Llywodraeth Cymru
Welsh Government

Social Services and Well-being (Wales) Act 2014

Working Together to Safeguard People

Volume 3 – Adult Practice Reviews

Part 7

Guidance on Safeguarding.

Issued under section 139 of the Social Services and Well-being (Wales) Act 2014.

Chapter / Contents

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1 Introduction

1.1. This guidance sets out arrangements for multi-agency adult practice reviews in circumstances of a significant incident where abuse or neglect of an adult at risk is known or suspected. Chapters 1 - 7 of this guidance are issued under section 139 of *The Social Services and Well-being (Wales) Act 2014.* As such, it forms part of the compendium of statutory guidance issued under Part 7 of that Act.

1.2. The criteria for adult practice reviews are laid down in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[1]. The arrangements came into force from 6 April 2016.

1.3. The guidance is addressed to all Safeguarding Adults Boards (Boards) and their partner agencies. The overall purpose of the review system is to promote a positive culture of multi-agency adult protection learning and reviewing in local areas, for which Boards and partner agencies hold responsibility. To achieve this, it sets in place a foundation for learning together by professionals from different agencies and, in those circumstances where more formal review is required when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended adult practice reviews. The outputs are expected to generate new learning which can support continuous improvement in inter-agency adult protection practice.

1.4. Every safeguarding board should have a complaints procedure in place for the handling of complaints about practice reviews. The complaints process should address the multi-agency nature of a review rather than the complaint against the actions of a single agent which should be pursued through their own complaints procedure.

1.5. The framework has a number of important features which strengthen it from the previous serious case review system:

- it involves agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability;
- it has the potential to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different professionals with whom they work;
- it strengthens the accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need;
- it recognises the impact of the tragic circumstances of non-accidental adult deaths or serious harm on families and on staff, and provides opportunities for serious incidents to be reviewed in a culture that is fair and just;
- it takes a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases;
- it allows a more constructive and appropriate use of resources than in the previous system and works to shorter timescales;

1 Regulation 4(3) and 4(4). http://www.legislation.gov.uk/wsi/2015/1466/contents/made

- it draws on learning from other related review processes and increases compatibility with different review systems; and
- it focuses on key learning identified through the review process which results in relevant recommendations and action to improve future practice, recorded in anonymised reports which are published by Boards.

1.6. The guidance includes the following annexes:

- Annex 1 contains a set of templates to assist in streamlining communication and reporting during the process of an adult practice review.
- Annex 2 is an exemplar of terms of reference for an adult practice review.
- Annex 3 demonstrates how the new review process can be used by Boards to ensure improved practice and systems are in place in circumstances of historic, organised and multiple abuse.

1.7. The Welsh Government website provides the parallel guidance for child practice reviews along with a guide for organising and facilitating learning events[2].

1.8. The development of these arrangements has been informed by extensive discussion, consultation, feed back and testing through workshops of stakeholders, and pilots of child practice reviews by several Boards. They have all made an invaluable contribution to developing the detail of the guidance. In addition, this version has been informed by the findings of an independent review undertaken on behalf of the Welsh Government by Cordis Bright, into the implementation of the child practice review framework

2 http://gov.wales/topics/health/publications/socialcare/guidance1/safeguard12/?lang=en

2 Principles underpinning the new arrangements

2.1 The framework is underpinned by a set of principles to guide Boards, their partner agencies and other community partners in their responsibilities for learning, reviewing and improving local adult protection policy and practice. The principles have played an important role in shaping the design and development of the new arrangements for multi-agency adult practice reviews. These ensure:

- professionals in all services working with individuals and their families in the local area are given the assistance they need so they can undertake the complex and difficult work of protecting adults with confidence and competence;
- organisational cultures, and the processes that underpin the culture, are experienced as fair and just, and promote supportive management and work environments for professionals;
- a positive shared learning culture is an essential requirement for achieving effective multi-agency practice; and
- a culture of transparency is created that:
    - provides regular opportunities to address multi-agency collaboration and practice, and multi-agency learning, reflection and development;
    - has processes for learning and reviewing that are flexible and proportionate and are open to professional and public challenge;
    - engages with individuals and families in cases and takes account of their wishes and views;
    - provides accountability and reassurance to individuals, families and the wider public;
    - identifies promptly the need for systemic or professional changes and ensures timely action is taken;
    - shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally and nationally; and
    - the work of learning, reviewing and improving local multi-agency adult protection policy and practice is audited and evaluated for its effectiveness.

2.2 The principles underpinning the new framework are in accord with the *Principles for Older People*[3] and can be found similarly reflected in the statutory instruments and guidance of other relevant bodies for their systems of reviews, investigations and tribunals

3 UN Principles for Older People, adopted by General Assembly of the UN on 16 December 1991.

3 Learning and reviewing framework

3.1 The learning and reviewing framework has been developed with the intention that Boards and their partner agencies provide an environment in which practitioners and their agencies can learn from their own and others' casework and from sources, such as audits, research and inspection. The framework, underpinned by the principles in chapter 2, consists of a foundation for learning through multi-agency professional forums. Where there is a need for the Board to undertake a more formal review, criteria are clearly specified in regulations for setting up multi-agency adult practice reviews that are either concise or extended.

3.2 In summary, the framework consists of several inter-related parts, as laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[4] and *the Statutory Guidance on Part 7 of the Act*[5]. The detail of multi-agency professional forums and concise and extended adult practice reviews are set out in more detail in the subsequent chapters of this guidance.

Multi-Agency Professional Forums

3.3 Multi-agency professional forums are a continuous Board programme for learning together of multi-professional facilitated events for practitioners and managers. They provide an opportunity to examine case practice that allows for consultation, and reflection, and to disseminate findings from adult protection audits, inspections and reviews, in order to improve local knowledge and practice and to inform the Board's future audit and training priorities. Where the Adult Practice Review Sub-Group considers a case does not meet the criteria for either a concise or an extended adult practice review, it may recommend the case be considered by the Multi-Agency Professional Forum to enable them to undertake a more proportionate approach than that required by APRs.

Concise Reviews

3.4 A Board must commission a concise adult practice review where an adult at risk who has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

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

3.5 The purpose of a review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the detail and context of agencies' work with an individual and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice.

4 http://www.legislation.gov.uk/wsi/2015/1466/contents/made

5 http://gov.wales/docs/phhs/publications/160404part7guidevol1en.pdf

3.6 A concise review is made up of a number of interconnected activities described below, all of which contribute to the rigour of the process and to the learning drawn from the case being reviewed.

3.7 The review is managed by a *Review Panel* and a reviewer is appointed to work with the *Review Panel.* The review engages directly with individuals and family members, as they wish and is appropriate, so their perspectives are included, and it involves practitioners who have been working with the individual and family, and their managers. A planned and facilitated practitioner-focused learning event is a key element of the review, conducted by a reviewer independent of the case management, to examine current case practice within a limited timeline and using a systems approach.

3.8 A draft anonymised adult practice review report and an outline action plan are produced and presented to the Board. Board members consider, challenge and contribute to the conclusions of the review, and identify the strategic implications for improving practice and systems to be included in the action plan.

3.9 The final report is approved by the Board, submitted to the Welsh Government for information and then published by the Board. The process will be completed as soon as possible but usually not more than six months from the date of a referral from the Board to the *Review Sub-Group.*

3.10 The action plan is finalised within four weeks of the final report, approved by the Board, and forwarded to the Welsh Government for information. The implementation of the action plan is regularly reviewed and progress reported to the Board.

3.11 Action plans should lead to improvements in adult protection practice and the Board needs to ensure they are carefully audited to see whether actions are being carried out, with what effect, and whether they are making a difference.

Extended Reviews

3.12 A Board must commission an extended adult practice review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

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

3.13 The review follows the same process and timescale as a concise review, engaging directly with individuals and families, in so far as they wish and is appropriate, and involving practitioners, managers and senior officers throughout. 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.

3.14 The review is undertaken by two reviewers working closely together, appointed by the *Review Panel*. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the *Review Panel* and the Board.

3.15 An anonymised report is considered and approved by the Board, submitted to the Welsh Government for information and published by the Board. The process will be completed as soon as possible but usually not more than six months from a referral from the Board to the *Review Sub-Group*.

3.16 The action plan is finalised within four weeks of the final report, approved by the Board, and forwarded to the Welsh Government for information. The implementation of the action plan is regularly reviewed and progress reported to the Board.

3.17 Action plans should lead to improvements in adult protection practice and the Board needs to ensure they are carefully audited to see whether the actions are being carried out and with what effect, and whether they are making a difference.

4 Implications for Safeguarding Adults Boards

4.1 Achieving improvement in safeguarding policy, systems and practice is a core business of the Board. The Board has responsibility for:

- establishing adult practice reviews and ensuring they are effectively managed;
- contributing to the reviews and providing professional challenge;
- identifying strategic implications for improving systems and practice in individual agencies or on an interagency basis;
- signing off the final report and action plan when a review has been completed;
- publishing the adult practice review report; and
- implementing and auditing changes in local policy, systems and practice to identify what difference they have made.

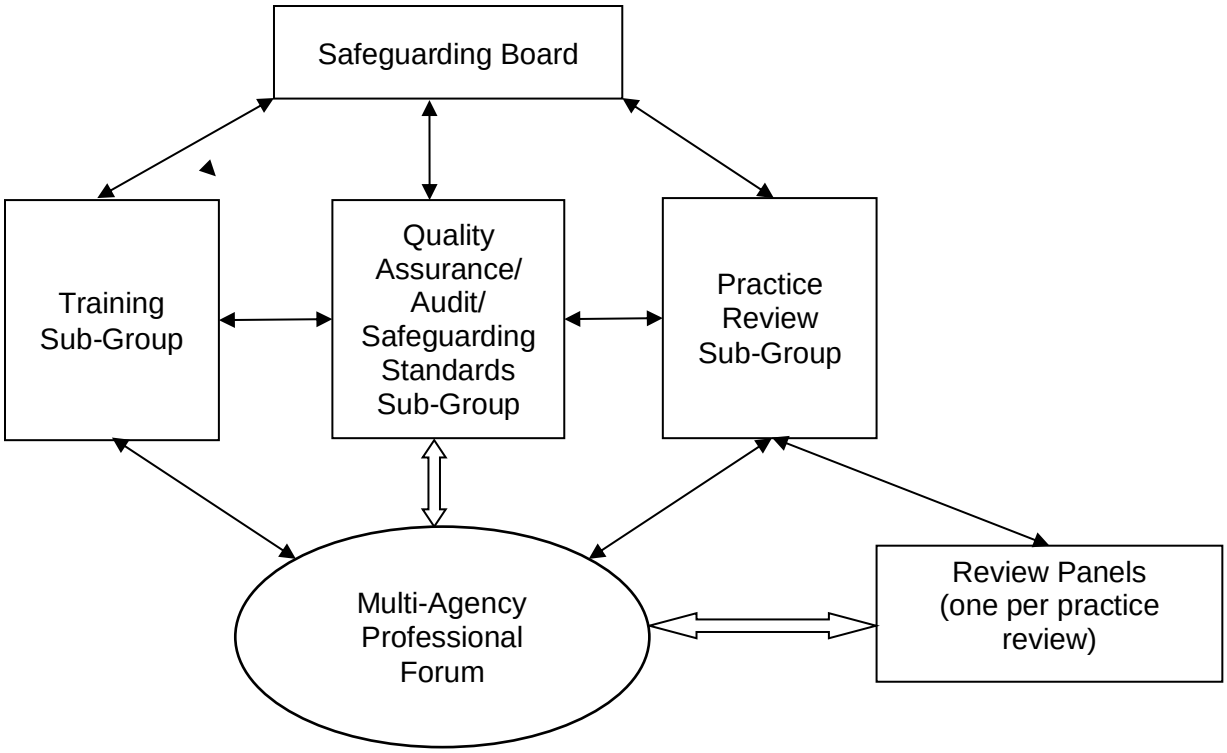
4.2 These responsibilities require committed, well functioning, challenging, inspirational and strongly led Board together with the full and consistent support of agencies represented on the Board. They require active partnership with other community services that are not Board members but working locally with individuals and families[6].

4.3 The Board needs to be focused on learning and on outcomes, and to be encouraging a supportive environment. In order to be in touch with the challenging and complex work of adult protection that professional staff in local agencies undertake, the Board needs to be able to maintain a close oversight and understanding of practice. The role of the Board in approving adult practice review reports is an important means of doing so, so that they can provide appropriate professional challenge and support, and ensure the learning from reviews is used to take effective action by the Board and its partner agencies.

4.4 In order to achieve the objectives of the learning and reviewing framework, there will need to be certain functions in each Board to deliver them. The structure and purpose of the Board's standing sub-groups or sub-committees will need to reflect the core business of the Board, ensure appropriate cross representation, and have fully co-ordinated processes and programmes of work between the sub-groups. The inter-relationships that need to be developed for the implementation of the learning and reviewing framework are represented in the diagram (Fig. 1).

6 See Standards in J Horwath & T.Morrison for CSSIW (2009) *Self Assessment and Improvement Tool (SAIT) for LSCBs* v.6 http://www.scie-socialcareonline.org.uk/self-assessment-and-improvement-tool-sait-for-local-safeguarding-children-boards-lscbs/r/a11G00000017uLYIAY

Fig. 1: Potential Safeguarding Board infrastructure of sub-groups supporting the learning and reviewing framework



5 Multi-Agency Professional Forums

5.1 Multi-agency professional forums are a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep individuals safe. They utilise case information, findings from adult protection audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice, and to inform the Board's future audit and training priorities.

5.2 Multi-agency professional forums are defined in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015* as:

"forums arranged and facilitated by a Board for practitioners and managers from representative bodies, and other bodies or persons deemed relevant by the Chair of the Board, with the purpose of learning from cases, audits, inspections and reviews in order to improve future child or adult protection policy and practice."

5.3 Forums should be set up as a continuous programme of active learning by each Board and will constitute an integral part of the Board's Business Plan.

5.4 Responsibility for establishing a programme of work for the forums may fall to an existing Board sub-group, such as *Quality Assurance* (also known in some Boards as *Audit* or *Safeguarding Standards Sub-Groups* or *Sub-Committees*) or the *Training Sub-Group*, or a specific sub-group may be established for the purpose. The activities will inevitably be closely related to those of other sub-groups of the Board, including the *Adult Practice Review Sub-Group,* and require appropriate cross-membership of sub-groups and regular exchange of information.

5.5 The forums have two main purposes – they can be used for case learning events and for dissemination and exploration of learning from audits, inspections and reviews but they can also be used to provide other important opportunities for local multi-agency practitioner and manager learning:

- **Case learning:** facilitated discussion, consultation and reflection by practitioners, managers or core groups, using a systems approach to examining and analysing individual current or no longer active cases. These may include complex cases where there have been good outcomes, current cases that have become stuck, or cases which cause professional concern or interest that do not meet the criteria for concise or extended adult practice reviews.

- **Dissemination of new knowledge and findings:** from multi-agency adult protection audits and from adult practice reviews, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

Case learning

5.6 The forums which focus on case learning should be facilitated events, undertaken in environments that provide safe, professional support and professional challenge, with a clear set of working principles or processes so that staff know what to expect and the confidentiality of any case material is respected. The forums may use a range of creative methods already familiar in training and continuing professional development, such as multi-agency supervision, appreciative inquiry or sculpting, as appropriate. The practice learning should be recorded and formally reported to the Board. The learning may be disseminated more widely to staff, and should inform the Board's annual review of its Business Plan.

5.7 The forums should allow assessments, decision making and practice to be explored openly with each other by staff. However, if any issues of individual staff training needs or staff malpractice emerge during the course of a multi-agency professional forum, these should be managed through the relevant agency's own staff procedures.

5.8 It is expected that if at any time a level of concern is identified that would trigger a concise or extended adult practice review under the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015* then the case should be reported to the Chair of the Board and referred to the *Adult Practice Review Sub-Group* for consideration and action (as set out in chapters 6 or 7).

Dissemination of new knowledge and findings

5.9 The learning from forums which have been concerned with individual cases or the dissemination of findings from audits and other sources may require local action through changes in operational policy, protocols, service delivery or practice, and this should occur promptly and without delay.

5.10 Where the learning from these forums is of wider relevance, the Board will need to develop plans for dissemination locally and/or nationally, for example through the National Independent Safeguarding Board and relevant professionals whose roles and responsibilities encompass protection and where messages need to be conveyed to agencies locally, the process should be managed by the relevant standing sub-group of the Board.

5.11 The effectiveness of these forums requires the commitment of senior agency representatives who are members of the Board and positive support from agencies to enable professional staff to make use of these learning opportunities.

5.12 The programme of work will require resourcing by the Board and periodic evaluation by the *Quality Assurance Group* to ascertain the impact on local adult protection practice. The findings should be reported back to the Board.

5.13 There are examples where this approach has already been developed by Boards in Wales and experience of what has worked well should be shared between Boards. Three examples are included below:

One Board has established multi-agency case consultation over a number of years which is initiated by practitioners and brings together key staff to look at cases that are, for example, stuck or difficult, and provides reflective

supervision. It has been found to be successful in building understanding of the need for multi-agency responsibility for work with families.

A facilitated case learning event was held by one Board for practitioners to consider a serious case of neglect which did not meet the criteria for a concise review. It identified key learning points and messages for the Board. More importantly, it was valued by the practitioners because it was experienced as non-threatening, constructive and empowering. It allowed other agencies' perspectives to be explored and better understood, and relationships to be built between agencies. The process highlighted the positive work that the family and practitioners had been doing, and showed that progress had already made.

Another Board has established a programme for multi-agency practitioner forums, on the basis of at least three multi-agency workshops being held a year for focused practice learning from audited cases and a fourth for disseminating learning from case reviews based on the child practice review model. These events involve at least 50 practitioners from different services at any one time.

5.14 Multi-agency professional forums are therefore, built on some long-standing prior experience and draw on good practice across Boards in Wales.

6 Concise Adult Practice Reviews

Criteria for a concise review

6.1 A Board must undertake a concise adult practice review[7] where an adult at risk who has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

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

Process for undertaking a concise review

6.2 Any member of the Board, agency or practitioner can raise a concern about a case which it is believed meets the above criteria. Advice may be sought from the agency Board member prior to making a referral. However any such referral should be directed to the Board Business manager (or equivalent) who will ensure the Chair of the Board is informed. Each Board will have a standing *Adult Practice Review Sub-Group (or Sub-Committee)*. The referral should then be forwarded to the Chair of this sub-group for its consideration.

6.3 The review process is represented as a flow chart (fig. 2 page 29).

6.4 It should be noted that there may be matters which may require negotiation and resolution by the *Review Sub-Group* before a *Review Panel,* to manage the review, can be put in place.

6.5 **More than one Board is involved:** where a referral received by the *Review Sub-Group* involves more than one Board, co-operation and careful planning between the respective *Review Sub-Groups* of those Boards will be required to agree the way forward. The guiding principle should be that the Board in which the individual is or was normally resident should take lead responsibility for conducting the review. The decision reached on how the review will be handled should be reported to the respective Boards.

6.6 **More than one Board in different countries is involved:** where a referral received by the *Review Sub-Group* involves more than one authority in different countries within the United Kingdom, the principle of ordinary residence will determine which Board should take lead responsibility for undertaking a review. However, co-operation and careful planning may be required between Boards in order to agree how the respective review procedures will be followed and how any additional matters will be addressed by the review. These decisions may also need to involve the respective governments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.

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7 Regulation 4(3) of the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.* http://www.legislation.gov.uk/wsi/2015/1466/contents/made

Parallel reviews of practice are involved: There are a number of statutory responsibilities to review deaths and serious incidents. These include, domestic homicide reviews, the provision of mental health services by Healthcare Inspectorate Wales following a homicide, or a Prisons and Probation Ombudsman investigation where an individual has died in a custodial setting.

6.7 Where the case gives rise to other parallel reviews of practice:-

The *Review Sub-Group* should:

- consider the opportunities and potential arrangements for coordinating with those other bodies involved;
- discuss with those bodies and agree how a coordinated or jointly commissioned review process best addresses the outcomes that need to be delivered, in the most effective way and with minimal delay;
- consider a joint review or adding additional questions to the review's terms of reference;
- ensure the individual's interests are always appropriately represented in other investigations of practice;
- provide the Chair of the Board with a recommendation on the way to proceed.

The Chair of the Board should:

- inform the *Review Sub-Group* of his or her decision in respect of the recommendation on the way to proceed, and
- inform the Board;
- at the conclusion of the review, if undertaken by another review body, ensure the review report is always considered by the Board and anonymised learning points relevant to the individual or individuals are published; and
- ensure an action plan is put in place as required.

6.8 **Concurrent police investigations or judicial proceedings:** where the case is subject to police investigations or judicial proceedings, these should not inhibit the setting up of an adult practice review nor delay immediate remedial action being taken to improve services. It is important that the purpose of the review process, which is to support professional and organisational learning and to promote improvement in future inter-agency adult protection practice, is understood and remains the focus. The Crown Prosecution Service and the Association of Chief Police Officers have published guidance which recognises that CPRs and criminal proceedings can be managed simultaneously. The same principals would apply for APRs. The guidance provides a framework for the sharing of relevant information generated through both processes[8].

6.9 **Relationship with other formal staff processes:** the review process is about practice learning. If any issues of individual staff training needs or staff malpractice emerge during the course of a concise review, these matters should be referred and managed through the relevant agency's own staff procedures.

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8 Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews: http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

6.10 Even where there are other formal processes or investigations underway, such as complaints procedures, there is no reason to delay undertaking an adult practice review. A review is focused on learning to improve future practice and is not a quasi-process for dealing with complaints. The Board should consider how other processes may run in parallel with an adult practice review and relevant learning resulting from the different processes should be shared.

6.11 **More than one index adult subject to review[9]:** there may be cases where more than one adult has died or has suffered serious harm as the result of abuse or neglect and each adult is the subject of the same review, i.e. there are several index adults of that review. The review process must consider each adult's perspective and experience individually but ensure the learning arising from the adult's circumstances is brought together in one comprehensive adult practice review report at the conclusion of the review. It is important that the Chair of the Board is informed by the *Review Sub-Group* of each adult to be included in the review in its recommendation for the way forward.

Recommendation to the Chair of the Board

6.12 The *Review Sub-Group's* decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Board, with the following information:

- a brief outline of the circumstances of the case;
- the reasons for holding a concise review;
- the proposed terms of reference;
- a timeline for the review; and
- an assessment of the likely communication and media issues, as known at the time.

6.13 A template (Annex 1) has been provided for this to simplify the process, ensure consistency and provide a report for informing the Welsh Government. The Welsh Government should be informed of every case that meets the criteria for a concise review that has been considered by the *Review Sub-Group*, including those where the lead Board may be in another country, and should be informed of the outcome of the recommendation.

6.14 The Chair of the Board will inform the *Review Sub-Group* of his or her decision as to whether the recommendation to hold a concise review is approved, and inform the Board. Should the recommendation for a concise review be declined by the Chair of the Board, then the Board should be informed and further discussion held. If the final decision is no, then the Chair of the Board will need to inform the Welsh Government in writing, with the reasons given, and any conflicting views also reported.

6.15 If the decision is yes, the *Review Sub-Group* will establish a multi-agency *Review Panel* to manage the review.

9 *Index adult* is a term used to indicate the adult who is the subject and focus of a review, to distinguish that adult from other adults who may also be involved. In some reviews, there may be more than one adult who has died or been significantly harmed, and they may all be subjects of the same review. They will all be 'index adults' of that review.

Terms of Reference

6.16 Initial terms of reference will be submitted to the Chair of the Board based on information known at the time. It should be noted that the terms of reference are **a living document** and not set in stone. They may need to be amended, in the light of new information, at any point during the course of a concise review. The *Review Panel* will have responsibility for agreeing any variation to the terms of reference.

6.17 The final terms of reference (anonymised) will be included in the Report at the completion of the review.

6.18 An exemplar of a terms of reference is included in Annex 2.

Review Panel

6.19 The *Review Panel* manages the review process and plays a key role in ensuring that learning is drawn from the case. Representatives should be appointed to the *Review Panel* from those agencies involved in the case. The *Review Panel* members should have working knowledge of the services but not have had direct involvement in the case. A multi-agency *Review Panel* should always be convened, even where the case may involve only a single agency or a small number of agencies. Because the *Review Panel* is an integral part of the review process, it is essential that, once appointed, there should be consistency in *Review Panel* membership and in attendance at *Review Panel* meetings. Deputies should only be permitted in exceptional circumstances.

6.20 Services that have been involved with the individual and family will be requested by the *Review Panel* to provide information of contact with the family by preparing an agency timeline of significant events (within a timescale agreed by the *Review Panel* –paragraph 6.21 refers) together with a brief analysis of relevant context, issues or events. Information about action already taken or recommendations by staff for future improvements in systems or practice may be included, if appropriate. The preparation of timelines and analyses should be undertaken by managers who have not had operational responsibility for the case but understand the service.

Timelines and genogram

6.21 A **timeline** of a maximum of 12 months preceding the incident should be prepared. The 12 month timeline may be extended only if there are exceptional circumstances but as the focus of the review is on current practice, the timeline should in those cases be no longer than 2 years. The timeline may be extended to include decisions and action following the incident. Any extension of the timeline should be agreed by the *Review Panel.*

6.22 Where there is significant background information or a previous incident, this can be included in the brief analysis accompanying the timeline. Family history is vitally important but the critical issue in a review is who was familiar with the family history, how it was shared within the professional network and how it was taken into account in current decision making.

6.23 A full and accurate **genogram** (also known as a Family Association Network in the police service) should also be prepared by the *Review Panel* as a means of clarification of family relationships. It should be used during *Review Panel* discussions with the reviewer and be available for reference at all stages of the review process, although not included in the published report.

6.24 The *Review Panel* will produce a merged timeline of significant events from the individual agencies' timelines. The merged timeline, genogram and brief agency analyses will then be used by the *Review Panel* members and the reviewer to develop questions and ideas about what happened in the case. This initial understanding will inform the preparation of a learning event for practitioners and line managers to test out and further explore operational practice issues. The reviewer will also have access to and will read documentary and other relevant written material, as appropriate. During discussion, issues for clarification may arise and the *Review Panel* will ask services to respond; the terms of reference for the review may be amended or extended, as a result.

6.25 At any point in the course of conducting a concise review, the *Review Panel* and/or the reviewer may reach the conclusion that, from the analysis of timelines or other sources, the review does not meet the criteria for a concise review or the review cannot be conducted as laid out in the guidance. If the concise review is terminated, it will require:

a. the agreement of the *Review Panel;*

b. a report to be written and presented to the Board;

c. the Chair of the Board asked to approve the action by the Chair of the *Review Panel;* and

d. the Safeguarding Team of the Welsh Government notified.

6.26 The report will need to set out not only the reasons for the termination but also what alternative action is proposed to enable learning.

Commissioning the Reviewer

6.27 The *Review Panel* will identify and commission a reviewer who must be independent of the case management and who may be a member of the Board, or a member of another Board, or from a neighbouring authority, or a person with relevant skills and experience as required by the case. Relevant experience may be determined by issues of language, ethnicity, religion or health, such as disability, or other factors instrumental to the circumstances of the case[10].

6.28 If the *Review Panel* considers that, given the circumstances of the case, it would be helpful to appoint another person to work with the reviewer, the appropriate commissioning arrangements should be made expeditiously.

6.29 When choosing a reviewer, it will be important to remember that the quality and experience of the reviewer is crucial to the quality of the outcome. The role requires a wide range of knowledge, skills and abilities which include a thorough knowledge of adult protection systems, issues, responsibilities and practice, an understanding of multi-disciplinary working, an ability to enquire and communicate about practice with professionals and with individuals and family members, and skills in facilitating and managing group processes effectively. In appointing a reviewer, the Board will need to be satisfied that safe recruitment practices have been observed.

10 For example, organisations such as AFRUCA, *Africans Unite Against Child Abuse*, or AAFDA, *Advocacy After Fatal Domestic Abuse*, may be called upon to give advice, advocacy and expertise.

Engagement of individuals and family members in the review process

6.30 Engagement with family members and listening to their perspectives and experiences are essential to developing learning when a case is under review. Family members may include the individual, children, parents, carers, or other significant family members (as appropriate to the case). They should wherever possible be informed of the review and their views incorporated into the review process. The *Review Panel* will need to consider how this can be most effectively achieved. This may best be done by contacting and talking to family members about the purpose of the review process and identifying with them the messages, perspectives or experiences they would want to contribute to practitioner learning at a learning event and what they might expect from the review.

6.31 How such contact is made will need to be discussed by the *Review Panel* and the reviewer. In some cases it may involve the lead professional or others who are working with the individual and family. Experience has shown that the reviewer has an important role to play in meeting the individual and other family members shortly before the learning event, if appropriate and the family so wishes, and carrying their messages into the event.

6.32 It is important that the individual is provided the opportunity to contribute to the review to help influence the learning of those involved and to have the opportunity to see and discuss the report and its findings at the conclusion of the review.

6.33 The Board should think creatively about how families can be engaged in the review and how explanatory information is provided to individuals and family members, taking account of circumstances such as disability and first language. An example is given below:

A reviewer designed a leaflet for an individual to take to a discussion with them and leave at the end of the visit. It explained why a review was being held, how the review was carried out and what the reviewer's responsibilities were. Questions were included to help the individual contribute to the review and the reviewer left contact details on the leaflet for the individual to use if needed.

6.34 Careful arrangements need to be made for reporting back at the conclusion of the review and sharing the findings of the report. The reviewer and/or the *Review Panel* Chair may be the most appropriate person to do this. Family members will vary in their response as to whether and how they would want to receive feedback, not necessarily face-to-face but by telephone or letter. The timing of sharing the content of the report will need to be carefully considered in relation to the date of publication and other sensitive issues for the family. Copies of the report should not be given to family members to retain until it has been finalised, approved by the Board and published.

6.35 The feedback may have a number of functions according to the circumstances. It may provide reassurance or validation, help to draw a line or provide a turning point in a programme of care and treatment or it may bring distress or revive painful memories. In some circumstances, appropriate support from key professionals may need to be made available to the respective individuals or family members.

Learning event

6.36 The learning event is a critical part of the review. It ensures the voice of practitioners directly contributes to the review, that practitioners can hear the

perspectives of the family during the event and, with other practitioners who have worked with the individual and family, they are able to reflect on what happened and identify learning for future practice.

6.37 Practitioners and managers are expected to attend if asked. The *Review Panel* should think creatively about how relevant practitioners and line managers can be engaged in the review. In some instances it may be appropriate for more than one learning event to be held to ensure the contribution of key staff to the learning process. Reflection and confirmation of the learning points may be part of the learning event or a separate session may be held with the participants of the learning event at a later date. The *Review Panel* has responsibility for supporting the reviewer in carrying out an effective learning event[11].

6.38 The *Review Panel* Chair will normally attend the learning event on behalf of the *Review Panel* to ensure that the questions and issues identified by the *Review Panel* are fully addressed. Should the Chair of the *Review Panel* be unable to attend, another member of the *Review Panel* may attend.

6.39 At the conclusion of the learning event, the reviewer with the practitioners will identify single and inter-agency issues and practice learning points for consideration and further discussion by the *Review Panel*.

Adult Practice Review Report

6.40 Following the learning event, the reviewer has responsibility for collating and synthesising the learning to date for discussion with the *Review Panel* in the form of a draft report, using the agreed template outlined in Annex 1. The reviewer also has responsibility for confirming that the learning process was undertaken appropriately.

6.41 The draft report should be succinct and focused on improving practice. It should include the circumstances which led to the review, the practice and organisational learning identified during the review, including highlighting effective practice, and considerations about what needs to be done differently to improve future practice. Actions should be identified that will bring about improvements in systems and practice, and should be specific, workable and affordable, and have clearly defined anticipated outcomes.

6.42 Meetings between the reviewer and the *Review Panel* combine important opportunities for professional challenge with quality assurance. Practice issues originally identified by the *Review Panel* can be re-examined in the light of the reviewer's findings and the learning event, and there may be issues identified for further clarification either with practitioners or managers or the *Review Panel*. Once agreed, the anonymised draft report and an outline action plan will then be presented to the Board. A template (in Annex 1) has been provided for the report.

6.43 However, because a review has been held, it does not mean that practice has been wrong and the reviewer may conclude there is no need for change in either operational policy or practice.

6.44 The *Review Panel* will have responsibility for producing an anonymised summary of the merged timeline (the summary timeline should be included with the report when published).

11 The Welsh Government website provides the parallel guidance for child practice reviews along with a guide for organising and facilitating learning events.

Presentation of the Report to the Board

6.45 The draft report and an outline action plan should be presented to the Board by the Chair of the *Review Panel* and the reviewer. The presentation of the report is an important means of the Board maintaining a close relationship with practice. In order to carry out this role, when presenting the draft report to the Board members, the reviewer will need to take them through the detail of the timeline as well as the practice and organisational issues arising from the review. The role of the Board is to engage and contribute to the analysis of case issues; to provide appropriate challenge; and to ensure that the learning from the review can be used to inform systems and practice development.

6.46 The Board may identify additional learning issues or actions of strategic importance for individual agencies or for the collective responsibility of the Board. These may be included in the final report or in the action plan, as appropriate.

6.47 The *Review Panel* and the reviewer will then complete the final report to reflect the range of learning identified. The Board has responsibility for accepting the report and providing direction regarding the proposed action plan.

6.48 The Chair of the Board will submit the report to the Safeguarding Team of the Welsh Government which will then draw in other parts of the Welsh Government and the Inspectorates as appropriate for information purposes. The Welsh Government will require the report at least two weeks before the proposed date of publication by the Board.

6.49 The finalised adult practice review report together with the summary timeline will be published on the Board website for a minimum of 12 weeks. A reference on the website thereafter will indicate that the report may be available on request.

6.50 The review process will be completed as soon as possible but not normally longer than six months from the date of referral to the Board's *Review Sub-Group*.

Action Plan

6.51 *The Review Panel* and the reviewer will have responsibility for preparing an outline action plan, to accompany the draft report for presentation and discussion by the Board. The action plan should reflect the learning identified in the report, including where appropriate effective practice. The actions may be directed either at single agencies or require multi-agency action. The action plan should be outcome-focused and indicate how actions are intended to make a difference to local systems and adult protection practice. It should have a clear focus on improving outcomes for individuals and their families.

6.52 The finalised action plan should be prepared by the *Review Panel* and the reviewer reflecting discussion by the Board. This should be within four weeks of the Board consideration of the report, and sent to the Chair of the Board for signing off by the member agencies. It should then be sent to the Welsh Government for information.

6.53 The action plan will be reviewed and progress will be monitored by the *Review Sub-Group* and reported to the Board. This must include dissemination of the report and action plan to local staff, as appropriate. Consideration will be required by the respective Board sub-groups of the critical learning points and how they will be incorporated into any changes in operational systems and practice, training and supervision, and in shaping priorities for future work undertaken by the Board.

6.54 Action plans should lead to improvements in safeguarding practice and the Board will need to ensure they are carefully audited to see whether they have been carried out and with what effect, and whether they are achieving the intended outcomes.

6.55 The reviewer may be requested by the *Review Panel*, as part of taking forward the action plan, to undertake an event with staff groups either to disseminate what has been learned or to follow-up the impact on practice of changes being made as the result of learning from the review.

6.56 The *Training Sub-Group* and *Audit Sub-Group* will need to include any issues emerging from the concise review in the Board's future training and audit programmes or incorporate into the work programme of the Multi-Agency Professional Forum.

6.57 On completion of the work, the action plan will need to be signed off by the Board and a report made to the Safeguarding Team of the Welsh Government about the difference the actions taken have made to practice.

7 Extended Adult Practice Reviews

Criteria for an extended review

7.1 A Board must undertake an extended adult practice review[12] where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has

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

Process for undertaking an extended review

7.2 The same process for undertaking a concise review (as laid out in chpater 6) should be followed for undertaking an extended review. Additional issues to be addressed by extended reviews can be found at paragraph 7.13. For reading ease:-

- paragraphs 7.3 to 7.11 are the same as paragraphs 6.3 to 6.11

7.3 The review process is represented as a flow chart (fig. 2 page 22).

7.4 It should be noted that there may be matters which may require negotiation and resolution by the *Review Sub-Group* before a *Review Panel* to manage the review can be put in place.

7.5 **More than one Board is involved:** where a referral received by the *Review Sub-Group* involves more than one Board, co-operation and careful planning between the respective *Review Sub-Groups* of those Boards will be required to agree the way forward. The guiding principle should be that the Board in which the individual is or was normally resident should take lead responsibility for conducting the review. The decision reached on how the review will be handled should be reported to the respective Boards.

7.6 **More than one Board in different countries is involved:** where a referral received by the *Review Sub-Group* involves more than one authority in different countries within the United Kingdom, the principle of ordinary residency will determine which Board should take lead responsibility for undertaking a review. However, co-operation and careful planning may be required between Boards in order to agree how the respective review procedures will be followed and how any additional matters will be addressed by the review. These decisions may also need to involve the respective government departments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.

Parallel reviews of practice are involved: there are a number of statutory responsibilities to review deaths and serious incidents. These include domestic homicide reviews, the provision of mental health services by Healthcare

12 Regulation 4(4) of the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*

Inspectorate Wales following a homicide, or a Prisons and Probation Ombudsman investigation where an individual has died in a custodial setting.

7.7 Where the case gives rise to other parallel reviews of practice:-

The *Review Sub Group* should:

- consider the opportunities and potential arrangements for coordinating with those other bodies involved;
- discuss with those bodies and agree how a coordinated or jointly commissioned review process best addresses the outcomes that need to be delivered, in the most effective way and with minimal delay;
- consider a joint review or adding additional questions to the review's terms of reference;
- ensure the individual's interests are always appropriately represented in other investigations of practice;
- provide the Chair of the Board with a recommendation on the way to proceed.

The Chair of the Board should:

- inform the *Review Sub-Group* of his or her decision in respect of the recommendation on the way to proceed, and
- inform the Board;
- at the conclusion of the review, if undertaken by another review body, ensure the review report is always considered by the Board and anonymised learning points relevant to the individual or individuals are published; and
- ensure an action plan is put in place as required.

7.8 **Concurrent police investigations or judicial proceedings:** where the case is subject to police investigations or judicial proceedings, these should not inhibit the setting up of an adult practice review nor delay the holding of a multi-agency learning event with practitioners. It is important that the purpose of the review process '*to support professional and organisational learning, to promote improvement in future inter-agency adult protection practice*' is understood and remains the focus. The Crown Prosecution Service and the Association of Chief Police Officers have published guidance which recognises that CPRs and criminal proceedings can be managed simultaneously. The same principles would apply for APRs. The guidance provides a framework for the sharing of relevant information generated through both processes[13].

7.9 **Relationship with other formal staff processes:** the review process is about practice learning. If any issues of individual staff training needs or staff malpractice emerge during the course of an extended review, these matters should be referred back and managed through the relevant agency's own staff procedures.

7.10 Even where there are other formal processes or investigations underway, such as complaints procedures, there is no reason to delay undertaking an adult practice review. A review is focused on learning to improve future practice and is not a quasi-process for dealing with complaints. The Board should consider how other

13 Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews:http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

processes may run in parallel with an adult practice review and relevant learning resulting from the different processes should be shared.

7.11 **More than one index adult subject to review[14]:** there may be cases where more than one adult has died or has suffered serious harm as the result of abuse or neglect and each adult is the subject of the same review, i.e. there are several index adults of that review. The review process must consider each adult's perspective and experience individually but ensure the learning arising from the individuals' circumstances is brought together in one comprehensive report at the conclusion of the review. It is important that the Chair of the Board is informed by the *Review Sub-Group* of each individual to be included in the review in its recommendation for the way forward.

Recommendation to the Chair of the Board

7.12 The *Review Sub-Group's* decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Board, with the following information:

- a brief outline of the circumstances of the case;
- the reasons for holding an extended review;
- the proposed terms of reference;
- a timeline for the review; and
- an assessment of the likely communication and media issues, as known at the time.

7.13 A template (Annex 1) has been provided for this to simplify the process, ensure consistency and provide a report for informing the Welsh Government. The Welsh Government should be informed of every case that meets the criteria for an extended review that has been considered by the *Review Sub-Group*, including those where the lead Board may be in another country, and should be informed of the outcome of the recommendation.

7.14 The Chair of the Board will inform the *Review Sub-Group* of his or her decision as to whether the recommendation to hold an extended review is approved, and inform the Board. Should the recommendation for an extended review be declined by the Chair of the Board, then the Board should be informed and further discussion held. If the final decision is no, then the Chair of the Board will need to inform the Welsh Government in writing, with the reasons given, and any conflicting views also reported.

7.15 If the decision is yes, the *Review Sub-Group* will establish a multi-agency *Review Panel* to manage the review.

Terms of Reference

7.16 Initial terms of reference will be submitted to the Chair of the Board based on information known at the time. It should be noted that the terms of reference are **a living document** and not set in stone. They may need to be amended, in the light of new information, at any point during the course of an extended review. The

14 *Index adult* is a term used to indicate the adult who is the subject and focus of a review, to distinguish that adult from other adults who may also be involved. In some reviews, there may be more than one adult who has died or been significantly harmed, and the may all be subjects of the same review. They will all be index adults of that review.

Review Panel will have responsibility for agreeing any variation to the terms of reference.

7.17 The final terms of reference (anonymised) will be included in the Report at the completion of the review.

7.18 An exemplar of a terms of reference is included in Annex 2.

Additional issues to be addressed by the Extended Review

7.19 There will be additional issues to be addressed as part of an extended review and these will require additional external professional challenge. An additional level of scrutiny will include consideration of the following issues in the preparation of the terms of reference and timelines, and during 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 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 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 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; and
- 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).

7.20 Further relevant issues in relation to the circumstances of the case may also be identified by the *Review Panel* and/or the reviewers.

7.21 The 12 month timeline (referenced in paragraph 7.23) may be extended, but only when necessary, to reflect the period of time the individual was subject of actions to protect them from abuse or neglect. The timeline can be extended from 12 months to up to two years if circumstances so warrant but the focus of the analysis is on current practice and on the relevant protection / care and support plan.

Review Panel

7.22 As with a concise review, the *Review Sub-Group* will formulate the initial terms of reference for the extended review (an exemplar is contained in Annex 2) and will set up a multi-agency *Review Panel.* As with a concise review the *Review Panel* manages the review process and plays a key role in ensuring the understanding and learning from the case. The *Review Panel* will build on the initial terms of reference formulated by the *Review Sub-Group* and will develop questions and

ideas about what happened in the case informed by the merged timeline[15] of significant events, the agency analyses and in the context of local knowledge. The terms of reference will either be further amended in the light of new information or *Review Panel* discussions and will need to be agreed with the reviewers when appointed.

Timelines and genogram

7.23 A **timeline** of a maximum of 12 months preceding the incident should be prepared. The 12 month timeline may be extended only if there are exceptional circumstances (see paragraph 7.21 above) but as the focus of the review is on current practice, the timeline should in those cases be no longer than 2 years. The timeline may be extended to include decisions and action following the incident. Any extension of the timeline should be agreed by the *Review Panel.*

7.24 Where there is significant background information or a previous incident, this can be included in the brief analysis accompanying the timeline. Family history is vitally important but the critical issue in a review is who was familiar with the family history, how it was shared within the professional network and how it was taken into account in current decision making.

7.25 A full and accurate **genogram** (also known as a Family Association Network in the police service) should also be prepared by the *Review Panel* as a means of clarification of family relationships. It should be used during *Review Panel* discussions with the reviewer and be available for reference at all stages of the review process, although not included in the published report.

7.26 The *Review Panel* will produce a merged timeline of significant events from the individual agencies' timelines. The merged timeline, genogram and brief agency analyses will then be used by the *Review Panel* members and the reviewer to develop questions and ideas about what happened in the case. This initial understanding will inform the preparation of a learning event for practitioners and line managers to test out and further explore operational practice issues. The reviewer will also have access to and will read documentary and other relevant written material, as appropriate. During discussion, issues for clarification may arise and the *Review Panel* will ask services to respond; the terms of reference for the review may be amended or extended, as a result.

7.27 At any point in the course of conducting an extended review, the *Review Panel* and/or the reviewer may reach the conclusion that, from the analysis of timelines or other sources, the review does not meet the criteria for a review or the review cannot be conducted as laid out in the guidance. If the review is terminated, it will require:

a. the agreement of the *Review Panel;*

b. a report to be written and presented to the Board;

c. the Chair of the Board asked to approve the action by the Chair of the *Review Panel;* and

d. the Safeguarding Team of the Welsh Government notified.

15 It was found during the pilots that the police service has software which produces high quality single agency and merged timelines and genograms which considerably assisted the effectiveness and efficiency of the work of the *Review Panels,* the reviewers and the learning events.

7.28 The report will need to set out not only the reasons for the termination but also what alternative action is proposed to enable learning.

Commissioning the Reviewers

7.29 The *Review Panel* will identify and commission a reviewer who must be independent of the case management and who may be a member of the Board, or a member of another Board, or from a neighbouring authority, or a person with relevant skills and experience as required by the case. Relevant experience may be determined by issues of language, ethnicity, religion or health, such as disability, or other factors instrumental to the circumstances of the case.

7.30 Extended reviews will be undertaken by two reviewers. One reviewer will be appointed who is not involved in the case management but who has knowledge of the local context. The other reviewer will be appointed to contribute external professional challenge and relevant experience. Both reviewers will have responsibility for scrutiny of the additional issues to be addressed and will work jointly with the *Review Panel.*

7.31 When choosing a reviewer, it will be important to remember that the quality and experience of the reviewer is crucial to the quality of the outcome. The role requires a wide range of knowledge, skills and abilities which include a thorough knowledge of adult protection systems, issues, responsibilities and practice, an understanding of multi-disciplinary working, an ability to enquire and communicate about practice with professionals and with individuals and family members, and skills in facilitating and managing group processes effectively. In appointing a reviewer, the Board will need to be satisfied that safe recruitment practices have been observed.

Learning Event

7.32 As with a concise review, a critical part of the extended review will be a learning event which will be organised and facilitated by the two reviewers.

7.33 The learning event is a critical part of the review. It ensures the voice of practitioners directly contributes to the review, that practitioners can hear the perspectives of the family during the event and, with other practitioners who have worked with the individual and family, they are able to reflect on what happened and identify learning for future practice.

7.34 Practitioners and managers are expected to attend if asked. The *Review Panel* should think creatively about how relevant practitioners and line managers can be engaged in the review. In some instances it may be appropriate for more than one learning event to be held to ensure the contribution of key staff to the learning process. Reflection and confirmation of the learning points may be part of the learning event or a separate session may be held with the participants of the learning event at a later date. The *Review Panel* has responsibility for supporting the reviewer in carrying out an effective learning event[16].

7.35 The *Review Panel* Chair will normally attend the learning event on behalf of the *Review Panel* to ensure that the questions and issues identified by the *Review Panel* are fully addressed. Should the Chair of the *Review Panel* be unable to attend, another member of the *Review Panel* may attend.

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16 The Welsh Government website provides the parallel guidance for child practice reviews along with a guide for organising and facilitating learning events.

7.36 At the conclusion of the learning event, the reviewer with the practitioners will identify single and inter-agency issues and practice learning points for consideration and further discussion by the *Review Panel*.

Adult Practice Review Report

7.37 Following the learning event, the reviewers have responsibility for collating and synthesising the learning to date for discussion with the *Review Panel* in the form of a draft report, using the agreed template outlined in Annex 1. The reviewers have responsibility for reporting on the additional issues for scrutiny and also have responsibility for confirming that the learning process was undertaken appropriately.

7.38 The draft report should be succinct and focused on improving practice. It should include the circumstances which led to the review, the practice and organisational learning identified during the review, including highlighting effective practice, and considerations about what needs to be done differently to improve future practice. Actions should be identified that will bring about improvements in systems and practice, and should be specific, workable and affordable, and have clearly defined anticipated outcomes.

7.39 The meeting between the reviewers and the *Review Panel* combines important opportunities for both professional challenge and quality assurance by *Review Panel* members. Practice issues originally identified by the *Review Panel* can be re-examined in the light of the reviewer's findings and the learning event and there may be issues identified for further clarification either with practitioners or managers or with the *Review Panel*.

7.40 Once agreed, the anonymised draft report and an outline action plan will then be presented to the Board. A template (in Annex 1) has been provided for the report.

7.41 The reviewers and the *Review Panel* may conclude that practice in this case has not failed or been inappropriate and there may be no recommendations for changes in local operational policy or practice.

Presentation of the Report to the Board

7.42 The draft report and outline action plan will be presented by the Chair of the *Review Panel* and by the reviewers to the Board for its consideration. As with a concise review, the presentation of the report serves to connect Board members with current practice and organisational issues arising from the practice learning. The Board may identify learning issues or actions of strategic importance for individual agencies or that may come within the collective responsibility of the Board, for inclusion in the final review report or in the action plan, as appropriate.

7.43 The *Review Panel* and the reviewers will then complete the final report to reflect the range of learning identified. The Board has responsibility for accepting the report and providing direction regarding the proposed action plan.

7.44 The Chair of the Board will submit the report to the Safeguarding Team of the Welsh Government which will then draw in other parts of the Welsh Government and the Inspectorates as appropriate for information purposes. The Welsh Government will require the report at least two weeks before the proposed date of publication by the Board.

7.45 The finalised report will be published on the Board's website for a minimum of 12 weeks, and thereafter reference will be made on the website to the availability of the report on request.

7.46 The review process is to be completed as soon as possible but not normally longer than six months from the date of referral to the Board's *Review Sub-Group*.

Action Plan

7.47 *The Review Panel* and the reviewer will have responsibility for preparing an outline action plan, to accompany the draft report for presentation and discussion by the Board. The action plan should reflect the learning identified in the adult practice review report, including where appropriate effective practice. The actions may be directed either at single agencies or require multi-agency action. The action plan should be outcome-focused and indicate how actions are intended to make a difference to local systems and adult protection practice.

7.48 A finalised action plan should be prepared reflecting this discussion within four weeks of the Board's consideration of the report, and sent to the Chair of the Board for signing off by the partner agencies. The action plan should have a clear focus on improving outcomes for individuals and their families

7.49 The action plan will be reviewed and progress monitored by the *Review Sub-Group* and reported to the Board. This must include wide dissemination of the report and action plan to staff, as appropriate. Consideration will be required by the respective Board sub-groups of the critical learning points and how they will be incorporated into any changes in operational systems and practice, training and supervision, and in shaping priorities for future work undertaken by the Board.

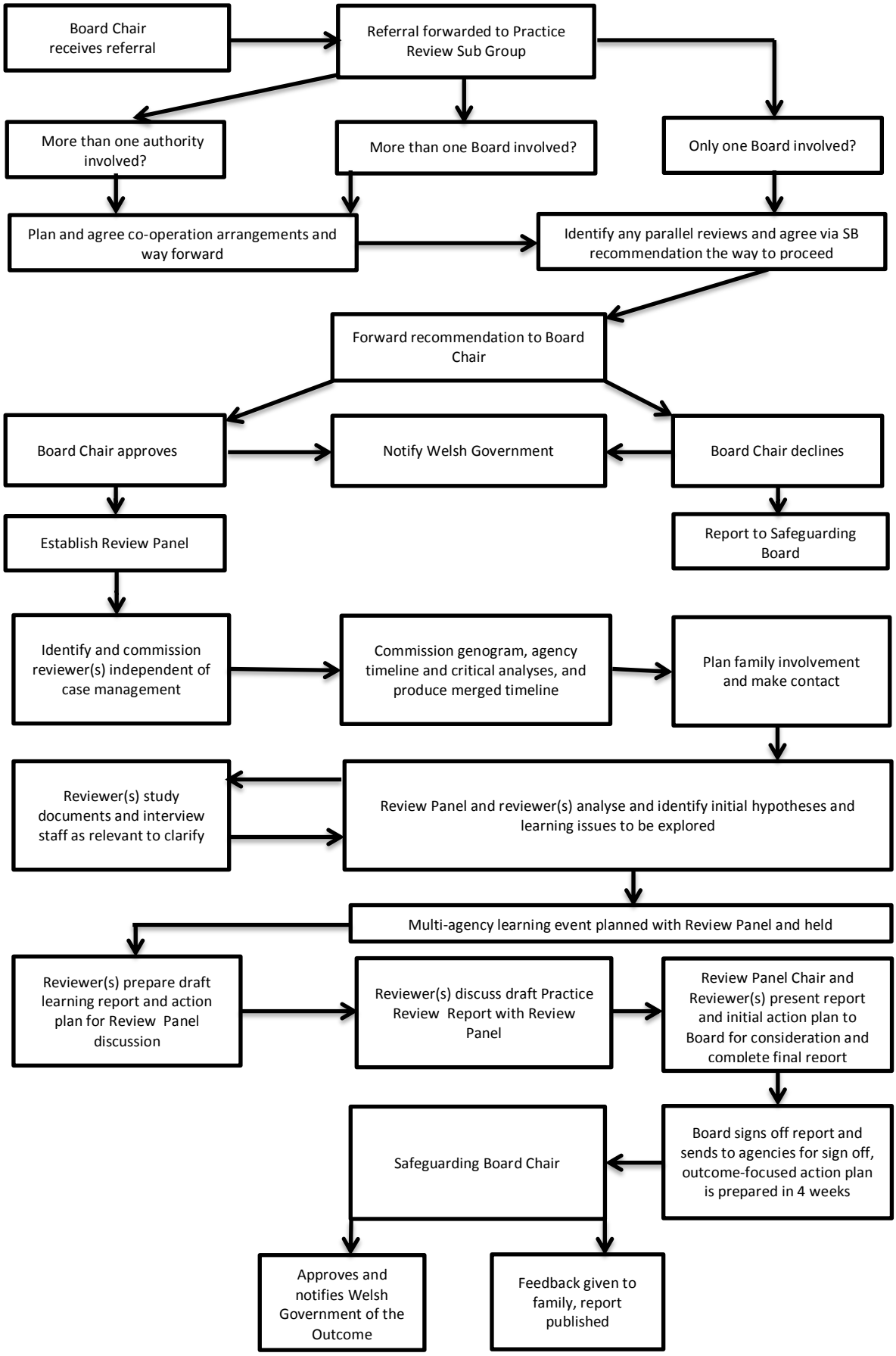
7.50 Action plans should lead to improvements in safeguarding practice and the Board will need to ensure they are carefully audited to see whether they have been carried out and with what effect, and whether they are achieving the intended outcomes.

7.51 The reviewer may be requested by the *Review Panel*, as part of taking forward the action plan, to undertake an event with staff groups either to disseminate what has been learned or to follow-up the impact on practice of changes being made as the result of learning from the review.

7.52 The *Training Sub-Group* and *Audit Sub-Group* will need to include any issues emerging from the concise review in the Board's future training and audit programmes or incorporate into the work programme of the Multi-Agency Professional Forum.

7.53 On completion of the work, the action plan will need to be signed off by the Board and a report made to the Safeguarding Team of the Welsh Government about the difference the actions taken have made to practice.

Fig. 2 Flowchart of adult practice review process



8 Applying the adult practice review process to historic abuse

8.1 It is the responsibility of the Board to determine whether a case meets the prescribed criteria for undertaking a child practice review. The Board may decide that a review is required in relation to a case involving historic or contemporary organised or multiple abuse. The aim of such a review would be to examine what can be learned from practice to ensure that current practice and organisational systems are strengthened and improved.

8.2 This may include putting in place a means of identifying and acting on lessons learned from the investigation (e.g. in respect of policies, procedures and working practices which may have contributed to the abuse occurring) as the investigation proceeds, and at the close of the investigation, assess its handling and identify lessons for conducting similar investigations in future.

8.3 Historic reviews that meet the criteria for an adult practice review should follow the principles, approach and process outlined in chapters 1 to 7 of this guidance. Practice guidance is provided in Annex 3 about how such a review may be undertaken.

Annex 1: Adult Practice Review Templates

Template 1
Recommendation to Chair of Board from Review Sub-group

From: Chair of the APR Sub-group – Name and Designation

To: Chair of the Board – Name and Designation

Re: Insert numerical case identifier **(to be used in all future correspondence-** *These are based on the year a APR began. So, for example, the first APR undertaken by CYSUR next year will be (CYSUR 1/ 2017)***)**

Brief outline of Case/Incident Please include the status of individual/individuals prior to incident and any immediate remedial safeguarding action taken by relevant agencies.	
Recommendation The APR Sub-group has considered this case and recommends that it meets the criteria for a:	
Concise review	☐
Extended review	☐
If the criteria are not met for the above reviews, what alternative review process will be undertaken:	
Referred to multi-agency professional forum	☐
No review	☐
Alternative review process	☐
*Please specify or detail alternative review process e.g. Domestic Homicide Review***:** …… ……	
Decision	
Unanimous	☐
Majority	☐

Rationale for Decision/Recommendation This should include:- • Guidance criteria. • Range of reviews considered. • Alternative types of review considered to meet the case needs. • How the needs of any other review will be incorporated into the terms of reference. • If majority decision – explanation and outcome.

Proposed Initial Outline of Review

(This is an initial outline which will need to be updated as the review proceeds.)

Time period to be covered by the review in line with guidance.

0-6 months	☐	6-12 months	☐

Rationale for time period.

More than 12 months	☐

If more than 12 months - As this is outside timeframe recommended in guidance please specify rationale

Agencies involved in the case being reviewed

(Include name and designation if known)

Care Provider	☐		Police	☐	
Housing	☐		Probation	☐	
Local Health Board	☐		Public Health Wales	☐	
NHS Trust	☐		Social Services	☐	
Other Safeguarding Board	☐		Third Sector	☐	
Other (please specify if known or yet to be identified):			☐		

Agency identified to Chair Review Panel

(Include name and designation if known)

Care Provider	☐		Police	☐	
Housing	☐		Probation	☐	
Local Health Board	☐		Public Health Wales	☐	
NHS Trust	☐		Social Services	☐	
Other Safeguarding Board	☐		Third Sector	☐	
Other (please specify if known or yet to be identified):			☐		

Is the Chair independent in that they have had no involvement/oversight of the case?	Yes	☐	No	☐
Rationale for choice of Chair:				

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

- To examine inter-agency working and service provision for individual x 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 here.*)
- To produce a report for publication and an action plan.

Indicative Roles and responsibilities

- The Board Co-ordinator 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 all matters relating to the review. In particular this will include advice on:
  - terms of reference;
  - disclosure of information;
  - guidance to the *Review Panel* on issues relating to interviewing individual members of staff.

Appointment of Reviewer Independent of the Case Management

Is an independent reviewer to be appointed?	Yes	☐	No	☐
Is the name and designation of independent reviewer known?	Yes	☐	No	☐
*If **yes** please state nominated designation of independent reviewer plus any additional information):*				

Review Independent of the Case Management – Extended Review

In the case of an extended review the following core questions will be addressed as per the guidance by the reviewers in the Terms of Reference of the Review.

- 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 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 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 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).

Further relevant issues in relation to the circumstances of the case may also be identified by the *Review Panel* and/or the reviewers.

Any additional specific questions which are appropriate to be raised at this stage?

Approximate cost (if known) of independent reviewer and how this will be met	£ …….
Additional costs identified (if known). Please specify:	£ …….
Date of First Review Panel meeting	……

Will the report be completed within Guidance timeframe? *i.e. 6 months from date of referral*	Yes	☐	No	☐
Please identify any issues that may impact on the timeframe and how these will be managed:- *Include issues such as:- Criminal prosecution / Coroner's decision*				

Anticipated completed report date	……..

To be completed by Practice Review Sub-group Chair

Signature ……

Title ……

Date ……

Telephone number ……

Decision of the Chair of Safeguarding Adults Board

I agree with the recommendation	☐
I agree with the recommendation **with the following amendments**:-	☐
I disagree with the recommendation *If disagree, reasons why and proposed action*:-	☐

Signature ……

Title ……

Date ……

Telephone number ……

In discussion with Chair of Sub-group

Date information to be presented to the Board ……
Date information sent to Welsh Government ……

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Date information received …….. ……..……..……..……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant Inspectorates / Policy Leads ……..

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

Template 2
Adult Practice Review Report

Adult Practice Review Report

(insert name) **Safeguarding Adults Board**

Concise/ Extended *(delete as appropriate)* **Adult Practice Review**

Re: *insert numerical case identifier*[17] **xx Board 1/17**

Brief outline of circumstances resulting in the Review

To include here: -

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

An … review was commissioned by … Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Adult Practice Reviews. The criteria for this review are met under *x:*

(a succinct anonymised account of the circumstances which required a review to be held by the Board)

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

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

17 These are based on the year an APR began. So, for example, the first APR undertaken by CYSUR safeguarding Board next year will be (CYSUR 1/ 2017)

Improving Systems and Practice

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

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

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)*	.....	**Reviewer 2** *(Signature)*	.....
Name *(Print)*	.....	**Name** *(Print)*	.....
Date	.....	**Date**	.....

Chair of Review Panel *(Signature)*	……
Name *(Print)*	……
Date	……

Appendix 1: Terms of reference
Appendix 2: Summary timeline

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 the services that attended.* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Template 3. Summary Timeline

Safeguarding Adults Board *(insert Board name)*
Summary Timeline
Re: *insert numerical case identifier*

Type of activity	2016							2017										
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
Hospital Services																		
Social Care and Support Sevices[1]																		
Police																		
Criminal Justice																		
WAST																		
GP																		
Social Services																		
Housing																		
Education																		
Contextual issues																		

1 *Residential care etc*

Detailed timelines were produced by the relevant services for the purposes of the review to assist the understanding of the complex interactions between events and services in the case. This summary and partial timeline contains limited and anonymised details and is provided to supplement the outline of circumstances in the Practice Review report.

Annex 2: Terms of reference for concise and extended reviews – an exemplar

Terms of reference for a concise / extended adult practice review (delete as appropriate)

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

For extended reviews ONLY. In addition to the review process, to have particular regard to the following:

- 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 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 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 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).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and 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 hypotheses.

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the 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, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board 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.

Tasks of the Safeguarding Adults Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Panel* completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Annex 3: Undertaking a review in a case of historic organised or multiple abuse

1. The aim of a review following an investigation of a case of historic organised or multiple abuse, which meets the prescribed criteria for an adult practice review, is to identify issues arising from past practice and to ensure learning has informed current practice so that improved systems are in place. The purpose is to promote improvement and learning and not to apportion blame. Any competency or disciplinary matters fall outside the remit of a review and they are a matter for individual agency disciplinary procedures.

2. The learning should be shared with those agencies and staff currently carrying responsibility for adult safeguarding action. Learning from the review should be used by the Board to assure the quality and robustness of agencies' current systems and practice in responding to any concerns, suspicions or allegations in relation to adults in residential institutions or other forms of group care.

The review process

3. The review should examine how adult protection agencies responded to disclosures of abuse and identify learning points from the processes followed and the decisions and actions taken in response to allegations. The review process will need to be flexible and challenging in order to capture relevant issues and take account of changes in staff and procedures that may have occurred in the intervening period. This can be done by a range of methods including examining records of meetings and other documentary sources, and individual interviews with staff and family members (as appropriate) to clarify information. The review should include a learning event held with relevant managers and practitioners.

4. The review should follow the principles, approach and process outlined in chapter 6. The flowchart (Fig.2 on page 29) of this guidance outlines the process to be followed.

Core tasks of the Review

5. The core tasks are as follows:

    - to ensure current policy, procedures and practice of the named services and the Board have been informed by the issues and learning arising from the case, by examining:
        - decision making across agencies and through the whole authority as related to this case.
        - the extent to which decisions and actions were individual-focused.
        - inter-agency working and service provision for the individual's concerned and their families.
    - to seek contributions to the review as appropriate or available from individuals and family members, and to provide them with feedback.
    - to take account of the learning from parallel investigations or proceedings related to the case at the time of the incidents and subsequently.
    - to hold a multi-agency learning event to identify where practice has already changed or should be different in future; and

- to prepare a report of the review using the template in Annex 2 of this guidance.

Specific tasks

6. The review should be managed by a multi-agency *Review Panel* set up by the *Review Sub-Group* of the Board. The agencies represented on the *Review Panel* may be drawn from Education, Police, Health, Social Services, Probation together with the Board Co-ordinator. Experienced staff external to the agency may be included to provide additional expertise and challenge. The *Review Panel* members should have working knowledge of the services but not have had direct involvement in the case.

7. The responsibilities of the *Review Panel* members during the review should be to:

   - act as a link to their respective agencies to facilitate the work of the reviewers and keep their agencies informed of issues arising from the review in line with its organisational reporting arrangements.
   - confirm or amend the terms of reference as required including time period to be reviewed.
   - commission agency timelines and analyses of involvement.
   - present their agency timeline and initial analysis to the *Review Panel*.
   - offer professional expertise and challenge to the practice identified in the merged timeline and agency analyses.
   - identify issues to be explored in a learning event.
   - following the learning event, the *Review Panel* should consider the learning issues identified when the report has been drafted by the reviewers; and
   - contribute to developing a report and action plan as required.

8. A timeline should be agreed by the *Review Panel* for the examination of records and other material. The *Review Panel* should commission agencies to provide timelines of their involvement in the case and a succinct analysis of actions and practice from their agencies' perspective.

9. The *Review Panel* should appoint a reviewer (or reviewers), who is independent of the Board, in accordance with guidance for concise and extended adult practice reviews. He/she will be expected to work closely with the *Review Panel* and be offered practical support by the Board Co-ordinator or a nominated *Review Panel* member.

10. The reviewer/s should examine the individual agency timelines and analyses, and have access to relevant documentary evidence identified from the agencies involved, particularly any multi-agency documents. As needed, he/she should interview the agency representative who prepared the timeline to clarify information as well as draw on available guidance and reports.

11. When this has been completed, the reviewer/s, with the *Review Panel,* should formulate ideas and hypotheses, to be tested in a learning event, based on the key issues that have emerged through analysis of the merged timeline and summary reports.

12. A learning event should then be planned by the reviewer/s with the *Review Panel* bringing together key relevant staff from different agencies who would be currently involved in the handling and management of the multi-agency response to such concerns and in subsequent decisions and action that would have to be taken.

Participants in the learning event should be identified and prepared. Particular care in planning the event is likely to be needed when it involves staff who may have been in post at the time of the matters under review, as well as staff newly appointed since then. The focus of the event should be on learning and not blame for what has happened in the past, and should be about identifying where practice has already changed or should be different in future. Although the review is likely to be about the processes to be followed, the reviewer/s need to ensure there is an individual-focus throughout.

13. The reviewer/s with the *Review Panel* should consider and manage how any individuals' or family members' perspectives may be included and contribute to the learning event

14. The learning issues and conclusions from the event should inform discussion with the *Review Panel* and a draft report should be prepared by the reviewer/s for consideration and discussion with the *Review Panel*. The report together with an outline action plan should be presented to the Board. The preparation of a report should follow the template format (Annex 1).

Board tasks

15. A draft report should be presented by the Chair of the *Review Panel* and the reviewer/s to the Board for members to consider and approve the report. The role of the Board is to provide professional challenge and to consider the strategic implications of the findings and future action for the Board and its constituent member agencies.

16. On approval of the final report by the Board, it should be sent to the agencies involved for sign off. The report will then be sent by the Chair of the Board to the Safeguarding Team of the Welsh Government for information. The learning outcomes should be published on the Board website, as outlined in paragraphs 6.49 and 7.45.

17. The Board should consider the outline action plan prepared by the *Review Panel* and the reviewer/s. The action plan should identify the difference any action is intended to make to practice and how the Board will audit this in the future. The final action plan should be signed off by the Board within four weeks of the report and sent to the Welsh Government.