Adult Practice Review Report

***North Wales* Safeguarding Adults Board**

Extended Adult Practice Review

Re: NWSAB1/2021/FCC

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 (APR) was commissioned by the North Wales Safeguarding Adults Board on 24/11/2021 on the recommendation of the Adult Practice Review Sub-Group in accordance with statutory legislation set out in section 139 of the Social Services and Well-being (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (Welsh Government, 2016).

The criteria for this review is met under Chapter 7, Extended Adult Practice Reviews:
The Board must undertake an extended adult practice review where an adult at risk who has, on any date during the six 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 purpose of the review is to identify learning for future practice. It involves practitioners, managers, senior officers and direct engagement with individuals and families exploring the detail and context of agencies' work with an individual and family. The review considers the work of statutory agencies and the statutory plan(s) which were in place for the individual. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice (Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (Welsh Government, 2016).

The review is undertaken by two reviewers working closely together, appointed by the Review Panel. They have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the Review Panel and the Board.

Methodology

- Review Panel convened with a Chair.
- Two Reviewers appointed.
- Terms of Reference agreed
- Timelines were developed by each agency
- Panel members produced a summary/analysis of each services' involvement.
- A letter sent to the family providing the opportunity to participate in the process.
- A Learning Event for practitioners.
- A Review Report produced with learning points and presented to the Review Panel.
- Review Panel meeting to finalise the report.
- Action plan developed from recommendations.
- Review Report presented by Reviewers and Chair of the Review Panel to the Regional Adult Practice Review Subgroup and the North Wales Safeguarding Adults Board.
- Submission to Welsh Government.
- Feedback to Family.
- Publication of Report on NWSB website.

The services represented on the Review Panel were as follows:

- Health (BCUHB & Countess of Chester)
- Welsh Ambulance Service NHS Trust
- Local Authority Adults Services

Timeline

The timeline for this APR is from the 21st February 2017, which was the last known significant period of intervention with the adult prior to the twelve-month period of the timeline required for the review, up to the 21st April 2021 which is the date of the death of the adult. The extension to the timeline was agreed with the APR Panel upon the request of the adult's family.

Agencies were also asked to consider their involvement prior to the timeline, if relevant.

Information was made available in regards to professional involvement with the adult. This provided a clearer picture of the functioning of the adult and an understanding of their daily lived experience.

Circumstances resulting in the review

On the 12th April 2021 the adult was taken into hospital by ambulance following a fall at home. At the time the adult's physical presentation was noted by ambulance and hospital staff to be of significant concern however staff at the hospital did not note any concerns relating to mental capacity. On the 21st April 2021 the adult passed away with self-neglect listed as one of the causes of death. The Coroner confirmed that there was no requirement for an inquest due to the adult's decision to withdraw from receiving services.

The Adults History and Contextual Information

The adult was an eighty-three-year-old man who had been a fire fighter with the RAF and subsequently a steel worker. He was a father to two children, a son and a daughter, and his daughter describes him as a shy family man who was well respected in the community and with a range of interests including gardening and dog agility classes. The Social Worker who worked with the adult in 2017 described him as being a very pleasant, courteous and humble man. During his assessment with Social Services in August 2017 the adult shared that “I don't have any friendships or good neighbours, I'm a private man, I've always been a bit of a loner. I enjoy my own company, reading, doing crosswords, looking on the internet etc”.

The adult’s wife passed away in 2003 and following her death he gradually withdrew from society and contact with his family became less and less. During the period between 2003 and 2017 the adult had little contact with family, the community or services and during this time he increasingly neglected himself and his home. During the review the family shared that during this period of time they had little contact with him other than occasional phone calls and email exchanges and that he would not let them enter the family home. A neighbour of the adult would look out for him and would contact the adult’s daughter if they had any concerns.

In July 2017, the adults’ neighbour contacted the daughter to raise concerns that they had not seen him for a number of days and upon visiting his home the family raised concerns that the adult was not at home and could not be contacted. Following contact with the Police it was established that the adult had taken himself to the Countess of Chester Hospital with serious leg ulcers having not removed his shoes for over a month. He was seen by the psychiatric liaison team who shared concerns that a frontal lobe impairment may be affecting his judgement. He was placed on mirtaxapine and a decision was reached that an adult at risk report was to be made to Social Services however it is unclear if this report was made. While in hospital he admitted to drinking alcohol to excess (up to fourteen units a day) and he was diagnosed with depression and unresolved grief. Whilst the family attended the hospital the adult refused to let them see him and specifically asked that no information was shared with them about his presenting condition.

On the 17th July 2017 the GP entry in the practice review timeline notes a diagnosis of Diogenes syndrome however during this review it was confirmed by BCUHB that this was noted on the GP system following a letter from the family but that this was not confirmed as a formal diagnosis.

During his admission to hospital, members of the family visited the adults home and raised concerns with the GP about the planned discharge of the adult back to his family home due to the poor home conditions. Social Services undertook an assessment with the adult and during discussions with the Social Worker, the adult shared that he wanted to engage with services and that he wanted to stop drinking as he knew he was doing it to block out his grief.

On the 7th August 2017 the adult was transferred to a local hospital and was seen by a Social Worker and CMHT Community Psychiatric Nurse. He was noted to be positively engaging with the services being offered.

During the learning event the Social Worker shared that the adult admitted that he had not cleaned the house since his wife died in 2003 but that his house had been his pride and

joy. When she visited the adults' home she observed that he essentially "existed in the house", he was sleeping on the sofa, the gas fire had broken glass and there was evidence of vermin and dirt within the main room he spent most of his time. During the visit to the home, to support the adult's discharge from hospital, the Social Worker did look in every room in the house and noted that they were fine such that she suggested he sleep in the second living room but he wouldn't go into the room. During the assessment the adult shared that his "dog dying was the last straw". At the time of the assessment the Social Worker shared that the adult was clean and well presented as he had been supported at hospital. The adult also made it clear to the Social Worker that he did not want his family to see the home as he was deeply ashamed of how things were and did not want them to see it and he did not want any contact with them or any involvement from them at that time. A full care plan was prepared to help support the adult on his discharge, including help cleaning his house and referrals to mental health and drug and alcohol services. Shortly before his discharge, the adult declined all the services that had been arranged and he returned home without any support.

During the learning event the Social Worker shared that within three days of the home visit and assessment she went off on sick leave and the case was transferred to the Senior Practitioner and during this handover the adult dis-engaged and declined support.

On the 19th September 2017 the case was closed by Social Services due to him declining support and on the 21st September he discharged himself from hospital prior to the works being completed on his home. The GP records note that there were no concerns relating to his capacity to make the decision to discharege himself. It is important to note that no formal capacity assessment was completed by either Social Services or Health.

Between the 21st September and 17th October 2017 the adult was seen by the CPN and District Nurses on more than one occasion and it is noted his condition was improving and he was making arrangements to make improvements to the home. There are no records to indicate if this was followed up to ensure the improvements to the home were made.

The family shared that following his discharge from hospital he did make contact with them via email on three occasions during September and October 2017. In his first contact (September 2017) he shared that he had discharged himself from hospital and that nothing was working at home and he had tried to order a fridge and some food but the payments had not gone through and should he go back into hospital he would not want his daughter to get in touch. In a later email in the October he shared that he had ordered a new car, that a plumber was at the house fixing the heating and to share his new email address. Shortly after this the adult stopped messaging the family.

In January 2018 the adult was seen by the leg ulcer clinic and the timeline entry notes that he had declined the seasonal flu vaccine, he was experiencing shortness of breath and that his legs were improving and that the district nurse was managing the dressings. Shortly after this time the adult declined any ongoing support with managing dressings from the District Nurse. This is the last time the adult agrees to health assessment and treatment prior to being admitted to the Countess of Chester hospital in 2021.

On the 17th September 2019 the GP called to see the adult at home as concerns had been raised that he had not been seen for some time and there was a need to review his medication but the adult refused entry and the GP was only able to see the adult on the

doorstep. Between the 9th October 2019 and the 11th September 2020 between the District Nurse and the GP there are a further five attempts to engage the adult but he either does not respond to the contact or refuses entry to the home. Following a doorstep visit on the 17th October 2019 the GP noted that at the time "the patient looked unkempt, garden overgrown, house looked untidy through windows". Attempts were made by the GP surgery to contact the family however the contact details on record were incorrect and the family was not contacted. On the 18th February 2020 the adult was contacted again by the GP surgery and he refused care and support that was offered, it was queried why he had not collected his medication and the adult refused a visit. During this period of time between October 2019 and February 2020 there were three MDT meetings held internally within the GP surgery (involving GP, practice manager, advanced nurse practitioner, practice nurse) and on the 19th February 2020 an Adult at Risk report was made to the Flintshire Social Services Single Point of Access team (SPOA). The report stated that "Patient lives alone, known Dementia, Diabetes, Asthma and Hypertension. History of Depression and reclusive. Non-compliance with medication, refusal of health care input and monitoring. Home visit attempted on 17/10/19 access refused into the property. Patient looked lightly unkempt, garden overgrown, house looked untidy through the window. Query capacity due to diagnosis of Dementia and decline in mental health".

In response to the Adult at Risk report a Senior Practitioner in the SPOA team called the adult on the phone to discuss his situation and to establish if support was required and the adult declined the offer of any support. During the learning event the Senior Practitioner shared that the adult did put the phone down on them as he was taken aback by the call as he had not given his consent for the referral to be made from the GP to Social Services.

A case discussion took place between the Senior Practitioner, Team manager and Dementia support worker and an action was agreed for the Dementia support worker to complete a welfare check which subsequently did not take place due to the adult refusing support and the case was closed by Social Services on the 23rd March 2020. It is noted in the Social Services records that there was no reason to question his capacity (although capacity had been queried in the GP's referral). There is no record of Social Services contacting the GP to report back that support had been refused and neither is there evidence of the GP following up on the report to confirm action was taken.

In March 2020 the nation was placed into lockdown restrictions due to the COVID pandemic and the adult's daughter at this time made contact with him to see if he required any support and he agreed to the family doing some shopping for him and he would provide a list of what he needed over the phone and they shared that when they spoke with him he sounded to be okay. During the review the family shared that they would take food to the gate and he would wave in the window but he would not be seen or let them into the house. On the first occasion of dropping shopping at the house the family shared that the adult had taped his bank card and pin number to the front door with a note instructing the family to withdraw £200 for the cost of the shopping. The adult's daughter shared that during this period of contact when they would do his shopping for him they would speak more regularly on the phone and she would ask for advice about the garden and on occasion he would leave gardening books for her when he would leave the bank

card for shopping. For the adult's daughter this was the best their relationship had been for a number of years.

In January 2021 the adult declined his seasonal flu vaccination.

On the 8th January 2021 the adult attended the GP surgery for his first COVID vaccination. During the learning event the paramedic who attended the adult on the 12th April confirmed that the adult shared with him that he had taken himself to the GP surgery for his vaccination and presented no differently as to how he had always been which included not having changed his clothes for over two years. It has been questioned by professionals and the family how his presentation could not have caused concern amongst staff at the clinic, but there was no note or record made of any concerns. The adult is noted to have been able to use the internet and his mobile phone with confidence, and he arranged the appointment himself getting himself to the clinic. During the learning event the GP surgery representative confirmed that the piloting of a mass vaccination programme was happening at this time and the clinic was one of the first GP surgeries to be rolling it out and they were seeing up to 650 people in a day. As part of the process the adult would not have been required to wait fifteen minutes after his vaccine in the waiting area which would have reduced the opportunities for contact between the adult and any members of the vaccination team. It was also confirmed that the COVID vaccination team did receive basic safeguarding training as part of being employed by the organisation but the depth of this training is unclear.

On the 12th April 2021 the adult made a 999 call himself requesting an ambulance as he had fallen at home (it has been confirmed by the Ambulance Service that this was recorded as a non-injury fall). It is noted in the timeline that there was a six-and-a-half-hour delay to the ambulance attending the home. It is important to note the national picture across the Welsh Ambulance Service at this time and the pressures on the services leading to long delays. In the early hours of the 13th April 2021 the adult was admitted to the Countess of Chester hospital.

On review of the records shared and the accounts shared by practitioners at the learning event there were references made to the physical condition of the adult and the true extent of the self-neglect of himself.

The accounts shared by the attending paramedics and the accounts of the family who attended the adult's home following his hospital admission describe the very poor home conditions that the adult was living in leading up to his death including: weekly shopping delivered to the house left in the hallway and kitchen untouched and still in bags (the family shared that when the visited the home that it was clear the adult had been eating the cream cakes that were always on his shopping list); the living environment being unhygienic and infested with insects in large quantities. Evidence was also obtained that the adult had not been taking his medication for heart issues, diabetes and asthma as this was discovered in the garage of the home. The Wales Ambulance Service did make an Adult at Risk report to Social Services due to the levels of concern they had.

Despite the extent of his injuries and physical presentation and the home conditions staff at the hospital noted that there were no concerns in relation to his mental capacity and the sense they were given was that he had "given up a little". During the learning event the attending paramedic shared that the adult opened up in the ambulance that he would not

let anyone into his home and gave the impression of being relieved that someone was there to help and he no longer needed to be ashamed and he talked about his family coming back round to the house. He was noted to say “I’m going to get my life back”.

On the 21st April 2021 the adult sadly passed away with self-neglect listed as one of the causes of death.

View of the family

The daughter and son-in-law of the adult were informed of this adult practice review and invited to meet with the reviewers. One of the reviewers met with them at their home address on 8th July 2022. The reviewer explained the purpose of the visit and explained that this was an opportunity for them to share their views. They welcomed the reviewer into their home and presented as being comfortable in speaking openly about their experience.

Observations made by the family have been shared above in relation to the adult’s history and contextual information. In addition to these the family shared the following observations and reflections.

The family shared their grief and sadness of the death of their father and how hard it had been for them that their relationship with him had deteriorated in the way it had over the years. Whilst there were periods of contact it was often from a distance however they did share examples of how they felt that family did matter to the adult, for example on the 40th birthday of his daughter the adult arrived at the house with a puppy (of the breed she had always wanted) and it brought them closer together at the time. When the daughter was in work her father would collect the puppy from the house and take it for a walk. The family also shared that when they were able to enter the adults’ house they found pictures of the family that he had printed from Facebook and framed. The adults’ daughter also shared reflections of their common interest in gardening.

The family were aware that the adult was asthmatic and did have regular checks with the GP along with regular checks of his blood pressure and they understand that during one review with the GP he did offload about how he wasn’t coping and as a result was placed on anti-depressants. They were also aware that the adult was on other medication and questioned how his medication was being prescribed given he was not attending the surgery for reviews. The family later shared that when they visited the adult’s home following his final hospital admission that his medication had not been taken as it was found in the garage.

The family shared that they were aware the adult had refused any home visits from services as he was not happy that the only time they could visit was 8am and this did not suit him.

The family questioned what checks Social Services and Health had undertaken when they were made aware of the concerns about the adult given the condition of the one living room the adult was living in. They noted that had anyone looked through the window they would have been led to believe that the home conditions were satisfactory as all the other rooms in the house were untouched since his wife had passed away.

Reflecting on how their father had not been seen by anybody for so long and knowing the physical presentation of the adult on his final hospital admission they questioned how he

had attended his COVID vaccination three months before his death and how nobody at the clinic had been concerned about his presentation, for example his smell.

The family shared their sadness that they feel their father knew he was going to die because of the possessions he had with him on his final hospital admission, including his ID, bank details and a large amount of cash. It is important to reflect at this point on the observations made by the attending paramedics that the adult had shared with them a sense of relief and being grateful that he would be able to get help, turn his life around and have his family back to visiting his home.

Learning Event

A learning event took place on the 07/09/2022. The two independent reviewers facilitated the day, the Panel Chair was unable to attend due to being taken ill the morning of the learning event. Practitioners with direct case involvement with the adult were invited to the learning event to consider their involvement, practice, assessments and decision-making processes.

Agency representation attending the learning event included:

- Health (BCUHB & Countess of Chester)
- Welsh Ambulance Service NHS Trust
- Local Authority Adults Services

The learning event highlighted good practice between all professionals involved with the adult and it was clear that all professionals had strived to engage and support the adult. All professionals working with the adult were experienced practitioners and communicated with their partner agencies however the quality of the information shared was identified as an area for learning as has been noted within the report.

The learning event also recognised the limitations to creating meaningful change for the adult while working through the constraints of a pandemic.

During the learning event, professionals highlighted key learning areas which will be detailed within the body of 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

The following themes relating to practice and organisational learning have been identified through the review.

Assessment and understanding of mental capacity when an individual chooses not to engage with services

Throughout the period covered by this review there were numerous occasions whereby the adult was assessed by practitioners in both social care and health with a number of

instances whereby the adult chose not to engage with practitioners and receive support being offered. Taking this into account a recurring theme within the review has been if and how the mental capacity of the adult was assessed and understood, particularly given the nature and level of concerns relating to the adult and his decisions to decline support between 2017 and 2021.

There has been no evidence presented during the review to indicate that a formal assessment of mental capacity was undertaken and practitioners who had contact with the adult during the time period have shared that during their interactions with the adult there was no reason to question his capacity.

In his review of self-neglect and safeguarding adult reviews Preston-Shoot (2018) highlights incidences of fluctuating capacity not being addressed and notes that 'mental capacity is assumed, despite sometimes a history of 'unwise decisions' rather than assessed, including consideration of legal options to safeguard the person. In the case of the adult who is the subject of this review it is clear that his capacity was on a number of occasions assumed, based on him stating he did not feel that he needed support. Preston-Shoot also refers to assessments not being revisited and the need for the impact of impairment of executive brain function to be considered alongside contextual factors such as home environment and family dynamics. He also identifies the importance of "robust assessments, located in the historical progression of the case, may help to address…… risks associated with gradual deterioration….and the importance of considering and responding to repeating patterns". He goes onto highlight the significance of each referral or hospital admission not being seen in isolation and instead needs and risks being assessed in the context of the history of the individual. In 2017 it is evident that these contextual factors were considered as part of the social care assessment. However, in 2020 the GP surgery submits an Adult at Risk report to the local authority based on their concerns that they are not able to engage the adult; concerns about him living alone; known Dementia, Diabetes, Asthma and Hypertension; history of depression and reclusive; non-compliance with medication, refusal of health care input and monitoring; appearance of looking lightly unkempt; garden overgrown; house looked untidy through the window. The report also queries capacity due to the diagnosis of dementia and a decline in mental health. No formal assessment was undertaken by Social Services at this time and it is not evident that assessments were revisited and contextual information reviewed, the case was closed due to the adult expressing he is fine, has put in his prescription and does not feel he needs help. During the learning event it was shared by the Social Worker who led the discussion with the adult at this time that there was no reason to be concerned about his capacity.

On the 18th September 2017 a full Addenbrooke's Cognitive Assessment[1] is carried out producing a score of 71/100 (in the agency timeline for this review it notes that this suggests areas of mild and moderate impairment) and it is noted that the adults' self-account suggests limited understanding of care needs and a refusal to receive care upon discharge. On the 19th September 2017 the Social Worker telephones the CPN to inform them that the case is being closed as he is adamantly declining social care. A discussion

[1] Addenbrooke's cognitive examination III is a screening test that is composed of tests of attention, orientation, memory, language, visual perceptual and visuospatial skills. It is useful in the detection of cognitive impairment, especially in the detection of Alzheimer's disease and frontal-temporal dementia

in relation to whether the gentleman had capacity to decline care was not recorded at this time. Further to this, on the 21st September 2017 the adult is discharged from hospital at the adult's request and the timeline for the review notes that no concerns were noted in relation to his capacity to make this decision. It is unclear whether the results of this assessment were shared amongst the practitioners involved in the assessment and planned hospital discharge of the adult. It also raises the question as to whether there was an opportunity missed to apply the Mental Capacity Act and best interest principles following this assessment. During the learning event it was questioned by practitioners whether the assessment took into account his alcohol consumption and why the assessment was not repeated.

Application of safeguarding procedures and ability to apply professional curiosity

In his review of self-neglect and safeguarding adult reviews Preston-Shoot (2018) highlights the impact of limited knowledge and use of safeguarding pathways and identifies "concerns about the poor management of alerts, the failure to follow approved procedures, delays in raising or following up on concerns, poor communication about levels of risk and missed opportunities to ensure multi-agency working and agree risk management plans".

In considering the application of statutory safeguarding processes during the period of the review it is important to note that Wales was experiencing a transition in procedures from the Protection of Vulnerable Adults (POVA) procedures (2013) in 2016 to the implementation of the Wales Safeguarding Procedures in 2020[2] with the Working Together to Safeguard People (Volume 6 Handling Individual Cases to Protect Adults at Risk)[3]. The Wales Safeguarding Procedures for Adults at Risk were implemented with training provided through the North Wales Safeguarding Board however it is unclear the extent to which this training was provided to all members of staff working across health and social care. Within the Safeguarding Procedures there are new definitions of 'adults at risk', new statutory duties to report concerns about adults at risk and new processes to be followed for managing the response to reports and arrangements to protect adults from abuse and neglect. Within the definitions of 'adults at risk' in the procedures there is the inclusion of self-neglect[4]. The duty to report within the procedures states that a report should be made whenever there are concerns for an adult at risk who:

1. is experiencing or is at risk of abuse or neglect,
2. has needs for care and support (whether or not the authority is meeting any of those needs), and
3. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.[5]

Reviewing the information provided for the review it is evident that opportunities to identify the adult as an adult at risk were missed.

- On the 7th July 2017 the adult is seen by the psychiatric liaison team at the

[2] Issued under the Social Services and Wellbeing (Wales) Act 2014
[3] Issued under the Social Services and Wellbeing (Wales) Act 2014
[4] https://www.safeguarding.wales/en/adu-i/adu-i-ap/a1p-p2/
[5] https://www.safeguarding.wales/en/adu-i/adu-i-a2/a2-p2/

Countess of Chester hospital and it is noted that the input is needed from Social Services as an adult at risk. Whilst a referral was made the case was assessed under Part 3 of the Social Services and Wellbeing (Wales) Act 2014 and was not considered through safeguarding processes.

- In January 2018 the adult is seen by the leg ulcer clinic and does not attend or engage in other planned reviews by health professions until 2020
- In October 2019 concern is first raised by the GP surgery about the adult and his non-engagement with the surgery and concerns about his medication and an MDT (internal within the surgery so not a multi-agency MDT) on the 15th October 2019 discusses the concerns. Further attempts are made to engage the adult with no success and additional MDT meetings are held between this date and February 2020 (with notable good practice in relation to the practice nurse trying to engage the adult due to having an established effective relationship with the adult) yet no Adult at Risk reports were made until the 19th February 2020. During the learning event representatives of the GP surgery were asked why this was the case and it was reported that they did not feel they had enough information and all avenues of contact had not been exhausted (it should be noted that attempts were made to contact the adults' daughter and son but these were not successful as the contact details were incorrect)
- On the 19th February 2020 Social Services managed the report within the Single Point of Access team and did not bring the report to the attention of the Social Services Safeguarding Team

In addition to the points noted above it is also identified within the timeline for this review that the GP surgery submitted the Adult at Risk report on the 19th February 2020 and on the 4th March 2020 they were still awaiting the outcome of the report. During the learning event the GP surgery representative shared that the surgery had not received any information in relation to the report that had been made and any decisions made and actions taken in response. At the time of the adult at risk report being made the Wales Safeguarding Procedures had not been implemented which now place a duty on the local authority to acknowledge receipt of the report within 7 working days with the report maker[6]. If the report maker does not receive this, they are required to contact Social Services again. At the time of the report being made by the GP surgery Wales was working to Working Together to Safeguard People 2019[7] which states that "if having made the initial report in writing the person making the report has not received acknowledgement within 7 days they should always contact Social Services again, this did not happen.

It is important to highlight that the processes in place within the Wales Safeguarding procedures to be able to build a more holistic picture of concerns relating to risks for individuals were not followed at this time which did not allow for an overall analysis of the adult's situation with input from a range of agencies. In his review, Preston-Shoot (2018) highlights how effective working depends on information sharing and highlights the impact of examples of poor information sharing not enabling a shared understanding of risks or an agreed multi-agency approach. He cites examples including risks arising from non-

[6] https://www.safeguarding.wales/en/adu-i/adu-i-a3pt1/a3pt1-p4/
[7] Working Together to Safeguard People (Volume 6 Handling Individual Cases to Protect Adults at Risk) 2019

engagement or mental distress culminating in missed assessment or safeguarding opportunities and disjointed or delayed service provision.

Quality of information sharing

During the review it was evident that there was communication between key practitioners supporting the adult however the timeliness of this was not always effective and the level of detail within the information shared not always accurate and/ or sufficiently detailed. Examples of this include:

- On the 17th July 2017 the GP surgery entry notes that there is a diagnosis of 'Diogenes syndrome'[8] however this was not shared with practitioners within other agencies and it has been established that this was not a formal diagnosis and in fact was recorded as it had been indicated/ suggested in a letter of concern sent by the adults' family to the GP.
- On the 19th February 2020 the Adult at Risk report made by the GP surgery to Social Services noted that the adult was known to have dementia and that there was a query with regards to his capacity due to a diagnosis of dementia and decline in mental health. On the 4th March 2020 there is an entry in the timeline for this review that states "No dementia review completed due to refusal of help/care by Patient". During the learning event Social Workers confirmed that they were unaware of a diagnosis of dementia as this was noted within the records they held. Practitioners from Health also questioned whether the dementia was a formal diagnosis or whether it was an assumption made based on the results of the Addenbrookes assessment in 2017.
- Whilst the Social Services records note that a dementia support worker would be asked to complete a welfare check it was confirmed at the learning event that this was not on the basis of the adult having dementia but as an example of good practice as they are also employed to engage with individuals who are often hard to engage as they can more flexible in their contact.
- It is unclear whether the outcome of the Social Worker's assessment in 2017 was shared with health practitioners working with the adult
- Whilst a number of MDT meetings took place internally within the GP surgery no formal records (e.g. meeting minutes) are taken during these meetings which leads to the detail of the concerns discussed during the meeting not being formally recorded

Understanding and application of the regional self-neglect policy

In 2016 the North Wales Safeguarding Adults Board issued its regional policy in relation to self-neglect (updated in 2020)[9]. The aim of the multi-agency policy and procedure is to prevent serious injury or death of individuals who appear to be self neglecting by ensuring that:

- Individuals are empowered as far as possible, to understand the implications of their actions;
- There is shared, multi-agency understanding and recognition of the issues;

[8] Diogenes syndrome is a disorder characterized by self-neglect, domestic squalor, apathy, compulsive hoarding of garbage and more importantly lack of shame.

[9] North Wales Regional Safeguarding Board policy and procedures to support people who self-neglect (reviewed 2020)

- There is effective multi-agency working and practice;
- Concerns receive appropriate prioritisation;
- Agencies and organisations uphold their duties of care;
- There is a proportionate response to the level of risk to self and others

Within the policy there is a clearly defined process to be followed when there are concerns relating to an individiual who is self neglecting and they appear to be at significant risk. The process includes: assessment of the individual; active engagement of the individual; a multi-agency meeting; development of an action plan and monitoring arrangements of the plan. This review has idenitified that opportunities were missed to initiate or implement the policy by any of the agencies involved in supporting the adult. For example:

- On the 7th July 2017 when the adult attended the GP surgery with chronic ulcers due to not removing his shoes for over a month
- On the 9th September 2017 when the Addenbrookes assessment was completed and the adult's self account was noted to suggest he had limited understanding of his care needs and a refusal to receive care on discharge from hospital
- In September 2017 during the assessment completed by the Social Worker
- On the 17th October 2019 when the MDT in the GP surgery discussed the potential for a safeguarding referral
- On the 11th September 2020 when the MDT in the GP surgery discussed the potential for a safeguarding referral
- On the 19th February 2021 when Social Services closed the case based on the adult stating he did not require help

If the self-neglect policy had been used it would have provided the opportunity to identify, as a multi-agency group, the legal options available to be able to gain access to see the adult.

During the learning event all those attending confirmed that at the time of the death of the adult they were not aware of the detail of the regional policy. There was however confirmation that the awareness of the policy and issues relating to self-neglect has increased.

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: -

In considering the evidence provided during the review and the reflections and learning presented during the learning event the following have been identified as the key learning points for system and practice improvement:

Information sharing and professional clarification

The detail of information shared between agencies (for example in referrals and reports) needs to be accurate and up to date, this includes: outcomes of assessments; formal

diagnosis; who has seen the individual, where and in what circumstances; confirmation of support being provided. Where information is vague this needs to be clarified by all professionals involved.

Where individuals are failing to attend for appointments (such as medication reviews) processes are in place to identify this and raise concerns.

Understanding and application of the Wales Safeguarding Procedures

All agencies to ensure staff who work directly with adults with care and support needs and/or who may be experiencing or at risk of experiencing abuse or neglect are aware of the content of the Wales Safeguarding Procedures and their duties relating to identifying and reporting concerns in relation to self-neglect.

Social Services to ensure adult at risk report makers receive acknowledgement of receipt of a report within 7 working days.

All agencies with a duty to report concerns about adults at risk are clear about their duty to follow up reports of adults at risk if acknowledgment has not been received by the local authority within 7 working days.

Understanding of mental capacity and assessment where appropriate

All agencies to ensure staff who work directly with adults are aware of the signs that an individual may be lacking in mental capacity, are aware of the overarching legislation, namely the Mental Capacity Act (2005) and are clear about their internal processes for identifying when an individual may lack capacity and the processes to be followed to ensure they are appropriately and proportionately assessed.

Understanding and application of the North Wales Self Neglect Policy

Regional multi-agency awareness raising (including the Countess of Chester hospital) of the North Wales self-neglect policy including focused training sessions to support managers and practitioners in its implementation (particularly in circumstances where cases close and new concerns emerge).

Conclusion

When considering recommendations in relation to practice to support the identification of adults who are at risk of abuse and neglect there needs to be consideration of what is currently available to support the desired outcomes. This includes the following resources developed by the North Wales Safeguarding Adults Board:

- 10 top tips for making an adult safeguarding report
- Regional practice guidance tool for adult safeguarding decisions
- Dealing with a different point of view: guidance for health and social care professionals working with adults at risk in North Wales
- Professional curiosity guidance

It is recommended that this guidance is adopted by all professionals working with adults at risk.

In addition, there are a number of pointers for practice within the Wales Safeguarding Procedures in relation to assessing capacity and engaging people who choose not to engage.

Consideration needs to be given to the value of reproducing what is currently in existence and any action plan moving forward needs to be innovative and meaningful.

The reviewers would like to thank all those practitioners who took part in the review and to reassure them that from examination of all the documentation presented to the reviewers and the discussions and reflections during the learning event there is no evidence to suggest or indicate that the death of the adult could have been predicted.

Reference List

North Wales Regional Safeguarding Board policy and procedures to support people who self-neglect (reviewed 2020)

Preston-Shoot (2018) *Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change*

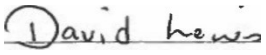
Wales Safeguarding Procedures (2019)

Welsh Government (2014) *Social Services and Well-being (Wales) Act 2014 and accompanying guidance*

Welsh Government (2016) *Working Together to Safeguard People – Volume 3 – Adult Practice Reviews*

Welsh Government (2019) *Working Together to Safeguard People (Volume 6 Handling Individual Cases to Protect Adults at Risk)*

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 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 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 *(Signature)*  **Name** Vicky Allen **Date** 09.02.2023	**Reviewer 2** *(Signature)*  **Name** David Lewis **Date** 09.02.20223

Chair of Review Panel

(Signature) 

Name Frances Millar

Date 09/02/2023

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.*
☐ 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	☐	☐	