Extended Adult Practice Review Report

CWMPAS 5/2018

Date report presented to the Board:

17th October 2023

Adult Practice Review Report
CWMPAS: Mid & West Wales Safeguarding Adults Board
Extended Adult Practice Review Re: CWMPAS 5 2018

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*

An Extended Adult Practice Review (EAPR) was commissioned by CWMPAS: The Mid & West Wales Safeguarding Adults Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales)act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 3 – Adult Practice Reviews*[2] (Welsh Government, 2016). The criteria for this review are met under Chapter 7 Extended Adult Practice Reviews.

A Board must undertake an Extended Adult Practice Review in any of the following cases where, an adult at risk who has, on any date during the six 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.

The criteria for extended adult practice reviews are laid down in *the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[3]*.*

The purpose of the review is to identify learning for future practice and is not an investigation. It involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with the adult and their family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and adult protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations about what needs to be done differently to improve future practice.

There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) which were in place for the individual, which has required external professional challenge and a close and critical level of examination by giving consideration to the following issues, both within the terms of reference to the review and at the Learning Event:

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V3 – APRs (Welsh Government,2016)
[3] Regulation 4(4) of the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

and decision making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.

- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

The Terms of Reference for this Extended Adult Practice Review are included at **Appendix 1**.

Circumstances Resulting in the Review

The young woman (Adult M) was a 22-year-old, third year residential learner (funded through a Further Education placement by Welsh Government and the Local Authority), who was found deceased in her residence attic room at the residential College in England where she resided during term time; nine days into the New Year and just three months prior to her 23rd birthday in 2016. The cause of her death was recorded at the inquest which took place in February 2023 as a 'case of suicide'.

Adult M had a diagnosis of Asperger's Syndrome[4], Raynaud's disease[5] and depressive illness[6]. She was under the care of a Consultant Psychiatrist who provided consultation and support whilst she was at home, during college holidays and at times of crisis. Adult M had an allocated social worker from the Adults Disability Team.

Adult M had a history of depression and was also at risk of self-harm and suicide, which was detailed in a WARRN (Wales Applied Risk Research Network) Risk Assessment and Care and Support Plan[7]. There were three attempts at self-harm noted in the contextual

[4] https://www.autism.org.uk/advice-and-guidance/what-is-autism/asperger-syndrome#:~:text=persistent%20difficulties%20with%20or%20differences,on%20day%20to%20day%20life.

[5] **Raynaud's** affects blood circulation. When cold, anxious or stressed, fingers and toes may change colour. Other symptoms can include: pain, numbness, pins and needles, difficulty moving in the area. The skin may turn white or a lighter colour as blood flow is restricted. The symptoms of Raynaud's may last from a few minutes to a few hours. http://www.nhs.uk Raynaud's.

[6] **Depression** is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems. Source www.nhs.uk

[7] **WARRN** is a formulation-based technique for the assessment and management of serious risk for users of mental health services. https://orca.cardiff.ac.uk/id/eprint/125368/1/Snowden.%20WARRN%20survey.pdf

information. There was also a psychotic episode[8] recorded in documents for the review which was reported to have reoccurred during the review timeline.

Adult M's mental health and emotional wellbeing deteriorated in late December 2015 after a difficult term in her new residential house and placement on her new course, through to early January 2016. Contact between the Local Authority and the residential college is recorded in detail in an email communication, which included an agreed plan of action in response to the concerns that were being raised by Adult M's family.

Due to the concerning circumstances of Adult M's death whilst in residential care, her history and contextual information, alongside the involvement of a number of agencies (some of whom, at the time of commencement of the review, had acknowledged their failings in letters of apology following complaints processes) and concerns shared by Adult M's family, it was felt that there should be a referral for consideration under the Adult Practice Review process, as the criteria for an Extended Adult Practice Review (EAPR) had been met.

Time Period Reviewed, Timescale of the Review and Why

To reflect the significant amount of information and the multi-agency involvement that is covered in the years prior to Adult M's death, the timeline of the review was extended to cover the fourteen-month period prior to her death. The timeline reviewed was from 1st December 2014 to 31st January 2016.

In context, this was from the late Autumn term of Adult M's second year at the residential college until the time of her death. The Reviewers looked at some more historical information, in order to understand some of the context that predated the review period, particularly in relation to Adult M's diagnosis, educational and personal journey and her lived experience, to inform the learning within the timeframe of the review.

When Adult M died, the immediacy of her death was dealt with under the English Safeguarding Adults Review (SAR) guidance[9], which was introduced under the Care Act 2014[10]. The purpose of a SAR is to determine what the organisations and individuals involved in the case might have done differently that could have prevented harm or death, so that (as under the Welsh Guidance for EAPRs) lessons can be learned from the case, and those lessons can be applied to future practice to prevent similar harm from occurring again. It is not, as stated in the introduction to this EAPR, a reinvestigation of an incident, nor is it to apportion blame.

Adult M's death was considered under the SAR process, but the Local Safeguarding Adults Board in which the residential college was based, and where Adult M's death occurred, decided that a SAR was not required, as the residential college in which Adult M resided had completed their own internal investigation and identified learning derived from that. The case was then referred by the Local Authority, who had funded the residential placement,

[8] The combination of hallucinations and delusional thinking can often severely disrupt perception. Thinking, emotion, and behaviour. Experiencing the symptoms of psychosis is often referred to as having a psychotic episode. Source 2 Feb 2023. www.nhs.uk
[9] Safeguarding Adults Review (SAR) care Act 2014. ssab.safeguardingsomerset.org.uk
[10] Care Act 2014

and whose services were supporting Adult M, to the CWMPAS Adults Safeguarding Board who, as stated above, approved for an EAPR to be undertaken.

The EAPR commenced in 2019 and experienced a number of complex challenges and delays owing to the ongoing coronial process as well as the impact of the COVID pandemic. Due to the impact on the EAPR of the delay with the inquest, the Chair of the CWMPAS Adult Safeguarding Board raised a formal complaint under the Judicial Complaints process, on the grounds of unreasonable delay and failure to respond to correspondence. This enabled the review panel to provide an accurate and updated position to Adult M's family and to continue to support them to understand what had led to the tragic set of circumstances and some possible closure for them. The complaint was upheld, and the review panel proceeded with the review. There was then a further postponement notice received from the Coroner with regard to the inquest taking place in February 2023. It was felt by the Panel Chair, Independent Reviewers and the CWMPAS Safeguarding Board that the review would proceed without further delay, to ensure that the learning from the review could be elicited and shared as soon as was practically possible.

Adult M's Family History and Contextual information

The Reviewers learnt about the person that Adult M was from her parents as well as those who had worked with her and got to know her over the time that they had supported her. The Reviewers also had access to detailed written information from Adult M's parents, agencies and a statement from a close friend who also resided in the residential college.

From her parents, the Reviewers understood that Adult M was very much loved and cherished by them and that they thought the world of her; they were highly supportive and always wanted and strived to do their very best for her. Adult M was their world, and particularly for her mother, her daily life revolved around Adult M and her needs, even when she was living away at the residential college. Adult M's parents had throughout her life, placed their absolute faith and trust in the agencies and the professionals who were supporting their daughter. It was therefore a shock and extremely distressing for them, that following Adult M's death, they discovered through several complaints processes, that a number of their concerns regarding Adult M's care and situation were upheld.

Adult M's extended family were also very important to her. She loved and was well loved by them; this included her Nan, Grandad, and most specifically her Great Grandmother and her older half-brother. One of her Aunts was also noted to be a person that Adult M could rely on if her parents were not available for any reason.

From an early age, Adult M demonstrated a very real sense of right and wrong, which was seen played out in some of her lived experiences. Adult M had told her parents that she had always felt different, and this led ultimately to her Asperger's diagnosis (at aged 13). It was living with Asperger's[11] that created Adult M's anxiety and depression. Adult M was a loyal friend to others and was very supportive when her friends were in trouble. Academically, Adult M performed well and achieved to an excellent standard in her educational

[11] Asperger's syndrome is a developmental disorder. Young people with Asperger's syndrome have a difficult time relating to others socially and their behaviour and thinking patterns can be rigid and repetitive. www.nationwidechildrens.org

qualifications (GCSEs, AS levels and Extended Diploma in Health & Social Care Level 3), in spite of her own misgivings and worries that she was not going to achieve due to the very high expectations Adult M set for herself.

Adult M was an observant, insightful, and very truthful young woman. She was an active listener and cared deeply about others. When Adult M took time out from her studies when she felt it necessary to leave the sixth form owing to her anxieties, her mother assisted her to find activities that she could participate in. Adult M enjoyed a number of activities, including: drama, cookery, horse riding, swimming, stone carving and learning Spanish. Adult M completed these activities on her own or would jointly undertake them with her mother. Because of the rurality of Adult M's home, it was not possible for her to partake in activities or socialising if she was not driven to events by one of her parents.

As Adult M got older, she struggled when she witnessed her peers learning to drive, having boyfriends etc.; she felt that these were the things that she was not going to be able to achieve. Adult M had struggled in school and had on occasions felt bullied. For the reasons described, however, Adult M had progressed into her school VI form to study for her AS levels, but this was not successful in relationship terms. Adult M had also attempted to study at the local Further Education (FE) College, but she felt that they could not meet her needs.

It was all of these factors, as well as feeling that she needed to get away from her peer group who knew her, that led Adult M to decide that for her ongoing education she needed to be away from her local area, and why the search for a suitable residential provision was undertaken. Adult M identified several colleges and had visited them with her mother before deciding on the one that she preferred. Funding was made available for Adult M to access the residential provision under the then Welsh Additional Learning Needs (ALN) Code of Practice by the completion of an FE template and the production of a 'Learning and Skills Plan' (Section 140) by Careers Wales. This was subsequently approved by Welsh Government, who agreed that there was sufficient evidence to support a placement for Adult M in a specialist college placement. Her academic ability was such that her studies could have been accessed in Wales but for all the reasons stated, Adult M chose a college in England that best suited her wants and needs.

Once at the residential college, Adult M flourished and loved the area in England that she had moved to. It was noted by professionals at the learning event, who had worked directly with Adult M, that having previously looked very young for her years, Adult M had changed significantly in her appearance. It was noted in information received from the college that Adult M experimented with hair colours and different fashion styles. It was further evidenced that in the residential college setting, Adult M had matured and was living a life that young people would very much wish to emulate.

At no time in her educational journey did Adult M have a 'statement of educational need', however, she was recognised to have Additional Learning Needs (ALN).[12] In July 2015,

[12] A person has **additional learning needs** if he or she has a learning difficulty or disability (whether the learning difficulty or disability arises from a medical condition or otherwise) which calls for additional learning provision. A child of compulsory school age or person over that age has a learning difficulty or disability if he or she – a) has a significantly greater difficulty in learning than the majority of others of the same age, or b) has a disability for the purposes of the Equality Act 2010 which prevents or hinders him or her from making use of

within the residential college report, it was acknowledged that Adult M had 'blossomed into a mature, strong and confident young lady. She was consistent in her beliefs, however she listened to advice from staff which enabled her to reconsider her judgement at times, particularly when dealing with her peers. Students find her approachable but understand that she will tell the truth when asked advice which is an admirable trait.'

Unusually, on request, Adult M was provided with a third year of funding at the residential college, having completed her Level 3 Extended Diploma in Health and Social Care at a neighbouring FE college that had a partnership with the residential college. Adult M wished to pursue a career working with children and was in her third year at the residential college, progressing to undertake a work-based learning qualification as a teaching assistant in a primary school.

With the third year of study and residential provision, there was greater independence afforded to Adult M, in the form of a move of residence to a more independent house on the college site. There was also an initial greater expectation of independence in regard to travelling to placement, requiring Adult M to travel alone. These greater levels of independence had a significant impact on Adult M during the Autumn term of 2015 and led to significant anxiety for her. Following a review and notification of the issues, the residential college put supportive measures in place to assist Adult M to get to placement. There was, however, a deterioration in Adult M's mental health and wellbeing during the term, which was also affected by a situation that had arisen in the residence, regarding a friend of Adult M's. The primary school placement had also been affected by Adult M's tiredness, attendance, motivation, and self-confidence dipping significantly during the term. This caused Adult M to be worried about how her longer-term placement and qualification would be affected. The Autumn term's residential college report in December 2015 noted that it had been 'an extremely difficult time for Adult M.'

Immediately prior to her death, Adult M had written an email which she had wanted to be shared with the college, which had been sent to her social worker. In the email, Adult M described her feelings of resentment to the service provision at the residential college. This was because of the demands that she had felt had been expected of her in the Autumn term of her third year. These demands she felt had impacted on her mental health and had led to her feeling depressed for, what she described as, most of the time. Adult M noted that she had been having reoccurring suicidal thoughts over the Christmas period and that she 'no longer thought that she had a future.' Adult M also spoke of how she would like things to change going forward. The contents of the email were shared verbally by the social worker with the residential college. At the time of her death, Adult M had returned from the Christmas vacation at home having been seen by the mental health team in the area where she lived.

facilities for education or training of a kind generally provided for others of the same age in mainstream maintained schools or mainstream institutions in the further education sector. www.wales.gov.

Adult M's Voice

Adult M was not afraid to make her views known to professionals, either when she was asked directly or if she felt that she had to say something. Throughout her life, she made her views, wishes and feelings known to her parents, either directly or through written communication. On numerous occasions, Adult M's mother represented her views and did her utmost to support Adult M. There was significant evidence in the large amount of information that her mother shared with the Reviewers, of communication from mother to professionals who had worked with Adult M, advocating for her wishes and feelings. There was also evidence of Adult M's wishes for her future, to live independently and to gain employment, working with children in a role that she was training for. She also wanted to learn to drive and to develop friendships and relationships.

Adult M's voice was very much heard in the review process by the Independent Reviewers, who spoke at length with her parents, and who read the voluminous information that was provided to them by Adult M's family and by professionals who spoke at the learning events about their conversations with Adult M about her wishes and feelings for her future. What the review acknowledges however, was that on occasions there was learning to be derived from how that information was shared and subsequently how actions were then followed through and confirmed back to the sharing agency.

Agencies that were Involved with Adult M

The agencies involved are listed on page 43 of the review report.

At no time either historically or during the timeline of the review was the protocol for professional disagreement invoked.

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.

The identification of the practice and organisational learning has been drawn from the following key elements of the review:

- The production of a merged multi-agency timeline and agency analysis
- Two Learning Events
- Adult M's family's perspective
- Case record reviews
- Consultation with professionals directly involved
- Discussions within the Review Panel's meetings
- Internal investigation reports
- Independent Investigation report commissioned by the LA
- Records of complaints processes and Ombudsman's Report
- Independent Reviewers/Chair's analysis

1. Independent Investigations/Complaints that Preceded the Review and Identified Implemented Learning

Following Adult M's tragic death, her parents raised a number of questions concerning aspects of her care. The answers to these questions from agencies led to concerns being raised and further queries, which ultimately led to formal complaints being made to the following agencies:

- Residential Further Education College
- Local Authority
- Health Boards (there were 2 Health Boards involved as Health Board 2 was commissioned to provide mental health services in the locality services by Health Board 1 during the timeline of the review, and they provided services to Adult M). Since that time Health Board 1 now provide mental health services; Health Board 2 no longer provide mental health services.

Adult M's mother kept meticulously detailed records of all interactions with agencies; alongside diarising her daughter's concerns and any incidents that occurred where Adult M would seek her assistance or advice.

In regards to one of the formal complaints that were raised, the complaint was referred on to the Ombudsman for Wales.

By the onset of the EAPR, the formal complaints and onward processes in relation to them had been completed with outcomes/actions and any learning that had been recorded and addressed.

For contextual purposes and implications of learning, the Reviewers have considered in the EAPR report, the complaints, reviews and investigations that were undertaken; whether they were upheld and also noted the learning that had been implemented prior to the EAPR process. There will be elements which are relevant to some sections of this review report. However, only learning identified through the EAPR process that has not been implemented will be referred to as further learning within the context of this EAPR review report and included in the Improving Systems and Practice section of the EAPR on page 32.

The previous investigations and complaints processes identified shortfalls in practice and acknowledged lessons to be learned in a number of areas regarding Adult M's care, and made recommendations for improvements and actions to be implemented. This included an acknowledgement that significant information in respect of Adult M's history, including previous episodes of self-harm and suicidal ideation, were not shared with all staff who cared for Adult M. This included a known risk during the night. Risk assessments and care plans were not updated with key and significant information, in particular, regarding Adult M's deteriorating mental health, including an apparent known psychotic episode in late 2015. No direct communication with Adult M's medical practitioners, including her GP and psychiatrist, took place by staff at the residential college; this was done indirectly by Adult M's mother. Opportunities therefore to ensure that staff were fully aware of and able to manage all of Adult M's needs and associated risks were missed.

Recommendations were made and implemented from the agencies involved in these processes, which included improvements in communication processes/risk assessment, the quality of written records, information sharing, assessment, and care plans. It was recommended that direct communication should always take place with mental health services who are delivering services where a resident has a care and treatment plan in place. There were also recommendations regarding improvements to how risk assessments are undertaken, with particular attention to the resident's environment and ligature points. Specialist training being made available to staff who are working with people identified to be at risk of suicide were also mandated.

As part of the EAPR process, all the agencies involved have confirmed to the panel chair/Reviewers that the learning and recommendations identified through these processes had been implemented and that the learning remains current in today's practice. Reminders and training for staff are still provided in these areas of improvement. There has also over the passage of time of the EAPR process been significant changes in statutory legislation in relation to ALN and in the development of the Welsh Government's work on suicide.

1.1 Residential Further Education College Complaints Raised, Investigation Outcome and Identified Learning

Immediately following Adult M's death, the residential college commissioned a review into the circumstances leading up to Adult M's death. Their review was thorough and there were 13 recommendations made. Arising out of the conclusions there were lessons to be learnt by the entire group of residential homes/colleges.

The Provider was thorough in providing the Reviewers with an audit spreadsheet which contained the recommendations from their report, alongside evidence to support the implementation of the recommendations and the person responsible. It was also noted during the learning event and through the review panel, that the residential college included in the EAPR report is no longer under the management of the wider organisation that it was when Adult M was in residence. It is now part of a specialist education and children's home provider in the UK. Since September 2022 there are two divisions, one for care and one for education. The operational divisions of the home are supported by central services including Human Resources (HR), Information Technology (IT), Learning and Development, Estates, Complaints, Quality Teams (one for each division), Safeguarding, Finance and Health and Safety. The move has also included a move away from providing residential services within their schools. These changes, however, are not related to the tragic circumstances relating to the death of Adult M.

1.2 Local Authority Complaints Raised, Investigation Outcome and Identified/Implemented Learning.

An independent investigation was undertaken by the LA following the family's complaint which supported and correlated the findings of the independent investigation of the college within the context of communication, staff training, the sharing of information, understanding

the mental health needs of Adult M, the infrequency of visits made to Adult M whilst at the college and the risk assessments associated with this.

The Investigation report also concluded that 'a relatively large number of issues were considered during the investigation with some being more significant than others, whist all were relevant matters, the single most crucial issue was the failure of both the college and the council to sufficiently monitor Adult M's wellbeing and general progress.'[13]

1.3 Health Boards Complaints Raised, Investigation Outcome and Identified/Implemented Learning

The complaints that were made against the Health Boards were referred to the Ombudsman by Adult M's family, as they were not comfortable with the individual internal serious incident investigation that took place. The family felt that throughout Adult M's life they had struggled to get the appropriate support and treatment for her, that there was a breach in the duty of care and treatment provided to Adult M and that there was severe negligence when vital information was not shared amongst professionals. The family stated that there had been missed opportunities to intervene when Adult M should have been assessed and a risk assessment carried out. They also believed that this lack of care could well have led to lack of understanding of how Adult M was feeling, leading to the resulting tragedy.

The Ombudsman largely upheld the complaints that had been made. However, though the Ombudsman through his Clinical Advisor identified significant failings in Adult M's care, they found no evidence to suggest that these failings caused or contributed to Adult M's tragic suicide.

Both Health Boards agreed to implement the recommendations of the Ombudsman. At the time of the publication of the EAPR report, the Health Boards confirmed to the Reviewers that they had implemented the recommendations.

Highlighted Effective Practice

- It was apparent that Adult M's educational needs were well met, academically she was a successful student, achieving a Distinction, Distinction, Merit in her L3 Extended Diploma in Health and Social Care. She had very good GCSEs and had completed AS study. Adult M had also participated on a project overseas with an orphanage in Bulgaria where she had reportedly thrived.
- Uniquely, Adult M was funded for a third year of placement, where she was undertaking a programme of supported internship where she would achieve a certificate in Supporting Teaching and Learning in Schools. It was the intention that this would provide her with the experience and qualification to pursue a career as a teaching assistant.

[13] The independent investigation and review commissioned by the Local Authority into concerns expressed by Adult M's parents concerning the death of their daughter at the Residential College

Family's Perspective

- They felt that they had tried for years to get professionals to listen and provide appropriate support and treatment for Adult M.
- The complaints that they raised and outcomes have never been about money. That has been of no interest to them. It has been about making sure that lessons are learnt to make sure that this does not happen again.
- They feel that more attention should have been paid to all the medication Adult M had been prescribed. They were concerned that the medication could have been the cause for many of Adult M's symptoms.
- They feel that a lot more attention should have been taken when Adult M suffered a second psychotic episode.
- They felt that through the complaints processes there have been so many discrepancies in the information that has been provided.
- That there were many missed opportunities to intervene due to the negligence and non-communication when Adult M should have been assessed and a risk assessment carried out.
- They genuinely believed that Adult M was in the safest place where she was being cared for and feel that they took things for granted.

Learning

The learning that has been identified in this section of the EAPR report was historical following the outcomes of the independent internal and external investigations. The learning that has taken place and implemented is contained within section 1.

2. Understanding the Person with Autism Spectrum Disorder (Asperger's) and associated Mental Health and Well-being

Adult M had a diagnosis of an Autism Spectrum Disorder (ASD); Asperger's syndrome[14]. It is noted by the National Autistic Society(IBID), that many people who fit the profile for Asperger syndrome are now being diagnosed with an Autistic Spectrum Disorder instead. Each person is different, and it is up to each individual how they choose to identify. Some people with a diagnosis of Asperger syndrome may choose to keep using the term, while others may prefer to refer to themselves as autistic or on the autistic spectrum**.** Adult M had received this diagnosis when she was a younger child (2006) and always referred to her diagnosis as Asperger's, therefore within this review report, the term will be used throughout where it is specifically referenced to Adult M.

Adult M's early diagnosis evidenced good practice as more recent research has suggested how women and girls with autism are often diagnosed well into their adult lives. Research

[14] https://www.autism.org.uk/advice-and-guidance/what-is-autism/asperger-syndrome#:~:text=persistent%20difficulties%20with%20or%20differences,on%20day%20to%20day%20life.

notes that traditionally, autism has been seen to be more readily and easy to diagnose in boys than girls[15&16].

Adult M's parents told the Reviewers that they knew from an early age that Adult M had needs different to her peers and that Adult M herself felt that she was different to her friends.

Asperger's is often associated with other mental health issues and in the case of Adult M, she had anxiety and depression. These conditions are related to those who have ASD struggling with the world around them and not seeing things the way that others do. It is hard for those with autism to understand social cues, and therefore can lead to anxiety and depressive illness.

For these reasons, Adult M had been known to Mental Health services both as a child and an adult. Adult M's GP was also actively involved in her care and there is evidence of good liaison between the mental health care team and her GP in the locality of her home.

Prior to the timeline for the review, Adult M had been known to the community mental health team. At a time when she was more stable, Adult M was discharged from the team and her ongoing treatment was under the care of a psychiatrist and GP.

Records, educational plans, and risk assessments showed a great understanding of Adult M and the difficulties she had understanding the world around her and her place within it. When discussed with professionals at the learning events, it was clear that there were also misunderstandings regarding how the difficulties associated with Adult M's Asperger's would manifest. Being under the care of a psychiatrist alone appears to have been for the purpose of accessing the right advice and medication to manage the symptoms of the stress that Adult M experienced. Her medication regime included anti-depressants, antipsychotics and sleeping medication.

As Adult M had previously been known to secondary mental health services within the previous three years, she was entitled to the provisions of part three of the Mental Health (Wales) Measure (2010)[17]. During the timeline of the review, this provision was usually accessed via Adult M's mother, directly with the psychiatrist. It has been noted that Adult M, when feeling well, requested to have her antipsychotic medication reduced as she did not feel she needed it and it was making her sleepy. This was reduced in accordance with her wishes and feelings, whilst being monitored by her mother reporting back to the psychiatrist on Adult M's progress. This evidenced good practice and showed person centred care. When, however, Adult M's mother was worried about a slump in her mental health and an increase in her 'persecutory ideas[18]', the psychiatrist increased Adult M's medication significantly to manage these symptoms without seeing Adult M or assessing her. This issue has been dealt with as a part of other investigations (see section 1) as this is not good

[15] Asperger and Autism Spectrum_ Women and Girls – The Asperger _ Autism Network (AANE). https://www.aane.org/women-asperger-profiles/

[16] MILNER, V. Et al. (2019) A Qualitative Exploration of the Female Experience of Autism Spectrum Disorder (ASD). Journal of Autism and Developmental Disorders, 49(6), pp. 2389–2402.

[17] **The Mental Health (Wales) Measure 2010 https://ctmuhb.nhs.wales/patient-advice/mental-health-wales-measure-2010-parts-2-and-3 /**National Assembly for Wales

[18] Persecutory ideas are, strongly held beliefs that other people intend to harm us. http:wwww.psych.ox.ac.uk.

practice, and was an aspect of learning from the Ombudsman's report.

What has become apparent was that Adult M's dip in mental health was attributed to issues at the residential college that she had become involved with (see Section 9), and to which she was a witness, alongside relationship issues. These issues came on top of Adult M feeling that she was being expected to be more independent in year three of her college placement and was feeling compelled by staff at the college to undertake elements of her course and work placements that she felt put too much pressure on her. Due to the high expectations that Adult M always placed on herself to excel and succeed, the stress on her at this time was immeasurable and created an increase in her anxiety and depression. These circumstances caused Adult M significant difficulties that were based on her Asperger's traits, her rigid thinking and not being able to understand lies; the sense of injustice that lies may bring were enormous for her. This led to her displaying features that could have been misconstrued as psychotic thoughts. Without being seen or assessed by a qualified mental health professional at that time, it was not possible to diagnose psychosis.

The learning events for this review were fortunate to have a psychiatrist present who was able to put the behaviours and difficulties that Adult M had into a clear Asperger's framework.

On further review of the mental health records, the psychiatrist was able to identify that Adult M's difficulties were indeed seen and recorded to be directly related to her Asperger's and were not due to any evidence of psychotic illness per se[19]. Adult M's behaviours that were referred to as 'psychotic episodes' in records (not mental health records) and discussions by her mother to other professionals, is noted by the GP and psychiatrist as more likely to be of obsessional recurrent ideas; mental health records state that she "knows these things didn't occur but gets the strange idea they did", which shows that the thoughts were not fixed and unshakeable, and therefore not delusional in their intensity. The underlying diagnosis was therefore one of Obsessional Compulsive Disorder (OCD)[20] (predominantly obsessional thoughts/ruminations), exacerbated by her underlying ASD. The antipsychotic drugs[21] that were used to treat Adult M on occasions were appropriately prescribed to manage individual symptoms as opposed to ongoing psychotic illness. Whilst the Ombudsman's report detailed in section 1 highlighted the concerns regarding psychosis, the learning events and the whole EAPR process benefitted from multi-agency discussion and debate with professionals who knew Adult M well. With this additional time, reflection, and information it is of note that this review is enabled to form learning from a different perspective by using an autism lens. This does not change the outcome of the Ombudsman's report as the practice issues highlighted are the same whether there had been a psychosis or behaviours that might be viewed as psychosis but were in all probability related to ASD for the reasons described above.

[19] Adverb in itself-Oxford English Dictionary
[20] Obsessional Compulsive Disorder (OCD) is a mental health condition where a person has obsessive thoughts and compulsive behaviours. OCD can affect men, women and children. People can start having symptoms as early as 6 years old, but it often begins around puberty and early adulthood. OCD can be distressing and significantly interfere with your life, but treatment can help to keep it under control. www.nhs.uk
[21] Antipsychotic medicine which can relieve the symptoms of psychosis. www.nhs.uk

Highlighted Effective Practice

- Adult M was diagnosed as a younger child meaning that she was able to access the provisions for learners with additional needs.
- There is clarity that everyone who worked with Adult M understood that she had an Asperger's syndrome diagnosis.
- The letter to Adult M and her parents from the psychiatrist was clear regarding section three measure provision when Adult M had been discharged from mental health services.

Family's Perspective

- They were instrumental in seeking out a diagnosis.
- They believed Adult M's dip in mental health was attributable to psychosis; no one told them any different.
- They wished that they had been communicated with and understood more about Asperger's and how that could have impacted on Adult M.

Learning Points

- Professionals need to understand how a person's ASD will manifest in difficult times and in crisis and explain this to parents/family/carers.
- Mental health diagnoses need to be made upon assessment, not on the telephone reporting of a third party.
- Pressure on a person with ASD to succeed can be significant when added to the pressure they may put on themselves.
- Professionals from all agencies must be accountable and give pivotal importance to maintaining scheduled care conferences/reviews.
- When concerns arise, professionals must share information and, when appropriate, convene a meeting.

3. Crisis Management

What was very clear at this point was that at no time was Adult M referred to or seen by Asperger's specialist services. Adult M herself had indicated that she needed to be able to manage symptoms of her Asperger's effectively. Whilst Adult M had previous input from a community psychiatric nurse to support her, once discharged, Adult M had no ongoing Asperger's support service involved with her. The whole focus from mental health services and the GP was her mental health illness that were in fact side effects of her Asperger's; it was her Asperger's that needed support. Sadly, this was not available or recognised and leads to learning.

Further learning regarding understanding Adult M and her needs comes from how her care was managed when she moved to spend much of her time at a college over 100 miles away from her rural home in Wales. The Reviewers have studied the initial thoughts that this was not the best for Adult M, being away from her parents and her care team. By understanding Adult M in more detail and from discussions with her parents and practitioners who supported her, it was very clear that this was an opportunity that Adult M very much wanted

for herself. It can be seen that the work that was undertaken using the FE Template to procure that for Adult M was good practice, and it was evidenced through the referral process that her voice was heard, and that agencies were person centred in their approach. As a result of joint funding, Adult M was able to undertake her continuing education in a specialist environment. Whilst this was new and challenging, it was also an opportunity for Adult M to start again where she felt she would be on a level playing field with others and that those that knew her and whom she felt had labelled her, were in her past.

There were, however, several issues that were not thought through carefully and were not seen as a robust part of the plan. Firstly, the intention had been that Adult M would be seen by her mental health team (psychiatrist and GP) when she was home in the college holidays. This was not practical. Whilst initially, Adult M was home most weekends, those services were not available at the weekends for routine follow up, only in a crisis. There was no provision identified for any mental health crises care whilst at the residential college. It was not considered because Adult M had been stable for a fair period of time and had thrived in her first two years at the college. This may have been short-sighted given that Adult M was still struggling inside. She was described as a person who hated people knowing how she was really feeling, described as a swan who was able to mask her symptoms but that underneath, she was swimming hard to keep up the swan like appearance.

One of the benefits of remaining with a Welsh team was the Part Three provision previously mentioned, which is not available in England. Adult M was also not registered with a GP in England and remained under the care of her GP at home. When she was seen by a GP in England, this was on a temporary basis and as they had no records, her history may not have been known or understood in its entirety. What needed to happen as part of Adult M's risk assessment was a risk benefit analysis that sought options for her long-term care, as well as local crisis care by the services that were providing care, as well as those acceptable to Adult M once she commenced college. This leads to further learning.

Highlighted Effective Practice

- Adult M's wishes and feelings were listened to in order to gain a placement away from home and Wales.

Family's Perspective

- They felt that Adult M had been fairly stable and listened to professionals who informed them that she could receive mental health support and primary health care whilst at home on holidays. The family were never challenged over agreeing with this.
- They were deeply upset that no risk assessment had been undertaken when Adult M moved into the new residence in her third year.
- They believe that between the ages of 18-25 are the most vulnerable years.
- It was their understanding that up-to-date risk assessments were in place for Adult M.
- They had never had or been involved in any discussions concerning Health Care Plans.
- They were never consulted over GP arrangements at the residential college.

- They were concerned that professional curiosity was not applied by professionals.

Learning Points

- When a person reaches a mental health crisis, there needs to be local access to mental health and primary care support; agreements between areas may need to be reached regarding responsible clinician duties and crisis access.
- Provision of primary healthcare services should be arranged locally for learners in residential placements outside of their home area.

4. Assessing Risk

The other piece of clear learning that has been obtained from other investigations is that Adult M's risk assessment that was undertaken by the social worker when she commenced at the residential college was never further reviewed during her subsequent time at the college. Her placement was reviewed by those who were involved directly with her placement and education, but the risk assessment was not, nor was a risk assessment considered when she moved residence at the residential college in her third year of study. This was a significant move for Adult M as she moved into a residence that was suited to more independent students who were able to do most of their own cooking and other domestic tasks. Nor was a ligature risk assessment undertaken, despite previous risks presenting in this regard and her being assigned an attic bedroom.

It is also of note that her mental health team and GP were not involved in her placement reviews. This was a missed opportunity for the residential college and social worker to have a full understanding of Adult M's medication, management of her Asperger's and mental health needs. This needed to include any ongoing risk of suicide, alongside Adult M's other risky and impulsive behaviours that were a feature of her Asperger's and associated stress levels.

Highlighted Effective Practice

- Albeit that it was never reviewed when it should have been, it is acknowledged that the detailed risk assessment that was in place when Adult M commenced in college did highlight the risk of suicide.

Family's Perspective

- They were disappointed over the risk assessment processes in place for Adult M and the fact that these had not been reviewed at points of transition. They trusted that due process would be followed.

Learning Points

- Risk assessments should be reviewed with involvement from all of those providing care and support regularly and at the point of any change/transition.

5. Self-Harm and Suicide

Noted within the documents for the review and debated within the learning events was Adult M's risk of suicide, and this was included within the initial risk assessment (see above). It is important that clarity is recorded within all records as to what this actually refers to in order to ensure the appropriate care plans are in place to mitigate risk. In terms of Adult M, the psychiatrist identified that the risk of suicide was not due to any suicidal ideation until the end of the timeline of the review when this was expressly stated. In all previous consultations, Adult M always stated no suicidal ideation. At that point, her risk of suicide was due to her use of self-harm to manage her emotions and stress.

A report by the Royal College of Psychiatrists[22] acknowledges the complex relationship between those who self-harm and then go on to complete suicide. It is important to recognise that different approaches are required, and 'risk of suicide' is not enough to identify what action needs to be taken as a result. Once the behaviour and expressed thoughts change, as it did post-Christmas just before Adult M died, action to directly manage the ideation should have been received by her from mental health services, who should have undertaken a thorough assessment of the issues and risks.

Of the issues that affected her in the Autumn term, Adult M stated, 'this has led me to have a complete mental breakdown and now I feel depressed mostly all of the time.' She felt that 'as a student I do not have a voice over my care provision which I undoubtedly need evident to my mental health.' 'I have been having reoccurring suicidal thoughts over the Christmas break as I no longer think that I have a future.'
The multi-agency response that this crisis required is discussed in the section related to safeguarding and multi-agency working (section 10).

Other investigations detailed previously in section 1 have also alluded to the lack of risk assessments in the residential college and a training need for college staff regarding mental health awareness. This was particularly evidenced in the residential college setting, who have appointed safeguarding staff, delivered training to staff including mental health training and as a matter of routine, had risk assessments in place, including ligature risk assessments prior to the commencement of this review.

Highlighted Effective Practice

- Risk of suicide was included in initial risk assessment
- Initial 'Risk of suicide' was seen appropriately as possible misadventure from self-harm

[22] **Royal College of Psychiatrists, (2020) Self-harm and suicide in adults Final report of the Patient Safety Group CR229, July 2020**
https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2020-college-reports/cr229

Family's Perspective

- Family expected that the risk after Christmas was understood and that the professionals around Adult M would take appropriate action to keep her safe. Her mother stated that had she known that Adult M's risk was not understood or acted upon, she would have kept her daughter at home in that period**.**
- They listened when all the professionals felt that the safest thing was for Adult M to return to the college.

Learning Points

- Iterations from persons stating suicidal ideation must be acted upon until evidence to the contrary is demonstrated. For this reason, these aspects of learning are not captured below as they are noted and addressed earlier in the report.

6. Working with Parents pre and post a Young Person being 18/Transition and Mental Capacity Arrangements.

Adult M's parents had recognised that Adult M was developing differently to other children. Historically and during the timeframe of the review, Adult M's needs were fought for by her mother. Her father was fully supportive of his family, however his work took him away and he worked long hours, so it was generally Adult M's mother who was the parent professionals saw and communicated with.

Whilst Adult M, her mother, careers adviser and social worker considered her future education, it was Adult M's mother who sourced activities to keep her occupied, as mentioned previously. If Adult M did not have structure, her mother reported that she would stay in bed all day. From this, we see Adult M's mother continued to be a great support for her daughter into adulthood.

Throughout the timeframe of the review, it is evident that Adult M had been very used to her mother undertaking this role, and appeared to be happy to let this continue after she reached 18. This did cause some issues for the professionals involved, whilst others appeared to be happy to let her mother undertake the ongoing parenting and decision maker role. Thus, it is noted there was an interdependency between the parent and child that, under usual circumstances, would have changed by the age Adult M was within the timeline of the review (22 going on for 23 years of age). This is by no means unusual in cases where a child, growing into a young person and then an adult, has additional needs.

Under the law in England and Wales, all mothers and most fathers have legal rights and responsibilities as a parent, including making decisions about their care and future up until a child reaches 18. This is known as 'parental responsibility'[23]. Those rights and responsibilities end when a child reaches 18 and becomes an adult. The law under the

[23] Parental responsibility – all mothers and most fathers have legal rights and responsibilities as a parent – known as parental responsibility. If you have parental responsibility, your most important roles are to provide a home for the child, protect and maintain the child. https://www.gov.uk

Mental Capacity Act (2005)[24] then changes between 16 and 18, but once a person reaches 18, a parent can no longer automatically make decisions on behalf of their child. It is of concern that, at the time, records do not evidence how the Mental Capacity Act, including assessments and consent, were being used across services.

The Mental Capacity Act protects the rights of those who do not have capacity to make decisions, to be supported to make decisions or to have decisions made in their best interests. In the case of Adult M, there was never any doubt that she had mental capacity to make her own decisions, and therefore no one could make decisions on her behalf.

An adult also has the absolute right to confidentiality in most circumstances and needs to provide explicit consent[25] for anyone else to have or to discuss information about them. Generally, this did not cause any issues, as most important decisions were made by Adult M with her parents' knowledge and support. Adult M was on one occasion offered the use of an advocate to support her; advocacy was a service routinely available to Adult M, if she had felt at any point that she either did not want her mother involved for any reason, or felt that she was a burden to her parents, which was a feature of her Asperger's at times. This was possibly due to the fact that her peers were mostly more independent by this age and not so reliant on their parents. It was, however, abundantly clear that Adult M's parents did not regard Adult M as any sort of burden; to the contrary, as was stated in the 'Young Woman's Family History and Contextual Information' part of this review report, Adult M was an adored daughter, whose parents' sole aim was to do the very best that they could for her and support her in any way possible.

There were occasions where, because of the close relationship that professionals knew that Adult M and her mother had, that the law appeared to be overlooked, causing issues for both parents and professionals. Examples were the upset that Adult M's mother felt when a social worker stated that she could not discuss information about Adult M without her consent, and when doctors spoke to Adult M's mother about concerns regarding her and that treatment was changed, without Adult M being involved in these decisions.

It is important to note that there is no suggestion at all that Adult M's mother ever acted in any way other than in a supportive, caring, devoted manner, and who always and on all occasions, was acting in what appeared to be in Adult M's best interests.

It can be difficult for parents and some young people to make the transition into adulthood. What needed to happen for professionals to act within the spirit of the law, and to ensure that Adult M's voice was at the heart of all of her care and treatment, was for preparation to commence in advance of Adult M becoming 18, for the differences and changes that would occur post her 18th birthday. This would have ensured that both Adult M and her parents

[24] **The Mental Capacity Act 2005** came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. https://www.scie.org.uk/mca/introduction

[25] Consent means that a person voluntarily and wilfully agrees in response to another person's proposition. The person who consents must possess sufficient mental capacity. Consent is a fundamental legal and ethical principle. All patients have the right to be involved in decisions about their treatment and care and to make informed decisions if they can. http:www.gmc.org-uk.org.

were very clear and understood the next steps as to what would happen when parental responsibility ended. It would also have provided reassurance to them that they would still very much have been involved, but that there would be some changes.

Adult M could have provided written or verbal consent readily when needed and they could as a family have discussed matters. Professionals and managers in the learning events recognised that this time of transition is often thought through well in terms of movement from children to adult services, in most cases. The change in responsibility for parents is not as well prepared for however; it is often assumed that parents will know what that change means. Adult M's parents told the Reviewers that they had not been aware of the significance of this change, as for them, Adult M was their daughter who still needed a considerable amount of support. This is not an unusual finding for professionals and indeed the Reviewers have experienced this previously. There is little research regarding the parental role and responsibility post 18 for children, with additional needs with the main focus being on other elements of the transition process. Professionals agreed that they did not focus on supporting parents post 18 in this element of transition. This therefore leads to system learning, regarding a part of the transition process that appears to be missing or is not robust.

That said, it is anticipated that the new ALN reforms in Wales[26] that have been being implemented in a phased approach from September 2021 will address this very important aspect of work, and provide clear guidance to both parents and young people aged 0-25 years of age.

Legislation[27] will also ensure that arrangements and communications are documented in Individual Development Plans[28] (IDPs) and Educational Health Care Plans (EHCP)[29]. There is also a Parents' Guide[30].

Additionally, although not necessarily related to Adult M being post 18, it was also not clear to Adult M's parents how in the case of the respective Health Boards where one was commissioning services from the other, who was responsible for the efficacy of the organisational leadership. This was evidenced in conversations that were had with Adult M's parents and the Reviewers. It was also illustrated in the complaints processes that followed this tragedy. Learning had already taken place ahead of this review and since 2017,

[26] The Additional Learning Needs (ALN) Act creates a single legislative system for supporting children and young people aged between 0-25 years who have ALN and will transform the separate systems for special educational needs (SEN) in schools or PRUs and learning difficulties and/or disabilities (LDD) in further education to create a unified system for supporting learners from 0-25 with ALN.
[27] Additional Learning Needs Code for Wales 2021(ALN Code) contains statutory guidance for the following public authorities in Wales or England; governing bodies of maintained schools in Wales or England(including maintained nursery schools and pupil referral units); governing bodies of further education institutions in Wales or England; proprietors of academies, youth offending teams for an area in Wales or England; Local Health Boards, NHS trusts; the National Health Service Commissioning Boards; clinical commissioning groups; NHS foundation trusts; and Special Health Authorities. The code is made under the Act which, together with this Code and regulations made under the Act. Provides the statutory system in Wales for meeting the additional learning needs of children and young people. It is aimed at ensuring that children's and young people's additional learning needs are identified early and addressed quickly to enable them to achieve their full potential. www.gov.wales
[28] IDPs are a legal document which describes a child's or Young Person's additional learning needs, the support they need, and the outcomes they would like to achieve. It is a "plan" because it not only describes the ALN, but it also plans the action that must be taken for the child or young person. It also provides a record against which a child or young person's progress may be monitored. Over the next three years, these will replace all other existing plans and will be reviewed every 12 months or at any time to revise the plan. www.snAcymru.org
[29] An education, health care plan (EHC) is for children and young people aged up to 25 who need more support than is available through special educational needs and sets out the additional support to meet those needs. http:www.gov.uk.
[30] Additional learning needs (ALN) system parents' guide. www.gov.wales. May 2022

mental health services have returned to the management of the local Health Board, where there is now a clear and visible leadership structure in place.

Highlighted Effective Practice

- Professionals understood that Adult M had mental capacity to make her own decisions supported by her parents.
- Advocacy services were offered to Adult M for any time that she wanted to discuss issues without her parents present; this offer was not taken up.

Family's Perspective

- Adult M's parents had not been prepared for or advised on what the transition to being an adult would mean for their daughter or for themselves, and what that would mean in terms of consent or future communication. This caused distress when a social worker would not speak to mother without specific consent from Adult M.

Learning Points

- Support needs to be provided for parents when their child turns 18, in order that they know what to expect, the arrangements surrounding consent and the management of the ongoing relationship and how that may/will change.
- The arrangements for provision of mental health services and differences between those commissioning services and those providing services need to be clear to patients and their families from the outset.

7. Working with and Supporting Learners post 18 with ALN

Adult M had undertaken a Learning and Skills Plan section 140 assessment[31] as part of her application for residential funding. It was a requirement in Wales under the then (2013) Welsh ALN Code of Practice, that a Learning and Skills Plan (Section 140s) is undertaken when funding applications are being made to support young people progressing to specialist college. The Welsh Government then reviews the funding application and associated evidence to decide whether or not there is sufficient evidence to support a placement at a specialist college. Specialist placements are usually for 2 years.

Adult M's plan noted that she had attended mainstream school but that her placement had broken down there at the end of year 12, as she was unable to cope in a mainstream setting. At the time of entry to residential provision, she needed to develop strategies to assist her to understand Asperger's Syndrome and how it affected her life. To support this, Adult M needed tutors who could understand the issues related to her Asperger's Syndrome.

One of the key actions was in regard to developing a friendship group within her peer group. In achieving this, tutors needed to encourage Adult M to initiate conversation and ensure

[31] A section 140 assessment is an assessment resulting in an LSP, identifying a young person's post-16 educational and training needs and the provision required to meet them. Section 140 of the Learning and Skills Act 2020 outlines the circumstances in which such an assessment must take place.

that she was included in the class discussions that were required. Adult M needed to develop her confidence. She also had low self-esteem and self-image, and as has been stated previously in this report, she had high expectations of herself. Adult M was on occasions, despite her good marks, dissatisfied with her achievements and felt that she had failed.

Adult M's application for a third year of study was made as she did not want to return to her home area and felt that she could still benefit a lot from remaining in the residential placement. She felt that through her time in residential provision, her confidence and independence had grown. Adult M had also enjoyed being in a town setting, and she felt that to return to the rural location in which she had grown up, would not provide her with the same opportunities as living in or near a town.

It is, as stated in other sections of the review report, unique that Adult M was awarded a third year of funding. A third year of funding would only be usually awarded if a young person was going to complete their existing programme of study that they were working towards and not begin another one. Adult M's new course was also in a different FE college that worked with the residential college to offer a larger range of courses, and was not the college where Adult M had undertaken her Extended Diploma in Health and Social Care.

It was not evidenced during the review that a Health Care Plan was in place for Adult M. As Adult M was over the age of 19 and did not have a statement of special educational needs (SEN), there was no requirement of the Special Educational Needs Code of Practice for Wales (2004), section 9.6.1, where the natural completion of an academic year or completion of a particular course would take a learner with a statement beyond their nineteenth birthday[32].

Given Adult M's health situation and how it affected her day-to-day life, It would have been beneficial for there to be a documented Health Care Plan in place which could have been shared with professionals who were supporting her. A Health Care Plan would also have been holistic in considering not only her mental health, but also her physical health. This would then have been helpful during the difficult times she was experiencing in the Autumn term of her third year of study.

Individual Healthcare Plans (IHP) by their definition set out what support is required by a learner. The overall aim of the IHP is to capture the steps which need to be taken to assist a learner to manage their condition and to overcome any potential barriers. It was Adult M's mother who informed the residential college of Adult M's health care needs. Throughout the learning from this review, it has been evidenced that Adult M's mental health impacted on her physical healthcare presentations at times. This was compounded in some respects by the distance from home and the impact of travel to spend time with her family during weekends and holidays. Given the discussions that were being held between Adult M's mum, healthcare professionals and the college, there was a potential for an IHP to be written. The responsibility for the IHP lies with the education setting, under the guidance of the appropriate healthcare professionals, parents and the learner, thereby being a

[32] learning.gov.wales/docs/learning wales/publications/131016-sen-code-of-practice-for-wales-en.pdf

partnership plan. Had this been the case, the IHP would have also illustrated any staff development needs that needed to be addressed in relation to training. This was therefore a missed opportunity for Adult M; this has since been identified as learning for the education and health care professionals involved.

Highlighted Effective Practice

- Welsh Government and the Local Authority uniquely provided Adult M with three years of funding in order that she could undertake a professional placement which could have led to employment.
- There was consistent professional support for Adult M's education post 18.
- Adult M flourished at college due to the support given to her in her first two years.

Family's Perspective

- Adult M's mother was not aware that Adult M could have had an Individual Healthcare Plan in place; no one ever discussed this with her.
- They have been surprised and disappointed post the tragic death of Adult M of what they have uncovered, resulting in a lack of trust in public sector agencies who were providing support services to their daughter.

Learning Points

- Learners post 19 (where it is appropriate) must have an Individual Educational Health Plan that sets out the specific needs of the learner whilst at college from a holistic perspective and which is contributed to by learners, parents and the health professionals involved for both physical and mental health. The plans should be reviewed regularly and when any change in arrangements is anticipated.

8. Regulated Activity, Quality Assurance and Transition Arrangements in Residential Placements

The college that Adult M attended was a co-educational college that provided further education for young people who had been diagnosed as having a diagnosis of autism spectrum disorder, including pervasive development disorder or autistic or Asperger syndrome traits[33]. All learners attending the college were in receipt of funding for high levels of needs.(IBID) The college enabled learners to follow programmes which were aimed at preparing them for adulthood and independent living.

Learners attending the college were able, as Adult M did, to live at the college and then attend with support (1:1 support in Adult M's case) their academic/vocational programme of study at other further education colleges in the locality. These colleges had formed or entered into a respective partnership with the residential college.

[33] Ofsted Inspection Report 15th – 17th February 2022

In addition to the residential provision offer, there was also day provision offered by the college. In the documentation that was considered as part of the review process, information stated that the age of learners that were accommodated at the college were aged between 16-20 years of age. Through the review process, there was no evidence found of the specific arrangements that would have been in place for learners aged between 19 and 23 years of age, as Adult M would have been in this age category when enrolling at the college. It has therefore been unclear as to how the independent external quality inspection processes would have worked, and how the quality of the provision provided for Adult M would have been externally assessed, reported and monitored.

In England, the Social Care Common Inspection Framework (SCCIF) is used as the inspection framework for residential provision in further education colleges. The framework for the inspection is not a 'one size fits all framework' and through the review process, clarity was not able to be sourced or evidenced as to how a young person of Adult M's age would be included in the external inspection framework. Additionally, in Adult M's situation, she was a Welsh young adult placed in English residential provision. In Wales, Further Education Residential Provision is inspected by Care Inspectorate Wales under the published guidance 'inspection of boarding schools, residential special schools and further education colleges with boarding (under 18)'.[34]

Likewise in England, the National Minimum Standards for residential special schools are for the safeguard and promotion of the welfare of all children for whom residential accommodation is provided.[35] This guidance aligns itself to the Keeping Children Safe in Education Guidance.[36] In Wales, the Welsh Government Guidance initially introduced in 2015 is Keeping Learners Safe 283/2022.[37] In Wales, this would also align to the National Minimum Standards for the Accommodation of Students Under 18 by Further Education Colleges, Welsh Assembly Government.[38]

In reality, the adult residential unit at the college was not regulated, and whilst Ofsted were the main regulators at the time of Adult M's attendance, they only reviewed young people up to the age of 18 years. There could therefore be a legal argument that Adult M was not in regulated activity[39], which because of her age was indeed the case. The discrepancy arises in that the residential college itself would have been in regulated activity with many of its other residents. Adult M would, from the beginning of her residential provision, have been outside of the regulated framework, but was, as per all the other residents, experiencing the same care and service.

[34] Guidance published for the inspection of boarding schools, residential special schools and further education colleges with boarding (under 18s). www.careinspectorate.wales
[35] Department for Education, National Minimum Standards for residential special schools. www.gov.uk
[36] Keeping Children Safe in Education 2023: Statutory guidance for schools and colleges. www.gov.uk
[37] www.gov.wales Keeping Learners Safe- The role of Local authorities, governing bodies, and proprietors of independent schools under the Education Act 2002. This statutory guidance must be read and followed by local authorities and governing bodies of maintained schools, voluntarily aided and foundation schools, and further education institutions, under section 175 of the Education Act 2002. The guidance also sets out effective practice for wider education settings and related agencies, particularly those inspected by Estyn and is recommended for work-based learning providers.
[38] https://www.careinspectorate.wales
[39] Regulated Activity - Activity is regulated if it is carried out frequently or the period condition is satisfied. Carried out at an educational institution which is exclusively or mainly there for the provision of further education to children. Carried out for/in connection with the purposes of the establishment. Period condition- more than 3 times in a 30-day period = frequent and intensive. At any time between 2am and 6am with opportunity for face-to-face contact overnight.

In 2018, there had been discussions with the Care Quality Commission (Independent Health Regulator of Health and Social Care in England), however at the time of the review report being written, there was no identifiable evidence that this had been progressed any further to date.

Accommodation in the residential college was in five different boarding houses, one of which (where Adult M resided in her third year of study) was the smallest of the residences and operated as a supported independence house. From referencing the Ofsted inspection reports both historically and from the most recent report of the college in 2022, it is noted that no learners in the smallest boarding house were under the age of 18.

Given the ages of the learners that were stated in the documentation, Adult M would have been one of the oldest learners at the residential college, as she would have entered the college at the age of 20 years and entered her third year of study at the age of 22 years.

There was in the review documentation no examples of evidence where consideration had been given to the different ages of the learners that were in residence and how they may impact upon each other, either because of age or need. This was significant in Adult M's case, as throughout the timeline of the review (and as was noted in the introduction to this review report), Adult M did have issues with some of her peers and situations. It was also evidenced through the timeline and at the learning events that there were no risk assessments (at the time) undertaken which looked at and considered in the placing of the young adults, how they or their behaviours/needs may impact on the other learners with whom they were being residentially placed (since this tragedy this is learning which was not only identified but implemented).

For Adult M her transition from the second to the third year, where she also moved residence to the smaller house that promoted independent living, was noted to be a difficult time. The reasons for her struggles were the arrangements for her placement and the requirement that was placed upon her to independently travel there; alongside this, in the residential setting, there were issues that have been previously mentioned in the review report, regarding Adult M's relationship with a peer, with whom she did not get along.

Adult M was never afraid to speak out and to tell staff if she thought that they should be aware of something. It was also of significance in her third year at the residential college that Adult M commented that she 'had lost confidence in how support was provided and expectations of her.' In the email that Adult M sent to her social worker, which was intended to be a letter to her residential college; Adult M noted that during the first term of her third year, there were a number of demands expected of her during the first term of the academic year and that she had felt completely let down by staff, who she felt had not apologised to her when she believed that they were in the wrong about expecting so much of her.

In 2022, a decision was made by the Specialist Children's Services organisation that had charge of the residential college to no longer offer residential home provision at the residential college where Adult M was resident. The review was informed that this was not as a result of Adult M's death.

Highlighted Effective Practice

- The residential college enabled Adult M to develop effective independence skills and build relationships with peers.

Family's Perspective

- They had absolute faith and trust in the agencies and the professionals that were supporting Adult M.
- They understood the residential college to be the safest place for Adult M and were advised of this by professionals.

Learning Points

- There had been some discussions with the Care Quality Commission (the independent health regulator of health and social care in England), however this has not progressed further to date. At the time of Adult M's attendance in residential provision Ofsted were the main regulators, but it was evidenced in the review process that there is no regulated activity in regard to learners over 18**.**

9. Supporting Learners Affected by Peer-on-Peer Abuse

From 2015, in England more so than in Wales, there was an increased emphasis and awareness of peer-on-peer abuse, and training in safeguarding for both school and college staff was required to be reflective of this. Guidance at the time in terms of keeping learners safe in both further education and school settings stated that all staff should be aware that safeguarding issues could manifest themselves via peer-on-peer abuse. This could include bullying and cyberbullying, gender-based violence, sexual assault and sexting. College Safeguarding Policies in England at this time were advised in educational safeguarding guidance to include within them procedures to minimise the risk of peer-on-peer abuse and set out how allegations would be investigated and dealt with. The policy was also requested to be clear of how victims of peer-on-peer abuse would be supported. At the time of writing the review report (2023), there has been significant work and awareness raising surrounding peer-on-peer abuse in both England and Wales. This followed a rapid review of sexual abuse in schools and colleges in 2021, by Ofsted and a thematic review undertaken in Wales by Estyn in relation to peer-on-peer abuse in schools, and on the 7th June 2023, a thematic report was published by Estyn in relation to Further Education colleges in Wales.

Within the timeline of the review, there was significant impact on Adult M when a peer-on-peer abuse incident allegedly occurred involving learners at the residential college, where Adult M was required to give a witness statement. The college referred the matter to agencies in compliance with Ofsted guidance that 'allegations of peer-on-peer abuse that involves sexual assault and violence must always result in a multi-agency response.'

It was evidenced in the documentation provided to the Reviewers that the Autumn term of 2015 was very challenging, and there was a lot of stressful situations for the residents, including Adult M. In a statement given by one of Adult M's close friends, they noted that

'many of the residents were very unhappy.' When the Police became involved in the alleged peer-on-peer abuse situation, Adult M was very worried about giving a statement in case she forgot something. She also struggled a great deal with the entire situation due to her strong sense of right and wrong, alongside the strong loyalty that she had to her friends.

Such was Adult M's distress at this time that she was feeling that the resident who had made the allegation against her friend was getting into her head and whispering to her, and this was making her scared; she was having nightmares about the situation. This incident also made Adult M reflect back on an earlier situation in her life which has been detailed in the review report under what was described as a psychotic episode.

What was not evidenced from the documentation provided, however, was how staff in the residential college were supporting the residents in the college who were affected by the situation. Adult M at this time was receiving counselling, but there was no evidence to see how procedures for dealing with a peer-on-peer abuse situation were being followed in regard to the other affected residents, nor was there any evidence of a risk plan being in place to manage the situation or consider the implications for others. Adult M again in this situation, as did another resident, sought to go home to receive support there and to get themselves out of the situation.

Family's Perspective

- That the incident of peer-on-peer abuse had a detrimental impact on Adult M and that she was furious with another resident for their behaviour. This caused significant upset for Adult M which affected her emotional well-being and she wanted to return home.
- No member of the residential college staff contacted Adult M's parents to explain what was happening.

Learning Points

- Current research informs us that understanding the impact of peer-on-peer abuse in colleges is an important element of safeguarding those who are victims, perpetrators, and observers.
- Colleges through their designated safeguarding leads need to provide clarity for learners and staff on the processes to be followed when there is peer-on-peer abuse.
- With appropriate consent, it is important that practitioners and carers notify parents where there is a serious matter involving the Police where their provision of support may be a helpful addition.
- The recommendations of the Estyn 2023 peer-on-peer abuse report must be implemented by all the Further Education Colleges (FEIs).

10. Multi-Agency Partnership Working, Communication and Working Together to Safeguard Adult M

As highlighted throughout this review report, there were a number of agencies working with Adult M. The Reviewers found many examples of effective practice that were noted from records and during the learning events related to how professionals worked together, not only with each other, but with Adult M and her parents. Some of these have been previously highlighted in relevant sections above.

This section will therefore summarise some of the learning in terms of multi-agency working, and look further into how that work could have led to a greater understanding of Adult M and may have safeguarded her from harm.

Whilst Adult M's mother told the Reviewers that their experience of care received for Adult M when she was a child was better than as an adult, some of this may relate to the learning in section 6 regarding their preparedness for the changes that they would experience post 18 and in adult services.

The Reviewers noted that there were many services that evidenced continuity in care. The workers in the careers advisory service, adult social care as well as in adult mental health services and within primary care with the GP, remained the same. This meant that the majority of those professionals working with Adult M knew her well and she knew them. This is particularly good as multiple changes in staff are often cited as creating gaps in service and 'start again syndrome', where a new practitioner needs to spend time building a relationship with the person and take time to understand their history. Whilst this happening occasionally is inevitable, where there are multiple changes in worker, this can mean that effective working, assessing, and reviewing can take time and have an impact in understanding risk.

It was clear that the reviews in placement when Adult M was at college were attended by Adult M and her mother, college staff, social worker, and careers advisory service. Although on occasion these were cancelled and rearranged due to various issues, they were positive from the working together perspective. These could have been enhanced by having health information represented at these meetings in order that any health issues could be considered. For example, her mother told professionals that Adult M had a possible diagnosis of chronic fatigue[40]. In conversations and reports, Adult M's parent felt that this fatigue was having an impact on Adult M's ability to keep to timetabling deadlines and to attend her work placement. It was not clear if this had been an actual diagnosis and whether there were other causes for her ongoing fatigue e.g. anxiety and stress, or impact of medication and lack of sleep. Although strategies were put in place to manage this, understanding the cause may have made for more effective strategies.

There were also examples of where improved multi-agency working and collaboration would have supported a better understanding of occasions when Adult M's mental health was dipping. There was no apparent clarity regarding the diagnosis of ongoing 'psychotic episodes'; understanding the aetiology[41] of these issues for Adult M may have been better

[40] Chronic Fatigue or Myalgic encephalomyelitis, is a long-term condition with a wide range of symptoms. The most common is extreme tiredness. It can affect anyone, including children. It is more common in women and tends to develop between mid-20s and 40s.
[41] Aetiology – Medicine the cause, set of causes, or manner of causation of a disease or condition.

supported if the residential college and the social worker had a better understanding of her mental health on an ongoing basis, by inclusion of mental health services and how best to observe and offer robust multi-agency support for her times of crisis.

Alongside the risk assessment that was not reviewed, the impact of the issues that presented to Adult M in the third year of college were not understood from a multi-agency perspective. When the difficulties emerged in the Autumn term with her significant downturn in her mental health, there could have been a multi-agency meeting and plan that included education, health, and social care. This would have given a holistic view of the issues, including advice and strategies as to what each agency could offer in terms of support and understanding. There was no one agency who was taking the lead; in fact it was Adult M's mother who was desperately calling different agencies to support Adult M and ensuring that her needs were being met. This could be viewed as the parent being the key worker. Adult M's mother understood that the issues presenting in Adult M's behaviour were psychosis[42]; this was not diagnosed by mental health professionals, but this was not explained to Adult M's mother, and albeit that it is known that this was not a psychosis but part of her ASD presentation, the focus for her mother was ensuring psychiatry involvement when it could have been a referral to specialist ASD services for interventions to manage her feelings and emotions.

The guidance that the Welsh Government provides in this regard states: 'Multi-agency arrangements between education settings, healthcare professionals, social care professionals and local authorities, parents and learners is of critical importance. Healthcare needs, policies and procedures should identify the collaborative working arrangements and demonstrate how they will work in partnership to meet the needs of learners with health care needs.'[43] There is therefore learning here.

Whilst Adult M did improve and felt better after the half term, it was during the Christmas holidays that Adult M opened up to her mother about how she was feeling, and that she was finding the pressure of the third year too much, alongside friendship issues with the move to a new residential house onsite.

As there had been no multi-agency plan in place, the communication of how Adult M was feeling in the new year period whilst at home, that had been discussed by Adult M and her mother, was not managed in the way that it should have been.

Adult M had a clear message that she wanted to convey to the residential college, and that included that the pressures and how she felt had made her feel suicidal. There were immediate concerns expressed by her mother to the social worker, and these were recorded to have been passed on to the residential college in a timely manner via telephone. Assumptions were then made on what would happen because of the sharing of that information. Adult M did not want the whole letter she had written to be shared with the residential college for fear of reprisals. It is clear from social work records evidenced in the review process, that all of the information was shared with the residential college, however

[42] Psychosis is where you see or hear things that are not there (hallucinations) or believe things are not true (delusions). www.nhs.uk
[43] Welsh Government Supporting learners with health care needs. Original guidance 2010, updated in 2017 215/2017, March. www.gov.wales

this was not recorded by the college, and therefore there is no clarity as to exactly what was said other than what the social worker recorded in their records. Any action plan, however, to deal with the suicidal feelings that Adult M reported, did not receive the immediacy that they should have. Adult M was seen by an assistant psychologist and a counsellor on day 4 post her return to the residential college, but there was no mention by Adult M of suicidal ideation. It does not appear that Adult M was asked about any plans and there is no confirmation that either the psychologist or the counsellor were aware that Adult M had mentioned this in her email to the social worker, despite this being recorded by the social worker as read out over the telephone to the residential college. As this was not recorded by the residential college, it is likely that the psychologist and the counsellor did not know this crucial piece of information. Adult M completed suicide before further intervention to address her feelings had taken place.

The investigations internally and externally that resulted from this tragedy[44], particularly the residential college's response to the information they had received, have all made recommendations and implemented learning, as previously mentioned, but it is for this review to consider the multi-agency factors that lead to learning.

For Adult M, her voice was heard but was not acted on, as the information sharing system was not robust. Whilst the majority of professionals, and in this case, all of the professionals, understand the need to share information in order to safeguard people, where the system is less robust is that the guidance in 'Working Together To Safeguard People'[45] ends at the point of having shared the information appropriately, proportionately, securely and recorded the rationale for sharing. An effective information sharing system also requires that those sharing and in receipt of information have to be clear what they expect to happen and how quickly action is expected to be taken. The ASK-DO-SHARE-CHECKBACK mantra is useful as a reminder to professionals that responsibility is not just to share, but to check back that information has been understood and what action is expected as a result of the shared information. Adult M's mother expected that by following up with the social worker following Adult M sending her letter to them, that her daughter would be safe.

Of the safeguarding arrangements within college, it is noted in the college Ofsted report dated 2015 (which would have been undertaken at the time Adult M was a learner), that there had been a review of safeguarding arrangements, and that there had been improved communication between educational, residential and therapy staff who have improved the timeliness and effectiveness of responses in safeguarding concerns or incidents.[46] In Adult M's case, the review noted learning from the follow up of information provided to the residential college by her social worker in Adult M's final days.

Leading on from that learning and post the death of Adult M, a further Ofsted report in May 2022 noted the following in relation to the residential college: 'Learners are not confident that staff will take their safeguarding disclosures seriously or deal with them promptly. As a result, too many learners do not feel safe and suitably protected from harm at the college. The arrangements for safeguarding are not effective throughout the college, or that all

[44] Tragedy definition Cambridge Dictionary – a very sad event or situation, especially one involving death. https://dictionary.org
[45] Working Together to Safeguard People: Code of Safeguarding Practice. For Individuals, groups, organisations offering activities or services to children and adults in Wales. Social Services and Well-being (Wales) Act 2014. January 2022.
[46] Ofsted Inspection Report 2015

learners feel safe. Managers do not consistently follow college safeguarding policies and procedures. Too often they do not respond quickly enough to learners' disclosures or involve other relevant agencies.'[47] Then, in a re-inspection visit in October 2022, it was noted: 'leaders identify promptly lessons to be learned from previous safeguarding incidents and put in place actions to continually improve the safeguarding arrangements.'[48]

It important to note that even with this learning for the system, it cannot possibly be known that if other action had been taken, that Adult M would not have completed suicide.

Highlighted Effective Practice

- There was good continuity of care with practitioners remaining constant, which was of benefit to Adult M and her family.
- Adult M was in receipt of good care as a child.
- Placement reviews were identifying progress and monitoring issues that Adult M was experiencing

Family's Perspective

- Family found the multi-agency working when Adult M was an adult was less effective. Adult M's mother felt that she was in effect the one who was trying to get support for Adult M, rather than it being forthcoming from professionals when Adult M was in crisis.
- Adult M's family trusted that the information sharing system would work to safeguard their daughter.

Learning Points

- Placement reviews require a consistent multi-agency involvement.
- Multi-agency working/conferences are required when suicidal ideation risk increases.
- Where there are several agencies involved, it is essential that a key worker is identified; this enhances information sharing and multi-agency working. Families should not be left in a 'key working role'.
- Recording prompt, clear actions and follow up are required when critical information is shared.
- The importance of risk assessments being kept up to date and being regularly reviewed at all stages of a learner's residential/educational placement.

Improving Systems and Practice

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

[47] Ofsted Report 2022. Files.ofsted.gov.uk
[48] Ofsted Social Care Common Inspection Further Education College Report. reports@ofsted.gov.uk

These recommendations will lead to specific action plans for CWMPAS to be assured that the learning is being addressed across the Board region by all relevant agencies.

Understanding the Person

1. Clinicians within the Health Board providing mental health services must ensure that they continue the practice that when they are prescribing and changing medication for a person in mental health crisis, that this is only undertaken with the adult present where they can be assessed.

2. In line with the Autism Act (2009), national autism strategy and Code of Practice, CWMPAS will task commissioners and providers to ensure that the current responses to adults with autism in terms of ongoing support services is aligned to the wider national strategy.

3. Health Boards' mental health services need to review policies and processes for the arrangements for mental health care when an adult moves to an alternative address on a temporary basis, i.e. when an adult moves to a residential setting out of the area.

4. For Education services to implement in accordance with the statutory guidance the ALN Code under the Additional Learning Needs and Education Tribunal (Wales) Act 2018, and to report via their LOGs their progress during the implementation phase.

5. For CWMPAS to continue to receive updates on the implementation of the National/ Regional and Local Suicide Prevention Action Plans that meet the local response to the Welsh Government's Talk to me 2 Strategy

Working with Parents pre and post a Young Person being 18

6. For all multi-agency partners who work with young people at the point of transition into adulthood, to ensure that they have appropriate written communications with parents as to what that transition will mean for them and publish this on their websites.

Working Together to Safeguard Adults

7. CWMPAS must remind all agencies of the requirement to accurately record conversations between professionals in order that defensible decision making is evidenced. Records audits may provide such evidence.

8. CWMPAS should consider what prevents robust multi-agency information sharing given the strong multi-agency protocols in place across the Board region for information sharing. Issuance of a reminder that 'Fire and Withdraw' practice does not constitute effective communication in order that the sharing of information is not seen as an end of duty but is an ongoing process e.g. ASK-DO-SHARE-CHECKBACK (available on request).

9. CWMPAS should seek to be assured that agencies have processes and triggers in place in agencies for the promotion of MDT meetings when risk or concerns are escalating.

10. The Welsh Further Education Colleges must implement across the CWMPAS region, the five recommendations from the Estyn Thematic Report 'Peer on Peer Sexual Harassment among 16–18-year-old learners in further education' that was published on 7th June 2023, and for the colleges to confirm via the FE Board representative that this has been achieved by June 2024.

Quality Assurance and Transition Arrangements in Residential Placements

11. CWMPAS will write to Welsh Government to raise awareness of the non-regulation that has emerged within this review report concerning funded residential placements for 18-25 year olds.

Statement by Reviewer(s)			
Reviewer 1	**Karen Rees**	**Reviewer 2**	**Maxine Thomas**
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 adult 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, 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 adult 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, 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)*	**Karen Rees**	**Name** *(Print)*	**Maxine Thomas**
Date	17th October 2023	**Date**	17th October 2023
Chair of Review Panel		*(Signature)*	
Name *(Print)*	**Cameron Ritchie**		
Date	17th October 2023		

Appendix 1: Terms of Reference for The Extended Adult Practice Review (EAR) CWMPAS 5/2018

Core issues to be addressed in the terms of reference of the review will include:

- To examine inter-agency working and service provision for the individual through defined terms of reference.
- To seek contributions to the review from the individual/individuals and appropriate family members and keep them informed of key aspects of progress.
- To identify particular issues for further clarification. (*List issues relevant to particular case.*)
- To produce a report for publication and an action plan.

Core Tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine the effectiveness of inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were in the best interests of the adult and outcome 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 multi-agency learning event for practitioners and identify required resources.

For this Extended Review – In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the adult and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child/adult, the family and their circumstances. How that knowledge contributed to the outcome for the adult.
- Whether the actions identified to safeguard the adult were robust, and appropriate for that adult and their circumstances.
- The effectiveness of transition planning
- Whether actions were effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency actions?
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the adult and family were fulfilled. This will concern the duties imposed by the legislation and guidance in force during the time period being reviewed.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both

organisational issues and other contextual issues).

Indicative Roles and responsibilities:

- The Board Business Unit will be responsible for maintaining links with all relevant agencies, families and other interests.
- The *Review Panel* Chair will inform the Chair of the Board and the Board sub-group of significant changes in the scope of the review and the terms of reference will be updated accordingly.
- 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. It is anticipated that there will be no public disclosure of information other than the Final Board Report.
- The Board and *Review Panel* will seek legal advice on any matters relating to the review as needed. In particular, this may include advice on:
    - terms of reference;
    - disclosure of information;
    - guidance to the *Review Panel* on issues relating to interviewing individual members of staff.

Specific tasks of the Review Panel

- Identify and commission Reviewers to work with the *Review Panel* in accordance with guidance for extended reviews.
- 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 learning outcomes.
- Plan with the Reviewers 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 Reviewers contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the CPR/APR Sub Group 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.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Child/Adult Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR/APR Sub Group:

- Agree and Approve draft ToR for each case recommended for CPR/APR

- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Monitor CPR/APR action plans to ensure all recommendations are carried out on behalf of the Board

Tasks of the CWMPAS Safeguarding Adults Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a CPR/APR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR/APR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- 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 for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals. Report to be sent to Welsh Government prior to publication.
- 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.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them.

Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate.

The statement of confidentiality (as below) will be highlighted to and agreed verbally by all panel members at each Panel meeting, to reaffirm the boundaries within which information is being shared:

- In working with sensitive information in relation to a Child/Adult Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 3 – Adult Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought

from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.

- However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.
- All Panel members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the adult practice review process.

Adult Practice Review Process

To include here in brief:

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

Extended Adult Practice Review (EAR) Process

Due to the concerning circumstances of Adult M's death (whilst in residential care), her history and information known, the criteria for an Extended Adult Practice Review (EAPR) had been met. The matter was considered at the Local Operational Group (LOG) and referred to the Child/Adult Practice Review Sub-group of the CWMPAS Mid and West Wales Regional Safeguarding Board, for an EAPR to be undertaken. The Chair of the CWMPAS Mid and West Wales Regional Safeguarding Board approved that an EAPR should be undertaken.

In accordance with the guidance, an EAPR Panel was convened to manage the review. The services represented on the Panel were:

- Police
- Local Authority (LA) Adult Services/Disability Services
- Residential College Provision
- Local Health Boards
- Mental Health Services
- Careers Wales
- CWMPAS Mid & West Wales Regional Safeguarding Board

An Independent Chair for the Panel was appointed from another agency who had significant senior leadership/management experience of services, but who had no involvement, knowledge or awareness of the young woman or the case. The original Independent Chair, after the third meeting of the Panel, gained promotion and moved to Her Majesty's Inspectorate of Constabulary. The Panel Chair was then re-appointed from within the original Panel Chair's organisation, and again, had significant senior

leadership/management experience of services and safeguarding matters, who had also had no involvement, knowledge or awareness of the young woman or the case.

As this was an EAPR, two Reviewers were appointed who had both not been involved, nor were they aware of, the case or young person. The first reviewer is completely independent of Wales and works nationally, and the second reviewer has a knowledge of Wales and the local context. Both Reviewers are from a senior management background and respectively have been/are from a Health and Education background. Alongside being independent consultants, both Reviewers have the relevant experience, abilities, knowledge and skills as required by the case. They have throughout the review worked jointly to scrutinise the additional issues to be addressed alongside the review panel.

The review was commenced on 12th December 2019 and has, throughout its time, been run with the inquest as a parallel process in place, as the review panel is duty bound to consider any ongoing parallel processes and the potential impact these may have on the outcome of the review. The inquest concluded in February 2023, following a very difficult and delayed process for the family. The delays and postponements to the inquest (which were lengthy, in addition to the pandemic) resulted in the EAPR being suspended on 24th September 2020. The Chair of the CWMPAS Mid & West Wales Regional Safeguarding Board made a formal complaint regarding the significant delay being experienced in commencing the outstanding inquest, which was subsequently upheld. The review panel recommenced on 10th November 2022.

It was also noted by the review panel that the review was started prior to the pandemic and its initial meetings took place face-to-face. With the onset of the pandemic and the halt to processes, the review panel then met in a virtual environment using Microsoft Teams. However, post the pandemic, it was the decision of the review panel that the Learning Events should take place face-to-face, and they happened in February/March 2023.

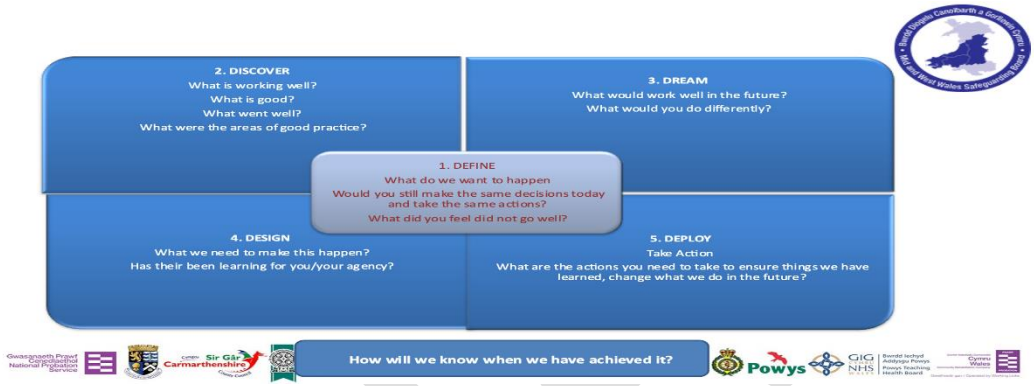
Owing to the extenuating circumstances that have affected the work of the review panel, there was in the Autumn of 2022 a review undertaken by the new Chair of the panel to consider its membership, as some previous panel members had needed to be replaced owing to retirement, and also with regard to the situation of the residential college, which had by then closed its residential provision and moved ownership to a new education and children's home provider in the UK.

Throughout the review process, communication with the family as detailed below (page 46) has been maintained.

The Learning Events

In accordance with the EAPR guidance, two Learning Events for this EAPR were held on 28th February 2023 (Practitioners) and 1st March 2023 (Managers). The Learning Events were facilitated by the Reviewers and introduced by the Chair of the EAPR panel, who was in attendance, to represent them and to ensure that the questions and issues identified by the review panel were addressed. There was a total of 5 participants at the practitioners' Learning Event and 8 managers at the managers' Learning Event. The purpose of the two events was to:

- Give practitioners and managers the opportunity to directly contribute and input to the review;
- Share the perspectives of family members;
- Enable the professionals involved to reflect and listen to each other whilst contributing to and identifying the learning;
- Clarify, explore, question and inform the detail of the merged multi-agency timeline;
- Identify and explore through an appreciative inquiry[49] approach incorporating the 'Signs of Safety' [50]:



- Inform the findings, learning and actions for this Report; and
- Consider the additional remit of an EAPR, as per the guidance Social Services Well-being (Wales) Act 2014, Working Together to Safeguard People, Volume 3 Adult Practice Reviews.

Practitioners and agencies represented at the Learning Events were from:

- LA Adult Social Services
- LA Learning Disabilities Team
- Residential College Provider
- Local Health Boards
- Mental Health Services
- Careers Wales
- CWMPAS Mid & West Wales Regional Safeguarding Board

Evaluations from the respective Learning Events recorded very successful events where reflection and learning had taken place at both an individual and agency level. A sample of the comments are illustrated below:

"Good , important Event to identify learning"

"Good to hear feedback from Practitioners"

[49] Appreciative Inquiry Model – is an asset-based Approach to organisational and social engagement that utilises questions and dialogue to help participants uncover existing strengths, advantages, or opportunities in their communities, organisations or teams. http://organizingengagement.org

[50] Turnell Andrew& Edwards Steve: Signs of Safety (A Solution and Safety Orientated Approach to Child Protection Casework) USA, WW Norton & Company, 1999.

" A constructive working environment – all listened to"

"Very professional and useful"

"Very informative, great reflective practice"

"Opportunity to share the learning and development"

"Very Good, Ten Plus"

Actions to improve practitioner and agency working were identified and have been reflected within the EAPR Report.

Family Participation in the Review Process

The Family (Adult M's parents) were significantly involved and fully engaged in the EAPR process, they met in person with the Independent Reviewers, who were able to hear directly from them, their views about what happened, and to offer the panel members' sincerest condolences.

The Reviewers explained the following:

- Why there was an extended adult practice review and how it would be conducted;
- The purpose of an extended adult practice review;
- The role of the Independent Reviewers and the Panel Chair;
- The Learning Event; and
- Report writing and publication timescales.

The family had open access to the Reviewers by telephone (as their preferred method of communication) outside of face-to-face meetings.

They also at the outset of the review met with the CWMPAS Regional Safeguarding Board Manager at their home.

The views of the family have been considered by the review panel and the Independent Reviewers in the compilation of this report. The family's views are also quoted directly within the main body of the report.

They were also afforded the opportunity to submit any information that they wished to the Reviewers and Panel Chair. In doing so, they provided the Reviewers with significant and voluminous information, pertaining to their daughter and their work with agencies.

The Reviewers provided consistent feedback to the family in writing, following meetings with them, the Learning Events and when receipting further written communication from them.

The family have been offered a further face-to-face meeting with the Reviewers and Panel Chair prior to the publication of the EAPR report.

Family Expectations of the Review

The family raised many queries, concerns and questions that were included and explored at the Learning Events and in the content of the EAPR. Their lived experience post the death of their beloved daughter, as they have engaged with parallel processes, has been one of mistrust of agencies, integrity and processes.

With Immeasurable Gratitude

The Independent Panel Chair and the Independent Reviewers have received exemplary support in respect of the completion of the EAPR and would sincerely like to thank the CWMPAS Mid and West Wales Regional Safeguarding Board and their Administration/ Management team, Dyfed Powys Police for their invaluable assistance in transporting the documentation provided by the family to the Independent Reviewers and Panel Chair, and NPTC Group of Colleges' Principal/Student Services Director/Manager and the IT team, who assisted the EAPR by providing one of their college campuses for face-to-face and remote meetings held with the family.

The support, contributions, facilitation of resources and flexibility provided, have been invaluable, in what has been an extended, lengthy review process, owing to matters outside of the Panel's control (COVID-19 pandemic, delays in the Inquest process), in which to conduct, sustain and complete an EAPR.

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Date information received: ……
(date)

Acknowledgement letter sent to Board Chair:
……*(date)*

Circulated to relevant inspectorates/Policy Leads:
…….*(date)*

Agencies	**Yes**	**No**	**Reason**
CIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			