



Adult Practice Review Report

North Wales Safeguarding Adults Board

Extended Adult Practice Review

Re: NWSAB1/2017/FCC

Brief outline of circumstances resulting in the Review

The criteria for adult and child practice reviews have been clearly referenced within the Safeguarding Board (Functions and Procedures) (Wales) Regulations 2015 (came into force April 2016)

Practice guidance for completing practice reviews have been issued under section 145 of the Social Services and Well-being (Wales) Act 2014 and adhered to during this extended practice review.

<http://www.northwalessafeguardingboard.wales/policies-and-procedures-adults/>

The reviewers, by following the above guidance have worked within the principles of transparency, multi-agency collaboration, lessons learnt, accountability and reassurance to individuals, families and public.

The purpose of the practice reviews was to clearly identify multi-agency learning for future practice. To this end, the two reviewers interviewed key practitioners, managers and senior officers involved in the care of Adult A exploring the detail and context of agencies' work with the individual and their family. These practitioners were also invited to a learning event and have fed into the shaping of themes, learning and action sets to strengthen practice and where possible acknowledge good practice.

Background:

Adult A was a resident of North Wales and lived in their own home with an adult son who was a registered carer. Based on Adult A's complex health /social care needs, Adult A was in receipt of direct payments for up to 43 hours a week (managed by the son who also acted as second carer).

Adult A was deemed not to have capacity, was bedbound and appears to have been dependent on carers for all health and social care needs.

There were significant contacts over the years between the family and statutory services (in particular, District Nurses, Social Workers, Occupational Therapists, Specialist Nurses and

General Practitioner).

There had, over the years been numerous safeguarding reports raised in relation to the domiciliary set up and, at times agency's ability to access the property (in particular District Nursing services). Within the time period reviewed (August 2016 – March 2017), four adult at risk reports were submitted to the host Authority's Safeguarding team by the District Nursing staff which highlighted anecdotal concerns in relation to suitability of the son to care for Adult A.

Over the last 12 months prior to Adult A's death, all agencies note there was significant deterioration in health resulting in a joint package of care under Direct Payments and NHS Continuing Health Care funding. Despite the concerns raised by agencies, Adult A's health and care needs were not formally reviewed by an MDT.

Adult A was transferred from home to a secondary care unit in England on the 7th March 2017 following multi-agency concerns in relation to the clinical presentation and sadly passed away in hospital on the 28th March 2017.

The cause of Adult A's death was attributed to Bronchopneumonia, secondary to cardiac enlargement due to left ventricular hypertrophy.

It is important to note that there is no evidence that Adult A's death was attributable to a direct result of abuse or harm.

Timeline under review:

Section 7.21 of the practice guidance indicates that timelines for review should focus on a maximum of 12 months preceding the incident. Whilst there is discretion within the guidance for extending this, the panel agreed that the review would commence from 1st August 2016 until Adult A's death 28th March, 2017).

(Rationale: August 2016 marked notable challenges in District Nurses gaining access to the property which resulted in a flurry of safeguarding reporting)

An Extended Adult Practice Review was commissioned by the Regional Safeguarding Adults Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Welsh Government practice guidance for Adult Practice Reviews.

<http://www.northwalessafeguardingboard.wales/policies-and-procedures-adults/>

The criteria for this review are met as:

- Adult A had been subject to an adult at risk referral prior to their death
- Additional level of scrutiny of the work of statutory agencies and the statutory plan (s) which was in place.

Practice and organisational learning

We are grateful for each agency for their valued and proactive contribution towards this review, and are confident that the views expressed within this report are directly attributed to narratives and views expressed during individual interview and during the learning event.

The chronologies received from each statutory agency involved in the case, along with the

information shared within individual interviews and subsequent learning events have identified five (5) main themes for practice and organisational learning.

Identification of five themes:

Theme 1 (a) : Care and support needs of Adult A:

1.0 With the exception of the District Nursing services, all agencies involved note that Adult A “always looked well cared for” and had no formal concerns in relation to the quality of care offered by the son and carers (although acknowledgment was made that there had been numerous changes in carers).

1.1 All agencies note that “what worked well” was their ability to ensure that Adult A was cared for at home (in line with Adult A`s wishes).

1.2 All agencies note that Adult A had no capacity, was bedbound, dependent on care for all needs, and had limited speech to communicate their needs and wants. Despite this, there does not appear to have been any formal review of Adult A`s capacity (with the exception of the GP leading to a best interest decision to admit under S5 of the MCA in March 2017).

1.3 Although reference is made to capacity assessment within the timelines and subsequent interviews, it is clear that agencies were not confident in their roles in assessing mental capacity (in line with the requirements of the MCA) – which culminated in Social Services manager offering advice to Adult A`s GP how to assess capacity and make a best interest decision to admit under Section 5 of the MCA.

1.4 There is no doubt that Adult A`s son undertook his role as second carer and managed the direct payments process.

1.5 No request (in line with the Mental Capacity Act 2005) was made by statutory agencies for a copy of the Power of Attorney to enable Adult A`s son to act with legal authority to make decisions about personal welfare/property and affairs.

<http://www.legislation.gov.uk/ukpga/2005/9/section/9>

1.6 No court of protection was in place for any individual to legally manage the finances of Adult A.

1.7 The Local Authority acknowledges that this case was “simmering along and on the radar for a few years”, with no clear nomination of a care coordinator and an admission that they may “have been lax in their approach to monitoring”. This was further aggravated by the fact that Adult A lacked capacity and was in receipt of 43 hours of Direct Payments a week and Continuing Health Care funding (20%).

1.8 Acknowledgement was made within the various interviews and learning events that there was

no coordination of care or formal MDT review of care needs during this period by any of the agencies involved.

1.9 Three weeks prior to Adult A being transferred to hospital, there seems to have been a flurry of concerns which forced a virtual MDT to review safeguards (not care and support needs) culminating in an emergency admission to hospital. At this stage Adult A was deemed clinically to be towards end of life.

Theme 1 (b): Review of care and support needs:

1.10 Within the timeframe reviewed, District Nursing services within BCUHB raised x4 adult at risk reports (enquiries) and sent them to the host Local Authority as the statutory lead.

1.11 **Episode 1:** During July 2016 concerns were raised by the District Nursing services that they were unable to access the property and review Adult A's pressure areas. There does seem to have been an adult protection strategy discussion – where a request was made to “put the referral on hold” whilst awaiting further information from the District Nursing Services (19th August). In addition, the Local Authority's Occupational Therapist was tasked to review Adult A's pressure areas during one of their planned visits whilst in September 2016, practitioners are advised the case has not met threshold.

1.12 **Episode 2:** During February 2017, concerns raised by District Nursing services concerned that Adult A's son was not allowing staff into the property. Historical concerns raised by District Nursing services that Adult A's son was not concordant with care being offered and was force feeding Adult A. Strategy discussion held 15th February and deemed not to meet threshold for adult at risk (action was for BCUHB to manage operational issues in house).

1.13 **Episode 3:** On the 1st March 2017, concerns were raised by District Nursing team that Adult A's son was using social media / “live stream” to seek clinical advice (globally) for treatment and management of a pressure sore on Adult A's sacral area. District Nursing staff became increasingly concerned when son informed them he had purchased equipment to debride a Grade 4 pressure ulcer on Adult A's sacral area. District Nurses claim, that based on the clinical appearance of the pressure ulcer that the area had been subject to recent debridement. There are significant anomalies within documentation in relation to whether Adult A's son offered admission that he had debrided Adult A's Grade 4 pressure sore or whether this had in fact been attributed to some of the topical ointment that had been prescribed. For the purpose of the review, staff interviewed were able to physically offer minutes of the safeguarding meetings which do not offer an admission – but clearly recall a multi-agency meeting where Adult A's son verbally indicated he had in fact undertaken debridement of the area.

1.14 **Episode 4:** On the 6th March, 2017 concerns were raised by the District Nursing services about son's approach to caring duties (allegations of unsafe practice/forceful practice or straightening contracted limbs, speaking in a derogatory way to Adult A). Agreed threshold met – discussed at a strategy meeting on 13th March, 2017

1.16 The reviewers wish to note, that from a safeguarding perspective, it is evident that all the risk assessments reviewed as part of the adult safeguarding process have focussed on the safety of the District Nurses (double handed visits) and their relationship with Adult A's son rather than the wellbeing and safety of Adult A.

1.17 This approach was not questioned within the four concerns raised with the Local Authority - nor was a trigger made to review the care package through a multi-disciplinary meeting. This is further highlighted in the strategy discussion which took place on the 6th of March where risk

reduction strategies were noted as continued support from District Nursing services / consideration of admission to hospital / require place of safety? (No action for MDT/ discussion with son). When this theme was discussed in the individual interviews, the District Nursing services noted that they “did the best we could at the time based on what we knew... It’s a valid point as to what consideration was given to the patient and not the son”...

1.18 All agencies agree that Adult A was elderly and deemed not to have capacity. From the records reviewed, and the subsequent learning event, there is no evidence of a best interest meeting (nor access to IMCA) to review care package and review the safeguards in line with the requirements of the code of practice for the Mental Capacity Act.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mentalcapacity-act-code-of-practice.pdf

1.19 Multi-agency communication in relation to assessing the care and support needs of Adult A were not robust, resulting in no care coordination or review of a rapidly declining individual. As part of the learning from this case, all agencies acknowledged that in trying to appease the son, the voice of Adult A was lost.

Theme 2 : Initial assessment of risk for Adult A`s son

2.0 All agencies note within their timelines, individual interviews and learning event that the relationship between Adult A`s son and some core services (in particular District Nursing services) were fraught and at times broken.

2.1 The Local Authority note that Adult A`s son was offered a carers assessment in 2012 but declined.

2.2 The Social Services and Wellbeing (Wales) Act clearly notes within **Part 3** (sub section 24, 25) the duty to assess the needs of a carer for support. Where a local authority has been discharged from its duty under section 24 by a refusal under this section, the duty is reengaged if the local authority considers that the carer's needs or circumstances have changed.

<http://www.legislation.gov.uk/anaw/2014/4/contents>

2.3 Arguably, the visible deterioration of Adult A in 2017, accompanied by challenging behaviour from Adult A`s son towards professionals may indicate stressors of being a carer.

2.4 Verbal responses from Local Authority note that Adult A`s son could at times be derogatory towards women and clearly “hated District Nurses with a passion”, which led to expletive language and comments towards individual members of staff.

2.5 The District Nursing Services appear to have exhausted their approaches to defuse the situation but clearly communication had broken down (leading to a senior manager to attend the address to set expectations). It is clear, despite this meeting that there was no apparent improvement in the relationship between Adult A`s son and the District Nurses.

2.6 No baseline standard of behaviour was offered to Adult A`s son (i.e. zero tolerance to aggressive outbursts/ expletive language) and it is clear through the review process that the District Nurses risked burnout from this particular case as they were clearly intimidated by Adult A`s son.

2.7 The risk assessment for Adult A`s son`s relationship with the District Nurses were mitigated by doubling up on calls (for the witness purposes) rather than formally setting ground rules and expectations – resulting in daily friction and episodes where entry to the house was (for various reasons) denied

2.8 There does not appear to have been any formal /informal record of supervision in place for the

District Nursing team when dealing with complex cases, and the reviewers note concern that some staff may still be traumatised by this case.

2.9 Concern by District Nursing services in relation to inappropriate comments between Adult A and the son was dismissed during the individual interviews as “family banter” rather than inappropriate comments towards mum. (N.B professionals noted that as dementia progressed “Adult A didn’t understand the “banter” resulting in confusion in relation to whether or not comments had in fact caused offense as suggested by the District Nurses).

2.10 In the absence of information from Adult A’s son, we can only surmise that, despite the fact District Nurses note they knocked on doors, and called out prior to entry to the property that this was perceived as an invasion of privacy/ human rights by Adult A’s son.

Theme 3: Escalation of concerns

3.0 Four safeguarding reports were generated by District Nursing services within the seven month timeframe of this review. Whilst it is clear that the host authority felt that thresholds had not been met, the duty to assess the needs of an adult for care and support under

Part 3 (sub section 17) of The Social Services and Wellbeing (Wales) Act was overlooked by all agencies. <http://www.legislation.gov.uk/anaw/2014/4/contents>

3.1 The reviewers were concerned to learn (anecdotally) during the interview process that, although individual case holders were accountable for their own practice, the escalation process in relation to peer support, advice and guidance was not always present.

3.2 The reviewers were presented with a picture of depleted District Nursing services, isolated from management with “*no time to document everything*” and tolerated abusive comments from families rather than challenge and “face a complaint”.

3.3 The adult safeguarding process was at times used as a tool by District Nurses to escalate their concerns in relation to the son’s behaviour.

3.4 Concerns appear to have been “*simmering*” for a while with no clear ownership or review of the care package. This led to anecdotal concerns resulting in an urgent admission to hospital for medical review (X-rays) to rule out fracture and potential safeguarding issues (which were not proven).

3.5 Contact made between the GP and Out of Hours (prior to the admission of Adult A) suggests lack of understanding in relation to adult safeguarding practice. The GP has recorded within the timeline, that Mental Health cases and children took priority and discussions in relation to Adult A’s admission should be made the next working day (i.e. it was not deemed an emergency situation). During interview with the managers from the Local Authority, the reviewers were advised that this is reflected within the Standing Operating Procedure /Service Level Agreement for the OOH service which an emergency service is dealing in the main with Child protection, Adult protection and Mental Health Act assessments.

3.6 No clear process in place in relation to non-access to a clients’ home.

3.7 Confusion (from District Nursing services) in relation to escalation of concerns in relation to care package, communication and triggers for safeguarding alerts (including definition of an adult at risk).

Theme 4: Dealing with (perceived) difficult people:

4.0 During the interviews with key staff, it is clear that all agencies were aware of significant communication issues between District Nursing Services and Adult A’s son which may have

deflected the focus of multi agencies towards appeasing the son rather than focussing on Adult A`s health and social care needs.

4.1 Clear absence of formal training to manage difficult people (some of which are only available via e-learning).

4.2 No forum to discuss/share practice for difficult cases.

4.3 No formal supervision in place within BCUHB to discuss complex/difficult cases resulting in risk of burnout for some staff (who become desensitised by the experience)

**Theme 5: Handover at the Secondary Care Hospital (outside BCUHB catchment area)
Events leading up to the admission :**

5.0 Following a capacity assessment and a best interest decision that Adult A needed to be admitted to hospital, and in the absence of anyone with lawful authority to make the decision, Adult A was admitted to a secondary care hospital in England for a full assessment under Section 5 of the Mental Capacity Act based on *“potential injury to knee with cracking sound heard witnessed by District Nurse... Need to act immediately to fully assess in place of safety”*. This admission was supported by the GP, District Nurse and Social Worker based on risks identified with a detailed summary of the rationale:

“Lack of cot sides and risk of fall/injury, rough manual handling witnessed by DN, wet pads and dressings on pressure area at risk of infection.

Allegations made by DN that no signs of regular carers in attendance to vulnerable lady with nursing needs, and (Adult A`s son) boasting about holidays, drug use. Aggressive towards DN and they report verbal aggression “ (towards Adult A)

5.1 The GP, District Nurse and Social Worker agreed to visit Adult As home to advise son of admission under MCA. In addition, an ambulance was called and a 999 call made to North Wales Police to support should Adult A`s son become hostile or aggressive *“(Adult A`s son) “was raising his voice and becoming agitated...was intimidating but made no physical threats”*.

5.2. There is clear reference within the GP records that Adult As son did not agree with the rationale for admission and was concerned that Adult A would be admitted to the nearest DGH. To address the needs of the son, the GP arranged Adult A would be admitted to a secondary care hospital in England.

5.3 There is no evidence that a transfer of care documentation was presented on admission to the secondary care hospital in England. One of the main themes from this review is the lack of a care coordinator for complex cases for clients who lack capacity where there is multi-agency interface (i.e. had Adult A been admitted under the MHA – an AMPH would have offered comprehensive documentation and handover to ensure staff were fully briefed).

From interviewing staff, it has been confirmed that a verbal handover was offered by the Social Worker and GP to the secondary care lead. This handover was then transferred 3rd and 4th hand via nurses in the secondary care hospital from A&E to the wards where Adult A was nursed. We understand from the individual practitioner in interviews and the learning event that the role out of Adult Nursing documentation across BCUHB will ensure transfer of care documentation/communication is shared when individuals have new episodes of care.

5.4 No single point of contact for handover of Adult A which led to confusion in relation to rationale for admission resulting in one of the wards *“feeling as if they didn`t have clear communication”* resulting in a build up of information that was at best *“drip fed”* over a period of time.

5.5 Anecdotal concerns from Social Services in relation to risk to staff and request for security to be in attendance were initially put in place whilst Adult A was in Emergency Department and the son was supervised by both a nurse and a security guard.

5.6 Once Adult A's condition had been established, an initial meeting was held between the hospital's safeguarding lead and the nurses on the wards to establish facts and agree a plan of action.

5.7 There is no doubt within the recorded information available and verbal updates offered by the secondary care hospital in England that Adult A's son was at times challenging to manage. However, when Adult A's son demonstrate challenge to the nursing staff and raised his voice /shouting, this was immediately escalated to senior nurses who met with the son and set clear boundaries based on acceptable standards of behaviour. When Adult A's son became challenging (i.e. refusing to comply with the ground rules/physically recording nursing practice and personal care on a mobile phone), security was alerted and escorted the son from the ward. It would appear, as part of the learning event, that this is the first time staff had drawn clear boundaries between agencies and Adult A's son.

5.8 Safeguarding process was instigated upon arrival with a strategy discussion to further support fact finding and a review of the risks. Whilst this is reported as best practice, some of the agencies interviewed were clear that invitations to attend the strategy discussions were sent to managers (who were not briefed on the case) and by- passed the practitioners.

5.9 The safeguarding team at the Secondary Care Hospital acknowledged during interviews, submission of timelines and the learning event that there was an apparent lack of understanding in relation to MCA/Best interest process and functions prior to admission from primary and community services.

Improving Systems and Practice

Recommendations: (as agreed within emerging themes noted within the learning event)

Recommendation 1a:

Regional Adult Procedures Group to develop multi-agency guidance for managing challenging families and carers.

Recommendation 1b:

Each Local Authority and BCUHB to review their training in relation to conflict management techniques for front line staff and supervisors (front line approach to defusing challenging situations with families and carers) .

Recommendation 2:

BCUHB to ensure their practitioners and independent contractors have received training to ensure that they are aware of the principles of the Mental Capacity Act (including awareness of the code of practices for best interest meetings, power of attorney, court appointed deputies, and general

powers within the Act itself)

Recommendation 3:

Safeguarding strategy discussions should as a minimum include detail of agency risk assessment and protection plans where there have been significant concerns raised about an adult at risk (these plans should clearly note how agencies plan to mitigate risks).

Recommendation 4:

4a Local Authorities to have clear process in place for the review of direct payments offered to long term complex cases. This process should clearly detail the review and management of direct payments when there is an increased need of additional hours.

4b As part of direct payment programme, Local Authority to develop a screening process of the main carer's suitability to care for complex clients where there are significant health care needs (including evidence that full consideration is offered for cases of carer breakdown and how this manifests).

Recommendation 5:

5a BCUHB and Local Authorities to agree on a process for reviewing joint packages of care to ensure those who have increased needs /complexities are formally reviewed by an MDT – including where appropriate completion of Decision support tool. This process should clearly identify the lead agency (care coordinator)

5b For episodes where frequent concerns are raised, as a minimum a professionals meeting should be held to identify options for the MDT.



Recommendation 6:


BCUHB to develop a clear process for formal management and clinical Supervision of their staff, ensuring they're supported in escalating concerns and reduce risk of burn out with complex cases. Where there are concerns that staff are not confident in their approach to safeguarding complex cases the corporate safeguarding team should support bespoke training /offer peer support and supervision.

Recommendation 7:

BCUHB to identify a lead officer to ensure full implementation of the failed access policy for community services across the region.

Statement by Reviewer(s)			
REVIEWER 1	Eleri Lloyd-Burns Head of Nursing – Safeguarding Adults Betsi Cadwaladr University Health Board	REVIEWER 2 <i>(as appropriate)</i>	Jo Ramseur Williams Detective Superintendent/Head of PVPU North Wales Police
Statement of independence from the case <i>Quality Assurance statement of qualification</i>		Statement of independence from the case <i>Quality Assurance statement of qualification</i>	
<p>I make the following statement that prior to my involvement with this learning review:-</p> <ul style="list-style-type: none"> • I have not been directly concerned with the individual or family, nor have I given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. 		<p>I make the following statement that prior to my involvement with this learning review:-</p> <ul style="list-style-type: none"> • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. 	

Reviewer 1	Reviewer 2
(Signature) 	(Signature) 
Name Eleri Lloyd-Burns	Name Joanne Ramessur-Williams
Date 06/06/2018	Date 07/08/2018

Chair of Review Panel	
(Signature)	
Name	Charlotte Walton
(Print)	
Date	21/08/2018

Appendix 1: Terms of reference **Appendix 2:** Summary timeline

Adult Practice Review process
<p>The host Local Authority presented a case for an Adult Practice Review to the Adult Practice Review Group on the 8th of May, 2017.</p> <p>The Adult Practice Review group accepted that the criteria for an extended adult practice review had been met and advised the Chair of the Regional Safeguarding Adults Board (who agreed and notified Welsh Government).</p> <p>In line with national Practice guidance for completing practice reviews, a multi-agency <i>Review Panel</i> was established to manage the review and appointed two reviewers (representing Betsi Cadwaldr University Health Board and North Wales Police).</p> <ul style="list-style-type: none"> • The panel which consisted of the two reviewers, representation from agencies involved and Chair met on the 21st August 2017 to discuss terms of reference and outline basic parameters (timeline for chronologies of agency contact, provisional date for learning event, date for provisional completion). • A letter was sent via recorded delivery to Adult A`'s son, inviting him to meet with the reviewers on the 2nd of November 2017 (failed to attend).

• Interviews were held on the 9th of November with professionals who had been directly involved in the care and support of Adult A.

• A second session was offered on the 30th November for those unable to attend the 9th and for further clarification from District Nursing services.

• A learning event was held on the 4th December and was well attended by all agencies.

• Unfortunately it was not possible to interview the GP due to long term sickness absence.

Family declined involvement

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	<input type="checkbox"/>	<input type="checkbox"/>	
Estyn	<input type="checkbox"/>	<input type="checkbox"/>	
HIW	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Constabulary	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Probation	<input type="checkbox"/>	<input type="checkbox"/>	

Appendix 1: Terms of reference

(Adopted from Annex 2: Terms of reference for concise and extended reviews – an exemplar)
<http://www.northwalessafeguardingboard.wales/wp-content/uploads/2015/09/161123guidanceen.pdf>

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

Core tasks

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

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

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.
- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses.

