



Adult Practice Review Report

North Wales Safeguarding Adults Board

Concise Adult Practice Review

Re: NWSAB/2/2024

Brief outline of circumstances resulting in the Review

A concise review was commissioned by North Wales Safeguarding Adults 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 in accordance with part 7, Social Services and Wellbeing (Wales) Act 2014. Meeting the criteria under 3.11, The Welsh Government (2016) Working Together to Safeguard People, Volume 3 Adult Practice Reviews, namely:

- An adult at risk has not, on any date during the 6 months preceding the event, been a person for whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry.
- The adult has:
 - Died, or
 - Sustained serious and permanent impairment of health.

The purpose of the review would be to determine if there is any learning for agencies.

Circumstances resulting in the review

In April 2024, North Wales Police were called to the address in North Wales, by the Welsh Ambulance Service. The report was to a deceased male, who paramedics believed may have been subject to a criminal act leading to his death.

It was identified at the time, that a second male was living at the address with the deceased. The evidence gathered thereafter was sufficient to charge the second male with murder, this led to a subsequent conviction of the same crime.

Background of individual

The individual was a male in his early 50s, as a young man, he had been a keen artist and was accepted into art school. However, whilst working as a labourer, had sustained an injury to his hand, which resulted in him not attending art school and never working again.

After separating from the mother of his children when they were very young, he lived with his parents and saw his children fortnightly, often taking them on day trips to Rhyl or to watch Wrexham play football.

He is described to be a considerate and kind man, who encouraged those around him to have fun. His mother died approximately 6 years ago and since this time family saw less of each other, and this reduced further after the second male moved into his home.

He avoided technology and social media, which likely contributed to reduced family contact over time despite knowing each other's whereabouts.

Following the work-related injury, he developed alcohol dependency and experienced recurrent episodes of poor mental health, receiving intermittent NHS support for both. His alcohol use led to deteriorating physical health and related medical diagnoses, including inpatient detox interventions. Over time, his family perceived him as increasingly vulnerable.

In the years he resided in his property, it is reported that the neighbours would frequently socialise together both inside and outside their properties. In early 2023, it appears that he had a friend who was part of this social network, move in temporarily, reportedly until the friend was allocated his own flat.

Determining

In the twelve months prior to the date of death, the deceased had been subject of two duty to report referrals to the Local Authority regarding concerns of being financially abused and identifying the deceased as a vulnerable adult due to history of alcohol dependency. The first referral named the perpetrator as the Male who was subsequently convicted of murder. This referral resulted in a joint visit and the matter was closed with no further action.

The second referral had been made by this perpetrator, naming a relative of the individual as a potential perpetrator. This referral was directed to single point of access for information, advice and assistance.

Therefore, neither referral led to Social Services or Police having cause to take action to protect the individual at those times.

Considering the prior referrals to social services and the police regarding concerns of financial abuse and the potential vulnerabilities of the individual who had lost their life, the case was referred for consideration of an APR to determine if there is any learning for the multi-agency response.

Time period reviewed

A timeline from 1st January 2023 to date of the incident April 2024, was agreed to be the focus of the review. The rationale was that this coincided health records, the individual was admitted to hospital for observation of a head injury and alcohol withdrawal following an assault by un-named assailants and the perpetrator was seen to be frequenting his property more frequently.

To determine the time period for review, all agencies were asked to review their records, whilst the specifics were not explored, it was noted that some years prior to the agreed time period, the individual had accessed different parts of the health services. These may be referenced but not explored within this review.

Practice and organisational learning

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

The following analysis was developed from information shared by family. Information made available by agencies to the panel and the reviewer, and perspectives gained from practitioners in the learning event. There were several themes that were highlighted and explored. These have been broken into subject areas to provide narrative relating to the relevant circumstances, identify good practice and learning points.

Need for Better Understanding of Social Cohesion and Community Dynamics:

The learning event highlighted that the neighbourhood in question had a long-standing culture of close social interaction. Residents frequently visited one another's homes, and there were high levels of informal socialising in and around the properties. This environment was also associated with alcohol use, substance misuse, and reports of anti-social behaviour.

Such close-knit communities can sometimes create challenges for professionals in distinguishing individual relationships and identifying safeguarding concerns, as the community may be perceived as a single social unit. However, in this case, it was evident from both records and feedback during the review that housing officers and tenancy support staff made significant efforts to engage with individual residents.

In particular, the individual at the centre of this review had developed a positive and professional relationship with housing staff. Officers were known to him by name and sight, and their regular presence in the area reflected a proactive approach that went beyond statutory duties. This consistent engagement was recognised as an example of good practice in tenancy support and community-based safeguarding.

Understanding of Communication and Engagement:

Overall, inter-agency communication was timely and appropriate throughout the period under review. However, communication with the individual himself was significantly hindered by practical barriers. He did not have access to a personal telephone, was often not at home, and was known to be unresponsive to letters or visits. While agencies made efforts to leave calling cards when visits were unsuccessful, there was no evidence in the latter part of the period, that consideration had been given to the individual's reported visual impairment. This may have further limited his ability to receive or respond to communication attempts.

The individual was known to have variable engagement with services. A review of the multi-agency chronology revealed a pattern of disengagement that coincided with periods of deteriorating wellbeing—particularly in relation to his mental health and alcohol use. However, this pattern was not easily identifiable by any single agency due to fragmented contact and the challenges in reaching him through conventional means.

Assessing Vulnerability and the Importance of Information Sharing:

There were two Duty to Report (DTR) referrals made to social services, during the period reviewed. Based on the information available to social services and the police at the time, as evidenced in the chronology, the evaluation and strategy discussion outcomes were proportionate and appropriate.

Subsequent, feedback from the individual's family as part of this review, is that the individual was viewed to be increasingly vulnerable by them.

Documentation reviewed indicate that the individual's lifestyle may have been perceived as primarily linked to alcohol dependency. However, a broader range of vulnerabilities were identified by all agencies in attendance at the learning event that hadn't necessarily been shared in a holistic manner. These included both historical and situational factors that contributed to the individuals overall risk profile, including poor mental health and physical health conditions related to alcohol use, and his attendance at hospital due to assault and subsequently poor physical health, for which there was no evidence identified, relating to an offer for a referral to other agencies by Welsh Ambulance Trust or the hospital.

There is also no evidence that social services sought information from either of these agencies, at the time of the DTRs. This does raise the fact that had the information been available to Social Services and the Police regarding vulnerability at those times, it would have provided a more comprehensive understanding of the individual's needs and risks, potentially influencing the decision-making during the evaluation of Duty to Report (DTR)

There is a need to strengthen multi-agency information sharing and protocols, when concerns are raised about a potentially vulnerable adult.

Hearing the Voice of the Individual:

Records indicate that housing professionals attempted to maintain regular contact with the individual and developed a positive working relationship. However, there is limited evidence of similar opportunities for other professionals to explore matters relating to the individual's safety, health and wellbeing. Where such conversations did occur, they were not held in private.

The individual's lack of access to a personal phone meant that telephone communication was facilitated through the alleged perpetrator's device, frequently on loudspeaker. During home visits, professionals were often unable to speak with the individual alone due to the presence of others in or around the property. These circumstances may have impacted the individual's ability to speak openly and confidentially.

There are also documented instances where conversations were held jointly with the individual and the alleged perpetrator, or where the perpetrator spoke on the individual's

behalf. This raises important considerations about how the individual's views were captured and whether he was able to express himself freely and without influence.

Understanding of Exploitation and Coercive Control:

Exploitation and coercive control can manifest in various forms, and this review identified complexities in recognising and responding to such dynamics in this case. The situation was made more challenging by the changing narratives presented by the perpetrator and the individual's reported consent to maintaining what was described as a co-dependent relationship.

While there were indicators of potential exploitation and coercive control, the true nature of the relationship remained unclear. Contradictory accounts from both the individual and the perpetrator made it difficult for professionals to identify the extent of exploitation or coercive control.

Whilst the DTR referrals were acted upon appropriately through consideration and discussion in a multi-agency strategy discussion. Resultant actions were primarily around speaking with the individual and not about understanding the relationship or the potential risks posed to the individual and others by the alleged perpetrator named in the referral.

Discussions and considerations by the reviewer during the review considered several relevant frameworks, including:

- Ask and Act: A Welsh Government policy aimed at identifying and responding to domestic abuse, sexual violence, and coercive control.
- Domestic Violence and Abuse legislation: Including the Serious Crime Act 2015, which introduced the offence of controlling or coercive behaviour in intimate or family relationships.
- Cuckooing: A form of exploitation where an individual's home is taken over by others, often linked to criminal activity or abuse.
- Crime and Disorder Act 1998: While this Act provides a framework for addressing anti-social behaviour and community safety, it was not directly applicable to the safeguarding concerns in this case. However, use of S115 for information sharing purposes could have been considered.

It was acknowledged during the learning event that the presented situation did not clearly align with any single legislative framework, and at the time of the events, agency protocols and policies varied. Some of these inconsistencies have since been addressed.

There is a need for a multi-agency approach to identifying situations involving potential exploitation and coercive control, particularly in cases that do not clearly fit within existing frameworks.

Understanding Cuckooing and subtle exploitation:

The review identified several indicators of exploitation, which may not have been fully recognised or responded to at the time due to the complexity of the situation and the evolving nature of the relationship between the individual and the perpetrator

While the term *cuckooing*—a form of exploitation where an individual's home is taken over by others, often for criminal purposes—was not formally applied during the period under review, several features of the case align with known indicators of this form of abuse.

These include:

- An adult with a history of alcohol dependency, poor mental health, and social isolation.
- The perpetrator's increasing presence in the property, under the guise of a temporary arrangement, aligns with patterns seen in both cuckooing and exploitative cohabitation.
- The individual's lack of access to a personal phone, and reliance on the perpetrator for communication
- A decline in the individual's visibility to services following the cohabitation.
- Concerns of financial abuse, including a Duty to Report referral naming the perpetrator.

These elements point to a potential pattern of exploitation that was subtle, layered, and difficult to categorise within existing safeguarding frameworks. The individual's vulnerabilities—combined with the perpetrator's influence—created a situation where exploitation could occur under the radar of traditional thresholds for intervention.

Although the individual was reported to have consented to the living arrangement, the inconsistent narratives, and the eventual outcome suggest that the relationship may not have been as consensual or co-dependent as it was observed and reported to be to professionals.

Areas of effective practice

Housing Officers and Tenancy Support Officers consistently worked beyond their statutory duties, making repeated efforts to engage the individual despite disengagement. Their regular presence in the area fostered familiarity with local residents, and they raised safeguarding concerns appropriately.

At the time of the first duty to report, based upon the information received, the safeguarding team in social services were timely in their response to arrange a strategy meeting.

Social Services and the Housing Department worked collaboratively on the safeguarding visit, ensuring a housing officer known to the individual was present to support engagement.

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: -

1. Strengthen Understanding of Exploitation in a wider context

For consideration by safeguarding board training sub group, and policy group to inform work being undertaken nationally by Welsh Government

- Improved awareness among professionals of the varied and sometimes subtle ways exploitation can present, including coercive control and cuckooing.
- Multi-agency training and guidance should include exploitation as a broader spectrum, including financial, emotional, social, environmental control, such as cuckooing, with clear pathways for assessment and intervention. Including when the situation does not involve overt criminal activity or drug-related exploitation.
- Safeguarding training and supervision should include emphasis on recognising cumulative risk factors and the value of a holistic, multi-agency perspective when assessing vulnerability.
- Training and supervision should support professionals in recognising the potential safeguarding implications within tightly connected communities, including the risk of exploitation or coercive dynamics being normalised or overlooked.
- Safeguarding training should include case examples that reflect the nuanced and evolving nature of adult exploitation, including scenarios that fall outside traditional definitions.

2. Strengthen Communication and Engagement Approaches

For consideration by all agencies at an operation level

- Professionals to make greater consideration of individual communication needs, including access to technology and sensory impairments.
- Agencies to adopt flexible and person-centred engagement strategies for individuals who may have variable or limited contact with services.

3. Improved Multi-Agency Information Sharing

For consideration by the Safeguarding Board policy and procedure group

- Safeguarding board to review and reinforce protocols for timely and proportionate information sharing in safeguarding contexts.
- Practitioners to be reminded of the importance of professional curiosity, information sharing and relevance of historical and current health information to support informed decision-making. Including legal frameworks available to facilitate information sharing, such as S115
- Strengthened protocols to ensure that historical and contextual vulnerabilities are considered in safeguarding assessments.

4. Hear the Voice of the Individual-

For consideration through Audits by regional delivery groups and the safeguarding board practitioners sub group

- Practitioners to routinely identify and document any communication barriers—such as lack of access to a phone or sensory impairments—and adapt their communication approach accordingly.
- Professionals to make concerted efforts to ensure individuals are given opportunities to speak privately and without influence from others.
- Agencies to routinely offer use of independent advocacy where communication barriers or concerns about coercion are present.

5. Promote Use of Chronologies to Support Risk Identification

For consideration by the Safeguarding Board Workforce Development & Training Group


- Agencies to promote greater use of multi-agency chronologies to help identify patterns of disengagement or deterioration in wellbeing that may not be visible to individual services.


6. Review multi-agency Policy and Practice Guidance

For consideration by the Safeguarding Board policy and procedure group

- All agencies to work together to review and align inter-agency policies and procedures relating to exploitation and coercive control, with consideration for emerging legislative changes.
- It is recommended that cuckooing be explicitly referenced in inter-agency safeguarding protocols, particularly where there is a combination of vulnerability, cohabitation, and concerns about control or exploitation.
- Safeguarding board to development a shared multi-agency approach to complex social and safeguarding scenarios that may fall between existing frameworks.
- Multi-agency safeguarding protocols to be reviewed to ensure they reinforce the importance of hearing directly from the individual wherever possible and recognising when their voice may be obscured or influenced by others.

Statement by Reviewer(s)			
REVIEWER 1	Becky Griffiths	REVIEWER 2	
		<i>(as appropriate)</i>	
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.
<p>Reviewer 1</p> <p>(Signature) </p> <p>Name <i>Becky Griffiths</i></p> <p>Date 11/11/2025</p>	<p>Reviewer 2</p> <p>(Signature)</p> <p>Name (Print)</p> <p>Date</p>

<p>Chair of Review Panel</p> <p>(Signature)</p> <p>Name</p> <p>(Print)</p> <p>Date</p>	<p></p> <p>Neil Ayling</p> <p>11/11/2025</p>
---	---

Appendix 1: Terms of reference Appendix 2: Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel.*
- *A learning event was held and the services that attended.*

- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

In accordance with the statutory guidance for Adult Practice Reviews, a multi-agency panel was convened to manage and steer the process. It was chaired by an independent Chair and reviewer and made up of representatives from:

- North Wales Police
- Adult Safeguarding
- BCUHB
- Housing

Although not part of the panel, Welsh Ambulance Trust provided call out information.

The panel initiated the learning process by collating chronologies for the agreed time period and considering the following analysis for their agencies:

- Decision making and service delivery
- Interagency communication
- Perceived barriers to working with the individual
- Identified learning for individual agencies
- What good practice occurred
- Themes for future learning

The Learning Event was held on 16th June 2025 from 10 until 3.00 and was facilitated by the chair and the Reviewer. Practitioners and Agencies represented at the event were from:

- Adult Safeguarding
- Adult services
- Housing
- North Wales police
- BCUHB- ward consultant and manager

During the first half of the event, participants explored the timeline of agencies involvement with the individual.

They were asked to explore several aspects:

- What did they know about the individual himself?
- How did they view him in terms of vulnerability at the time? on reflection do they have a different view of his vulnerabilities?
- what did you understand of believe the relationship with / role of the perpetrator within the household to be at the time?
- On reflection is there anything they may have questioned differently?

They were asked to explore the themes of vulnerability and exploitation in a group discussion and identify good practice and areas for learning.

During this review family members were contacted to be invited to participate. However, only one family member chose to meet the Reviewer and Panel Chair. Their opinions and reflections are represented in this report.

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"/>	

