Adult A

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

In February 2013 Adult A was placed by (Local) Authority A in an out of county specialist dementia residential home which is in Authority B's area.

Sadly, three months later Adult A passed away in hospital. The coroner recorded cause of death due to pulmonary embolism, deep vein thrombosis and a fracture of the left pubic ramus. Adult A had three falls and the last one resulted in her admission and she did not recover from this.

Four days after Adult A's death, a Protection of Vulnerable Adults (POVA) referral was made to Authority B.

The family made a complaint about how the POVA process was undertaken and this went to a stage 3 Panel. The complaint process ended in April 2016 when the Public Services Ombudsman for Wales issued his final report.

The family were advised that if they were not happy with the findings following from their complaint, including the Ombudsman's report, they could refer to the Safeguarding Adult Board for an Adult Practice Review. The board felt it was not required, but upon appeal this decision was overturned and the case proceeded to Adult Practice Review.

Circumstances of, and challenges faced by the individual

- Adult A could have been admitted into hospital earlier.
- The care home staff's observation and opinion of Adult A's deterioration was not given enough consideration by?
- Care home staff felt that they were not part of the continuum of care.

What happened?

- The care home did not record informal conversations with the family accurately.
- There was no accurate recording of falls. The recording implies a fall but no details of what happened and no record of any observations such as damage to furniture.
- There was a lack of a care plan at the care home for Adult A.

- The care home felt that it could not challenge the health professionals' opinions.
- The hospital medical notes only show information from the family, not from the care home.
- The rationale behind the decision made at the strategy meeting was not recorded in the minutes.
- Adult A's family's voice was not included in the POVA process.
- There is no evidence that advocacy was offered to support Adult A's family.
- Timelines show no evidence that any agency involved in the care of Adult A before her death had considered making a POVA referral.
- No clear ownership of communication with the family, no one from Authority A or B was identified as the lead contact for the family and there is no evidence of proactive contact with the family.
- The family were advised to apply for the minutes of the POVA meeting through Freedom of Information. Reviewer felt that support for the family through this process would have created less of a barrier to overcome.
- The care home requested the social worker from Authority A to review placement due to breakdown in relations between the home and family. This review did not take place.

Why it happened?

- Due to lack of input from care home staff during admission, the medical staff only received one perspective about Adult A's care.
- The information from the minutes of the strategy meeting was not accessible due to format and made it harder to record or identify key points.
- The report cited 'significant' harm – this phrase was very difficult for the family to understand.
- The Client Information System has more accurately reflected the findings of the POVA but not on the minutes, which did not give clarity for the family.
- The Protection Plan section of the minutes was not clearly recorded, and the information it contained was not a protection plan, but a summary of discussions and issues raised. There were no details about the actions to be taken, by whom and by when, to protect others within the care setting.
- No evidence of discussions with the family regarding their preferred method of communication or the frequency of that communication.
- No evidence that professionals had explained to the family the POVA process, the implication of criminal and non-criminal investigations and 'burden of proof' required.
- No evidence that POVA timescales were clearly explained to the family.

- It appears that no information was shared with the family about legitimate delays caused by the coroner's process and independent investigation.
- Authority A did not have any further contact with the care home, Adult A's family or Adult A until they were informed of Adult A's death.
- There were five strategy meetings held during the 15-month POVA investigation. Authority A only attended the fourth and fifth meeting. Apologies were given for the first three.
- When Adult A was admitted into the care home there was no care and support package in place, and no evidence that there was one implemented during her time at the care home.
- The care home expressed anecdotal concerns that they could no longer meet the needs of Adult A and that she might require a nursing home placement. This was not explored further. The care home also expressed anecdotal concerns about their ability to control positive interactions with the family.

Report recommendations

The serious case review makes 12 recommendations:

1. The care home's record keeping should be improved to provide detailed information concerning the circumstances of a fall, the location, witnesses, those present, injuries suffered, damage to property in the vicinity, etc.
2. It is recommended that information be recorded about who participated in the communication, what issues were discussed, what actions were agreed (if appropriate) and who would be responsible for those actions.
3. The Social Services and Well-being (Wales) Act 2014 now places a 'duty to report' on agencies, prior to the Act's implementation in April 2016, agencies were expected to consider safeguarding referrals and to record their rationale for not submitting referrals if they so decided.
4. It is recommended that the format of the strategy meeting minutes be improved to make them easier to read. The minutes should accurately reflect the discussion in the room and not replicate information presented, which can be presented as an appendix.
5. It is recommended that families are supported to obtain information under the relevant access request processes.
6. Actions from the strategy meetings should reflect the decisions made within the meeting. 'It is recommended that a clear action plan (including roles, responsibilities and timescales) be completed and recorded within the strategy meeting minutes and that this action plan is reviewed in subsequent meetings and the outcomes recorded'.
7. It is recommended that the 'Individual/General Protection Plan section is completed to accurately record the general protection plans put in place, even if the individual concerned has passed away'.
8. It is recommended that the rational for decisions made or conclusions reached in strategy meetings

is not limited to the 'options' within the POVA Procedures but that more detail is provided in the narrative together with reasons/rationale.

9. It is recommended that a leaflet explaining the adult safeguarding process be produced, paying specific attention to the criminal and non-criminal investigations (including an explanation of the burden of proof), the role of the coroner, the Public Services Ombudsman for Wales, advocacy support and the complaints process.

10. It is recommended that a communication agreement be created with the service user and / or their family to agree who will be their lead professional point of contact, the family or service user's agreed frequency of communication and their preferred method of communication (for example, email, phone call, etc.).

11. It is recommended that guidance be developed to assist providers and commissioners to support the communication between care homes and families when difficulties and differences of opinion arise.

12. It is recommended that all local authorities involved in an adult safeguarding process attend strategy meetings, take responsibility for relevant actions and are part of the decision making process.

Citation

Pierce A. and Davies J. (2018)
APR3/2016/Conwy
North Wales Safeguarding adults board

www.safeguardingboard.wales/2018/06/17/extended-adult-practice-review-north-wales-4-2016-conwy