Extended Adult Practice Review Report

CWMPAS 5/2019

Date report presented to the Board:

18th October 2022

Adult Practice Review Report

CWMPAS: Mid & West Wales Safeguarding Adults Board

Extended Adult Practice Review Re: CWMPAS 5/2019

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*

Legal Context:

An extended adult practice review was commissioned by CWMPAS - the Mid and West Wales Safeguarding Adult Board, in accordance with statutory legislation set out in Section 139 of the Social Services and Well-Being (Wales) Act 2014 and accompanying guidance "Working Together to Safeguard People Volume 3 – Adult Practice Reviews" (Welsh Government 2016).

The criteria for this review is met under Chapter 7 of this statutory guidance for Extended Adult Practice Reviews:

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

The criteria for extended adult practice reviews are laid down in *the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[1]*.*

The purpose of this review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail of agencies' work with an adult and their family. The outcome of a review is intended to generate professional and organisational learning and promote improvement for future inter-agency practice. This report informs of the circumstances which led to this review being undertaken. It includes recommendations about what needs to be done differently to improve future practice.

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

Circumstances Resulting in the Review

This review concerns adult G who had dementia and was living at home with her husband, supported with a care package.

G was admitted to a residential care home in September 2018 as an emergency placement following concerns about her safety at home and the care that she was receiving from her husband.

On admission to the home, it was noted that she had significant injuries and bruising; this included 70% bruising to the left side of her body including her legs, arm and head.

G died in October 2018 at the residential setting. The cause of death was a cardiac arrest.

In the months leading up to her admission to the home and her subsequent death, the care agencies who had been working with G raised several safeguarding referrals to the Local Authority Safeguarding Team. This was in relation to bruises which were subsequently believed to be as a result of her husband's attempt to move her without help or support.

As a result of the safeguarding referrals, the local authority assessed that G's husband was trying his best to care for her at home, however, it was recognised that further intervention was needed from the Occupational Therapy Service.

Previously, a package of domiciliary care had been put in place in 2015, which precedes the timeline captured by this review. At that time, a capacity assessment was undertaken in German, G's first language, using a translator. It was deemed that G lacked capacity to make decisions about her care and support needs, and was unable at that point to communicate her wishes and feelings, or to articulate her experiences of the care that she was receiving, both from formal and informal care givers.

Prior to G's death, implementing domiciliary carers had been difficult, and the review notes evidence that there were regular issues reported by G's husband regarding the quality of care provided. For example, he frequently commented that care was not provided at the right time and that the carers did not engage and communicate with G appropriately. As a result, he often had to undertake routine care tasks himself. Agencies, however, viewed G's husband as resistant to any aids or adaptations and reported problems delivering care. Records indicate ongoing problems sourcing Occupational Health provision and undertaking care plan reviews as a result of this.

There were three changes in care providers over the duration of the care delivery. Apart from the first care agency, the views from the care staff and other professionals were that her husband did not positively engage with the staff responsible for delivering G's care. G's husband however, when spoken to as part of this Adult Practice Review process, spoke about his concerns and extreme frustration about the poor quality provision of care. As well as the unreliability of the care providers, he also expressed concerns regarding the level of training and experience they had in relation to caring for someone with dementia. His perception and view is that they did not treat him with respect or recognise and acknowledge him as the expert in his wife's care. Records indicate planned support follow-up meetings did not take place due to staff sickness.

When G's husband refused G's carers entry into the home, a multi-agency decision was made to admit G into a care home following concern about her wellbeing. This included concerns regarding severe cuts and bruises on her body. She passed away from cardiac arrest a few days later.

T**ime Period Reviewed and Why**

The statutory guidance recommends that a timeline of a maximum of 12 months preceding the events subject to review should be considered and analysed. The guidance states that in certain circumstances, the timeline can be extended. However, in this circumstance, the Review Panel agreed that a timeline of 12 months gave the reviewers sufficient information to analyse the key events in G's situation.

The review therefore considered the period of 4th October 2017 to 3rd October 2018.

The Family

The Chair of the review panel, the reviewers and panel members wish to acknowledge the contribution that G's family have made to this review, and in particular, G's husband and daughter, who willingly participated in the review process. The Lead Reviewer and a Panel Member met with the family in an initial meeting, to gain their views and perspective of the situation.

The Review Panel would like to thank the family for sharing information and for providing some lovely photographs of G, which helped the panel members understand more about G's lived experience, her personality and the life she had led before the circumstances which led to the subject of this review.

The family were able to share their concerns about how domiciliary care is provided to people with dementia. The views and perspective of the family were discussed at the learning event. As a result, some of the issues of practice and organisational learning that have been identified during this review reflect the learning gained from speaking with G's family.

The Adult

G was born into and grew up in a large, affluent family in Germany. Her husband describes her as being in a different class due to her wealthy upbringing.

In early adulthood, G moved to London to improve her English, where she met her husband in 1953. After marrying and purchasing their first property together, G and her husband had two children, a son and daughter.

G's family described G as an intelligent and hard working person, and both G and her husband strove hard to create a comfortable life for their children and themselves. G was always smartly dressed and took great pride in her appearance, which was evident from the lovely photographs that the family shared.

G's family stated that during their family life, G would often return to Germany to see her family there, and G's husband would take care of the children when she did so.

After living in London for some time, G and her husband sold their property and moved to live in Scotland.

G's great love was to show and judge dogs and she spent a great deal of time pursuing this hobby.

After spending time on holiday in Wales, G and her husband decided to move to Wales, and relocated in 2004.

G was sadly diagnosed with Alzheimer's Disease in 2009. G's husband cared for her at home until she was admitted to residential care as an emergency placement, just before she died.

G and her husband had been together for 65 years when she died. Her husband described G as a "Princess".

The Carer

G's husband was the sole main carer for G. He did not have any other support locally to help him with the physical care of his wife. A carer's assessment was completed in March 2018 with G's husband, and an increased care package was agreed. It was agreed that respite care would be part of a contingency plan should this be needed.

Following the receipt of the initial safeguarding referral at the end of March 2018 and the undertaken of a safeguarding enquiry, it was concluded that G's husband, as sole carer for G, was struggling, but was doing his best to care for her. He was offered further support but he declined this, believing that it was his responsibility to be the primary carer for his wife, with ongoing support from domiciliary care staff.

G's husband was offered respite which he agreed to accept, however, it is not evident if this offer was ever taken up. Records indicate ongoing concerns expressed by G's husband about the keeping of the call times, with the Social Worker involved agreeing to speak to the agency about this. It is evident that G's husband continued to provide support to his wife without practical support on some occasions, including transfers within the home.

When G's husband was spoken to as part of this review, he reiterated the concerns and frustrations expressed to agencies at the time, and his perception that the experience of having carers support G had not been positive. This included concerns that the carers did not always do what they were supposed to do, i.e. undertake aspects of personal care, and as outlined previously, ongoing concerns regarding poor communication from carers to both him and his wife, and a disrespectful attitude towards him and his home environment.

From his perspective, these unresolved issues caused a lot of tension and had a significant impact on his wellbeing.

Practice and Organisational Learning

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

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

- The production of a merged multi-agency timeline.
- Analysis and discussion of the information in the timeline in the review's panel meetings.
- Gaining the views and perspective of G's family.
- A Learning Event for Professionals which was carried out as a face to face event.
- Reviewers' analysis of the information and main themes which were gathered from the Learning Event.

Practice and organisational learning is outlined below and categorised by the key themes identified.

Lack of Timely Reviews and Monitoring

Learning obtained via this review process identified a need for improved multi-agency working for complex community cases, with an emphasis on developing and cascading Moving and Handling Plans. There was uncertainty over the involvement of the Occupational Therapist to assess and prescribe in regards to equipment and safer handling practices. Also, where an individual has complex care and behavioural needs, a multi-agency review should be held with the care agency involved, community psychiatric nurse (CPN), occupational therapist (OT) and social worker to help support and enable domiciliary care staff to have the support, advice and guidance needed in relation to how staff can support the individual and their family to manage the complex needs.

There is also a need for regular reviews of care packages, ensuring the wishes, feelings and views of family members and informal carers are captured, understood and considered. The learning event participants felt there was no reflection of G's wishes and feelings, nor was there a sufficient understanding of G's husband's discontent with services provided by agencies.

Care Management Processes

Care Management teams need to ensure that their reviewing and monitoring processes are undertaken in a timely manner, especially where there are identified issues with service delivery and/or increased care and support needs. Where an individual's needs are complex, and where there have been safeguarding concerns, reviews for the individual should be prioritised. Where someone has complex needs, reviews should be multi-agency and should involve the care providers. Due to a dementia condition, the involvement of a CPN may be beneficial in assisting providers to understand the most appropriate ways of managing any challenging behaviour in relation to resisting care and support.

Where there are disagreements between family and professionals about care/equipment that should be provided, robust application of the Mental Capacity Act principles and Best Interests processes should be applied in order to facilitate decision making.

Care Management Teams should ensure that they use Advocacy services for people who lack capacity, to ensure that the voice of the person is heard as much as possible. An advocate for the carer should also be considered.

Commissioners and Providers

This review has identified a need for commissioners and providers to consider improved record-keeping by agencies to ensure clear communication and review. Consideration should be given to domiciliary care agencies using one recording system, so that multiple providers have access to concerns and can promote the best outcomes. Commissioners and providers should ensure good record-keeping and that any instructions are clearly communicated.

Care Providers need to demonstrate to commissioners of service staff that they have access to good quality training and development to support them in their care of service users with complex needs, including dementia care. G's husband was able to cite examples of good quality care provided by a previous care agency, where staff used techniques such as singing to calm and distract G when she became upset or agitated.

It is important to add that the Health Board now have a Community Dementia Wellbeing Team who are offering dementia-specific training for up to 12 weeks, to support staff who are caring for those living with dementia in care homes. This will be extended to care agencies and to people in their own homes.

Since the period of time reviewed through this report, it is important to note that there has been ongoing work on a national (Welsh) level to develop the delivery of more person-centred home care provision, and there has been some emphasis on the needs of people who are living with dementia. The National Commissioning Board Wales – Welsh Local Government Agency have established a Community of Practice Outcome Focussed in Domiciliary Care Forum. This established forum involves commissioners from local authorities and providers from across Wales, and discusses the developments in domiciliary care provision and the sharing of good practice between commissioners and providers in the provision of domiciliary care, so that local authorities and providers can learn from each other and can develop and implement better provision in their areas. Some local authority commissioners from this region attend this national forum.

Compliance with Statutory Guidance and Primary Legislation

Whilst there was clear evidence of timely intervention of the concerns raised, it could be said that there were opportunities to apply the best interest guidance on a number of occasions.

It was difficult to document that all steps had been taken to involve both G's husband and G in the decision-making regarding equipment, and little was understood about what steps had been taken to communicate and mediate with G's husband as to the provision of equipment. There is no evidence that the potential benefits and drawbacks were discussed or understood by the client and her family. For example, the family were focussed on the assessment for a high-low bed, and assessors could have listened to what the person was saying and incorporated this into their assessment. G liked to move freely in her double bed and by providing a specialist bed, her husband felt this would take away what little autonomy she had left. There is no evidence in the records this view was shared with the professionals who were assessing.

There is no evidence that the family understood the limitations of service intervention without having the necessary assessment and equipment to comply with regulations i.e., safer handling to ensure worker and client safety is paramount.

Safeguarding

It is of notable good practice that referrals were made regularly in respect of G to the Local Authority Safeguarding Team. The learning event identified the importance of acknowledging safeguarding reports made by agencies and sharing information proportionately. This will ensure that agencies are cited on relevant issues and outcomes following any S126 enquiry[2].

Domiciliary care agencies shared at the learning event how important it is to know the outcome of enquiries, whether referrals were appropriate, and what protective factors could be improved upon going forward.

Where there are concerns about injuries to a person, and the person lacks the capacity to tell people what has happened, and does not have the capacity to consent to medical intervention, consideration needs to be given to a medical assessment as soon as possible. Practitioners

[2] Section 126 of the Social Services and Well-being Act (Wales) 2014 places a duty on a local authority to carry out an investigation where it suspects that a person is an "adult at risk".

should ensure that the GP is requested to undertake a medical review of the individual in order to ascertain whether further intervention or treatment is needed. Practitioners should ensure that appropriate medical opinion is sought.

There were reoccurring reports in relation to injuries that G had sustained, and an overreliance on the belief and assumption that these injuries were caused by poor moving and handling techniques. Further enquiries may have needed to be made, with an increased level of professional curiosity in this approach.

It should be embedded in safeguarding practice that when an adult at risk has reported bruising and/or other injuries, that a medical review should be sought from the GP. Where a person lacks the capacity to make that decision, the decision should be made in the person's best interests.

Safeguarding Teams should provide as much feedback as possible to Care Providers about the outcomes of safeguarding enquiries that have been made where the agencies themselves are the referrers, so that the providers can understand what the outcome are and the reasoning in reaching the outcome. It will also enable the providers to understand their role in protecting people in the future and report any further concerns that may arise.

Managing Complaints

There needs to be a more effective mechanism for resolving conflict and difficult situations between care providers and families. The providers and family raised concerns about each other without resolution on several occasions, and it is recognised there were missed opportunities to mediate and agree solutions which might have improved outcomes for G.

Advocacy

Opportunities to appoint an advocate could have been sought at an earlier stage. There were missed opportunities to appoint an advocate to support decision making relating to G's care and support plan.

G's husband had no regular external support from friends or family, and relied on paid carers to assist him in caring for G. An advocate could have helped bridge the gap and allow professionals to understand G's wishes and feelings prior to losing capacity to engage in her care and support. Also, advocacy support for the carer would have been a significant advantage in this situation.

As well as advocacy support commissioned via the local authority, it is important to note that the Health Board now have a team who have specialist trained nurses who provide support, advice, signposting and advocacy to the carer of the cared for living with dementia, based in primary care.

All patients who are accepted on to the memory assessment service pathway[3] will now have an allocated Dementia Connector, commissioned currently by the Alzheimer's Society, and they remain that single point of contact throughout their journey. All patients diagnosed with dementia via the memory assessment service will have the offer of post-diagnostic support which includes: a tailored plan of care; the offer of "Journey through dementia", a six-week rolling programme (if they meet the eligibility criteria, which is based on the severity of the dementia diagnosis) for the

[3] The memory assessment service is a primary care diagnostic pathway hosted by the older adult mental health service in Hywel Dda University Health Board for people of any age with a suspected dementia. The service offers timely and sensitive diagnosis for people with dementia; tailored information and education; psychological and medical treatment dependant on need; and a plan of care and post diagnostic support before return to the care of a GP.

person living with dementia; and the offer of an Assessment of Motor and Process Skills (AMPS) by a specialist Occupational Therapist. Hywel Dda University Health Board is committed to look to offer this to those diagnosed outside of the memory assessment service teams going forward.

The Admiral Nurse

The Admiral Nurses are now in place and work collaboratively in a family-centric manner across health and social care pathways to provide support, expert guidance and practical solutions to enable families/carers, including the person living with dementia, to maximise their wellbeing and improve the experience of those affected by dementia. This service is currently available in Ceredigion, Carmarthenshire and Pembrokeshire.

Areas Identified as Effective Practice

During the course of this review, there were areas identified as effective, good practice:

- Domiciliary Care Agency staff consistently made safeguarding referrals to the Local Authority Safeguarding Team, when they had concerns regarding G.
- The Capacity Assessment[4] undertaken in 2015 under the Mental Capacity Act[5] appropriately involved an interpreter who could assist the assessment in relation to G's first language of German.
- Carers' Assessments were undertaken with G's husband, and options of support discussed with him, as well as increasing the care package when this was necessary.

[4] The Mental Capacity Act 2015 requires the undertaking of a capacity assessment to determine a person's capacity to make specific decisions. Information about this assessment can be found here.
[5] Mental Capacity Act 2015

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:

Action 1

The principles of the Mental Capacity Act (MCA)[6] must guide all practitioners if P has been assessed as lacking capacity to consent to the decision being made. The human rights framework should be employed, including language of dignity and respect, to give practitioners a sharper edge to addressing areas of concern. It is imperative that the human rights legislation and principles of the MCA is at the heart of all health and social care intervention.

Action 2

Where a service user lacks capacity to consent to their care and support plan, a multi-agency approach should be deployed to ensure outcomes are captured and adequately reviewed. Wishes and feelings in line with the Mental Capacity Act should be recorded as best practice. Where practitioners are aware Moving and Handling Plans are not being followed, the multi-disciplinary team should review policies, procedures and risk assessments, and maintain a risk register of all service users with dementia who are unable or unwilling to comply with plans in place.

Action 3

Commissioners should review training for carers working with those who are resistant to care and have complex needs and dementia.

Action 4

Where several safeguarding concerns have been raised, the outcome of any s126 enquiry under Part 7 of the SSWBA[7] should be mindful of previous concerns raised, and seek to engage the referrer further to improve outcomes for the individual.

Action 5

An Adult Protection Care and Support Plan should include specific risk reducing practices, roles and responsibilities of all parties whilst reflecting the wishes and feeling of the adult at risk and their main family carer, if appropriate.

Action 6

Multi-agency reviews should be regular and integral to delivering effective care to clients with complex needs. Where an agency is not engaging, attempts to resolve the non-engagement should be made by raising the issue via the agency's management structure. If this is unsuccessful and does not resolve the issue, consideration should be given to enacting the Multi-Agency Protocol for the Resolution of Professional Differences.

Action 7

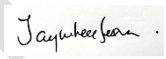
Consideration must be given to advocacy at the first sign of any dispute or conflict, and advocacy referral pathways embedded into practice. A holistic review of the care and support plans,

[6] Mental Capacity Act 2015
[7] Part 7 Social Services and Well-being Act (Wales) 2014

including any adult protection care and support plan, should be convened at the earliest opportunity with the aim to resolving conflict.

Action 8

Where there are concerns about injuries to a person, and the person lacks the capacity to tell people what has happened, and does not have the capacity to consent to medical intervention, due consideration needs to be given to a medical assessment as soon as possible. Practitioners and/or providers should ensure that the GP is requested to undertake a medical review of the individual to ascertain whether further intervention or treatment is needed.

Statement by Reviewer(s)			
Reviewer 1	Karen Arthur	**Reviewer 2** *(as appropriate)*	Elizabeth Upcott
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 child 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 child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)* 		**Reviewer 2** *(Signature)* 	
Name *(Print)*	Karen Arthur	**Name** *(Print)*	Elizabeth Upcott
Date	5/10/2022	**Date**	5/10/2022
Chair of Review Panel *(Signature)* 			
Name *(Print)*	Jayne Wheeler-Sexton		
Date	5/10/2022		

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 Board.
- Examine the effectiveness of inter-agency working and service provision for the adult and family.
- Determine the extent to which decisions and actions were in the best interests of the adult and outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a multi-agency learning event for practitioners and identify required resources.

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

- Whether previous relevant information or history about the adult and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult, the family and their circumstances. How that knowledge contributed to the outcome for the adult.
- Whether the Plans were robust, and appropriate for that adult and their circumstances.
- Did agencies contribute to effectively support the adult?
- What aspects of the agencies' interventions worked well and did not work well. The degree to which agencies were evaluating the effectiveness of their plans, including the effectiveness of their intervention.
- Whether the respective statutory duties of agencies working with the adult 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 reviewers to work with the *Review Panel* in accordance with guidance for extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewers a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the APR Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Adult Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the APR Sub Group:

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

Tasks of the CWMPAS Safeguarding Adults Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of an APR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final APR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- 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.

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.*

- The first panel meeting in relation to this Adult Practice Review was held on 1st February 2021. There have been seven subsequent panel meetings. The agencies represented on the panel were representatives from two Health Boards in the region, Dyfed-Powys Police and representatives from three local authority areas.

- A learning event was held in October 2021 and was of a day's duration. This learning event was held as a face to face event and in accordance with COVID-19 guidelines. The agencies represented at the learning event included personnel from Dyfed-Powys Police; Independent Sector providers, including representatives from two domiciliary care providers and a residential care home setting; representatives from the Local Health Board, including staff from Mental Health/CPN, Community Nursing and Occupational Health Services; and representatives from the Local Authority, which included staff from the Safeguarding, Assessment/Care Management and Occupational Therapy services.

- The husband and daughter of the subject of this report were the family contacts who were involved in the review, and they were consulted with during the process. This was achieved by a face to face meeting with the family in order to gain their views prior to the learning event.

Thanks are extended to all learning event attendees and panel members for their significant, valuable contribution and dedication to this review.

Family declined involvement: no

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Date information received: …… *(date)*

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

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

Agencies	Yes	No	Reason
CIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			