BDCT CTSB
BWRDD DIOGELU CWM TAF CWM TAF SAFEGUARDING BOARD

Cwm Taf Safeguarding Board

Extended Adult Practice Review Report

Ref: CTSB1/2017- Adult C

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*

Cwm Taf Safeguarding Board (CTSB) commissioned an Extended Adult Practice Review on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Multi Agency Adult Practice Reviews. The criteria for this review are met under:

The Safeguarding Boards (Functions and Procedures) (Wales) Regulation2015. and section 139 of the Social Services and Wellbeing (Wales) Act 2014.

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.

Adult C was 92 years of age and lived at a care home in Rhondda Cynon Taff, having moved there from a residential home in January 2013. Prior to this Adult C lived in Merthyr Tydfil for the majority of their life.

On 29 December 2015, the Welsh Ambulance Service NHS Trust (WAST) received a 999 call regarding Adult C due to concerns about low blood pressure and respiratory problems. On obtaining the history from Care Staff, Paramedics were advised that Adult C's condition had deteriorated the previous day, with poor dietary and fluid intake. No call had been made to the General Practitioner or to emergency services when Adult C's condition had deteriorated the previous day. This resulted in a Paramedic making an Adult Protection referral because of concerns of possible neglect, and because they also noted an injury to Adult C's right leg that appeared not to have been treated appropriately.

Adult C was transferred to Hospital by Welsh Ambulance Service staff, who alerted the admitting Consultant of their concerns.

Adult C died in hospital on the 2nd January 2016. The cause of death was recorded as Sepsis, Urinary Tract Infection and Dementia.

This Extended Review covers the period from 4th February 2015 to 9th August 2016 to take into account a previous Adult Protection Referral made regarding Adult C in July 2015 and the independent review that was undertaken in July 2016.

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

Policies and Procedures

During 2015, three Adult Protection Referrals were raised in relation to poor care and treatment provided to Adult C. The first and last referrals were delayed, with these being either misdirected or not actioned within recommended timescales. One of these referrals related to an incident occurring in March 2015, with the strategy meeting held in June 2015. The Wales Interim Policies and Procedures for the Protection of Vulnerable Adults from Abuse (2013) states that "a strategy meeting should be held within seven working days of an alert". There were also inaccuracies in the spelling of Adult C's surname on one of the referrals, which resulted in a delay in linking it to previous referrals made in relation to Adult C.

Quality of Care

The records in the care home available for this review consisted only of 'Daily Logs' with no evidence of any care plans. The care home reported that the care plans appeared to have gone missing. As a result, the reviewers were unable to fully understand the circumstances relating to the care provided by the care home for Adult C. Due to this it remains unclear whether staff would have been aware of when to escalate physical health concerns.

Communication

The Social Worker responsible for conducting Adult C's annual review was not aware of the Multi Agency Operational Group (MAOG) meetings that had raised a risk rating and embargo on the care home and therefore subsequently closed the case without considering any implications for the care of Adult C. Furthermore two Adult Protection Referrals were raised at the same time that the MAOG were monitoring concerns about general care within the home and the embargo being put in place. The MAOG and Safeguarding processes were running in parallel at certain points but in isolation. Therefore the resulting plans that were developed focused on different elements, one focusing on the individual, the other on the care home but they were never linked.

Deprivation of Liberty Safeguards (DoLS)

Merthyr Tydfil Adult Services advised the Care Home to make a DoLS application in

February 2015. A follow up letter was sent in March 2015, which reiterated the need to make an application for a standard authorisation under DoLS (Mental Capacity Act 2005). In June 2015, Merthyr Tydfil Adult Services recorded that no application for DoLS had been made by the care home but no action was taken to rectify this situation.

Independent Commissioned Review - Non-Criminal Investigation
It was a year from Adult C's death before a referral was made to the Adult Practice Review Group (APR). This was due to an ongoing Adult Protection Investigation under the Wales Interim Policies and Procedures for the Protection of Vulnerable Adults from Abuse, Version 2 (2013).
It also emerged during the review that the parameters of the non-criminal investigation were unclear in terms of who should be spoken to and timescales set. Assumptions were also made in the non-criminal investigation which went unchecked and led to recommendations being made that were not relevant.

Cross Border Responsibilities
Residents within the care home were from different local authority areas. Merthyr Tydfil County Borough Council were the placing authority and Rhondda Cynon Taf County Borough Council were the hosting authority. Although there is some evidence of communication between the two local authorities in relation to the individual referrals concerning Adult C, the reviewers could find no evidence to indicate that Merthyr Tydfil County Borough Council were made aware of the MAOG risk rating and embargo on the home.

EFFECTIVE PRACTICE:

Good practice was identified when Adult C first moved to the care home, where there was an apparent improvement in Adult C's health and wellbeing. This was evident from the health records provided by Cwm Taf University Health Board, which indicated that Adult C had gained weight and pressure ulcer wounds were healing, with involvement from the Tissue Viability Nurses, Dieticians, Speech and Language Therapy staff and staff within the care home.

The Welsh Ambulance Service NHS Trust also acted appropriately by making an immediate referral when they suspected possible abuse and neglect when transferring Adult C to hospital after noting an injury to Adult C's leg and the suspected delay in seeking medical attention.

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:

Recommendation 1. Policy & Procedure (Strategy Discussion/Meetings)
Cwm Taf Safeguarding Board should assure itself that all strategy discussions/meetings are accurately recorded and entered onto the multi agency information system MHub and shared with relevant others including placing authorities and commissioners within the recommended timescales. The placing authorities and commissioners must also be

included in the strategy discussions/meetings.

Recommendation 2. Quality of Care
Cwm Taf Safeguarding Board should receive information from MAOG in order for the Board to be assured of the quality of care provided within the care home sector within Cwm Taf area.

Recommendation 3. Communication
Cwm Taf Safeguarding Board should assure itself that the safeguarding concerns concerning an individual are linked to the organisational Multi Agency Operational Group (MAOG) process, to ensure that these systems share information with one another and do not run in isolation.

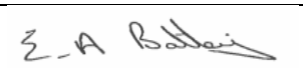
Recommendation 4. Deprivation of Liberty Safeguards (DoLS)
Cwm Taf Safeguarding Board should assure itself that commissioning Local Authorities have processes in place to ensure that DoLS applications are submitted by Care Homes in line with legislation.

Recommendation 5.Independent Commissioned Review-Non-Criminal Investigation
Cwm Taf Safeguarding Board should assure itself that there is a clear process for submitting a case to the Adult Practice Review Group and that staff are aware of the process and their responsibilities. The Board should also assure itself that the quality of Investigations is monitored. Investigations must have clear terms of reference and agreed timescales before being undertaken.

Recommendation 6. Cross Border Responsibilities
Cwm Taf Safeguarding Board should assure itself that placing authorities are informed when the MAOG process is implemented within the host authority.

Statement by Reviewer(s)			
REVIEWER 1	Ann Batley	**REVIEWER 2**	Debbie Pachu
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		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	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)* Ann Batley **Date** 05/04/2018	**Reviewer 2** *(Signature)*  **Name** *(Print)* Debbie Pachu **Date** 05/04/2018

Chair of Review Panel (Signature)	
Name *(Print)*	Ann Batley
Date	05/04/2018

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review Process

To include here in brief:

- *The process followed by the Safeguarding 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.*

The process followed in carrying out this review was in line with the Welsh Government guidance on Adult Practice Reviews.

An independent chair was appointed from Rhondda Cynon Taf (RCT) Children's Services and two independent reviewers (one from Public Health Wales and the other also from RCT Children's Services) were appointed.

The panel compromised of the following services;

- Police
- Adult Services
- Health
- Ambulance Service
- Commissioning and Procurement Services

- Care Home Provider

A letter was sent to Adult C's next of kin to advise that an Adult Practice Review was being conducted and inviting them to contribute to the review, however the family declined involvement.

A learning event was held which was attended by representatives from the following services;

- Adult Services from both Merthyr Tydfil and Rhondda Cynon Taf local authorities
- Procurement and Commissioning Services from both Merthyr Tydfil and Rhondda Cynon Taf local authorities
- Care Home Provider
- South Wales Police
- Cwm Taf University Health Board

The practitioners who attended and contributed to the learning event worked hard and without defensiveness to identify organisational learning. They demonstrated a commitment to making changes to improve future practice.

A letter was also sent to Adult C's next of kin to inform them that the review had concluded and of the resulting recommendations and also asking if they wished to view the report prior to publication. No response was received from Adult C's next of kin.

☑ Family declined involvement as they were satisfied with the level of care that Adult C had received.

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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	☐	☐	