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Request for Professional Advice

Date: 21 March 2024

Case reference number: 20230XXXX

Caseworker Name: [Redacted]

Contact details: [Redacted]

Name of Local Authorities involved:
Carmarthenshire County Council ("CCC")
Neath Port Talbot Council ("NPTC")

Nature of the advice required:

Adviser required:

Social worker with experience of adult safeguarding procedures

Brief details of issues requiring advice:

Advice is being sought about the actions taken following concerns about coercive control / isolation of Mr R by his partner. Advice is also being sought about whether appropriate information was requested/considered as part of safeguarding procedures following the death of Mr R.

The Ombudsman is seeking a peer review of the care provided. The complaint is about the actions of professionals in the above specialism, and it is for this reason this adviser has been requested. The adviser is asked to advise on the complaint in this capacity.

Estimation of time required to undertake work

For each element (and for each piece of advice requested), you should tick which criteria applies and then add up the scores to find the indicative time for the case.

Elements to be considered	Points matrix					
		1		2		3
Volume of case records to be considered.	< 250 pages	☐	250 - 500 pages	☐	Over 500 pages	✓
Number of questions (including sub-questions) to be answered.	1-3	☐	4-6	✓	7-9	☐
Length of time the complaint relates to.	Up to 7 days	☐	Several weeks	☐	Several months or longer	✓
Complexity of complaint - number of 'Heads of Complaint'	1	☐	2-3	✓	4 or more	☐
Column Totals*				**4**		**6**
Total score	10					

Key	
Total Score of	**Indication of time required to consider case**
4-6	1 - 5 hours
7-9	6 - 10 hours
10-12	11 - 15 hours

Note for Adviser – Please could you confirm, following an initial consideration of this complaint, that you are content to provide your advice within the timescale indicated. If you do not consider the timescale identified sufficient, please contact the Professional Advice Co-ordinator or the caseworker to discuss how long you consider the advice will take to prepare.

Investigation Officer to provide details of documents/sub file/CDs to be sent to Adviser with advice request.

Sub File Name as on Workpro	Activity date on workpro
HOME – IPA complaint subfile	15/3/24
HOME – IPA Council records subfile	14/3/24
HOME – IPA third party subfile	15/3/24

Professional Adviser

I set out below my request for clinical advice.

The complainant and their relationship to the patient

Mrs C has made a complaint about the actions of both NPTC and CCC in regard to her late brother, Mr R.

The complaints subject to investigation

The investigation will consider Mrs C's complaint against CCC and NPTC. Mrs C complained that the Stage 2 investigation about her late brother, Mr R, did not fully address her concerns. She complained that:

a) The Stage 2 report did not sufficiently consider complaint 1, whether Mr R was being isolated by his partner from family, community and services.

b) The outcome of the safeguarding Strategy meeting in August 2021 was flawed as it should have considered witness statements prepared by staff at ["the first"] Hospital.

Background and the events

Page references in this section relate to the Council records subfiles unless otherwise stated

Mr R lived in the area of NPTC (Skewen) and was in a relationship with Ms P, who resided in the area of CCC (Ammanford).

In April 2021 Mr R fell and was admitted to [the second] Hospital. During his admission he was diagnosed with Motor Neuron Disease ("MND"). His capacity was found to be fluctuating. On 23 April a safeguarding referral was submitted to NPTC due to concerns that Mr R was going to attempt to discharge himself on the advice of his partner, who at times he had said he did not trust, at a time he was deemed to lack capacity (page 183/434/457). Ms P was also refusing for an OT home environmental assessment at Mr R's home, despite him giving consent. She said this was because she wanted to protect his dignity as the home was in a state of disrepair. An urgent DOLS authorisation was also requested (Third party subfile page 16). Another doctor also emailed the safeguarding team his views (page 155). The safeguarding referral was closed on 28 April (page 191) when it noted that Mr R was now happy to remain on the ward so discharge could be planned, the OT home visit had taken place, and there were no outstanding safeguarding concerns. Ward staff had been asked to explore with Mr R when he made comments that he did not trust his partner. It was also noted that Mrs C could be spoken to if she expresses concerns again. A domestic abuse checklist had also been completed by the ward (Third party subfile page 22). Following this Mr R was then deemed to have capacity and was wishing to be discharged to

Ms P's address. He was discharged on 30 April. No package of care was deemed necessary and neither CCC nor NPTC were involved in the discharge arrangements.

Following discharge, Mrs C made a referral to NPTC due to concerns for Mr R (page 193 / 444). The hospital was contacted to discuss the discharge arrangements which were made including the home OT assessment. Mrs C was contacted to discuss and was advised he had been discharged as per discharge arrangements. On 5 May attempts were made to contact by phone Mr R and the community physiotherapy department, both of which were unsuccessful. Mrs C had also not been able to contact Mr R. It was discussed with management and agreed for a welfare check to be undertaken.

The MND community team were also unable to contact Mr R or his partner (page 202).

Mr R was supported by his partner to attend an outpatient appointment with a consultant on 10 May (Third party subfile page 10) and the consultant confirmed to NPTC that he had no concerns regarding abuse or neglect based on Mr R's presentation during the consultation (page 205).

On 14 May Age Cyrmu shared concerns with the NPTC on behalf of Mrs C (page 151). Mrs C also expressed her concerns at not being able to speak with Mr R (page 207). Home visits were carried out by NPTC to both Mr R and Ms P's addresses but there was no answer (page 209). Notes were left requesting contact.

On 19 May letter was sent asking for contact to be made (page 212).

On 20 May MND team were contacted (page 217 - 218). Plan was noted to await response from letter, that a further home visit would be attempted next week and MND team would also write to Mr R requesting contact.

On 21 May Mrs C made further contact expressing concerns that she had not been able to speak to Mr R, was aware the physiotherapy had been attempting to contact without success. She questioned whether a police welfare check would be appropriate.

On 25 May a further visit was undertaken to Mr R's address. Ms P answered the door and eventually agreed for Mr R to come to the door. It was noted that the situation was "very concerning". Ms P advised she did not participate in appointments unless she had prior written correspondence. There were questions regarding Mr R's capacity and whether his care and support needs were being met (page 227). Mr R's MND was progressing rapidly.

On 26 May Mr R was allocated to NPTC social worker LD. She contacted Mr R's GP practice for background information (page 228). On 27 May LD carried out a joint visit with a colleague to Mr R's address but no one was home (page 232). A

t/c was made to the safeguarding team who advised to submit a referral. LD also spoke with MND team who confirmed they had still been unable to contact Mr R (page 231). On 27 May LD submitted a safeguarding referral (page 144 / 1).

CCC safeguarding were contacted (page 44) and it was agreed that CCC would take responsibility as Mr R was currently residing in CCC (page 234). A safeguarding referral was submitted to CCC with request for urgent welfare check (page 240). PPU were also contacted. CCC assessed the safeguarding referral (page 84).

On 27 May CCC attempted a visit to Ms P's addressed but no one was home (page 243 / 91). A further visit to Skewen was requested and CCC planned a further home visit the following day. LD visited Mr R's property but there was no answer (page 244). Further visits by NPTC took place on 28 May but was unsuccessful (page 245) and on 1 June (page 249).

On 2 June a family member of Ms P contacted CCC with concerns about Ms P caring for Mr R (page 91).

On 2 June CCC social worker visited Mr R at Ms P's address (page 255 / 7). He was deemed to lack capacity in regard to his care and support needs (page 425). It was noted that Ms P was reluctant to engage with professionals and serious concerns for Mr R wellbeing.

Further visit from CCC on 3 June confirmed there were no immediate concerns for Mr R's wellbeing (page 262). The visit was 5 hours 30 minutes (page 10).

On 10 June the MND community team undertook a visit (pages 428 – 433) which noted that they had "grave concerns" for Mr R safety.

CCC held a strategy meeting on 15 June (page 270 / 127) following which a joint visit by LD and CCC social worker EG to be undertaken to complete assessment and further information to be obtained re discharge arrangements on 30 April. A joint visit took place that afternoon (page 274 / 11). Consent was gained for a Care and Repair referral. Ms P was shown how to use the mobile phone.

Further visit to Ms P on 16 June (page 276). A referral to Care and Repair was sent on 17 June.

The strategy meeting was reconvened on 17 June (page 285). It concluded there was no evidence to suggest that Mr R was at risk of abuse/neglect. If Ms P did not engage with services offered he could be re-referred back. LD agreed to visit weekly.

On 21 June LD undertook a home visit (page 288). During the visit Mr R fell and an ambulance was called and he was taken to hospital the following day. He was diagnosed with a subdural haematoma and urinary retention.

Social Worker assessment (page 165) was completed on 24 June in preparation for Mr R's discharge from hospital. It includes relationship with Mrs C can be supported without Council input. Relationship with Ms P is also noted. There is no reference to wider networks or religious beliefs. It notes that Ms P at that time was unable to use a mobile phone to make outgoing calls. It also noted a best interest meeting and DST to be held on 15 July.

Joint home visit was undertaken with Care and Repair on 28 June to Ms P (page 311).

Mr R remained in hospital while undergoing assessments/medical intervention. A professionals meeting took place on 28 June (page 20) to discuss discharge planning. On 30 June a best interest discussion took place (page 22). Consideration was given as to which are Mr R would wish to reside in an interim placement. On 16 July a DST and best interest meeting took place (page 343)

On 30 July ward staff submitted a safeguarding referral due to concerns about Ms P force feeding Mr R (page 371, complaint subfile page 208). Health Board safeguarding team advised the risk could be managed through observation on the ward (page 389).

Sadly, on 4 August Mr R died (page 396 / 132). A safeguarding referral was made due to the circumstances of his death and concerns that Ms P had been force feeding him (page 27 / page 39 / Third party subfile page 59). A strategy discussion took place on 5 August (page 31). An initial strategy meeting took place on 13 August (complaint file page 27). A strategy meeting took place on 15 September (page 40 / minutes page 32 complaint subfile). A timeline of events by the HDUHB SALT team had been prepared (page 140). The referral was closed as it was concluded there was no evidence of neglect or abuse.

Summary of the complaints procedure

Mrs C was concerned about the care and support her late brother had received. She made a complaint to CCC on 12 April 2022 via an advocate. It was decided to proceed straight to Stage 2 investigation and this was a joint investigation for NPTC and CCC, lead by CCC. The complaint response was issued on 2 May 2023. The unredacted stage 2 report and appendices have been included in the complaint subfile. The outcome of the Stage 2 investigation was that 3 of the complaints investigated were upheld and recommendations made in relation to these.

Mrs C was unhappy with the Stage 2 report and submitted a detailed complaint to the Ombudsman. This included a significant volume of supporting documentation, a lot of which has also been provided directly to the Ombudsman by the relevant bodies. Therefore, to avoid duplication, these documents are within the Council records subfile and only additional information provided by Mrs C, or documents she has annotated, are included in the complaint subfile (pages 151 – 240).

Following assessment of this complaint it was deemed appropriate to investigate 2 heads of complaint as detailed in the investigation start letters (pages 241 – 252).

In response to the investigation, CCC have provided further comments on the issues subject to complaint (pages 253 - 256). NPTC provided copies of the transcripts of relevant staff discussions with the Stage 2 independent investigator (pages 257 - 274).

Please note –

There is a large volume of documentation and work has been done to bookmark relevant documents within the pdf subfiles and include page references for ease. Due to the relevant bodies working together there is some duplication of records such as email trails between the organisations within the subfiles of documents provided. Efforts have been made to remove multiple copies of the same documents where possible but some duplication remains.

Also included are some third party records which were requested SBUHB and HDUHB to aid the investigation, such as copies of documents submitted to CCC as part of safeguarding procedures. However, these bodies are not subject to the investigation and this documentation is for information purposes only. SBUHB also provided to the Ombudsman copies of the inpatient records relating to Mr R's admission to [the second] Hospital in April 2021. Although these provide background/context I have not included these in the IPA subfile as the investigation is considering the actions of the Council's based on the information known to the Council. If the IPA would like copies of these additional records please let me know and they can be provided.

The CCC complaint file has not been provided. It contains a significant volume of emails relating to the complaint handling and queries regarding this process from Mrs C, rather than specific information relating to the events complained about. If the adviser wishes to have this as well it can be provided.

Known guidance / legislation applicable in Wales

Social Services and Wellbeing Act (Wales) 2014, particularly part 7, and codes of practice.
Wales safeguarding procedures
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

<u>Information provided by the individuals complained about</u>

Contained within the complaint subfile is a copy of safeguarding guidance provided by NPTC.

Questions

I set out below questions relating to the complaint. For each question, please would you set out what happened, what should have happened, the impact of any difference between the two, and any remedy or recommendations to prevent recurrence or improve care for the future.

a) The Stage 2 report did not sufficiently consider complaint 1, whether Mr R was being isolated by his partner from family, community and services.

1) Please comment on whether you consider appropriate action was taken, including the timeliness of the action, by NPTC and CCC following Mr R's discharge from hospital in April 2021 until his death in August 2021, specifically in relation to whether he was being isolated from:

   - Professionals
   - Family
   - Friends and the wider community such as Chapel.

If you identify a failure in the action taken, please specify what action you consider would have been reasonable in the circumstances.

2) Mrs C specifically feels the lack of use of mobile phones contributed to isolation and was not considered in the stage 2 report (complaint file page 145). Please include specific comment on whether appropriate action was taken in regard to concerns about isolation and communicating by mobile phone.

b) The outcome of the safeguarding Strategy meeting in August 2021 was flawed as it should have considered witness statements prepared by staff at [the first] Hospital.

3) The safeguarding strategy meetings, following the death of Mr R, were multi-agency and chaired by CCC. Mrs C is unhappy that the witness statements prepared by HDUHB staff were not considered by the chair and believes, as a result, the outcome of the meeting was flawed (complaint file page 148). CCC have provided further comment on why these were not considered directly by the chair (complaint subfile page 255).

   Please comment on whether you consider it was reasonable that these statements were not requested or viewed by CCC in its role as chair of the safeguarding strategy meeting.

   Please note, copies of the statements have been provided in the third party subfile. However, as we are unable to consider events with the benefit of hindsight, please do not consider their content when advising as to whether they should have been requested.

4) If you consider these documents should have been requested by the Chair of the Strategy meeting, please comment on what impact you consider this would have had, if any, on the outcome of the safeguarding procedures.

Please let me know if, in considering my questions, you identify any other relevant matter that gives you cause for concern.

Thank you for your advice. If you need to discuss the case, please do not hesitate to contact me.

[Redacted]
Swyddog Ymchwilio/Investigation Officer

TO BE COMPLETED BY ADVISER

Advice

Any comments on Background and Chronology:

Provision of Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference): XXXXXXXX
Adviser's Name and Qualifications: XXXXXXXXXXXXXXXXX; [Relevant qualifications provided]
Relevance of qualifications and/or experience to aspects of this case: Full outline of experience relevant to this case provided
Conflict of Interest (clarification of any links with Body or professionals complained about): None
Confirmation that the Ombudsman's Clinical Standards [insert link] have been applied in the provision of the advice Yes
Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant events Yes

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3. Background provided as follows:

3.1. Mr R (DOB xxxxxx) of [redacted] was admitted to [the second] Hospital Swansea Bay University Health Board, on 25th March 2021 with a fractured humerus sustained after a fall at home. An Occupational Therapy (OT) referral was made on 30/3/2021. Following further tests Mr R was diagnosed with motor Neurone Disease and advised of the condition by the Consultant on or around the 19/4/2021 Prior to admission to [the second] Hospital neither he nor his partner, were known to any services.

3.2. In April 2021 Mr R fell and was admitted to [the second] Hospital. During his admission he was diagnosed with Motor Neuron Disease ("MND"). His capacity was found to be fluctuating. On 23 April a safeguarding referral was submitted to NPTC due to concerns that Mr R was going to attempt to discharge himself on the advice of his partner, who at times he had said he did not trust, at a time he was deemed to lack capacity.

3.3. Sadly, on 4 August Mr R died. A safeguarding referral was made due to the circumstances of his death and concerns that Mr R's carer had been force feeding him and additional safeguarding concerns raised.

4. Sources of Information.

- Motor Neurone Disease Association
- Mental Capacity Act 2005.
- Wales Safeguarding Procedures 2019
- Working Together to Safeguard People: Code of Safeguarding Practice (Jan 2022)
- Social Services & Wellbeing (Wales) Act 2014
- Human Rights Act 1998

Questions and Responses:

Question 1: Please comment on whether you consider appropriate action was taken, including the timeliness of the action, by NPTC and CCC following Mr R's discharge from hospital in April 2021 until his death in August 2021, specifically in relation to whether he was being isolated from:

- Professionals
- Family
- Friends and the wider community such as Chapel.

6.1. On the 30th of April 2021, Mr R was discharged from [the second] Hospital, Swansea. Prior to the discharge home in the community, and on the 29th of April 2021; Mr R's Mental Capacity was assessed to determine as to whether Mr R was able to decide on being discharged home in the community.

6.2. Mr R's hospital notes prior to this time suggest Mr R's decision making on specific matters appeared to be fluctuating at times, particularly with regards to retaining information after a short period of time. However, capacity is time and decision specific. This means the assessor should assess an individual's ability to make a specific decision at the time it needs to be made, which is reflected in the actions taken in 5.3.

6.3. A letter written by [redacted], dated 14th July 2021, referring to the assessment of capacity on the 29th of April 2021; states "Assessed as having full capacity and full understanding of discharge to [Ms P]'s house and he had no concerns. He clearly stated numerous times he wanted to go to [Ms P]'s house and wanted to be looked after by her".

6.4. Therefore, it appears that, at the time of the assessment, there were no concerns regarding Mr R's ability to decide on the matters related to being discharged home in the community with his partner.

6.5. Further, behaviour is generally viewed as a form of communication and behavioural responses are often purposely observed by professionals to understand the meaning of such communication, the letter notes that Mr R's discharge home to his partner was facilitated by an Occupational Therapist who had no concerns upon facilitating Mr R's home.

6.6. The Wales Safeguarding Procedures states possible indicators observed in vulnerable adults with regard to maltreatment, including psychological and emotional abuse; some examples are, one may observe 'an air of silence when a particular person is present and/or 'withdrawal or change in the psychological state of the person'. Upon discharge, in my professional opinion, there was no evidence at this point within the case file to suggest anything of this nature to give rise to a cause of concern.

6.7. Shortly, prior to Mr R's discharge from hospital, within the notes there are indications of professional concerns as to whether the care available to Mr R at home with his partner was able to meet Mr R's care and support needs. However, Mr R's appears to be clear and consistent with his wishes to return home with his partner.

6.8. It is not clear whether it was discussed specifically with Mr R's the concerns that professionals had about his care and support at home with his partner. Despite this, it is important to note, Principle 3 of the Mental Capacity Act

2005, in relation to 'Unwise Decisions' states; "People have the right not to be treated as lacking capacity merely because they decide something that others deem 'unwise'. In summary, everyone has their own values, beliefs and preferences which may not be the same as those of other people. However, as discussed, Mr R was deemed to have capacity to decide on discharge on the 29th of April 2021.

6.9. On the 30th of April 2021, a safeguarding concern was raised with Neath Port Talbot Council by Mrs C, sister of Mr R regarding difficulty contacting her brother. The Motor Neurone Disease specialists also had the same issue. Neath Port Talbot Council opened up the referral and staff tried to make contact. When they failed, a Safeguarding referral was made to Carmarthenshire County Council Safeguarding Team.

6.10. Responding to a report means professionals gathering information to:

- determine whether the concerns raised provide a reasonable cause to suspect an adult is;
- experiencing abuse and/or neglect;
- has care and support needs and;
- as a result of these needs is unable to protect themselves against abuse or neglect or the risk of it (Section 126(1) (s.126) of the Social Services and Well-being (Wales) Act 2014);
- make or cause to be made, whatever enquiries social services thinks necessary to enable it to decide whether any action should be taken;
- decide whether any such action should be taken and if so what and by whom.

(Wales Safeguarding Procedures and The Social Services and Well- being (Wales) Act 2014).

6.11. In reference to the above procedures, reviewing the case file and cross referencing with the Wales Safeguarding Procedures and The Social Services and Well-being (Wales) Act 2014, in particular Section 126(1) (s.126), I found that Neath Port Talbot Council acted in a timely, reasonable, and appropriate manner in their scrutiny of the safeguarding information provided and the gathering of information when the Safeguarding referral was made by [the second] Hospital on 23/4/21 and then subsequently on 30/4/21.

6.12. The safeguarding referral information is explored in the report written by [redacted], Independent Investigating Officer, and to prevent repetition, does not need to be further explored here. In reviewing the case file and cross referencing with the Wales Safeguarding Procedures and The Social Services and Well-being (Wales) Act 2014, I found that Carmarthenshire County Council responded to the initial referral from Neath Port Talbot Council in a timely manner.

6.13. The following issues appear to be the salient factors and points of concern related to question one, specifically in relation to whether Mr R was being isolated from:

- Professionals
- Family
- Friends and the wider community such as Chapel.

6.14. Prior to Mr R's discharge to the community, the case files note that Mr R's partner refused to allow OTs to assess the suitability of the [redacted] property, citing she wanted to protect Mr R's dignity.

6.15. Instead, her property at [redacted], Ammanford was assessed by [the second] Hospital OTs as the address for patient discharge. Mr R returned to the Ammanford address on 30/4/2021.

6.16. However, Mr R had capacity at the time of discharge and his wishes and feelings were clearly noted, that he wished to be discharged to his partner's home, his wishes, and feelings although on the balance of probability, likely unwise, due to his declining physical presentation and the risks to him.

6.17. Mr R's wishes and feelings would typically be a priority for professionals. Nevertheless, professionals would need to pay due regard to the Mental Capacity Act and Article 8: Respect private and family life, and the right to live your life privately without government interference.

6.18. However, it is clear from the case file, both Carmarthenshire County Council and Neath Port Talbot Council's actions were appropriate and proportionate in their response to what was a complicated situation, continuing making contact as far as possible and within their professional abilities to engage Mr R and his partner.

6.19. Over May 2021, attempts were made by professionals to contact Mr R. Neath Port Talbot Council opened up the referral and staff tried to make contact. When they failed Carmarthenshire County Council also failed to in their attempts to contact Mr R throughout May 2021 to no avail.

6.20. In a letter written by Dr M, dated 5th May 2021, the letter observes some concerns regarding Mr R's future care at home, including concerns regarding the care to be provided for Mr R by his partner.

6.21. However, on the 10th of May 2021, Mr R and his partner attended an outpatient appointment. Mr R is noted to have difficulty with his hearing, but no professional concerns regarding abuse or neglect. There is evidence of safeguarding joint working between clinicians and Neath Port Talbot Council continuing making

contact as far as possible and within their professional abilities to establish Mr R's presentation and well-being.

6.22. On the 25th of May 2021, professional concerns arise from observing Mr R at the property by the front door accompanied by his partner, consequently concerns were raised by professional regarding Mr R's capacity and care and support needs. Therefore, concerns appear to relate to the possibility of a carer's ability to meet the care and support needs of Mr R's and reference is made to Mr R's condition 'rapidly progressing'. As a result, gathering information within the safeguarding duties of professionals progressed.

6.23. Safeguarding enquiries are made under s126 of the Social Services and Well-being (Wales) Act 2014. Following a report, social services have a duty to make enquiries, if there is reasonable case to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk.

6.24. Enquiries should normally be completed within 7 working days of the report/referral. The 7 working day enquiry period will commence once the report has been received by the local authority. As such, the safeguarding concern raised on the 14th of May 2021, and again on the 21st of May 2021, with a visit and welfare check arranged by social services on the 25th of May 2021 and enquiries initiated. The Wales Safeguarding Procedures states professionals should include:

- checking general factual accuracy of any report;
- completing an initial evaluation: This will involve collecting, reviewing, and collating information. (They may ask other relevant partners to complete this on their behalf but retain case responsibility);
- determining what, if any, action should be taken.
- The factual accuracy, initial evaluation and determination process do not need to follow consecutively, practitioners can proceed to the element that is applicable in each case.

6.25. The following questions are advised to be considered under the Wales Safeguarding Procedures, throughout the enquiry process:

- Are the enquiries person-centred?
- Does the adult at risk lack capacity to decide to protect themselves from abuse?
- Should police be involved because a crime is suspected or becomes known?
- Are care and support needs being recognised as they emerge?

6.26. From the 25th of May 2021, there is evidence of appropriate enquiries being undertaken, and multi-disciplinary joint working as part of such enquiries.

6.27. On the 2nd of June 2021, a Carmarthenshire County Council social worker visited Mr R and his partner. He was deemed to lack capacity in regard to his care and support needs. It was noted that Mr R's partner was reluctant to engage with professionals and serious concerns for Mr R's wellbeing, reflecting earlier concerns regarding the possibility of a carer's ability to meet the care and support needs of Mr R.

6.28. In early June 2021 Carmarthenshire County Council staff managed to make contact by initiating a visit after office hours. There followed approximately 3 weeks of activity to try and establish a working relationship with Mr R's partner as his main carer. She was reluctant to have strangers involved in their lives.

6.29. Between the 2nd and 10th June 2014, a further two concerns were raised regarding carers ability to meet Mr R's care and support needs. On the 3rd of June 2021, a further visit from Carmarthenshire County Council on 3rd June confirmed there were no immediate concerns for Mr R's wellbeing. Conversely, on 10 June the MND community team undertook a visit which noted that they had "grave concerns" for Mr R's safety.

6.30. Wales Safeguarding Procedures notes some 'Pointers for Practice' in Identifying adults and their carers who may require early interventions to prevent the adult becoming an adult at risk of abuse and neglect; which states;

"Risk of abuse or neglect by a carer to an adult at risk may increase if the carer is isolated and lacks support. Somerset Safeguarding Board have identified possible situations where an adult at risk is potentially vulnerable to abuse or neglect by a carer.
Carers who:

- do not have their own needs met.
- are or are vulnerable to abuse or neglect from the adult at risk.
- lack understanding or insight into the adult at risk's condition and/or needs.
- had to change their lifestyle unwillingly.
- do not receive practical and/or emotional support.
- feel isolated, undervalued, or stigmatised.
- requested help but did not receive it or received help that did not address the issue.
- have other responsibilities for example, caring for a family, working.
- have no personal or private life outside their caring role.
- feel unappreciated or exploited by the adult at risk, family and/or practitioners".

(Wales Safeguarding Procedures, accessed 2024).

6.31. In consideration of the above, there appeared to be several professional concerns regarding Mr R's carer and partner's ability to provide appropriate care and support, which may or may not reflect a lack of understanding or insight into the adult at risk's condition and/or needs. It is difficult to be definitive about whether or not; when there are professional concerns about a carers' ability to meet care and support needs for a vulnerable adult, what the reasons for this might be.

6.32. On 10th June the MND community team undertook a visit to Mr R and raised concerns about the carers ability to manage Dr R 's care and support needs at home.

6.33. There are several reports from several professionals related to the carers ability to manage Mr R 's care and support needs at home. Some examples of these are below;

1. "She stated that she "did not have time" to read the information we had brought on living with MND and said she did not think the team could be of any help to her. It was obvious from the minimal input we were given to discuss the condition that she knows very little about MND and she dismissed suggestions of 1. A neck collar to help manage Mr R's head drop, 2. A wheelchair to reduce the risk of falls as she would "not be able to push it" or 3. To consider carer support from social services", (MND community team report, dated 11th June 2021).

2. "This visit has left us with grave concerns for Mr R's safety. Not only due to the physical environment, which in itself holds many risks, but also because of [Ms P]'s lack of insight and dismissive nature of his condition and prognosis and more importantly her refusal to engage with the MND team. To this end, she is denying him the care and support he requires, and he lacks the ability to do anything about this". (MND community team report dated 11th June 2021).

3. On 2nd June a social worker visited Mr R's at the carers address. He was deemed to lack capacity in regard to his care and support needs. It was noted that carer was reluctant to engage with professionals, a view that carer was not acting in the best interests of Mr R and serious concerns for Mr R's wellbeing. (Senior Safeguarding Officer report dated, 2nd/3rd June 2021)

4. Concerns about Mr R's carer's ability to provide a caring role for Mr R, and also has concerns about the condition of the property. (MDT Integrated Report, dated 3rd June).

6.34. The strategy meeting held on the 17th of June 2021 concluded with all present, agreeing that there is no evidence to suggest that Mr R is at risk of abuse/neglect at that point. The report notes if the carer does not engage with services offered to Mr R in relation to his health and care needs to be brought back to the Safeguarding arena.

6.35. In light of the information assessed, and upon Mr R’s clarification as to whether he had capacity to make decisions upon his care and support arrangements, it was established on the 2nd of June 2021, that Mr R’s did not have capacity to make decisions upon his care and support arrangements. Therefore, and on the balance of probability, as a result of these needs Mr R was unable to protect himself against abuse or neglect or the risk of it (Section 126(1) (s.126) of the Social Services and Well-being (Wales) Act 2014).

6.36. Under the Social Services and Well-being (Wales) Act 2014, the Duty to Assess states a local authority must offer an assessment to: Any adult where it appears to that authority the adult may have needs for care and support:

- A local authority must assess whether an adult does have needs for care and support and if so, what those needs are.
- The duty applies in relation to adults who are ordinarily resident in the area and to other adults in the area, regardless of the level of need for care and support and the level of the adult’s financial resources.
- The assessment must focus on the outcomes the adult wishes to achieve in his or her daily life and the extent to which the provision of care and support, preventative services, or the provision of information, advice, or assistance, could contribute to the achievement of those outcomes.
- The assessment itself must be proportionate to need and involve the adult and where feasible, the adult’s carer.

6.37. During the strategy meeting on 15th June following which a joint visit arrangement was actioned to be undertaken to complete an assessment of Mr R’s needs and involve the adult and where feasible, the adult’s carer. In such circumstances with current arrangements for care and support provisions being of particular concern to professionals, and where professionals determine, there are no immediate concerns, as was the situation and view of professionals on the 3rd of June and 17th June 2021 in the case of Mr R, a Best Interests Meeting is a helpful process to initiate to care and support for an individual who is unable to make such a decision.

6.38. Under the Social Services and Well-being (Wales) Act 2014, Part 3 Code of Practice (assessing the needs of individuals), If an adult refuses an assessment, the local authority’s duty to carry out the assessment does not apply except for two cases where the local authority must carry out an assessment notwithstanding a refusal.

6.39. The first case is where the adult lacks capacity to make the decision to refuse the assessment and an assessment would be in his or her best interests. The second case is where the adult is experiencing or is at risk of abuse or neglect. If the adult experiencing abuse has capacity and chooses to endure the abuse and refuses to participate in an assessment, the local authority must assess the situation given the information it holds or has received from its partner agencies.

6.40. Similarly, for an adult unable to protect himself against abuse or neglect or the risk of it (Section 126(1) (s.126) of the Social Services and Well-being (Wales) Act 2014); where there may be concerns regarding the care and support provided, the Duty to Assess remains relevant.

6.41. On the 15th of June 2021, social workers planned to visit Mr R to begin such an assessment, the strategy meeting minutes note on the 17th of June 2021, if Mr R's carer did not engage with services offered, Mr R would likely be subject to a further safeguarding referral.

6.42. Further, there is evidence that Mr R's carer was attempting to prevent professionals from visiting the home, however, the reasons as to why this was an issue, is not clear in Mr R's case file and doesn't appear to have been explored directly with Mr R's carer by professionals. There appeared to be less issues engaging with professionals when going to outpatients' appointments outside of the home environment.

6.43. There does appear to be a lack of understanding or insight from Mr R's carer into Mr R's risk's surrounding his condition and/or needs and willingness to take on professional advice. However, the importance of having these difficult conversations with Mr R's carer was a critical need to prevent any future harm. The Safeguarding Officers who visited on the evening of 2/6/21 made it clear to Mr R's partner what would happen should she at any point in the future obstruct officers and professionals from visiting.

6.44. During the review of the case file, I was unable to identify any specific direct incidents of harm to Mr R prior to his death or concerns arising that may have been associated with or as a direct result of the risks presented by the carer's challenges working with professional advice surrounding his condition and/or needs and willingness to take on professional advice. There are several professional observations in the home that note no concerns for Mr R's presentation.

6.45. It is not possible to establish, whether or how Mr R was possibly isolated from his family, friends, and the wider community such as Chapel. Mr R's case file notes significant deterioration in his presentation, including his hearing noted by his consultant. Therefore, it is not known to what extent such needs acted as a

barrier in independently engaging with family, friends, and the wider community. However, there are several references to 'rapid deterioration in Mr R's presentation'.

6.46. During the case review, I was unable to identify evidence of concerns of domestic abuse relating to isolating Mr R from his family, friends, and the wider community as well as understand to what extent his needs acted as a barrier in independently engaging with family, friends, and the wider community or whether there were additional concerns preventing such engagement. Such information would allow a balanced assessment of the circumstances surrounding such issues.

6.47. However, from the information assessed, while I feel it is clear that that Mr R's carer was attempting to prevent professionals from visiting the home, the reasons as to why this was an issue, is not entirely clear in Mr R's case file given the deterioration noted in his MND. However, the focus for a social worker would be to assess the impact and risk for the service user, which although concerns did arise for Mr R's wellbeing, on the 3rd of June, professionals considered there to be no immediate risk to Mr R's wellbeing and were able to gain entry to see Mr R and his carer, and begin intervention required which would also enable professionals to assess the needs of Mr R and his carer and also serve to some extent as a protective factor in progressing care and support provisions.

6.48. I would agree with the conclusion noted in the investigation report, which states; "Once they had moved away from the Safeguarding arena one would have expected to see multi-disciplinary meetings being held with the associated professionals to plan the way ahead. That was at its first tentative steps during those middle weeks of June. [Mr R]'s fall and admission to PPH on 22/6/21 halted all of that".

6.49. In conclusion, I have not been able to identify a failure in the action taken by professionals, but such exploration and difficult conversations but important discussions need to be addressed with carers in such circumstances and in the best interests of those being cared for.

6.50. A care and support needs assessment were actioned by professionals as discussed. However, professionals' observations of Mr R note no immediate concerns to proceed with more formal actions and immediate arrangements to safeguard Mr R, and therefore, proceeding with assessment of Mr R's needs to look at care and support required.

6.51. Mr R's past wishes on his care and support decisions were made clear to professionals regarding his wish to return home with his partner and would usually continue to be considered when an individual is no longer able to make

such decisions, equally with full consideration to the needs and best interests of the current circumstances.

6.52. Section 6(3)(b) of the Social Services and Wellbeing (Wales) Act 2014, stresses 'the importance of promoting the adult's independence where possible'. This is amplified by para 56 of the Part 2 Code of Practice (General Functions) which states that the well-being duty 'includes key aspects of independent living as expressed in the UN Convention on the Rights of Disabled People [CRDP].

6.53. Article 19.' Article 19 recognises the right of disabled people to 'full inclusion and participation in the community'; to choose where they live and with whom they live; and to have access to a range of community support services 'to support living and inclusion in the community, and to prevent isolation or segregation from the community.' 'Suitability of Accommodation' is a clear element within the needs assessment under the Social Services and Wellbeing (Wales) Act 2014 and would form part of the social work assessment initiated with Mr R.

6.54. The case file notes, Mr R regularly went out in the community with his partner, notably to one of his favourite eating places in Swansea. He was also transported and accompanied to his building society in Swansea whenever he wanted. In the presence of the social workers Mr R was witnessed gesturing to his partner to take him out in the car and his partner responded to this request without hesitation. Mr R was spoken to in private on at least 3 occasions and asked explicitly about any potential abuse or neglect within the relationship and denied there to be any issues.

6.55. Practitioners were acutely aware of the concerns raised relating to alleged isolation and paid particular attention to any signs of this. There were occasions when practitioners arrived unannounced, and sometimes Mr R and his partner were not at home, this was evident by the car not being in sight however, when the practitioners returned later in the day they were not prevented from meeting with Mr R. In addition to being alert to any signs of isolation or any other potential safeguarding concerns the practitioners were focused on working at establishing a good working relationship with Mr R and his partner to fully support them both. Contact was made with other professionals throughout the intervention.

6.56. It is not possible to establish, whether or how Mr R was possibly isolated from his family, friends, and the wider community such as Chapel. Mr R's case file notes significant deterioration in his presentation, including his hearing noted by his consultant. Therefore, it is not known to what extent such needs acted as a barrier in independently engaging with family, friends, and the wider community. However, as discussed, in the presence of the social workers Mr R was witnessed gesturing to his partner to take him out in the car and his partner responded to this request without hesitation.

6.57. Mr R was spoken with privately at home and although his communication was limited, he indicated that he was happy and well cared for through professionals' assessment of his behavioural communication.

6.58. Mr R's partner took him out frequently in the car at his request and ensured he attended all health appointments. As a result of concerns raised by Mr R's family, his building society was contacted, and it reported no unusual activity with his account and no concerns about his partner who would accompany him. It was evident that Mr R and his partner were not frequent users of mobile phones and found them to be a challenge to use. Further, I am not clear as to whether Mr R was able to use a phone due to his deterioration and hearing.

6.59. On this basis of the above assessment of the case files, I believe appropriate action was taken, including the timeliness of the action, by NPTC and CCC following Mr R's discharge from hospital in April 2021 until his death in August 2021.

Question 2:

6.60. Mrs C specifically feels the lack of use of mobile phones contributed to isolation and was not considered in the stage 2 report (complaint file page 145). Please include specific comment on whether appropriate action was taken in regard to concerns about isolation and communicating by mobile phone.

6.61. Some examples from the case file, notes;

- After initial difficulties in gaining access [redacted] felt partner engaged relatively well. Both [Mr R] and partner had mobile phones. Partner had a new Android Phone; the problem was that she didn't know how to use it. [redacted] put her number into partner's phone and showed her how to use it. [redacted] noted that Mr R would not have been able to make or receive calls independently by this point. He had lost the verbal and physical ability to make phone calls independently.
- When they asked how other members of the team could get hold of the couple in order to assess Mr R, the partner explained that she only had Mr R's 2 mobile phones, and she did not know how to use them. They suggested she ask for help with that as it was extremely important to be able to speak to them, but the partner stated she would not do so. She agreed that professionals could contact her in writing but "they probably wouldn't be there" when professionals turned up.
- Neither party had use of a telephone, mobile phones appeared to be kept in a plastic carrier bag turned off, no landline was present.
- Partner was noted as anxious about using the mobile phones, she was frightened about who would be on the other end of the line. She was slowly getting better at using the phone. We suggested that she ask for help with

this as it was extremely important to be able to speak to them, but she stated she would not do so. She agreed that we could contact her in writing but they “probably wouldn’t be here” when the professionals turned up.

6.62. In conclusion, according to professionals, Mr R’s carer did have an android mobile phone that was working. She did not know how to work it, therefore professionals demonstrated how to use the phone on each visit and numbers were stored for Mr R’s carer. In summary, I believe appropriate action was taken by professionals in regard to concerns about isolation and communicating by mobile phone.

6.63. Question 3:

b) The outcome of the safeguarding Strategy meeting in August 2021 was flawed as it should have considered witness statements prepared by staff at [the first] Hospital.

3) The safeguarding strategy meetings, following the death of Mr R, were multi- agency and chaired by CCC. Mrs C is unhappy that the witness statements prepared by HDUHB staff were not considered by the chair and believes, as a result, the outcome of the meeting was flawed (complaint file page 148). CCC have provided further comment on why these were not considered directly by the chair (complaint subfile page 255).

Please comment on whether you consider it was reasonable that these statements were not requested or viewed by CCC in its role as chair of the safeguarding strategy meeting.

4) If you consider these documents should have been requested by the Chair of the Strategy meeting, please comment on what impact you consider this would have had, if any, on the outcome of the safeguarding procedures.

5)55. The Wales Safeguarding Procedures highlights process for agency reports as below;

- Each agency invited to attend the conference should provide to the chair, 2 working days in advance a written report, which summarises:
- basic information the agency holds about the adult at risk;
- up to date chronology of relevant agency involvement (see pointers for practice on preparing chronologies);
- involvement in current incident/cause for concern;
- past concerns about abuse and neglect unmet care and support needs who concerns were shared with and any actions taken and by whom;
- frequency of contact with the adult at risk and the nature of the contact;
- assessment of current issues/protective and risk factors;

- knowledge of adult at risk's desired outcomes, wishes and feelings, values, and beliefs.

6.64. From assessment of the safeguarding strategy meetings in accordance with Wales Safeguarding Procedures, Multi Agency meetings were held to discuss the reports and identify any action required. Professionals from appropriate agencies attended relevant meetings and prompt and appropriate action was taken to respond, including further and ongoing social work intervention.

6.65. The chair notes that in addition to personally chairing most of the safeguarding strategy meetings during which she heard accounts from practitioners directly involved in the care of Mr R, she had subsequently spoken again with practitioners in Swansea Bay Health Board, Hywel Dda University Heath Board, Carmarthenshire County Council and Neath Port Talbot Council and had also worked closely with the Safeguarding Teams in each organisation and with Dyfed Powys Police.

6.66. Based on the correspondence I have observed, reviewing the case and after extensively reflecting on the action of all involved, further, I note that the police advised that all statements from staff had been reviewed. On this basis, appropriate action was taken and in line with the Wales Procedures and appropriate information was requested and considered as part of safeguarding procedures following the death of Mr R.