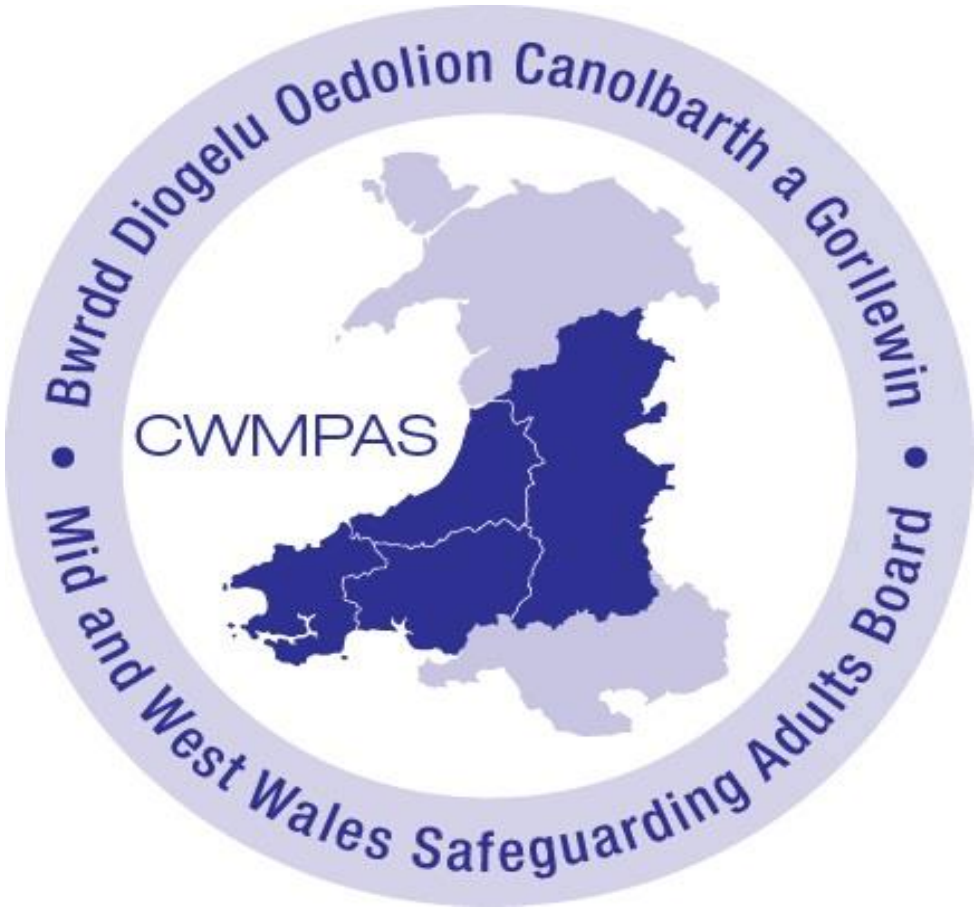

Concise Adult Practice Review Report

CWMPAS 1/2022

Date report presented to the Board:

29th April 2025

Adult Practice Review Report

CWMPAS: Mid & West Wales Safeguarding Adults Board

Concise Adult Practice Review Re:
CWMPAS 1 2022

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*

Legal context:

A concise adult practice review was commissioned by CWMPAS – the Mid and West Wales Safeguarding Board on the recommendation of the Adult Practice Review Subgroup in accordance with the Guidance for Multi-Agency Adult Practice Reviews and statutory legislation set out in Section 139 of the Social Services and Well Being Act (Wales) 2014[1], and accompanying guidance "Working Together to Safeguard People Volume 3 – Adult Practice Reviews" (Welsh Government 2016)[2].

The criteria for this review are met under Chapter 7 of the statutory guidance for Concise Adult Practice Reviews:

A Board must undertake a concise adult practice review where an adult at risk who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health.

The criteria for concise adult practice reviews are laid down in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015[3].

The overall purpose of this review is to identify learning for future practice, and this could apply to all agencies involved. The review has involved practitioners, managers and senior officers in reviewing their agencies' work with the individual. The intended outcome is to generate professional and organisational learning and to promote improvement for future inter-agency practice. This report will include a summary of the circumstances that led to the commissioning of the review and recommendations for how future practice can be improved.

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V3 – APRs (Welsh Government, 2016)
[3] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015)

The Terms of Reference for this Concise Adult Practice Review are included at **Appendix 1**.

Relevant contextual information

Mr X has been involved with statutory and non-statutory services since at least 2009, when he first appeared before the Courts for committing criminal offences. However, his family recall difficult behaviour from a young age, with his mother actively seeking help from education and health.

When he left formal education, he initially began an apprenticeship in a local garage and achieved his HGV licence. He went on to secure employment in a local factory, developed a stable relationship and was able to secure and sustain independent accommodation. However, following the breakdown of the relationship, his behaviour and lifestyle began to deteriorate. Initially Mr X sought help from his GP, however his lifestyle continued to deteriorate. Not long afterwards, Mr X began to use illicit drugs.

Following the loss of his mum, who family described as his anchor, it became more difficult for Mr X to achieve and maintain stability for any period.

In his early twenties, Mr X became involved in criminal activity and ongoing substance misuse. He would display violent and aggressive behaviour, and there were periods of significant deterioration in his mental wellbeing. There were also periods where he could present as well and engaged with services.

Mr X was assessed as presenting a high risk of harm, and this included a risk to practitioners working with him as a result of his exhibition of aggressive and violent behaviours at times. Whilst this type of behaviour usually occurred when Mr X was unwell, balancing his treatment needs with the safety of professionals and risk management became exceptionally difficult. The chaotic lifestyle and substance misuse issues made it difficult to diagnose and treat mental health issues; deterioration was regularly attributed to drug induced psychosis, and effective treatment was difficult to maintain.

Circumstances prompting review

For the purposes of this review, the focus is on the period from 1st October 2021 to 20th April 2022, when Mr X sadly passed away. This timeframe was agreed by the panel as being the most significant in terms of planning for release and the support that was available to Mr X following transition into the community.

During this time, Mr X was involved with the following services, all of whom have engaged in this review:

- His Majesty's Prison and Probation Services
- Local Authority Adult Services
- Police
- Drug and Alcohol support services
- Local Authority Housing Services
- Health Board in local area

- Health Board in prison which provides substance misuse services, mental health provision and primary health care

Relevant contextual information prior to agreed timeline

On 15th January 2021, Mr X was sentenced to 15 months custody for an offence of assault. The offence occurred in a local pharmacy when Mr X attended requesting medication to alleviate symptoms of withdrawal from substances. Mr X described feeling unwell, including seeing and hearing things. During the interaction Mr X began talking about becoming violent and produced a weapon, and stated he was in possession of a knife, making threats to harm others in the area.

Mr X was initially released from custody on 16th August 2021 and resided in a Probation Approved Premises (AP). Following a successful period at the AP, he returned to independent accommodation in his local area. There is documented deterioration in his behaviour and wellbeing following his return to his local community. Mr X presented as increasingly paranoid and described hearing voices and believing that people were following him. He would call emergency services regularly (up to 30 calls in one morning) asking for help, and on one occasion, jumped from a second-floor window as he believed someone was chasing him. When police attended, he was in his garden holding a crowbar.

Relevant information during official timeline

From 1st October 2021 there is evidence of a decline in Mr X's wellbeing. He would regularly contact Police via 999 and report that his house was surrounded by people trying to get in. Police were in close contact with the probation service, who were trying to put a risk management plan in place. Inappropriate calls to 999 continued, and Mr X was arrested on 4th October for misuse of 999 calls. This deterioration is very similar to the behaviours displayed in August 2021, where there is an increase in paranoia and Mr X reaching out for help.

By 18th October 2021 a deterioration is again reported, more inappropriate calls to emergency services and paranoid thoughts are described. On 21st October he is found in possession of a crowbar, and enforcement action is considered by the probation service. Over 30 calls to Police are made on this date. This continued up to 28th October when Mr X was arrested again for inappropriate use of emergency calls.

On 28th October 2021, Mr X attended the local police station, having consumed a bottle of whiskey, and told police he was being followed and could hear voices. He produced a wooden pole, approximately 1.5m in length. He was asked to put it down, which he did, but threatened to use it to smash police vehicles. This led to his arrest for possession of an offensive weapon and threats to damage/destroy property. The decision was made to recall Mr X to custody as he was subject to Probation supervision at that time.

On 29th October 2021 he attended the local police station and produced a wooden pole. Mr X iwas subsequently arrested for possession of an offensive weapon and threats to cause damage to police vehicles. Recall to custody is actioned.

During his time in custody, Mr X is offered support from the prison based Mental Health and Learning Disabilities Team delivering a stepped care model, resettlement services, safer custody and prison-based substance misuse services. Community-based services maintained oversight of progress and preparation for release. Housing services confirmed within days that his property would not be held until release, which at the latest would be 31st March 2022.

Liaison took place between community- and prison-based health services, and Mr X was provided with the medication that he had received in the community. Substance Misuse Services introduced an opiate reduction programme although Mr X continuously reported that the dosage was not enough to prevent withdrawal symptoms. There is continuous focus throughout November and December on achieving and maintaining a suitable dose of opiate replacement medication to support abstinence.

By early January 2022, there are reports of paranoid ideation noticeable in Mr X's behaviour in custody. He is refusing to leave his cell and reports seeing someone sitting on his bed. His trust in some agencies supporting him seemed to have been lost, with him stating he would no longer work with the local authority. Paranoid behaviour continues and results in Mr X damaging his cell, describing his vapes being tampered with and was acting erratically.

In February, preparation for release had commenced with resettlement services attempting to complete a housing application for assistance, but Mr X refused to sign. Concerns about his presentation and wellbeing continued through the remaining days in custody. He was removing his fire alarm in his cell as he believed it contained cameras, and he assaulted another prisoner who he believed to be guilty of a high-profile murder.

Assessments for mental health took place in custody and services were actively seeking appropriate accommodation for release. This was difficult to achieve given level of risks and recent behaviour.

Mr X was released at Sentence and Licence Expiry date (SLED) on 31st March 2022, without supervision by the probation service, following completion of his sentence. He was assessed by a psychiatrist in custody on 29th March 2022 following an incident involving another prisoner/inmate and concerns about Mr X's mental state. The assessment indicated that Mr X was experiencing deteriorated mental health and resulted in a request for a "gate assessment" on the day of release, noting that the use of Part 3 Mental Health Act 1983 (Amended 2007)[4] could not be utilised, due to time constraints and completion date of Mr X's sentence. The "gate assessment" would determine if Mr X met the criteria for detention under the Mental Health Act and provide a legal framework for his detention to an appropriate hospital setting.

On the day of release, the two assessing medical practitioners and Approved Mental Health Practitioner assessed Mr X and determined that he did not meet the criteria for detention under the Mental Health Act. He was therefore released to return to his local community and receive ongoing support from the community mental health team. Following release there is extensive evidence of involvement from all relevant services. Mr X was a complex individual and efforts were made to engage with and support him.

On the day of release, Mr X returned to his home area and was placed in local authority accommodation. He initially attended all appointments with agencies supporting him.

By 2nd April 2022, Mr X was attending the local police station and calling emergency services describing feeling unsafe, hearing voices outside his flat and asking for help. An assessment by the community mental health team took place on 4th April, and the two assessing medical practitioners and Approved Mental Health Practitioner concluded that Mr X did not meet the criteria for detention under the Mental Health Act 1983 (Amended 2007)[5] and his needs could be met in

[4] Part 3 Mental Health Act 1983 (Amended 2007)
[5] Part 3 Mental Health Act 1983 (Amended 2007)

the community provide by the community mental health team. There was planned contact arranged with the psychiatrist on 27th April 2022, and Mr X was to have access to the community mental health team in work time hours and Crisis Resolution home treatment team in hours 5pm to 9pm daily.

Mr X was last seen by professionals on 7th April 2022, when he attended a planned appointment at Probation offices, and later that day, attended the police station expressing concerns about his mental health and safety. He agreed for crisis services to be contacted but left the site before he could be seen.

On 11th April, it is identified that Mr X has not attended pharmacy to collect his script. Communication took place across agencies which established he had not been seen since 7th April, and he was therefore reported as a missing person. There were significant efforts to locate him and good liaison between agencies. Emergency multi agency meetings were called in attempts to bring agencies together to locate Mr X and keep him safe.

On 20th April 2022, Mr X was sadly found deceased in a local river.

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

This review was undertaken in accordance with statutory legislation set out in section 139 of the Social Services and Wellbeing Act 2014 and the relevant accompanying guidance, *Working Together to Safeguard People, Volume 3 – Adult Practice Reviews (Welsh Government 2016)*[6].

An independent Panel Chair and one Independent Reviewer were commissioned, who were, in accordance with the guidance, independent of the case management and had the relevant experiences, knowledge and skills as required by the case and circumstances under review.

The review panel consisted of representation of the following organisations, who had been involved with the individual at the centre of this review:

- HMPPS in Wales (Probation and Prison)
- Health Board
- Local Health Board for mental health
- Local Authority Housing Services
- Police
- Substance Misuse Services

10 Panel Meetings were held in total.

Family engagement has been conducted by the Panel Chair and the Independent Reviewer. Mr X's sister agreed to engage in this review. A virtual meeting was held with his sister on 16th May

[6] Working Together to Safeguard People – V3 – APRs (Welsh Government, 2016)

2024 and the purposes of the review were fully explained. Mr X's sister was given an opportunity to discuss her views on the care and support her brother experienced, and to present questions she would like the review to consider. These have been included in this report. The panel were pleased that this engagement could be achieved and are grateful for the valuable contributions which have informed the good practice and learning identified in the review.

Learning events were conducted over two days on 26th and 27th June 2024, a day for practitioners and a day for managers. The following agencies were represented on both days:

- Housing
- Police
- Substance Misuse Services
- HMPPS for prisons and probation
- Health from local community and prison health services

The format for the days included an overview of the review process, a description of Mr X as remembered by his family and time to review the chronology prepared by each agency, in smaller groups, with time for discussion and reflections before feeding back to facilitators. The groups were then presented with the following questions:

- What were the main challenges in this situation?
- What went well?
- What could have been done differently?
- Were there any missed opportunities?

Similar themes were drawn out over the course of the two days, and this has been captured in the next section of this report.

Family declined involvement: No

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.

During the review process, it was clear that agencies had worked exceptionally hard to provide Mr X with the care and support he needed. A comprehensive timeline and analysis undertaken by practitioners, managers and agencies provided a detailed insight into practice and services available and the context in which this occurs. Invaluable contributions made by Mr X's family, namely his sister, provided unique insight into their experiences that have supported and informed the learning process.

1. **Recording**

Agencies evidenced a high level of recording of their interactions with Mr X and the work that went on to support him. This has enabled this review to be undertaken with a full and thorough overview from all agencies.

Learning Event – Themes

The level of information recorded for each of Mr X's interactions with agencies was to a good level, which is clear from the timeline produced.

2. **Multi-agency oversight**

Although complex, there is good evidence of multi-agency approaches to assessing and managing the risk presented by Mr X and putting plans in place.

Multi Agency Public Protection Arrangements (MAPPA) continued following his release in March 2022, despite Mr X no longer being under the statutory supervision of the Probation service. Managing complex needs requires a variety of agencies across both the statutory and the third sector, combined with numerous multi-agency approaches, such as Integrated Offender Management (IOM) and MAPPA. At times, this became complicated, and roles and responsibilities became blurred.

Agencies are often working to different statutory frameworks, and they do not always align. Agreement amongst agencies on making best use of the legislative powers within our gift to achieve the best outcomes would be beneficial, balancing risk management and treatment effectively.

Numerous agencies worked collectively to offer support to Mr X. Appointments with professionals took place almost daily, and where appointments did not take place face to face, regular telephone contact was maintained. Regular home visits were made by support services and whilst Mr X did appear to be engaging, there is clearly documented deterioration in his behaviour and wellbeing.

Mental Health services monitored and reviewed medication periodically, and where necessary, medication was adjusted.

Appointments often involved more than one agency and Mr X is reported to have engaged well.

Learning Events – Themes

MAPPA and IOM schemes were in place to support Mr X and to manage the risks presented. However, Mr X was deselected from IOM whilst in custody.

Multi-agency approaches were responsive to the best of their ability at most times. A focus during meetings on the legislation available to all agencies to provide the best service and manage risk would have been beneficial, with a collective view and defensible decision making on what to make use of at what times.

3. **Liaison between agencies**

All agencies communicated well, with good evidence of email and telephone communication.

Chronology Review – Themes

There is extensive evidence in the timeline of good communication between agencies, by telephone, email and attendance at relevant meetings.

Learning Event Themes

The recording of concerns and interventions was robust, with in depth notes, and a lot of communication between agencies.

4. **Staff commitment**

There is significant and consistent evidence of practitioners in agencies being committed to working with Mr X, often under very challenging circumstances. Practitioners planned to meet with Mr X together to enable structured, consistent contact whilst maintaining safe practices, and not overwhelming Mr X with multiple appointments. Where face to face contact could not be facilitated, telephone contact was regular and consistent.

Due to the number of agencies involved, one email thread was developed that included all relevant practitioners, to ensure that information sharing and communication was streamlined, effective and meaningful.

Learning Event Themes

Everyone wanted to do their best for Mr X. Everyone was doing everything they could to help him. There was some very good communication between the agencies/services, with a lot of compassion shown for him and his situation.

5. **Information sharing**

Barriers to information sharing often created obstacles in being able to access the right information at the right time. This was particularly evident in sharing information between health services and other departments within the prison establishment. Confidence to share and an awareness of the legal framework that supports sharing, rather than prevents it, would be beneficial for all agencies. This was identified as a particular issue in prison, with the health care and substance misuse services provider.

Learning Events Themes

During the learning events, information sharing was raised as a barrier or obstacle to being able to effectively deliver a service. Health colleagues, who also deliver substance misuse services in the prison, believed that information they held could or should not be shared. However, there are statutory frameworks that exist to support the safe and justifiable sharing of information, especially when relevant to risk and safeguarding. For example, all statutory agencies are involved in MAPPA, either as a responsible authority, or having a duty to cooperate, and this should enable rather than prevent information sharing.

Practitioners noted that information sharing was often difficult between agencies, and requests for and access to information were not always forthcoming.

Agencies working on different recording and case management systems was also cited as an obstacle. Practitioners are unable to access all information that exists from one shared system.

6. Holistic assessment process

Assessments often appeared to be based on a moment in time. Practitioners involved noted that it was clear that Mr X was able to mask symptoms and behaviours. Even though Mr X could present as well, this was often only for short periods of time, and the long-documented history of being unwell indicated that deterioration was likely to occur rapidly. Assessments were therefore not dynamic and responsive to his changing circumstances; assessing the here and now was not always useful, nor did it result in the best outcomes for Mr X. However, assessments conducted to consider detention under the Mental Health Act are based on the “here and now”, and the challenge here is how rapidly and frequently risk could fluctuate, making decision making complex and difficult.

Family Perspective – Sister

Discussions with Mr X’s sister highlighted frustrations with the assessment processes from a family perspective. She informed us that she could not understand how assessments, often completed within days of each other, could reach different conclusions. For example, an assessment that took place days before release recommended detention under the Mental Health Act, yet within days a different professional reached a different conclusion. The question raised by his sister was if two professionals reach a different conclusion, who decides which outcome prevails?

Following the loss of her brother, Mr X’s sister advised that services had had sight of numerous assessments that had been completed over the years, discovered amongst his belongings. She advised of examples where assessments have been completed without apparent sight of or consideration of previous reports. In her view, this led to reports and treatment outcomes not being followed up and this went on for several years. One example is a psychiatric assessment from 2012, which had a clear diagnosis, which she described as being a relief for her brother. However, it did not appear from the family’s perspective to have led to a change in the services and support available to him.

Learning Events - Themes

Assessments and relevant accompanying processes were the focus of discussion at the learning events. Attendees noted that assessments often appeared to be too narrow, and tunnel visioned, rather than a holistic view of the individual. There is a view that more perspective needed to be considered when assessing, allowing fluctuations in wellbeing to be included, rather than a snapshot or moment in time, as it was well documented that he was able to mask symptoms.

Outcomes of assessments were also considered, and it was felt that rationale was not always captured. It was unclear if people were looking at a moment in time or were they considering all events that led up to that moment. During the events, the chronology was thoroughly reviewed and did not provide any clarity on the information used to inform an assessment.

7. **Co-ordinating services**

Movement between health board areas, particularly when entering and leaving the custodial estate, appears to be complex and would benefit from a streamlined process. Clarity around roles and responsibilities became blurred and responsibility and accountability for care and support became unclear. This is articulated in the feedback from the learning events as follows.

Learning Events – Themes

Movement between health board areas and in and out of custody caused issues as different health boards use different systems. Individuals were named as Care Co-ordinators but there is no framework in place to adhere to when working across borders. Mr X effectively had two Care Co-ordinators, one in his “home” health board and one in the health board for the prison.

Whilst these individuals had the same title, they had different roles and work differently in different areas.

Care responsibilities should be handed over as people transition in and out of custody. It is unclear how effective the handover was at critical points of transition.

Chronology and Organisational Analysis – Themes

A review of the chronology illustrates that there is no evidence that formal handover took place at any point. This was not identified in the organisational analysis by any of the relevant agencies.

8. **Person Centred Approach**

It was often felt that Mr X was not central to the process. Whilst it is acknowledged that he was not always easy to work with, and presented a risk to professionals, there is little evidence that he was included in the processes and systems available to him. Being a complex individual, involved in a complex multi-agency approach to supporting him, it would be useful to identify a single person who could act as his advocate, and support him to navigate the complex systems around him.

Family Perspective – Sister

Mr X's sister raised the question, who was there for him? Who was responsive to his needs?

Whilst there were lots of services involved, he was also excluded from support services, and he did not have an assigned person who could represent him.

Learning Events – Themes

Both learning events identified that Mr X was not central to all the processes and systems around him. Whilst there is some evidence of agencies meeting him together, the points at which decisions were being made about how to support him and manage the risks he presented, did not include him.

There were numerous risk management meetings, and the attendees at the learning events questioned how meaningful they could be as they did not include Mr X.

Mr X was being supported and managed in a complex system, which could be difficult for professionals to navigate at times, and so it was felt that Mr X needed a dedicated form of support to assist him through these processes.

9. **Shared understanding of legislative frameworks**

A consistent approach or a co-ordinated agreement between agencies on what action was being taken, at what point, by who and why would have been beneficial. It appeared that deferring decisions at certain points resulted in missed opportunities; for example, when presenting as unwell in prison, a decision to detain under the Mental Health Act at that point, could have enabled the right level of support to be in place when he was released into the community. However, this review has highlighted that when a person is "a prisoner" they are managed differently under the Mental Health Act (Sc. 47, Sc.48) rather than a member of the public, and different sections of the Act (Sc. 2, Sc. 3) are utilised.

When the prison Mental Health Team were concerned and raised the potential for admission to hospital, he was a "sentenced prisoner". The hospital process is lengthy for any prisoner requiring admission, and can take in excess of 100 days, from referral, to assessment, to decision at panel, to finding a bed (prisoners cannot go to open wards and must go to secure units), and to apply for a warrant under the Ministry of Justice. There was not sufficient time for this process to take place between the date it was identified that Mr X may benefit from a period of assessment and treatment in hospital, and his scheduled date of release.

For this reason, a Mental Health Act assessment was arranged for the day of release, as this marks the change in being able to assess using the Mental Health Act as a civil patient, which would allow Mr X to then be assessed and treated as a member of the public in a local mental health unit. The assessment was carried out as legislated by a Sc. 12 approved doctor, psychiatrist and an Approved Mental Health Practitioner who is provided by the Local Authority.

Family Perspective – Sister

One of the biggest questions for Mr X's sister is how her brother ended up being allowed to come back to a rural area, when he was assessed as high risk of harm and a few days before release an assessment concluded that he be detained under the Mental Health Act.

Learning Event – Themes

Admission to hospital whilst he was in custody may have helped – although it is understood that he may have been very adept at masking his behaviours to different people. There was an opportunity to transfer from prison to a secure hospital for observation and treatment.

There was acknowledgement that thresholding is challenging. Thresholds differ, and there were clearly different perspectives between agencies and across different areas within Wales. There is a lack of consistency.

An individual being detained in the secure estate requires a different process and different element of the Mental Health Act and there was insufficient time left in custody for this to be followed for Mr X. Therefore, the decision to request a "gate assessment" was based on release being the required change in circumstances to follow a different section of the Act.

10. **Gaps in service provision**

Crisis/reactive interventions were limited. During periods where Mr X was excluded from services due to risk issues, there was no alternative in place. This resulted in him inappropriately contacting police for help, via emergency call services, and ultimately further offences for doing so.

Family Perspective – Sister

Mr X's sister questions how he was allowed to return to a rural area, where there may not be services available 24 hours to offer support, or to deal with the well-documented crises her brother experienced. This is why he would attend the police station, often at night, asking for help.

He was brought to a rural area to be managed in the community, after being assessed as high risk and being unwell, Mr X's sister felt that services were reluctant to see him due to his previous behaviour, and that his access to support was further limited as a result of the limitations in the area.

Chronology Review – Themes

There is substantial evidence throughout the chronology of Mr X contacting police via 999 calls or attending the police station. The majority of these occur outside of core office hours.

Learning Event – Themes

- The services available in smaller, more rural communities can be limited, especially out of core office hours.
- There are currently no specialist mental health forensic teams in the area.
- Mr X himself could at times present challenging behaviours and high levels of risk, and this could present challenges for all services involved in his care, particularly in light of the need to consider the risk that he at times posed to them. Safe working practices concluded that he should be seen by two members of staff.
- It was difficult to undertake some visits as safe working practices concluded that he should be seen by two members of staff. Male staff attending could often have a negative impact on Mr X, therefore committing resources for two members of staff, preferably female, to attend was often challenging for agencies.
- Staff had a real sense of the risk Mr X could pose in terms of risk to professionals and this was clear at the learning event.
- There is no evidence of crisis meetings being organised in response to the volume of 999 calls being made.
- Outpatient appointments were often required to be made, which could be weeks in advance, when Mr X would have benefitted from a response at the point in time in which the challenge was presenting.
- Assertive engagement (an outreach approach) may have been beneficial for Mr X, to provide an appropriate response to his needs whilst managing risk to professionals.
- Supported housing in the area is limited.

Organisation Changes Since 2022

The NHS 111, press 2 service is now available, 24 hours per day, but was not in place at the time of Mr X's involvement in services – this may have been a platform he could have utilised. This would have directed him to services rather than him being picked up by police. It is a more structured route and professionals' meetings may have been arranged.

Organisations in the area are looking to engage more effectively with individuals requiring mental health support, such as free drop-in groups; however, engagement has been low and this would only meet the needs of low-risk individuals.

11. **Dual diagnosis**

Substance misuse and mental health issues appeared to be intrinsically linked in this case, creating complexities around achieving stability and successful treatment. Instances of diagnosis focussing on drug induced psychosis may have hindered effective treatment for underlying mental health issues and created an increased likelihood of substance misuse for self-medication.

Family Perspective – Sister

Mr X's sister explained that a lot of reports she has read about her brother say that the drug misuse came before any mental health issues. However, she strongly disagrees. Their mother had been asking for help for her brother since he was a child, and she says that he had always had behavioural issues. Mum felt very unsupported and was told he was "just naughty". She would always get upset when she asked for help as she never got any.

Following the breakdown of his relationship, her brother attended the GP asking for help, but he felt this was not forthcoming, and he left deflated. She believes that if he had received better treatment earlier in his life, maybe the outcomes would have been different.

Mr X's sister feels very strongly that an important message is that more help and support is needed when people are younger, and that the issues faced by her brother need to be more recognised and addressed.

Learning Event – Themes

A specialist role for dual diagnosis is needed with relevant skills and expertise; there was no specialist available for Mr X. Focussed assessments and interventions on dual diagnosis were required but unavailable.

There is still a culture and stigma surrounding substance misuse.

Organisational Changes Since 2022

The prison now has specialist dual diagnosis workers.

PTHB also provides a Dual Diagnosis worker based with the CMHT.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

The following recommendations are drawn from the themes and learning detailed above.

1. **Information Sharing** – to ensure Health and Substance Misuse Services within prison settings are provided with guidance in relation to their ability to share personal information via legislative powers and frameworks (such as MAPPA), to ensure the effective management of risk and complex behaviour. Where barriers are identified, routes of escalation should be made clear to staff, to ensure that the right support is given to enable sharing.

2. **Legislative Powers** – a coordinated approach to understanding and identifying the most appropriate legislative powers to support risk management and treatment needs of individuals within prison settings should be developed, with a focus on mental health needs and consideration of identification of a lead agency/service for the individual. For example, there was a lot of confusion over the use of the Mental Health Act whilst in custody. Including all services in the multi-agency arrangements and facilitating focussed discussions and recording of the rationale through forums such as MAPPA could have supported the wider understanding.

3. **Co-ordinating Transition** – movement between areas, whether due to periods of imprisonment or for other reasons, should be supported by timely and effective transfers and handovers. A review of services required and identifying lead agencies, roles and responsibilities at critical points would ensure that needs are met, plans are in place and all those involved understand how support, treatment and risk will be managed throughout these times. This is particularly relevant for health services, where transitions between areas and community and the secure estate added complexities.

4. **Service User Voice** – including individuals in the decisions that are made about them can be more effective in terms of securing and maintaining engagement. All agencies should consider how to make decision making and care/treatment/support processes more inclusive of individuals with complex needs and/or who can at times present risk to themselves and others.

5. **Pre-release Planning** – for complex cases, release planning should always have a contingency that can be activated at short notice and agencies are aware of their roles and responsibilities. Where further detention is possible, but not definite, agencies should work together to have a contingency plan that manages risk and offers relevant support to the individual.

Statement by Reviewer(s)			
Reviewer 1	Emma Winston	**Reviewer 2** *(as appropriate)*	N/A
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 child or family, or have 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 child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)* 		**Reviewer 2** N/A *(Signature)*	
Name *(Print)*	Emma Winston	**Name** *(Print)*	N/A
Date	05/06/2025	**Date**	N/A
Chair of Review Panel *(Signature)* 			
Name *(Print)*	Donna Pritchard		
Date	05/06/2025		

Appendix 1: Terms of Reference

Terms of Reference for Concise Adult Practice Review
CWMPAS 1 2022 (Powys)

- **Nominated Safeguarding Lead** – Karen Arthur
- **Review Panel Chair** – Donna Pritchard
- **Independent Reviewer(s)** – Emma Winston

Core Tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine the effectiveness of inter-agency working and service provision for the adult and family.
- Determine the extent to which decisions and actions were in the best interests of the adult and outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a multi-agency learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission reviewers to work with the *Review Panel* in accordance with guidance for concise reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewers and Panel membership
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewers a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Practice Review Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Adult Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the Practice Review Sub Group:

- Agree and approve draft ToR for each case recommended for APR
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Monitor APR action plans to ensure all recommendations are carried out on behalf of the Board

Tasks of the CYSUR/CWMPAS Safeguarding Children/Adults Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a APR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final APR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them.

Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate.

A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared:

- In working with sensitive information in relation to an Adult Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 3 – Adult Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
    - However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.

For Welsh Government use only

Date information received: …… *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……*(date)*

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