CYSUR: The Mid & West Wales Safeguarding Children Board

Child Practice Review Protocol

APPROVED

Version	Revision Date	Author	Approval Date	Review Date
V1	19/12/2016	Rosie Rae	n/a	n/a
V2	31/01/2017	Business Unit	n/a	n/a
V3	20/03/2017	CPR Sub Group	April 2017	April 2018

Context

This protocol has been developed to clarify the working arrangements for Child Practice Reviews within the Mid & West Wales Safeguarding Children Board region. The document focuses on the broader principles of Child Practice Reviews prior to a decision being made by the Regional Safeguarding Board to formally commission a Child Practice Review or Multi Agency Professionals Forum. The supporting principles of this protocol are grounded in the following;

- Consistent decision making across the Mid and West Wales region regarding Child Practice Reviews
- Multi-agency engagement at all levels
- Openness and transparency of decision making

This document should be read in conjunction with the following key documents;

- Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People Vol. 2 – Child Practice Reviews
- PRUDiC Protocol (*specify latest version*)
- SSWB (Wales) Act Part 8 Code of Practice on the role of the Director of Social Services (Social Services Functions)
- Child Practice Review Sub Group Terms of Reference (*February 2015*)
- Local Operational Groups (LOGs) Joint Terms of Reference (*April 2017*)

The Purpose of Practice Reviews

In accordance with The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015, Safeguarding Children Boards have a statutory responsibility to undertake multi-agency child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

The prime purpose of practice reviews, as defined in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015, is to identify any steps that can be taken by Safeguarding Board partners or other bodies to achieve improvements in multi-agency child protection practice.

While reviews may vary in their breadth and complexity they should be completed in a timely manner. Lessons learned from practice reviews should be disseminated effectively and any recommendation arising should be implemented promptly so that the changes required result wherever possible, in children being protected from suffering or harm in the future. Where possible lessons should be acted upon without necessarily waiting for the completion of the review.

Practice reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively to determine as appropriate.

Practice reviews are not part of any disciplinary process or inquiry relating to individual practitioners. Where information emerges during any practice review which indicates disciplinary action would be appropriate, this should be undertaken separately to the practice review and in line with the employing organisations disciplinary procedures. These

processes may be conducted at the same time but should be separate. In some cases it may be necessary to immediately evoke disciplinary action in order to protect other children from harm or suffering.

Safeguarding siblings and other children

When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority for local organisations should be to immediately consider whether there are other children suffering or likely to suffer harm and therefore require safeguarding (siblings, or other children in the setting). Where such concerns exist local child protection and safeguarding procedures should be followed.

Concise Reviews

A Safeguarding Board **must** undertake a concise child practice review in any of the following cases where, within the board area, 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 neither on the child protection register nor a looked after child in the 6 months preceding-

- The date of the event referred to above; or
- The date on which the local authority or relevant partner* identifies that a child has sustained serious and permanent impairment of health or development.

Extended Reviews

A Board must undertake an extended 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 a 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 years of age, but who 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 or relevant partner* identifies that a child has sustained serious and permanent impairment of health and development.

**Local authority or relevant partner means a person referred to in s28 of the Children Act 2004 or body mentioned in s 175 Education Act 2002.*

Referring a Case for Consideration for a Practice Review

Any member of the Regional Safeguarding Board, any agency or individual practitioner supported by their line manager can raise a concern about a case which is believed to meet the above criteria. Advice may (though not essentially) be sought from the agency Board member prior to the referral.

The Regional Safeguarding Board Manager will be able to advise multi-agency professionals regarding the CPR process and where there are any doubts regarding cases meeting the criteria.

All referrals should be made in writing using the relevant Board referral form. It is the responsibility for the referrer to collate all relevant information needed for the initial referral.

Advice, guidance and support can be provided to the referring agency (where this is not the Local Authority) by the designated Local Authority Safeguarding Lead and Regional Safeguarding Board Business Unit.

In order to inform the decision making and to assist in the scoping of any agreed Child Practice Review, it is essential that the CPR Sub Group is provided with accurate, succinct information with the required level of detail from all organisations. In Mid and West Wales, the Local Authorities hold a core role to support this process.

When a case is known to the Local Authority it is likely that the majority of information will already be held by them so where the referral does not originate from the Local Authority, the Local Authority Safeguarding Lead should support the referring agency in pulling together all appropriate information.

It is acknowledged that discussions in other forums such as Case Planning Meetings and Local Operational Groups may take place within a multi-agency context before a case is referred into the Regional CPR Sub Group. Such discussions, however, should not prevent or act as a barrier to agencies making referrals directly into the Regional CPR Sub Group. Accountability for decision making in relation to Child Practice Reviews rests with the Regional CPR Sub Group and the Executive Board Chair, as defined in Statutory Guidance.

Any debate, discussion and decision making in relation to any lessons to be learned and benefits from undertaking a Child Practice Review is a matter primarily for the Regional CPR Sub Group and the Executive Board Chair.

Where it is considered that a case meets the criteria for a concise or extended CPR as defined above, it should always be referred to the Regional CPR Sub Group.

Any such referral should be directed to the Board Business Manager who will ensure the Chair of the Board and the relevant Statutory Director are informed. The referral should then be forwarded to the Chair of the CPR Sub Group for its consideration.

All referrals should be and emailed to the Safeguarding Board Business Unit via cysur@pembrokeshire.gov.uk and will be allocated a regional designator e.g. *CYSUR ##/YYYY (Local Authority Area)*. This designator should be used for all further correspondence when referring to the case. The Regional Safeguarding Board Manager will then forward the referral to the Chair of the CPR Sub Group for its consideration and review of the information.

The CPR Sub Group's decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Executive Board by the Regional CPR Sub Group Chair.

The Chair of the Board will inform the CPR Sub Group of his or her decision as to whether the recommendation to hold a Child Practice Review is approved and inform the Board. Should the recommendation for a review be declined by the Chair of the Board, then the Board should be informed and further discussion held. If the final decision is no, then the Chair of the Board will need to inform the Welsh Government in writing, with the reasons given, and any conflicting views also reported.

In the event a referral to the Regional CPR Sub Group identifies safeguarding issues that require immediate attention or action, it is the responsibility of each agency to ensure this is carried out.

The Role of the Regional Child Practice Review Sub Group

The Regional Child Practice Review Sub Group is a standing committee which oversees and quality assures all Child practice reviews undertaken by the Regional Safeguarding Board and provides advice to the CYSUR Board Chair as to whether the criteria for conducting a practice review is met.

This committee involves local authority representatives as well as representatives from all statutory partners.

The Regional Child Practice Review Sub Group considers all cases referred for consideration for a Child Practice review and makes a recommendation to the Board Chair on behalf of the Board in accordance with statutory guidance.

Where the Regional Child Practice Review Sub Group considers that a case does not meet the criteria for either a Concise or Extended Child Practice Review, it may recommend the case be considered at a local level by a Multi-Agency Professional Forum to enable them to take a more proportionate response than that required by a Child Practice review. Local Operational Groups will be responsible for considering the recommendation to undertake a MAPF, which would be managed locally.

The Role of the Local Operational Groups

It is accepted that a case not being discussed at the Local Operational Group should not prevent or act as a barrier to agencies making referrals directly into the Regional CPR Sub Group.

However, discussion within the multi-agency context at the Local Operational Groups may be considered appropriate and aid any scoping exercise for any relevant information. It will also enable local knowledge at a practitioner level to be shared in an open forum.

This may be particularly useful where cases are not clear-cut and further robust discussion is needed as to whether a case should be considered for referral into the Regional CPR Sub Group.

Accountability for decision making in relation to Child Practice Reviews rests with the Regional CPR Sub Group and the Executive Board Chair, as defined in Statutory Guidance.

The Role of the Regional Safeguarding Board Business Unit

The role of the Regional Safeguarding Board Business Unit is to support the Regional Child Practice Review Sub Group, Board Chair and Executive Board in their respective identified roles. The Regional Safeguarding Board Business Unit will be a central point of contact for all cases across the region in respect of cases referred for consideration for CPRs. This will enable a clear audit trail to be developed across the region which can support the Board in having regional oversight of referrals and outcomes; and to ensure learning from CPR reviews are disseminated in a robust and timely manner.

The Regional Safeguarding Board aims and endeavors to promote and encourage a consistent threshold across the region in respect of referrals that are made into the Regional CPR Sub Group.

The Regional Safeguarding Board Business Unit will have oversight of all MAPFs carried out across the region and will undertake an annual review of regional MAPF activity which will be reported within the Board's Annual Plan.

Multi-Agency Professional Forums

If a decision is made by the Regional Child Practice Review Sub Group and upheld on behalf of the CYSUR Board by the Board Chair that a Multi-Agency Professional Forum (MAPF) is the most appropriate review mechanism; responsibility for this process will lie with the relevant Local Operational Group.

MAPFs sit locally outside of the Child Practice Review Sub Group and should be completed with three months. MAPF outcomes are not reported to the Regional CPR Sub Group or to the Board via the CPR Sub Group. Learning outcomes and how this learning will be disseminated locally will be reported by Local Operational Groups into the Executive Board via the Quality Assurance framework and LOG Chair report. If any local learning identified is considered useful regionally by the Board. The dissemination of learning on a regional basis will be considered and managed by the Regional Training Sub Group.

Parallel Reviews or Inquiries

There are a number of statutory responsibilities to review deaths and serious incidents across the multi-agency safeguarding partnership. These include, Domestic Homicide Reviews, provision of mental health services by Healthcare Inspectorate Wales following a homicide and Youth Justice Board Serious Incident Review.

In such cases the Regional Child Practice Review Sub Group should;

- Consider the opportunities and potential arrangements for coordinating with those other bodies involved;
- Discuss with those bodies and agree how a coordinated or jointly commissioned review process best addresses the outcomes that need to be delivered, in the most effective and timely way.
- Consider a joint review, or adding additional questions to the reviews terms of reference;
- Ensure that the Interest of the Child is always appropriately represented in other investigations of practice.

- Provide the Chair of the Board with a recommendation as to how to proceed in compliance with statutory guidance.

The Procedural Response to Unexpected Death in Childhood (PRUDiC) Policy is initiated where a child dies unexpectedly and is considered complete when the record of the child death is submitted to the Child Death Review (CDR) Team. If during the PRUDiC process it is considered that the case may meet the criteria for a child practice review, then a referral will immediately be made to the Regional Safeguarding Board Business Unit.

Complaints or Disputes arising from Practice Reviews

CYSUR: The Mid & West Wales Safeguarding Children Board will continue to follow guidance issued by Welsh Government *'Working Together to Safeguard People – Volume 2: Child Practice Reviews* a for processing regional practice reviews.

Any complaints or disputes received will be processed following the Board's complaints policy.

Annex List

- **Annex 1** CPR Process Flow Chart

- **Annex 2** Referral to CYSUR Child Practice Review Sub Group for consideration to undertake an CPR (Template)

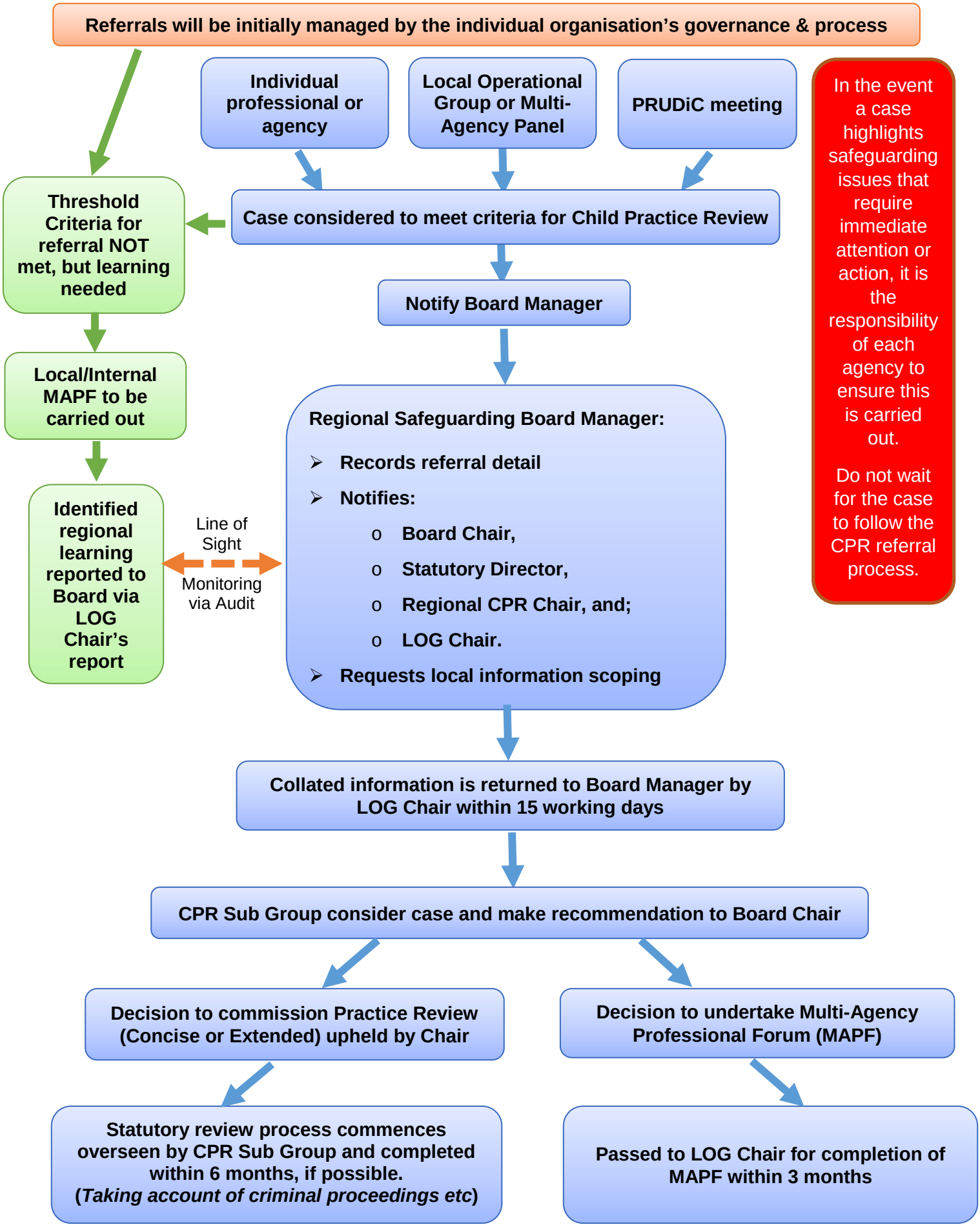
- **Annex 3** Recommendation to Chair of CYSUR Regional Safeguarding Children Board from CYSUR Children Practice Review Sub Group (Template)

- **Annex 4** Decision of the Chair of CYSUR Regional Safeguarding Children Board from CYSUR Child Practice Review Sub Group (Template)

- **Annex 5** Proposed Initial Outline of Review & Terms of Reference (Template)

Annex 1

Child Practice Review Flowchart



Annex 2

Referral to CYSUR CPR Practice Review Sub Group for consideration to undertake a CPR

Ref: CYSUR */2017 (*********)

Subject's Initials: **DoB:** **DoD/Incident:**

From: **Date discussed at LOG:**

Date of CPR Sub Group:

Brief outline of Case/incident Please include the legal status of child/children prior to incident and any immediate remedial safeguarding action taken by relevant agencies.

Rationale for Request.

Any other relevant information

Agencies involved in the case *(E.g. Childrens Services, Police, Education, Probation, Youth Offending, Health Board, Local Authority, WAST, Public Health Wales, Other.)*

To be completed by referring agency:

Name: Designation:

Contact details:

Annex 3

Recommendation to Chair of CYSUR: The Mid & West Wales Safeguarding Children Board from CYSUR Child Practice Review Subgroup

From: xxxxx, Chair of the CPR Subgroup

To: xxxxx, Chair of CYSUR: Safeguarding Children Executive Board

Re:

Date of referral to CPR Sub Group:

Brief outline of Case

Recommendation	
The CPR Subgroup has considered this case and recommends that it meets the criteria for a:	
Concise review	☐
Extended review	☐
If the criteria are not met for the above reviews, what alternative review process will be undertaken:	
Multi-agency professional forum	☐

Decision	
Unanimous	☐
Majority	☐

Rationale for Decision/Recommendation

Annex 4

Decision of the Chair of CYSUR Regional Safeguarding Children Board from CYSUR Child Practice Review Sub Group
Re: CYSUR */** ( )**

I agree with the recommendation	☐
I agree with the recommendation with the following amendments:-	☐
I disagree with the recommendation *If disagree, reasons why and proposed action:-*	☐

Signature:
Title: Chair
Date:
Telephone Number:

In discussion with Chair of Sub Group
Date information to be presented to MAWWSB ……..……
Date information sent to Welsh Government ……

Annex 5

Proposed Initial Outline of Review

(This is an initial outline which will need to be updated as the review proceeds)

Re: CYSUR */** ( )**

Time period to be covered by the review in line with guidance

0-6 months	☐	**6-12 months**	☐

Rationale for time period

More than 12 months	☐

If more than 12 months - As this is outside timeframe recommended in guidance please specify rationale

Agencies involved in the case being reviewed

(*Include name and designation if known*)

Care Provider	☐		Police	☐	
Housing	☐		Probation	☐	
Local Health Board	☐		Public Health Wales	☐	
NHS Trust	☐		Social Services	☐	
Other Safeguarding Board	☐		Third Sector	☐	
Other (please specify if known or yet to be identified):	☐				

Agency identified to Chair Review Panel

(*Include name and designation if known*)

Care Provider	☐		Police	☐	
Housing	☐		Probation	☐	
Local Health Board	☐		Public Health Wales	☐	
NHS Trust	☐		Social Services	☐	
Other Safeguarding Board	☐		Third Sector	☐	
Other (please specify if known or yet to be identified):	☐				

Is the Chair independent in that they have had no involvement/oversight of the case?	Yes	☐	No	☐
Rationale for choice of Chair:				

Core issues to be addressed in the terms of reference of the review will include:

- To examine inter-agency working and service provision for individual x through defined terms of reference.

- To seek contributions to the review from the individual/individuals and appropriate family members and keep them informed of key aspects of progress.

- To identify particular issues for further clarification.
  (*List issues relevant to particular case.*)

- To produce a report for publication and an action plan.

Indicative Roles and responsibilities:

- The Board Co-ordinator will be responsible for maintaining links with all relevant agencies, families and other interests.

- The *Review Panel* Chair will inform the Chair of the Board and the Board sub-group of significant changes in the scope of the review and the terms of reference will be updated accordingly

- 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. It is anticipated that there will be no public disclosure of information other than the Final Board Report.

- The Board and *Review Panel* will seek legal advice on all matters relating to the review. In particular this will include advice on:
  - terms of reference;
  - disclosure of information;
  - guidance to the *Review Panel* on issues relating to interviewing individual members of staff.

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

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.

All Panel members will adhere to the principles of the Data Protection Act 1998 when handling personal information as part of the child practice review process.

Appointment of Reviewer Independent of the Case Management

Is an independent reviewer to be appointed?	Yes	☐	No	☐
Is the name and designation of independent reviewer known?	Yes	☐	No	☐
*If **yes** please state nominated designation of independent reviewer plus any additional information):*				

Review Independent of the Case Management – Extended Review

In the case of an extended review the following core questions will be addressed as per the guidance by the reviewers in the Terms of Reference of the Review.

- 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 child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency action plan.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement 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 (this should include consideration of both organisational issues and other contextual issues).

Further relevant issues in relation to the circumstances of the case may also be identified by the *Review Panel* and/or the reviewers.

Any additional specific questions which are appropriate to be raised at this stage?

Approximate cost (if known) of independent reviewer and how this will be met	£ ……
Additional costs identified (if known). Please specify:	£ ……
Date of First Review Panel meeting	……

Will the report be completed within Guidance timeframe? *i.e. 6 months from date of referral*	Yes	☐	No	☐
Please identify any issues that may impact on the timeframe and how these will be managed:- *Include issues such as:- Criminal prosecution / Coroner's decision*				

Anticipated completed report date	……..

To be completed by CPR Sub Group Chair:

Signature ……..

Title ……..

Date ……

Telephone number ……