



Findings from a thematic analysis of Adult Practice Reviews in Wales

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Abbreviations

AAR- Adults at Risk

APR - Adult Practice Review

CIW- Care Inspectorate Wales

CPR - Child Practice Review

DHR - Domestic Homicide Review

DoLS - Deprivation of Liberty Safeguards

GDPR - General Data Protection Regulation

HIW – Health Inspectorate Wales

MHHR - Mental Health Homicide Review

NISB - National Independent Safeguarding Board

POVA – Protection of Vulnerable Adults

RSB – Regional Safeguarding Board

SAB – Safeguarding Adult Boards

SCIE – Social Care Institute for Excellence

Background

This research project was commissioned by the National Independent Safeguarding Board (NISB) (via Welsh Government) to push forward the intellectual agenda and learning that can be achieved from a systematic analysis of Adult Practice Reviews (APRs). Furthermore, this research provides an opportunity to maximise the value from such reviews; these are costly investments and are potentially under-utilised as learning resources. The current study builds upon an earlier study of adult death reviews, funded by the National Independent Safeguarding Board (see Robinson, Rees and Dehaghani, 2018) and of Child Practice Reviews (CPRs) (see Rees et al., 2019; 2021). A range of cross cutting themes was identified in both of the previous studies and these will be considered alongside the findings of this report.

Overview of the project:

The aim of this study is to progress the intellectual agenda and learning relevant to policy and practice in adult safeguarding that can be achieved from a systematic analysis of APRs. The current 'coding team' has allowed for continuity and for connections to be made, where appropriate with the two previous studies.

The objectives of this review are:

- To create a reliable and valid baseline of safeguarding learning from within a 32-month timeframe
- To identify
 - (i) the commonly occurring themes coming out of the reviews with regard to the settings in which the themes arise and
 - (ii) information which is relevant to the needs of safeguarding practitioners
- To consider how the themes and information resonate with findings from the two previous phases of review (2018; 2019).
- To test-out the themes and information with safeguarding practitioners in focus groups.

Previous reviews

Other syntheses of reviews into deaths and serious incidents have shown the importance of increased training for health and social care professionals; improved risk assessment and improved responses to those with complex needs; missed opportunities for safeguarding and improved record keeping (Brandon et al. 2020; Neville and Sanders-McDonagh, 2014; HIW, 2016; Preston-Shoot 2018, Sharps-Jeff and Kelly, 2016). It is hoped that findings from this research will help improve practice in the field and amongst those charged with undertaking reviews and inform the governance arrangements going forward for reviews and inspections taking place in Wales.

Methodology

The overall approach to this study is qualitative, involving the thematic coding of reviews complemented by focus group discussions with practitioners from across Wales.

Sample

The sample of reviews to be coded was provided by the NISB. A total of 20 APRs - completed between 2014 and 2020 - were quadruple coded by the research team from a legal perspective, a criminological perspective and a social work perspective (x2). The project team was assembled to deliver a robust, multi-disciplinary overview of Adult Practice Reviews (APRs) in Wales. One of the APRs was a historic review (APR 19). Fifteen of the APRs were undertaken as a result of an adult death, with causes of death ranging from factors associated with medical and/or other forms of neglect, self-neglect and suicide. Two were undertaken on the basis of a domestic homicide (APRs 12, 20). Fourteen were in residential care homes (APRs 3, 4, 5, 6, 7 (supported accommodation), 8, 10, 11, 12, 13, 14 (supported accommodation), 16, 17 & 19). Many of the APRs identified that vulnerable people had been subject to abuse and neglect, often over protracted periods of time.

An overview table of the sample, containing key details of each review, is contained in Appendix A.

Coding framework

A method and framework to identify key themes was established by the research team. Briefly, this involved reading and discussion of three APRs by four researchers (law, criminology, and social work), which then enabled the development and refinement of a coding framework. Researchers were asked to identify up to five key themes under each of the following categories: Residence/circumstances of adult; Perpetrator/s (if there is one); Mental capacity; Other demographic information; Characteristics of abuse; Carers (both formal and informal); Agency performance – Adult's Services; Agency performance – Health (including mental health); Agency performance – Housing; Agency performance – Police; Agency performance – Other (including third sector); Multi-agency partnership working; Identification of good practice; Key recommendations going forward; Comments on quality of APR; Other comments (e.g., from a legal, criminological, or social work perspective).

As per the research specification, each review was thematically coded by each member of the coding team. This resulted in coding being undertaken from each perspective (i.e., a minimum of four sets of coding per review). Weekly team meetings over a five-week period were used to discuss batches of reviews. After the coding was completed, the results were combined into a single Excel database, containing the coding from every team member, so that these could be evaluated for their similarity and points of divergence. This exercise revealed only some small differences, even though the research team was notionally assembled to bring three different perspectives to the coding and analysis.

From the coding exercise, a group of five cross-cutting themes was identified. These five themes were subject to a validity check through the discussion and feedback provided by the practitioner focus groups. An overview table depicting how the themes relate to each APR review is provided in Appendix A.

Focus groups

Virtual focus groups were undertaken (via Microsoft Teams) to discuss the identified themes and gain feedback on potential interpretation of their meaning. The invitation to the focus groups were sent out via the NISB. One focus group was held for North

Wales on 24th February 2021, and one in South Wales held on 4th March 2021. Ten people attended the North Wales group and thirteen attended the South Wales group. Both focus groups lasted two hours.

Participants occupied a variety of practice, managerial and strategic roles within police, social services, probation and health. Participants were asked to indicate their level of experience with each type of review (no experience; have read this type of report; have participated by providing evidence or information; have had overall responsibility for the process; have had strategic responsibility for ensuring that recommendations are implemented). All participants had some level of knowledge and/or experience with APRs.

There was some consistency of views across the two focus groups; both broadly concurred with the themes identified. Focus groups were recorded and notes were taken throughout, with all members of the research team able to access the recordings and notes taken. The information from the focus groups were then distilled into the wider themes.

Limitations

It is important to acknowledge the limitations of this study, before moving on to the findings. First, the sample was a convenience sample provided by the NISB. It does not necessarily provide a representative sample of APRs that have been carried out in Wales. However, they were chosen with a view to ensuring a wide geographic spread of cases within Wales, and to illustrate the diverse range of issues that tend to be found in such reviews. Since their inception, according to the NISB, 36 APRs have been completed. 20 APRs were thematically analysed in this study (56% of all completed APRs), two of these were also included in the 2018 study¹. Across the two studies 24 individual APRs have been reviewed, accounting for 67% of all APRs (2018; 2021). The research took place during COVID-19 and both focus groups were held virtually. One of the members of the coding team was ill during the study period and could not attend all of the weekly meetings but managed to catch up with the coding and feed into the overall review of findings. Timescales provided for completion of the project had thus to be extended, with the first draft report submitted in April 2021.

¹ These were APRs 8 and 17 in the current study.

Background

Safeguarding Adults Boards

Safeguarding Adults Boards (SABs) were established under section 134 of the Social Services and Wellbeing (Wales) Act 2014. Their functions are to:

- Cooperate with other Safeguarding Boards and the National Board
- Develop and review procedures for Safeguarding Boards to increase their effectiveness
- Follow national policies and guidance provided by the National Board
- Undertake relevant reviews, audits and investigations
- Make recommendations and ensure these are being followed within the Board
- Ensure appropriate training is available for anyone working to improve adult safeguarding practice
- Work in partnership with other organisations to safeguard and protect the welfare of adults in its area.

Adult Practice Reviews

APRs are led by SABs in accordance with The Safeguarding Boards (Functions and Procedures) Wales Regulations 2015. There are two types of APR:

1 - Concise Reviews

A Safeguarding Board must undertake a concise APR 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.

2 - Extended Reviews

A Board must undertake 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.

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 at risk being protected from suffering or harm in the future. Where possible lessons should be acted upon without necessarily waiting for the completion of the review.

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

APRs aim to do the following:

- Identify any steps that can be taken by the SAB to improve multi-agency adult safeguarding practice.
- Encourage an open and transparent culture of learning.
- Provide accountability and reassurance to individuals, families and the wider public.
- Enable prompt identification of the need for systematic or professional changes, whilst encouraging prompt actions.
- Promote effective information sharing and learning on a local and national level.

Following an APR, the SAB is required to hold a multi-agency learning event and produce a practice review report indicating what recommendations and action (if any) are required.

When an APR Report has been written, the SAB must submit a copy, with a copy of the Action Plan to the Welsh ministers and National Board. APRs should be placed on the Regional Safeguarding Board (RSB) website for a minimum of twelve weeks.

Findings

The five themes identified from the APRs are as follows: (i) Safeguarding, capacity and duty to report; (ii) Commissioning and inspection; (iii) Transitions; (iv) Voice of vulnerable people; and (v) Family and carers.

Theme 1 – Safeguarding, capacity and duty to report

There was a lack of a clear understanding of safeguarding procedures by some working with adults at risk (APRs 1, 2, 5, 6, 7, 8, 17, 19). This may be because adult safeguarding procedures are less well developed or that older people are not seen to be as immediately at risk or vulnerable, when compared to (working with) children and young people. There was also a lack of understanding of the duty to report, which is incumbent on all those working in the field of adult services (APRs 2, 5, and 16). The focus groups concurred with this theme, noting the need for greater understanding and more training across the sector. It was noted that the responsibility to report when people were living in residential care often fell to care home staff who had limited training and understanding (APRs 2, 6, 7, and 19). For example, in APR 2 it was identified that all agencies should be aware of the definition of an adult at risk and that professionals need to ensure the availability of safeguarding advice, support and supervision; this would appear to be particularly lacking in residential care homes. The hierarchical nature of residential care home structures was also noted to be a potential hinderance with designated safeguarding leads (or similar) often being managers; potentially giving rise to conflicts of interest in some instances (see theme 2).

Confidence in making a referral was often also complicated by the deterioration in people's presentation as part of the trajectory of their particular condition or as result of aging and developing dementia, for example, and did not always demonstrate professional curiosity (APRs 11, 17 & 19). When individuals did deteriorate, professionals did not always ask questions, explore or look for alternative explanations (APRs 7, 11 & 19). It appears that where people are living in residential care there is an assumption that they are being well looked after and that any decline is medical. Thus, medical conditions were seen to be the cause of deterioration as a first assumption and explanation. A finding from one APR (17) was that professionals should always '*Think the unthinkable and ask the unaskable*'; something that resonates with the need for 'healthy scepticism' that has become a mantra in the safeguarding of children and young people.

Self-neglect was an issue in three of the APRs (2, 14 & 18); this related to keeping the home in a state of significant disrepair; not following medical advice; and alcohol abuse. Practitioners found it difficult to manage this behaviour because it was potentially interpreted as a *lifestyle choice*, especially where people were seen to have capacity in other areas of their lives. The three individuals in APRs 2, 14, and 18 all died as a result of self-neglect. The complexity and difficulty of understanding how best to support people who struggle with self-neglect places considerable stresses on both individual practitioners and wider services - something that has potentially been exacerbated by the curious neglect of this topic in contemporary Welsh Government policy and guidance.

Unlike the Care Act (2014) in England, the Social Services and Well-being (Wales) Act (2014) does not define, or otherwise identify, self-neglect. The Wales Safeguarding Procedures (Cardiff and the Vale of Glamorgan Regional Safeguarding Board with Horwath, last updated 2020) do provide some information about self-neglect but this is largely taken from information provided by the Social Care Institute for Excellence (SCIE) (2015, updated 2020). At present, RSBs have been developing their own guidance, although it is understood that Welsh Government guidance is being devised.

Mental capacity, in particular, was seen to be a problematic concept in the majority of APRs. Capacity was often viewed as a static concept, rather than something which was fluctuating and dependent on context, time and situation (APRs 14, 16). In APR

16 the individual moved from home, to hospital, to residential care; each change of context should have triggered a new assessment. Once someone was deemed to lack capacity this was seen to be a blanket assessment, which stopped individuals exercising choice in all areas of their lives, regardless how far certain choices related to risk. There was little understanding of gradients of choice (Rochira, 2014).

In certain circumstances this lack of understanding about mental capacity could lead to the infantilisation of older people and used to justify arrangements which did not allow people to have any agency or choice. For example, in APRs 3, 11 and 13, the care home used a stairgate restricting people wandering from their room. Lack of capacity was sometimes seen to be used as a reason for residential homes to institutionalise residents, so they had little choice over, for example, meal-times, and when to get up or go to bed (something exemplified in APR 6). This was also noted in the Older Peoples Commissioner Report (Rochira, 2014:7) 'Care homes are often characterised by institutional regimes, where a task-based approach to delivering care concentrates on schedules, processes and checklists, rather than the needs of an individual'.

The uncertainty of how to understand mental capacity in the context of safeguarding concerns was further highlighted in the discussions about the interface between Deprivation of Liberty Safeguards (DoLS) and Protection of Vulnerable Adults (POVA) (now Adults at Risk (AAR) processes). The focus groups highlighted that there had in fact been a gap in guidance with regard to DoLS and POVA/AAR, with interim guidance being issued which led to further confusion.

In addition to issues associated with making referrals, professionals were not always clear about how to respond to adult safeguarding referrals (APR 6). When safeguarding referrals were made, they were not always responded to effectively or in a timely manner (APRs 1 & 3). The process of referring was also linked to wider discussions about information sharing, something noted to be problematic in both practical terms, and the understanding held by practitioners about the duty to share information (APRs 2, 4, 15, 17, 18 & 19). The focus groups echoed the latter point noting that GDPR has served to heighten anxiety about information sharing.

It should be noted that the safeguarding of adults has been through a period of considerable change and revision over the last ten years. The Social Services and

Well-being (Wales) Act 2014 sought to provide a more cohesive approach to adult safeguarding legislation in Wales, something that it has generally done well. However, there were delays in the production of secondary legislation, which led to a protracted period of change with interim guidance being issued to bridge between the former POVA processes and AAR. The extended transition may have served to further complicate practitioners' understanding of an already complex legal and policy framework. The creation of the Wales Safeguarding Procedures (WSP) is doubtless a positive step in promoting awareness and understanding of adult safeguarding. Now that legal and policy frameworks have been effectively developed, there is an urgent need for training on these approaches. Thus, we could see three interconnected difficulties which impacted on decision making in adult safeguarding: (i) Mental capacity (DoLS, POVA and self-neglect); (ii) data protection (GDPR); and (iii) a duty to report.



Interdisciplinary and multi-disciplinary training on each of these areas would be helpful for all those working in adult safeguarding. Note, we would strongly encourage this to be training delivered across sectors (e.g., statutory, private/independent and third sector) AND at various levels (e.g., those with and without professional status, and including both managerial and 'frontline' colleagues).

Theme 2 – Commissioning and inspection

Commissioning of residential care was a particular issue cited in a number of the APRs (APRs 3, 4, 6, 10, 11). Many of the residential homes across the 20 APRs were small,

independent (e.g., private) providers, as is typical of the profile of resource commonly found in adult services' residential care. Moultrie and Rattle (2015) noted that "Between local authorities [in Wales] there is significant variation in the structure of local markets. Overall, there are relatively few larger group providers, with the majority of provision in Wales provided by single home providers" (2015: 2). In 2015, there were 84 local authority run homes out of the 673 care homes in Wales (12%) and they account for 2,464 of 22,706 beds (11%). This is a higher holding of local authority homes than England, where less than 5% of care homes for older people are owned by local authorities (Moultrie and Rattle, 2015: 3). None of the APRs identified concerns relating to local authority homes; however, we would caution against this being interpreted as being a sign that they are qualitative better (there is no evidence from the APRs that this is, or is not the case); rather, the prevalence of independent providers in APRs should be seen as simply a reflection of their predominance in the contemporary market.

Given the high skew towards independent providers in adult social care, the commissioning process has a particularly important function in ensuring the delivery of high-quality and safe care to vulnerable people. It was not always clear what bench marking checks had taken place in the commissioning process (e.g., what factors were considered and whether the commissioners were checking that appropriate training of staff, recording or safeguarding procedures were in place within the homes) (APRs 6, 7,10,11 &17). In APR 10 staff had no induction when commencing in post. In APR 11 there was no recording protocol. It was suggested in APR 6 that there was need for '*a safeguarding clause in the domiciliary framework when commissioning, to ensure there is sufficient knowledge of safeguarding procedures amongst staff*'. Other care homes (APR 8) were not recording accurately and did not have care and support plans for each resident. In APR 3 it was noted that '*commissioners should always have processes to ensure that DoLS were submitted by care homes*'. The duty to report often falls to care home staff, despite a range of other professionals visiting the care home, yet it was not always clear that care home staff had received the requisite training to know about the duty to report and how to initiate this (APR 6).

Further to the complexities of training and record keeping, it is not readily apparent what powers exist for APR reviewers to obtain the records of care home providers. This was noted as a potential hinderance to the learning that can result from APRs and was a point echoed in the focus groups.

The Older People's Commissioner highlighted similar findings with regards to training back in 2014 (Rochira, 2014) noting '*Current basic mandatory training for care staff, which consists only of manual handling, fire safety and health and safety training, does not sufficiently prepare individuals to understand the needs of older people and provide the appropriate support. Furthermore, a significant number of care staff (estimated to be 40% of the workforce) are delivering care without even this most basic of training*' (Rochira 2014:11).

Alongside issues of record keeping and poor understanding of safeguarding, training on pressure sores, in particular, was often noted to be lacking and featured widely within the reviews (APRs 2, 3, 6, 10, 14 & 16). Operation Jasmine reporting on 63 deaths in care homes in South East Wales (Flynn, 2015) found similar difficulties with lack of training, knowledge and inappropriate treatment of pressure sores, in particular, noting 'older people's injuries, pain and life-threatening deep pressure wounds were unobserved, unreported, reported inaccurately and/or reported belatedly'. Flynn (2015: recommendation two) noted the process of responding to pressure ulcers has three elements: (i) prevention – setting up a well-ordered service and paying attention to recruitment and training; (ii) secondary prevention – being alert to signs and symptoms so that concerns are picked up quickly and inquiries made; and (iii) taking action to support and protect those who are known or believed to have been harmed.

Even when processes and training had been established within a care home at the point of commissioning, it was not always clear how commissioners' maintained oversight of these issues going forward, or indeed how they were informed when residential homes were experiencing difficulties. One residential home (APR 7) was set up with a particular resident in mind and ensured that a clear behavioural training programme and plan was provided for staff. The initial training provided to staff stood as an example of good practice; however, the fast turnover of staff meant that this was not maintained. In this particular APR (7), the home was situated in a remote location which meant that the resident who was living alone (with the exception of

care staff) had no means of socialising and limited access to community resources, despite her having lived communally previously and it being known that she enjoyed social interaction. The young woman began living alone, as the only resident, in an isolated location and the most critical aspects of what was important to her were no longer catered for. The choice of location might have been based on cost, but this left her out of sight, with less surveillance of the residential home. It has been noted previously that all care homes need to be linked to or within the gaze of the local community (Elkan and Kelly, 1991). It is perhaps surprising that commissioners did not think about these considerations when commissioning the placement.

Many of these difficulties were highlighted by Moultrie and Rattle (2015:2) who noted that 'More could be done in Wales at a national, regional or local level to systematically monitor and analyse information about services, ownership, financial stability, staffing and quality of care to ensure that risks can be minimised.' Care home managers have been obligated to register with Social Care Wales for some time, but the requirements for social care workers in adult care homes and residential family centres will not be mandatory until April 2022 (Social Care Wales, 2021). It is unclear what impact this will have on the safeguarding of adults at risk of abuse and neglect.

The regulation and high turnover of staff present some ongoing challenges for both Social Care Wales and social care providers; however, responsibility for inspecting residential care homes (and many other social care settings) predominately rests with Care Inspectorate Wales (CIW) (known as the Care and Social Services Inspectorate (CSSIW) prior to changes made by the Regulation and Inspection of Social Care (Wales) Act 2016). The CIW (and its predecessor) have the power when issuing a certificate of registration to impose conditions and are able to revoke registrations if conditions set via initial registration, or as a result of an inspection, are not met.

There was also some difficulty with communication between inspectorate and commissioners, across the APRs (APRs 11, 19) in particular, having rights to access the home (APR 7) and the information being made being made available to them. Focus groups noted how this had been exacerbated through COVID as understandably CIW had not been visiting care homes. We are aware however that

throughout the pandemic CIW have made strenuous efforts to meet regularly with commissioners to share information. In APR 11 it was noted that record keeping, supervision, appraisal, disciplinary procedures and care plans should all be available for discussion between the commissioners and the inspectorate. In certain APRs when the inspectorate visited and information was not available this did not raise a red flag, but the visit was re-arranged sometime later. There also seemed to be a lack of direct communication between the inspectorate and commissioners. Where inspections had revealed negative evidence, this was not reported directly to the commissioners or to social services in a timely manner, but the onus seemed to be on commissioners to check for information on-line rather than being directly alerted as standard practice (APR 19) .

The focus groups noted that the inspectorate does not directly notify local authorities, or other agencies, about the outcomes of inspections (unless there are profound concerns); rather information is published online and requires commissioners to actively seek out information which increases the risk of information being missed

The current legal framework(s) poses considerable challenges to inspectorates in the gathering of evidence and the pursuit of legal enforcement (both civil and criminal). For example, information can take some time to enter the public domain as care settings will need to be given due time to rectify issues and dispute concerns raised through the inspection process. Equally, there is the potential that additional packages of support provided by commissioners to care settings that are struggling, might hinder the visibility of deficits that are ordinarily present.

A clear system for alerting local authorities, and other statutory agencies, at the earliest opportunity about the outcomes of care inspections in their area would likely promote positive commissioning and more effective safeguarding. Ideally, inspections would be able to utilise records of residents to notify all local authorities and other agencies about concerns for people they have 'placed' in the residential setting. This approach would effectively promote identifying concerns to all agencies, including instances of 'out of area' placements.

The situation for those self-funding (see APR 10) seemed to leave people with limited to no oversight; it seemed solely at the discretion/ability of families to identify and utilise

information. Across Wales, approximately 51% of care homes are filled by local authority placements and 49% are self-funded (Moultrie and Rattle, 2015). The Older People's Commissioner also raised this as an issue noting,

'Residents who are self-funders and their families are fearful about raising concerns and complaints with a provider because of the perceived risk that they may be asked to leave the residential home and would not know how to manage such a situation without support. The health and care needs of self-funders are not sufficiently monitored and are therefore often not recognised and acted upon by visiting Local Authority and Health Board staff because they only monitor the individuals who are funded by their bodies' (Rochira, 2014: 11).

The Social Services and Wellbeing (Wales) Act 2014 aimed to transform the way that social services were delivered in Wales. Further, legislation in the Regulation and Inspection of Social Care (Wales) Act 2016 aimed to improve the quality of life for people living in care homes and to reform the regulation and inspection processes. It is difficult to know what effect, if any, these changes have made, as the APRs that we analysed straddled this time frame of implementation.

The lack of willingness/ability of residents and families to raise complaints, or access information about concerns held for residential care homes was also reflected in social care staff in adult residential care settings. Whistleblowing procedures and the reluctance to whistle-blow was seen as a recurring theme in residential homes (APRs 7, 10, 17 & 19). Whistleblowing was a particular issue because of lack of a policy within some of the homes, and also because private homes in particular often employ friends and relatives. The employment of relatives was a feature in three APRs (7, 10, 19). In these homes, in addition to there being a lack of a clear policy and lack of knowledge about a duty to report by residential staff, family members were reluctant to whistle-blow on relatives. In these homes, this meant that there was a delay in reporting and residents experienced some extreme, enduring and prolonged abuse (APRs 7, 10, 19). In APR 17 a previous working relationship with the care home manager led to a lack of robust scrutiny of the home.

There appeared to be barriers for the inspectorate to shut care homes down; with care homes closed only in extreme cases (APR 19) where staff were prosecuted and subsequently imprisoned. For CIW there is a difficult balance to be struck between promoting positive change and acting in a definitive and decisive manner (see page 15 around constraining legislation). Understandably, CIW wants to provide residential care homes a fair chance to make positive changes, particularly given the fragility of the market in some areas; however, this should not come at the expense of resident's quality of life. This was noted as a concern raised by Moultrie and Rattle, 2015 some six years ago, and by Flynn et al. 2014. A sharing of information with local authorities (and other statutory agencies) and residents (and their families) in a timely manner would help to ensure that difficulties do not escalate and could help to avoid cases of abuse.

Theme 3 – Transitions

Transitions were a particular theme that emerged across the APRs. The room for error increases when people transition (Robinson et al. 2018; Rees et al. 2019) and risk increases, mostly because information gets lost or does not travel with people. This may be exacerbated because of the lack of pre-existing relationships when people arrive in a new setting. There was significant movement of people within the APRs under study. Moving between residential care homes (APRs 7) (from educational facility to adult home) 16, into hospital (APRs 3, 4, 5, 6, 9 (secondary care unit), 10, 15, 16) and across hospital facilities (APR 6) and back to family (APRs 6, 15). We also saw people moving across borders and of the county of the commissioning local authority (APRs 3, 6, 7, 8, 10 & 17²).

Across the APRs we saw movement between services, for example, a child with a learning disability becoming an adult (APR 7) necessitating the need for new residential accommodation. In this APR, whilst the young woman's needs were known when moving into an adult services facility (as she had received tailored services for many years and there had been a long period of preparation of the new facility), many of these needs were no longer catered for (e.g., being part of a community or social network) when she moved to this new accommodation.

² Information for APRs 10 and 17 is slightly unclear as they refer to out of county commissioners but do explicitly not specify whether these were out of county placements.

The transitions of people moving into residential facilities was also a major risk factor (APRs 4, 8, 11, 12, 13, 17). In APR 17, a new resident moved into the home and, whilst a detailed assessment was undertaken as to whether the facility could meet his needs, there was no consideration of the risk he posed, or the impact he could have on other residents. The new resident had a history of harmful sexual behaviour and committed a serious sexual assault. Similarly in APRs 4 & 5 (both of which related to incidents committed by the same perpetrator), the impact of a new resident/patient on existing community was not sufficiently considered. In APR 5 the person who instigated the assault was moved into a Specialist Dementia Assessment Ward and assaulted an elderly patient, having previously assaulted seven people (including a member of staff) over a period of seven months when living in a residential care home (see APR 4). The complexity of attributing abuse and neglect as a cause of death was noted through these incidents³. It is crucial to consider the needs of current patients and residents when moving an individual into a residential setting.

People who moved into residential care out of county (APRs 6, 8, 10), also became more at risk as the communication mechanisms were not clearly developed. In APR 10, even though standards in the home were declining, this information was not fed back to the commissioning county. Further, in APR 15, the individual was transferred back to family (her mother) without full discussion; it later transpired that her mother, who was vulnerable herself, may have felt under pressure to accept her daughter which in fact, also placed the mother at risk, as she was later assaulted by her daughter⁴. The placement was also noted as unsuitable for the daughter, particularly because of the condition of the accommodation. It was noted that a meeting prior to

³ APR5 refers to an earlier assault that resulted in death, which is presumed to refer to APR4. In APR4, it was stated that the 'police investigation ... concluded that there was no direct causal link between the assault and victims [sic] death.' In order to establish causation in criminal law, there must be cause in fact and cause in law. Cause in fact requires that 'but for' the defendant's actions, the outcome (in this case, the death) would not have occurred (*R v White* [1910] 2 KB 124). Cause in law requires that the defendant's actions were a 'substantial cause' (but not necessarily the sole or overwhelming cause – *R v Cato* [1976] 1 WLR 110) and that there must not be a break in the chain of causation. There are three events that can break the chain of causation: acts by the victim, acts by third parties, and natural events. Acts by the victim must be 'free, deliberate and informed' in order to break the chain of causation. Further, any foreseeable acts will not break the chain of causation. Moreover, the defendant must also take the victim as they find them (the thin skull rule – *R v Blaue* [1975] 1 WLR 1411). It may be that there was no causal link between the assault and the death, i.e., if the victim had fully recovered or if another free, deliberate, informed and reasonably foreseeable act occurred that broke the chain of causation. However, there is nothing in either APR 4 or APR 5 to suggest that this was the case.

⁴ Practitioners (unspecified) felt that the mother was 'keen' to take her daughter in, however, the police relayed that the mother felt under pressure.

discharge should have taken place with the family, but that resource and capacity issues would mean that this would not always be possible. The daughter later ended her life by suicide. Within the APRs, changes in capacity occurred, with people transitioning in and out of capacity (APR 6), but this transitioning was not responded to; rather, capacity was seen as a blanket, static assessment (see theme 1). Some of the APRs (7, 10, 17) also faced the transition of staff turnover, which increased the room for error. For example, in APR 7, staff were originally trained in the individual's needs, but, as staff left and new staff replaced them, this training was not replicated. Similarly, in APR 17, frequent staff turnover and transfer of existing, experienced staff to new accommodations diluted knowledge of how to manage the individual's behaviour. Not only was there turnover of staff, there was also inadequate supervision. Lack of supervision was noted in APRs 7, 9, 11 and 17. For example, in APR 11, there was a notable lack of support for District Nurses, and absence of peer support, advice, and guidance, and no supervision on complex cases.

Another area of difficulty in relation to transition was movement out of services through disengagement. Where people were not attending appointments, not responding to treatment or where there was no engagement with a service (APRs 15, 18, 20) they were discharged or rolled off from services. In these circumstances, there did not seem to be any professional curiosity, or any understanding that this might heighten risk. In APR 18, the vulnerable adult was 'off rolled' from services relating to his fracture (specific service not specified); initially, he advised that he was unable to attend his first appointment, but subsequently did not attend further appointments, resulting in discharge. It was seen to be good practice in APR 20 when the case was kept open due to non-attendance, and continued attempts were made to engage the individual.

Theme 4 - Voice of vulnerable people

The guidelines require that APRs cover a timeline of a maximum of 12 months preceding the event (see 6.21 in Welsh Government, 2016) 'The 12-month timeline may be extended only if there are exceptional circumstances but as the focus of the review is on current practice, the timeline should in those cases be no longer than 2

years'. The readers of the APRs found that in some instances, this renders a very limited picture for the reader.

In some of the cases the readers struggled to make sense of the context surrounding the APRs because of the limited information provided, for example, APRs 1, 4, 5, 8, 9, 17 & 18 did not mention age. The lack of information about people's history or interests (APRs 1, 2, 3, 4, 6, 8, 10, 17 & 18) almost objectified the individual and did not present any contextual understanding of their experiences or needs. In one APR there was a positive attempt to provide this information, but the only information given related to the individual's interest in costume jewellery (APR10). In APR 1 the person almost became a faceless 'bedbound' figure at the centre of the review, where even the relationship and history between the subject and their carer was either not known about or not relayed in any detail in the review

Endeavouring to apply the learning without context was challenging and it raises questions about how useful this might be to practitioners from different areas attempting to draw learning from reviews. Furthermore, without any personalising information, it is difficult to remember learning from an APR. Much learning is conveyed through narrative and most stories are memorable because people can identify with the characters or remember some interesting details about them (Boris, 2017). There were examples of good practice which did include rich detail (6, 7, 11, 12 & 13) and these were far more memorable and easier to recall amongst the research team. Interestingly, this lack of personalisation almost iterates the treatment that many vulnerable and older people receive particularly in residential care (Rochira, 2014). There were some APRs which included a work and/or relationship history and an understanding of what mattered for the individual, such as in APR 15. However, the researchers noticed that these tended to be included more regularly in cases of more middle-class individuals; perhaps these were people with whom the reviewers could more easily identify. This was not always the case, as in APR 11, the individual was presented warmly, favourably and with some empathy.

In none of the APRs (where an individual was still alive) (APRs 7, 16, 17 (2 people) & 19 (2 people)), were any of the subjects involved in the review and yet, the APR is supposed to:

'ensure that the perspective of the adult of the review is obtained and that the subject's perspective contributes to the new process, so far as

practicable and appropriate to the circumstances of the case' (Welsh Statutory Instruments, 5 b, page 7).

Family's views were drawn upon and some good practice was demonstrated in this regard. However, the voices of the adult/victim were not central to practice (APRs 7, 16, 17 & 19). In this respect, the reviews, like Child Practice Reviews, seemed to mirror some aspects of practice.

In some of the APRs, professionals were not always able to see the adult alone (APRs 1, 2 & 20); something that is heavily discussed when safeguarding children and young people.

The lack of voice of individuals in residential care and lack of personalisation was also demonstrated in practice in several APRs (6, 10 & 11), in particular where someone was regularly being dressed in other resident's clothing and where family members recounted that other people's belongings were regularly found in their room (for example, in APR 6).

Access to chiropodists and hairdressers was limited or not available in residential homes (APRs 6, 10, 11), as was also found by Rochira (2014). Lack of services going into care homes left people isolated and with less surveillance (APR 3). The lack of voice, consideration and respect for the needs of the individual undoubtedly impacted on wellbeing, with people left in incontinence pads for long periods, with one person arriving in hospital wearing an incontinence pad, and no underwear (APR 11). Child stairgates were being used to restrict movement (APRs 3, 11 & 13). All of these factors gave the sense of a lack of dignity in care homes. It was noted in APR 10 that there had been a positive initiative in the region of a multi-disciplinary care home project working on enhancing the lives of people in care homes, although this related to only four homes and was a time-limited project. It was also noted in this APR (10) that there are some beacons of good practice, and it would be helpful for care homes to have the opportunity to learn from each other. Similarly, in APR 6 mention was made of good practice with regard to the regional implementation of 'Good Work: a dementia learning and development framework' (Care Council, 2016). The Developing Evidence Enriched Practice (DEEP) initiatives that have taken place across some care homes in Wales also help to develop good practice (Andrews, 2016).

Theme Five - Family and carers

'Family and carers' is the fifth theme that emerged from our thematic analysis.

Communication with family was seen to be problematic in many of the cases (APRs 6, 8, 10, 11, 13, 16, 17, 18, 19 & 20). Family and carers were viewed as periphery to the care given to the adult, and their voices were often not listened to. When people enter residential care, their relatives (and previous informal carers) are often keen to maintain their involvement in their new life in the home, and to continue in their caring role, albeit in a new guise. Relatives often wish to have oversight of their relative's well-being; with family seeing their involvement in the care of their relative as making a positive contribution (APRs 3, 4, 6, 7, 8, 10, 11, 12, 13, & 19). Families often struggle when they are not kept in the loop, especially given relatives are often the people who have the most knowledge of the resident and are likely to be keenly attuned to their needs (APRs 4, 6, 12 & 13). However, families were not always welcomed by residential homes and were often framed as being difficult or were expected to take a back seat (APR 13).

Family members were often not informed of significant changes, especially where a resident deteriorated (APRs 6, 10 & 13). Similarly, families may not have been consulted and/or may not have understood why changes were judged to be necessary (APR 4). Moreover, families were not always given sufficient information about their family member's needs (APR 11). For example, in APR 11 the family were unaware that their elderly relative was only permitted to have pureed food and concerned with her significant weight loss, gave her biscuits and chocolate – unaware of the potential choking hazard.

When families themselves noted a deterioration, raised concerns, or complained, they were rarely listened to (APRs 4, 13, 15 & 18). Here we can see a repetition of the 'hierarchy of knowledge' seen in both previous reviews (2018; 2019), where the knowledge that family hold is not sought or valued. Thus, family members often noted an individual's deterioration before staff recognised this, but such concerns were not acknowledged (APRs 6, 13 & 18). Families were often not made aware of any form of complaints procedure and were often unaware of who to tell or what action to take when they were concerned (APRs 8 & 11). When people are moving through periods of transition (see theme three above), the knowledge that family held was especially important.

Lack of communication was a feature in APRs when people were sent home (APR 15) or to a new facility (APR 16) without the family being alerted or consulted as part of the planning process. In both cases the adult presented a potential risk to family, but this did not appear to be a consideration in decision-making on discharge. In APR 15, the mother did not have the room to accommodate her adult daughter, but she was nevertheless sent to her mother's from the psychiatric unit. In this APR, the daughter went to live with her mother in unsuitable accommodation and she went on to assault her elderly mother, and the daughter subsequently committed suicide. In APR 16, the family was notified but not consulted about several transitions, including not being part of discharge arrangements to the family home. Three days later police attended the address, and the individual was arrested for a domestic incident. It was surprising that family were not consulted in either of these two cases.

In APR 6, the adult children felt that their concerns about their father's care in the out of county residential care home were not recognised or acted upon. Communication from the residential home was experienced by the family as poor and they were not told about how seriously unwell their father had become, until he was admitted to a hospital. He died a few days later. The communication issues identified by families could be further exacerbated by their family member being moved to a residential home that is further away and/or less accessible for the family. For example, the daughter in APR 13 had previously visited daily and attended appointments with her mother. However, her need for nursing care and the move to a new home meant a loss of role for the daughter and a deterioration in communication between the residential home and the family.

Whilst some families were not consulted when returning to the community, nor listened to when a relative was in a residential setting, there were four APRs (APRs 1,2, 9, 20) where carers, looking after their relative in their own homes were not receiving oversight from professionals. In APR 1 the carer was a family member (assumed to be male, but not specified), in APR 20 the 'carer' was the husband, and in APR's 2 and 9 the 'carer' was the son. In APRs 1 and 2 there was little professional curiosity as to why vulnerable adults were deteriorating or the nature of the 'caring' relationship. Male carers were a feature of APRs 1 (assumed), 2, 9, 12 & 20; the stresses for male carers taking on a traditionally feminised role was perhaps not fully recognised (Greenwood and Smyth, 2015). Carers then became the

gatekeepers to the vulnerable adult (APRs 1, 2, 9 & 20) and in some APRs it is not clear whether the adult was seen alone (APRs 1, 2, 9 & 20) (this was echoed in CPRs regarding children). It was not clear in APRs 1, 2 or 9 whether the carer was indeed abusing their relative, but certainly the vulnerable adults were living in unsatisfactory conditions (APRs 1, 2 & 20). For example, in APR 1, there were known issues relating to alcohol and substance use and domestic violence in the home and the home care provider had raised concerns that the adult had been physically assaulted by the carer. In APR 12 it was the husband (previously carer) who killed the vulnerable adult, albeit in what might be considered a mercy killing, and indeed has been labelled as such by Crown Court Judges in similar cases. In APR 9, a lack of oversight by professionals meant that the carer took on too much responsibility, undertaking medical procedures, including the 'debriding' of a Grade 4 pressure sore, straightening limbs, and force-feeding. This carer was also sometimes verbally abusive to the vulnerable adult and indeed to visiting community nurses. Whilst the district nurses made four at risk reports, these were not acted upon. The health staff felt intimidated by the carer in APRs 1, 2, 9 & 20 and in APRs 2 & 9 such that they only visited the household in pairs. It is surprising that, given the intimidation felt by health staff, they did not translate this into a likely significant risk to the vulnerable adult. Lack of professional training in working with difficult individuals, particularly men was a finding from our first study (Robinson et al. 2018). Similarly, there were instances where the police were called to the home because of a disturbance and violent behaviour of family members (APRs 1 & 2). Public Protection Notices (PPNs) were generated in APR 1, but the vulnerable adult was not named because she was not directly involved in the conflict, and this meant the PPN was not shared with Adult Services. On the one occasion when she was named, she was not the main subject and, in line with locally agreed policy at the time, the PPN was not then shared with Adult Services. The need to view situations more holistically and consider the impact of conflict on vulnerable adults who may be present, though not directly involved, has now been recognised and local practice changed.

Concise and extended reviews

As noted in the thematic review of CPRs, the research team could not readily discern the difference between concise and extended reviews, especially since they are often the same length. This does not necessarily mean that the distinction is meaningless to reviewers, rather it illustrates a need for greater clarity to be provided about what impact, if any, this has on the final outcomes of reports.

Quality

There was a wide range of quality across the APRs as identified by the research team, and this was also confirmed in the focus groups. Consistency is thus an issue. Importantly, there was widespread use of vague and imprecise language and this could make it very difficult to establish what had happened and who the key agencies were. For example, the term ‘practitioner(s)’ was used across the reviews, but it was often unclear if the organisation was health, social services – or another agency. In APR 1, reference is made to ‘practitioners’ not sharing understandings of what constituted acceptable home conditions. It is accepted that actions or decisions taken at the time may well have been sensible at that time, but clearly identifying who (role and organisation) may help with not only understanding what, but why there were unintended outcomes. It is through this understanding that improvements to the system might be made. A key barrier to achieving this may be a concern across agencies with moving away from ‘blame culture’ and, with this an attendant concern, therefore not providing timelines or sufficiently detailed accounts in order to obscure potential opportunities to ‘name and shame’ individuals and/or agencies. As noted by Vincent (2004), “The slogan of ‘moving beyond a culture of blame’ ... is a call to abandon poor systems of accountability and ... not a tolerance for an absence of accountability”. It is important to be clear that we are not suggesting that vague and imprecise language are understood as multiple and deliberate attempts to deceive. However, it could be tentatively suggested that a drive to move away from an unhelpful ‘culture of blame’ may be incorrectly understood as inferring the need for an overly anonymised, vague and imprecise account that obscures the potential to understand what happened and why. Whilst potentially identifying individuals should be avoided, accountability is important and good practice is linked to clearly

explaining what part(s) of the system did not work, whether partially or entirely (Fish, 2012).

In addition to vague and imprecise language, there were also examples of the overuse of medical terms without explanation. For example, in APR 9 the adult's carer is noted as attempting '*debridement*' on his mother's pressure sore. This is not a term that is understood by any member of the research team, including the two social work experts. It might then be reasonable to suggest that other readers may also not understand the term and therefore its potential significance. It is understood that medical terms may be necessary, but it would be helpful if a short explanation could be provided for non-expert readers. There were also several occasions where abbreviations were used, and again the meaning was not known by the readers. For example, in APR 9 the abbreviation 'MDT' was used and in APR 10 the abbreviations CIW, CSSIP and JIMP were all used. Following standard writing practice of defining a term alongside the abbreviation would be helpful, as would providing a glossary of terms in some cases. The Older People's Commissioner similarly provided a glossary of terms because of these identified difficulties (Older People's Commissioner Care Home Review, Follow Up, 2017).

Some reports were of far better quality in terms of their level of detail and analysis than others, and writers of reviews may benefit from more training, a consistent standard and benchmarking. Unpredictable variability within reviews was also highlighted as a barrier to learning. There would seem to be high level of support for increased training and those involved in APRs. The action plans were seen to be an essential component of the review.

Good Practice

The system framework approach to case reviews, advocated by Fish (2012), borrows principles from health and aviation and is premised on the idea that workers' performance is linked to their own skill and knowledge, and the organisational setting in which they are working. In a similar way that an air crash investigation seeks to understand the reason(s) for the crash by thoroughly investigating the plane and the pilot(s) as parts of an interconnected system, so too can adult and child case reviews look at the individuals and organisations involved in the care of a person as 'a system'. As noted in the previous sections, the very nature of case reviews means

that there have been unintended outcomes and many of the recommendations may be indicate a need to improve. However, it is as important to recognise examples of good practice. As noted by Vincent (2004), a particular case is made to act as a “window” on the system – providing the opportunity to study the whole system, learning not just of flaws, but also what is working well (Fish, 2012). In considering the quality of the case reviews, there are a number of noteworthy examples of good practice. For example, the background information provided about the adults, their lives, their likes and dislikes, gave a meaningful sense of the adult as a person – something that is often missing from case reviews. Particularly noteworthy examples of good practice in relation to this include APRs 9, 11 and 20. Providing a chronology would be useful in all cases and whilst none of these 20 cases did, APRs 4, 7 and 16 had timelines of significant events either in the text or the appendices and these were helpful.

Discussion

The learning from reading across the APRs allows for an ‘aerial’ view to be taken to determine patterns and cross-cutting themes that cannot necessarily be gleaned from reading a single review, although there are undoubtedly benefits from exploring individual reviews and taking more of a ‘worm’s eye view’. Reading the 20 APRs at the same time forcibly illuminated some very poor practice across the residential home landscape in Wales. Reading them together highlights that they are not individual aberrations or one-off incidents, but representative of a pattern of poor practice in care homes.

A distinctive aspect of this research, and in our two previous studies, was to have a research team from three different disciplines – criminology, law, and social work – code and analyse the data. Different disciplines enabled a range of perspectives to be brought to the reflection and analysis which helped the team to avoid ‘silo thinking’ and the privileging of one particular perspective over another. As previously, this approach also facilitated the corroboration of findings through triangulation. All four researchers independently identified similar themes from each of the review documents. These themes also resonated with the participants in the focus groups. When comparing the themes from this study with those of the previous two studies undertaken into adult reviews (Robinson et al., 2018) and CPRs (Rees et al., 2019),

some of the same themes emerged across all three samples, regardless of whether the review was a CPR, DHR, APR or MHHR. These included the lack of listening to family (previously termed hierarchy of knowledge); lack of voice of the vulnerable adult (previously lack of voice of the child in analysis of CPRs); transitions (in CPR study of 2019, and previously termed Crossing Boundaries in the adult death reviews from 2018); and dealing with difficult and hostile people (also found in Robinson et al. 2018). This demonstrates that these issues are not confined to working with adults or with children, but routinely emerge in both spheres of professional practice. Information-sharing is another prominent feature of both previous studies and emerges here within the theme of transitions, where information does not travel with people when they move across boundaries (also found Neville and Sanders-McDonagh, 2014; HIW, 2016; Sharps-Jeff and Kelly, 2016; Sidebotham et al., 2016). Reading the 20 APRs revealed some disturbing practice taking place in care homes (7, 10, & 19), and in adult social care more generally. Many of the same concerns in this study were found some years ago in Operation Jasmine (Flynn, 2015), although this may be because some of the APRs relate to incidents which occurred as far back as 2014. Concerns with care home practice were also raised by Rochira in her 'A Place to Call Home' Report of 2014.

Whilst the aim of the change to both the APR and CPR model was to take a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases (WG guidance, 2012), as found in the CPR review it may be that learning is somewhat compromised by this overly pared-down approach. Our findings from reading the APRs, similar to our previous study, found the reviews to be 'often devoid of background detail (see theme four), which is difficult for those outside of the situation to follow, although they can convey helpful analysis and learning points for those involved' (Robinson et al., 2018).

It is noted in the Working Together to Safeguard People document (2016) that 'The learning and reviewing framework has been developed with the intention that Boards and their partner agencies provide an environment in which practitioners and their agencies can learn from their own and others' casework and from sources, such as audits, research and inspection' (2016: 3). It maybe that in certain circumstances this approach does not lend itself to more broad and national learning, as readers require an understanding of context. Our previous research (Robinson et al. 2018)

suggested a number of ways in which the reviewing process could enhance the likelihood of wider, deeper learning and focus group participants in 2018 expressed a desire for a more centralised approach to facilitate learning from reviews which is specific to Wales. Although not discussed in the focus groups this time, it would also seem to be the case for APRs. Currently there is no current complete Welsh repository for such reviews, although we believe this is under construction. We approached the NISB to obtain the numbers of APRs completed since their inception; NISB helpfully confirmed that 36 had been commissioned, however their list was not complete with regard to information about receipt and publishing of the 36 reports.

In undertaking this research, the researchers were conscious of the complex frameworks that exist in both safeguarding adults at risk of abuse and neglect, and in social care services generally. The complexity of understanding, navigating and having the voice of people using services heard is something that is recognised in primary statute; most commonly by the provision of advocates through the Social Services and Wellbeing (Wales) Act 2014, the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and the Mental Capacity Act 2005⁵. In the APRs it was evident that some efforts had been made to seek the input from families, although this was less common (for a variety of reasons) for the individuals to whom the reviews related. This led us to note the following points:

- Access to advocates – Advocates were conspicuous by their absence in the APRs. It is unclear from the APRs how much advocates are, or are not, being utilised in contemporary social care. Involving advocates may greatly aid with helping to consider the perspectives and needs of adults at risk of abuse and neglect; consideration of the use of advocates should be encouraged in all safeguarding work.
- Support for families – From the focus groups it seems that some RSBs have been developing lay guidance on APRs to provide to families (and potentially those for whom an APR is being undertaken). There does not seem to be any attempt to devise an advocacy system, or to draw on existing advocacy systems, in a way that might enable family members to be supported in the APR process. This would likely aid with engagement and also help reviewers

⁵ Note, at the time of publication the Mental Capacity Amendment Act 2019 has yet to be implemented.

to more effectively capture the perspective of individuals at the heart of these cases.

It is important to note that there have been many relatively recent changes to the policy and legislation of adult safeguarding in Wales, which include: Social Services and Well-being Act (Wales) (2014) (primarily Part 7); The Regulation and Inspection of Social Care (Wales) Act (2016); Mental Capacity Amendment Act (2019); Liberty Protection Safeguards (2020); and the registration of residential care home staff (Social Care Wales, 2021). It will be interesting to see how these changes to adult safeguarding influence practice in coming years, and how this is reflected in any future review of APRs.

Single review mechanism

Whilst undertaking an analysis of the reviews we considered issues of quality, consistency and format. We were cognisant of APRs 12 and 20 which were essentially DHRs undertaken in an APR format. We discussed this format and felt overall that it worked well, although the exhaustive lens of coercive control in APR 12 was not helpful in this instance. Reviewers must always be open to exploring a range of complex and adverse situations, but at the same time they must be judicious in determining when a concept is or is not relevant to the given case (e.g., they should not feel obligated to utilise and heavily rationalise a given concept(s) unnecessarily). In light of this we are minded to recommend a single, unified review which could help standardise the process, aid with benchmarking and quality assurance, and streamline the training requirements. This would also increase the number of people who develop expertise in writing reviews and could allow for some training to become standardised.

Recommendations

The evidence contained in this report suggests a number of recommendations, which are listed below:

1. Training for all staff in the sector around (i) duty to report, (ii) capacity, (iii) self-neglect, (iv) GDPR and (v) pressure ulcers is urgently required.

2. Regulation around employing friends and family in care homes should be put in place, if this has not already been done.
3. Clearer communication pathways should be developed between inspectorate and commissioners, so that any deficits in standards of care homes are quickly reported.
4. More schemes around increasing choice and dignity in care homes should be initiated across Wales and care homes should be encouraged to regularly share examples of good practice.
5. Consideration should be given to the use of advocates in both safeguarding practice and potentially in the APR process.
6. Training for all staff in the sector on working with difficult and resistant people.
7. The development of a single, unified assessment tool for all reviews (APR, CPR, DHR and MHHR) be developed in Wales, which would help with consistency and training.
8. APRs be deposited in the new central repository to promote the accessibility of completed reviews to facilitate learning pan-Wales. Each review should be indexed according to the issues arising within it, so that others working in the same area may benefit from this easily accessible information.
9. APRs should include more detail and background of the subject of the review to help dignify and avoid further de-personalisation and institutionalisation (as a minimum, age, gender, family, and previous employment).
10. The training for APRs (2016) be revisited with regard to repositioning the vulnerable adult centre stage and guidance on how their voice might be presented. At the very least reviewers need to identify whether the subjects have been spoken to (they had not in any of the APRs reviewed) and, if not, what the reasons are for this.
11. As found in our previous report (Rees et al., 2019; 2021) we suggest regular publication of the major themes emerging from all reviews is produced and disseminated widely in order to enhance learning across Wales.
12. The use of creative methods is explored to disseminate the messages from the reviews, for example, the use of 'webinars'. These could provide excellent opportunities for teaching and learning and could form the basis of team or inter-disciplinary supervision.

13. Reviews be uploaded on Safeguarding Board websites for more than 12 weeks.
14. More clarity with regard to the distinction and purpose of the concise and extended reviews.
15. Similar to CPRs, we recommend additional training to improve the consistency of the quality of review is developed for and completed by all those charged with undertaking reviews in Wales. This needs to include a focus on involvement of the vulnerable adult, timelines/chronologies, genograms, cooperation, responsibilities, and information-sharing by different agencies contributing to reviews. Regular meetings of APR chairs and reviewers to be convened.

We anticipate that improving the process and the outputs will increase the status of the APR, and thus result in improved outcomes as practitioners will have better access to relevant learning from reviews taking place in Wales, with the ultimate aim of reducing the number of incidents requiring reviews over the longer-term.

We would like to thank the National Safeguarding Board for giving us access to the APRs, which have proved illuminating. We are also very grateful to the busy professionals who conduct these reviews and to those who took time to participate in the APR focus groups.

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APPENDIX A

Descriptive table to provide a snapshot of each review and overview of the sample and the relevant themes identified.

APR No.	Safeguarding board	Period of review Concise or extended	Incident or death	Individual details	Broader circumstances of the case	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
APR1	Cardiff and the Vale	1 October 2016-30 April 2017, Extended	2017	Female, age unknown	Carer, family member. Family history of drug and alcohol abuse, history of volatile relationships within home.	Yes	Yes		Yes	
APR2	Cardiff and Vale	2 Sept 2016-10 Nov 2017 Concise	2017	Female, aged 59	Living at home with son, who was presumed to be sole carer.	Yes			Yes	
APR 3	Cwm Taf	4 February 2015 to 9 August 2016, Extended	2015-16	Female, aged 92	Lived in a care home, died in hospital from sepsis, urinary tract infection and dementia.	Yes		Yes		
APR4	Cwm Taf	2017(further dates unspecified), Extended	2017	Adult male x 2 (E & D), no age specified	Two adult males living in EMI residential care home. Assault by E, D was admitted to hospital having sustained a fractured skull and passed away.	Yes	Yes	Yes		
APR5	Cwm Taf	Not specified, but seems to be July 2017 to June 2018, Extended	2018	Two adults – F (female) and G (male), no age specified	One female and one male admitted to hospital. G assaulted F whilst on ward.	Yes			Yes	

APR6	Mid and West Wales	Jan 2011 to Jan 2012, Concise	2012	Adult male in his 70s	Adult A placed in Residential Care Home. Upon admission to hospital, dehydrated, with pressure ulcers, A passed away shortly after admission.	Yes	Yes	Yes	Yes	Yes
APR7	Mid and West Wales	1 March 2016 to 7 March 2018, Extended	2017	Female, Unclear age at time of event; 28 at time of review.	Adult M placed in supported living in 2016. M has learning disability and requires constant support and supervision. M suffered physical and verbal abuse by staff members.	Yes	Yes			
APR8	North Wales	4.5 weeks (extended by 13 days – unclear) – from first fall to hospital admission, Extended	2013	Female, age unclear	A placed in out of county specialist dementia placement. A sustained multiple falls in care home – three of which led to hospital admission. A died as a result of final fall.	Yes	Yes	Yes	Yes	Yes
APR9	North Wales	1 Aug 2016 (when DNs noted difficulty accessing property) until A's death on 28 Mar 2017, Extended	2017	Assumed female as references to 'Mum' later in report. Age also unknown.	Adult A resided in own home with son who was the 'carer'. Issues of neglect that led to hospitalisation. History of safeguarding concerns.	Yes	Yes	Yes	Yes	
APR10	North Wales	April 2015 until to December 2016 (following closure of Beach Residential Care Home), Extended	2016	Female, possibly 81 years of age	A living in specialised MH care home but due to deterioration in physical health moved to privately owned care home. No medical attention sought by care home in respect of pressure ulcer.	Yes		Yes	Yes	Yes

APR11	Gwent/South East Wales	3 rd March 2015 to 16 th January 2016, Concise	2015-16	Female, aged 82	82-year-old woman – who had Alzheimer’s living in a care home and had sustained 9 falls -fractured neck of femur.	Yes	Yes	Yes	Yes	Yes
APR12	Gwent/South East Wales	4 th October 2015 to 4 th October 2017, Concise (D-APR)	2017	Female (victim A); Male (B – also deceased); Age not specified	A had been diagnosed with dementia. A moved to care home for dementia. Died while on a visit out of home.	Yes		Yes		
APR13	South East Wales	17 February 2015 to 16 August 2016, Concise.	2016	Female, aged 94	A resident in care home who had suffered serious injury from fall. Issues raised about standards of care received. Admitted to hospital (with fractured neck of femur).	Yes		Yes	Yes	Yes
APR14	South East Wales	1 October 2016 to 31 October 2017, Concise	2017	Female, aged 64	A lived-in sheltered accommodation. A been assessed for a learning disability. A’s health deteriorated and she died from septic shock / infected ulcers.	Yes	Yes	Yes		
APR15	West Glamorgan	Time frame unclear Concise	2015	Female, in her 40s	Death by suicide. At time of death – receiving mental health care in local hospital as informal patient.	Yes	Yes	Yes		
APR16	Western Bay	29 October 2014 to 19 January 2015, Concise.	2014	Male, aged 46 (at time of incident)	A found unconscious and later had various admissions to hospital, private residential care home and acute mental health wards.	Yes	Yes	Yes		Yes

APR17	Western Bay	1 February 2014 until 31 March 2015, Concise.	2014	Two males (S1 & S2), ages unknown	Two vulnerable adults living in a residential care home. Exact incident unknown, but circumstances suggest that sexual assault committed by S2 on S1.	Yes	Yes	Yes	Yes	Yes
APR18	Western Bay/W Glam	18 March 2015 to 18 March 2016, Concise	2016	Male, age unknown	A was living alone or with girlfriend. A died of decompensated liver disorder, having been admitted to hospital.	Yes		Yes	Yes	Yes
APR19	Western Bay/W Glam	20 May 2015 to 1 March 2016, Historic	2015-16	One male (A) and one female (H); A aged 57 and H aged 62	A and H were at a residential care home. Concerns over standard of care provided at residential home.		Yes	Yes	Yes	Yes
APR20	Gwent	29 September 2016 to 28 April 2018, Extended	2018	Female (A), age unknown	A who previously lived in supported living accommodation, was, at the time of her death, living with her partner (B) in the community.		Yes	Yes	Yes	Yes