ADULT PRACTICE REVIEW REPORT

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review

Re: CTMSB 2/2019

Circumstances resulting in the Review

An Extended Adult Practice Review (APR) has been undertaken in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3". The guidance states that an Extended Review must be commissioned by the Safeguarding Board where an adult at risk who has, 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.

Key Code:

G	Person subject of the review
H	Partner of adult G
J	Carer, family member
K	Main carer, family member & Mother of J
Y	Representative of other family members

Due to the nature of the event it was agreed at the Cwm Taf Morgannwg Safeguarding Boards Joint Review Group that the criteria was met for the Extended Review. The circumstances of these are as follows:-

G was admitted into hospital in 2018 after an ambulance was called by a family member. G was in a critical condition with a perforated bowel, 2 fractured ankles, and a large necrotic area from the vagina to perineum, a black area to the right heel and discoloured right heel. It was not known how these injuries were sustained, although it was likely that some were as

a result of pressure damage owing to immobility. On admission, the hospital raised a safeguarding concern regarding G.

G required emergency surgery for a perforated bowel, required ventilation and nursing in the Intensive Care Unit (ITU). G recovered consciousness and allegedly told another family member and nursing staff that J had been horrible to her, but she would not speak with police without a family member present. Unfortunately, G passed away in hospital without this being arranged. A police investigation commenced, and an inquest opened.

A social worker had visited the home a few days prior to the hospital admission and spoke to G to complete a Section 126 enquiry (s126) following a safeguarding concern (Section 126 of the SSWA 2014 places a duty on a local authority to carry out an investigation where it suspects that a person is an "adult at risk"). The concern had been raised by the domiciliary care provider for the partner H who had a diagnosis of dementia and resided at the same address.

It was stated that G was frightened of a family member J, who supported the couple but was emotionally and potentially physically abusive. During this visit from the social worker G denied having said this and did not raise any concerns about the support they received from J. The outcome of the s126 enquiry was no further action was needed from Safeguarding, but that G would be allocated a social worker as there were concerns G was not recognising her own and her partner's needs and they would benefit from support.

The GP was contacted to visit and examine G's legs as there was some concern regarding their condition. G was known to be resistant to the involvement of services and had reluctantly agreed to a package of care for H.

H received a care package consisting of four daily domiciliary care calls, with support from J and K. G & H had five adult children. Social Services understood that one (K) provided support daily but the other siblings had limited contact. It was understood that another family member (J) also provided support daily.

The other family members had previously raised concerns about the quality of care provided by J & K. They felt J & K neglected G & H. The social worker had concerns regarding J and K's understanding of H's needs, but these were not sufficient enough to consider the need for legal action.

Y was the spokesperson for the extended family members and was convinced that J and K were responsible for G's death. Y and other family members had expressed concerns for G's wellbeing for a considerable time prior to G's death. However there appeared to have been a lack of evidence that this was the case. The concerns were expressed in the context of a difficult dispute between the adult children in the family.

It is the role of this Adult Practice Review to establish learning for professionals. This role does not extend to a re-investigation of the case. Below is the conclusion of the Coroner regarding the Death of G:-

> *G died from overwhelming infection following a necessary surgical procedure. G's death was contributed to by infection from developing*

pressure ulcers and a period of reduced mobility following an accident at home. That accident directly caused ankle and rib fractures, placing increased physiological stress upon G. An absence of earlier insightfulness as to G's condition prior to admission likely contributed to those physiological stresses, leading to the cause of her admission, the necessary surgery, and her death.

Practice and organisational learning

A learning event was held on the 16 March 2020. A timeline of significant events in respect of both individuals, G and H was shared with practitioners who had the opportunity to identify areas of effective practice and areas for improvement.

The reviewers identified the following themes within this practice review:

1. Family Relationships
2. Assessment and risk assessments
3. Communication & Recording

It must be noted that no health professionals were present in the learning event although they were invited. The reviewers have not been able to access information from the Community Psychiatric Nurse (CPN) who visited H on a regular basis. However, there is no documented evidence in the social work case notes that any concerns had been raised by the CPN with regards to G or H. We have attempted to gather further information regarding involvement of the CPN. Following several requests, no information has been provided by Health. However, this has been discussed with Health and action has been put in place to prevent this from occurring again.

Prior to the learning event the Reviewers met with two members of G's family in person, J and K to share the purpose of the APR and to also gain their views and experiences to share within attendees at the learning event.

J & K described G as a very private person who could be stubborn. They gave examples of this that showed G may have found change difficult particularly when it came to the care needs of G. They described G as having routines that resulted in poor hygiene and a very sedentary lifestyle that they felt negatively affected G's health and made it challenging for G to provide the care that G needed. They described G as someone who was reluctant to invite any professionals into her home without K being present.

J & K were very complimentary of the social work support, although commented there had been numerous changes of social workers and social care staff within the home who they felt were all very supportive of G & H and said the carers were wonderful with H. J & K commented that when social workers visited H they always asked how G was.

It was also acknowledged by J & K that there was conflict between two groups of family members. J & K felt other family members had very little input into the care of G & H. It was initially agreed to set up a rota of care between J, K and the other family members. However, J & K reported that this never took place. J and K commented that the other family members

had no contact for a number of years, but especially the last year of G life. J & K felt strongly that Y was overly interested in the financial aspects of the couple G and H. K felt strongly that G did not like Y for this reason and did not like Y coming to the flat. During discussions with J & K they were clear how upsetting they found the frictions between family members. They felt strongly that Y and other family members felt guilty about the lack of support they provided which has led them to look for others to blame.

J spoke of the allegation against him of assaulting G. He was clear about how upsetting this allegation was for him. Following a police investigation J (and K) were advised that based on the evidence available the matter did not meet the threshold for a criminal prosecution. This decision was later upheld in a Victim's Right to Review. This process involves police supervisory review of the original investigation.

Y and other family members were initially reluctant to meet with the reviewers. However, after some time they agreed. The reviewers met with Y who was the spokesperson for the other family members who attended via virtual video conferencing facilities. Unfortunately, the extended family did not agree to meet with the reviewers until well after the learning event had taken place. Therefore, this information was not available to discuss or explore during the learning event.

Y explained that the other family members feel let down by Social Services. Although they reported that Social Services met with them on two occasions, they felt strongly that the actions they felt appropriate following the meeting were not the actions carried out by social services. Y explained that she also expressed concerns to the social worker via telephone calls.

One of the above meetings was in person in a Council building. It involved Y and other family members. Y explained that the family expressed concerns regarding G's ability to care for H due to her own poor physical health, feeling isolated and low in mood. Y also explained when they visited G's property, there was no food in the property and only gone off milk available, therefore G could not make a cup of tea. This had been observed by Y and family on more than one occasion. Y and family reported the property was dirty and unhygienic and smelling of urine. Y also commented that J and K were observed verbally abusing G and H and that G was prevented from to speak to Y and other family members by J & K. J also prevented Y and other family members from visiting. Y also thought G was fearful of J and K and that K was misusing H's money, for their benefit not that of H.

The above described the opposing views of two sides of G's family. It is not the role of this Practice Review to address these issues. However, the above demonstrates some of the complexities and opposing views with which practitioners involved were dealing.

Theme One: Family Relationships

G & H had a number of adult children. The main carer being K who visited on a daily basis to provided support with personal care, shopping, cleaning etc., with support from J. H partner to G had established dementia and was the main focus of the social work visits. G and K were offered a carer's assessment on one occasion however this was declined. The last social worker involved with G acknowledged they never had any direct contact with Y

and other family despite a number of contacts made previously to the local authority to express concerns regarding the care and support G & H received.

J & K expressed that G was 'lazy' and could do more for herself but waited for K to attend each morning to support H with care needs & breakfast. J & K did not appear to recognise that G possibly had care needs of her own but indicated G was in good health and could phone the GP if required. The main focus of J & K was on H who had established dementia and may have lacked insight into the possibility that G had care and support needs of her own. J & K indicated to Social Services that G did not like Social Services or want any involvement. Y and other family held the view that G had care needs of her own and therefore could not provide the care to H that was needed.

Learning Points:

1. As H's dementia progressed, carers assessments could have been re-offered to G and K periodically and especially during the review of the care package or if there was a change in circumstances within the household.

2. Family perhaps gave the perception during social work visits that G did not need any support other that what was provided to them. G often said that her arthritis was playing up but there were no other concerns that she wasn't coping. G was deemed to have capacity and therefore could refuse assistance/assessment. Increased professional curiosity is likely to have led to better insight into G's own appearances of need.

3. It was deemed by professionals that G had capacity to make decisions. However, there is nothing recorded on file to evidence why professionals believed G had capacity.

Theme Two: Assessment and risk assessments

Y and other family members contacted Social Services on a number of occasions with allegations of financial abuse by K and verbal abuse and neglect by J and K. On each occasion this information was passed to the social worker who undertook announced visits, on occasions with another colleague, to undertake section 126 enquiries with no abuse or neglect being identified by the social worker. There was a number of other professionals involved in the care of H. Examples are District and Community Mental Health nurses. Neither of these raised safeguarding concerns to the social worker. It followed that the allegations were not substantiated.

A concern was reported to the MASH from the care agency regarding J possibly abusing G. G had fallen on the floor and hurt her foot, the allegation reported that J pulled her up from the floor and threw G onto the sofa and was also verbally aggressive towards G. There was also a concern raised by Y and other family that G may be self-neglecting. The social worker visited alone to speak to G, the allegation was denied by G but the social worker noted that G's mobility was poor, she was incontinent of urine and her feet were purple in colour. The social worker with G's permission telephoned the GP who visited that afternoon. G also accepted a referral to Social Services for an assessment in her own right. However, this assessment never took place due to G being admitted into hospital 3 days later.

Professionals were visiting the home on a regular basis. Although K and J presented a view otherwise, had professional curiosity been exercised it seems likely G's appearance of need would have been more apparent to professionals and that an offer of (and encouragement to accept) assessments at an earlier point would have been more likely to have taken place.

At the request of the social worker the GP visited G, although G was not registered with the GP practice. The medical examination suggested no deep vein thrombosis, no signs of infection or a fracture. The GP did express concern regarding G not accessing care and for K to register G with the GP practice. The GP examined G's foot and provided advice and related treatment. However no other assessments were made by the GP who had been made aware that G had not seen a doctor for several years.

Learning Points:

4. Issues of verbal abuse, financial abuse and neglect were considered on each occasion they were raised as part of the 126 enquiries. One issue was a recurring theme around the finances of H, the social worker did advise the family to apply for Deputyship however this was not pursued by the family and not followed up by the social worker.

5. Due to H's diagnosis of dementia and a care package in place, the focus of visits appeared to be around H. Y and other family did express concern that G was neglecting herself. Although the social worker acknowledged that G had poor mobility, the issue of self-neglect was not followed through due to G having capacity and refusing assessments of her own needs. It was only a few days prior to G's death that a referral was made for G in her own right and the offer of an assessment was accepted. Perhaps the issue of self-neglect could have been explored earlier in more depth and on a multi-agency basis. Additionally, if professional curiosity had been applied, the requirements of Parts 3 and 4 of the Social Services and Wellbeing Act, 2014 to assess would have triggered the offer of a proportionate assessment being undertaken and at an earlier point.

6. There was evidence of an examination, advice and treatment plan relating to G's foot. However there was a missed opportunity by the GP by not exploring if G had any other health issues, especially as the GP was aware G had not seen a GP for a number of years, the GP did not undertake any further examinations or assessments. This was a missed opportunity.

Theme Three: Communication & Recording

An anonymous neighbour telephoned the Adult Social Services Single Point of Access Team explaining G was distressed and crying, she was crying because she could not get off the single bed in the living room and asked the neighbour to take a plate out to the kitchen before K arrived. H was reported to be sat in a chair, with no trousers and wearing only an incontinence pad. The neighbour described the flat as having a strong smell of urine and the kitchen to be in a disgraceful state with mostly dirty dishes piled up. Bags of laundry were described along with clutter and damp in the bedroom. The neighbour had stated that G and

H had 'deteriorated' in the last 6 months and family were not keeping an eye on them as they should.

Following this anonymous phone call, the social worker visited with a colleague later the following morning and confirmed that H did not have trousers and the continence pad required changing. The social worker asked G how she managed this morning. G explained her arthritis has ceased and she cannot get off the bed. G stated that she would wait for K to return explaining that she had an appointment with the GP that morning. The social worker asked if G & H had breakfast that morning. G said no and that K could not call that morning because she had to go to the bank.

G stated that K calls every morning, lunchtime and tea time and she did not want any support from social services. G agreed the social worker could ring K to check she was visiting. G stated she did not have any credit on her mobile phone and asked the social worker to ring her. K was contacted and said they did not want any help and she would be there soon.

Y and other family had previously met with local authority officers, phoned the local authority several times and expressed similar concerns to that above approximately 2–3 months prior to this social work visit. However according to the records, it would appear no immediate action was taken following this visit and the social worker did not visit for a further 6 weeks. This is a missed opportunity by the social worker as there are identified issues of neglect for both G & H.

There were two anonymous phone calls to the police regarding H shouting out for help, calling out for his mother and banging could be heard. It was also known that he experienced hearing loss. K told G not to let anyone she was not expecting into the property, this information was relayed by the police. J & K explained H had severe dementia and they frequently shouted so H could hear them. Police described this behaviour as loud but not aggressive and considered normal by the family present.

There appeared to be good communication between the Adult Social Services Single Point of Access team, the social worker and MASH. However not all of the initial information regarding G was recorded on G's electronic file due to G not receiving services at that time. Therefore, a lot of initial information regarding G was recorded on H's electronic file.

G had a right for her data to be recorded in line with the accuracy principles in line with Article 5 (1) (f) of the General Data Protection Regulation (GDPR). The way in which G's data was recorded could have led to that information not being accessible for her or a third party with the right to access. In this case her right was hindered, and this could have led to barriers to her being safeguarded.

Learning Points:

7. When the social workers were present it seems, there were concerns that required urgent attention. There is no evidence of any measures being taken to address the immediate issues that were before the professional. There seems to be an assumption that K would resolve these issues quickly, despite evidence that K visits less frequently and offers less support that G reported to her.

Social services professionals have a duty to report safeguarding issues in line with the Social Services and Wellbeing Act, 2014. There is no evidence on record that the safeguarding issues witnessed by this professional were reported as would be expected either to their line manager or MASH.

8. On each occasion the police visited to check on the situation and submitted a PPN to the Local Authority which is the usual practice. However, on one occasion the police were told by K that a social worker had just left the property prior to the incident. SWP did not submit a PPN (the attending officer thought he was attending a 'domestic' incident but he perceived it as an adult welfare matter and as a social worker had attended he did not submit a PPN). The fact that a social worker was reportedly at the property just before the incident should have been confirmed by the police.

9. Information relating to an individual's own personal circumstances and needs has to be recorded on their own file. A file not being available should not be a barrier to this. No policy guidance specific to case recording seems to have been in place during the timeframe of this practice review. However Social Care Wales' Code of Professional Practice for Social Care was in place, making it clear that social care staff are required to maintain "clear and accurate records in accordance with legal and work setting requirements" (Section 6: 6.2). Since this time a local authority Adult Social Services Recording Policy has been developed and is in place. Consideration should be given to making the point above more explicit within this Policy.

Improving Systems and Practice

Recommendations:

The reviewers identified that there were appearances of need which although resulted in an offer to assess the needs of carers no attention was given to repeat offers to assess. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

1. **As prescribed by the Social Services and Wellbeing Act 2014, where there is an appearance of need, a carer assessment should be offered. A person- centred approach to this would be to reoffer, to ensure any refusal is a fully informed choice.**

The reviewers identified that the information available to the local authority officers during the visit that occurred as a response to a report from an anonymous neighbour was concerning. The local authority officers' response to this seems in contrast to the evidence.

This left G & H exposed to unmitigated risk without a professional risk analysis taking place. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

2. **When there is evidence of current or potential significant risk to an individual, professional curiosity should lead to an analysis of risks and strengths before any decisions are made to take action or not take action. When there is any significant risk, management oversight should be available and used as part of the essential decision-making process.**

The complexity of G's personal circumstances involved a significant level of risk of self-neglect. This challenging situation is likely to have benefited from a co-ordinated multi-agency approach informed by a regional policy designed to support professionals in the management of self-neglect. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

3. **Via the Protocols and Procedures Sub Group, it completes and ratifies a multi-agency Self-Neglect Policy.**

The reviewers identified that the GP who visited G at home had an opportunity to assess her wider needs beyond the presenting issue. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

4. **Where there is evidence that there may be unmet health needs, General Practitioners look beyond only immediate health needs and approach their patient holistically.**

The reviewers identified that the Police following their visit ended involvement relying only on information from their single agency. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

5. **Where there is potential risk such as with G & H and it seems that another agency is involved, professional curiosity should be used to ensure that wider information is sought from the other agency to inform decision making.**

The reviewers identified that there were issues with the recording of pertinent information on the correct electronic file in WCCIS[1]. It is therefore recommended that the Cwm Taf Morgannwg Safeguarding Board ensures that:

6. **All agencies are aware of their professional standards in relation to the recording of information. All information should be recorded in line the standards outlined by GDPR legislation.**

   And additionally:

7. All agencies should have in place their own policies and mechanisms for clear and accurate record keeping

[1] Welsh Community Care Information System

Statement by Reviewers			
REVIEWER 1	Terri K. Warrilow	**REVIEWER 2**	Jon Eyre
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 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		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 ▪ 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)*	Terri K Warrilow…	**Name** *(Print)*	Jon Eyre……

Date	31/3/2021……..	**Date**	…04.05.21……

Chair of Review Panel *(Signature)*	E Walters…….....….
Name *(Print)*	Emma Walters …….....…….
Date	20/5/21 …….....…….

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult Practice Review process

The circumstances of this case were considered by the Cwm Taf Morgannwg Safeguarding Board's Joint Review Group on 21 January 2020, where it was agreed that it met the criteria for an Extended Adult Practice Review.

The review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 “Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Wales Ambulance Service Trust
- Cwm Taf Morgannwg Emergency Duty Team
- Cwm Taf Morgannwg University Health Board
- RCTCBC Commissioning Team

A learning event was held on the 19th June 2018 attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Wales Ambulance Service Trust

- Cwm Taf Morgannwg Emergency Duty Team
- RCT Commissioning Team
- Care Home Representatives

Family members engaged in the Review process, both prior to and after the Learning Event. Y and other family members were initially reluctant to meet with the reviewers. However, after some time they agreed. The reviewers met with Y who was the spokesperson for the other family members who attended via virtual video conferencing facilities. Unfortunately, the extended family did not agree to meet with the reviewers until well after the learning event had taken place. Therefore, this information was not available to discuss or explore during the learning event. The views of the family have been incorporated into this report.

☐ Family declined involvement

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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	☐	☐	

ADULT PRACTICE REVIEW PANEL
ADULT G – CTMSB 2/2019

Terms of Reference

Case Reference details
Adult G – CTMSB 2/2019

Circumstances leading to the APR
The adult at risk (Adult G) was admitted to hospital on 11.09.2018 after an ambulance was called by a family member. A social worker had visited the home on Friday 07.09.2018 and spoken to her to complete s126 enquires following a safeguarding concern being raised by the domiciliary care provider for her husband, who resided with her. It was reported that Adult G had stated that she was frightened of her grandson who supported the couple but was emotionally and, potentially, physically abusive. Adult G was allocated her own worker as there were concerns that she was not recognising her own needs and would benefit from support.
Adult G was admitted to hospital in a critical condition, with various injuries and required emergency surgery. She recovered consciousness and allegedly told another family member and nursing staff that her grandson had been horrible to her, but she would not speak with police without a family member present. Unfortunately, she passed away in hospital prior to this being arranged.

Agencies Involved

The following agencies were involved with Adult G and will be completing a timeline and analysis of their involvement:

- South Wales Police
- Adult Services, RCT
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance Service Trust
- RCT Commissioning and Contracting Department

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.
- 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 CTSB 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
Emma Walters (Chair)	Child Protection Coordinator	Rhondda Cynon Taf County Borough CouncilS
Jon Eyre (Reviewer)	Principal Manager Safeguarding	Merthyr Tydfil County Borough Council
Terri Warrilow (Reviewer)	Safeguarding and Quality Manager	Bridgend County Borough Council
David Harris	Safeguarding Specialist	Welsh Ambulance Service
Beverley Brooks	Deputy Head of Safeguarding	Cwm Taf Morgannwg Health Board
Phil Dallyn	Detective Inspector PPU	South Wales Police
Sarah Evans	Adult Services	Rhondda Cynon Taf County Borough Council

There are no parallel reviews underway.

Timeframe for the APR

The timeframe set for the Review is 18 months from the date of death, the rationale being a letter was received from a local MP in October 2018 highlighting that concerns had been reported 18 months prior to the death of Mrs Staple, so agencies felt this timeframe was pertinent to the review. Summary reports to be completed prior to this.

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 at the beginning of March 2020.

Completion Date

The completion date set for the Review is June 2020.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Send the report and action plan 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.