent and receive any interventions, having concerns on the risks posed to Adult A, Daughter 1 and Daughter 2. As detailed previously, after the District Nurses escalated concerns around mental capacity, the GP attempted a re-assessment but was refused into Adult A's home with her only engagement through telephone contact on medication. The GP was also aware of Daughter 1 being capable and present in the home. Therefore, the presumption of mental capacity remained as the GP assessed there was no further information to challenge this assessment.

The review found the inability to complete a mental capacity assessment in person was a missed opportunity which could have led to an additional safeguarding report, were all known circumstances considered surrounding the deterioration of self-care and presentation. For instance, problematic alcohol use often impacts upon an individual's mental capacity. There is reference in the Review Chronology to Adult A drinking alcohol problematically, however, this was not fully explored or accounted for in consideration to the mental capacity assessment.

During discussions at the learning event, professionals acknowledged the principles of the Mental Capacity Act, that the presumption of capacity is taken by professionals with the understanding an individual has the rights to a private life. Confidence is required by professionals in their responsibility to provide a duty of care, considering risks and what interventions are required. The learning event highlighted the effect of COVID upon professionals' confidence in their decision making and daily operations.

In the months leading to the passing of Adult A, none of the agencies were accessing the home to review her mental capacity and Adult A was not in receipt of care or support.

The Cardiff and Vale University Health Board (UHB) have taken positive action to improve guidance to health care professionals with the establishment of a Mental Capacity Act (MCA) Team that sits within the Safeguarding Team as a standalone team that provides advice, support and training to practitioners across the UHB. The team has grown in the last year and has two MCA practitioners that are available Monday to Friday and are raising awareness and providing bespoke training as required. District Nursing staff can access this training and seek advice from this team.

Learning Point: Safeguarding Processes

The safeguarding report by a District Nurse in June 2020 sufficiently outlined the concerns with Adult A's presentation and deterioration in health and support needs since returning to the family home. It included risks from the prior hospital admission, mental capacity concerns and issues surrounding the care and responsibility of her daughters. Adult A was not deemed to be an adult at risk from the safeguarding report made, Adult A was documented to have presumed capacity and the outcome noted 'there was no indication of harm, or risk of harm.' Actions were set for the District Nurse to request the GP re-assess mental capacity and after the mental capacity assessment was undertaken a further referral should be made if necessary. Concerns for the daughters were also documented within the safeguarding report outcome and an action was set for Adult Services Learning Disability Team working with Daughter 2 to be informed of the report. A further mental capacity assessment was not undertaken as Adult A refused the GP permission to attend her home. The action of the Adult Learning Disability Team being informed of the safeguarding report was not undertaken. Therefore, there was a missed opportunity for an additional safeguarding report after completion of the actions and upon the District Nurse reporting a further decline in Adult A's self-care and presenting behaviours, questioning her mental capacity. Without a safeguarding report progressing and all agencies being informed of the initial safeguarding reports, professionals were not working in a multi-agency or whole family system approach.

The review found; the outcomes of the safeguarding report were also not recorded as expected within health digital systems (Paris). This again further reduced the opportunities for a multi-agency approach in response to the concerns, as agencies continued to work separately with members of the family without key knowledge of each other's involvement. The learning event also identified some disparities within health practitioners' familiarity with the internal procedures of reporting, receiving and reviewing safeguarding referrals. There was a clear recognition of the role of the Health Safeguarding Team but not its interconnectivity with Adult Safeguarding. More recently an advanced level of safeguarding training has been commissioned by the Cardiff and Vale UHB to provide additionality and improved confidence in health care practitioners, on the expectations of individual and agency safeguarding processes.

Regarding the recording of the outcome of the safeguarding report, health practitioners are expected to record these once received to enable all health practitioners' oversight of ongoing safeguarding concerns and mechanisms to review. The review found without this recording it prohibited a continuous review by health practitioners as although concerns were escalated and a report had been made, practitioners were affected by the barrier of presumed mental capacity and a misunderstanding of the outcome. Adult A continued over the course of 2020 to present with self-neglect behaviours and therefore a further safeguarding report would have maximised the likelihood of a strategy meeting being considered. This would have enabled all agencies involved with Adult A and her daughters to share information on the presenting risks.

Additionally, upon District Nurses ceasing their treatment provision to Adult A once the wound had improved, there was a period of 3 months prior to the passing of Adult A, when neither the Learning Disability Team or the care and support providers were

able to contact Adult A or her daughters. Adult A's Daughter 2 was receiving support by Adult Services Learning Disability Team and care providers. The care provider was not providing the usual package of assistance for the duration of the review period due to the impact of the COVID 19 pandemic upon operations. Adult A had informed the Learning Disability Team she was able to care for Daughter 2 and that Adult A's sister was assisting with shopping. The Learning Disability team assessed care and support needs through telephone contact and Adult A reassured Social Services Daughter 2 was fine, and assistance was not required. The Learning Disability Team were not aware of concerns around Adult A's mental capacity, self-neglect or the safeguarding report. The care and support provider escalated concerns on their inability to establish contact with Daughter 2 or Adult A, in the months leading to Adult A's passing. They were the only agencies working with the family at this point, and the review identified the delayed response to the escalation of reduced contact by the care provider as a missed opportunity by the Learning Disability Team to consider safeguarding.

Learning Point: Information Sharing & a whole family approach.

Agencies and Professionals did not have a holistic understanding of this family and who was caring for whom. Adult A defined herself as a carer and it was readily accepted by professionals that both daughters had vulnerabilities. Prior to Adult A's first hospital admission, Daughter 1 and Daughter 2 had cared for Adult A at home during the period she was on the floor, which was known by all agencies. District Nursing Services were aware of Daughter 1's caring role and offered appropriate support, such as a referral to Adults Services and the Community Resource Team (CRT). The Adult Learning Disability Team contacted Adult A's sister as a carer for Daughter 2 in Adult A's absence when in hospital; she was very supportive to the family, but records illustrate Daughter 1 was the main carer for her sister. Daughter 2 had identified care and support needs related to her learning disability and was directly impacted by her mother's return home, and this was not explored with her, the aunt or Daughter 1 to see if any additional support was required prior to the discharge taking place.

The COVID 19 pandemic changed the way all services operated for a significant period as the care and support provider for Adult A's daughter were not visiting the home. The new Self-Neglect Toolkit requires professionals to consider the whole family circumstances and the impacts upon everyone. It seems Daughter 1 had a caring role for both her mother and her sister yet on agency records it was thought she had mental health issues. There were also observations made by professionals during the learning event on the manner of Adult A's engagement with her daughters, which was controlling in nature at times, with her daughters deferring to their mother's instructions. This was witnessed by the Police and WAST upon their intervention to take Adult A to hospital for treatment in 2020 and 2021, with both daughters distraught from not adhering to their mother's wishes. There was no consideration of the suitability of Daughter 1's ability to meet Adult A's and her sister Daughter 2's needs.

Furthermore, the review found systemic challenges of information sharing faced by agencies working with Adult A and her family when the threshold of an adult at risk had not been met. This meant that key information regarding safeguarding, self-

neglect and mental capacity was not shared between agencies. The learning event found that professionals working with Adult A, viewed the statutory requirements of GDPR as affecting the confidence of professionals in their ability to share information relevant to risks unless formal arrangements such as strategy meetings were in place. Other avenues to share information linked to risks should have been sourced by professionals, especially when agencies work across families. Although there was evidence of emerging risks, the ability to share information was exacerbated by the COVID 19 pandemic as agencies working with the family were not provided the same opportunities to connect through the provision of services within the family unit.

A whole family approach would have supported the exploration with the whole family of who was supporting whom following Adult A's hospital admission and this would have been an opportunity to understand what support Daughter 1 may have needed in her caring role and if Daughter 2 needed additional support to maintain their health and wellbeing.

The other element of information sharing is the contrasting digital systems used by practitioners and digital barriers of interconnectivity. All professionals recognised the responsibility to store and record information on their respective agency digital case recording systems. Adult A's safeguarding report outcome was not accessible to the Adult Learning Disability Team as the AS1 for Adult A was not linked to Daughter 2. The outcome of the AS1 should have been recorded on the health digital system (Paris) so all District Nurses working with Adult A were aware of concerns, but this did not take place. The GP, however, does not have access to the (Paris) system and would therefore not have received the outcome. Improved connectivity of digital systems and recording process of safeguarding reports would improve a whole system approach to safeguarding by Adult Social Services and Health services. Consideration of a marker on each agency's digital system to identify the vulnerability of self-neglect or inter-family vulnerabilities should be given to reduce useful information not being shared outside formal procedures.

Learning Point – The COVID 19 pandemic/Vicarious trauma

During the learning event, the lasting impact of the COVID 19 pandemic was very apparent on all agencies and professionals working with Adult A and the family. All agencies' policies and procedures were amended in accordance with the national guidelines and restrictions. This placed added obstacles on professionals who were attempting to maintain sufficient levels of service combined with the practitioner's experiencing trauma from working with complex issues within their professions. All agencies reflected on Adult A's presentation of self-neglect and the effect of working with an individual experiencing self-neglect and resistance. Agencies should consider how structures and supporting mechanisms should be developed to assist practitioners when faced with vicarious trauma. The circumstances of the pandemic restricted the ability to develop an assertive response and working in isolation hindered an understanding of the family's situation.

Learning Point-Person Centred Approach/Professional Curiosity

There is reference throughout the records of all agencies on Adult A's resistance to engage in services. There is positive practice demonstrated by health services throughout, on working with Adult A to consider interventions, obtain consent and accept support services to meet the needs of her health and well-being. It was evident the District Nurses felt restricted within their capacity of attending the home to provide Adult A with wound care and made attempts to escalate concerns of welfare and well-being through escalation to the GP and through the safeguarding report. At the learning event professionals discussed the balance of individual's rights to a private life and practitioners' professional assessment of welfare and risks. Resistance to agency support is a common feature in individuals presenting with self-neglect behaviours, as was the case with Adult A. The implementation of the self-neglect tool kit should assist practitioners with the development of skills sets on the approach to working with resistance. Further considerations on additional training to agencies on working with resistance, and how the behaviour can present as a risk factor would support improved outcomes.

Adult A was the decision maker within the whole family unit and whilst as detailed there was positive practice on working with resistance, there were opportunities for agencies to use professional curiosity to obtain a holistic view of the risks presented by Adult A and the family unit. Whilst Adult A was determined as having mental capacity prior to hospital discharge and her behaviour was seen by some as 'unusual', there were missed opportunities for the use of professional curiosity to explore the risks to both her and her family should she become ill or fall at home again. The learning event identified health practitioners should have explored the 'unusual' behaviours, exploring if there were additional diversity considerations such as neurodiversity. Adult A presented with a strong aversion to noise for example, alongside her reclusiveness. Use of professional curiosity in exploring Adult A's individual needs, could have provided consideration of an alternative approach to her presenting behaviours, risks and engagement.

When Adult A, Daughter 1 or Daughter 2 did not respond to attempts of the GP or the care and support provider to visit the family home, additional steps could have been taken to review potential emerging risks. Adult services working with Daughter 2, missed an opportunity to respond due to a break in communication when call logs utilised in the COVID pandemic were not updated correctly. It would have been beneficial for the GP to have considered a further safeguarding report when they were unable to gain access to the family home.

Effective Practice

The review identified areas of effective practice that should be highlighted and considered. As noted above, the time parameters of the period reviewed was during the pandemic. It was evident from the learning event the constraints placed on professionals from changes to operational guidance and practice in response to the pandemic guidelines. The District Nurses, whilst navigating the challenges and limitations presented, demonstrated positive practice working with Adult A's resistance to engage in care and support. The District Nurses attempted to be persuasive in their approach to the offer of interventions, treatment and support

services available to meet Adult A's presenting needs, upon providing wound treatment. Whilst Adult A struggled to engage with agency support, the District Nurses were able to maintain and provide continuous care to her health, escalating concerns at critical points of deterioration of health and care.

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:-

Learning Point – Self Neglect:

Professionals working with people where there is evidence of self-neglect; would benefit from guidance to improve their confidence when self-neglect is a feature. Improved agency training and clear mechanisms to identifying and approaching self-neglect in a multi-agency way will assist this. There was limited research and guidance available to practitioners and agencies during the review period, on working with people who self-neglect and are resistant to intervention or support. Interlinking self-neglect into safeguarding practice is paramount to improving an individual's well-being and shared agency recognition of concerns. Cardiff and Vale Safeguarding Board due to similar recommendations from other Adult Practice Reviews have developed a Practitioners self-neglect toolkit which was launched in November 2024.

The Reviewers recognise that a substantial amount of work has been undertaken by the Safeguarding Board since the time period of this review, in developing and promoting the self-neglect toolkit, and that work is now required to embed the toolkit in to practice and then monitor and evaluate outcomes.

Recommendation: All Cardiff and Vale Safeguarding Board agencies should provide evidence to the Board of their plans around implementation of the self-neglect toolkit to enhance practitioner awareness of self-neglect and embedding of the tool kit.

Recommendation: The Cardiff and Vale Safeguarding Board should review how the establishment of the self-neglect toolkit and associated self-neglect and hoarding panels has improved the approach to self-neglect in the region.

Learning Point – Mental Capacity

All public sector workers working with those individuals where mental capacity concerns arise when a specific decision is required to be made at a specific time must be fully conversant with the Mental Capacity Act 2005 (MCA). Professionals require clarity around the escalation route internally and where to access support and guidance if concerns around mental capacity are identified.

Recommendation: The Cardiff and Vale UHB should provide training to District Nurses on their responsibilities around MCA assessments to increase confidence and understanding and develop an escalation route for staff to access support and guidance if concerns around mental capacity are identified.

Learning Point - Safeguarding Processes

District Nurses reported to the GP, Adult Services and the UHB Safeguarding concerns around capacity and self-neglect but outcomes of the decision making, and next steps were not recorded. Practitioners require clarity on the internal and joint agency safeguarding processes to enhance the actions undertaken to achieve effective safeguarding. Adult Safeguarding strategy discussions and case review feedback systems require improvement to ensure communication with front line staff.

Recommendation: Cardiff and Vale UHB should ensure that training for District Nurses covers internal and multi-agency safeguarding processes in relation to making safeguarding reports and recording outcomes, to provide clarity on the distinction between the two processes but also how and when they interlink.

Recommendation: Cardiff and Vale UHB should ensure that Safeguarding outcomes are recorded on Health systems so that all Heath professionals (including GPs) are aware of decisions made and action required.

Recommendation: Implement an Adult Safeguarding Threshold Document that supports and enables consistent and informed decision making within adult safeguarding reporting.

Learning Point - Information Sharing

It was identified by all agencies that when working with cases with emerging risk/support factors such as concerns around mental capacity and self-neglect, that information is not always shared, especially on a continual basis. Everyone's information is important to understand when trying to support a particular individual living in a household with several adults where vulnerabilities such as poor mental health, learning disability or substance misuse have been identified. There were missed opportunities for different adult service teams to be aware of potential risks and a whole family approach applied. Leading to information not being sufficiently shared.

Recommendation: Flags/alerts/markers should be used across Board agency systems to identify individuals who are at risk from self-neglect to improve informed inter and intra-agency decision making where there are concerns regarding known or emerging risk factors.

Recommendation: Association markers or links between family members on agency records should be used to support a holistic understanding of how each family member's individual needs can impact upon others within the household/family. This will help to encourage information sharing within and between agencies when subtle risk factors are identified regarding adults/families.

Learning Point – The COVID 19 pandemic and vicarious trauma

There was a clear impact on the professionals dealing directly with Adult A and her family navigating both self-neglect, mental capacity and resistance to the receipt of services throughout the COVID 19 pandemic. It is important to consider the support individual professionals received during this exceptional period and the impact upon them and their daily operational practices. It is acknowledged that there is an impact upon workers when working with individuals who self-neglect, and who ultimately have a role in observing a person's slowly declining health. The individual workers are at risk of experiencing trauma vicariously which is likely to impact on their wellbeing. It is important that this is acknowledged, and staff receive the appropriate support from all agencies to ensure their wellbeing.

Recommendation: The Reviewers are aware that a recently published APR (APR 02/2020) within the region also identified the risk of vicarious trauma to professionals in situations involving self-neglect. It is therefore recommended that in conjunction with the learning arising from this review, the actions arising from APR 02/2020, are progressed as a priority.

Learning Point - Person Centred Approach/Professional Curiosity

Professionals throughout their contact with Adult A were aware of her resistance to receiving services. It is professionally challenging working with individuals who are resistant to working with agencies. Although, the District Nurses continued to demonstrate positive practice, proactively offering services throughout their involvement to all family members and attempting to roll with Adult A's resistance to engage.

Research tells us that a relational approach is vital in working with involuntary clients in social work which includes those who don't respond to any contact, and this is transferrable across to all services when working with self-neglect. Working with those who are resistant takes time and requires openness and transparency and to be clear about concerns. (Social Work, Edinburgh).

Recommendation - When implementing the self-neglect toolkit, the Cardiff and Vale Safeguarding Board should offer training and support to staff about working with resistance. This should include the principles of engaging with those who are resistant to service intervention or a willingness to consent, to promote better understanding by practitioners of the behaviours of those who self-neglect and better outcomes for individuals.

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)* …… **Name** *(Print)* …… **Date** ……		**Reviewer 2** *(Signature)* …… **Name** *(Print)* …… **Date** ……	

Chair of Review Panel (Signature)	……
Name *(Print)*	……
Date	……

Adult 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.*
The following agencies were represented on the Review Panel: Cardiff and Vale University Health Board Cardiff Local Authority Adult Services Cardiff Local Authority Safeguarding Care and Support Provider for Daughter 2 South Wales Police Welsh Ambulance Services University NHS Trust (WAST) A Learning Event took place on 14th March 2024 with professionals from Adult Social Services Learning Disability Team, Adult Services Safeguarding Team, Cardiff and Vale UHB, WAST and Daughter 2's Care and Support Provider. Unfortunately, the Police were unable to attend due to other work commitments. The GPs views have been gathered by convening a separate meeting following the learning event. The Review Chairperson and the Reviewers agreed to approach Adult A's daughters via the Manager of Daughter 2's Care and Support Provider who has a good relationship with the sisters. It was agreed that the Manager of the Care and Support Provider would give Daughter 1 a leaflet about the Adult Practice Review process and explain what that meant and offer to arrange for us to get in touch with her. Daughter 1 has declined this offer on behalf of the family. Daughter 1 was offered the opportunity to read the review prior to publication, again via the Manager of the Care and Support Provider, however she declined the offer and has requested to receive a copy of the report on publication.
☐ X Family declined involvement

For Welsh Government use only

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 1: Terms of reference

Appendix 2: Summary timeline

Appendix 1

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Terms of Reference for a (Concise) Adult Practice Review

Re: APR 01/2021

Introduction

A concise adult practice review will be commissioned by the Cardiff & Vale Safeguarding Board in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. A concise adult practice review will be commissioned where an adult 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.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be ***1st January 2020 – 4th June 2021***

- The following services will produce a timeline of significant events of its involvement with the Adult, for the timeframe above. A merged timeline will then be produced.

  Panel membership:

  - Cardiff & Vale University Health Board
  - South Wales Police
  - Adult Safeguarding Cardiff including Learning Disabilities
  - Welsh Ambulance Services NHS Trust
  - Ategi
  -

Core Tasks (for a concise adult practice review)

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and 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.
- Examine and understand the context in which professionals were working and the effect this had on actions taken and decision making.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review not already requested by the C&V Case Review Group, 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 individual and 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 C&V Case Review Group and the RSB for consideration and agreement.

- Produce a 7-minute briefing on the learning identified from the Adult Practice Review.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Regional Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review panel* completes the report and action plan.

- RSB send 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 C&V Case Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSB website.

- Agree dissemination to agencies, relevant services and professionals.

- The **Cardiff co-chair of the RSB** will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Any Parallel Reviews

- The Coronial process has concluded and found a natural cause of death contributed to by self-neglect.

Appendix 2

Summary Timeline

January 2020	Adult A taken to hospital from home. Daughter 2's Care Provider had raised concerns with the Local Authority about Adult A being on the floor of her home. Daughter 2's Social Worker requested the GP visit. When the GP was unable to gain access, the Social Worker requested a welfare check by police via 101 who had to force entry and request attendance of WAST. PPN submitted by police and Safeguarding Reports submitted by WAST.
February 2020	Adult A remained in hospital with a grade 3 pressure ulcer. She declined suggested interventions with regards to discharge planning. She was transferred to a second hospital for rehabilitation. District Nurses requested a capacity assessment prior to discharge, and this was deemed unnecessary by hospital staff as Adult A was reported to have capacity.
March 2020	MDT meeting held to plan for discharge. Adult A declined a wound review from the Wound Healing Team. She wrote to Daughter 2's care provider advising that in light of the Covid lockdown her daughter would not require support from them. Adult A was medically fit for discharge at the end of the month, mobilising with a Zimmer frame and using the toilet independently but awaiting a hospital bed at home.
April 2020	Discharged from hospital on the 8th of April and visited at home by District Nurses on the 9th of April. Plan for daily visits for wound care to the pressure ulcer. Adult A was reporting that she was in pain and not able to walk. She continued to change her dressings herself against the advice of the District Nurses.
May 2020	District Nurses continue attending the property for wound care. Telephone triage undertaken by GP after concerns raised by District Nurse about Adult A's mental health. Referrals to Community Resource Team, Mental Health Team, Physiotherapy and Occupational Health all declined by Adult A.
June 2020	Concerns raised by District Nurse to GP regarding Adult A's capacity. Referral made to Community Resource Team. Following a visit to Adult A on the 22nd of June District Nurses liaised with UHB Safeguarding Team and on the 24th of June made a safeguarding report to the Local Authority which was later closed due to Adult A being deemed to have capacity.
July 2020	District Nurses visiting three times per week for wound care. Learning Disability Team made attempts to contact Adult A and her sister by phone. These calls went unanswered.

August 2020	District Nurses attending for wound care. Wound reported to be improving. Contact with Adult A by Daughter 2's care provider. Adult A declined support at this time but asked for a call back in a few weeks.
September 2020	District Nurses change to twice weekly for wound care. District Nurse referred Adult A to GP due to pitting oedema to legs. GP offered home visit which was declined. District Nurses documented that Adult A was mobilising less and was stationary most of the time. Contact with Adult A by the Learning Disabilities Team who documented Adult A was unsure about Daughter 2 returning to activities. She declined support from the care provider for Daughter 2 at the end of the month. Adult A was discharged from the Wound Healing Team.
October 2020	District Nurse documented Adult A appeared under the influence and stated she had drunk vodka that morning and that alcohol helped her relax. Contact made with Adult A by Learning Disability Team and she stated the family were fine. GP had a conversation with Adult A over the phone due to swollen and uncomfortable legs. Home visit for examination declined.
November 2020	Wound reported to be infected, antibiotics advised by the District Nurse. Contact made with Adult A by Learning Disability Team. Adult A requested less frequent telephone calls. Support from care provider for Daughter 2 again declined by Adult A.
December 2020	Wound remained infected and it was documented Adult A was in receipt of antibiotics but had not started taking them. Adult A's bed was noted to be cluttered, impacting on her being able to lie down. Adult A requested calls from the Learning Disability Team reduce to monthly. Daughter 2's care provider were unable to make contact with Adult A.
January 2021	District Nurse visits reduced to once a week. Adult A's hospital bed was noted to be cluttered and advice was given.
February 2021	Wound noted to be healed and Adult A was discharged from the District Nursing Service. At the final visit Adult A's bed remained cluttered.
March 2021	GP received letter from Adult A requesting water pills and reporting that her legs were swollen and she was unable to stand. The letter was logged by administration staff. Daughter 2's care provider raise with the Learning Disability Team that they have been unable to contact Adult A. It was identified that no calls had been made to Adult A by the Local Authority Team since December. Adult A was added back on to the list of families to make contact with (in relation to Daughter 2).
April 2021	GP received medication request for Adult A. A medication review was required and a letter was sent to Adult A advising that she needed to speak with the GP.

May 2021	WAST responded to call from Adult A's daughter who reported her mother had fallen from her bed around 2 months ago. Adult A's sister had attended the property and had contacted 999. Adult A was taken to hospital where she passed away.