Extended Adult Practice Review Report

CWMPAS 1/2019

Date report presented to the Board: 14th July 2020

Adult Practice Review Report

CWMPAS: Mid & West Wales Safeguarding Adults Board

Extended Adult Practice Review Re:
CWMPAS 1/2019 (Pembrokeshire)

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

A Board must undertake an Extended Adult Practice Review in any of the following cases where, here an adult at risk who has, on any date during the six months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has

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

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

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with the adult and their family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and adult protection practice. It should include the circumstances, which led to the review, including highlighting effective practice and considerations about what needs to be done differently to improve future practice.

There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s), which were in place for the individual.

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

[1] Social Services & Well-being (Wales) Act 2014

[2] Working Together to Safeguard People – V3 – CPRs (Welsh Government, 2016)

[3] Regulation 4(4) of the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*

Circumstances Resulting in the Review

The person at the heart of this review is M. She is now 28 years old who whilst placed in supported living in 2016, was subject to physical and verbal abuse over a period of at least ten months. She is vulnerable young adult because of her learning disability, developmental levels (reported around 18 months) and communication difficulties. She requires constant support and supervision due to her needs, which includes challenging behaviour, ADHD (Attention Deficit Hyperactivity Disorder), diabetes and epilepsy. While M was not contacted as part of this review, we know from her family, professionals and her Positive Behavioural Support (PBS) Plan that she is generally, a very happy and outgoing young lady.

M has a very close relationship with her family and enjoys spending time with them. She is very sociable and enjoys being with others, especially when people communicate with her in an enthusiastic and animated manner.

M enjoys lots of sensory activities and especially likes bath time / water play and pampering activities. She loves being out and about, either in the garden or out for walks and loves fast rollercoasters in theme parks!

Some context around M's challenging behaviours is important to this review, as she is mostly non-verbal, but inventive at letting others know what she wants. M's behaviours which can challenge can present for a variety of reasons including:

- To communicate a want or a need
- To gain interaction from others
- To escape or avoid a situation she does not want to be
- To get something she wants
- From confusion (cannot make sense of what is happening)
- If she is feeling unwell

Her placement in supported living was monitored by multiple professionals from different agencies and a comprehensive support package and risk assessment was in place, but despite these, she was subjected to physical and verbal abuse by two known members of staff who were working in the support living accommodation.

Time Period Reviewed and Why

To reflect the significant amount of information and multi-agency involvement in commissioning this young woman's care, the time period covered in this review is from 1st March 2016 to 7th March 2018. In March 2016, plans were in progress to transition M from an out of area education residential placement to a more permanent home. The decision making around this planning was thought to be important to this review and the subsequent impact such a placement had on M.

The review is informed by an understanding of what would have been possible at the time, with the knowledge/guidance available then.

A summary timeline of significant events is included in Appendix 2.

It should be noted that there was a Police investigation, which resulted in criminal convictions for two staff members employed by the independent provider of the supported living setting. This delayed the commencement of this Adult Practice Review. A non-criminal safeguarding investigation ran in parallel with the police investigation and concluded that there was clear evidence that M had been subject to significant verbal and physical abuse and neglect over a period of at least 10 months.

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.

Placements

Finding an appropriate placement that will enhance the quality of life for someone with complex needs is not an easy task. Sometimes the focus shifts to looking at whether a person will fit the resource rather than does the resource fit the person. Two things can help to ensure that a placement is the most appropriate and to prevent placement breakdowns:

- Firstly, in order for commissioning to be proactive there needs to be a robust transitions service that can begin the planning when a young person reaches the age of 14. This requires both a well-resourced specialist team and effective links between children's and adult services
- Secondly, for commissioners in Health and Social Care to use this information to be proactive and shape and influence the market, making explicit future requirements

Although roles around transition have been established, they do not operate as an integrated service. The high volume of work means they are having to concentrate on the most urgent cases; those at the point of needing to move placement and so they cannot be as proactive as they would like.

In this situation, there was a sense of urgency for M as her placement at the Residential Educational Establishment had been extended by over a year. Consideration of whether or not the single person living scheme was the most appropriate placement was overshadowed by professional anxiety about lack of alternatives and the need to move M as quickly as possible from the Residential Educational Establishment.

In order to support placement moves, organisational systems need to be speedy. Providers are businesses and cannot keep placements open for too long as they are losing money. A previous placement for M had fallen through because the funding was not secured in time. This resulted in a year of uncertainty for her.

The geographical location of a placement has an impact on the care provided for an individual. In this situation, the single person living scheme that M moved into was quite isolated. It was 14 miles from the private provider and in a small community, which had an effect on the monitoring and oversight of the placement, as well as staff recruitment, relationships and staff supervision.

It is important to consider the physical environment provided by a placement and how this might influence the care provided. M had moved from a large residential facility with lots of space to move around in, to a small bungalow. M is someone with lots of energy who likes to be engaged in a wide range of activities. Was the physical space, therefore, too restricting for her?

Caring for people with complex needs is very intensive work and requires high levels of energy. It is imperative, therefore, to think about how long a working shift should be in order to sustain and maintain the level of interaction required. In this situation, staff initially worked three shifts in every twenty-four hours, however after the 'settling in' period this was changed to two shifts. Even with two members of staff, this is a very long time to work consistently and appropriately with the detailed care plans that were in place for M.

Changes of placement are often inevitable as children and young people move into adulthood; however, it is important to understand and recognise the impact of placement moves on the individual and to look at how they can be helped, not just to settle in, but also to live in the placement in the longer term. For M there was a pattern of her settling in well, enjoying the placement and then after a time her behaviour deteriorating. Was this something to do with what

was happening to her; or was she becoming bored or were staff becoming tired and experiencing some burn out?

Staff Support

Staff training is not a single event but an integral part of the ongoing development of knowledge, skills and practice. In this situation, an initial, detailed, bespoke training programme was delivered to the staff team in preparation for M moving in. However, with turnover of staff this programme was not repeated for new members of the team. What happens in such situations is that new members of the team look to established staff as role models and 'copy' what others are doing but often without an understanding of why it is important to work in a certain way or the reason for particular approaches. It may then be difficult for some newer members of staff to distinguish between appropriate interventions and poor practice. It is important, therefore, that training is ongoing and updated.

Perhaps better use could have been made of staff meetings, both for updating staff but also for checking out if not all team members were understanding and following the detailed Positive Behaviours Strategy plan that had been drawn up for M.

The provision of good quality supervision is extremely important to monitor, to support and to develop staff. Supervision needs to create a reflective space within which individuals can debrief; increase their understanding and develop the necessary professional curiosity, which is the capacity and skill to explore and understand what is happening for individuals. Supervision is also a means of ensuring that staff are working consistently with and adhering to care plans and promoting the ethos and values of compassionate care. Supervision, when carried out well, is an important tool for empowering staff and giving them space to whistle blow if this is needed. M's team did have supervision but it was superficial and perfunctory. Some staff did raise concerns about the behaviour of some colleagues towards M but these concerns were ignored and not acted upon by a specific manager who was subsequently subject to a disciplinary procedure.

Investigations of any kind can be stressful for staff. It is important to recognise this and support staff so that it does not have a detrimental impact on the work with clients. In this instance, the safeguarding investigation took a year which was relatively speedy and there was an outcome which is not always the case. However, it still had an emotional impact on the remaining staff.

Scrutiny and Oversight

All placements have to be monitored to ensure they are meeting the needs of the people placed in them. It is important to clarify who is monitoring and to co-ordinate how it will be done, but also to recognised limitations on scrutiny and oversight. For instance, M was a tenant and CIW (Care Inspectorate Wales) cannot go into tenancies unless they have consent to do so.

In order for placement scrutiny to be robust it requires those with oversight to operate from a place of 'respectful uncertainty'[4]. This is not about being cynical or overly distrustful but rather about not testing things out and making assumptions. For instance, the Provider accepted that M had been taken to all the activities listed in her weekly schedule when in fact care records had been falsified and she had been confined to the placement. It is therefore about thinking how to check that she had indeed been swimming by perhaps contacting the providers of a particular activity. Best practice would be for professionals to observe care in action. Other than planned visits there is no evidence that anyone actually observed the care and interaction staff were providing for M.

The CTLD (Community Team Learning Disabilities) and Health Board staff visited M in placement but these were always pre-planned and M's staff team were expecting them. Unannounced visits can sometimes provide useful data about how an individual is getting along within a placement. There was a 6 monthly review of the placement but it is not clear who was involved in this review and again it was based on a planned visit.

[4] HM Government (2003) *The Victoria Climbie Inquiry* Report of an Inquiry by Lord Laming

The Pre-conditions for Abuse

The safeguarding investigation concluded that there was clear evidence that M was subjected to significant verbal and physical abuse and neglect over a period of at least ten months. There were several factors in this situation that increased the risks to M and enabled the abusers to establish a culture of fear, bullying and intimidation within the placement. The placement was isolated from the main provider unit and was a single person placement, which meant that M was also isolated from her peers.[5] The placement was in a small community and the staff team had links with one another outside of the workplace and indeed some were related to each other. Those team members who raised concerns were not listened to; there was collusion and also fear and ignorance. A lack of training for newer members of the team meant they thought some of the behaviours they witnessed were acceptable. All of these factors provided the preconditions for an abusive culture to develop. The abusers were highly manipulative and able to 'groom' both professionals and family members.

Indicators of abusive relationships can sometimes be spotted in the behaviours and the physical and emotional presentation of the victim of abuse. In this situation, none of the usual flags were present. For instance, M would follow the abusive members of staff when they left the room. Did this mean she was fond of them or frightened of them? She was not able to articulate this. When she was tearful or her behaviour deteriorated did this mean she was depressed, bored or frightened? The collusion, intimidation and the suppression of staff concerns meant this was never explored. NICE Clinical Guideline 11[6] highlights that challenging behaviour often indicates an unmet need and therefore the importance of assessment and the regular review of behaviour that challenges as this could indicate, amongst other things, exploitation, abuse or neglect by others. It is crucial therefore, to always 'think safeguarding' and that abuse may be a possible cause, especially when behaviours deteriorate or an individual becomes distressed. In this situation there was delay in reviewing the PBS plan. It only happened when there was concern about M's depression, which was shortly before the whistleblowing.

Information Sharing and Working Together

There was some good inter-professional working together in this situation, which health and social care teams perceive was aided by the co-location of health and social care teams. However, it was also hampered by staff shortages and the inevitable turnover of professionals, especially social workers. The teams are no longer co-located which has implications for communication and information sharing, and therefore will require a more conscious effort to maintain effective working together.

Working in partnership with families is also an essential component of working with individuals. In this situation, a lot of work was put in to maintaining communication with all members of M's family. However, because one of M's parents was a Social Care professional, maybe there was sometimes a blurring of roles and some assumptions made about scrutiny and monitoring of the placement.

Effective Practice

The review highlighted the following four points as examples of effective practice:

1. The single person placement required some refurbishment and adaptations before M could move. These were completed in an efficient and timely manner.

2. The transition from the Residential Educational Establishment was thorough and person centred. Staff from the placement went to the Educational Establishment and spent time with M and participated in her daily activities and routines over a 24-hour period.

[5] NB: single person placements are no longer supported because they can open people up to risk

[6] NICE Guideline 11 (2015) *Challenging Behaviour and Learning Disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*

3. The original team in the single person placement were handpicked because they wanted to work with M. They underwent an intense programme of bespoke training before M moved in and so were well prepared.

4. The safeguarding investigation was conducted to a high standard and there was effective communication and collaborative working amongst the professional network.

Improving Systems and Practice

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

1. Consideration to be given to bringing together the transition workers into an integrated transition team.

2. Commissioners, CIW and Responsible Individuals should carry out unannounced visits which must be routine and review their scrutiny and assurance processes for ensuring that:
    - Supervision fulfils the functions of supporting and developing staff, provides a reflective space and monitors standards and consistency of practice.
    - All providers have comprehensive induction programmes that include safeguarding, the nature of abuse, the importance of whistle blowing and the core values underpinning care.
    - Provider staff have safeguarding refresher training staff every 3 years.

3. Establishing a working group to consider developing an Independent Reviewing System for adults with learning disabilities whereby Independent Reviewing Officers ensure that placements and care plans fully reflect the needs of the adult. This recommendation would be welcomed by professionals and the family.

4. All practitioners should be reminded about the need for respectful uncertainty, professional curiosity and the consideration of abuse as a reason for deteriorating challenging behaviour.

Statement by Reviewer(s)			
Reviewer 1	Barbara Firth	**Reviewer 2** *(as appropriate)*	Mandy Nichols-Davies
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the adult or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge 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 adult or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge 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 Barbara Firth …… *(Print)*		**Name** Mandy Nichols-Davies …… *(Print)*	
Date …….		**Date** …….	
Chair of Review Panel ……..…… *(Signature)*			
Name Anthony Griffiths …….... *(Print)*			
Date …….			

Adult Practice Review Process

To include here in brief:

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

Adult Practice Review Process

M is now 28 years old who whilst placed in supported living in 2016, was subject to physical and verbal abuse over a period of at least ten months. She is vulnerable young adult because of her learning disability, developmental levels (reported around 18 months) and communication difficulties. She requires constant support and supervision due to her needs, which includes challenging behaviour, ADHD (attention Deficit Hyperactivity Disorder), diabetes and epilepsy. However, M is a happy and lively individual, who thrives on attention and activities.

Her placement in supported living was monitored by multiple professionals from different agencies, and a comprehensive support package and risk assessment was in place, but despite these, she was subjected to physical and verbal abuse by two known members of staff who were working in the support living accommodation.

Whilst M cannot tell us what impact the abuse she has suffered had on her, the seriousness of her experience indicated that the criteria had been met for an Adult Practice Review. The matter was considered at the Local Operational Group and agreement reached that this should be referred to the Adult Practice Review Sub Group. This group subsequently made a recommendation to the Chair of CWMPAS, the Regional Adult Safeguarding Board that an Extended Adult Practice Review should be conducted. The Chair approved this recommendation.

In accordance with the statutory guidance for conducting Adult Practice Reviews, a multi-agency panel was convened to manage the review. The services and agencies represented are as follows:

- Police
- Local Authority Commissioning
- Local Authority Learning Disability Services
- Health Board Commissioning and Learning Disability Services
- Health Board Safeguarding Team
- Representative from CYSUR Regional Safeguarding Board Business Unit
- Care Inspectorate Wales

An Independent Chair was appointed who holds a senior position within the Police Force and is experienced in multi-agency practice reviews. They had no prior involvement or knowledge of the young woman in this case.

As is the case in an Extended Adult Practice Review, a Lead Reviewer and a Second Reviewer were appointed. Neither had previous knowledge or involvement with the management of M. the Independent Reviewer was commissioned from an external company and has conducted may reviews across the UK and advised on practice review guidance. The second reviewer had an understanding of local context.

The Learning Events

In accordance with the Extended Adult Practice Review Guidance, two learning events were held. One for practitioners held on 21st January 2020 and one for managers on 23rd January 2020.

Both events were facilitated by the reviewers and the Chair of the panel was present to represent the Panel. The purpose of the learning events was as follows.

- Share the perspectives of family members
- Give practitioners and managers the opportunity to directly contribute and input to the review by telling M's story form their involvement;
- Enable the professionals involved to reflect and listen to each other whilst contributing and identifying the learning

Attendees at both learning events were asked to give thought to:

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of good practice
- Areas where there could be some improvements

Practitioners and Agencies represented at the Learning Events were from:

- Police
- Local Authority Commissioning
- Local Authority Learning Disability Services
- Health Board Commissioning
- Health Board Learning Disability Services
- The independent service provider
- CIW

Evaluations from the practitioner learning event were positive and those who attended valued the opportunity to reflect and learn. The insights and reflections of practitioners and managers informed the learning and recommendations detailed in the report.

Family Involvement in the Review Process

Members of M's family were invited to participate in the review process. They welcomed this opportunity and were postive that an Adult Practice Review was taking place. The reviewers met with family members directly and the family's views and feelings were shared with practitioners and managers at the respective learning events.

The family's perspective of M's experience in commissioned services has been integral to this review and the learning and recommendations. The family have had an opportunity to comment on the embargoed report.

Appendix 1

Terms of Reference

Core tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Mid & West Wales Safeguarding Board (MAWWSB).
- Examine inter-agency working and service provision for the individual and family.
- 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 two Learning Events: one for practitioners and one for managers. Identify the 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 & 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 two reviewers, one of whom will be the lead reviewer, to work with the review panel in accordance with guidance for the review.
- 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 reviewers two Learning Events to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with family members prior to the Learning Event if appropriate.
- 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 MAWWSB for consideration and agreement.
- Where appropriate plan arrangements to give feedback to family members.

Tasks of the MAWWSB:

- Consider and agree any Board learning points to be incorporated into the final report or the action-plan.
- Review Panel complete the report and action-plan.
- MAWWSB send 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 APR sub-group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on MAWWSB and any other agreed websites.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the MAWWSB, in agreement with the Local Authority Lead Director for Social Services will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2

Significant Events

- From April to July 2016 preparations were underway for M to move from the residential educational unit to a private supported living tenancy in her home county.
- The care team was provided by a private provider, which was 14 miles away.
- M moved into the bungalow on 4 July 2016. She settled well and was excited at being in her new home.
- There was a staff team of 9 people and 3 shifts in every 24 hours.
- The first week went well. Staff were positive and asking for more activities.
- 5th July 2016, interim PBS plan and ABC recording chart sent to CTLD.
- On 8th July 2016, staff requesting more activities.
- On 12th July 2016, staff raised concerns that there was insufficient time for handover, including time read the PBM plan. Pan to be reviewed in six weeks.
- At the end of July 2016, the staffing ratio was reduced from 3:1 to 2:1.
- M's mother expressed concerns that gas and electricity bills were too high and staff were not planning or budgeting.
- On 13th August, 2016, a staff member left as she failed her probationary period. One of the perpetrators went on extended leave.
- At the end of August 2016, Health Board raised concerns, which included incidents not being recorded (kicks/hair-pulls); staff not understanding the PBS plan and the structure and consistency of shifts.
- A structured plan was developed for staff to work around PBS plan with opportunities for staff to reflect, make changes, support & identify strategies.
- 6th September 2016, staff on shift reported they did not find the PBS plan easy to follow and asked for an easy read version.
- On 8th September 2016, staff were working longer shifts.
- On 19th September 2016, a new member of staff joined the team.
- At the end of September 2016, concerns raised by visiting professionals that staff were struggling to cope with rota cover and that not all staff working with M had been trained in PBM.
- On 12 October 2016, there was a meeting with staff members on shift regarding aspects of the PBS plan.
- At the beginning of November 2016, the 6 monthly review concluded that the placement was in M's best interests; that she remain as the sole tenant and activities to be formalised.
- On 21 November 2016, another member of staff left and on 5 December someone else joined the team
- In January 2017, a CTLD meeting discussed the escalation in M's behaviours and general health decline. Discussion on how activities were being managed. M had not had antibiotics for a UTI.
- At the end of January 2017, staff reported that they felt unsupported by management and were struggling to cope. Incidents occurred and were not passed to CTLD.
- In February 2017, a multi-disciplinary team meeting (MDT) discussed the provider management releasing staff for reflective practice workshops.

- On 3rd April 2016, a new staff member joined the team and one of the perpetrators was back providing care in the bungalow.
- At the end of April 2017, there was some discussion about M moving to residential care but mum felt at this point it was best to leave things as they were.
- In June 2017, M's Mother asked if the private provider could offer a more stimulating environment and more outdoor space as the current environment was isolating and intense. It was agreed to discuss this further when suitable accommodation in the private provider residential was identified.
- In July 2017 at a staff meeting, concerns were raised about M's escalating behaviour.
- At the beginning of August 2017, the family were concerned about M's presentation and wondered whether she might be depressed.
- At the beginning of September 2017, the Registered Manager at the private provider service resigned during a disciplinary process.
- On 18 September 2017, the Adult Safeguarding Team were contacted by the service provider Director to say a whistle blower was alleging that M had been assaulted by a perpetrator.
- A safeguarding inquiry was initiated, the perpetrator was arrested and interviewed. Another perpetrator was also interviewed under caution.
- M was moved to the provider's residential unit.

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Date information received: …… *(date)*

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

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

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			