WEST GLAMORGAN SAFEGUARDING BOARD

Adult Practice Review Report

West Glamorgan Safeguarding Adults Board

Historic Adult Practice Review

WBA N11 2019

Brief Outline Of Circumstances Resulting In The Review

Legal context:

The West Glamorgan Safeguarding Adults Board (WGSAB) commissioned an Adult Practice Review on 20th March 2019 on the recommendation of the Practice Review Management Group in accordance with part 7 of the Social Services and Wellbeing (Wales) Act 2014 and the underpinning Practice Guidance for Multi-Agency Adult Practice Reviews.

Reviews that meet the criteria for an Adult Practice Review should follow the principles, approach and process outlined in chapters 1 - 7 of Part 7 of the Social Services and Wellbeing (Wales) Act 2014, Volume 3.

The purpose of a review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the context and detail of agencies' work with an individual and their family. The outcome of reviews intend to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice.

The Practice Review Management Group felt that this review could generate multi-agency learning around self-neglect. As such the Group agreed that this case met the criteria for a Historic Adult Practice Review.

Methodology and Scope of the review.

The scope of the review was from the 1st January 2016 to 30th January 2019. Following the decision to carry out this Review, an Adult Practice Review Panel was formed comprising of the following:

Chair: Eve Davis, South Wales Police

Independent Reviewers: Lisa Collins/Ffion Larsen, Swansea Council.

Panel Members:

- Swansea Bay Health Board UHB
- Neath & Port Talbot Social Services
- South Wales Police
- YMCA
- Routes
- NSPCC

The panel met on five occasions prior to the learning event. As part of the preparatory work, the reviewers met with the subject of the review (A) to ensure that his wishes and feelings were represented at the learning event and within the report.

- All attendees were sent the chronology prior to the learning event in order to allow them time to consider the following:

  - ✓ What did they know?
  - ✓ What didn't they know?
  - ✓ What concerns did or didn't they have?

- There was a delay in conducting the review which was further impacted by the coronavirus pandemic. The learning event was held on the 11th November 2020 with representations by professionals, managers and practitioners from the following agencies:

  - ✓ South Wales Police
  - ✓ Local Authority Social Services (children's / adults)
  - ✓ Health Board representatives
  - ✓ YMCA
  - ✓ Goleudy

- The Chair reminded the attendees of the event from the outset that the point of the review was not to apportion blame to organisations but to rather to learn on how to improve our services, minimise risk to individuals in future and that the review should be seen as an opportunity to learn from previous experiences.
- The learning event provided managers and practitioners with the opportunity to reflect and to identify a key interagency learning point.
- The outcome of the event was positive for all involved. All participants were reflective and were prepared for the learning event.
- Wellbeing support was offered to all attendees of the learning event by the Chair and the panel members.

Circumstances resulting in the need for review:

The referral for the Adult Practice Review was made following an investigation by South Wales Police.

- On Wednesday 30th January 2019, police had cause to attend a property within the South Wales Police area, following information being received that a young adult male residing at the address potentially subject to slavery and a series of assaults.
- On attendance, A was discovered at the premises with swelling to his face and head and other cuts and grazes, some recent and some historic.
- Enquiries at the scene determined that A had limited and ill-fitting clothing, that the caravan he was residing in was in a poor state of repair and he appeared under-nourished.
- Whilst initially stating that he was fine and not making any allegations against others, it became apparent that the occupiers of the property (father and son) had been mistreating A, and effectively had caused him to reside at this caravan, within the confines of their land as a slave. A was clearly in fear of the suspects.
- An investigation was commenced, A was safeguarded after an initial extended period in hospital to treat his injuries, which were extensive, and the two suspects were arrested.
- On 1st February 2019, the father and his son were both charged with Modern Slavery offences and a series of assaults against A. Both individuals charged with the offences have subsequently been convicted and are serving significant custodial sentences.

Background to the Adult Practice Review:

- It was agreed by the panel to conduct the review over a three year timeline between 1st January 2016 – 30th January 2019. This period afforded the review detail around a transitional period for A into adulthood.
- A initially lived with his family, and during this period A moved to more independent living before subsequently becoming homeless. Following on from this, A experienced abuse and serious injuries.
- A was diagnosed with ADHD in April 2005 and ASD Asperger's in June 2007. Records also indicate that he has been diagnosed with a moderate learning difficulty.

Subject of the review:

- The review relates to A, he is 22 years old.
- A used to live with his mother and siblings.
- A had a diagnosis of ADHD and ASD
- A had a history of challenging behaviour and could be aggressive, was known to self-harm and was sometimes reluctant to take his prescribed medication.
- A has previously experienced a period of being looked after by the Local Authority, before he was eventually discharged to his uncle's care for a few months prior to returning home to his mother's care.
- A became homeless. He was temporarily accommodated with an independent living provider however, the tenancy was unsuccessful and he later moved to live with his abusers, where he suffered from physical and emotional abuse.
- A was previously supported by the local authority, and had a good relationship with his social worker until he reached the age of 18 and was referred to adult services.
- A was asked to leave the temporary accommodation due to lack of engagement.
- When A left, he moved to live with the abusers and subsequently became exploited.

Practice And Organisational Learning

Transitions and post 16 work – Children's Services

A was a previously looked after child who had a difficult relationship with his mum. When A was 17 and still a child the relationship with him mum was fractious and resulted in mum contacting the police on several occasions. Each time both A and mum explained that they could no longer live together and made a request for A to return to care. Mum told professionals she was frightened of A, who was described as aggressive with threats of violence towards her. Mum said that she was worried about the safety of her younger child as well as her own safety. At this point A's diagnosis of ASD and ADHD were well known to agencies, he had been excluded from college for poor behaviour, and was planning to start a mechanical course. It was known that A was not taking his ADHD medication regularly and was reported to be smoking cannabis.

A previous children's services assessment, undertaken in May 2015, 7 ½ months prior to the police contacts, identified a volatile relationship between mum and A which included A threatening his mother with a knife, threatening to self harm and also reflected on a previous, historical, incident where he set fire to his bedroom resulting in him becoming a looked after child. A had since returned home under a successful rehabilitation plan signed off by the worker and manager (same person) with the following comments:

*Rehabilitation plan has been successful. A is now residing full time with his mother. No current assessed on going support needs from Social Services. Case to close. A will be entitled to support under Section 24 CA 1989 (**qualifying young person) and can contact Route 16 for advice, guidance and befriending if required up to the age 21 years old. May 2015.***

The later Children's Services assessment undertaken in January 2016 (7 ½ months later) resulted in referrals to Action for Children and Dewis for support with accessing independent living with no reference or offer of advice, guidance and befriending from R16 service.

At the learning event, it was acknowledged that the Children Act 1989 and 2004 are premised on principles that families should be promoted to stay together when it is in the best interest of the child / children and appropriate to do so. Practitioners attending the event felt this was still relevant despite both mum and A clearly stating they could no longer live together and acknowledged A's younger sibling living within a domestically abusive situation. Following this assessment it was also concluded that A was no longer eligible for the support identified in the pathways assessment due to the length of time he had been back in the care of his mother. The assessment did not take account of the risk posed by A within the family as a domestic abuse perpetrator nor did it consider his needs for an independent advocate given his diagnosis of ASD and ADHD.

Instead, the local authority supported police action to encourage A to stay at a friend's house. From this point on the focus of support was based on care and support from his friends' mother who was considered a carer for A despite this being an informal arrangement, until accommodation was found with an independent living provider.

Homelessness support

A's transition to homelessness support followed usual practice. Historically, the local authority will have had contracts with commissioned homelessness services which included support, advocacy and monitoring for young people accessing these services. Over recent years services from 3rd sector homeless support providers have been de commissioned from statutory services and have faced difficult management decisions resulting in cuts to service provision. By the time A was introduced to the independent living provider and given a place to live, the wider support provision previously in place was no longer available and only basic tenancy support was on offer. Without advocacy and support from transition services A was given a room, an agreement to sign to confirm he accepted the terms and conditions of the placement offer and the case was closed to Children's Services as he had reached 18. Despite decisions around the commissioning of homelessness service provision in 2006, the reviewers were unable to establish how widely and effectively such decisions had been communicated. Therefore, there remains a question as to how informed those accessing homelessness provision were about the type of homelessness support offer available.

It was clear that A had care and support needs however transition to adult services was not straightforward. At the time, his individual circumstances lead to a lack of clarity about what A's needs were and how best to meet his needs as an adult and so he was left in the homelessness provision without the support of adult or mental health services and no social work support. Had A been placed in supported accommodation there would've been an opportunity to undertake a care and support needs assessment which would inform any tenancy needs assessment and better respond to his needs. However, the referral to homelessness support was limited and did not provide sufficient information on what his needs were and how they should be responded to.

When reviewers spoke with A, he explained that at the time he was keen to get his own place but did not truly understand what this meant. He said that he felt he was too young to be expected to understand everything, that he didn't know the rules and was surprised when he was issued with an eviction notice. A says that he had nobody to explain what was happening to him. Homelessness agencies identified that A was referred to them with the involvement of a social worker. This information was contained within the referral however, if A's needs had been accurately assessed and communicated appropriately, the decision on eligibility for adult services may have been different.

It remains unclear whether or how de-commissioning decisions and the impact that has on 3rd sector provision was or is, communicated to front line staff. The social worker involved was not available at the learning event because she had retired and so the reviewers have been unable to establish what A's needs were and what was expected from the homelessness provision at the time he moved there. Reviewers have since been assured that there are processes in place to ensure these discussions occur.

The independent living accommodation providers were not made aware of A's learning difficulties or his need for additional support in decision making. Staff at the accommodation did not know whether or not A could read, whether he understood the rules or what was expected of him. As a tenancy support provision there is no expectation to receive such information and so A's behaviours and "disengagement" were taken on face value based on what is generally considered as anticipated behaviours within his age group. Without any statutory interventions at this point no consideration was made for a capacity assessment.

A spoke very highly of his social worker and it was clear that they were very good at communicating with A on a level that he understood. However, it remains unclear as to what information was available to inform the placement decision to make the referral into homelessness support.

Safeguarding is Everyone's responsibility

Whilst it may not be appropriate to expect accommodation providers to continue to provide the support services previously in place once they have been decommissioned by the local authority, it remains that safeguarding is everyone's responsibility. Consideration of how policies, procedures and guidance can support decisions where a person has known

vulnerability should be considered. Of equal importance is the need to ensure that providers have access to appropriate training, advice and support to enable them to adopt and apply those processes highlighted. The Safeguarding Board has responsibility for ensuring such access to all providers.

A explained that when he received his eviction notice from the independent living provider, he left the building and did not know where to go or what to do. It was during this time that A was approached and became vulnerable to exploitation.

Pathway and transition.

Transition social work role

It is obvious that transition did not occur in the recommended manner, planning for transitioning from children services to Adult Services was missing. The Social Services and Wellbeing (Wales) Act 2014 (6th April 2016 enacted) makes it clear where an individual is identified with having a disability the local authority has a responsibility for a service from "cradle to grave". This means that a young person such as A with ongoing social care needs may be required to transition from children services to adult services. It was acknowledged that transition services were required within the previous legislation (Children Act 1989 & 2004 and NHS & Community Care Act 1990) however, it was recognised nationally that previous legislation was not routinely implemented or followed. The new legislation was expected to respond far more robustly to this area of need and support young people to move through services more smoothly. This would mean a purposeful and planned intervention for A to transition to adult services, with all agencies involved in his care and support involved in the transition planning. This would identify what support A would need now and potential support for future, and importantly, which team would support A into adult services.

In response to the requirements of the [then] new legislation a transition social worker had been employed by NPT Children's services. At the learning event he explained the role required of him at the time to be working with strategic heads in developing a robust transition process and focussing on children identified at the time as expected to need transition support. During this time A was already approaching his 18th birthday and the focus for the new transition social worker was on younger children and planning a supportive transition and so A's needs were not considered using this new approach. Had the transition process been undertaken in this way for A, the problem of not fitting into a particular service in adult services would have been resolved before he transitioned into adult services. The approach taken to transitioning should always be in a planned way to minimise any problems. However, at the time A was involved in children services, the legislation was new and the transition pathway had not been fully developed.

Systems and multi agency working

We know from many previous practice reviews and even serious case reviews (pre 2013) that issues with individual agency's information systems can have a detrimental impact on multi agency working. The recent implementation of the Welsh Community Care Information System (WCCIS) is intended to respond to some of these issues however, any system can only be as effective as those who use it, collating individual agency's needs, complexity of systems will have its own obstacles to overcome.

A accessed health services on three separate occasions during which time it is now known he was living as a modern day slave. These hospital attendances cannot be considered unusual or excessive and each time all appropriate processes for treating an adult patient were followed. There was one attendance to A&E whereby staff identified that A's injuries were not consistent with the account given. His injuries were significant enough to require surgery and therefore he was admitted to hospital where he stayed for three nights. During this time he was seen by several health professionals including a senior matron who was asked to speak with him because of the level of concern. A was spoken to alone on several occasions and offered opportunities to disclose his abuse. Consent was sought from A for a referral to adult social services due to safeguarding concerns. However, A did not disclose any abuse and declined the referral despite significant efforts by staff. When considering a safeguarding referral for an adult at risk, capacity to consent is usually required. A safeguarding referral to social services can be made for an adult at risk without consent if that adult is deemed not to have capacity. A was assessed as having capacity to make this decision and therefore his refusal for consent had to be respected. However, there are occasions where consent can be overridden where the concerns may be so great that they outweigh the necessity to obtain the consent.

Staff treating A at A/E and on the wards do not always have easy access to records due to different information systems. Although staff were aware of A's ASD and ADHD diagnosis It was noted by staff that it would have been useful to have systems that were compatible with each other, to share information between agencies. However, in this case, we recognise that this information is unlikely to have impacted on the decision making for A.

Police Information/Public Protection Notification (PPN)

In 2017, South Wales Police received three calls in relation to A's welfare. A was rescued on 30th January 2019.

The first was in relation to concerns that A was living in a caravan and was malnourished. Officers visited and spoke to A on that occasion exploring his accommodation and access to basic needs. A was described as looking gaunt although food was available to him and he told officers that he was living there due to a family fall out. A's access to his own finances and independence were not explored and a PPN was submitted due to the possible risk of

homelessness. Upon receipt at Public Protection Unit the PPN was risk assessed as not requiring sharing with other agencies despite markers for self harm and mental ill health. At this point, no safeguarding concerns had been identified and so sharing of the information within the PPN would not have triggered safeguarding processes.

Three months later, A's mother contacted the police with concerns that A was living within an abusive environment, that he was vulnerable due to his ASD and ADHD, had no money of his own and was unlikely to be taking his medication. On this occasion officers visited the premises twice. Firstly they spoke to Mr B and returned later to speak with A. Both Mr B and A confirmed that A was working and staying on the farm. A described his living arrangements and confirmed he was happy with them. He explained to officers that he worked for Mr B in his scrap metal business and said that by doing so he considered himself to be "paying for his rent". These circumstances were not explored further by officers despite the circumstances around employment being questionable. Modern Slavery indicators include money being deducted from salary for food and accommodation (as well as living/sleeping in their place of work and a lack of money and access to their earnings). Irrespective of whether officers had received training in the recognition on the indicators of Modern Slavery, there was an opportunity for officers to ascertain the legitimacy of A's conditions of work and pay, which could have revealed concerns that he was being exploited.

Additionally, there was an expectation that officers would afford A the opportunity to speak to them alone given the circumstances of the report however this does not appear to have taken place.

A further four months later an anonymous call via NSPCC's childline alerted police to concerns regarding A's living arrangements. This report claimed that A was living there against his will and that he was being subjected to physical and sexual abuse. Despite the caller being anonymous the NSPCC had sufficient information to pass directly to police who responded immediately upon receipt. Within 2 hours of the call to childline, police were notified and were able to respond. Officers spoke with A again who denied the concerns raised about him, confirmed his arrangements and GP details and refused consent to a safeguarding referral to Adult Social Services. On submission of a PPN to the Public Protection Unit the decision was made by the DI in charge to override Adult A's withheld consent and submit the safeguarding referral due to possible concerns of modern day slavery.

Safeguarding Referrals

Following the decision to override consent the safeguarding referral was made to social services gateway team and a strategy discussion under safeguarding procedures was held between police and social services. Safeguarding Procedures require strategy discussions to be multi agency with a minimum of police and social services contributions however analysis from police information suggests that health could have been included in this. If health were included as part of the strategy discussion there would have been clear opportunity to share information regarding previous concerns about A during his hospital admission however, the decision was made to undertake safeguarding enquires as a single

[social services] agency. The Social Services & Wellbeing Act (Wales) 2014 (SSWBA) identifies within its legislation the duty to make enquiries and the duty to cooperate. The duty to make enquiries, if followed would mitigate against not having health representation at the strategy discussion as their duty to cooperate would enable them to share the information. There are no records in Adult Social Services to suggest that A's social services history was checked, the duty to make enquiries was followed or that health were given the opportunity through enquiries to share the information they held.

Through the Adult Practice Review (APR) panel meetings, it was identified that the information provided in the VA1 document submitted on 13th September 2017 by the Vulnerable Adult Unit (police) was a summary of the original report. Therefore, information omitted may have influenced decision making at point of screening.

Following the decision for a single agency enquiry a social worker was tasked to undertake a welfare visit and to offer an assessment to A. Efforts were made by the social worker to locate the address but could not find it and so returned to the office without seeing A. The agreement was to return to the location with a colleague. This took place two days later and social workers located the property and spoke to a young man who said he knew A. He explained that A was not available at that time as he was out with Mr B.

Without seeing A, social workers closed the case. The rationale for closure was that he had already been seen by police and was said to be feeling safe and well. A discussion took place between police and social services and agreed to close the case. Police later provided feedback to the NSPCC which suggests that A was safe and well and the report was considered malicious as were the previous reports in the year.

Despite the agreement under safeguarding procedures for a single agency assessment to be triggered, A was not spoken to by social workers to offer a care and support needs assessment, A was never seen by a social worker during this period. Instead, the original description by attending officers was taken on face value and the senior police officer decision to override consent due to safeguarding concerns was not taken into account.

A did not come to the attention of any agencies for another 15 months when a further anonymous call with very similar concerns was raised. Once again police officers responded and A was safeguarded having suffered significant physical and emotional harm and neglect.

Modern Slavery

It is difficult for professionals and the public to accept the fact that modern slavery happens in our communities. Training and awareness is fundamental in reminding everyone of the risks of exploitation and modern slavery and that this can happen to anyone. Often modern slavery is perceived as an issue for immigrants and people from non UK nationalities however the reality in this case demonstrates that anyone can be vulnerable to modern slavery. As professionals we have a duty to consider the risks of

exploitation and modern slavery alongside vulnerability and promote awareness of these issues across all of our communities.

Improving Systems and Practice

(What needs to be done differently in the future and how this will improve future practice and systems to support practice)

Transition and post 16 work – Children's Services

It is evident from the most recent children's social care work undertaken that A's age had an impact on how his care and support needs were assessed. His assessed eligibility for support post 16 following a period of being looked after expired prior to his last assessment and no alternative support or provision was considered. The family intervention clearly focused on assisting A to a pathway of independent living without a plan for post 18 years support.

RECOMMENDATION:

Social Services Departments should review their transition pathways when assessing care and support needs of children aged over 16 to ensure that children who had previously been considered as "eligible" for ongoing support are offered access to appropriate and alternative support than that of eligible children.

Children with ADHD and ASD diagnosis should always have a transition care plan to enable adult services and independent sectors to respond appropriately to their needs.

Homelessness support

It is unclear how well independent provider services are understood by social workers in relation to what is on offer and what can and cannot be achieved when a young person is offered homelessness accommodation. There may have been assumptions made by placing children's social workers that a more holistic level of support and intervention was available for A at the time of securing his accommodation which was not the case. A describes feeling very confused and told reviewers he had no idea what he was signing but was keen just to have somewhere to live. A explained that he did not understand his responsibilities or what was expected of him in order to maintain his placement. No advocacy was offered and no preventative support considered.

RECOMMENDATION:

When placing children & young people into homelessness accommodation, advocacy for young people should be offered as part of an assessment of homelessness support needs. This should also include assessed future/ongoing support needs and should accompany any referral to homelessness support.

When homelessness providers identify tenants at risk of eviction they should consider what prevention supports are available to maintain tenancies.

Safeguarding is everyone's responsibility
RECOMMENDATION:
Contracting and commission teams should include in any contract arrangements the expectation of the contracted provider to undertake Safeguarding Board training (whether it is delivered directly or endorsed) regarding identifying risk, vulnerability and exploitation.

When making difficult housing decisions such as eviction of a young adult, Independent providers should review their internal policies to ensure the consideration of risk and vulnerability to exploitation and their duty to report is included.

Pathways and Transition

The Social Services and Wellbeing (Wales) Act 2014 or SSWA provides people with the opportunity to be heard and puts people's voices at the heart of assessments and planning needs. The whole ethos of the Act ensures greater voice, choice and control over the services they receive. Transition for A did not happen and so his voice was lost. It was concluded that A was a victim of circumstance as legislation changes were not embedded and transition support was not offered. If it had been, A may have been offered an advocate and would have been offered opportunities to express what mattered to him and this would have allowed services to respond to his wishes and his voice would not have been lost in the process. If A had been supported through transition, adult services agencies would have been better informed of his needs and better able to respond. Contingency does not appear to have been considered for A and so no contingency planning took place.

RECOMMENDATION:
The WGSB should ensure that local authorities adhere to their responsibilities under the SSWA around advocacy. Each LA should establish a clear pathway to advocacy to ensure individuals have a voice in ***all*** *processes. These pathways should be promoted and always considered during assessment processes and throughout each intervention. The WGSB's Quality & Performance sub group should include in their audit programme regular dip sample audits to provide assurances that what matters to people is captured effectively and responded to appropriately.*

The WBSB should ensure that local authorities adhere to their responsibilities under the SSWA around transition between children's and adults' services. The WGSB's Quality & Performance sub group should include in their audit programme regular dip sample audits to provide assurances that what matters to people during transition is captured and responded to appropriately.

Contingency planning processes should be applied consistently across all social services teams and be easily accessible for practitioners when considering support.

Police Information/PPNs

Police responded to concerns raised for A's welfare by visiting A on 3 separate occasions in 2017. On the third occasion concerns around Modern Slavery were identified, but there appears to have been no consideration of the previous two reports and viewing A's situation holistically. As mentioned previously Modern Slavery indicators include money being deducted from salary for food and accommodation (as well as living/sleeping in their place of work and a lack of money and access to their earnings). Irrespective of whether officers had received training in the recognition on the indicators of Modern Slavery, there was over the course of 7 months opportunity for officers to ascertain the legitimacy of A's conditions of work and pay, which could have revealed concerns that he was being exploited. Mention was made that A had been beaten and attended hospital, enquiries with Health would have revealed 3 hospital admissions for 'work related' injury.

SWP did not provide full and accurate information they had received from NSPCC in the VA1 Referall to Adult Services. Greater care should have been taken in the preparation and sharing of information that had been provided by NSPCC in their e-transcript.

RECOMMENDATION:

South Wales Police should review the Modern Slavery training and Operational Guidance provided to police officers and police staff in order to ensure that modern slavery can be effectively identified; victims are safeguarded and protected; Modern Slavery Act crimes are effectively investigated, recorded and reported.

VA1/Safeguarding Referral

As already indicated the safeguarding procedures require a multi-agency discussion to determine whether an adult is at risk. The expectation is that each organisation play their part and contribute to safeguarding and promoting the wellbeing of an adult at risk. A key principle would be that it's necessary to always make sure that the individual is safe. The initial enquiry should ensure that the information is accurate and consider existing records from other agencies to assist in making a decision. In A's circumstances wider agency information was not considered and the over reliance on the initial views of police led to missed opportunities and further harm.

Despite safeguarding process being instigated by police, the case was closed by social services without considering fully whether A was experiencing or at risk of experiencing abuse or neglect, whether A had care and support needs or whether as a result of those needs A was unable to protect himself against the abuse or neglect or the risk of it. It would have impossible to determine the level of risk he was under without considering all the

information all the agencies held on him. A single agency approach meant that not all relevant information was considered. Neither the social worker or team manager, due to exceptional circumstances involved in this decision making were available for the learning event and so have not had an opportunity to provide the review with feedback in relation to this.

Through the Adult Practice Review (APR) panel meetings, it was identified that the information provided in the VA1 document submitted on 13th September 2017 by the Vulnerable Adult Unit (police) was a summary of the original report. Therefore, information omitted may have influenced decision making at point of screening.

RECOMMENDATION:

The WGSB should seek assurances from NPT Social Services that safeguarding practice issues identified within this report have been responded to, including what additional support, advice and training has been provided to the Gateway Team members following this case.

The WGSB's Quality & Performance sub group should include in their audit programme regular dip sample audits to ensure Adult At Risk referrals are responded to appropriately, proportionately and within the Safeguarding Procedures.

Modern Slavery

This Historical Practice Review is likely to be one of the first of its kind in Wales. It is clear from the information within this report that there is a lot of learning to be had. Therefore, this case should be used as an example case in Modern Slavery training to emphasize the exploitative nature of perpetrators and the vulnerability of their victims. As a case study, this case should be used to enable professionals to increase their awareness and understanding that Modern Slavery is a form of exploitation, and that decisions and interventions can have an impact on future vulnerability of a person to become exploited. Due to the very nature of an individual's vulnerability to exploitation, victims will not always recognize themselves as victims of abuse.

Statement by Reviewer(s)			
REVIEWER 1	Ffion Larsen	**REVIEWER 2** ***(as appropriate)***	Lisa Collins
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the 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.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1:		**Reviewer 2:**	
Name *(Print)*	Ffion Larsen	**Name** *(Print)*	Lisa Collins
Date	14.03.22	**Date**	14.03.22

Chair of Review Panel*:*	
Name *(Print)*	Eve Davis
Date	14.03.22

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Date information received ……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	