Adult C

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

Adult C was 92 years old and sadly died on 2 January 2016 of sepsis, urinary tract infection and dementia. This adult was living in a care home since 2013.

Adult C lived in Merthyr Tydfil for the majority of their life.

Circumstances of, and challenges faced by the individual

- Adult C was admitted into hospital on 29 December 2015 due to concerns around low blood pressure and respiratory problems.
- Paramedics were informed that Adult C's condition had deteriorated the previous day with poor dietary and fluid intake.
- Paramedics made an adult protection referral due to possible neglect and an injury on Adult C's right leg which appeared not to have been treated appropriately.
- Due to the care plan being missing from the home, the reviewers could not fully understand the circumstances relating to care provided by the home for Adult C. It is not clear if staff would have been aware when to escalate physical health concerns.

What happened?

- No calls were made to the GP or emergency services when Adult C's condition deteriorated the previous day.
- No care plans were provided by the care home (cited as missing) only daily notes where shared.
- Strategy meeting didn't take place until three months after the first alert when it should be within seven days.
- Adult C's surname was misspelt which meant that there was a delay with linking it to previous referrals made related to Adult C.
- Adult C's social worker, who is responsible for annual reviews, was not aware of the Mutli Agency Operational Group (MAOG) who had raised a risk rating and embargo on the care home and had closed the case without considering any implications for the care of Adult C.

- There were two adult protection referrals, which were raised at the time of the MAOG monitoring concerns about general care within the home and embargo being put in place.

- The adult service advised the care home to make a Deprivation of Liberty Safeguards (DoLS) application in February 2015. This was followed up in March 2015 to reinforce the need to make application. In June the adult service record showed that no application for DoLS was made by the care home, but no action was taken to rectify this situation.

Why it happened?

- There were three referrals made in 2015. The first and last referral was delayed (either misdirected or not actioned within recommended timescales).

- MAOG and safeguarding were never linked. One was focusing on the individual and the other was on the care home.

- The non-criminal investigation was unclear in terms of who should have been spoken to and timescales set.

- Assumptions were also made which went unchecked and led to recommendations being made that were not relevant.

Report recommendations

The serious case review makes six recommendations:

1. 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 within the recommended timescales. The placing authorities and commissioners must also be included in the strategy discussions/meetings.

2. 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.

3. 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.

4. 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.

5. 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.

6. Safeguarding Board should assure itself that placing authorities are informed when the MAOG process is implemented within the host authority.

Citation

Scott S. and Green T. (2016)
re:ECPR Denbshire

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