

28<sup>th</sup> August 2023

[REDACTED]

Ms R Knight,  
Assistant Coroner for South Wales Central Coroner Area

[REDACTED]

Dear Ms Knight,

**Re: Cardiff Council response regarding Regulation 28 Report - Stella Ann James (deceased)**

I am writing on behalf of [REDACTED] to formally acknowledge receipt of the correspondence from the Coroner's Office dated 4<sup>th</sup> July 2023. I was greatly concerned to read about Ms James's tragic and untimely death.

A thorough review has been undertaken in respect of Cardiff Adult Service's involvement with Ms James to gain a comprehensive overview of how her case was managed. We recognise the importance of identifying any lessons that can be learned from the Coroner's report, understanding the important contribution this makes to preventing future deaths.

I am now in the position to respond appropriately to the two points of concern outlined in your Regulation 28 Report and address them below.

- 1. Stella appeared to meet the criteria as an 'adult at risk of neglect' due to her food avoidance and very low body weight, yet there was no apparent mechanism for Social Services to be aware of Stella's status. Stella was very secretive and formally had capacity when assessed months before her death, although it is noted that this can fluctuate.**

Cardiff Council staff were not directly involved in Ms James's care whilst she was living in Cardiff, however, we do have officers working in the Pendine Centre as part of the Multi-disciplinary Community Mental Health Team (CMHT).

Having received your correspondence, we have now had the opportunity to access Stella's medical notes on PARIS (Cardiff and Vale University Health Board

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**GWEITHIO DROS GAERDYDD, GWEITHIO DROSOCH CHI**

Mae'r Cyngor yn croesawu gohebiaeth yn Gymraeg, Saesneg neu'n ddwyieithog. Byddwn yn cyfathrebu â chi yn ôl eich dewis, dim ond i chi roi gwybod i ni pa un sydd well gennych. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

**WORKING FOR CARDIFF, WORKING FOR YOU**

The Council welcomes correspondence in Welsh, English or bilingually. We will ensure that we communicate with you in the language of your choice, as long as you let us know which you prefer. Corresponding in Welsh will not lead to delay.



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Database) and we have also had access to the Draft Internal Review conducted by Cardiff and Vale UHB's Mental Health Directorate. In addition, we have also had the opportunity to discuss the case with the Deputy Directorate Manager for Specialist Services within Cardiff and Vale UHB who has overall responsibility for the Serious High Risk Eating Disorder Service (SHED).

As you are aware, Ms James received input from a number of professionals employed by Cardiff and Vale UHB which included Consultant Psychiatrists, Clinical Psychologist, Dieticians and Nurses from various teams including SHED, Liaison Psychiatry, Dietetics, and the District Nurse Service.

When Ms James returned to live in Cardiff she was referred to SHED. To access this service a patient needs to be open to a Community Mental Health Team which in Ms James's case was the team based at the Pendine Centre. This team is a multi-disciplinary team made up of local authority and health professionals.

As Ms James's needs were identified as being health and not social care related, she had no direct involvement from local authority staff when under this team. Her case, however, would have been discussed at the multi-disciplinary team meetings, in which local authority staff would have been present. If any issues had been raised during these meetings that indicated that input from local authority social work staff was required, this would have been acted upon, however this was not the case.

When Ms James was closed to the Serious High Risk Eating Disorder Service (SHED) in December 2020, a plan was put in place should the situation change. It was agreed that if Ms James' parents had concerns and Ms James had not been able or willing to get help, they could contact services directly as they had done previously.

At point of closure to secondary mental health services Ms James continued to have other health professionals, namely her GP and District Nurses involved in her care who could have raised concerns or made a referral to social services at any time if they felt it appropriate.

Therefore, we are confident that although the local authority staff had no direct involvement with Ms James's care, the professionals involved from Cardiff and Vale UHB could have made a referral for social work assistance if that was required.

The process and procedures around this are well established and we have no doubt that if the professionals involved felt it appropriate a referral would have been made.

**2. Could there be a register to include a person in Stella's position, whereby unannounced house visits from a social worker can be an option? Perhaps involving a mechanism for anonymous referral?**

At the time of the closure of her case to secondary mental health services, Ms James was deemed to have capacity to make decisions about her care and during her involvement with services had declined to see anyone face to face, choosing to see professionals 'virtually.'

One of the points of learning from the internal review carried out by Cardiff and Vale UHB Mental Health Clinical Board was that, with one exception (in June 2019), none of the health professionals involved saw her in person. This made physical health monitoring difficult.

It was acknowledged during the internal review that although Ms James had declined face to face meetings, there was nothing to stop this from happening, and the health professionals involved could have taken a more assertive approach and insisted on a home visit. As Ms James was living with her parents, there would have been no issue with gaining access, and I understand that Ms James's parents would very much have welcomed a home visit from the health professionals involved in their daughter's care.

Other findings from the internal review included the need for better case co-ordination and a more formal multi-disciplinary approach to the closure of cases. I understand that the learning from this review was shared appropriately, including with senior clinical staff.

While the findings in this case applied to the Cardiff and Vale UHB rather than the local authority, we have reviewed these to ensure that we are also learning from the outcome of this very tragic case.

In terms of holding a register of adults with similar needs to Ms James, as her needs required clinical expertise, it would be more appropriate that any ongoing review arrangements were carried out by Cardiff and Vale UHB.

In cases such as Ms James, involving complex medical and health issues, it requires the input of health professionals with the appropriate knowledge and training to make any determinations, this would include whether an unannounced visit should take place and also to undertake that visit.

In terms of holding a register of vulnerable adults more generally, we think that this could potentially negatively impact on the existing arrangements in place for appropriate multi agency involvement in future complex cases.

In this case the decision not to refer for social worker involvement was the correct one and, having reviewed current arrangements, all partners are confident that should such a referral be assessed as needed in a future case then the process is clear and unambiguous. There is also the potential that the creation of a much wider vulnerable adults list would give the misguided impression to someone referring an individual onto the register, that the individual would be safeguarded.

Currently, all professionals involved with each vulnerable individual must ensure that appropriate monitoring and oversight is in place and, the internal review carried out by Cardiff and Vale UHB brought invaluable learning into this aspect of current working practice.

Therefore, after full consideration, we suggest that the creation of a separate list would not answer the key issues arising from this tragic case and would not reduce the risk that future deaths might occur. Further, potentially we would be concerned that such a step would potentially negatively impact on effective multi-agency referral arrangements and make professional accountabilities less clear.

I would like to assure you that the Council has fully considered the concerns set out in the Regulation 28 report and whilst we have concluded that it would not be appropriate for the Council to operate a separate register for vulnerable adults in similar circumstances, please be assured that we have reviewed the learning from the internal review carried out by Cardiff and Vale UHB and have appropriately reflected on the points raised. We are committed to ensure that the learning from this case informs practice going forward.

Yours sincerely,



Corporate Director People and Communities