Adult Practice Review Report

Adult Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Adult Practice Review

Re: CTMSB 02/2021

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

A Concise review was commissioned by the Chair of the Cwm Taf Morgannwg Safeguarding Board (*CTMSB)* in October 2020 following a recommendation of the Joint Review Sub-Group, in accordance with the Guidance for Multi-Agency Adult Practice Reviews. The criteria for this review are met under:

Social Services and Well-being (Wales) Act 2014: Working Together to Safeguard People: Volume 3 – Adult Practice Reviews

'*A Board must undertake a concise adult practice review where an adult at risk who has **not**, on any date during the 6 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:*

- *died; or*
- *sustained potentially life-threatening injury; or*
- *sustained serious and permanent impairment of health.'*

NB The pseudonym Aaron is used throughout the report to represent the person who is the subject of the Review

Aaron died in the summer of 2020, age 74, having been struck by a train.

In the months prior to his death, Aaron had become increasingly confused, he had been referred by his GP to the Cwm Taf Morgannwg University Health Board (CTMUHB) Older

Person's Mental Health Team. He was assessed at his home in June 2020 and had a 'highly probable' diagnosis of dementia.

There were 8 incidents between February 2020 and his death, where Aaron was reported to South Wales Police having been found lost and/or confused at different locations, often in the late evening or early hours of the day. These incidents had increased in frequency over the weeks prior to this death.

Aaron had a learning disability; he lived independently in sheltered accommodation, which has a peripatetic scheme co-ordinator, and received a package of care and support, including specialist domiciliary care. Aaron had been well-known to Adult Services; he had been subject to annual reviews of his Care & Support Plan by the Community Review Team until February 2020. At that time, he was referred to the appropriate Adult Social Services Team for further assessment when concerns began to emerge both that his mental health was deteriorating and also about his safety and wellbeing.

Because of the coronavirus pandemic, between March 2020 and July 2020, an interim telephone arrangement was in place with both Adult Services and the Housing Provider to check on Aaron's wellbeing. Aaron's assessment by the CTMUHB Older Person's Mental Health Team was delayed as a consequence of the pandemic. Aaron continued to receive direct support from the specialist domiciliary care provider throughout the timeframe of the review.

A social worker from the Care & Support Team (a team serving adults of all ages with a wide variety of needs and risks) was allocated to Aaron in July 2020 and completed a well-being assessment, a mental capacity assessment, in relation to his ability to keep himself safe when out in the community and a risk assessment. It was decided by the social worker's managers that a further mental capacity assessment in relation to whether Aaron could make the specific decision about where he should live was required.

The Review was told that if that assessment concluded that Aaron did not have capacity to make such a decision about where he should live, a best interests decision, led by the social worker, would need to be made, as set out in the Mental Capacity Act 2005. This would be done in accordance with the Act and would necessitate the involvement of an Independent Mental Capacity Advocate (IMCA), given Aaron's circumstances and lack of contact with family or friends who would have been in a position to advocate for him. It would also involve obtaining Aaron's wishes and feelings about the issue, notwithstanding his lack of mental capacity to make a decision himself. If Aaron did not want to move from his flat and the local authority took a different opinion, then it is likely that an application to the Court of Protection would have been necessary. The process of considering a change of accommodation for Aaron had therefore commenced, although not concluded prior to his death.'

As a result of a previous assessment in relation to capacity around managing finances, the Local Authority had deputyship following a Court of Protection application.

The timeframe for the review was August 2019 to August 2020. This is in accordance with guidance, the period 12 months prior to the date of Aaron's death and there being no exceptional circumstances identified which would require a more extensive time period to be considered.

At the start of the Review, it was not possible to identify family members of Aaron to contribute. However, following the Learning Event, two family members were identified via the probate process, who had not had any contact with Aaron for 25 years.

The following information was gleaned from those who worked with Aaron.

Aaron was not in touch with his family, nor they with him, for a long time. He had been employed for 25 years in the same job. He was described as happy in his employment and

remained at work for a further 3 years after he was 65. Aaron was said to be fiercely independent, when he retired, he volunteered at a local charity shop for 2 days per week.

Aaron loved to sit in the foyer of his sheltered accommodation and watch people go by and have a chat.

He also enjoyed horse riding and walking when he was younger.

Social enjoyment came from his love of music and eating out in many of the bars and cafes in his local area. He enjoyed unsupported holidays throughout the UK when he was able to participate and loved meeting new people.

Aaron had an outgoing and friendly personality. He made friends easily and would always help those around him.

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

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

Learning points

1. **The importance of an Independent Advocate being available when individuals have no family or friends to speak up for them and support them to express or represent their views and best interests.**

Aaron had no contact with family members for a significant period of time. The Domiciliary Care provider arranged Aaron's funeral on behalf of the local authority. However, following the Learning Event, two family members were identified via the probate process who had not had any contact with Aaron for 25 years. Consequently, Aaron was dependent on professionals making informed judgements and decisions in accordance with his views, he had no one whose sole purpose was to advocate for him.

As Aaron's mental health deteriorated, he was increasingly less able to recall and consider information and make informed decisions. Aaron had been subject of a mental capacity assessment in relation to his ability to keep safe within the community and a further assessment in relation to his capacity to make decisions as to where he should live was in progress. This was not concluded prior to his death. Participants at the Learning Event were informed by Adult Services that it was the likely intention to involve an IMCA in this process, as required by the Mental Capacity Act 2005, that is in determining what decision would have been in Aaron's best interests.

Aaron would in any event have been entitled to an independent advocate as set out in the Social Services and Well-being (Wales) Act 2014. This does not appear to have been considered despite the emerging deterioration in Aaron's mental health during and prior to the timeframe for the Review and the absence of family or friends to advocate for him.

References

https://gov.wales/sites/default/files/publications/2019-12/social-services-and--well-being-wales-act-2014-part-10-code-of-practice-advocacy.pdf

*Local authorities **must** arrange for the provision of an IPA when a person can only overcome the barrier(s) to **participate fully** in **the assessment, care and support planning, review and safeguarding processes** with assistance from an appropriate individual, but there is no appropriate individual available.*

***Participating fully** enables the individual to express or have represented and taken into account their views, wishes and feelings; that they understand their rights and entitlements; the decision making process; what matters to them; the personal well-being outcomes that they wish to achieve; the barriers to achieving those outcomes, and the options and choices available to them.*

Section 35 of the Mental Capacity Act 2005 which provides for the appointment of an Independent Mental Capacity Advocate (IMCA)

Sections 35 to 41 of the Mental Capacity Act create a scheme designed to provide the input of an independent mental capacity advocate ('IMCA') where certain decisions need to be taken for particularly vulnerable people who lack capacity.

This may include older people with dementia who have lost contact with all friends and family, or people with severe learning disabilities or long term mental health problems who have been in residential institutions for long periods and lack outside contacts. Such people will be represented and provided with support when decisions are to be made about;

(a) serious medical treatment; and/or

(b) where the person is to be provided with accommodation in a hospital for more than 28 days or in a care home for more than 8 weeks

There is also a discretion to provide an IMCA under Regulation 8 and 9 of The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007, in relation to care reviews (accommodation) and/or safeguarding where there is no person, other than a person engaged in providing care or treatment for person in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in persons' best interests; and where it would be of benefit to for the person to be so represented and supported.

The Mental Capacity Act 2005 Code of Practice provides guidance and information as to how the Mental Capacity Act works in practice.

2. **The importance in recognising the impact of deterioration in people, both with regards to mental and physical health and therefore re-evaluating the response or action planned and the urgency of that action. Practitioners at the learning event considered this a 'safety first approach'**

Aaron's confusion and disorientation began to become more apparent in January 2020, when he was seen by his GP, along with his domiciliary carers and was referred for assessment by the Older Person's Mental Health (Psychiatry) Team (MHT). The GP had found it difficult to assess Aaron given his learning disability. This MHT assessment was delayed due to the impact of coronavirus.

Shortly after this GP appointment, Aaron became confused whilst travelling on public transport and South-Wales Police (SWP) were summoned, domiciliary carers were contacted and transported him home. This was the first of 8 reports to police of a similar nature.

Following this incident, Aaron was referred to Adult Social Services by his Domiciliary Care Provider and seen in a timely manner in a joint visit, support was increased a little to assist him getting to his volunteer placement. Aaron's care plan was reviewed and both a risk

assessment and capacity assessment in relation to his care and support needs were carried out and he was referred to the Adult Services Care & Support Team for further assessment, including consideration of alternative, more supported or residential accommodation.

Aaron's case was not allocated until some 4 months later, in July 2020. The country was in lockdown for much of that time due to coronavirus, Adult Social Services was undertaking critical visits only, telephone checks had been made on Aaron by Adult Social Services (via the domiciliary care provider) and the housing provider.

During this intervening period there had been considerable changes to Aaron's circumstances. Three further incidents had occurred of Aaron being confused within the community, requiring police involvement and therefore, following concerns for his safety, Public Protection Notices (PPNs) were submitted. Both the Domiciliary Care and Housing Providers had raised concerns about Aaron's safety and well-being. He had received a 'highly probable' diagnosis of dementia. This probable diagnosis did not result in consideration of temporary residential care or immediate increased support for Aaron despite both the Doctor from the MHT and Domiciliary Care Provider indicating this was necessary.

A further 5 incidents involving SWP took place prior to Aaron actually being seen and assessed by a social worker and PPNs were again submitted. Whilst the assessments were of good quality, unfortunately, there was no sense of urgency in addressing the risks of Aaron accessing the community during both the day and night and getting lost. There did not appear to have been any consideration of an immediate increase in support for Aaron given the escalation of risk. He had not come to any harm at this stage, but there did not appear to be recognition of the severity of the risk of harm or immediate action taken.

It does not appear that the significant changes referred to above influenced the action planned or pace of that action or action to safeguard Aaron given the increased likelihood and severity of risk of harm.

3. **Understanding and assessing the impact of significant change in a person's life and the possible consequences for mental health and well-being. In this case the impact of coronavirus pandemic.**

Although Aaron's confusion and disorientation began to become more apparent from January 2020, he continued to volunteer twice a week and support from his domiciliary care provider was increased to support him in travelling to this volunteering venue. In March 2020, lockdown began and for Aaron, as with the rest of the community, this had a huge impact on his daily life. Aaron was unable to volunteer or go out and take part in the things he enjoyed, such as eating out and socialising or meeting with others living within his sheltered accommodation. Aaron had no family; his only contact was limited to the domiciliary carers who visited between 1 and 3 hours each day.

The context for Aaron of this immense change to his daily routine was his emerging dementia accompanied by a learning disability. Aaron's carers explained the pandemic and lockdown to him, but it is unlikely that he understood and retained this information.

Agencies' ability to undertake their functions effectively was impacted by the coronavirus pandemic, however Aaron's Housing Provider and Adult Social Services made arrangements to keep in contact with vulnerable people and therefore undertook telephone checks on Aaron's wellbeing during this period. The records of these actions considered by the Review do not reflect the impact on Aaron shared by his domiciliary carers at the Learning Event or an appreciation of his individual circumstances as outlined and the particularly profound impact on his life. There did not appear to be a focus on his ability to comply with stay at home or shielding guidance for clinically vulnerable people.

Aaron was described as being bored, lonely and of very low mood as a consequence of lockdown, he was very isolated had little to do and no social contact, the routine of his life

had disappeared. The Learning Event was given examples of behaviour which were out of character for Aaron, such as being angry or frustrated and refusing to work with domiciliary carers and leaving the property, with carers following to make sure of Aaron's safety. It is likely Aaron's confusion worsened during this period, examples included milk in the kettle, mixing up wallet and mobile phone and lack of recognition of money were described, as well as the incidents SWP were called to.

The domiciliary care provider's escalation policy was utilised by Aaron's immediate daily carers, managers in turn reported to Adult Social Services, however this failed to convey the severity of the impact of lockdown on Aaron and his deteriorating mental health. Consequently, these factors were not given the significance they merited in safeguarding Aaron and responding to his additional need for care and support and alterative accommodation.

4. **Processes should be in place to risk assess each new incident (PPN) of concern for a person's safety and wellbeing in the context of previous concerns (PPNs submitted) to inform safeguarding actions, and decision making**.

South Wales Police (SWP) were called to assist Aaron on 8 different occasions between February and August 2020. Incidents escalated during the latter part of this time period. Incidents were often during the early hours of the morning or late in the evening and typically described an older person lost or confused located by a member of the public. SWP responded appropriately on each occasion, safeguarding Aaron and submitting a PPN on 7 occasions. However, the review was only able to establish that 6 PPNs had been received by Adult Social Services. Each PPN was submitted to the Multi Agency Safeguarding Hub (MASH) where it was reviewed by Public Protection Officers and referred on to Adult Social Services. The number of previous PPNs within a 3 month period is recorded on the form. Despite the number submitted being, 7, and the increasing frequency the available escalation processes and/or multi-agency problem solving arrangements were not utilised by SWP at MASH. A consequence of this was that the escalating frequency of incidents and therefore concern for Aaron's safety and wellbeing was not considered and addressed on a multi-agency basis.

PPNs were received by the Adult Social Services in MASH (Multi -Agency Safeguarding Hub) and referred to the relevant team, although the response appears to be telephone contact with the domiciliary care provider and MHT. Aaron's case was not allocated to a social worker until the end of July 2020, assessment then commenced at the beginning of August. The submission of these PPNs does not appear to have influenced the pace or the plan of response to concern for Aaron's safety and wellbeing. The initial focus remained on maintaining Aaron within the community, despite the Consultant and Domiciliary Care Provider suggesting residential care was required.

Clearly, appropriate assessments needed to be undertaken to establish Aaron's views and whether this was the necessary course of action required in his best interests. They did proceed but without appreciable urgency.

The impact of the PPNs is uncertain in assessment of any immediate safeguarding action required, given the increased likelihood and severity of risk of harm to Aaron. This was a missed opportunity.

The Reviewers were told Adult Services have since implemented a system which would identify and address such a pattern.

The Herbert protocol, which was not in place at the time of these events, and the Keep Safe Cymru scheme were not used in respect of Aaron. However, they do provide useful safeguarding tools for people in similar situations. It is important to raise awareness amongst

agencies of these safeguarding options which are available in anticipation of vulnerable people going missing.

https://www.south-wales.police.uk/notices/af/herbert-protocol/

https://www.south-wales.police.uk/police-forces/south-wales-police/areas/campaigns/campaigns/keep-safe-cymru-card-scheme/

5. **Technical options can be useful tools in safeguarding people with dementia who are at risk of going missing.**

In Aaron's case, the use of a tracker or GPS and a door sensor service, which would provide an alert when an individual leaves home in an unplanned way, were considered by Social Services and the Domiciliary Care Provider. However, this potential opportunity to safeguard Aaron did not proceed, largely it appears because there were no family members or close friends who could be contacted, should such an incident occur. If deployed, these options could have been a trigger to identify the increased level of risk to Aaron and therefore consideration could have been given to alternative options to safeguard him.

The Panel were informed that in fact a door sensor alert service was available to those without close family members as a team of responders had been established. It is evident that this information was not known to agencies working with Aaron.

6. **Sharing information is essential to enable each organisation to play their part in identifying, supporting, and safeguarding adults with care and support needs or at risk**

It became apparent during the Learning Event that individual organisations had different information about Aaron's circumstances, needs and incidents that had occurred. For example, the impact of the coronavirus lockdown for Aaron as described by Aaron's domiciliary carers. In addition, the Housing Provider was not informed of every incident that resulted in SWP involvement and the submission of PPNs. The person allocated by Adult Social Services to carry out telephone checks was not aware of Aaron's learning disability.

The existing Social Services case management processes do not appear to be have been utilised to enable agencies to share information in a co-ordinated and, proportionate manner to be able to inform assessments and plan to collectively safeguard Aaron and meet his care and support needs.

7. **Notifiable incidents**

Aaron's case meets the requirements of the National Reportable Incidents process within the Wales NHS. The review established this process had actually not been complied with, Aaron's death had not been reported. It took the CTMSB APR process to identify this fact. Notification has now taken place some considerable time following Aaron's death.

https://du.nhs.wales/files/incidents/phase-1-policy-guidance-document-v1-0-pdf/

Effective Practice

- Joint visit Social Worker/Domiciliary Care Provider in February 2020, Case summary to transfer to new Social Worker
- Domiciliary Care Provider arranging and accompanying Aaron to GP appointment when his functioning/memory began to deteriorate

- Joint visit -Consultant Old Age Psychiatry and Domiciliary Care Provider appointment had been brought forward as concerns raised by Domiciliary Care Provider which the Social Worker acted upon
- Domiciliary Care Provider tried to provide consistent staff for Aaron during the pandemic

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes: -

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

1. Adult Social Services should review the arrangements for offering individuals timely Independent Professional Advocacy, in order to be satisfied they address the learning identified in this APR. The outcome should:
   - be reported to the CTMSB and
   - be incorporated into case management processes.

2. Adult Social Services should review the arrangements for risk assessments for those with developing dementia to ensure there is an understanding of the potential harm and emerging risks. Including:
   - when accessing community alone
   - when there are significant changes to daily routines
   - recognition of the impact of deterioration and
   - therefore, re-evaluating the response or action planned and the urgency of that action.

3. CTMSB should be assured that partners organisations have escalation processes which are clear, timely, transparent and utilised effectively.

4. SWP should review the process for risk assessing PPNs and escalating risk to ensure appropriate safeguarding responses are made. The outcome should;
   - be reported to CTMSB and
   - be incorporated into existing processes

5. CTMSB should raise awareness about the Herbert protocol and Keep Safe Cymru across all agencies

6. Adult Social Services should review the recently implemented arrangements for risk assessment and escalation when repeat PPNs are received to be satisfied they address the learning identified in this APR

7. CTMSB should ensure that partner agencies are aware of the digital/technical tools available to assist in safeguarding people, including those without family members or close friends.

8. Adult Social Services should build the learning from this review into existing case management processes to ensure assessments and plans are informed by a multi-agency perspective, in order that agencies are able to work together collectively to safeguard people and meet their care and support needs.
   - CTMSB should be satisfied there is a programme of quality assurance in place to demonstrate the effectiveness of this approach and address any deficits

9. CTMUHB should review the arrangements in place for Mental Health Clinical Services to comply with the National Reportable Incidents process, to ensure that they are aware of Nationally and Locally reportable incidents and comply with the agreed timescales

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: - ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and		I make the following statement that prior to my involvement with this learning review: - ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review	

experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)* 	**Reviewer 2** *(Signature)* .....  .....
Name *(Print)* Lloyd Griffiths	**Name** *(Print)* Liz Pearce
Date 24 November 2021	**Date** 24 November 2021

Chair of Review Panel (Signature)	S Hurley
Name *(Print)*	Sue Hurley
Date	24 November 2021

Appendix 1: Terms of reference –

ADULT PRACTICE REVIEW PANEL
Aaron – CTMSB 02/2021

Terms of Reference

Case Reference details
Aaron – CTMSB 02/2021

Circumstances leading to the APR
In August 2020 Aaron was involved in a collision with a train on a railway line resulting in his death.

Prior to this Aaron had become increasingly confused which was thought to be linked to his diagnosis of 'probable dementia'.

There are a number of police occurrences leading up to this incident each involved Aaron being found confused/disorientated.

Aaron had a learning disability and had been subject to annual Review of his Care & Support Plan by Adult Services' Community Review Team. Aaron had lived in sheltered accommodation and received a package of care and support.

Due to concerns about Aaron's wellbeing and safety a social worker from the Care & Support Team had been allocated in July 2020 and had completed a well-being assessment, a mental capacity assessment and risk assessment.

Agencies Involved
The following agencies were involved with Aaron and will be completing a timeline and analysis of their involvement:

- South Wales Police
- Adult Services, RCT
- Cwm Taf Morgannwg University Health Board
- Trivallis
- Innovate Trust

Core Tasks
The Core Tasks of this Adult Practice Review Panel are to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.

- Determine if the Coronavirus pandemic had any impact on the safeguarding arrangements for Aaron.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel:

- Identify and commission a reviewer/s to work with the Review Panel in accordance with the guidance on APRs
- Agree the time frame
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken
- Produce a merged timeline, initial analysis and hypotheses
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the family members prior to the event.
- Receive and consider the draft adult/child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the CTMSB for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Panel Members

NAME	TITLE	ORGANISATION
Liz Pearce	Independent Reviewer	Rhondda Cynon Taf County Borough Council
Lloyd Griffiths	Independent Reviewer	Cwm Taf Morgannwg University Health Board
Sue Hurley	Independent Chair	South Wales Police
Beverley Brookes/Claire O'Keefe	Deputy Head of Safeguarding	Cwm Taf Morgannwg University Health Board

Jackie Neale	Safeguarding Service Manager	Rhondda Cynon Taf County Borough Council
Jon Lane	Independent Protective Vulnerable Persons	South Wales Police
Lorraine McGrath	Senior Manager	Innovate Trust
Trudy Hawkins	Corporate Director	Trivallis

Additional Areas of Focus
There is nothing to note here.

Any Parallel Reviews or Other Such Activity to be Noted
There are no parallel reviews to note.

Timeframe for the APR
The timeframe set for the Review is between 22nd August 2019 and 22nd August 2020 with summary reports to be completed of any significant event prior to this. The rationale for this is to capture the apparent deterioration in Aaron's mental health.

Learning Event
The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

It is anticipated that the Learning Event will be held virtually on 29th June 2021.

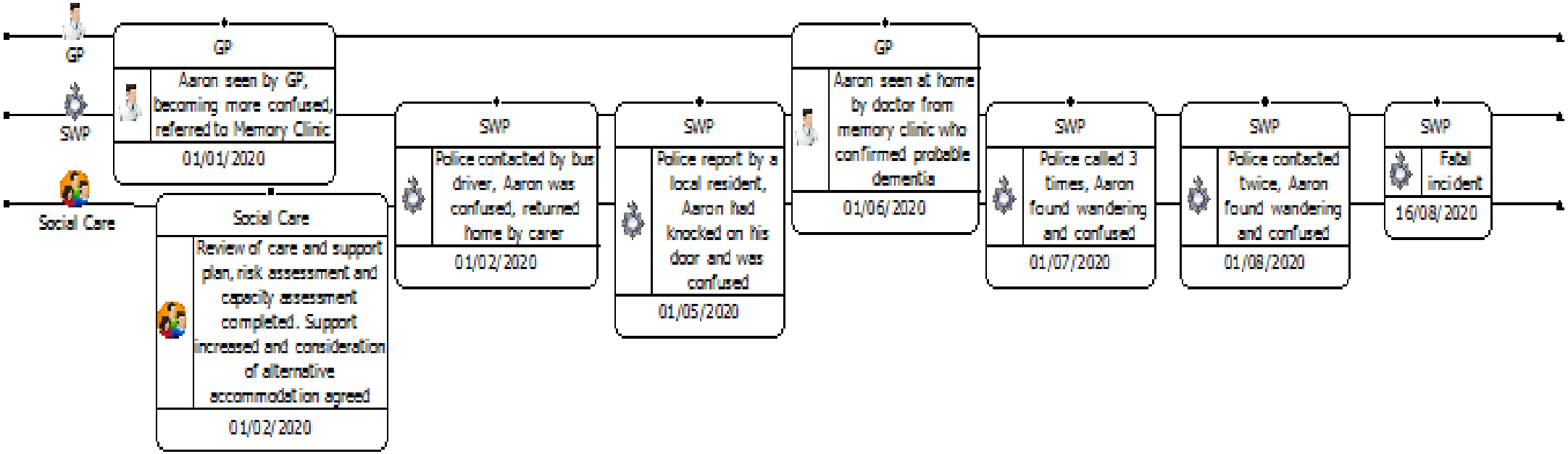
Completion Date
The completion date set for the Review is November 2021.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Prepare a 7-minute briefing
- Send the report, action plan and summary timeline to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and

responses to media interest concerning the review until the process is completed.

Appendix 2: Summary timeline



Adult/Child Practice Review process

To include here in brief:

- *The process followed by the SAB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

A Panel was established to undertake the APR, it met on 8 occasions:

- Chaired by Protecting Vulnerable Persons Manager, South Wales Police
- Two independent reviewers were appointed
- Agencies represented, Adult Social Services, CTMUHB, South Wales Police Housing Provider, Domiciliary Care provider

A hybrid learning event was held in June 2021, some participants located together at the same venue and others attending virtually. Each of the above agencies, apart from CTMUHB was represented along with the GP

At the start of the Review, it was not possible to identify family members of Aaron to contribute. However, following the Learning Event, two family members were identified via the probate process, who had not had any contact with Aaron for 25 years.

☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	