

CWMPAS: The Mid & West Wales Safeguarding Adults Board

Adult Practice Review Protocol APPROVED

Version	Revision Date	Author	Date approved by Board	Review Date
V1	7/6/2017	Business Unit – based on CPR Protocol	n/a	n/a
V2	19/6/2017	APR Sub Group	13/07/2017	13/07/2019

Context

This protocol has been developed to clarify the working arrangements for Adult Practice Reviews within the Mid & West Wales Safeguarding Adults Board region. The document focuses on the broader principles of Adult Practice Reviews prior to a decision being made by the Regional Safeguarding Board to formally commission an Adult Practice Review or Multi Agency Professional Forum. The supporting principles of this protocol are grounded in the following;

- Consistent decision making across the Mid and West Wales region regarding Adult Practice Reviews
- Multi-agency engagement at all levels
- Openness and transparency of decision making

This document should be read in conjunction with the following key documents;

- ➤ Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People Vol. 3 Adult Practice Reviews
- PRUDIC Protocol
- > SSWB (Wales) Act Part 8 Code of Practice on the role of the Director of Social Services (Social Services Functions)
- ➤ Adult Practice Review Sub Group Terms of Reference (*January 2017*)
- ➤ Local Operational Groups (LOGs) Joint Terms of Reference (April 2017)

The Purpose of Practice Reviews

In accordance with <u>The Safeguarding Boards (Functions and Procedures) (Wales)</u> Regulations 2015, Safeguarding Adults Boards have a statutory responsibility to undertake multi-agency Adult practice reviews in circumstances of a significant incident where abuse or neglect of an adult at risk is known or suspected.

The prime purpose of practice reviews, as defined in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015, is to identify any steps that can be taken by Safeguarding Board partners or other bodies to achieve improvements in multi-agency adult protection practice.

While reviews may vary in their breadth and complexity they should be completed in a timely manner. Lessons learned from practice reviews should be disseminated effectively and any recommendation arising should be implemented promptly so that the changes required result wherever possible, in adults being protected from suffering or harm in the future. Where possible lessons should be acted upon without necessarily waiting for the completion of the review.

Practice reviews are not inquiries into how an adult died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively to determine as appropriate.

Practice reviews are not part of any disciplinary process or inquiry relating to individual practitioners. Where information emerges during any practice review which indicates

disciplinary action would be appropriate, this should be undertaken separately to the practice review and in line with the employing organisations disciplinary procedures. These processes may be conducted at the same time but should be separate. In some cases it may be necessary to immediately evoke disciplinary action in order to protect other adults from harm or suffering.

Safeguarding other adults

When an adult dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority for local organisations should be to immediately consider whether there are other adults suffering or likely to suffer harm and therefore require safeguarding (family members, or other adults in the setting). Where such concerns exist local adult protection and safeguarding procedures should be followed.

Concise Reviews

A Safeguarding 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.

Extended Reviews

A Safeguarding 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 a potentially life threatening injury; or
- Sustained serious and permanent impairment of health.

Referring a Case for Consideration for a Practice Review

Any member of the Regional Safeguarding Board, any agency or individual practitioner supported by their line manager can raise a concern about a case which is believed to meet the above criteria. Advice may (though not essentially) be sought from the agency Board member prior to the referral.

The Regional Safeguarding Board Manager will be able to advise multi-agency professionals regarding the APR process and where there are any doubts regarding cases meeting the criteria.

All referrals should be made in writing using the relevant Board referral form. It is the responsibility for the referrer to collate all relevant information needed for the initial referral.

Advice, guidance and support can be provided to the referring agency (where this is not the Local Authority) by the designated Local Authority Safeguarding Lead and Regional Safeguarding Board Business Unit.

In order to inform the decision making and to assist in the scoping of any agreed Adult Practice Review, it is essential that the APR Sub Group is provided with accurate, succinct information with the required level of detail from all organisations. In Mid and West Wales, the Local Authorities hold a core role to support this process.

When a case is known to the Local Authority it is likely that the majority of information will already be held by them so where the referral does not originate from the Local Authority, the Local Authority Safeguarding Lead can support the referring agency in pulling together all appropriate information.

It is acknowledged that discussions in other forums such as Case Planning Meetings and Local Operational Groups may take place within a multi-agency context before a case is referred into the Regional APR Sub Group. Such discussions, however, should not prevent or act as a barrier to agencies making referrals directly into the Regional APR Sub Group. Accountability for decision making in relation to Adult Practice Reviews rests with the Regional APR Sub Group and the Executive Board Chair, as defined in Statutory Guidance.

Any debate, discussion and decision making in relation to any lessons to be learned and benefits from undertaking a Adult Practice Review is a matter primarily for the Regional APR Sub Group and the Executive Board Chair.

Where it is considered that a case meets the criteria for a concise or extended CPR as defined above, it should always be referred to the Regional APR Sub Group.

Any such referral should be directed to the Board Business Manager who will ensure the Chair of the Board and the relevant Statutory Director are informed. The referral should then be forwarded to the Chair of the APR Sub Group for its consideration.

All referrals should be and emailed to the Safeguarding Board Business Unit via cwmpas@pembrokeshire.gov.uk and will be allocated a regional designator e.g. CWMPAS ##/YYYY (Local Authority Area). This designator should be used for all further correspondence when referring to the case. The Regional Safeguarding Board Manager will then forward the referral to the Chair of the APR Sub Group for its consideration and review of the information.

The APR Sub Group's decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Executive Board by the Regional APR Sub Group Chair.

The Chair of the Board will inform the APR Sub Group of his or her decision as to whether the recommendation to hold an Adult Practice Review is approved and inform the Board. Should the recommendation for a 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.

In the event a referral to the Regional APR Sub Group identifies safeguarding issues that require immediate attention or action, it is the responsibility of each agency to ensure this is carried out.

The Role of the Regional Adult Practice Review Sub Group

The Regional Adult Practice Review Sub Group is a standing committee which oversees and quality assures all Adult practice reviews undertaken by the Regional Safeguarding Board and provides advice to the CWMPAS Board Chair as to whether the criteria for conducting a practice review is met.

This committee involves local authority representatives as well as representatives from all statutory partners.

The Regional Adult Practice Review Sub Group considers all cases referred for consideration for an Adult Practice review and makes a recommendation to the Board Chair on behalf of the Board in accordance with statutory guidance.

Where the Regional Adult Practice Review Sub Group considers that a case does not meet the criteria for either a Concise or Extended Adult Practice Review, it may recommend the case be considered at a local level by a Multi-Agency Professional Forum to enable them to take a more proportionate response than that required by an Adult Practice review. Local Operational Groups will be responsible for considering the recommendation to undertake a MAPF, which would be managed locally.

The Role of the Local Operational Groups

It is accepted that a case not being discussed at the Local Operational Group should not prevent or act as a barrier to agencies making referrals directly into the Regional APR Sub Group.

However, discussion within the multi-agency context at the Local Operational Groups may be considered appropriate and aid any scoping exercise for any relevant information. It will also enable local knowledge at a practitioner level to be shared in an open forum.

This may be particularly useful where cases are not clear-cut and further robust discussion is needed as to whether a case should be considered for referral into the Regional APR Sub Group.

Accountability for decision making in relation to Adult Practice Reviews rests with the Regional APR Sub Group and the Executive Board Chair, as defined in Statutory Guidance.

The Role of the Regional Safeguarding Board Business Unit

The role of the Regional Safeguarding Board Business Unit is to support the Regional Adult Practice Review Sub Group, Board Chair and Executive Board in their respective identified roles. The Regional Safeguarding Board Business Unit will be a central point of contact for all cases across the region in respect of cases referred for consideration for APRs. This will enable a clear audit trail to be developed across the region which can support the Board in

having regional oversight of referrals and outcomes; and to ensure learning from APR reviews are disseminated in a robust and timely manner.

The Regional Safeguarding Board aims and endeavors to promote and encourage a consistent threshold across the region in respect of referrals that are made into the Regional APR Sub Group.

The Regional Safeguarding Board Business Unit will have oversight of all MAPFs carried out across the region and will undertake an annual review of regional MAPF activity which will be reported within the Board's Annual Plan.

Multi-Agency Professional Forums

If a decision is made by the Regional Adult Practice Review Sub Group and upheld on behalf of the CWMPAS Board by the Board Chair that a Multi-Agency Professional Forum (MAPF) is the most appropriate review mechanism; responsibility for this process will lie with the relevant Local Operational Group.

MAPFs sit locally outside of the Adult Practice Review Sub Group and should be completed with three months. MAPF outcomes are not reported to the Regional APR Sub Group or to the Board via the APR Sub Group. Learning outcomes and how this learning will be disseminated locally will be reported by Local Operational Groups into the Executive Board via the Quality Assurance framework and LOG Chair report. If any local learning identified is considered useful regionally by the Board. The dissemination of learning on a regional basis will be considered and managed by the Regional Training Sub Group.

Parallel Reviews or Inquiries

There are a number of statutory responsibilities to review deaths and serious incidents across the multi-agency safeguarding partnership. These include, Domestic Homicide Reviews, provision of mental health services by Healthcare Inspectorate Wales following a homicide and Youth Justice Board Serious Incident Review.

In such cases the Regional Adult Practice 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 and timely way.
- Consider a joint review, or adding additional questions to the reviews terms of reference;
- > Ensure that the Interest of the Individual is always appropriately represented in other investigations of practice.
- Provide the Chair of the Board with a recommendation as to how to proceed in compliance with statutory guidance.

Complaints or Disputes arising from Practice Reviews

CWMPAS: The Mid & West Wales Safeguarding Adults Board will continue to follow guidance issued by Welsh Government 'Working Together to Safeguard People – Volume 3: Adult Practice Reviews' for processing regional practice reviews.

Any complaints or disputes received will be processed following the Board's complaints policy.

Annex List

- Annex 1 APR Process Flow Chart
- Annex 2 Referral to CWMPAS Adult Practice Review Sub Group for consideration to undertake an APR (Template)
- Annex 3 Recommendation to Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group (Template)
- Annex 4 Decision of the Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group (Template)
- Annex 5 Proposed Initial Outline of Review & Terms of Reference (Template)
- Annex 6 APR Report (Template)

Annex 1:

Practice Review Flowchart

Referrals will be initially managed by the individual organisation's governance & process In the event a case Threshold **Another forum** Individual professional or highlights Criteria for identifies case meets agency considers case meets referral NOT safeguarding **Adult Practice Review** criteria for Practice Review met, but learning issues that (APR) criteria – notifies notifies Board Manager needed require **Board Manager** immediate attention or action, it is Local/Internal the **Regional Safeguarding Board Manager:** MAPF to be responsibility carried out Records referral detail of each agency to **Notifies:** ensure this Board Chair, is carried Identified Line of regional out. Statutory Director, Sight learning Do not wait reported to o Regional APR Chair, and; Monitoring for the case **Board via** via Audit o LOG Chair. to follow the LOG **CPR** referral Chair's > Requests local information scoping process. report Collated information is returned to Board Manager by LOG Chair within 15 working days PR Sub Group consider case and make recommendation to Board Chair Decision upheld to undertake Multi-**Decision to commission Practice Review** Agency Professional Forum (MAPF) (Concise or Extended) upheld by Chair Statutory review process commences overseen by APR Sub Group and completed Passed to LOG Chair for completion of within 6 months, if possible. MAPF within 3 months (Taking account of criminal proceedings etc)

Annex 2:

to undertake an APR					
Ref: CWMPAS */2017 (**	******)		CWMPAS		
Subject's Initials:	DoB:	DoD/Incident:	Sal Wales Safeguardin		
From:		Date discussed at LOG:			
Date of APR Sub Group:					
Brief outline of Case/inc Please include the legal stat safeguarding action taken by	tus of person prior to	incident and any immediate remedial			
Rationale for Request.					

Any other relevant information	
Agencies involved in the case (E.g. Adults Services, Police, Probation, I Wales, Other.)	Health Board, Local Authority, WAST, Public Health
To be completed by referring agency:	
Name:	Designation:
Contact details:	

Annex 3:

Recommendation to Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group

From: xxxxx, Chair of the APR Sub Group	4
To: xxxxx, Chair of CWMPAS Executive Board	
Ref: CWMPAS */2017 (********)	afeguardi
Date of APR Sub Group:	
Brief outline of Case	
Recommendation	
The APR Sub Group has considered this case and recommends that it meets the criteria for:	ì
A Concise review	
An Extended review	
If the criteria are not met for the above reviews, what alternative review process will be undertaken:	
Multi-agency professional forum	
No review	
Alternative review process	
Please specify or detail alternative review process e.g. Domestic Homicide Review:	
	,

Decision	
Unanimous	
Majority	(Number balance of votes)
Rationale for Decision/Recommend This should include: Guidance criteria Range of reviews considered Alternative types of review considered How the needs of any other revie If majority decision – explanation	dered to meet the case needs w will be incorporated into the terms of reference

Annex 4:

Decision of the Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group

Re: CWMPAS */2017 (**************)



Date of APR Sub Group:

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: Chair Date: Telephone Number:	
In discussion with Chair of Sub Group Date information to be presented to MAWWSB Date information sent to Welsh Government	

Annex 5:

Proposed Initial Outline of Review

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

Re: CWMPAS */2017 (****************************)

Date of APR Sub Group:



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

-	<u> </u>			1				
0-6 months		6-12 mor	nths					
Rationale for time per	iod							
More than 12 months	3							
If more than 12 months rationale	As this is	outside time	frame recom	mende	ed in gui	dance p	lease spe	cify

(Include name and designation if known) Care Provider Police Probation Housing **Public** Local Health Health **Board** Wales Social **NHS Trust** Services Other Third Sector Safeguarding **Board** 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 Probation Housing **Public** Local Health Health **Board** Wales Social **NHS Trust** Services Other Third Sector Safeguarding Board Other (please specify if known or yet to be identified): Is the Chair independent in that they have had Yes No no involvement/oversight of the case? Rationale for choice of Chair:

Agencies involved in the case being reviewed

Terms of Reference for Concise / Extended Adult Practice Review

(Insert Reference for Review)

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

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine 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.

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 subgroup 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:
 - o terms of reference;
 - o disclosure of information;
 - guidance to the Review Panel on issues relating to interviewing individual members of staff.

Specific tasks of the Review Panel

- Identify and commission 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.

Information Sharing and Confidentiality

In working with sensitive information in relation to an adult practice review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:

- The Panel meeting is called under the guidance of 'Working Together to Safeguard People: Volume 3 Adult Practice Reviews' from the Social Services & Wellbeing [Wales] Act 2014.
- The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

- If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
- However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.

A statement of confidentiality will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared.

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

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

All Panel members will adhere to the principles of the Data Protection Act 1998 when handling personal information as part of the adult practice review process.

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 independ information):	ent reviev	ver plus a	any additi	onal

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 how this will be met	and £	£		
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 APR Sub-group Chair:				
Signature				
Title				
Date				
Telephone number				

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

For Welsh Government use only
Date information received
Date acknowledgment letter sent to Board Chair
Date circulated to relevant Inspectorates / Policy Leads

Annex 6:



Adult Practice Review Report



Mid & West Wales Safeguarding Adults Board

Concise/ Extended (delete as appropriate) Adult Practice Review

Re: CWMPAS */2017 (Local Area)

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 <u>learning point</u> arising in this case (including highlighting <u>effective practice)</u> accompanied by a brief outline of the <u>relevant circumstances</u>

(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)

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	
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 the prior to my involvement with this review:-		I make the following statement that prior to my involvement with this learning review:-	
 I have not been directly concerned the individual or family, nor have professional advice on the case. I have had no immediate line 		 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 had no immediate line management of the practitioner(s involved. I have the appropriate recognise 			
qualifications, knowledge and experience and training to under review.	take the	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. 		 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

	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				

Appendix 2: Summary timeline

For Welsh Government use only					
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			