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

Adult Practice Review Report

Cardiff and Vale Safeguarding Board
Adult Practice Review

Re: *APR 02/2020*

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

An extended adult practice review was commissioned by Cardiff & Vale of Glamorgan Safeguarding Board on the recommendation of the Case Review Sub-Group in accordance with the Guidance for Multi Agency Adult/Child 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, paragraph 7.1:

A Board must commission an extended adult practice review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health.

For the purpose of this report, we have given the adult at risk the name of Glyn. This is not his real name.

Glyn died at home on 4th January 2020 with a Body Mass Index of 10. He was 53 years old.

Glyn was born and brought up in Cardiff, being the middle child of two sisters. He left school with 3 A levels and worked as a carpenter until he first became unwell in 1993 when he was diagnosed with bi-polar affective disorder. His father died when he was in his 20s. He continued to have a supportive relationship with his mother until the months leading up to his death. Glyn retained a social life and an interest in live music and art throughout his life, indeed Glyn travelled to the local art college in summer 2019 using his wheelchair on his own and presented his portfolio of work,

but unfortunately was rejected as the college tutors did not feel he was able to commit to the course.

Glyn had been known to mental health services since 1993 and had a number of hospital admissions, both compulsory and informal. In 2004, he attempted suicide by walking in front of a train while intoxicated with alcohol and drugs, where he sustained significant injuries resulting in his arm being amputated and a permanent limp. His last in-patient stay in hospital for assessment/treatment of his mental health was between March to June 2017. He was last reviewed by his psychiatrist in September 2018.

Glyn was known to use alcohol excessively at times and was a habitual smoker of cigarettes. He lived alone in housing association accommodation. His care and support was coordinated by the Community Mental Health Team (CMHT), who commissioned Care Agency A to visit once per week to support with domestic tasks such as cleaning and shopping.

This extended adult practice review considers in detail the events from 4th January 2019 to his death on 4th January 2020. The panel agreed to consider a full year to take into account a long hospital admission during 2019 and the subsequent months leading up to his death while he lived at home.

A Learning Event took place on 14th July 2022 with professionals from the Community Mental Health Team, Welsh Ambulance Service Trust, Cardiff and Vale UHB, South Wales Police, domiciliary care agency A and Cardiff Council Housing department. Unfortunately, due to resource issues, there was no representation from Adult Safeguarding.

The review chairperson had been in touch with Glyn's family, who expressed a willingness to contribute towards the review, but as they had not had any contact with Glyn since the summer of 2019, the family felt that their engagement would therefore be limited.

A summary of the chronology of events within the review timeframe can be found in the appendix to his 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)

Glyn presented as an assertively independent person who struggled to accept both health care and social care. He was sociable and enjoyed spending time with friends, attending pubs and watching music bands. He lived with a mental disorder

characterised with periods of mania and depression which for many years impacted on his ability to sustain employment and relationships, although he did enjoy working in charity shops and retained an interest in live music and art.

In the year leading up to his death, Glyn's mental state was often described as stable but with a tendency toward low mood; he had become increasingly physically frail with impaired mobility. Although he remained assertively independent, the first floor position of his home made it more difficult for him to access the community meaning he had become reliant on others to assist him. He would increasingly prioritise cigarettes and alcohol with support from neighbours and taxi firms. He had been using a wheelchair to mobilise around his community since before the timescale of this review. His acceptance of personal care and domestic support was minimal and variable, which alongside regular incontinence meant that he was not able to maintain a reasonable standard of personal or environmental hygiene. This behaviour also impacted on the ability of care workers to maintain their involvement, leading to only a few care workers willing to support him. His health appeared to deteriorate during the period of this review; he had a long stay in hospital (January 2019 to June 2019) and latterly a number of short attendances at Accident & Emergency. While an inpatient in hospital, he accepted that this flat was not suitable given his deteriorating mobility and expressed an interest in moving into alternative accommodation or even a care home, but his care team were not able to find a suitable placement. He appeared to lose confidence in the discharge plans, began to disengage with the hospital treatment and ultimately took his own discharge back to his flat. He never again engaged with health professionals during subsequent attendances at A&E and refused further treatment or tests despite his increasing frailty and more frequent episodes of vomiting blood. Throughout this time, Glyn appeared to maintain the mental capacity to make his own decisions about his health and social care.

Glyn was intelligent, assertive and in control of what he was willing to accept from health and social care professionals. He engaged with his care team during his hospital admission from January 2019 to June 2019, and remained in hospital, accepting medical tests and treatments and made positive requests for alternative accommodation options – both to his landlord and his care team. This appeared to be the window of opportunity to make a positive intervention in Glyn's life. Unfortunately, due to delays in his housing application, his request for high demand location and a lack of suitable care home options, Glyn's request for alternative accommodation came to nothing. The panel observed a deterioration in Glyn's level of engagement from this point onwards. Glyn then took control of his own destiny and discharged himself home to his flat that he knew was not suitable for his needs. Glyn did not meaningfully reengage with services again.

Following the six-month hospital stay, Glyn returned home with the support of the Community Mental Health Team who organised for a domiciliary care agency to visit a number of times each day. As stated earlier, Glyn was frequently resistant to personal care, meal support and domestic support, which alongside some personal behaviours such as discarding soiled incontinence pads on the floor, being incontinent in his bed and different areas of his flat made for an unpleasant and unsafe environment to both work and live in. Additionally, Glyn was not prioritising

his nutritional needs and was becoming more and more frail as he lost weight, and increasingly prioritised cigarettes and alcohol.

Glyn's social worker and community psychiatric nurse made regular home visits to Glyn, observing his deteriorating health and the deteriorating conditions of his living conditions. A deep clean of his flat was undertaken at the end of October 2019, but soon became soiled again. It was evident from the Learning Event that despite Glyn's resistance to care and his propensity to verbally abuse health and social care staff, Glyn was well liked by his care workers. He was intelligent and humorous, and retained his interests in music and art. During the months following his hospital stay, he developed a portfolio of art work, which he took to the local art college by propelling himself in his wheelchair hoping to enrol on an art course. His application was unfortunately rejected.

The home care workers and other professional visitors to Glyn's home, expressed their concerns regarding Glyn's welfare and home environment to his care team and made several Adult Safeguarding Referrals. In the months leading up to his death the home care agency reported their concerns that Glyn was not engaging with his care plan, he was becoming progressively frail and his home was becoming increasingly insanitary to both the mental health team and through Adult Safeguarding referrals. During December 2019, Glyn attended hospital on 3 occasions, with the last admission being for 10 days, leading to referral and liaison between the medical team, his mental health team and Adult Safeguarding. Following his discharge on 31st December 2019 and his death on 4th January 2020, Glyn was visited at home by home care workers, District Nurses and Out of Hours GP with further referrals to Adult Safeguarding and liaison with the community mental health team.

The impact of his self-neglect on his wellbeing was observed, understood and reported by multiple health and social care professionals. Glyn was consistently assessed by a number of different professionals to retain the mental capacity to make his own decisions about the way he lived his life, which was to decline personal care and domestic support, to decline nutritious food and to prioritise cigarettes and alcohol.

At the time of this review, there were no provisions within Adult safeguarding procedures to support and guide professionals to intervene when people are experiencing severe self-neglect.

Learning Points:

<u>Housing:</u>
It was well understood by all parties involved in Glyn's care that his first floor flat was not suitable for his needs. Although already reduced, his mobility had severely declined in the year leading up to his death. Although functionally able to walk, Glyn had become weak and unbalanced; he mobilised around his flat by holding on to walls and furniture. He had organised for himself a wheelchair in his flat and another at the bottom of the external stairs. He traversed by sitting on each step.

Glyn made very few positive requests for support from health and social care professionals, but he was clear that he needed alternative accommodation. The World Health Organisation has identified poor housing as having a major impact on people's health and identified the accessibility of housing for people with functional impairments as a main contributor to poor health. The professionals involved in Glyn's care acknowledged that his accommodation was inadequate and indeed supported him to make an application for alternative housing through the Cardiff Housing application process and approached a number of local care homes. Glyn himself had spoken positively about a care home, stating that it would be nice to live in a place with other people to socialise with.
Unfortunately, the team was not able to secure alternative housing for two main reasons:

- Glyn's application for accessible housing, through the Cardiff Housing application process was very unlikely to be successful due to the narrow geographical criteria he requested in his application, meaning that he could be waiting years for a suitable flat to become available in his chosen location.
- There is a scarcity of registered care homes that are set up to meet the needs of younger people with physical impairments and mental health problems, meaning that the care team was not able to find a suitable placement.

It cannot be known if a move to a more accessible home or to a care home environment would have contributed to an improvement in Glyn's health, but there is little doubt that the poor conditions of his flat did contribute to his deteriorating health and potentially to his lack of engagement with services.
Learning Point: That the importance of suitable housing is highlighted and fully understood by health and social care professionals when undertaking assessments.

<u>Personal Outcomes:</u>
It became apparent during the Learning Event that the professionals closely involved in Glyn's care and support were able to provide a rich and detailed description of his personality and his personal ambitions that were not so clear in the records provided to this review. In fact, it is fair to say that the chronology prepared for this review frequently described Glyn as non-compliant, aggressive, self-neglecting, incontinent, excessively using alcohol and living with mental health problems, whereas the professionals at the learning event described Glyn as a funny, intelligent, and determined person with a wide range of friends and interests such as music and art. While there is no doubt that Glyn presented a challenge to professionals, it is possible that the focus on his challenges contributed to a care plan that he could not engage with, whereas a care plan focussed on developing his interests in music and art may have offered greater opportunity for engagement and change.
It is also possible that the rejection he received from the college had a long-term impact on Glyn's confidence and sense of self-worth which in turn may have contributed to his self-neglecting behaviours.
Learning Point: The research and guidance supporting professionals when working with people who self-neglect highlights the importance of developing trusting relationships that accept the persons behaviours while at the same time working toward positive change.

DOLS/Capacity:
Glyn was observed to have maintained the mental capacity to make his own decisions about his care and support. There were times, when professionals questioned the wisdom of his decisions and therefore his mental capacity to make the decisions, leading to authorising his deprivation of liberty in hospital in his best interests. The review found an inconsistency in the understanding of application and effect of the Deprivation of Liberty Safeguards across public services.
Learning Point: All public sector workers that may be involved in the restriction or deprivation of liberty of mentally incapacitated persons MUST be fully conversant with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards to a degree relevant to their role.

Mental Health Act 1983:
Glyn had lived with a mood disorder for many years, which was characterised by periods of manic presentations and periods of low mood and suicidal behaviours, and latterly with a more stable but low mood. He was supported by mental health services for many years and had a number of hospital admissions both compulsory and voluntary. His self-neglect and disengagement from services during the period of this review was not considered to be as a result of a mental disorder that warranted admission into hospital for assessment of treatment, meaning that mental health services were unable to compel Glyn to adhere to a care and treatment plan. Glyn had a history of bi-polar affective disorder, characterised with periods of elated mood, mania and delusions, but in the 12 month's prior to his death, his mental health was assessed as stable or low in mood, and while we will never know if his low mood contributed to his self-neglect it did not warrant compulsory admission into hospital.
Point of Note: The compulsory powers of the Mental Health Act 1983 are limited to those suffering with a mental disorder that warrants compulsory admission into hospital, Glyn's mental health did not warrant compulsory powers during the period of this review.

Advocacy:
Glyn was consistently assessed as having capacity to make his own decisions and represent his views – but the right to advocacy is different. Advocacy must be offered where a person is not able to get over the barriers to fully participate in their assessment/care planning without the help of an appropriate person. There is little doubt that Glyn had the ability to participate in his care planning, indeed his care team stated that 'he had a clear concept of his care needs' but there was something preventing him from participating in a healthy and positive manner.
Glyn's loss of confidence in health, housing and social care services was a significant barrier to his full participation in his care planning, but this was not identified at the time. It is possible that an Independent Professional Advocate may have assisted Glyn in keeping his wish for alternative accommodation more assertively on the care planning agenda.
Leaning Point: The role of Independent Professional Advocacy should be properly understood and considered by all health and social care professionals.

Balancing right to privacy to right to life

Working with an adult who self neglects is one of the most challenging areas of care and support, in that professionals are faced with a delicate task of balancing a person's Article 8 right to a private and family life and the professional's duty of care and the person's Article 2 right to life. Health and Social Care professionals understand that Article 8 does not provide an absolute right to a private and family life as there may be justification to override it, for example, protection of health, prevention of crime, protection of the rights and freedoms of others.

A common theme from the research and guidance when supporting people who self-neglect is the need to develop a trusting relationship. However, Glyn found it hard to trust and accept support from professionals, particularly since his request for alternative accommodation was not met. His relationship with his social worker and the home care workers was ambivalent – he would accept only the minimal amount of care and assertively, sometimes abusively took control of the care he was willing to accept. All parties would agree that this left Glyn without the personal care required to maintain his personal hygiene, cleanliness of his home or provide adequate nutrition which ultimately impacted on his health. The provisions of the Mental Health Act 1983 or the Mental Capacity Act 2005 did not apply in Glyn's case, leaving professionals with a duty of care, not a duty of protection, with little ability to assert a more positive intervention. His care team remained involved throughout, offering as much support as Glyn was willing to accept.

Learning Point: Professionals working with people who self-neglect, and who ultimately have a role in observing a person's slowly declining health are at risk of experiencing trauma vicariously which is likely to impact on the professional's wellbeing. It is important that this is acknowledged and staff receive the appropriate support.

Role of family and friends

Glyn was known to be sociable and retained a number of relationships with neighbours and friends. Glyn's mother appeared to play a positive role in his life visiting weekly, providing food and encouraging him to clean his flat and look after his health. Unfortunately, due to her own deteriorating health and Glyn's resistance to her interventions, his mother's support reduced during the period of this review. It is highly likely that Glyn's mother's support had a stabilising and positive effect on his wellbeing which he could not replicate himself.

Point of Note: The contribution of significant people in the lives of adults who self-neglect often goes unseen but can be a significant source of safety. The loss of a significant person may exacerbate the risk of an escalation on self-neglectful behaviours and should therefore be acknowledged as part of a care planning process.

Response to his declining health in the days leading up to his death

It was clear in the last 12 months of Glyn's life that his health was rapidly deteriorating. Medical tests were not able to find any reason for his deteriorating health, but his self-neglect, poor nutrition and excessive alcohol and cigarette use is likely to have exacerbated his deteriorating health. Toward the end of his life, he had lost significant amounts of weight as a result of poor diet, which may have impacted on his mental state and mental capacity. Acknowledging this, his social

worker requested further mental capacity assessments during his last attendance at A&E, where he was again found to retain capacity despite his increasing frailty. Several Adult Safeguarding referrals were made in the last weeks of Glyn's life detailing severe self-neglect, describing his emaciated physical state, causing a grave concern for his life.

The Adult Safeguarding referrals were discussed internally and it was decided that because his ongoing self-neglect and his mental capacity to make his own decisions was understood by professionals, that the concerns raised in the safeguarding referrals were best met by the Community Mental Health Team. The opportunity to undertake a Strategy Meeting, where the perspectives of all involved professionals could have been shared was not taken. This was a missed opportunity.

Learning Point: Adult Safeguarding Referrals regarding an individual should not be seen as individual and unconnected events. In cases where multiple professionals are making separate but connected referrals a strategy meeting to share the perspectives of all concerned professionals should be undertaken.

Domiciliary care

The role of the domiciliary care workers who visited Glyn at his home multiple times every day needs to be acknowledged. Glyn's resistance to care interventions provided a significant challenge to his home care workers. He was often abusive toward his care workers, he was doubly incontinent and was not careful where he left used incontinence pads, or where he was incontinent. In addition to this he was frequently sick or coughing up blood, which again was to be found throughout his home. This provided an unhealthy place to live and to work, particularly as Glyn would refuse to allow the care staff to clean up. His flat was described as squalid and unsanitary. Despite these conditions, the domiciliary care staff continued to provide as much care and support to Glyn as he would allow, which needs to be acknowledged as going beyond what should be reasonably be expected from home care staff. The care agency was in regular contact with his social worker, made appropriate Adult Safeguarding referrals and called in emergency services on a number of occasions expressing their concerns about Glyn's deteriorating health.

Learning Point: The domiciliary care staff made frequent reports to the Community Mental Health Team and Adult Safeguarding, but did not receive sufficient feedback and were not included in decision making processes. It is imperative that the views of domiciliary care staff are considered at case management reviews and Adult Safeguarding strategy discussions.

Points of good practice:

Point of Note: It is important to note that Glyn's care team from the Community Mental Health Team remained actively involved in the coordination of his care; liaising with the domiciliary care agency and health professionals to ensure that opportunities to positively intervene in Glyn's deteriorating health were explored.

Point of Note: It is important to note that the domiciliary care staff, who are the lowest paid, were required to find the highest level of patience, care and resilience of all those involved with Glyn as they visited most frequently and were required to work in a very challenging environment while sometimes receiving abusive remarks from Glyn or indeed his neighbours.

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: The importance of suitable housing is highlighted and fully understood by health and social care professionals when undertaking assessments. Good quality, suitable housing is a fundamental need. The lack of suitable housing for Glyn was a significant contributor to his self-neglect. The Cardiff and Vale Safeguarding Board should acknowledge the importance of suitable housing for adults with care and support needs and be satisfied that there are processes in place to ensure there are sufficient accommodation options for adults with care and support needs and the process to access such properties is accessible and avoids unnecessary delay.

Recommendations:

- Acknowledging the importance of good quality housing and the provision of housing related support in support of people's wellbeing, it is recommended that housing professionals are involved in care planning discussions where an inappropriate or poor-quality housing is causing a detriment to the wellbeing of a person or persons with care and support needs.

Learning Point: The limited research on working with people who self-neglect highlights the importance of developing trusting relationships that accept people's behaviours while at the same time working toward positive change.

Recommendations:

- The Cardiff and Vale Safeguarding Board should consider establishing a Multi-Agency Framework to respond to cases of self neglect which will provide professionals with support, guidance and a wider perspective when working with people who chronically and dangerously self-neglect.

Learning Point: All public sector workers that may be involved in the restriction or deprivation of liberty of mentally incapacitated persons MUST be fully conversant with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Recommendations:

- The Mental Capacity Act 2005 provides fundamental guidance to all public sector workers (including those commissioned to provide a public sector service, such as care home and domiciliary care staff) whenever they are working with a person who may lack the mental capacity to make their own decisions. The Cardiff and Vale Safeguarding Board should ensure that all partners are fully conversant in the elements of the MCA and DoLS relevant to their role through a comprehensive training programme and monitoring of the application of the MCA throughout the organisations practice.

Leaning Point: The role of Independent Professional Advocacy should be properly understood and promoted by all health and social care professionals.

Recommendations:

- The Cardiff and Vale Safeguarding Board should ensure that Independent Professional Advocacy is available to all adult citizens accessing social care services. A positive offer should be made to all citizens accessing social care services where there is doubt that the person is able to fully participate and that they do not have an appropriate person to act on their behalf. A positive offer should consist of explaining the independence and remit of the advocate, acknowledging the specialist knowledge, skills and experience that the Advocate could bring.

Learning Point: Professionals working with people who self-neglect, and who ultimately have a role in observing a person's slowly declining health are at risk of experiencing trauma vicariously which is likely to impact on the professional's wellbeing. It is important that this is acknowledged, and staff receive the appropriate support.

Recommendations:

- The Cardiff and Vale Safeguarding Board should acknowledge the risk of vicarious trauma on partner organisations and the potential impact that this may have on the wellbeing of the staff. Supervision and support mechanisms need to be available to all staff.

Learning Point: Adult Safeguarding Referrals regarding an individual should not be seen an individual and unconnected events. In cases where multiple professionals are making separate but connected referrals a strategy meeting to share the perspectives of all concerned professionals should be undertaken.

Recommendations:

- The Cardiff and Vale Safeguarding Board should insert a requirement that wherever multiple Adult Safeguarding referrals are made regarding an individual or a community that a Safeguarding Strategy Meeting is convened in all cases.

Learning Point: The domiciliary care staff and health partners made frequent reports to the Community Mental Health Team and Adult Safeguarding but did not receive sufficient feedback and were not included in decision making processes. It is imperative that the views of domiciliary care staff are considered at case management reviews and Adult Safeguarding strategy discussions.

Recommendations:

- The Cardiff and Vale Safeguarding Board should recognise the important and valuable role that domiciliary care staff play in keeping people safe and in reporting concerns to other professionals. Whenever care workers are involved in a person's care, they should be seen as a core member of any Adult Safeguarding process and as such be involved in discussions and receive appropriate feedback.
- The Cardiff and Vale Safeguarding Board should promote the use of the Protocol for the Resolution of Professional Differences and remind partners of their responsibilities to follow up and seek feedback following any safeguarding referrals.

Statement by Reviewer(s)			
REVIEWER		**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,		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	

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	experience and training to undertake the review ● The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference

Reviewer 1 *(Signature)*	…….	**Reviewer 2** *(Signature)*	……
Name *(Print)*	Andy Cole	**Name** *(Print)*	Sarah Skuse
Date	…….	**Date**	……

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

Appendix 1: Terms of reference
Appendix 2: Summary timeline

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 feeGlynack had been provided to them.*
☐ Family declined involvement

Glossary of Terms

- **APR** – Adult Practice Review
- **A&E** – Accident and Emergency
- **CMHT** – Community Mental Health Team
- **CPN** – Community Psychiatric Nurse
- **CPR** – Child Practice Review
- **CVSB** – Cardiff and Vale Safeguarding Board
- **CVUHB** – Cardiff and Vale University Health Board
- **DoLS** – Deprivation of Liberty Safeguards
- **DN** – District Nurses
- **EDT –** Emergency Duty Team
- **GP –** General Practitioner
- **IPA –** Independent Professional Advocacy
- **OT** – Occupational Therapy
- **MCA** – Mental Capacity Act
- **SS&WBA** – **S**ocial **S**ervices **& W**ell**b**eing (Wales) **A**ct 2014
- **SW** – Social Worker

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

Terms of Reference for an (Extended) Adult Practice Review

Re: APR02/2020

Introduction

An extended adult practice review will be commissioned by the Regional Safeguarding Adults Board (RSAB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. An extended adult practice review will be commissioned where an adult at risk has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be ***4th January 2019 – 4th January 2020***

- 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
- Cardiff Adult Mental Health Services
- Cardiff Adult Safeguarding
- Welsh Ambulance Services NHS Trust
- Rumney Care & Ambulance Service (domicilliary care agency)
- Wales & West Housing Group
- Everycare Ltd (Home Care & Nursing Services)

Core Tasks (for a concise/extended adult practice review *(delete as appropriate)*

- 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.

For Extended review ONLY. In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.

- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.

- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.

- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.

- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

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 Sub 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 Sub 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.