Extended Child Practice Review Report

in respect of Child A

CYSUR 4/2017

Date report approved by the Board: 25th January 2018

Child Practice Review Report

CYSUR: The Mid & West Wales Safeguarding Children Board

Extended Child Practice Review Re:
CYSUR 4/2017

Brief outline of circumstances resulting in the Review

Legal Context

An Extended Child Practice Review was commissioned by CYSUR: the Mid & West Wales Safeguarding Children Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Vol 2 – Child Practice Reviews*[2] (Welsh Government, 2016).

The criteria for this review are met under section 3.12 of the guidance:

A Board must undertake an extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health or development; **and**

the child was on the child protection register and/or was a Looked After Child (including a person who has turned 18 but was a Looked After Child) on any date during the 6 months preceding –

- The date of the event referred to above; or
- The date on which a Local Authority (LA) or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for extended reviews are laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[4].

The overall purpose of the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which Regional Safeguarding Boards and partner agencies hold responsibility. To achieve this, it sets in place a foundation for learning together by professionals from different agencies and, in those circumstances where a more formal review is required when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency, concise and extended Child Practice Reviews. The outputs of these changes are expected to generate new learning which can support continuous improvement in inter-agency child protection practice.

The Terms of Reference for this Extended Child Practice Review are at **Appendix 1**.

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V2 – CPRs (Welsh Govt, 2016)
[3] Local Authority or relevant partner means a person or body referred to in S.28 of the *Children Act 2004* or body mentioned in s.175 of the *Education Act 2002*.
[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

Circumstances Resulting in the Review

Child A was a 17-year-old young person in the care of the Local Authority under section 20 of the *Children Act 1989*[5], when he sadly took his own life just three months before his 18th birthday. At the time of his death Child A was living with his foster carers where he had been for almost four years. This was a commissioned independent foster placement. In the period leading up to his final days Child A had experienced a high level of uncertainty about his pathway plan to independence and demonstrated significant worries about what would happen once he turned 18 years of age.

As an extended practice review, the learning is focused on the latter two years of Child A's life from the point at which the care planning for Child A was transferred to the 16+ team of children's social care. However, to make sense of the effectiveness of the multi-agency partnership working, it is essential to understand the context of Child A's life before the age of 16 years.

Child A's Family History and Context

Child A was placed in the care of the LA[6] from the age of two years as a result of severe physical and emotional abuse and neglect. The LA were granted legal parental responsibility and Child A was placed in foster care. Whilst under the court proceedings, Child A was diagnosed with an Attachment Disorder and assessments revealed that Child A had experienced significant abuse and neglect. His behaviour from a very young age was described as aggressive and very challenging – he was clearly a very troubled child with an extremely poor start in life.

As experienced foster carers, Mr and Mrs A were committed to trying to provide stability to Child A. However, there were many concerns within and across the professional group and from Mr and Mrs A themselves about their suitability as permanent adoptive parents for Child A.

Despite these apprehensions, disagreements and challenges, on the 5th November 2003 the court granted an adoption order and Mr and Mrs A became the legal parents of Child A. An adoption support plan was put in place and included financial support. The pursuit of therapeutic intervention was on-going.

By the time that Child A was 9 years old he had been assessed as unable to cope in a main stream school setting. He was identified as having some ADHD[7] behaviours, a Statement of Educational Needs had been undertaken and concerns remained about the impact of the diagnosed Attachment Disorder. By the age of 10 years the family situation had broken down and Child A was accommodated by the LA under section 20, with parental responsibility remaining throughout his life with the adoptive parents, who felt that they had let Child A down.

To understand how best to meet Child A's long-term needs, the LA made a significant investment and commissioned a holistic in-depth assessment through an independent adoption support agency. The aim of this assessment was to find a pathway through care that was right for Child A.

This assessment was of high quality and made qualitative and tangible recommendations about:

- The importance of placement stability and ensuring the right support to the carers so that Child A could attach to his foster carers.
- The need for significant decision making and good care planning to take account of historical context.
- The need for on-going psychiatric assessment to understand any underlying confusion, including risk that Child A posed to himself and others.
- Therapy for Child A that was directive in style and without delay.

[5] Section 20 of Children's Act 1989

[6] LA (Local Authority)

[7] ADHD (Attention Deficit Hyperactivity Disorder)

At approximately 13 years old Child A was in receipt of therapy which lasted around 18 months. He was supported throughout this time by the team around him from the independent foster care agency and his carers. Throughout the latter stages of Child A's life, he was cared for by very supportive foster carers who made a significant commitment to him as their foster son. As parents of grown up children the carers had a deep understanding of the challenges of being a teenager and the tribulations ahead as Child A transitioned into adulthood. The review was confident that whilst in this placement Child A felt wanted and cared for.

Practice and Organisational Learning

Child A spent 9 out of his 17 years in the care of the Local Authority. This meant that Child A's life was well documented, and he experienced a whole range of assessments as he passed through each child developmental stage. His section 20 accommodation status remained unchallenged throughout his care experience as illustrated below:

- 0-3 years with birth parents,
- 3-6 years fostered (Mr and Mrs A as foster parents)
- 6-10 years adopted (Mr and Mrs A as legal parents)
- 10-17 years in foster care

At the time of writing this review the Local Authority children's services had received a CSSIW[8] inspection and the report was published in October 2017; the inspection report itself examined the quality and effectiveness of children's services with them finding:

'Evidence of missed opportunities to safeguard children, despite requests for support. Risks were not being appropriately and robustly assessed and there is no effective system to identify and manage risks'.

'There are serious performance issues with frontline services, however these arose because of instability in management, poor and confused direction and weak governance. Without effective support and capacity to undertake the work frontline staff cannot be expected to undertake the complex work required in children's social services'.

This context, combined with significant changes within the Local Authority leadership throughout the lifetime of the review, was challenging with information often unavailable and ownership of the process limited until the most recent leadership team was established.

Given the above context the process of the learning event itself allowed professionals and carers the opportunity to walk back through Child A's life as he prepared for independence and in doing so the following areas were examined:

- How effective were the assessments throughout Child A's life at providing safe care and protection for him as he headed towards adulthood?
- How effective and robust was the care planning and partnership working as his vulnerabilities grew?
- What was the frequency, consistency and quality of supervision for front line staff so that social work staff (including the personal advisor) were supported to remain focused on achieving good outcomes, taking into consideration all the relevant information and history so that the child was seen in the context of his lived experience?
- How was management accountability across the partnership evidenced in driving forward young people's plans, securing the appropriate legal framework around care and in reviewing the impact of specific assessments undertaken?

[8] CSSIW (Care & Social Services Inspectorate Wales)

- How effective was the quality assurance framework in informing partners of how well they were doing to protect children at risk, Looked After Children and young people heading towards adulthood?
- How effective was the professional group at managing complex and challenging relationships with parents and carers whilst keeping focused on the best decisions for Child A?
- How did Child A's voice influence decision making about his life considering wishes, feelings, hopes, fears and anxiety?
- How effective was the Independent Reviewing Service at being the guardian of good practice across children's social care and the partnership to ensure the very best outcomes were achieved and Child A's voice influenced his care plan?
- How effective was the LA at managing commissioned fostering services in achieving positive care planning?

Partnership Working

Until the age of 16 years old Child A had a consistent social worker, his Independent Reviewing Officer (IRO) was consistent throughout his time in foster care from the age of 10 years old and the line management was relatively stable. All of which afforded a good opportunity to really understand the challenges faced by Child A and his carers. The independent foster care agency social worker and team parenting therapist were also a consistent feature for Child A. One has a picture of a small team wrapped around his care plan with a therapist that was in place for just less than two years.

However, the most significant challenge appeared to be the simplest, namely that of good communication and coordinated planning, based on a thorough understanding of Child A's daily lived experiences and the significant impact of serious early childhood trauma. Essentially the opportunity was plentiful for professionals to understand what being Child A must have felt like, particularly as he headed towards his chronological age of independence.

Learning: Effective communication and planning between professionals is an essential component of good multi-agency working.

Child A consistently told all the professionals around him of how scared he was about leaving care, how ill prepared he felt and he was highly anxious about a situation in which he was out of control and had no answers to. It appears that all agencies outside of the Local Authority looked to each other to find the answers, but critically overlooked the need to resolve professional difference with the Local Authority to hold the LA to account and call them to action in securing a positive, adequate and effective pathway plan that was needed to enable Child A to transition into successful adulthood. Compounded by the missed opportunity that the IRO service had to ensure challenge and scrutiny where there was evidence of poor quality care planning and to escalate concerns to a senior level. The opportunity was missed to challenge the progress of agreed actions and escalate for resolution. Given that the LA needed to be developing a scheme to enable vulnerable Looked After Children to remain with their foster carers post 18, as required in the *Social Services and Wellbeing (Wales) Act 2014*, Part 6 Code of Practice (Looked After and Accommodated Children)[9].

Learning: A professional resolution process would avoid drift and delay in care planning.

[9] SSWB (Wales) Act 2014, Part 6 Code of Practice (Looked After and Accommodated Children), (Welsh Govt, April 2016)

There were significant challenges for the professionals in trying to meet Child A's needs, affected by the communication with Child A's adoptive parents, who were highly anxious to see their son receive the support they perceived he needed. This meant that at times there was a fractious relationship between parents and the professionals. At times this resulted in a professionally held perception of Mr and Mrs A as difficult and overlooked their understandable level of worry about their son.

Learning: Professionals need to feel confident when working with parents who are perceived as challenging and be more empathetic in working with families.

Within the professional group the IRO role is a real asset to the professional partnerships in assisting them to get it right for children in care, by providing challenge and scrutiny of care planning. Child A retained a nice relationship with his IRO which could have been a real opportunity for the reviewing process to ensure he could remain in an extended placement beyond 18 years. The principles that underpinned the new practice namely: 'When I am Ready[10]' that promoted the opportunities for children in care to remain within their placement, appear to have been poorly understood across professionals. This resulted in a missed opportunity to be creative about Child A's pathway to adulthood so as to form a plan that would allay his growing fears.

Learning: All professionals need to have up to date knowledge of new guidance and legislation and be enabled to think creatively about planning with and for children in care.

Effective Practice

There were many good quality assessments undertaken at various stages of Child A's life with one of the most significant being the assessment undertaken by the independent adoption support agency, Family Futures. This assessment offered the LA and other partner agencies the chance to take stock and to form a tight co-ordinated team around Child A, as he started on the second significant fostering episode of his life.

Child A's foster care was provided through commissioned arrangements from the age of 10 years old. The commissioned agency knew Child A and his life story, and they were well thought of by their foster carers. They provided significant support to the carers and attempts at placement matching and stability.

The foster carers demonstrated a real commitment to Child A and a deep understanding about his daily lived experience.

The young people's advocacy service was extremely well positioned to intervene and enable the multi-agency group to hear and act on Child A's views, they did so effectively in relation to Child A's educational post-16 statement.

Child A received a total of 51 therapeutic sessions in which he positively participated in 47 of them. These sessions were provided by a very well trained and experienced therapist.

Transition Planning

The missed opportunity for joint planning within the LAC[11] reviews pre and post 16yrs, resulted in a disconnection between a care plan that was forward looking and informed by Child A's daily

[10] When I am Ready – Good Practice Guide (Welsh Govt, March 2016)
[11] LAC (Looked After Child)

lived experience of foster care and education instability. The 16+ team's approach to practical skills for independent living based on chronological age, without due consideration for Child A's, SEND[12] resulted in a lack of understanding of the impact that his care and early life experiences had on his cognitive, emotional and educational functioning and his proportionate concern about leaving the care system.

Learning: Pathway planning for young people in care to consider their holistic needs, emotional resilience and learning ability which are all key components of good planning with clear opportunities to hear a child's concerns and consider creative solutions beyond traditional routes to independence.

Management Decision Making

The social work recordings indicated that Child A had been seen regularly and within the relevant time scales. However, a sustained lack of management oversight from the children's social work service that had a focus on transition planning resulted in a shortfall in professional practice.

The approach adopted by independent foster care agency of Team Parenting was particularly strong, however the inconsistent participation of the right partners in the process resulted in a confused demarcation of professional roles and accountability. The practice was therefore well meaning but missed the opportunity to have greater impact on positive outcomes for Child A, this includes the need for problem resolution at source and good escalation practices when professional difference remains.

The use of safeguarding supervision for partner agencies could have resulted in a better corporate parenting and professional escalation of risk.

Learning: Good supervision practice and effective management oversight avoids drift and delay in care planning, keeps children safe and promotes good professional practice.

Resolving Professional Difference / Challenge

The confusion across the partnership about the statutory role of the LA social worker for children in care meant that at times the positive multi-agency team approach to Child A's care plan, led by the fostering agency fell short of accountability as the impact of partnership challenge was diluted through the lack of due process in resolving professional difference.

Learning: The statutory role of the IRO must be strengthened so that all professionals are held to account to achieve good outcomes for children in care. A problem resolution policy that is monitored by the senior leadership team formalises professional challenge.

Training and Workforce Development

Across the multi-agency partnership and within the Local Authority there appeared confusion about the underpinning principles of the newly launched *Social Services and Well-being (Wales) Act 2014* and the importance for young people in Child A's situation to be considered eligible to remain in their foster placement post 18 years'.

[12] SEND (Special Educational Needs and Disabilities assessment)

The opportunity to share practice wisdom and professional expertise across the multi-disciplinary team, based upon up to date legislation and practice guidance was plentiful. Had the professional team around Child A been equipped with up to date knowledge on the requirements, a greater understanding of care options for Child A could have been in place and may have avoided some of the professional shortfalls in good practice.

Learning: Systems and structures need to be in place to update all professionals on new practice guidance, alongside the need for all professionals to be equipped with a greater understanding of the statutory duties of children's social work.

Child's Voice and Participation

Child A presented his views about living independently very eloquently, both verbally and through his behaviours. He asked about the Laws in Wales having changed and demonstrated his growing anxieties about not being ready to leave care. However, the professional group presented as powerless in influencing decisions that would enable a stepped approach to adulthood, for Child A this was a significant shortfall in the professional practice of the team around him.

Learning: Clarity about how young people in care can influence decisions about their plan and day to day care is essential in promoting independence.

Learning: Enabling young people to communicate what is important to them is not the same as repeating what they say.

Improving Systems and Practice

There was a significant amount of help and support provided to Child A by all professionals involved in his life, however, his journey through care and the significant events that were well documented were not effectively considered by professionals in care/pathway planning. This resulted in a lack of evidence based needs assessment and pathway planning from age of 16 years, including a lack of robust legal advice and guidance in relation to Child A's care leaving status. The following actions have been identified as significant practice and systems improvements:

1. Transition Planning

Practitioners:

- Multi-agency staff training on SMART[13] pathway planning in line with the *Social Services and Well-being (Wales) Act 2014* 'When I am Ready' – good practice guide.
- Local Authority staff to be given an evidence based model of social work assessment so as to capture risks, strengths and opportunities to inform care planning.
- Local Authority training for practitioners on the legal framework for children in care, particularly where disruption is evident or the LA does not share Parental Responsibility.
- Young people to be involved in the delivery of training and quality assurance.

[13] SMART (Specific, Measurable, Achievable, Realistic, Timely)

Managers:

- Local Authority to develop and implement management systems to support SMART pathway planning in line with the *Social Services Well-being (Wales) Act 2014* 'When I am Ready' – good practice guide.
- Local Authority to produce good practice guidance to ensuring focused supervision of practitioners is based on high challenge and high support.
- Managers in the Local Authority must evidence the IRO challenge to all partners so as to achieve good outcomes for children in care.

2. Escalation and Challenge

Quality Assurance:

- The Local Authority to carry out an Audit of the effectiveness of Supervision.
- Implement a mechanism to capture the IRO quality assurance and scrutiny of care planning to inform good corporate parenting.
- The use of performance information that tracks good outcomes for children with better data reported regionally to assist in external challenge.
- Implement an assurance mechanism for reviewing the effectiveness of commissioned services.

3. Corporate Parenting

- The need to use multi-agency performance information that tracks good outcomes for children within the Local Authority and across the multi-agency partnerships.
- Assurance mechanism in place to monitor the effectiveness of the resolving professional difference policy.

4. Participation and Child's Voice

- A review of the effectiveness of the regionally commissioned service to advocate for children in care.
- All agencies to assure the Mid & West Wales Safeguarding Board on how the child's voice influences their ability to ensure good outcomes for children in care taking into account the child's lived experience.
- Consideration needs to be given to the value of Children and Young People delivering training and participating in a meaningful way in relations to quality assurance practices across all agencies.

To understand Child A's experiences as a young person leaving care and getting ready to transition into adulthood, both reviewers had the opportunity to meet with a current group of young people who had left or were in the process of leaving care. This group of young people were all around the same age as Child A. It was a privilege for the reviewers to have this opportunity with a mixed group aged between 18-21 years, all of whom had their own challenges and experiences.

The group process followed an organic and dynamic open discussion about their experience of:

- Effectiveness of pathway planning and stepping into independence.
- What helps and what hinders.
- What lessons they believe they learnt and what they wished for the professionals to learn.

All the young people spoke of their absolute fear of leaving care and being cut adrift, and the need for carers to remember to parent them, as they would their own children, to care and care enough to challenge them.

They all agreed that the role of the IRO was very important to them. They had various experiences of their IRO and the most dominant reflection was around the fact that when everyone changed

for one reason or another (change of social worker, school or placement) the IRO was the most consistent person. They all spoke of experiences when their IRO held others to account and at times stopped them spinning.

One of the young people in the group has remained with her foster carers, this was absolutely aligned to the principle of 'When I am Ready', she is due to go to university next year and spoke very highly of the support, care and encouragement she has received.

The overall messages from the young people were:

- Allow young people the chance to make mistakes, leaving care is scary and we might want to leave then come back so plan for that, it's not 'all or nothing'.
- Foster carers are brilliant, but they never replace our actual family so don't forget that, as we don't, when it comes to the time that we have to leave care
- Teach us how to do the simplest things that you take for granted like what does 'bleeding a radiator' mean when you live on your own in a flat and your heating breaks. That just sounds like a mad thing to tell someone to do.
- Remember to make decisions with us and when we are confused, make them for us, like your real parents would do. We need you even though we don't always think so at the time.
- Don't forget that once I've left care, I've got no one to ask about my history and what happened to me when. So, tell us the truth about our life story, don't fluff it up!
- Help us to succeed, make sure we are not hanging around. Apprenticeships are a great opportunity for us, but make them happen – don't just talk about them.
- Make sure we know when things can really start (apprenticeships, further education, work or university) so that they are not just promises that never go anywhere.
- Remember the good things that we achieve and help us hold on to them, not just all the mistakes we make.
- Let us stay with our foster carers until it's the right time to leave, just like their own kids.
- Laugh with us, or life is too heavy!

Child Practice Review Process

Child Practice Review Process

The case was considered by the CYSUR: Mid & West Wales Safeguarding Children Board Child Practice Review Sub Group in 2015. Subsequently, the CYSUR Board agreed that a Multi-Agency Professional Forum (MAPF) should be completed. This was undertaken by the Local Authority in which Child A had been cared for. A report was produced in October 2016. However, Child A's adoptive parents expressed their deep unhappiness about the MAPF process conducted by the Local Authority. Following an internal review of the process by the CYSUR Board a decision was made to commission an independently authored Extended Child Practice Review.

External Reviewer: Anne Coyle, Commissioned Independent Consultant
Internal Reviewer: Frances Lewis, Education & Children's Services Service Manager
Chair of the Panel: Det Supt Anthony Griffiths, Police

The Review Panel consisted of representatives from the following services:

- LA Children's Services
- LA Adult Services
- Police
- Health
- Education
- Independent Foster Care Agency

The Panel met regularly to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

Two Learning Events took place in November 2017, a practitioners' event and a managers' event. The Practitioners' Learning Event was attended by the following agencies:

- LA Children's Services
- LA Adult Services
- Child and Adolescent Mental Health Services (CAMHS)
- Health
- School
- Young persons' advocacy service
- Independent Foster Care Agency
- Police
- Education

The Managers' Learning Event was attended by the following agencies:

- LA Children's Services
- LA Adult Services
- Child and Adolescent Mental Health Services (CAMHS)
- Health
- School
- Young persons' advocacy service
- Independent Foster Care Agency
- Police
- Education

Family Members informed

The Reviewers engaged with Child A's foster carers and adoptive parents throughout the review process to ensure their views and feelings were taken into consideration as part of this report. Their input was also fed into both learning events.

Family declined involvement: No

Appendix 1: Terms of Reference

Statement by Reviewer(s)			
Reviewer 1	Anne Coyle	**Reviewer 2**	Frances Lewis
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** *(Signature)* 	
Name *(Print)*	Anne Coyle	**Name** *(Print)*	Frances Lewis
Date	25th January 2018	**Date**	25th January 2018
Chair of Review Panel *(Signature)* 			
Name *(Print)*	Det Supt Anthony Griffiths		
Date	25th January 2018		

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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			

Appendix 1 Terms of Reference for CYSUR 4/2017 (ECPR)

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 child and family.
- Determine the extent to which decisions and actions were in the best interests of the child 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.

For this Extended Review – In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child?
- Whether the Looked After Child Care Plan and Pathway Plan was robust, and appropriate for that child and their circumstances.
- The effectiveness of transition planning
- Whether the plan was effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- What aspects of the plan worked well, what did not work well and why? The degree to which agencies were held to account regarding the effectiveness of the plan, including progress against agreed outcomes for the child. Whether a protocol for dispute resolution was invoked.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties, including consideration of both organisational issues and other contextual issues.

Specific tasks of the Review Panel

- Identify and commission reviewers to work with the *Review Panel* in accordance with guidance for extended 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 Child 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 CPR 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 1998*[14] when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR Sub Group:

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

Tasks of the CYSUR Safeguarding Children Board:

- Inform Welsh Government of the Board's commissioning of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR 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 CPR 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 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 a Child 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 2 – Child 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.

[14] Key Principles of the Data Protection Act 1998