# Adult Practice Review Report

**North Wales Safeguarding Adults Board**

**Concise Adult Practice Review**

**Re: NWSAB 1 2023**

| **Brief outline of circumstances resulting in the Review**<br><br>*To include here: -*<br>• *Legal context from guidance in relation to which review is being undertaken.*<br>• *Circumstances resulting in the review.*<br>• *Time period reviewed and why.*<br>• *Summary timeline of significant events to be added as an annex.* |
|---|
| A Concise Adult Practice Review (APR) was commissioned by the North Wales Safeguarding Adults Board on 27/04/2023 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).<br><br>The criteria for this review is met under Chapter 7, Concise Adult Practice Reviews:<br><br>The Board must undertake a concise APR where an Adult at Risk who has **not,** 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:<br>• died; or<br>• sustained potentially life-threatening injury; or<br>• sustained serious and permanent impairment of health. |

The purpose of a review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the detail and context of agencies' work with an individual and family. 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 managed by a Review Panel and a Reviewer is appointed to work with the Review Panel. The review engages directly with individuals and family members, as they wish and as appropriate, so their perspectives are included, and it involves practitioners who have been working with the individual and family, and their managers. A planned and facilitated practitioner-focused learning event is a key element of the review, conducted by a reviewer independent of the case management, to examine current case practice within a limited timeline and using a systems approach.

**Methodology**

- Review Panel convened with a Chair.
- One Reviewer appointed.
- Terms of Reference agreed by the panel.
- Timelines were developed by each agency.
- Panel members produced a summary/analysis of their services' involvement.
- A letter was sent to the family providing the opportunity to participate in the process.
- A Learning Event for practitioners was held.
- A Review Report produced with learning points; a draft was presented to the Review Panel.
- Review Panel meeting to discuss the report.
- Action plan developed from the recommendations within the report.

**The services represented on the Review Panel were as follows:**

- Betsi Cadwaladr University Health Board (BCUHB)
- Welsh Ambulance Services NHS Trust (WAST)
- Local Authority Adults Services
- Housing
- North Wales Police (NWP)
- GP Practice (not able to attend the panel, but attended the learning event)

For the purpose of this report the individual will be referred to as Ann. The reviewer did not meet with the family, so it is hoped that reference to this fictional name does not pose any distress to them.

**Timeline**

The timeline for this APR is from the 8th December 2021 to 7th December 2022, which was the last known significant period of intervention with Ann prior to her death. Agencies were also asked to consider their involvement, if relevant, prior to the timeline. Information was made available in regard to professional involvement with Ann. This provided the reviewer with an understanding of her personal support needs and her daily lived experience.

**Background**

In December 2022 a member of the public contacted NWP and reported a body in the river on the high street near to the deceased person's home. The body was of a female, subsequently identified as Ann. Further information gathered by NWP both at the scene and a subsequent search of Ann's property indicated that she was on medication and had been unsteady on her feet over the previous 2 to 4 weeks. The location of her body was described as being close to a footpath covered in wet leaves adjacent to a slope leading to the river. She was described as being cold and had a slight bruise on her left forehead. NWP officers hypothesised that it was highly likely she may have slipped on the wet ground, lost her balance and slid down the embankment and knocked her head on some rocks in the river, rendering her unconscious. Given the cold weather, it was the police opinion that hypothermia had set in and she subsequently passed away.

**History**

In the course of undertaking this review, it was sad to note that little historical information had been made available to the Reviewer. As the family did not respond to be part of the review, the following detail has been pieced together based on the knowledge practitioners had of her during their involvement and shared in the chronology and learning event.

Ann is a single female who lived alone in a social housing tenancy bungalow in a North Wales town. She had 5 children with her previous husband, but it was noted that she had little or no contact with any of her children, and subsequently did not see any of her grandchildren. One son died of a drugs overdose and another son was believed to have a learning disability. It was alleged that she was historically sexually abused by her father and other unknown males, which caused her lifelong trauma and distress.

Information suggests that she had sporadic contact with her daughter and that this relationship was believed to be difficult. A letter was written to the daughter offering her the opportunity to meet with the Reviewer, but no response was received.

During the period of the timeline it was noted that her house was often unkempt and required intensive cleaning to rectify. Her general presentation throughout was one of self-neglect in both her physical and mental state and the state of her property. She had been diagnosed with a Borderline Personality Disorder. During the period of intervention by practitioners, there were several references to either bogus or confirmed falls, and photographs taken of the property show several items of equipment to aid mobility and access being present, which suggests that mobility and daily living tasks could be difficult for her. A 'What Matters' assessment was undertaken with Ann on the 5th of August 2022

noted that she was able to undertake daily living tasks. It noted further, however, that she suffered from involuntary movements due to the side effects of the anti-psychotic medication she had been taking for many years. It also noted that she suffered from low blood pressure. A previous physiotherapist intervention noted that they were of the view that Ann would require specialist rehabilitation as an inpatient but that she had not been willing to accept this.

There were numerous markers on the North Wales Police systems for concerns relating to suicide and mental health ranging from 2007 until the day of her death. She had been known to the mental health team and, given her history of making repeated and often unnecessary or vexatious calls to the police, she had been discussed at the local demand reduction and Vulnerable Adult Risk Management (VARM) meetings for multi-agency support.

Following Ann's death, police recovered handwritten notes she had written to several individuals including some practitioners where she thanked them for their intervention and apologised for her actions. The notes, however, were undated and cannot confirm if she had intended to end her own life on the day in question.

**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.*

**GOOD PRACTICE**

During the period considered for this review, it was evident that there was regular involvement by several agencies with Ann. Analysis of the chronology provided highlighted continued communication and partial partnership working by partners. Intense support was offered via her landlord's Tenancy Support and Neighbourhood Services Team as well as clear and consistent communication and joint visits with the Social Services Adults Team and with North Wales Police.

The mental health team consistently responded appropriately and attempted to encourage her to engage with their service to establish whether there were any mental health needs that they could assist her with.

In 2021 a Risk Management Plan was added to her record in discussion between CMHT and Police which sought to take positive action (prosecution) to reduce the demand from Ann. Despite the continuation of her actions, however, no further prosecution was sought and this appears to be linked to increasing concerns for her vulnerability and her personal situation. The decision not to prosecute is encouraging as it would be difficult to understand what benefit criminalising her actions would achieve.

The Learning Event demonstrated positively the wealth of knowledge and understanding the General Practitioner had about Ann. It is often overlooked that throughout an

individual's life, the one constant that is present is the GP practice involvement. Within the chronology there are several references to regular phone calls made with her by the GP practice throughout the period of COVID restrictions. This allowed Ann to discuss her current health issues and arrange access to advice, prescription changes and medications.

In a panel discussion, Local Authority and WAST panel members discussed opportunities to further develop close collaborative working in order to improve multi-agency information sharing and understanding of internal safeguarding processes.

**PRACTICE AND ORGANISATIONAL LEARNING**

**Capturing personal history**

There was a lack of updated history available to the Reviewer about Ann's circumstances, and had her GP not been present at the learning event, then key information about her life experiences and her current presentation would have been lost. One example of this was that some practitioners believed that Ann was misusing alcohol due to a full vodka bottle regularly being in sight at her home, and when practitioners referred to this with her, she had agreed to being referred to Cais for support with drinking issues. Her GP, however, advised there was nothing to evidence that she was misusing alcohol, and that the vodka bottle was a further means of drawing attention and support from practitioners. It was noted that when asked to remove the bottle, she would willingly pour the vodka away.

**Safeguarding Reporting**

In considering the timeline content and discussions held at the learning event, the reviewer identified that practitioners raised two specific matters:

- Practitioners referred to raising several 'safeguarding reports' over lengthy periods during their involvement with Ann. On reflection, however, these would be deemed to be welfare matters and possibly more in line with self-neglect concerns as opposed to safeguarding reports. Only one formal Adult at Risk report had been received by the Local Authority Adult Safeguarding Lead during the period of the timeline, dated the 7th of February 2022. As such, all other concerns had not been considered in line with the Wales Safeguarding Procedures.
- Lack of updated information being made available to partners may have potentially led to inappropriate attendances at emergency departments and hospital admissions, when GP support could have been a more appropriate intervention. Within the timeline period and discussed at the learning event, there were several references to the occasions when it was believed that Ann would raise concerns about her health so as to gain admission to hospital to avoid visits by practitioners to assess her home conditions. An example was shared at the learning event whereby on one occasion when an ambulance had been called, Ann had advised WAST staff that she had been evicted from her bungalow and was sleeping in a cave. Whilst there were discussions at this time as regards the risk to Ann's tenancy, at no time was she evicted from her property and, on that occasion, she had a home to return to. During this specific incident, she was assessed as requiring admission to hospital, but it was acknowledged at the learning event that if

current and correct information was routinely available to practitioners, then she may, in some instances, have been supported to remain at, or to return to, her home address with GP support.

**Multi-agency meetings and updates**

Whilst it is noted that agencies were active in sharing information with other agencies and there appears to be knowledge of other agencies involvement in the case, much of this communication was via e-mail dialogue and often with single agencies. There is little example in the timeline of any active and regular multi agency meetings or discussions. Meetings held under police protocols such as the VARM and local demand reduction, when held, did not have all relevant partners present. This was reaffirmed at the learning event when key partners noted that they had not been invited to the meetings. Whilst the period in question was largely during the latter period of COVID restrictions when face to face meetings would have proved difficult, there is no reference to any virtual meetings taking place as an alternative during this time.

**Self-neglect protocol**

For the timeline period, there were limited references to self-neglect as an identifying factor in Ann' s presentation, and in reviewing their own information, the WAST panel member noted that a reference to self-neglect was made in the last safeguarding report sent to the local authority shortly prior to Ann's death. Further enquiries with the local authority confirms, however, that this report was passed on as a referral for care and support. Despite these references, however, there is no indication that any agency had considered or requested adopting the North Wales Regional Self-Neglect Protocol as a process to guide practitioners and support Ann.

Whilst we cannot demonstrate that implementing the protocol would have influenced the final outcome and prevented her death, it could, however, have provided a clear and consistent multi-agency approach with clarity on lead roles and information shared, whilst also supporting the practitioners involved in her case.

**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*: -

**Personal History Recording**

There is a need to ensure that, where practicable, all personal history known to services is available to practitioners, and where appropriate, is updated at key points in any intervention. This will ensure that individuals do not need to repeat or revisit historical incidents in their lives and updated information added regularly to the personal history will guide practitioners.

**Self-neglect protocol**

Where key characteristics are identified in a case i.e., poor hygiene and health care (both personal and environment) and there is repeated concern and involvement regarding an individual by statutory agencies, e.g., where local demand reduction and VARM meetings are being considered by North Wales Police, all North Wales Regional Safeguarding Board partners should implement the North Wales Self-Neglect Protocol and convene an initial meeting in line with the protocol. All partners should also be reminded that they can directly request and initiate/convene a meeting under the protocol as opposed to requesting the local authority proceed with the arrangements. During the last panel meeting, the WAST representative highlighted that as a national organisation and emergency service they would initially raise concerns in relation to self-neglect through a WAST Adult Safeguarding Concern Report. It would be pertinent, however, that all partners may request via their reporting mechanisms that the case proceed to a Self-Neglect protocol meeting.

Should partners agree at the initial meeting that on-going application of the protocol is no longer required or appropriate, there should be agreement as to what on-going multi-agency format should be in place to support practitioners in the case.

**Safeguarding Reporting**

Understanding and awareness of safeguarding procedures as opposed to well-being (welfare) concerns needs further exploration. The North Wales Regional Safeguarding Board should undertake wider awareness raising across all partners of the distinction between what constitutes a safeguarding concern i.e., when the Adult at Risk criteria is identified, as opposed to when the matter relates to welfare and wellbeing considerations.

**GP engagement**

The need to maximise and support GP involvement in all self-neglect and safeguarding cases should be explored. Whilst the nature of GP practice activity means that attendance at any multi-agency meetings is difficult, there should be consideration as to how to ensure that information and advice from the GP is available to all multi-agency partners and meetings.

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<tr><td colspan="4">Statement by Reviewer(s)</td></tr>
<tr><td>REVIEWER 1</td><td>Alys Jones<br>Adult Safeguarding Lead<br>Conwy Council</td><td>REVIEWER 2<br>(as appropriate)</td><td></td></tr>
<tr><td colspan="2">Statement of independence from the case<br>Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">I make the following statement that prior to my involvement with this learning review: -<br><br>• I have not been directly concerned with the individual or family, nor have I given professional advice on the case.<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.<br>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</td><td colspan="2">I make the following statement that prior to my involvement with this learning review: -<br><br>• I have not been directly concerned with the individual or family, nor have I given professional advice on the case<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.<br>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</td></tr>
<tr><td colspan="2">Reviewer 1<br>(Signature) Alys Jones<br>Name (Print) Alys Jones<br>Date 23/05/2024</td><td colspan="2">Reviewer 2<br>(Signature) ……………………<br>Name (Print) ……………………<br>Date ……………………</td></tr>
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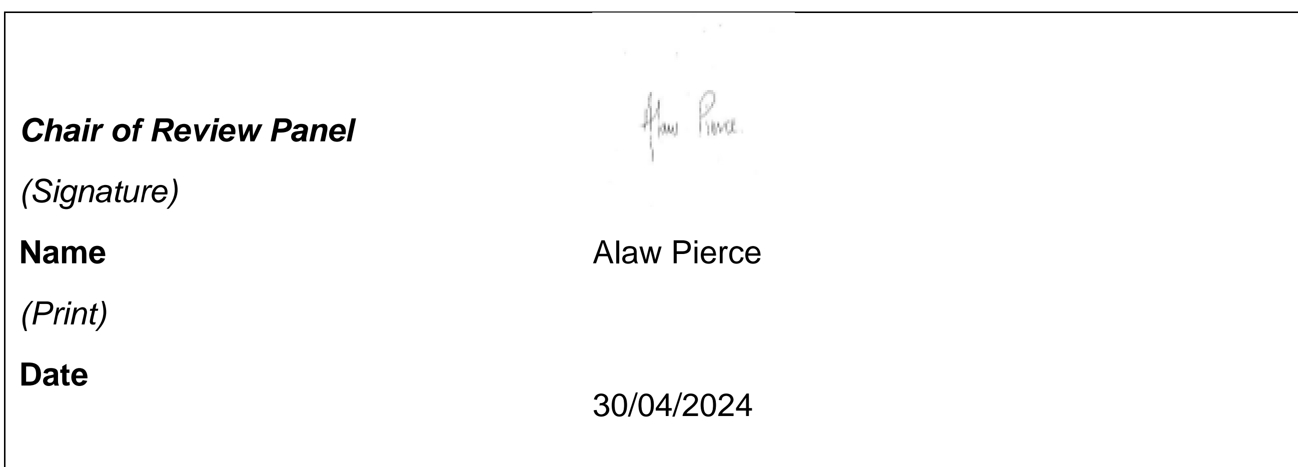

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| ***Chair of Review Panel*** *(Signature)* | |
| **Name** *(Print)* | Alaw Pierce |
| **Date** | 30/04/2024 |

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

| **Adult Practice Review process** |
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| *To include here in brief:*<br>• *The process followed by the Board and the services represented on the Review Panel.*<br>• *A learning event was held and the services that attended.*<br>• *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.* |
| The review process followed Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (Welsh Government, 2016).<br><br>Panel Membership:<br>• Health (BCUHB)<br>• Welsh Ambulance Service NHS Trust<br>• Local Authority Adults Services<br>• Housing<br>• North Wales Police<br><br>A learning event was held on 22nd November 2023. The following services attended:<br>• WAST<br>• CMHT<br>• BCUHB Psychiatric liaison Service<br>• Social Care<br>• GP<br>• North Wales Police (Community Policing) |

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| • Housing Association |
| ☒ Family declined involvement |

**For Welsh Government use only**

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 | ☐ | ☐ | |