

North Wales Safeguarding Adults Board



Adult Practice Review

Date ratified	Sept 2018
Review Date	Sept 2018

1.0. Context

1.1. This protocol has been developed to clarify the working arrangements for Adult Practice Reviews within the North 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 North 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
- 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
- Local Practice Delivery Groups (LPDGs) Joint Terms of Reference

2.0. The Purpose of Practice Reviews

2.1. In accordance with The Safeguarding Boards (Functions and Procedures) (Wales) 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.

2.2. 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.

2.3. 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.

2.4. 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.

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

3.0. Safeguarding other adults

3.1. 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.

4.0. Concise Reviews

4.1. 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.

5.0. Extended Reviews

5.1. 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.

6.0. Referring a Case for Consideration for a Practice Review

6.1. 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.

6.2. 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.

- 6.3. 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.
- 6.4. 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.
- 6.5. 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 North Wales, the Local Authorities hold a core role to support this process.
- 6.6. 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.
- 6.7. It is acknowledged that discussions in other forums such as Case Planning Meetings and Local Practice Delivery 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 Board Chair, as defined in Statutory Guidance.
- 6.8. 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 APR as defined above, it should always be referred to the Regional APR Sub Group.

- 6.9. Any such referral should be directed to the Board Business Unit 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.
- 6.10. All referrals should be and emailed to the Safeguarding Board Business Unit via Regionalsafeguarding@denbighshire.gov.uk and will be allocated a regional designator e.g. *NWSAB (APR No.)2017/Local Authority/Organisation*. 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 Board by the Regional APR Sub Group Chair.

- 6.11. 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.

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

7.0. The Role of the Regional Adult Practice Review Sub Group

- 7.1. 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 NW Board Chair as to whether the criteria for conducting a practice review is met.
- 7.2. This committee involves local authority representatives as well as representatives from all statutory partners and the independent sector.
- 7.3. 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.
- 7.4. 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 Practice Delivery Groups will be responsible for considering the recommendation to undertake a MAPF, which would be managed locally.
- 7.5. The Regional Adult Practice Review sub group jointly with the Local Practice Delivery Group will also monitor the implementation of the action plans following the completion of the review. The action plan will be presented at the Adult Practice Review sub group at the following stages:
- Two months.
 - Six Months.
 - Ten Months.
 - Four Months
 - Eight Months
 - Twelve Months
- 7.6. If the action plan is not complete after twelve months, an update will be provided to the Regional Safeguarding Adults Board, who will agree a timescale for completion. No action plan will remain uncompleted beyond two years.

8.0. The Role of the Local Practice Delivery Groups

- 8.1. It is accepted that a case not being discussed at the Local Practice Delivery Group should not prevent or act as a barrier to agencies making referrals directly into the Regional APR Sub Group.
- 8.2. However, discussion within the multi-agency context at the Local Practice Delivery Groups maybe 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.
- 8.3. 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.
- 8.4. Accountability for decision making in relation to Adult Practice Reviews rests with the Regional APR Sub Group and the Board Chair, as defined in Statutory Guidance.

- 8.5. The Local Practice Delivery groups will take the lead in the coordination of MAPF process.
- 8.6. The Local Practice Delivery groups will monitor the implementation of action plans in relation to that Local Authority area at each meeting.

9.0. The Role of the Regional Safeguarding Board Business Unit

- 9.1. The role of the Regional Safeguarding Board Business Unit is to support the Regional Adult Practice Review Sub Group, Board Chair and 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.
- 9.2. 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.
- 9.3. 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.

10.0. Multi-Agency Professional Forums

- 10.1. If a decision is made by the Regional Adult Practice Review Sub Group and upheld on behalf of the NW 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 Practice Delivery Group.
- 10.2. MAPFs sit locally outside of the Adult Practice Review Sub Group and should be completed within three months. MAPF outcomes are 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 Practice Delivery Groups into the Board via the Quality Assurance framework and LPDG Chair report.

11.0. Parallel Reviews or Inquiries

- 11.1. 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.
- 11.2. 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.
- 11.3 In some cases, it will be appropriate for the APR/CPR panel to request a completed internal review/SUI before making a final decision regarding whether to commission a full practice review

Complaints or Disputes arising from Practice Reviews

NWSAB: The NW 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.

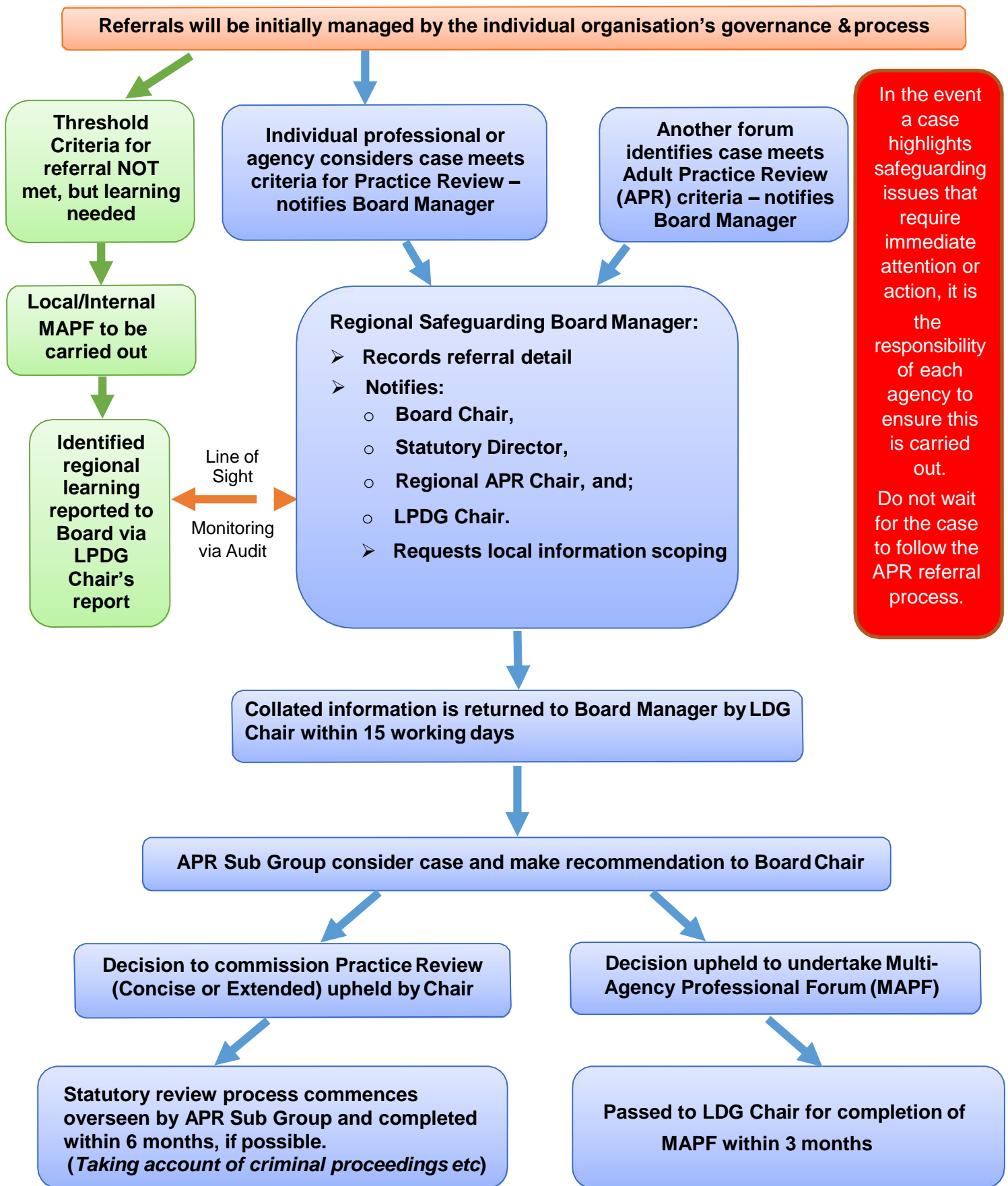
Any complaints or disputes received will be processed following the Board's complaints policy.

Annex List

- **Annex 1** APR Process Flow Chart
- **Annex 2** Referral to NWSAB Adult Practice Review Sub Group for consideration to undertake an APR (Template)
- **Annex 3** Recommendation to Chair of NWSAB Regional Safeguarding Adults Board from NWSAB Adult Practice Review Sub Group (Template)
- **Annex 4** Decision of the Chair of NWSAB Regional Safeguarding Adults Board from NWSAB 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



Annex 2:

Referral to NW Adult Practice Review Sub Group for consideration to undertake an APR

Ref: LA */2017 (***)**

Subject's Initials:

DoB:

DoD/Incident:

From:

Date discussed at LPDG:

Date of APR Sub Group:

Brief outline of Case/incident

Please include the legal status of person prior to incident and any immediate remedial safeguarding action taken by relevant agencies.

Rationale for Request.

Any other relevant information

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Agencies involved in the case

(E.g. Adults Services, Police, Probation, Health Board, Local Authority, WAST, Public Health Wales, Other.)

To be completed by referring agency:

Name:

Designation:

Contact details:

Annex 3:

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

From: xxxxx, Chair of the APR Sub Group

To: xxxxx, Chair of CWMPAS Executive Board

Ref: LA */2017 (*****) 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:
A Concise review <input type="checkbox"/>
An Extended review <input type="checkbox"/>
If the criteria are not met for the above reviews, what alternative review process will be undertaken:
Multi-agency professional forum <input type="checkbox"/>
No review <input type="checkbox"/>
Alternative review process <input type="checkbox"/>
<i>Please specify or detail alternative review process e.g. Domestic Homicide Review:</i>

Decision

Unanimous

Majority

(Number balance of votes.....)

Rationale for Decision/Recommendation

This should include:

- *Guidance criteria*
- *Range of reviews considered*
- *Alternative types of review considered to meet the case needs*
- *How the needs of any other review will be incorporated into the terms of reference*
- *If majority decision – explanation and outcome.*

**Decision of the Chair of NW Regional Safeguarding Adults Board
from NWSAB Adult Practice Review Sub Group**

Re: **LA */2017 (*****)** Date of

APR Sub Group:

<p>I agree with the recommendation</p> <p>I agree with the recommendation with the following amendments:-</p>	<input type="checkbox"/> <input type="checkbox"/>
<p>I disagree with the recommendation</p> <p><i>If disagree, reasons why and proposed action:-</i></p>	

Signature:

Title: Chair

Date:

Telephone Number:

In discussion with Chair of Sub Group

Date information to be presented to NWSAB

Date information sent to Welsh Government

Proposed Initial Outline of Review

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

Re: NW */2017 (***) Date of
APR Sub Group:**

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

0-6 months	<input type="checkbox"/>	6-12 months	<input type="checkbox"/>
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Rationale for time period

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More than 12 months	<input type="checkbox"/>
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<i>If more than 12 months - As this is outside timeframe recommended in guidance please specify rationale</i>

Agencies involved in the case being reviewed

(Include name and designation if known)

Care Provider	<input type="checkbox"/>		Police	<input type="checkbox"/>	
Housing	<input type="checkbox"/>		Probation	<input type="checkbox"/>	
Local Health Board	<input type="checkbox"/>		Public Health Wales	<input type="checkbox"/>	
NHS Trust	<input type="checkbox"/>		Social Services	<input type="checkbox"/>	
Other Safeguarding Board	<input type="checkbox"/>		Third Sector	<input type="checkbox"/>	
Other (please specify if known or yet to be identified):		<input type="checkbox"/>			

Agency identified to Chair Review Panel

(Include name and designation if known)

Care Provider	<input type="checkbox"/>		Police	<input type="checkbox"/>	
Housing	<input type="checkbox"/>		Probation	<input type="checkbox"/>	
Local Health Board	<input type="checkbox"/>		Public Health Wales	<input type="checkbox"/>	
NHS Trust	<input type="checkbox"/>		Social Services	<input type="checkbox"/>	
Other Safeguarding Board	<input type="checkbox"/>		Third Sector	<input type="checkbox"/>	
Other (please specify if known or yet to be identified):		<input type="checkbox"/>			

Is the Chair independent in that they have had no involvement/oversight of the case?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<i>Rationale for choice of Chair:</i>				

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 sub-group 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:
 - terms of reference;
 - 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	<input type="checkbox"/>	No	<input type="checkbox"/>
Is the name and designation of independent reviewer known?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes please state nominated designation of independent reviewer plus any additional information):				

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 reviewer and how this will be met	£
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Additional costs identified (if known). Please specify:	£
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Date of First Review Panel meeting
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Will the report be completed within Guidance timeframe? <i>i.e. 6 months from date of referral</i>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Please identify any issues that may impact on the timeframe and how these will be managed:- <i>Include issues such as:- Criminal prosecution / Coroner's decision</i>
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Anticipated completed report date
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To be completed by APR Sub-group Chair:

Signature

Title

Date

Telephone number

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

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Date information received

Date acknowledgment letter sent to Board Chair _____

Date circulated to relevant Inspectorates / Policy Leads _____

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Annex 6:

North Wales Safeguarding Adults Board Concise/ Extended *(delete as appropriate)* Adult Practice Review

Re:NWSAB */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 learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

(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 <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
(Signature)

Reviewer 2
(Signature)

Name
(Print)

Name
(Print)

Date

Date

Chair of Review Panel <i>(Signature)</i>
Name <i>(Print)</i>
Date

Appendix 1: Terms of reference

<p>Adult Practice Review process</p> <p><i>To include here in brief:</i></p> <ul style="list-style-type: none"> • <i>The process followed by the Board and the services represented on the Review Panel.</i> • <i>A learning event was held and the services that attended.</i> • <i>Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.</i>
<input type="checkbox"/> 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	<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"/>	