Adult Practice Review Report

***North Wales* Safeguarding Adults Board**

Extended Adult Practice Review

Re: APR 3/2015/Conwy

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 the North Wales Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Adult Practice Reviews.

- **Brief outline of circumstances leading to the Review**

  The gentleman at the centre of this review will subsequently be referred to as Adult A. He died in spring 2015. Following a post mortem cause of death was determined as: 1A – Hypothermia, 1B – Diabetes, Peripheral Vascular Disease and Neglect.

  Adult A was well known to the Local Authority, Health and Police. When he engaged with support from the multi-disciplinary team, intervention was intensive. However, engagement decreased when intensive support was reduced. There was very little contact from above organisations and the deceased in the three months preceding his death.

  The initial referral to the Adult Practice Review (APR) group made reference to the following areas which may need further exploration.

  - History of self -neglect

- Hoarding and cluttering
- Lengthy hospital stays
- Mental capacity
- Insight into own needs

➢ **Terms of Reference**

The APR panel consisted of representatives from the Police, Local Authorities and Health Board. The Terms of Reference for this APR were considered by the panel and agreed as follows;

- ➢ Was an appropriate mechanism put in place to escalate efforts to contact Adult A in the three months preceding his death.
- ➢ Did Adult A have capacity into his own care needs and was this fully considered?
- ➢ Adult A had a diagnosis of depression and personality disorder, did this require further consideration?
- ➢ How transfer of the case was managed within Social Services and between organisations?
- ➢ Was appropriate consideration given as to the experience of practitioners responsible for overseeing the case?

The timeframe agreed by the Panel was two years historically prior to the date of death.

➢ **Summary of Individuals circumstances.**

Adult A was a gentleman in his 40's. He had been married for 22 years, and lived with his wife at her parents' home until they moved to their marital home. He was employed as a shift worker until he was made redundant in 2007. Adult A and his wife worked alternate shift patterns for many years. Professionals involved in his case note that redundancy had a significant impact upon his self -esteem and perceived role within the marital relationship. Adult A was well known within his community.

Information gathered during the review indicated that the marital home was significantly cluttered with clear signs of hoarding behaviour. Reports indicate that kitchen and toilet facilities were at times, not fit for purpose, possibly due to the results of hoarding. It is not believed that the hoarding behaviour was directly associated with Adult A.

The circumstances and professional involvement during the two years was broken down into four periods of events. This was utilised at the Learning Event and feedback indicated that this was helpful for all involved.

To provide a starting point, the Police, Local Authority and Health Board were asked to provide the Reviewers with a 'timeline' of the professional involvement and interventions in this case. The information described in the four periods below has been compiled based upon this information and related additional information requested and ascertained by the Reviewers during the review process

Findings by Reviewers in response to the Terms of Reference

- Whilst there is clear evidence of agencies working together to support Adult A and a Protection plan in place, there does not appear to be a mechanism to review this plan should Adult A stop engaging.
- There is evidence that a capacity assessment was undertaken and notes from Psychiatric Liaison indicate that Adult A had capacity to make decisions in relation to his lifestyle choices.
- Depression is symptomatic of the diagnosis of Diogenes Syndrome. Adult A was prescribed medication to manage the effects of depression during the last two years of his life. There was little evidence to support any diagnosis of personality disorder.
- There is clear evidence that the hospital social worker continued to work with Adult A for a prolonged period after discharge. Additionally, there was multi-agency flurry of activity during Adult A's two hospital admissions and immediately following discharge. It is apparent from this review that Adult A was disengaging with services prior to the Community Social Worker's interventions which would suggest that it would be highly unlikely that a positive relationship could have been achieved at this time. The timing and context of the social work intervention was more significant than the experience of practitioners involved.

. **General Observations:**

- Adult A's overall improvement in hospital in relation to both physical and possibly emotional wellbeing. Appears to flourish in this environment
- Evidence of all agencies involvement with Adult A's case however, his engagement diminishes after time.
- There appears to be limited co-ordination of communication within and across all organisations leading to a lack of overview of the situation.
- Limited evidence of the protection plan driving practice and triggering regular reviews.
- Repeat prescription picked up without fail on a monthly basis between March 2014 and February 2015

- **Process of Review**

- Timelines prepared by stakeholders.
- Further information requested by reviewers after going through the timeline:
- Learning event held.
- Follow up questions following review
- Meeting with Psychiatric Liaison team worker
- Meeting with Adult A's wife.

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

Key themes and learning arising from the Review

Key theme 1: Communication, management of risk and joint work by agencies

What is fundamental in situations such as that of Adult A which had elements of self-neglect and disengagement is effective information sharing and joint working between agencies.

Good communication involves sharing of information between relevant appropriate individuals. That information should be shared in the context of decision making regarding any future multi agency discussions / interventions. In this instance, the persons' individual management of risk and the consequent risk to their wellbeing should have been central to any organisational risk management within this case.

Findings:

1. Within the hospital setting and whilst Adult A was an in-patient there appears to be a great deal of activity and communication from various agencies and a fair understanding by all of what was happening. Involvement of agencies at the POVA Strategy Meetings also seem to evidence this.
2. Within the Learning Event it was noted that a lot of "soft-intelligence" was shared verbally between agencies. People in their own time saw Adult A and shared concerns. It was evident that his wellbeing "was being kept an eye on" by the Police.
3. There is no evidence to suggest that Adult A's situation was being managed through co-ordinated interventions and no one agency or individual held an overview of the whole situation.
4. During the period of review, there appears to have been lost opportunities by all stakeholders to escalate Adults A's case to a further multi-disciplinary meeting in accordance with the protection plan included within the adult protection risk assessment form agreed in February 2014.
5. Opportunities missed in both June and July by the District Nursing Service and the Police Authority to escalate the case for multidisciplinary discussion. There appears to be clear evidence of disengagement and decline during these periods.
6. Opportunities missed in December onwards when Adult A failed to engage with the Social Worker.

Key theme 2: Adult Protection

The Wales Interim Policy for the Protection of Vulnerable Adults from Abuse (second version January 2013) did not recognise that self-neglect as an area to be dealt with under Adult protection procedures. In this case, the structure offered provided a useful framework.

Findings:

1. Protection of Vulnerable Adults procedure was utilised and provided a valuable framework for multi-agency working, with several strategy meetings being held and an Adult Protection Risk Assessment which also served as a Protection Plan developed.
2. However, all of this activity took place when Adult A was in hospital. There is little evidence to suggest that the Protection Plan informed practice of any agency when he returned to his own home.
3. There is no evidence that the Protection Plan was reviewed or any arrangements made to call a multi-agency meeting (please see point above in relation to missed opportunities by all agencies) when it was clear that Adult A's situation was deteriorating and he had disengaged.
4. During this 2 year period, Adult A's repeat prescriptions were collected from the surgery like clockwork on a monthly basis by his wife
5. The Adult Protection Plan agreed by all agencies, was not sufficiently robust to identify trigger points at which organisations should have met within an multidisciplinary team context. Similarly, there is no detail of individual organisations responsibilities. A detailed protection plan may have indicated the following trigger points in this case.
6. No planned review date for the protection plan or triggers to reconvene which could have included:-

    - Number of missed appointments.
    - Failure to engage with practitioners
    - Evidence of more time being spent in the car, including sleeping.

Key theme 3: Capacity

Opportunities were taken to assess Adult A's capacity to make decisions about his lifestyle on a number of occasions during which he was deemed to have capacity. These assessments were completed whilst he was in a hospital setting and whilst he was in good health and well cared for.

Findings

1. During these lengthy hospital stays, Adult A was seen and had his mental health reviewed on a regular basis by the Psychiatric Liaison service. There did not appear to be any evidence of discernible mental illness. His capacity to make decisions relating to his accommodation and support needs was also considered during these reviews, and he was deemed to have capacity

2. There was no evidence of consideration or completion of a formal capacity assessment at home, particularly when there was evidence of a decline in his living conditions. It is the view of the reviewers that had a multi-disciplinary team discussion taken place, when Adult A showed signs of decline, an assessment of capacity would have been triggered. With hindsight, it is impossible to know what the outcome of that assessment would have been and any subsequent actions to support Adult A.

Key theme 4: Family, Self-Neglect Other Issues.

During Adult A's hospital admissions, there appeared to be some involvement of extended family members including his wife. Anecdotally, it appears that during periods in which Adult A self-neglected, there was limited extended familial contact. As contact with family was difficult to make during the period of this review, it was not possible to explore this further.

The focus of the work appears to have been entirely on Adult A's needs and situation, although there is evidence to suggest that his wife displayed hoarding behaviours which we can reasonably assume contributed to the overall situation. Evidence suggests that Adult A's circumstances were considered in isolation of his family and relationships.

During the course of this case, it is evident that Adult A, during the latter part of his life self-neglected on a cyclical basis. There is no evidence to suggest that consideration was given to the reasons for Adult A's self-neglect and agencies tended only to deal with the effects of this self-neglect.

Findings:

1. At various times during the course of the 2 year focus of this review, Adult A was in need of health and social care services. His home was extremely cluttered, in poor condition and unhygienic. He also appeared to be living in his car for periods of time, and the condition inside the car also became unhygienic.

2. Throughout this 2 year period there is very little evidence of any consideration or any work being carried out with Adult A's wife or wider family.

3. There is no evidence of any psychological interventions being explored or offered.

Improving Systems and Practice

In order to promote learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:-

Recommendations

1. In circumstances such as Adult A, where self-neglect is recognised, the Adult protection plan should be clear and specific indicating trigger points at which a multi-disciplinary meeting will be called to discuss the individual and interventions to support them.

2. A lead officer / designated officer should be agreed in all cases were self-neglect is prevalent. The lead officer should be the person who knows the individual best from any agency.

3. In cases of self-neglect, all members of the multidisciplinary team should be aware of their individual responsibilities to report contact / lack of contact, with adult to the lead officer / designated officer.

4. In circumstances were multidisciplinary team meetings / discussions are called to discuss self-neglect, a review of capacity should always be considered.

5. In cases were self-neglect and hoarding are indicated, the wider family context should be considered. The focus of any intervention should take this into account.

Conclusion

There is no doubt that supporting individuals where there are elements of self- neglect can he highly challenging for the individuals, families and agencies concerned, as was the case here.

The review highlighted some areas of effective practice, namely the development and maintenance of a positive working relationship with the initial Social Worker; both Hospital Social Worker and Psychiatric Liaison Nurse carried on working with Adult A for a lengthier period of time than their roles usually permitted; the Police Community Support Officer had good knowledge and understanding of Adults A's circumstances and kept an eye out for him; there was a wealth of local knowledge about Adult A and his circumstances shared within agencies.

The POVA process was utilised to provide a framework for multiagency intervention, which at times enabled Adult A to engage and benefit from the support provided. There are however, significant areas of learning which are noted under specific themes and our recommendations.

The reviewers found examples of good practice throughout this case however, there is a clear indication that multi-agency arrangements were insufficiently robust and these are evidenced through the recommendations identified above. Implementation of these findings

will be essential to improve multi-agency risk management in cases such as Adult A's where self-neglect, disengagement and a complex family position is indicated.

Statement by Reviewer(s)			
REVIEWER 1	Alaw Pierce	**REVIEWER 2** ***(as appropriate)***	Olwena Davey
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, nor have I 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, nor have I 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	Reviewer 2
(Signature) 	*(Signature)* 
Name *(Print)* **Alaw Pierce**	**Name** *(Print)* **Olwena Davey**
Date *June 2017*	**Date** June 2017

Chair of Review Panel	
(Signature)	
Name *(Print)*	Alwyn Jones
Date	June 2017 Amended April 2018

Appendix 1: Terms of reference **Appendix 2:** Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the Board 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.*

1. Following agreement that the referral was to proceed, representation was sought and staff identified from the Local Authority, Health Board and Police to form a scrutiny panel. Representatives were also the organisational links to ascertain any additional information required from their respective agency.

   The panel met on a regular basis to up-date the progress of the review and were instrumental in ensuring that their respective agency was appropriately represented. Panel members had an opportunity to review the final draft of the report prior to presentation to the full Adult Practice Review group.

2. The learning event was held and feedback from the participants was predominantly positive. Attendees included relevant staff from the Local Authority, District Nursing, Police and Health. It was unfortunate that there was a gap in representation from one area of Health which could have provided the event with a truly holistic overview.

3. Contact with immediate and extended family members proved difficult to achieve despite the efforts of the reviewers and all agencies involved. Contact with A's wife was finally achieved in the presence of her social worker. This proved to be an understandably emotional experience for A's wife who was particularly complementary of the hospital social worker who had supported A. Prior to this report being published, the reviewers will endeavour to meet with A's wife to share its findings and recommendations.

☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	**Yes**	**No**	**Reason**
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Appendix A- Summary Timeline of Significant Events

Period 1: Early 2013 to late spring Hospital admission.

- ‘’Admitted due to self- neglect and infected bilateral leg ulcers’’ – taken from discharge summary.
- During this hospital admission, there was a flurry of activity which included: multi-disciplinary case conference with Adult A and his family, psychiatric liaison team involvement, referral to environmental health and mental capacity assessment.
- Whilst in hospital house was cleaned via Environmental Health services and Pest Control involvement.
- Adult A was discharged home and according to hospital discharge note to GP ‘’ he responded well to treatment”.

Period 2: Late spring to end of summer. – At home

- Successive days in May, District Nurse try to contact Adult A without success
- June 2013 he was seen on a regular basis at the surgery for change of dressing to his legs. He was also seen in Podiatry clinic
- July 2013 – seen in podiatry clinic, but did not turn up for subsequent clinic appointments during the month.
- August 2013 – Police intelligence reported that Adult A is reported sitting in his car for prolonged periods of time. Additionally, a concerned neighbour approaches Police Community Support Officer
- September 2013: a call was received by North Wales Police raising concern about Adult A’s’ welfare as he is reported to be seated in his car and there was an ‘’overwhelming smell of faeces’’ .Adult A was found slumped in his car which was full of urine and faces. Upon removal from the car, maggots were found in the driver’s seat. Adult A’s wife advises the Police that he had been living in the car for 3 weeks. He is taken by Ambulance to hospital. Upon admission, Protection of Vulnerable Adult (POVA) referral made by hospital due to grade 3/4 pressure sore.

Period 3: Autumn to late winter -Hospital admission

- POVA Strategy meeting convened following admission. Minutes from the meeting noted ‘Extensive *ulcers to feet, planter aspect with maggots, extensive ulcers to the back of both thighs expanding to sacrum’.*

- Further 4 strategy meetings held under POVA. Protection plan agreed
- Regular professional contact with Adult A and various family members
- Regular reviews by Psychiatric Liaison team; notes identified ‘’no evidence of mental illness’’, and deemed to have capacity in relation to his care and treatment needs throughout.
- Discharged home late winter with community intervention.

Period 4: Late winter 2014 to spring 2015 – At Home.

- March 2014: numerous regular visits / contacts by District Nurses and Social Worker. Only one incident of Adult A not being at home when District Nurse called.
- April 2014: slightly less contact (5 contacts as opposed to 10 previous month). One incident when Adult A was not at home.
- Police intelligence: Adult A reported to be parked in his car for lengthy periods of time.
- May 2014: 5 recorded contacts during this month – combination of District Nurses, GP, Clinic appointment. 2 incidents when Adult A didn't keep appointment. However, late May Adult A contacts the Social Worker which results in a home visit being arranged and carried out.
- June 2014: Evidence of an increased number of 'abortive' calls. District Nurse visiting once a week, but he was often out. Adult A seen by District Nurse for the first time in many weeks. Late June District Nursing notes indicate that he is sleeping in his car.
- July 2014: Early July District Nurse visits but no answer at home. Early July Police receive a call – concern for Adult A's safety; District Nurse reports that he has resumed living in his car. During this month Adult A contacts the Social Worker and this results in 2 home visits.

August 2014:
Seen in Out Patient Department by Consultant
Several telephone conversations between Adult A and Social Worker

September 2014:
Early September, telephone contact between Adult A and Social Worker
Early September seen by GP for medication review: notes stated ''much improved'', ''things coming together''
Week later, arrangements made by Social Worker for Adult A to attend a Heavy Workshop day activity. However, does not attend as planned and the placement is terminated.

October 2014:
Early October, seen by District Nurses for re-dressing of legs
Social Worker considers closing case
Police Community Support Office sees Adult A's car outside his property
Mid- October, referral to Vulnerable Adults Panel

November 2014:
Early November, case taken to Vulnerable Adults Panel, and eventually allocated to Social Worker end of November.
Early November, GP notes state '' team feel he has capacity''.

December 2014:
Early December, Social Worker makes several telephone calls and sends letter to arrange home visit
Mid December, Social Worker visits but Adult A not at home. Neighbour said he was out.

January 2015:
Mid-January, Home visit as arranged via letter by Social Worker. No answer

February 2015:
Late February, Social Worker telephones Adult A – no answer, leaves message followed by Home visit by Social Worker, no answer. Social Worker returns later and eventually he answers, stating that he's busy and arrangements agreed to visit again following month.

March 2015:

- In the last weeks of his life, reports indicate that Adult A does not leave the house. He emptied his bowels and urinated in the room where he died. Adult A wife reported to the Police that in the days leading to his death he appeared confused. Early March, he began to slur his words and despite the offer of an ambulance, Adult A refused stating that he would not let them in. Adult A, wife went to bed, checking on him during the night. Early morning on the day of his death, he had become increasingly confused, with one eye open and one closed. She called an ambulance and returned to Adult A to await their arrival.

- North Wales Ambulance arrived at the home some ten minutes after they receive the alert. The home is described as having a stench of faeces and being full of rubbish. Adult A was found lying on the floor, not alert and non-responsive however, there was evidence of breathing. Additional staff were required to remove him from the home due to his build and access issues. The surrounding area was soaked in urine and faeces.

- Adult A was removed from the home and transferred to the ambulance. Adult A arrested, and was successfully intubated and Cardiopulmonary Resuscitation continued. Sadly, staff were unable to resuscitate and he was pronounced dead.