Structured abstract

Purpose: The purpose of this article is to read across twenty adult practice reviews undertaken in Wales to identify cross cutting themes.

Design/method: The method was for each adult practice review (APR) to be read and independently coded by four researchers from differing disciplines of criminology, law and Social Work.

Findings: Five overarching themes were identified of (i) Safeguarding, capacity and duty to report (ii) Commissioning and inspection (iii) Transitions (iv) Voice of vulnerable people (v) Family and carers. In addition, quality and good practice are reflected on.

Implications for policy and practice: The study identified the benefit of adopting a single unified assessment tool.

Implications for further research: A further study capturing more APRs since the implementation of the Social Services and Well-being Act (2014) should be undertaken to help review changes in practice since the new legislation was introduced. Future research into APRs should adopt a similar multi-disciplinary approach.

Originality/value: This is only the second study of its type undertaking a multi-disciplinary perspective of APRs.

Keywords: Homicide, vulnerability, domestic abuse, adult safeguarding, inspection of adult services, Vulnerable adults.

Introduction

Since the first child death scandal of a child who was 'boarded out' in 1945 (Hopkins 2007) and the subsequent inquiry, the number of death and serious incident reviews taking place in the UK has burgeoned. We now have more of an 'inquiry culture' that has prompted death reviews becoming 'much more a feature of public life' (Nash & Williams, 2008, p. 134). All reviews are underscored by a desire to 'learn the lessons' from devastating and potentially avoidable deaths. Yet, despite the significant level of resources invested in producing these reviews, it is unclear how far their findings have added to professional knowledge (Salter, 2003) or if their recommendations give the impression of change to pacify the public (Robinson *et al*., 2018; Elliott and McGuiness, 2002). There are numerous analyses of death reviews, for example, Domestic Homicide Reviews (DHRs) (Home Office, 2013; 2016), of APRs (Stevens *et al*., 2017) and Safeguarding Adults Reviews SARs (Preston-Shoot *et al*., 2020; 2024), of Mental Health Homicide Reviews (MHHRs) (Health Inspectorate

Wales, 2016) (HIW) of Serious Case Reviews (SCRs) (Brandon *et al*., 2020; Sidebotham *et al*., 2016) and of Child Practice Reviews (CPRs) (Rees *et al.,* 2021 b).

This research project was commissioned by the National Independent Safeguarding Board in Wales (NISB) (via Welsh Government) to extend the learning both for policy and practice as a result of a systematic analysis of APRs. Furthermore, this study aims to maximise the usefulness of such reviews, which are costly and often underutilised as learning resources. It builds on a previous study undertaken across different types of adult death reviews including APRs, MHHRs and DHRs undertaken in Wales (Robinson *et al.,* 2018) and of CPRs (Rees et al., 2021 b).

APRs are commissioned by regional Safeguarding Boards and take place after an adult 'at risk' has died; or sustained potentially life-threatening injury; or sustained serious and permanent impairment of health. The APR may be concise or extended, depending on the circumstances of the case. Concise reviews should be held where on any date during the six months preceding the date of the event, the person has **not** been someone who the local authority has determined to take action to protect them from abuse or neglect, and has died, or sustained potentially life-threatening injury, or sustained serious and permanent impairment of health. A Board must undertake an extended APR where an adult at risk who has, on any date during the six 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.

Under Part 7 of the Social Services and Well Being (Wales) Act (2014), an 'adult at risk' is defined as a person who: (a) is experiencing or is at risk of abuse or neglect; (b) has needs for care and support (whether or not the authority is meeting any of those needs); and, (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Methodology

The project was commissioned by the NISB via Welsh Government and took place between January and April 2021.

The study is qualitative and involved thematic coding of APRs alongside the use of focus groups with practitioners from across Wales to test out initial findings. The research team chose to replicate a previous study of death reviews undertaken in Wales (rather than undertake a domain analysis) as this was the recommendation of the former study (Rees *et al.,* 2021 a). This would help to make direct comparisons and identify any changes in practice over time in Wales.

Sample

The sample of reviews to be coded was provided by the NISB. A total of 20 APRs - completed between 2014 and 2020 were coded by four members of the research team from a legal perspective, a criminological perspective and a social work perspective. Fourteen of the APRs were undertaken as a result of an adult death, with causes of death ranging from factors associated with medical and/or other forms of neglect, self-neglect and suicide. Two were undertaken on the basis of a domestic homicide. Twelve of the adults were in residential care homes. Seven adults were at home and one in hospital. Of those at home, only one was assisted by paid carers, all others were looked after by family members. Three APRs were undertaken owing to abuse and neglect in residential and community care settings, and one APR concerned the conduct of mental health assessments and deprivation of liberty. Many of the APRs identified that vulnerable people had been subject to abuse and neglect, often over protracted periods of time.

Analysing APRs

A framework to identify key themes was established by the research team. Briefly, this involved reading and discussion of three APRs by four researchers (social work-two, law and criminology), which then enabled the development and refinement of a coding framework. Once the coding framework had been agreed, researchers were asked to identify up to five key themes under each of the following coding framework categories: (i) Residence/circumstances of adult; Perpetrator/s (if there is one); (ii) Mental capacity; (iii) Other demographic information (iv) Characteristics of abuse; (v) Carers (both formal and informal); (vi) Agency performance – Adult's Services. Health (including mental health).

Housing. Police. Other (including third sector); (viii) Multi-agency partnership working.; (ix) Identification of good practice (x) Key recommendations going forward; (xi) Comments on quality of APR; (xii) Other comments (e.g., from their discipline specific perspective).

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

From the coding exercise, a group of five cross-cutting themes was identified. These five themes were subject to a validity check through the discussion and feedback provided by the practitioner focus groups.

Focus groups

Virtual focus groups were undertaken as COVID-19 lockdown was still impacting. The focus groups discussed the identified themes and provided feedback on how they resonated with practitioners and their potential interpretation of their meaning. The invitation to the focus groups were sent out via the NISB. One focus group was held for North Wales and one for South Wales. Ten people attended the North Wales group and thirteen attended the South Wales group; both focus groups lasted two hours. It is understood that the optimum face-to-face focus group size is generally believed to be between 4 and 8, with 5-6 being most commonly suggested. Both of the online groups in this study were larger, but levels of participation from the attendees suggests size was not a barrier in terms of their willingness and ability to engage with the discussion.

Participants provided some demographic information in their consent forms which indicated that they occupied a variety of practice, managerial and strategic roles within police, social services, probation and health. Participants were asked to indicate their level of experience with each type of review (no experience; have read this type of report; have participated by providing evidence or information; have had overall responsibility for the process; have had

strategic responsibility for ensuring that recommendations are implemented). All participants had some level of knowledge and/or experience with APRs.

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

Ethics

The research was submitted to (Institution) University ethics committee and approved in 2021. The APRs are publicly available documents, and we do not draw on any quotes from the focus groups. We do not provide any reference to the specific APRs, date or location.

Limitations

The sample was a convenience sample provided by the NISB. It does not necessarily provide a representative sample of APRs that have been carried out in Wales. However, they were chosen with a view to ensuring a wide geographic spread of cases within Wales, and to illustrate the diverse range of issues that tend to be found in such reviews. Since their inception in 2013, according to the NISB, 36 APRs have been completed. 20 APRs were thematically analysed in this study (56% of all completed APRs). Across this and our previous study (Robinson *et al.,* 2018) 24 individual APRs have been reviewed, accounting for 67% of all completed. The research took place during COVID-19 and both focus groups were held virtually. One of the members of the coding team was ill during the study period and could not attend all of the weekly meetings but managed to catch up with the coding and feed into the overall review of findings. Timescales provided for completion of the project had thus to be extended, with the first draft report submitted in April 2021.

Findings

Five themes were identified from the reading and analysis of the APRs, these are as follows: (i) Safeguarding, capacity and duty to report; (ii) Commissioning and inspection; (iii)Transitions; (iv) Context and perspective of vulnerable person; and (v) Family and carers. In addition, quality and good practice are commented on.

Theme One

Safeguarding, capacity and duty to report

The reviews consistently identified a lack of both safeguarding procedures and the duty to report adults at risk of abuse and neglect (under section 128 of the Social Services and Wellbeing (Wales) Act 2014), a finding that was also highlighted in Preston-Shoot *et al's* (2020) SAR report. Training on these issues was consistently highlighted by both reviewers and focus group participants. However, it was noted that the responsibility to report when people were living in residential care often fell to care home staff who had more limited time and/or limited previous knowledge of safeguarding. This coupled with the hierarchical nature of residential care home structures was also noted to be a potential hinderance with designated safeguarding leads (or similar) often being managers; potentially giving rise to conflicts of interest in some instances. Policy makers should consider how best to guide organisations, staff, regulators/inspectors and safeguarding services on best practice principles for small or geographically isolated settings.

Even where practitioners were aware of safeguarding procedures, their confidence in making referrals was often complicated by a lack of professional curiosity. For example, deterioration in people's presentation was assumed to be part of the trajectory of their particular condition or as result of aging and developing dementia. When individuals did deteriorate, professionals did not always ask questions, explore or look for alternative explanations. As noted in one APR, there is a need for professionals to '*think the unthinkable and ask the unaskable'*; something that resonates with the need for 'healthy scepticism' that has become a mantra in the safeguarding of children and young people (Muirden, 2022).

The lack of professional curiosity was often exacerbated by inadequate understandings of mental capacity (as defined by the Mental Capacity Act 2005), a finding similar to Preston-Shoot *et al's* SAR report (2020). Capacity was often inappropriately viewed as a static concept, rather than something which was fluctuating and dependent on context, time and situation. In certain circumstances this lack of understanding about mental capacity could lead to the infantilisation of older people and used to justify arrangements which did not allow people to have any agency or choice. Lack of capacity was sometimes seen to be used

as a reason for residential homes to institutionalise residents, so they had little choice over, for example, meal-times, and when to get up or go to bed. Training on mental capacity that is accessible to those working in a range of settings and at various levels would likely provide great benefit for improving the lived experience of people using services.

When safeguarding referrals were made by family or care workers, they were not always responded to effectively, often as a result of a misunderstanding held by practitioners about the duty to share information – something focus group participants felt had been exacerbated by the introduction of General Data Protection Regulation 2018 (GDPR).

Theme 2 – Commissioning and inspection of residential care homes

In Wales care home services are commissioned by the local authority. Many of the residential homes in the APRs were small, independent (e.g., private) providers, something that is reflective of the sector in Wales. Consequently, the commissioning process has a particularly important function in ensuring the delivery of high-quality and safe care to vulnerable people. It was not always clear what bench marking checks had taken place in the commissioning process (e.g., what factors were considered and whether the commissioners were checking that appropriate training of staff, recording or safeguarding procedures were in place within the homes).

One of the most insidious issues related to consistently poor record keeping processes, a finding that resonates with Preston-Shoot *et al*'s (2020) SAR Analysis in England. In another there was no recording protocol. Other care homes were not recording accurately and did not have care and support plans for each resident, something that should be routinely monitored via commissioning processes.

The lack of recording was partly noted as a training issue, but the deficits in training also included the omission, or poor provisioning of, training around safeguarding requirements (see theme 1), whistleblowing and treatment of pressure sores. Whistleblowing was often complicated by inadequately developed policies and processes, and conflicts of interests characterised by the employment of friends and relatives in smaller homes. Pressure sores

was noted by reviewers and focus group participants as being of particular importance given the profound impact they have on the welfare of individuals.

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

Care homes are regulated by Social Care Wales. The regulation and high turnover of staff present some ongoing challenges for both Social Care Wales and social care providers; however, responsibility for inspecting residential care homes (and many other social care settings) predominately rests with Care Inspectorate Wales (CIW) (known as the Care and Social Services Inspectorate (CSSIW) prior to 2016).

There was also some difficulty with communication between CIW and commissioners (e.g., local authorities) across the APRs, in particular, having rights to access the home, and the information being made being made available. Focus groups noted how this had been exacerbated through COVID as understandably CIW had not been visiting care homes. We are aware however that throughout the pandemic CIW have made strenuous efforts to meet regularly with commissioners to share information.

There also seemed to be a lack of direct communication between the inspectorate and commissioners. Where inspections had revealed negative evidence regarding the standard of care in a home, this was not reported directly to local authority commissioners in a timely manner, with the onus seeming to be on commissioners to check for information on-line, rather than being directly alerted as standard practice.

The current legal framework(s) poses considerable challenges to inspectorates in the gathering of evidence and the pursuit of legal enforcement (both civil and criminal). For example, information can take some time to enter the public domain as care settings will

need to be given due to time to rectify issues and dispute concerns raised through the inspection process. The development of a clear system for alerting local authorities, and other statutory agencies, at the earliest opportunity about the outcomes of care inspections in their area would likely promote positive commissioning and more effective safeguarding.

Theme 3 – Transitions

Transitions are understood in the broadest form covering a range of movements and changes including across location, services and staffing. Transitions, particularly movement between services and/or across borders and commissioning authorities, were identified as a key theme in many of the APRs. The room for error increases when people transition (Robinson *et al.,* 2018; Robinson *et al.,* 2019) and risk increases, mostly because information gets lost or does not travel with people. For example, a young women lost many of the tailored services she had provided to her as a child when she entered an adult services facility.

The transitions of people moving into new residential facilities was also a major risk factor. In one APR, a new resident moved into the home and, whilst a detailed assessment was undertaken as to whether the facility could meet his needs, there was no consideration of the risk he posed, or the impact he could have on other residents. The new resident had a history of harmful sexual behaviour and committed a serious sexual assault in the home. Further, in another APR, the individual was transferred back to family (her mother) without full discussion or pre-discharge meeting. The condition of the accommodation was unsuitable for the daughter, and the mother, herself a vulnerable person, may have felt pressure to accept her daughter who later assaulted her.

People who moved into residential care out of county also became more at risk as the communication mechanisms were not clearly developed. In one APR, even though standards in the home were declining, this information was not fed back to the commissioning county. In some of the APRs the transition of staff turnover also increased the room for error. Another area of difficulty was movement out of services through disengagement of the person at risk of abuse or neglect. In these circumstances, there did

not seem to be any professional curiosity, or any understanding that disengagement might heighten risk and potentially be seen as a red flag (also found in Rees *et al*., 2021 a).

Theme 4 – **Context and perspective of vulnerable people**

The timeline of APRs, as per the guidelines (see 6.21 in Welsh Government, 2016), involve a maximum of 12 months prior to the event, extended only in exceptional circumstances. The reviews in this study included cases with timelines of no more than two years. This, however, sometimes provided a confined picture for the reader.

Comprehending the context was incredibly challenging with limited information provided. Contrary to APR guidance on obtaining the adult's perspective and ensuring this contributes to the review 'so far as practicable and appropriate to the circumstances of the case' (Welsh Statutory Instruments, 5 b, p. 7), no APRs involving a person still alive included them directly. Seven APRs did not mention the age of the individual involved. In nine, information on their history or interests was absent as was any contextual appreciation of their experiences or needs. One was rendered as a faceless 'bedbound' figure whereby even their relationship and history with their carer was neither known nor relayed. A positive attempt to detail such information in another APR was limited to the person's interest in costume jewellery. This absence of context raises questions regarding the educative utility of and the ability to remember reviews, particularly given the importance of narrative and stories for memorability (Boris, 2017). Good practice was demonstrated in the rich detail provided in five APRs. This enhanced memorability and recallability amongst the research team. However, those richer in detail tended to involve more middle-class individuals, perhaps those with whom reviewers could more readily identify.

The lack of personal detail in APRs mirrored the treatment that older and vulnerable people receive, particularly in residential care. Across several APRs regarding those in residential care, personalisation and access to services were lacking. For example, one resident was regularly dressed in another's clothing and family members recounted often finding other people's belongings in their room. In three APRs, access to services (e.g., chiropodists and hairdressers) was limited or unavailable, resulting in isolation and reduced surveillance.

Some were infantilised and treated in an undignified manner, such as being left for long periods in incontinence pads or with no underwear or using child stairgates to restrict movement. In three APRs, professionals were unable to see the adult alone.

Theme Five - Family and carers

Communication with family was perceived as problematic across many reviews, with families and family carers on the periphery and their voices ignored. This is often contrary to their wishes to remain involved and continue in a caring role (Cooper, 2023) and is counterproductive as relatives often have a wealth of knowledge and are attuned to the individual's needs. Rather than being welcomed, residential homes framed families as difficult and they were expected to adopt a secondary position. The knowledge the family had was neither sought nor valued – there was a 'hierarchy of knowledge' (Rees *et al.,* 2019 a; Robinson *et al*., 2018). Where families noted deterioration and raised concerns or complaints, they were ignored. Families were often unaware of the complaints procedure and were unsure of who to report concerns to or what action to take. They were not kept abreast of or consulted regarding significant changes or informed about the resident's deterioration. For example, unaware that their elderly relative was permitted pureed food only and concerned with her substantial weight loss, one family fed her biscuits and chocolate, unaware of the resultant choking hazard. In another APR, a family were not advised of their father's deteriorating health until he was admitted to hospital (he died days later).

Communication issues intensified where the residential placement was far away and/or less accessible for the family. In one APR, the need for nursing care and a move to a new home meant the loss of caring role for a daughter who had previously visited daily and attended appointments with her mother, as well as a deterioration in communication between the residential home and the family. Family was also not always alerted or consulted when plans were underway to return their relative to their home (e.g., from hospital) or to a new facility. In two cases, the potential risk posed by the adult to their family was seemingly not a consideration in discharge decision-making. In one involving several transitions, family were notified but not consulted regarding discharge to the family home whereupon three days later the individual was arrested for a domestic incident. In another APR, the adult

children's concerns about their father's out of county residential care were neither recognised nor actioned.

Some APRs detailed problematic home caring arrangements. In four (all involving male 'carers', albeit one presumed male), professional oversight (typically of health and social care) was absent, and several demonstrated little professional curiosity regarding the vulnerable adult's deterioration or the nature of the 'caring' relationship. The pressures for men – five APRs featured male carers – of what is typically a feminised role was perhaps not fully acknowledged (Greenwood and Smyth, 2015). In four cases, carers were the gatekeepers to the vulnerable adult, and in four APRs it is unclear whether the adult was seen alone (see also Rees *et al.,* 2021b in respect of CPRs). In three APRs, the vulnerable adult's living conditions were certainly unsatisfactory, and abuse possibly present. One APR detailed known issues of alcohol and substance misuse, as well as domestic violence in the home and concern from the home care provider regarding a physical assault by the carer on the adult. In another, the husband (previously the carer) killed the vulnerable adult in what was considered a 'mercy killing'. The absence of professional oversight also meant carers took on tasks beyond their capability or competence, including medical procedures (debriding of a Grade Four pressure sore, straightening limbs, and force-feeding). Professionals also found some carers challenging to work with – in four APRs health staff felt intimidated by the carer and in two cases visits were conducted only in pairs. Yet, this intimidation did not translate into concerns for the vulnerable adult. Professionals seem to have difficulty working with challenging individuals, particularly men (see Robinson *et al*., 2018). Training on effective challenge is needed for professionals.

The Quality of APRs

There was a wide range of quality across the APRs identified by the research team, and this was also confirmed in the focus groups: consistency is thus an issue. Lack of detail and patchy information in the APRs meant it was difficult to know individual's precise circumstances. Importantly, there was widespread use of vague and imprecise language, and this could make it very difficult to establish what had happened and who the key agencies were. For example, the term 'practitioner(s)' was used across the reviews, but it was often unclear if the organisation was health, social services – or another agency. It is

through this understanding that improvements to the system might be made. A key barrier to achieving this may be a concern across agencies with moving away from 'blame culture' and, as noted by Woods (2005, p. 487), "The slogan of 'moving beyond a culture of blame' … is a call to abandon poor systems of accountability and … not a tolerance for an absence of accountability". The drive to move away from an unhelpful 'culture of blame' appears to have been incorrectly understood as inferring the need for an overly anonymised, vague and imprecise account that obscures the potential to understand what happened and why. Whilst potentially identifying individuals should be avoided, accountability is important and good practice is linked to clearly explaining what part(s) of the system did not work, whether partially or entirely (Fish, 2012).

Writing/format

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

Good Practice

It is as important to recognise examples of good practice; as noted by Vincent (2004), a particular case can act as a "window" on the system – providing the opportunity to study the whole system, learning not just of flaws, but also what is working well (Fish, 2012). In considering the quality of the reviews, there were a number of noteworthy examples of good practice. For example, in some APRs the background information provided about the adults, their lives, their likes and dislikes, gave a meaningful sense of the adult as a person. Providing a chronology would have been useful in all cases and whilst none of these 20 cases did, three included timelines of significant events either in the text or the appendices and these were deemed helpful.

Discussion

Reading the 20 APRs at the same time forcibly illuminated some poor practice across the residential home landscape in Wales. Reading them together highlights that they are not individual aberrations or one-off incidents, but representative of a pattern of poor practice in care homes.

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

When comparing the themes from this study with those of our previous two studies, undertaken into adult reviews (Robinson *et al.,* 2019) and CPRs (Rees *et al*., 2021b), some of the same themes emerged across all three samples, regardless of the type of review. These included the lack of listening to family; lack of voice of the vulnerable adult; transitions; and dealing with difficult and hostile people (also in Robinson *et al*., 2019). This demonstrates that these issues are not confined to working with adults or with children, but routinely emerge in both spheres of professional practice. Information-sharing is another prominent feature of both previous studies and emerges here as well as widely found elsewhere (also found Preston-Shoot *et al.,* 2020; Neville and Sanders-McDonagh, 2014; Health Inspectorate Wales, 2016; Sharps-Jeff and Kelly, 2016; Sidebotham *et al.*, 2016). This suggests despite being repeatedly flagged up, systemic and structural changes are more difficult to achieve (Dickens et *al.,* 2023).

Many of the same concerns about residential care in this study were found some years ago in Operation Jasmine (Flynn, 2015), although this may be because some of the APRs relate to incidents which occurred as far back as 2014. Concerns with care home practice were also raised by Rochira in her 'A Place to Call Home' Report of 2014.

Whilst the aim of the inception of the APR and CPR model was to take a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases (Welsh Government guidance, 2012), it may be that learning is somewhat compromised by this overly pared-down approach. Our findings from reading the APRs, similar to our previous study (Robinson *et al.,* 2019), found the reviews to be 'often devoid of background detail which is difficult for those outside of the situation to follow, although they can convey helpful analysis and learning points for those involved' (Robinson *et al*., 2018 p.12).

It is noted in the Working Together to Safeguard People document (Welsh Government, 2016) that 'The learning and reviewing framework has been developed with the intention that Boards and their partner agencies provide an environment in which practitioners and their agencies can learn from their own and others' casework and from sources, such as audits, research and inspection' (2016, p. 4). It maybe that in certain circumstances this approach does not lend itself to more broad and national learning, as readers require an understanding of context. Our previous research (Robinson *et al*., 2019) suggested a number of ways in which the reviewing process could enhance the likelihood of wider, deeper learning, and focus group participants in the previous study (Robinson *et al*., 2018) expressed a desire for a more centralised approach to facilitate learning from reviews which is specific to Wales. Currently, a repository for all Welsh reviews is under development and its inception is imminent (Robinson, 2019).

The importance of having the voice of people using services heard. Unfortunately, advocates were conspicuous by the absence in the APRs. It was evident that some efforts had been made to seek the input from families, but this informal advocacy relied heavily on the work/perspectives of individual professionals and was not always given the same credence as information provided by professionals. There was no indication that either individuals or their families were directed to paid advocacy support/services, primarily under section 181 of the Social Services and Wellbeing (Wales) Act 2014 (arguably the 'gateway' to social care support in Wales).

Additionally, there does not seem to be any attempt to devise a system that might enable family members to be supported in the APR process. This would likely aid with engagement and also help reviewers to more effectively capture the perspective of individuals at the heart of these cases.

In addition to those mentioned above, there had been many changes to the policy and legislation of adult safeguarding, which include: Mental Capacity Amendment Act (2019) [not implemented at the time of undertaking the study]; Liberty Protection Safeguards (2020); and the registration of residential care home staff (Social Care Wales, 2021). It will be interesting to see how these changes to adult safeguarding influence practice in coming years, and how this is reflected in any future reviews.

Whilst undertaking an analysis of the reviews we were cognisant of two of the APRs were essentially Domestic Homicide Reviews undertaken in an APR format. We discussed this format at length and felt overall that it worked well, avoiding reviewers having to learn and navigate different structures and requirements, thus becoming more adept and confident in a unified process.

Recommendations

1) Communication pathways - Clearer communication pathways should be developed between inspectorate and commissioners, so that any deficits in standards of care homes are quickly reported.
2) Content of reviews - Future reviews should include more detail and background of the subject of the review to help dignify and avoid further de-personalisation and institutionalisation (as a minimum, age, gender, family, and previous employment).
3) Dissemination of review findings - More use of creative methods be explored to disseminate the messages from the reviews, for example, the use of 'webinars'. These could provide excellent opportunities for teaching and learning and could form the basis of team or inter-disciplinary supervision.

4) Employing family and friends in care homes - Employing friends and family in small social care homes was noted as potential challenge for whistleblowing and effective safeguarding. It is possible that some regulation might aid with this topic, however we were advised that this is made difficult by problems with recruitment in rural areas of Wales. Clearer guidance about inspectorate' expectations and signposting of how staff can raise concerns with external agencies is needed.
5) Training for staff - In our final research report we recommended training for all staff in the sector is urgently required around (i) duty to report, (ii) capacity, (iii) self-neglect, (iv) GDPR and (v) pressure ulcers. These were all consistently noted as areas for development in APRs.
6) Training for reviewers - Reviewers would likely benefit from training on how to keep the vulnerable adult centre stage and guidance on how their perspective might be presented. At the very least reviewers need to identify whether the subjects have been spoken to (they had not in any of the APRs reviewed) and, if not, what the reasons are for this.
7) Unified reviews - We support the introduction of a single unified review process (Welsh Government, 2023; 2024) that brings together APRs, Child Practice Reviews, Mental Health Homicide Reviews, Domestic Homicide Reviews and Offensive Weapon Homicide Reviews In Wales. This will aid with standardising and streamlining training requirements.

Conclusion

The learning from reading across the APRs allows for an 'aerial' view to be taken to observe patterns that cannot necessarily be identified from reading a single review, although there are undoubtedly benefits from exploring individual reviews and taking more of a 'worm's eye view'. Whilst the findings and recommendation are broadly consistent with similar studies, there are unique elements that reflect the particular culture and challenges of adult safeguarding in Wales . This addition to the literature will be useful as a benchmark for future work in this area and also potential comparative analyses combining comparable data (where possible) from elsewhere.

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