

**WEST GLAMORGAN SAFEGUARDING BOARD**

**Adult Practice Review Report**

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| **Adult Practice Review Report**  **West Glamorgan****Safeguarding Adults Board**  **Concise Adult Practice Review**  **Re: WGA S25 2023** |

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| **Brief Outline of Circumstances Resulting In The Review**  *To include here: -*   * *Legal context from guidance in relation to which review is being undertaken.* * *Circumstances resulting in the review.* * *Time period reviewed and why.* * *Summary timeline of significant events to be added as an annex.* |
| A Concise Adult Practice Review was commissioned by the West Glamorgan SafeguardingBoard on the recommendation of the Practice Review Management Group (PRMG) in accordance with the Guidance for Adult Practice Reviews. The criteria for this review are met under the Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People: Volume 3, Section 6.1:  *“A concise adult practice review will be commissioned 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 the local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, has :*   * *Died; or* * *Sustained potentially life-threatening injury; or* * *Sustained serious permanent impairment of health”*     **Circumstances resulting in the review**    Adult A was a White Welsh female who was aged 65 years at the time of her death. She lived alone and had been bed-bound for a number of years. In April 2023 an ambulance was called by Adult A’s brother after he attended her address at the request of her friend and found her breathing to be erratic. Paramedics from the Welsh Ambulance Services University NHS Trust (WAST) attended, and upon examination of Adult A, concerns were raised in relation to neglect; she was found to have gangrene present in the bilateral lower limbs, faeces present and maggots living within her.  Mid and West Wales Fire Service were contacted to assist in moving Adult A from the address due to her having become fused to her mattress. South Wales Police attended due to the concerns around neglect. Adult A was taken to hospital where it was noted that the ulceration to her legs was severe, down to the bone, there were pressure ulcers to the left buttock and numerous skin lesions around her body. Adult A died 4 days later.  Following comments made which suggested a level of caring responsibility, Adult A’s brother and friend were arrested on suspicion of neglect. After investigation, both were released without charge.  An Inquest was held and the conclusion of the Coroner as to Adult A’s cause of death was ‘… multi-organ dysfunction due to sepsis associated with infected leg ulcers contributed to by self-neglect’.  **Time Period Reviewed**  The Panel agreed a time period of 18 months (11.10.21 to 09.04.23) for review, however, this produced a chronology of only 5 entries prior to the incident leading to Adult A’s death. As such, agencies were requested to provide information on involvement with Adult A outside of the timeline. This was shared with professionals at the learning event and has informed the learning points below. The Reviewers have however focused on learning relevant to current practice.  **Family Engagement**  Adult A’s two brothers and her friend who had been providing some assistance to her for a number of years, were invited to participate in the review. One of Adult A’s brothers wished to be involved and the Reviewers met with him on one occasion. His views were shared at the learning event and have been incorporated into the Practice and Organisational Learning section below. The Reviewers are grateful to Adult A’s brother for his participation and insight into his sister’s life.  **Background**  Adult A had a medical history of obesity, venous ulceration, immobility and falls (multifactorial), hypothyroidism, rheumatoid arthritis, chronic kidney disease (stage 3), and recurrent cellulitis. Records provided to the review document Adult A’s first foot ulcer as occurring in 2009. Regular (ranging from once a week to daily) dressing changes at the GP for ulcers to her feet and legs were then required for a number of years, with poor compliance frequently documented in the records, for example, not attending appointments, arriving late, refusing a number of dressings. In 2015 it is documented that Adult A was dressing her leg ulcers at home. Adult A stated that she was not able to attend the surgery “as it makes her depressed.”  Adult A fell from a chair at home in November 2017 and again in May 2018. After the 2018 fall she required a five-week hospital admission and declined any social input on discharge. Adult A’s brother told the Reviewers that following this admission, she told him she would never go back to hospital again and that she didn’t want any professional coming through the front door.  Adult A had input from Occupational Therapy (OT) Services between 2014 and 2018 which included three assessments at home (2014, 2016, 2017) resulting in the provision of some equipment to assist with her mobility, and involvement from the hospital OT during her period of rehabilitation after the fall in 2018. The records from these periods of involvement document non-engagement, difficulties in making and maintaining contact and challenges around Adult A accepting suggested interventions. Adult A was also referred for Physiotherapy input in November 2018 however after attempts to engage with her were unsuccessful, she was discharged from the service in January 2019.  The last face to face contact Adult A had with a Health or Social Care professional was in March 2019, when a District Nurse attended to take bloods following a request from Adult A for changes to her medication. No concerns for Adult A or her home environment were documented at this visit.  **Chronology**  During the time period reviewed, there was very little agency contact with Adult A:   * October 2021 a call was made to WAST reporting that Adult A had slipped from the bed without injury and assistance was required to get her back into bed. Due to significant pressures WAST were unable to send an ambulance and this was in line with the WAST Clinical Safety Plan in place at that time. * November 2021 Adult A had refused the kitchen and bathroom improvement scheme for her property and she was therefore removed from the scheme. * July 2022 an annual gas service was completed at Adult A’s property. No concerns were documented. * November 2022 Adult A declined a home visit from the GP Surgery for a flu and covid injection. * March 2023 Adult A contacted the GP surgery to speak to the Doctor about a prescription being withheld for dressings. This was the first request in many years and there was a historic entry in Adult A’s records not to provide any dressing packs directly because she required a nursing assessment. The surgery made two follow up calls to Adult A but there was no answer. |

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| **Practice And Organisational Learning**  *Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances* |
| (Relevant circumstances supporting each learning point may be informed by what was learned from the family’s contact with different services, the perspective of practitioners and their assessments and action taken, family members’ perspectives, evidence about practice and its impact, contextual factors and challenges)  A half day learning event was held in July 2024 with the following agencies represented:   * Swansea Bay University Health Board * Swansea Social Services * Swansea Council Housing Services * GP Surgery * Mid and West Wales Fire and Rescue Service * Wales Ambulance Services University NHS Trust * South Wales Police   The Reviewers are grateful to the practitioners who attended for their participation and assistance in identifying learning.  **Understanding and identifying self-neglect and seeing beyond ‘challenging’ behaviour**  The documentation provided to the review contained references to circumstances and behaviours that indicated Adult A self-neglected. This included long-standing poor compliance with medical care, refusal of support and interventions, an unkempt appearance (at times) including matted hair and on one occasion a professional documented flies within the home which were landing on her (2017). However, there were no references to self-neglect within the records provided to the review.  It is recognised that at the time some of the above concerns were being documented, there was less awareness and understanding of self-neglecting behaviours than there is today. However, it was of note that self-neglect was not identified or named by practitioners within the learning event until raised for discussion by the Reviewers. It also became clear during the learning event that although the West Glamorgan Safeguarding Board published their Self-Neglect Policy and Guidance in February 2023, none of the practitioners at the learning event in July 2024 were aware of the policy or the regional Self-Neglect Pathway.  At the learning event, practitioners disclosed that they and colleagues had found Adult A’s behaviour challenging at times; a number of staff from one agency had been reduced to tears during their interactions with her and had requested not to have contact with her again. Their descriptions of her were of a strong character who would assert herself forcefully at times. The Reviewers have questioned whether practitioners’ view of Adult A as a challenging, forceful, and at times upsetting character was a barrier to understanding her behaviour and circumstances within the context of self-neglect, and whether this was seen more as her lifestyle choice.  **Learning point 1: People who self-neglect may be assertive, forceful and sometimes abusive in their non-compliance or refusal of services. It is important that practitioners have the skills and knowledge to identify and understand this within the context of self-neglect and do not mistakenly label the behaviour a lifestyle choice.**  **Asking ‘why?’ and understanding personal history**  Adult A’s brother provided the Reviewers with his sister’s personal history. It was of note to the Reviewers that her brother recalled Adult A leaving the family home as a teenager due to what he believed was her becoming pregnant. His understanding was that his father had been unhappy about this, and Adult A had placed the baby for adoption. Adult A did not return to the family home until their father had passed away, and her brother believed that this was because he could be violent and had a ‘drink problem’. Prior to returning to the family home, Adult A had lived with a partner, although he sadly died of cancer whilst they were living together. Adult A’s brother recalled that she had returned home to ‘care’ for her mother, though he observed that Adult A often slept in very late in the day and was brought food by her mother. Though Adult A did have a job in a factory in her twenties, after leaving this job (to care for her mother) it is reported she never worked again.  Whilst there is no one over-arching explanatory model for why adults self-neglect, some common triggers are bereavement, trauma, mental health difficulties, social factors, and physical illness; it appeared that Adult A had experienced a number of these triggers. When practitioners at the learning event were asked what they had known about Adult A, notably, the above information appears not to have been known to any agency. Research[[1]](#footnote-1) and recommendations from previous Adult Practice/Adult Safeguarding Reviews[[2]](#footnote-2) have highlighted the importance of trying to understand why an adult is self-neglecting in order to offer effective intervention. In the case of Adult A, it appears that no agency sought to understand her poor compliance with health interventions and frequent refusal of offers of support.  Adult A’s forceful nature and the view that some practitioners had of her was likely compounded by their lack of understanding of her history, which led them to see her as difficult and challenging rather than potentially vulnerable and at risk from that very same behaviour.  **Learning Point 2: Professionals working with people who self-neglect must seek to understand the person’s history and possible triggers behind the behaviour in order to offer effective support and intervention.**  **Capacity Assessments and consideration of executive functioning**  Capacity was assumed even when Adult A displayed concerning behaviour i.e., non-compliance and disengagement over a long period. Evidence from research[[3]](#footnote-3) indicates that often professionals use capacity to justify not intervening, and with increasing demands on services might use capacity as a tool for closing cases. In cases where self-neglect is suspected this could leave individuals at considerable risk and it is important to balance autonomy and protection. Participants at the learning event did not appear to consider that Adult A was self-neglecting and this may have had an impact on how and what services were offered.  There was a clear message from participants that attended the learning event that Adult A had capacity right up until the incident that led to her final hospital admission but it is not clear whether any consideration was given to her level of executive functioning and how this might have impacted on her capacity. It is accepted that assessment of executive functioning is difficult for professionals who have one-off contact with individuals rather than an ongoing professional relationship.  Executive functioning plays a vital role in an individual’s capacity to make decisions. For instance, the ability to weigh the pros and cons of a decision, foresee potential consequences, and regulate emotional responses is directly linked to executive functioning. When these processes are impaired, a person’s capacity might be compromised.  The capacity to perform complex tasks is heavily dependent on strong executive functioning. A person with deficits in executive functioning may struggle with planning, organising and carrying out these tasks, which could indicate a reduced capacity in those areas.  Executive functioning is a crucial component of capacity. When executive functioning is impaired, it often leads to diminished capacity to make decisions, manage tasks, and function independently in various aspects of life.  Individuals with executive functioning deficits may lack insight into their own self-neglect, failing to recognise the severity of their situation or the need for help.  Adult A’s capacity was seen as a ‘barrier’ to support by those attending the learning event, however the Wales Safeguarding Procedures Practice Guide on self-neglect (currently out for consultation) states that “the fact that a person has the relevant mental capacity is not on its own a justification for non-intervention”. There was no evidence from the chronologies or from the learning event that attempts were made to reengage with Adult A and no evidence of further support being offered.  When the reviewers met with Adult A’s brother it was evident that he was distressed and frustrated by the times he had tried to access support on his sister’s behalf only to be told that due to her having capacity they would not be able to action his requests. Her brother questioned whether his sister did have capacity and recounted an incident in 2018 when she fell off the chair and paramedics and GP attended. He reported that paramedics felt she was ‘delusional’ at this time but despite making this comment they still informed him that they would not be able to convey his sister to hospital without her consent. Adult A did eventually go to hospital on this occasion but her brother felt that all the responsibility of getting her to agree to go fell on him.  Adult A’s brother also told the Reviewers that on the last occasion when paramedics were called, WAST staff told him that if Adult A refused to go to hospital they would not be able to convey her. WAST records of this incident document Adult A lacked capacity, with treatment and actions performed in her best interests and do not indicate non-conveyance was considered. Her brother was very clear that just because a person can speak this does not constitute capacity. The brother feels that someone should have spent time talking to Adult A about what could happen if things didn’t change.  Following her discharge from hospital in 2018, the presumption of capacity appears to have remained and there was no evidence that a formal capacity assessment was undertaken despite behaviours that may have indicated a risk of harm. A capacity assessment would have established whether Adult A had the capacity to make decisions which would have been classed as unwise. Evidence from other Safeguarding Adult Reviews have highlighted that many professionals lack confidence when assessing capacity and often some professionals incorrectly believe that it is not their responsibility.  **Learning point 3: Where there is an indication that executive functioning is impaired, practitioners should be professionally curious and capacity should always be assessed, and assessments must be clearly documented.**  **Withdrawal from services – monitoring and escalation**  Adult A’s compliance with medical care was frequently documented to be poor however in 2019 it was documented that she was not attending surgery for wound care, had declined District Nursing input and wished to dress her own wounds at home. By this time therefore, she had almost completely withdrawn from services, other than to make medication requests to the GP. Adult A’s brother suggested to the Reviewers that she didn’t want anyone coming to her house as she didn’t want professionals to see the way she was living. He described that by this point Adult A was sleeping in a bed downstairs and there was ‘mess everywhere’. The Reviewers did query whether there was an opportunity missed to alert services to Adult A’s self-neglect when the gas safety check was undertaken in July 2022, however the professional who attended advised they could not recall the property and if there had been any concerns these would have been raised with their line manager as per the Council’s process.  Adult A had been a frequent attendee at the GP surgery and it seems likely that her absence would have been notable. However, her withdrawal from services does not appear to have been identified as something that required any ongoing monitoring or escalation. There was no escalation process in place, no flag or alert on Adult A’s record that caused any action to be taken when services were refused. For example when home visits for covid and flu vaccinations were refused in 2020, 2021 and 2022, no further action was taken. It is accepted that in isolation, this refusal would not be a cause for concern, but if considered within the wider context of Adult A’s history and the fact that she had not been seen by a medical professional for a number of years, this could have indicated the need for further exploration or escalation.  Adult A was also on a repeat medication prescription but there was no documented medication review within the timeline considered. This would have been an opportunity to check in with Adult A to understand how she was managing her wound care which had previously required regular and ongoing intervention from a medical practitioner. Another such opportunity was in March 2023 when Adult A contacted the surgery to discuss her prescription for dressings being withheld. The surgery made two follow up telephone calls to Adult A but there was no answer. There appeared to be a lack of professional curiosity as to why Adult A was making this request after such a long time purchasing her own dressings and no consideration was given to a referral to the District Nursing service.  The Reviewers considered whether Adult A’s strong assertion that she would manage her wounds herself, alongside her occasional phone contact with the GP surgery for medication requests, led professionals to believe that she was capable of managing, and in control of, her health needs. This seemed however to be taken at face value as whilst she stated that she could manage her wound care herself, her history and the circumstances surrounding her indicated otherwise.  It was shared at the learning event that as a capacitated adult, Adult A would have been expected to be proactive in her access to medical care. The GP Surgery advised they do not have the provision to monitor and escalate where capacitated patients are refusing services offered.  **Learning Point 4: Professionals working with people who withdraw from services should ensure that all opportunities for contact are maximised and services should be offered and re-offered.**  **‘Think Family’ – involving and supporting family members**  Adult A was supported by one of her brothers and a female friend. It has been established that neither of these individuals were caring for her in an official capacity and they did not receive any financial gain from the care they provided.  The Reviewers met with Adult A’s brother and he provided them with the picture that he was responsible for collecting Adult A’s money and he would leave it in the house for her. He would also use her money to buy cigarettes and dressings for her. The friend would ensure that there were ready meals, snacks and drinks available and was also providing some personal care in the way of emptying the commode.  Adult A’s brother expressed that the relationship between him and his sister was sometimes very difficult and it would appear that he experienced similar behaviour to that described by professionals who had contact with her. Despite this he continued to assist Adult A right up until the incident that led to this Review.  Adult A’s brother reports that he did ask services for help for his sister. Around the time of her discharge from hospital in 2018 he was concerned that she was not adequately mobile to move around her property, but he was told that as Adult A had capacity and had refused services, there was nothing more that could be done. He also recalled speaking to a District Nurse and advising them that he felt his sister needed support and assistance with her legs but was told Adult A would have to make contact with them herself. He knew however that she would not do this. However, professionals could have listened to the concerns without compromising confidentiality. Family members are likely to hold information of relevance to assessment processes.  It was clear to the Reviewers that this was a frustrating and distressing situation for Adult A’s brother. It does not appear that any professional considered the impact on him of his sister’s self-neglecting behavior and he was not offered any support or guidance as to how he might manage the situation. Neither was consideration given to engaging with him as a possible support for, or a way to engage with, Adult A.  **Learning Point 5: Listening to family members is not a breach of confidentiality. Professionals working with people who self-neglect should listen to the concerns of family members, involve them in attempts to engage with the person who is self-neglecting, and signpost to services that can support them where they act as informal carers.**  **Communication across systems**  When a request was made by Adult A’s brother to WAST in October 2021 for assistance in getting Adult A back into bed, the Clinical Safety Plan in place due to the high level of escalation directed that an ambulance could not be sent and her brother was advised to seek assistance from 111 or the GP. It does not appear from the records that Adult A’s brother utilised either of these options. Whilst the attendance of WAST would have been an opportunity for contact with and assessment of Adult A, at times of significant pressure it is not possible for WAST to respond to every call.  Those present at the learning event felt that if information was shared in this situation, this may have alerted the GP to concerns for Adult A and further exploration of her situation at that time.  Clarity was provided by the WAST panel member in relation to information sharing with GP’s and the Panel were advised that mechanisms to share information between WAST Clinicians and GPs were in place during the 2021 incident and continue to be so. However, information is not routinely shared when a call does not progress past the initial Call Handler.  In this instance, the call did not progress past the initial Call Handler and signposting was offered as appropriate in the circumstances and in line with WAST’s Clinical Safety Plan.  Practitioners at the learning event acknowledged the challenges of systems within individual agencies communicating with each other.  **Learning Point 6: In line with multiple local and national Reviews, it is identified that the linking of data across agencies is required to improve information sharing and outcomes for adults at risk.** |

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| **Improving Systems and Practice**  *In order to promote learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes*:- |
| (What needs to be done differently in the future and how this will improve future practice and systems to support practice)  **Learning point 1: People who self-neglect may be assertive, forceful and sometimes abusive in their non-compliance or refusal of services. It is important that practitioners have the skills and knowledge to identify and understand this within the context of self-neglect and do not mistakenly label the behaviour a ‘lifestyle choice’.**  **Learning Point 2: Professionals working with people who self-neglect must seek to understand the person’s history and possible triggers behind the behaviour in order to offer effective support and intervention.**   * Recommendation: The West Glamorgan Safeguarding Board should review the regional Self-Neglect policy in light of the soon to be published Welsh Government Practice Guide on Self Neglect and re-launch the policy at the earliest opportunity. * Recommendation: The West Glamorgan Safeguarding Board should develop multi-agency training on Self-Neglect. This training must include the importance of understanding personal history and possible triggers for self-neglect. * Recommendation: The West Glamorgan Safeguarding Board should consider including a section on self-neglect on the Board’s website.   **Learning point 3: Where there is an indication that executive functioning is impaired, capacity should always be assessed, and assessments must be clearly documented.**   * Recommendation: Board agencies should ensure that any training delivered on mental capacity includes information about executive functioning and how this can impact on capacity. Awareness raising should also be undertaken across the workforce to address the perception of capacity as a ‘barrier’ for intervention and as justification for non-intervention.   **Learning Point 4: Professionals working with people who withdraw from services should ensure that all opportunities for contact are maximised and services should be offered and re-offered.**   * Recommendation: The Board should receive assurances from all agencies that systems are in place to flag people who withdraw from services so that professionals can easily identify those who may need additional offers of support or for services to be offered in a different way.   **Learning Point 5: Listening to family members is not a breach of confidentiality. Professionals working with people who self-neglect should listen to the concerns of family members, involve them in attempts to engage with the person who is self-neglecting, and signpost to services that can support them where they act as informal carers.**   * Recommendation: Board agencies should ensure that any assessments used for people who self-neglect include a section on views of the family. In addition, agencies should ensure that professionals understand that there is a duty under the Social Services and Wellbeing (Wales) Act 2014 to provide a carer’s assessment where it appears a carer may have needs for support. Finally, agencies should ensure that professionals are aware of support services for informal carer’s and that they signpost to these services as required.   **Learning Point 6: In line with multiple local and national reviews, it is identified that the linking of data across agencies is required to improve information sharing and outcomes for adults at risk.**   * Recommendation: WAST should explore options for information sharing with GPs in instances where calls do not progress past the initial Call Handler. This would support GPs in understanding their patients’ circumstances and needs, particularly in situations where they have withdrawn from the GP and other services. |

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| **Statement by Reviewer(s)** | | | | | |
| **REVIEWER 1** | |  | **REVIEWER 2 *(as appropriate)*** |  | |
| **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**  *(Signature)* | B. Aynsley | | **Reviewer 2**  *(Signature)* | | M. Higginson |
| **Name**  *(Print)* | BETH AYNSLEY | | **Name**  *(Print)* | | MARI HIGGINSON |
| **Date** | 21.01.25 | | **Date** | | 21.01.25 |

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| ***Chair of Review Panel*** *(Signature)* | N. Edwards |
| **Name**  *(Print)* | NICOLA EDWARDS |
| **Date** | 21.01.25 |

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| **Adult Practice Review Process**  *To include here in brief:*   * *The process followed by the Board and the services represented on the Review Panel.* * *A learning event was held and the services that attended.* * *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.* |
| **Services represented on the Review Panel**   * Swansea Bay University Health Board * Swansea Council, Social Services * Mid & West Wales Fire & Rescue Service * Welsh Ambulance Services University NHS Trust * Swansea Council, Housing Services   **Services that attended learning event**   * Swansea Bay UHB * Swansea Council, Social Services * Swansea Council Housing Services * GP Surgery * Mid and West Wales Fire and Rescue Service * Welsh Ambulance Services University NHS Trust * South Wales Police   **Family Involvement**  Adult A’s two brothers and her friend who had been providing some assistance to her for a number of years, were invited to participate in the review. One brother indicated he wanted to be involved and the Reviewers met with him in April 2024 to provide feedback. |
| Family declined involvement |

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| **For Welsh Government use only**  Date information received ………………………..  Date acknowledgment letter sent to Board Chair …………………………  Date circulated to relevant inspectorates/Policy Leads ………………………….   |  |  |  |  | | --- | --- | --- | --- | | **Agencies** | **Yes** | **No** | **Reason** | | CSSIW |  |  |  | | Estyn |  |  |  | | HIW |  |  |  | | HMI Constabulary |  |  |  | | HMI Probation |  |  |  | |

1. [working\_with\_people\_who\_self-neglect\_pt\_web.pdf (researchinpractice.org.uk)](https://www.researchinpractice.org.uk/media/xqqlavsi/working_with_people_who_self-neglect_pt_web.pdf) [↑](#footnote-ref-1)
2. [Second national analysis of safeguarding adult reviews, Final report: Stage 2 analysis (local.gov.uk)](https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%20%28branded%20and%20proofread%29%20v6-19.pdf) [↑](#footnote-ref-2)
3. [PolicyBristol\_PolicyReport76\_Adult-Safeguarding-practices\_Lariviere.pdf](https://www.bristol.ac.uk/media-library/sites/policybristol/briefings-and-reports-pdfs/2022/PolicyBristol_PolicyReport76_Adult-Safeguarding-practices_Lariviere.pdf) [↑](#footnote-ref-3)