Diogelu Gwent
Gwent Safeguarding

Adult Practice Review Report

Gwent Wide Adult Safeguarding Board
Extended Adult Practice Review

RE: GWASB 3 / 2019

Brief outline of circumstances resulting in the Review

An extended Adult Practice Review was commissioned by the Chair of the Gwent Wide Adult Safeguarding Board on the recommendation of the Joint Case Review Group in accordance with 'Working Together to Safeguard People: Volume 3, Adult Practice Reviews, Social Services and Well-being (Wales) Act 2014, following the death of a 48 year old women, who will be known hereafter as 'Ann' in accordance with her family's wishes.

Circumstances Resulting in the Review

An Adult Practice Review was commissioned by Gwent-wide Safeguarding Adults Board following the recommendations of the Case Review Group. Reviewers and Chair were identified at the Case Review Group however agreement was made to sequence this review in line with other Adult Practice Reviews therefore there was a delay in the start of this review.

Welsh Government were notified of the intention to commence this Adult Practice Review on the 19th September 2019. The completion of this report has been additionally delayed due to the Covid19 pandemic.

Ann was living with her Partner (Adult B) in the community they had lived together for 14 years. Ann had a Learning Disability and was Diabetic, she also experienced Anxiety and Depression; she had previously lived in supported living accommodation and had support services from both Health and Social Services Learning Disability Teams. Support Services ceased at Ann's request in 2004 after moving in with Adult B. Between 2004 and 2016 there were a number of safeguarding referrals raised by various agencies, these were primarily regarding Adult B's aggressive demeanour and controlling manner. On the occasions Ann

was spoken to she was deemed as having capacity to choose to live with Adult B and she declined intervention.

In June 2017 a further safeguarding referral was made by her G.P. Between June 2017 and February 2018 access to Ann was patchy, with a Physiotherapist and Occupational Therapist gaining some contact, but other staff being unable to gain access. As a result of the safeguarding concern, a joint Police and Social Services visit took place on 9th March 2018. Adult B was very aggressive towards Local Authority staff and only allowed the Police Officer into the property. The Police Officer briefly met Ann before Adult B became agitated and aggressive and demanded the Police Officer leave the property. Following this, further safeguarding measures were discussed and in April 2018 access was gained under an Adult Protection Support Order (APSO) under the Social Services and Well-being Act 2014. The APSO was used on the 10th April 2018 to gain entry to Ann. On this date a visit was made by Social Services and the Police. Social Services staff were able speak to Ann to assess her welfare and her wishes, and following a visit from the G.P. later the same day she agreed to be admitted to hospital. Ann remained in hospital from the date the APSO was served, until she sadly passed away on 28th April 2018.

Use of an APSO (Report included in appendix A).

The use of the APSO to gain access to Ann was good practice, as this provided an opportunity to meet with Ann for discussions to take place for disclosures to be made. Ann could be reassured that support was available for her to live outside of her home, away from Adult B. Contact with her family was re-established, and her voice was heard. Sadly, before further arrangements could be made she passed away. If this had not been the case plans for discharge would have been made, and Ann would have been supported to live in an environment away from Adult B. The panel recognised that this was the first time an APSO has been used in Wales, therefore further exploration of the process is included at the end of this report.

Ann as described by her family.

We visited Ann's Mother, Aunt, Sister and Daughter, in January 2020. During this visit we discussed a pseudonym for this report, and the name 'Ann' was chosen by her family. Ann was born in 1970, she was adopted at 3 months old. Ann attended a special school, and undertook college courses tailored to her ability. Ann later worked in a kitchen washing dishes. Ann had never lived independently. She met and married her husband, and they later moved to Wales to take on a business there. Ann and her husband had one daughter. When Ann's marriage to her husband ended due to domestic abuse, Ann was unable to care for her Daughter, and she went to live with her maternal Grandparents in England. Ann enjoyed social activities, craft work and going to clubs, she enjoyed being with people. Ann enjoyed family gatherings, and when she was able, she visited her family and daughter who live in England. Ann's family found visiting her hard at times, as Adult B was difficult and obstructive and would prevent access. Ann used to visit her family by train, and her daughter would travel to Wales. Ann's daughter would go and stay with her on occasions, however she found Adult B's behaviour overbearing. This made it difficult for her to be at the property, over time her

daughter was unable to visit due to Adult B's influence on Ann and because of his attitude to her family. Ann did however keep in touch with her family by phone, as much as she was able. Ann's family describe her as having a heart of gold and as everybody's friend. They also described Ann as childlike and vulnerable.

Time Period Reviewed.

The review time period is 29th September 2016 to 28th April 2018 this being a 19 Month period prior to Ann's death.

Practice and Organisational Learning

In undertaking this Review, we are grateful for the agency chronologies submitted and the information and time given by family members. We would also like to thank the professionals who attended the Learning Event.

It is noted that this Adult Practice Review has taken place sometime after the death of Ann and during the interim period it was acknowledged that changes to practice had already been made, such as the implementation of the Wales Safeguarding Procedures.

Themes and Learning Points

There were three overarching themes identified which have informed the learning points from this review.

- Working with antagonistic and uncooperative carers/families
- Primary Care Issues
- Use of Legislation, specifically: Social Services and Well-being (Wales) Act 2014, Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and the Mental Capacity Act 2005.

Theme 1 - Working with antagonistic and uncooperative carers/families

It is clear from the timeline and from practitioners at the learning event that Adult B acted in an obstructive and manipulative manner. He continually spoke for Ann and prevented practitioners from speaking to her and when they did it was very rarely on her own. This lack of access to Ann made it very difficult for practitioners to assess her situation, needs and wishes.

The GP records note that Ann had agreed that Adult B could contact the surgery on her behalf and all contact was through him. This was reflected by other practitioners who advised that contact was largely via Adult B.

Learning Points

- When a carer or family member is speaking on behalf of a person this should act as a trigger to consider further.
- Managing obstructive carers/families of adults at risk has a significant impact on assessment and support.
- Practitioners should be encouraged to find alternative methods of speaking privately to adults at risk.

Good Practice Example: Two Occupational Therapists in this case went to the property Adult B and Ann shared together. One of them asked Adult B a question that took him out of the room while the other spoke to Ann on her own. The Police stated that they also use this technique.

Adult B was at times verbally hostile, intimidating and abusive to staff from all agencies. He also threatened practitioners with complaints on numerous occasions. There were direct threats made to social workers but there was no physical violence. This information was not shared with the police through the safeguarding process. It is also unclear if there was sufficient detail in the information within the records for the police to act.

Learning Points

- Threatening behaviour has a detrimental impact on assessing the needs and providing care and support for an adult who may be at risk.
- It also raises issues about the impact on practitioners personally and professionally and how to ensure their safety.
- It would be helpful to convene a strategy meeting including the Public Protection Unit from police when threats are made to practitioners in safeguarding cases.
- In order for the police to act upon threats to practitioners they require detailed information about the incident to be able to decide on any suitable action. Raised awareness of the requirements and standard documentation for use within partner agencies would aid in obtaining police involvement where appropriate and necessary.

Good Practice Example: In Health there is an Area of Concern form that can be used when there are worries about behaviour.

The Regional Safeguarding Children Board has Multi Agency Guidance on Working with Hostile or Uncooperative Parents. However, there is no similar guidance for working with the families and carers of adults at risk.

Recommendation: The Regional Safeguarding Boards should provide multi-agency guidance on working with antagonistic and uncooperative carers and families of adults at risk.

Throughout the timeline Ann was seen as not engaging and or refusing services from various agencies. Given her willingness to accept help when it was offered to her personally, rather than these being decisions made by Ann herself it is felt that this was due to Adult B obstructing access, speaking for her and deflecting practitioners with feigned compliance and threats of complaints. An example was

the need for a level access walk in shower. The initial request was made in May 2017 but not completed until the September as Adult B variously refused access and made complaints about staff.

On several occasions due to a failure to speak to Ann she was written to and no response was seen as declining assistance. However at times Adult B demanded all communication be written and it was subsequently noted that he controlled all the mail in the home. There is also doubt, due to her learning disability, as to whether Ann would have been able to understand this written communication. Ann's daughter told us that Adult B would hide letters so Ann never saw them.

Learning Points

- Adults at risk with disabilities may be reliant on others to ensure their attendance at appointments and failure to attend may be due to the omission or actions of their carers/families.
- Consideration should be taken as to the most effective way to communicate with adults at risk particularly where there are concerns about their cognitive ability.

Good Practice Example: In child health there has been a move to use 'Was Not Brought' rather than 'Did Not Attend' when children fail to keep appointments. This is to reflect the fact that children are often not in a position to attend without the support of carers or family. Also, in children at risk, failure to attend appointments can be a deliberate ploy or a sign of neglect.

Recommendation: The Regional Safeguarding Boards should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.

Theme 2 : Primary Care Issues

This pattern seen by all agencies of Adult B controlling Ann's care was very clear in his interaction with her GP practice. His behaviour with practice staff was unreasonable. As a result the GP practice challenged Adult B about his behaviour and how it was not tenable to continue to discuss Ann's needs through him.
The GP practice has a policy for sharing patient information with relatives/carers and third parties. There was a clear note and flag in the medical record that Ann had given permission for Adult B to manage her health needs with the practice. There was no specific timescale for the review of this permission. Dealing with unreasonable relatives/carers representing patients was dealt with on a case by case basis but the practice felt that a policy in relation to this would be beneficial.
The GP recognised that there was persistent long term psychological and emotional abuse contributing to Ann suffering from anxiety and depression and it was impossible to help her individually because of the way Adult B controlled her. The GP consequently made a duty to report referral to social services in June 2017.
A change of GP practice was then instigated for Ann by Adult B after the original GP practice wrote to him about his unacceptable behaviour. There were concerns that this move was potentially detrimental to Ann as it was unclear how much information is shared when patients change GP practice. This is particularly important if there are ongoing concerns e.g. palliative care; safeguarding issues;

complex health needs.
It is important that when a patient changes GP practice that information about concerns related to them is transferred in a way that notifies the new practice. With the move to the electronic transfer of records this can be done by the use of flags and alerts that appear automatically in the GP record immediately on transfer. This relies on good quality practice records, the uniform use of this system and compatibility between GP IT systems.
The original GP practice had a clear flag on Ann's records that stated there was potential psychological abuse by her partner and contact information for the local social services team was included.

Learning points

- It is important to have a clear policy for sharing patient records. This must meet the requirements of the Mental Capacity Act. Where this is an ongoing agreement to allow a third party to manage a patient's medical care there should be a timeframe for it to be reviewed.
- It is important that concerns are clearly recorded in the patient record and that appropriate alerts/flags are consistently used.
- The use of warnings/flags in the GP record system to alert staff to concerns is particularly important when patients transfer practices.
- Alerts and flags should be shared as part of the electronic transfer of records
- It would be helpful for GP practices to have a policy for dealing with the unreasonable behaviour of relatives/carers representing patients.

Good practice Examples: There was an appropriate and good quality duty to report made by the GP practice in June 2017.
There was a flag/alert on Ann's records that warned of potential psychological abuse by partner and contact information for local social services team.
The GP Practice had a policy for sharing patient information with carers/relatives that included a flag on records that permission had been given to share information with a relative/carer.

Recommendation
Agencies to consider how they manage the sharing of information when patients/clients nominate someone else to co-ordinate their care.

Theme3 : Use of Legislation, specifically : Social Services and Well-being (Wales) Act 2014, Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and the Mental Capacity Act 2005.

The three acts, Social Services and Well-being (Wales) Act 2014 (SSWB), Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV) and the Mental Capacity Act 2005 (MCA) are important in this case. There was some good practice in relation to these pieces of legislation but it was also felt that at times there was a disconnect between them.
Due the complexity this case would have benefitted from the layering of these three pieces of legislation rather than each one being considered in isolation.

Social Services and Well-being (Wales) Act 2014

There were a number of referrals into social services over the period reviewed and prior to this. It does not appear that the case was ever closed to the local authority safeguarding team, although there is one report in September 2017 stating that it was. A factor in this case was the non-engagement with all services including the local authority. There is evidence of social services continuing observation and communication with other agencies and an effort to try and engage with Ann through a variety of means. However there were significant gaps between events.

There does not appear to have been a key worker until February 2018. It is noted that the updated Wales Safeguarding Procedures require a lead Co-ordinator and a Lead Practitioner.

In May 2017 a referral was made for a social work assessment due to Ann being bed ridden. It was decided to wait until after changes had been made to the home to aid Ann before this assessment happened. There had already been a number of referrals for Ann. Early intervention is important and an interim care package could have been put in place whilst this work was awaited.

Good Practice Example: Social Services Safeguarding Team involvement was not closed despite non-engagement and there were continuing efforts to speak to Ann.

In June 2017 following the duty to report an adult at risk referral made by the GP there was a strategy meeting. There does not appear to have been an outcome strategy discussion.

The Police Public Protection Unit (PPU) had not been invited to the Strategy meeting in February of 2018. This was an early opportunity for police with responsibility for adult protection to become involved.

Practitioners kept on trying to engage with Ann and were refused entry and there were concerns over hostile and abusive behaviour towards staff from Adult B. There was a joint welfare visit organised with social workers and a police officer. However the police officer was not one with responsibility for adult protection but a Crime and Disorder Reduction Officer (CADRO) and there was limited information shared about the safeguarding issues prior to this visit. PPU involvement in multi-agency discussions including on how to deal with these issues and provision of advice and guidance on utilising police resources would have been beneficial.

It is not routine for safeguarding concerns to be shared with the corporate safeguarding team or between community health teams. The District Nurses when they went in to provide episodes of care were unaware of the safeguarding concerns and that a duty to report referral to social services had been made. It was felt that this could lead to missed opportunities for community healthcare services to provide holistic care to vulnerable patients. When the APSO was being sought it was identified that Ann had not had her medical review and so a District Nurse was asked to visit to take bloods. The GP had asked the District Nurse to attend and they were unaware of the concerns regarding access and this was seen as a task to take bloods. A Health Care Support Worker attended. At the Learning event the District Nurse advised that had they been aware of the background and the

concerns they would have ensured that a qualified nurse undertake the visit so that they could carry out a more holistic assessment.

Welsh Community Care Information System (WCCIS) will allow some sharing of information across services. As this is implemented District Nursing and the community resource team will have access to the WCCIS as will four of the five local authorities in Gwent. This will provide a resource for routinely sharing more information across and between organisations.

Good Practice Example: In one local authority area Social Services and District Nurses meet on a weekly basis to talk through shared cases or concerns.

Regionally there is a move to implement local multi-agency hubs. These hubs will have links to District Nursing teams. It is expected that adoption of the WCCIS and the local hubs will improve information sharing.

Learning Points

- Social Services Safeguarding involvement was not closed despite non-engagement. There is guidance on the closure of cases due to lack of ongoing engagement by the adult at risk in the Wales Safeguarding Procedures.
- There needs to be a named key worker identifiable. The Wales Safeguarding Procedures have a clear requirement for a Lead Co-ordinator and a Lead Practitioner.
- The process for closing/delaying safeguarding process and the duty of care especially where there is non-engagement e.g. utilising interim packages of care needs further consideration.
- It is important that information regarding safeguarding concerns and duty to report referrals are shared within and across agencies to allow for the provision of holistic care.
- It is important that the relevant agencies are present at initial strategy discussion and subsequent strategy meetings. At the time of this case the duty to report process was different to the Child Protection Procedures. This has now been superseded by the Wales Safeguarding procedures which state that for adults at risk strategy meetings should include:
    - appropriate personnel with responsibility for adult protection in police and social services;
    - the practitioner making the report;
    - practitioners from services working with the adult at risk, their family and carers;
    - a doctor from the service who has/may be providing a medical examination.

The engagement of other practitioners will depend on the individual nature of the case

<u>Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015</u>

There had been previous concerns and referrals about Ann suffering from domestic abuse in all of her intimate relationships including with Adult B. Whilst continuing in this relationship was an unwise decision practitioners stated that Ann had capacity

to make this decision. Whilst repeated referrals and duty to report for Ann were in respect of domestic abuse there was not enough consideration to this pattern and for how long these concerns were raised.

Despite concerns about domestic abuse a risk assessment was not done for Ann. Practitioners were not able to speak to her on her own to assess the risk of domestic abuse. The Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool (DASH risk assessment) can be used without the potential victim present and may still indicate the need to act. There could have been consideration for whether coercive control was preventing Ann from making an independent decision about her circumstances.

There were concerns that Adult B's behaviour towards Ann was coercive control. This was expressed in previous referrals to safeguarding and was included in the GP duty to report referral.

At the learning event practitioners recognised that Adult B's behaviour was coercive and controlling. He prevented practitioners from gaining access to Ann and used aggression and complaints to services as a way of controlling access. Discussion with the family also revealed a long history of controlling behaviour by making access increasingly difficult. When they first started their relationship Ann would visit her family in England with Adult B. Over time they reported that contact became more limited and that the visits ceased. Ann's daughter continued to visit her but Adult B made her feel uncomfortable, and would follow her and prevent Ann from leaving the property. This pattern of behaviour meant that contact between Ann & her daughter was reduced to occasional phone calls, and at the point of her hospitalisation Ann had not seen her daughter for 4 years.

The offence of coercive control came into force on 29th December 2015 less than twelve months before the time period for this review. Awareness, understanding and training about this concept within agencies is a lot better today.

Early involvement of the PPU in this case would have afforded the opportunity to explore if a criminal prosecution of Adult B for coercive control was possible. This could occur as part of an Adult at risk strategy meeting.

Evidencing coercion is difficult. There is a difference between the information that may be gathered in an adult at risk investigation and the level of evidence required for a criminal prosecution. Training and guidance around identifying coercive control and gathering the relevant evidence required by the police would be helpful for all agencies.

Learning Points

- It is important that the relevant agencies are present at initial and subsequent strategy meetings
- Agencies need to be aware of the criminal aspects of coercion and control and how to provide information that the police will be able to use as evidence.
- Practitioners need to get into the habit of completing a risk assessment where they suspect domestic abuse
- Raising awareness and training is required around identifying, evidencing and

managing Domestic Abuse and Coercive Control and use of the DASH risk assessment.

Recommendation: Awareness and understanding of coercion and control, including how to provide the detail of information required for a criminal case, and use of the DASH risk assessment would be beneficial for front line staff.

Good Practice Example: Gwent Safeguarding Board has produced Supplementary Information for Practitioners: Coercive Control as an appendix to the Draft APSO protocol. This provides advice for practitioners.

Mental Capacity Act 2005 (MCA)

Ann's past history shows that she had a significant degree of learning disability (LD). She had previously been under local authority LD services but had withdrawn from these not long after moving in with Adult B. During the time period of the review practitioners were not clear as to whether Ann had a learning disability. It is not clear how she was lost to LD services and removed from the LD register. Social services only have ongoing records for people who are open to social services due to their disability.

Despite Ann's learning disability and concerns about Adult B's controlling behaviour there is no record of a mental capacity assessment until Ann was in hospital. There seems to be confusion over the MCA presumption of capacity and the need to assess capacity. The MCA does state, "The starting assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity". The two-stage test of capacity test is; "Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?" and "If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?"

Ann had a learning disability that meant that she had never lived independently and that constitutes an impairment of the mind or brain. There were also concerns about the decisions she was making. This should be a reason to question a person's capacity and to undertake an assessment. The MCA also says that "A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made." Where there is an impairment of the mind or brain this requires a formal assessment.

It appears that the lack of knowledge of Ann's LD led to practitioners feeling that she passed the two-stage capacity test and was consenting to her situation. The panel acknowledge that in this case the impact of Ann Learning disability was not fully explored. Over time her diagnosis had got lost and so the impact of this on her ability to make decisions was not always considered.

There were concerns at the learning event regarding how coercive control may affect an individual's mental capacity. It is accepted that coercive and controlling behaviour can impact on decision making and prevent a person from making their own choices. This can be due to adaptive behaviour caused by the coercion and

control or fear of potential punishment. However it is not seen as an impairment of the mind or brain, a disturbance affecting the way the mind or brain works or a mental health disorder and does not fall within the scope of the mental capacity act. Where someone does have the capacity to make decisions, but is experiencing coercion and control that may impair their decision making abilities the High Court can exercise its “inherent jurisdiction” but this is usually only done In extreme cases where there is a serious risk to life and all other legal and support avenues have been exhausted.

Good Practice Example: Gwent Safeguarding Board have produced Supplementary Information for Practitioners: Coercive Control as an appendix to the Draft APSO protocol. This provides advice for practitioners.

Learning Points

- It is important in adult LD to have a diagnosis and a level of disability to be able to consider capacity issues and plan care.
- There needs to be an improved process for the LD register both initially and for review to ensure that those needing continuing services or review are correctly identified.
- The MCA and capacity assessments should be used more widely and comprehensively.
- Capacity assessments should be done formally as required by the MCA and documented along with any subsequent decisions.
- Practitioners should be aware of when the “inherent jurisdiction” of the court may be helpful.

Recommendation: The Regional Safeguarding Board should consider how to raise the awareness and understanding of when to consider the inherent jurisdiction of the court in complex and serious cases.

Recommendation: The Regional Safeguarding Board should consider how to raise awareness and use of the MCA and capacity assessments.

In summary these are 3 key pieces of legislation. There was good practice in that Safeguarding maintained involvement. Had the safeguarding been viewed through a VAWDASV lens, with consideration of her capacity this may have supported agencies to intervene at an earlier stage.

Recommendation: Safeguarding training should include complex case examples to illustrate the importance of considering all the factors affecting adults at risk and how this relates to the relevant legislation.

Recommendation: The Regional Safeguarding Board should share this APR with the local VAWDASV Partnership Board.

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Improving Systems and Practice

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

RECOMMENDATION 1: The Regional Safeguarding Boards should provide multi-agency guidance on working with antagonistic and uncooperative carers and families of adults at risk.

RECOMMENDATION 2: The Regional Safeguarding Boards should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.

RECOMMENDATION 3: Agencies to consider how they manage the sharing of information when patients/clients nominate someone else to co-ordinate their care.

RECOMMENDATION 4: Awareness and understanding of coercion and control, including how to provide the detail of information required for a criminal case, and use of the DASH risk assessment would be beneficial for front line staff.

RECOMMENDATION 5: The Regional Safeguarding Board should consider how to raise the awareness and understanding of when to consider the inherent jurisdiction of the court in complex and serious cases.

RECOMMENDATION 6: The Regional Safeguarding Board should consider how to raise awareness and use of the MCA and capacity assessments.

RECOMMENDATION 7: Safeguarding training should include complex case examples to illustrate the importance of considering all the factors affecting an adult at risk and how this relates to the relevant legislation.

RECOMMENDATION 8: The Regional Safeguarding Board should share this APR with the local VAWDASV Partnership Board.

Appendix A – The use of the Adult Protection Support Order (APSO)

The Social Service and Well-being (Wales) Act 2014 which came into force April 2016 brought in comprehensive changes to safeguarding practice in Wales this included under part 7 (127) the use of an Adult Protection Support Order (APSO). This new civil order has to be obtained from the justice of the peace or judge and it enables an authorised officer to gain entry to the place a person who may be an adult at risk, resides.

An APSO can be requested when there is an inability to gain access to the person and there is reasonable cause to suspect the person is an adult at risk, and access is required in order that decisions can be made regarding any action that may need to be taken. The authorised officer has to demonstrate to the justice of the peace that the order is required. An APSO is a last resort option and all other avenues should be exhausted prior to making an application for an APSO.

Local authorities in Wales are required to appoint authorised officers under Part 7 of the Act and training was provided in 2016 by the Care Council Wales (now Social Care Wales) they also arranged online training and resources to enable skills to be kept up to date. The APSO process was new for everybody and as this was new legislation, it was unclear how often it would be needed.

The purpose of this report is to explore and identify learning and good practice following the first application and execution of an APSO in Wales.

The local authority applying for this APSO kindly agreed to discuss the process with us and provide feedback on both the challenges and areas that worked well, which has been included in our findings.

Welsh Government produced 'Working together to Safeguard People – Volume 4 – Adult Protection Support Orders guidance for practitioners' as a single point of reference for Local Authorities.

This guidance (1.19) advises that APSOs will be rarely sought. Applications should only made when less intrusive approaches have failed or are likely to fail.

An APSO was first considered in Ann's case because practitioners recognised that all contact was via Adult B and practitioners were unable to identify whether Ann was an adult at risk and had needs for care and support. Support regarding the APSO was gained from a senior manager of the local authority, who was not involved in the case, so was able to review circumstances objectively. She also had skills and links to legal services that were felt to be helpful in this case.

The triggers for consideration of the APSO were:

- Level of concern
- Number of times referred to safeguarding
- Concerns over capacity of Ann
- Inability to gain access to Ann

Authorised officers have a key role in scrutinising the decision making process prior to any application is made for an APSO.

The senior manager agreed with the safeguarding lead that a strategy meeting should be convened involving the APSO authorised officer from the local authority, this was in order that an APSO could be considered as one option. Appropriate challenge was given from the authorised officer as to whether all steps to speak to Ann had been exhausted. This is in line with guidance, with an APSO being 'a last resort option'. This led to the plan for staff to have another attempt to speak to Ann with police support, due to concerns over the behaviour of her partner, Adult B. This attempt again failed due to Adult B's obstruction.

Good practice example: Practitioners kept on trying to engage with Ann despite being refused entry. Concerns were identified regarding hostile and abusive behaviour towards staff from Adult B. A joint welfare visit was organised with social workers and a police officer. However the police officer was not one with responsibility for adult protection but a Crime and Disorder Reduction Officer (CADRO).

A review strategy meeting was held. At this meeting all present agreed that due to:

- the significant concerns
- the failure to speak to Ann despite multiple attempts including using experienced staff
- the fact that there was too much that was not known about Ann and her needs

Applying for an APSO was agreed to be appropriate.

Learning point

- Ensure everything has been done to attain access before applying for an APSO

Recommendation:
Involvement of the right police agency is critical to the response provided. Therefore there should be established links to agencies responsible for safeguarding.

Consideration also needs to be given by police agencies to alternative approaches

to the APSO such as coercive control, domestic violence and police and Criminal Evidence Act (PACE) legislation. Under new Wales Safeguarding Procedures, the Public Protection Unit will work more closely with the local authorities and other key agencies, offering a more cohesive approach. The new regional guidance, Gwent Adult Protection Support Order Protocol (Draft) document, includes a template to record police considerations and rationales on why the police consider alternative law is not appropriate (this information will be presented to a magistrate or judge as evidence if an APSO is sought).

In Ann's case there was detailed discussion about whether it was appropriate to inform the person who would be the subject of the APSO and their carers/relatives. This is in accordance Welsh Government guidance 'Working together to Safeguard People – Volume 4 – Adult Protection Support Orders' which advises that consideration should be given to issuing written notice to the occupier of the premises. If the authorised officer is concerned that giving notice may expose the person to potential harm, this information along with why the authorised officer has concluded this, should be included in the application.

Good practice example: in Ann's case the authorised officer was mindful of her safety being of paramount importance, and advance notice could be detrimental, so it was decided that no notice should be given and the judge agreed with this.

When the APSO process was initiated, the local authority identified that no internal processes had been written. Without internal policy or procedures being in place they compiled a guide to practice in readiness for the application.

The local authority felt that there was not sufficient "evidence" that the authorised officer had the authority to act on behalf of the local authority. Approved mental health practitioners have this explicit authority.

Learning point

- The authorised officer had a certificate confirming he had undertaken the training, the local authority solicitor felt this was not sufficient to assure the magistrate.

Having agreed that an APSO was required, the local authority decided that internal policies and a guide to practice were required. They also reviewed whether the authorised officer had sufficient evidence regarding being authorised in this role and whether the certificate was sufficient. They decided that there needed to be more robust evidence that the authorised officer was approved to act in this regard.

As the process unfolded the authorised officer put together a witness statement to present to the court in conjunction with the safeguarding lead, social worker, senior manager and solicitor. Witnesses can be asked to attend court, a statement was provided in lieu of this.

Good Practice example: in addition to the procedure and guidance compiled, the solicitor produced a summary explaining the legal framework of the APSO for the court, as the solicitor was aware that they would not have seen an application for one previously.

Learning point

- The solicitor stressed how important it is that this evidence is of sufficient detail and quality for the court. There has to be background and context for all the statements in the application and there has to be a case for every decision the court is asked to make, e.g. in this case using the APSO without notice to the subject or her partner.

- The solicitor's knowledge of the court process was crucial in that they provided guidance on the required standard of information that needed to be provided for the judge.

It is important that consideration is given to when the APSO will be executed and the length of time the APSO is required for. The judge required this detail.

The judge in Ann's case emphasised that it is important to remain focussed on the purpose of the APSO (a) to speak in private with a person suspected of being an adult at risk, (b) to enable the authorised officer to ascertain whether that person is making decisions freely, and (c) to enable the authorised officer properly to assess whether the person is an adult at risk and to make a decision as required by section 126(2) on what, if any, action should be taken.

The group planned the order from the perspective of being an opportunity to do a piece of social work or to build a relationship with Ann. However it was clear from the judge that the order was just a "power of entry" and was for a conversation only and that they could not ask for a "blank cheque". He said that they should just "go and find out" if any further actions were required. Once they had done this, it could be decided what action needed to be taken and the case could then be brought back to court if required. The judge or justice of the peace specifies how long the order lasts and how many times it can be used.

Learning point:

- It is important to remember that you are carrying out the APSO because you don't know what the situation is and the focus has to be on finding this out.

- You cannot plan any interventions in advance but you can consider what help and support may be needed and this should be on standby, if the situation requires swift action.

Prior consideration needed to be given to the length of time the order was required for and the specific purpose of the order being the opportunity to speak to Ann to ascertain if she was an adult at risk and to make a decision on what action, if any, should be taken.

Teamwork and planning is essential to support and prepare the authorised officer. The authorised officer stressed how important the preparation done by the team was for him to give evidence in court. He informed that he felt that applying for an APSO requires a multi-professional team approach and that this is essential for both supporting the authorised officer, particularly around the court process and getting the work done in the short time frame required.

The authorised officer requires a complex set of skills; the local authority felt that in order for the authorised officer to have the skills and knowledge to undertake this role they need to be an experienced senior member of staff and there should be certification documenting that the authorised officer is approved by the local authority. They also felt as only two authorised officers were trained in each local authority, it was important that the list of the authorised offices is kept up to date.

Learning point:

- APSO officers must have sufficient skills and knowledge to be able to provide challenge and scrutiny.

Welsh Government produced Working together to Safeguard People – Volume 4 – Adult Protection Support Orders, as guidance for practitioners and a single point of reference for local authorities. This document (1.9) details the skills and attributes required for the authorised officer.

The Gwent Adult Protection Support Order Protocol (Draft) document includes an 'appointment of authorised officer (APSO) form' which needs to be signed off by the relevant local authority, confirming the authorised officer has the relevant experience and training. There is also provision for an authorised officer to be appointed to work in another local authority in Gwent, if required. The same document advises that a list of authorised officers is kept by Welsh Government.

An APSO is not an emergency order. However given that it is the final option it is felt that there needs to be a level of urgency applied. If an application is delayed it may suggest to the court that it is not needed. The local authority would need to have agreed policy, procedures and processes in place in advance of an application to prevent any delay. An agreement is needed with partner agencies about prioritising this work for the same reason.

Recommendation:

An APSO application should be treated with the same urgency as a Mental Health 135 warrant, both in its preparation and the arranging of court time.

In this case it took about two weeks to get the application ready and one week for a court date. This included the writing of internal policies, it is expected that it should be quicker in the future, as the local authority now has policies and procedures in place, these include a draft order statement.

Agencies were aware that an application for an APSO was being made. It is important to plan for how the APSO will be carried out, by whom and when, prior to the court appearance.

Learning point

- Contingency planning such as having an advocate, ensuring there is appropriate transport and a place of safety available, should all have prior consideration along with any other professionals who may be needed. In this case the GP turned out to be an important attendee and this may need to be arranged in advance.

Good practice example:
The co-operation and team working with the GP practice and response by arranging an urgent assessment was essential in Ann's case. Positive feedback was provided from the other agencies involved in the APSO regarding this.

The Health Boards Corporate safeguarding team had not been involved, if they had been discussions would have taken place as to who would be best to lead from the Health perspective and they would assist in identifying the need for options such as hospital admission and ambulance transport, in turn providing more comprehensive approach.

Recommendation: Involvement of the Health Board Corporate safeguarding should be sought in all APSO applications.

The Authorised Officer would have liked to be able to state when there would be a multi-agency meeting to finalise arrangements.

This meeting would need to be arranged in advance, on the day of or day after the court attendance. This would ensure that the appropriate professionals would be available to agree and make any arrangements necessary for enacting the order. New guidance is included in the Gwent Adult Protection Support Order Protocol (Draft) and this advises that once the authorised officer has been granted the order, a multi-agency strategy meeting must be reconvened for the purpose of planning

and information sharing, where possible within 24 hours.

In Ann's case the order was executed the next day. The police attended and were able to secure access and assisted so that Ann could be seen on her own. Social services staff were able to speak to Ann for two hours and then to also return later the same day with the General Practitioner (GP).

Learning point:

- The authorised officer felt that it is important to consider where you can speak to the client without any potential undue influence present.

Ann was happy to speak to the social workers but was initially unhappy to leave her home. It was felt that she may not have been confident to leave because she was unsure about where she may go and how long she might be there. She agreed for social services to go back with a GP later that day and was happy to go to hospital when this was recommended. She was able to be taken to hospital by social services in a car.

Recommendation:

It is important to have a debrief after the APSO in a similar way to a practice learning event, to enable staff to discuss the process and the effect it has had on them as well as identifying areas for improving practice.

The Local Authority found that;

Overall the 'Working together to Safeguard People – Volume 4 – Adult Protection Support Orders guidance for practitioners' document was helpful. The authorised officer advised that they used this guidance as there 'go to' document when first being made aware of the potential for the APSO. The authorised officer found the guidance helpful and clear. They used this document as a reference to guide their practice when attending meetings and when sharing information with the wider adult protection team, as well as laying out the principles of the order for everyone, not just the authorised officer.

It would be useful to have a draft order to present to the judge for signing, as this is generally how the process in court works. The Solicitor drafted one for this case using other similar orders as a template.

Regional guidance would have been useful. The Gwent Adult Protection Support Order Protocol (Draft) regional guidance is now being developed. This APSO predated this guidance. This guidance includes certification, informs on training required, advises a list of authorised officer is maintained by Welsh Government, includes a pros and cons template and police consideration template. It also contains an information leaflet for the authorised officers to give out when they visit an individual, but his is not in easy read format.

It would also be useful to have information leaflets to give to the person involved and their carers/family, explaining the process written in clear and easy read language.
It would also be helpful to have leaflets for professionals, especially those from agencies outside of social services to explain and APSO and the process.

Recommendation:

The Gwent Adult Protection Support Order Protocol (Draft) regional guidance, should include an exemplar order, Information leaflets for professionals, and easy read information leaflets for adults at risk, families/carers.

References:

The Social Service and Well-being (Wales) Act 2014 Https://www.legislation.gov.uk/anaw/2014/4/contents

Working together to Safeguard People – Volume 4 – Adult Protection Support Orders guidance for practitioners
http://gov.wales/sites/default/files/publications/2019-05/working-together-to-safeguard-people-volume-4-adult-protection-and-support-order.pdf

The Gwent Adult Protection Support Order Protocol (Draft) regional guidance

Statement by Reviewer(s)	
REVIEWER 1	**REVIEWER 2**
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)* Nigel Farr	**Name** *(Print)* Claire Thomas
Date 10.08.21	**Date** 6/8/21

Chair of Review Panel (Signature) 	
Name *(Print)*	Ann Hamlet
Date	6/8/21

Adult Practice Review process

Adult Practice Review Process

The Gwent Wide Adult Safeguarding Board (GwASB) Chair notified Welsh Government on 9th September 2019 that it was commissioning an Extended Adult Practice Review.

Reviewer: Dr Nigel Farr, GP Lead, National Safeguarding Team, Public Health Wales

Reviewer: Claire Thomas, CHC Co-ordinator / ASPO Authorised Officer

Chair of Panel: Ann Hamlet, Head of Safeguarding, ABUHB

The services represented on the panel consisted of:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board
- Housing
- Welsh Ambulance Service Trust

The Panel met regularly from September 2019 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

A Learning Event took place in February 2020 and was attended by the following agencies:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board
- Housing

Family Members

Family members were informed that the review was taking place and meetings took place with Reviewers.

☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Appendix 1

Diogelu Gwent
Gwent Safeguarding

Terms of Reference for Extended Adult Practice Review

Core tasks

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

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

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.
- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.

- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel

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

- Timeline period is **1st June 2017 until date of death 28th April 2018**. Anything relevant prior to this period will be captured in the historical summary report.

- 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. **This should include the following:**

    - **Clarify if Ann had learning difficulties or a learning disability.**

    - **Identify episodes of coercive control in agency records.**

    - **Review all adult protection referrals and duty to reports.**

    - **Review the process and timeframe for the application and execution of an APSO**

    - **A genogram**

    - **Did Ann disengage or was she prevented from engaging with services?**

- 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.