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Protecting Children in Wales

Guidance for Arrangements for Multi-Agency Child Practice Reviews

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Printed on recycled paper

Print ISBN 978 0 7504 8015 4
Digital ISBN 978 0 7504 8013 0

WG16543

Foreword

The abuse and neglect of children in any form is totally unacceptable and I am determined to do all I can to safeguard children in Wales. When abuse does take place however, it is vital that there is an effective system to review what has happened and to learn from the experience so that our inter-agency child protection arrangements can be improved.

For that reason, I am very pleased that in Wales we have developed the innovative child practice review (CPR) framework to improve the culture of learning from child protection cases. Local Safeguarding Children Boards in Wales, who have been involved closely in both the development and implementation of the new framework, must make use of this new safeguarding tool from 1 January 2013.

I made a statement to the National Assembly for Wales in February 2011 setting out my intention to replace the serious case reviews (SCR) procedure in Wales with the new fit for purpose CPR framework.

This new process stems from the Care and Social Services Inspectorate Wales report published in October 2009 - *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews.* This work was pivotal to where we are today, and concluded that action was required to replace the SCR process which had become ineffective in improving practice and inter-agency working.

A key element of the new framework is different types of review – know as ‘concise’ and ‘extended’ – depending on the circumstances of chid involved. Documenting the tragic history of the child will not be the primary issue of reviews. Instead, CPRs will be effective learning tool for LSCBs where it is more important to consider how agencies worked together. Reports must now be succinct and focused on improving practice.

The formal review processes are underpinned by multi-agency professional forums. These will be critical to improving practice, and will allow practitioners to reflect on cases – and not only where things have gone wrong – in an informed and supported environment. We must make learning from practice fundamental to the day to day activity of frontline practitioners.

This work has been led by the Welsh Government. However, it could not have been achieved without the commitment and dedication of many front-line practitioners who have willingly contributed their time and expertise through the development phase. The framework was subject to a public consultation starting in January 2012, and included two well attended practitioner workshop events in Swansea and Conwy.

In addition, with the support of three LSCBs – and I would like to offer my thanks to Bridgend, Rhondda Cynon Taff and Conwy and Denbighshire LSCBs for their

invaluable support and assistance – the framework has already been tested in practice and the results have contributed to this final guidance.

I should also like to pay tribute to Wendy Rose, an Honorary Research Fellow in the School of Social Sciences at Cardiff University, for all her hard work and dedication. She has worked closely with my officials for a number of years and her passion, ingenuity and dedication has been key in delivering this guidance and the wider CPR framework.

We must sadly recognise that sometimes people treat children in a way that the rest of society finds reprehensible, and that there are often tragic consequences. However, we must also recognise that very many children across Wales are protected every day by front line professionals. These professionals work hard, often in difficult circumstances, and do not receive the recognition and thanks they deserve.

We must be open, honest and transparent when things go wrong and learn the lessons. I am confident the CPR framework allows for this process to be undertaken in a supported and positive environment that will contribute to improvements in practice and help prevent future abuse.

Gwenda Thomas AM
Deputy Minister for Children and Social Services

January 2013

Contents

1. Preface

1.1. This guidance sets out new arrangements for multi-agency child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected. Sections 1-6 of this guidance are issued under section 34 of the *Children Act 2004 .* The criteria for child practice reviews are laid down in the *Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012* (http://www.legislation.gov.uk/wsi/2012/1712/contents/made). The new arrangements come into force from 1 January 2013.

1.2. The guidance replaces *Chapter 10: Serious Case Reviews* in *Safeguarding Children: Working Together Under the Children Act 2004*[1]. It should be used in conjunction with the remaining chapters of *Working Together*. In due course *Working Together* will be subject to review and revision to reflect the new legislative framework for safeguarding and child protection in the *Social Services and Well-being (Wales) Bill.*

1.3. The guidance is addressed to all Local Safeguarding Children Boards (LSCBs) and their partner agencies. The overall purpose of reform of the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs 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 more formal review is required when there are serious incidents resulting from abuse or neglect, there is a new 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.

1.4. The new framework has a number of important features which mark it out from the previous serious case review system:

- it involves agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability;
- it has the potential to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different professionals with whom they work;
- it strengthens the accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need;
- it recognises the impact of the tragic circumstances of non-accidental child deaths or serious harm on families and on staff, and provides opportunities for serious incidents to be reviewed in a culture that is fair and just;

[1] Welsh Assembly Government (2006) *Safeguarding Children: Working Together Under the Children Act 2004.* Cardiff: Welsh Assembly Government.

- it takes a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases;
- it allows a more constructive and appropriate use of resources than in the previous system and works to shorter timescales;
- it draws on learning from other related review processes and increases compatibility with different review systems;
- it focuses on key learning identified through the review process which results in relevant recommendations and action to improve future practice, recorded in anonymised reports which are published by LSCBs.

1.5. The guidance includes the following annexes:

- Annex 1 contains a set of templates to assist in streamlining communication and reporting during the process of a child practice review.
- Annex 2 is an exemplar of terms of reference for a child practice review.
- Annex 3 develops the practice guidance in section 7 and demonstrates how the new review process can be used by LSCBs to ensure improved practice and systems are in place in circumstances of historic organised and multiple abuse.

1.6. Accompanying the guidance is a set of training tools and materials supporting the child practice review arrangements, available on the Welsh Government website.http://wales.gov.uk/topics/childrenyoungpeople/publications/safeguard12/?lang=en.

1.7. In the development of the new arrangements, they have been subject to extensive discussion, consultation, feedback and testing through workshops of stakeholders, and pilots of child practice reviews by several LSCBs. They have all made an invaluable contribution to developing the detail of the guidance.

2. Principles underpinning the new arrangements

2.1. The new framework is underpinned by a set of principles to guide LSCBs, their partner agencies and other community partners in their responsibilities for learning, reviewing and improving local child protection policy and practice. The principles have played an important role in shaping the design and development of the new arrangements for multi-agency child practice reviews:

- professionals in all services working with children and families in the local area are given the assistance they need so they can undertake the complex and difficult work of protecting children with confidence and competence;
- organisational cultures, and the processes that underpin the culture, are experienced as fair and just, and promote supportive management and work environments for professionals;
- a positive shared learning culture is an essential requirement for achieving effective multi-agency practice;
- a culture of transparency is created that:
    - provides regular opportunities to address multi-agency collaboration and practice, and multi-agency learning, reflection and development;
    - has processes for learning and reviewing that are flexible and proportionate and are open to professional and public challenge;
    - engages with children and families in individual cases and takes account of their wishes and views;
    - provides accountability and reassurance to children, families and the wider public;
    - identifies promptly the need for systemic or professional changes and ensures timely action is taken;
    - shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally and nationally;
- the work of learning, reviewing and improving local multi-agency child protection policy and practice is audited and evaluated for its effectiveness.

2.2. The principles underpinning the new framework are in accord with the Articles of the *Convention on the Rights of the Child* [2] and can be found similarly reflected in the statutory instruments and guidance of other relevant bodies for their systems of reviews, investigations and tribunals[3].

[2] UN Convention on the Rights of the Child, ratified by the United Nations, 20 November 1989.
[3] For example, The Tribunal Procedure (Upper Tribunal) Rules 2008, s.2; Jordan v UK (2003) EHRR 2 – 'minimum standards' for an article 2 investigation.

3. Learning and reviewing framework

3.1. The learning and reviewing framework has been developed with the intention that LSCBs 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. The framework, underpinned by the principles in section 2, consists of a foundation for learning through multi-agency professional forums. Where there is a need for the LSCB to undertake a more formal review, criteria are clearly specified in regulations for setting up multi-agency child practice reviews that are either concise or extended.

3.2. In summary, the framework consists of several inter-related parts, as laid down in *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*. The detail of multi-agency professional forums and concise and extended child practice reviews are set out in more detail in the subsequent sections of this guidance.

- **Multi-Agency Professional Forums:** a continuous LSCB programme for learning together of multi-professional facilitated events for practitioners and managers, primarily to examine case practice and provide opportunity for consultation, supervision and reflection, and to disseminate findings from child protection audits, inspections and reviews, in order to improve local knowledge and practice and to inform the Board's future audit and training priorities.
- **Concise Reviews:** a Board must undertake a concise 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 neither on the child protection register nor 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[4] identifies that a child has sustained serious and permanent impairment of health and development.
- The purpose of a review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice.

[4] 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* as set out in the new Regulations

- A concise review is made up of a number of interconnected activities described below, all of which contribute to the rigour of the process and to the learning drawn from the case being reviewed.
- The review is managed by a *Review Panel* and a reviewer is appointed to work with the *Panel.* The review engages directly with children and family members, as they wish and is appropriate, so their perspectives are included, and it involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner-focused learning event is a key element of the review, conducted by a reviewer independent of the case management, to examine current case practice within a limited timeline and using a systems approach.
- A draft anonymised child practice review report and an outline action plan are produced and presented to the LSCB. Board members of the LSCB consider, challenge and contribute to the conclusions of the review, and identify the strategic implications for improving practice and systems to be included in the action plan.
- The final report is approved by the LSCB and submitted to the Welsh Government and then published by the LSCB. The process will be completed as soon as possible but no more than six months from the date of a referral from the Board to the *Review Sub-Group.*
- The action plan is finalised within four weeks of the final report, approved by the LSCB, and submitted to the Welsh Government. The implementation of the action plan is regularly reviewed and progress reported to the Board.
- Action plans should lead to improvements in child protection practice and the Board needs to ensure they are carefully audited to see whether actions are being carried out and with what effect, and whether they are making a difference.
- **Extended Reviews:** 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 care leaver under the age of 18[5]) on any date during the 6 months preceding –

    - the date of the event referred to above; or

[5] *Care leaver* as defined by section 23A(2) of the *Children Act 1989*; section 19B(2) to Schedule 2 of that Act and Regulation 4 of the *Children (Leaving Care) (Wales) Regulations 2001* (s12189/2001(W1511)).

- the date on which a local authority or relevant partner[6] identifies that a child has sustained serious and permanent impairment of health and development.

- The review follows the same process and timescale as a concise review, engaging directly with children and families, in so far as they wish and is appropriate, and involving practitioners, managers and senior officers throughout. There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) which were in place for the child or young person.
- The review is undertaken by two reviewers working closely together, appointed by the *Review Panel*. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the *Review Panel* and the LSCB.
- An anonymised child practice review report is considered and approved by the LSCB, submitted to the Welsh Government and published by the LSCB. The process will be completed as soon as possible but no more than six months from a referral from the Board to the *Review Sub-Group*.
- The action plan is finalised within four weeks of the final report, approved by the LSCB, and submitted to the Welsh Government. The implementation of the action plan is regularly reviewed and progress reported to the Board.
- Action plans should lead to improvements in child protection practice and the Board needs to ensure they are carefully audited to see whether the actions are being carried out and with what effect, and whether they are making a difference.

[6] 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* as set out in the new Regulations

Implications for Local Safeguarding Children Boards

3.3. Achieving improvement in safeguarding policy, systems and practice is a core business of LSCBs. Boards have responsibility for:

- establishing child practice reviews and ensuring they are effectively managed;
- contributing to the reviews and providing professional challenge;
- identifying strategic implications for improving systems and practice in individual agencies or on an interagency basis;
- signing off the final report and action plan when a review has been completed;
- publishing the child practice review report;
- implementing and auditing changes in local policy, systems and practice to identify what difference they have made.

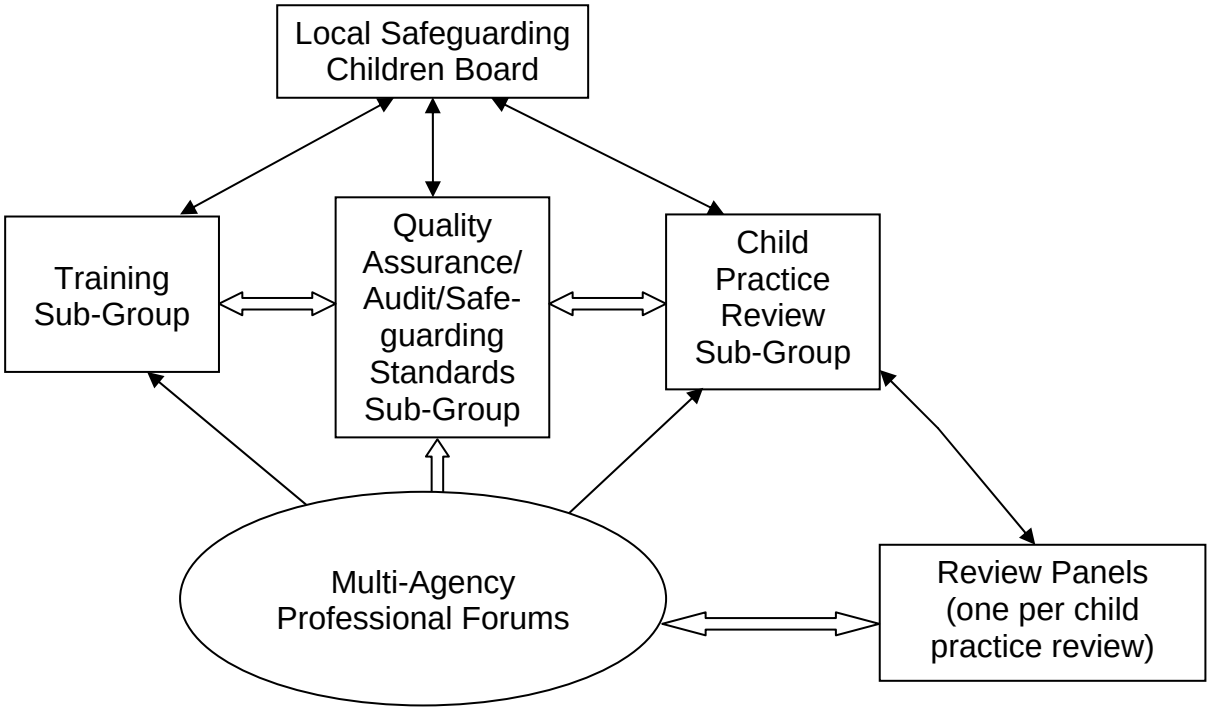
3.4. These responsibilities require committed, well functioning, challenging, inspirational and strongly led Boards together with the full and consistent support of agencies represented on the Boards. They require active partnership with other community services that are not Board members but working locally with children and families[7].

3.5. Boards need to be focused on learning and on outcomes, and to be encouraging a supportive environment. In order to be in touch with the challenging and complex work of child protection, that professional staff in local agencies are undertaking, the Board needs to be able to maintain a close oversight and understanding of practice. The role of Boards in approving child practice review reports is an important means of doing so, so that they can provide appropriate professional challenge and support, and ensure the learning from reviews is used to take effective action by the Board and its partner agencies.

3.6. In order to achieve the objectives of the learning and reviewing framework, there will need to be certain functions in each LSCB to deliver them. The structure and purpose of the Board's standing sub-groups or sub-committees will need to reflect the core business of the Board, ensure appropriate cross representation, and have fully co-ordinated processes and programmes of work between the sub-groups. The inter-relationships that need to be developed for the implementation of the new learning and reviewing framework are represented in the diagram (Fig. 1) below:

[7] See Standards in J Horwath & T.Morrison for CSSIW (2009) *Self Assessment and Improvement Tool (SAIT) for LSCBs* v.6, available on http://wales.gov.uk/cssiwsubsite/newcssiw/aboutus/providingsocialcare/guidance/sait/?lang=en

Fig. 1 LSCB infrastructure of sub-groups supporting the learning and reviewing framework



4. Multi-agency professional forums

4.1. Multi-agency professional forums are the foundation for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep children safe. A multi-agency professional forum is defined in the *Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012* as:

> *A forum, arranged and facilitated by the Board for practitioners and managers from representative bodies and other bodies or persons deemed relevant by the Chair of the Board, with the purpose of learning from cases, audits, inspections and reviews in order to improve future child protection policy and practice.*

4.2. The forums as laid down in regulations build on many creative developments by LSCBs across Wales. Forums should be set up as a continuous programme of active learning by each LSCB and will constitute an integral part of the LSCB Business Plan.

4.3. Responsibility for establishing a programme of work for the forums may fall to an existing LSCB sub-group, such as *Quality Assurance* (also known in some Boards as *Audit* or *Safeguarding Standards Sub-Groups* or *Sub-Committees*) or the *Training Sub-Group*, or a specific sub-group may be established for the purpose. The activities will inevitably be closely related to those of other sub-groups of the Board, including the *Child Practice Review Sub-Group,* and require appropriate cross-membership of sub-groups and regular exchange of information.

4.4. The forums have two main purposes – they can be used for case learning events and for dissemination and exploration of learning from audits, inspections and reviews but they can also be used to provide other important opportunities for local multi-agency practitioner and manager learning:

- **Case learning:**

  facilitated discussion, consultation and reflection by practitioners, managers or core groups, using a systems approach to examining and analysing individual current or no longer active cases. These may include complex cases where there have been good outcomes, current cases that have become stuck, or cases which cause professional concern or interest that do not meet the criteria for concise or extended child practice reviews;

- **Dissemination of new knowledge and findings:**

  from multi-agency child protection audits and from child practice reviews, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

Case learning

4.5. The forums which focus on case learning should be facilitated events, undertaken in environments that provide safe, professional support and professional challenge, with a clear set of working principles or processes so that staff know what to expect and the confidentiality of any case material is respected. The forums considering cases may use the same processes for learning from a case as used in a concise or extended child practice review. They may also use a range of creative methods already familiar in training and continuing professional development, such as multi-agency supervision, appreciative inquiry or sculpting, as appropriate. The practice learning should be recorded and formally reported to the Board. The learning may be disseminated more widely to staff, and should inform the Board's annual review of its Business Plan.

4.6. The forums should allow assessments, decision making and practice to be explored openly with each other by staff. However, if any issues of individual staff training needs or staff malpractice emerge during the course of a multi-agency professional forum, these should be managed through the relevant agency's own staff procedures.

4.7. It is expected that if at any time a level of concern is identified that would trigger a concise or extended child practice review under the *Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*, then the case should be reported to the Chair of the LSCB and referred to the *Child Practice Review Sub-Group* for consideration and action (as set out in section 5.1).

Dissemination of new knowledge and findings

4.8. The learning from forums which have been concerned with individual cases or the dissemination of findings from audits and other sources may require local action through changes in operational policy, protocols, service delivery or practice, and this should occur promptly and without delay.

Audit programmes

LSCBs should have a line of sight on practice from a rolling programme of audits, the findings of which should be disseminated through the multi-agency professional forums, and include the following:

- Children who have been on the child protection register for more than 2 years.
- Children who have been deregistered in the last 12 months
- Children subject of child protection conferences but not registered.
- Children with repeat registration within 12 months.
- Children on the register who were subject to a Child in Need Plan up to 12 months prior to registration (likely to be neglect due to parental problems).

- Working with uncooperative service users.
- Children who regularly go missing.
- Looked after children subject to a strategy meeting.
- Children on the register, or deregistered within the last 2 years, subject to repeat referrals relating to abuse or neglect.

4.9. Where the learning from these forums is of wider relevance, the LSCB will need to develop plans for dissemination locally and/or nationally, for example through the All Wales Child Protection Coordinators Meeting or the All Wales Child Protection Procedures Review Group. Where messages need to be conveyed to agencies locally, the process should be managed by the relevant standing sub-group of the LSCB.

4.10. The effectiveness of these forums requires the commitment of senior agency representatives who are Board members of the LSCB and positive support from agencies to enable professional staff to make use of these learning opportunities.

4.11. The programme of work will require resourcing by the LSCB and periodic evaluation by the *Quality Assurance Group* to ascertain the impact on local child protection practice. The findings should be reported back to the LSCB.

4.12. There are examples where this approach has already been developed by LSCBs in Wales and experience of what has worked well should be shared between Boards. Three examples are included below:

One Board has established multi-agency case consultation over a number of years which is initiated by practitioners and brings together key staff to look at cases that are, for example, stuck or difficult, and provides reflective supervision. It has been found to be successful in building understanding of the need for multi-agency responsibility for work with families.

A facilitated case learning event was held by one Board for practitioners to consider a serious case of neglect which did not meet the criteria for a concise review. It identified key learning points and messages for the Board. More importantly, it was valued by the practitioners because it was experienced as non-threatening, constructive and empowering. It allowed other agencies' perspectives to be explored and better understood, and relationships to be built between agencies. The process highlighted the positive work that the family and practitioners had been doing, and showed that progress had already made.

Another Board has established a programme for multi-agency practitioner forums, on the basis of at least three multi-agency workshops being held a year for focused practice learning from audited cases and a fourth for disseminating learning from case reviews based on the child practice review model. These events involve at least 50 practitioners from different services at anyone time.

4.13. Multi-agency professional forums are, therefore, built on some longstanding prior experience and draw on developing good practice across LSCBs in Wales.

5. Concise child practice reviews

Criteria for a concise review

5.1. A Board must undertake a concise 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 neither on the child protection register nor 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[8] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for concise reviews are laid down in the *Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*.

Process for undertaking a concise review

5.2. Any member of the Board, agency or practitioner can raise a concern about a case which it is believed meets the above criteria. Advice may be sought from the agency LSCB member prior to making a referral. However any such referral should be directed to the LSCB Business manager (or equivalent) who will ensure the Chair of the LSCB is informed. Each LSCB will have a standing *Child Practice Review Sub-Group (or Sub-Committee)*. The referral should then be forwarded to the Chair of this sub- group for its consideration.

5.3. The review process is represented as a flow chart (fig. 2 page 31).

5.4. There are matters which may require negotiation and resolution by the *Review Sub-Group* before a *Review Panel* to manage the review can be put in place.

5.5. **More than one LSCB is involved:** where a referral received by the *Review Sub-Group* involves more than one LSCB, co-operation and careful planning between the respective *Review Sub-Groups* of those Boards will be required to agree the way forward (*Children Act 2004*, s.25 and s.28). The guiding principle should be that the LSCB in which the child is or was normally resident should take

[8] 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* as set out in the new Regulations

lead responsibility for conducting the review. The decision reached on how the review will be handled should be reported to the respective Boards.

5.6. **More than one LSCB in different countries is involved:** where a referral received by the *Review Sub-Group* involves more than one authority in different countries within the United Kingdom, the principle of ordinary residency will determine which LSCB should take lead responsibility for undertaking a review. However, co-operation and careful planning may be required between LSCBs in order to agree how the respective review procedures will be followed and how any additional matters will be addressed by the review. These decisions may also need to involve the respective governments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.

5.7. **Parallel investigations of practice are involved:** where the case gives rise to other parallel investigations of practice, for example, a domestic homicide review where a parent has been murdered, or a review of the provision of mental health services by Healthcare Inspectorate Wales following a homicide, or a Youth Justice Board Serious Incident Review, or a Prisons and Probation Ombudsman investigation where a child has died in a custodial setting, the chair of the LSCB should be informed (see Annex 1) and agree a way forward with the *Review Sub-Group*.

5.8. The *Review Sub-Group* should then liaise with those other bodies and agree the type of review and the lead responsibility for conducting the review. Depending on the circumstances of the case, there might be a joint review or additional questions might be added to the terms of reference. In these cases, it is quite likely there will be a focus on more than one member of the family, some of whom may be adults. The *Review Sub-Group* has an important responsibility to ensure the child or children's interests are always appropriately represented in other investigations of practice. The *Review Sub-Group's* recommendation on the way to proceed should be confirmed by the LSCB. At the conclusion of the review, if undertaken by another review body, the review report should always be considered by the LSCB and anonymised learning points relevant to the child or children should be published. An action plan should be put in place as required.

5.9. **Concurrent police investigations or judicial proceedings:** where the case is subject to police investigations or judicial proceedings, these should not inhibit the setting up of a child practice review nor delay immediate remedial action being taken to improve services. It is important that the purpose of the review process, which is to support professional and organisational learning and to promote improvement in future inter-agency child protection practice, is understood and remains the focus.

5.10. **Relationship with other formal staff processes:** the review process is about practice learning. If any issues of individual staff training needs or staff malpractice emerge during the course of a concise review, these matters should be referred and managed through the relevant agency's own staff procedures.

5.11. Even where there are other formal processes or investigations underway, such as complaints procedures, there is no reason to delay undertaking a child practice review. A review is focused on learning to improve future practice and is not

a quasi-process for dealing with complaints. LSCBs should consider how other processes may run in parallel with a child practice review and relevant learning resulting from the different processes should be shared.

5.12. **More than one index child subject to review[9]:** there may be cases where more than one child has died or has suffered serious harm as the result of abuse or neglect and each child is the subject of the same review, i.e. there are several index children of that review. The review process must consider each child's perspective and experience individually but ensure the learning arising from the children's circumstances is brought together in one comprehensive child practice review report at the conclusion of the review. It is important that the Chair of the Board is informed by the *Review Sub-Group* of each child to be included in the review in its recommendation for the way forward.

Recommendation to the Chair of the Board

5.13. The *Review Sub-Group's* decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Board, with the following information:

- a brief outline of the circumstances of the case;
- the reasons for holding a concise review;
- the proposed terms of reference;
- a timeline for the review;
- an assessment of the likely communication and media issues, as known at the time.

5.14. A template (in Annex 1) has been provided for this submission to simplify the process, ensure consistency and provide a report for informing the Welsh Government. The Welsh Government should be informed of every case that meets the criteria for a concise review that has been considered by the *Review Sub-Group*, including those where the lead LSCB may be in another country, and should be informed of the outcome of the recommendation.

5.15. The Chair of the Board will inform the *Review Sub-Group* of his or her decision as to whether the recommendation to hold a concise review is approved, and inform the Board. Should the recommendation for a concise 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.

5.16. If the decision is yes, the *Review Sub-Group* will establish a multi-agency *Review Panel* to manage the review.

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[9] *Index child* is a term used to indicate the child who is the subject and focus of a review, to distinguish that child from other children who may also be involved. In some reviews, there may be more than one child who has died or been significantly harmed, and they may all be subjects of the same review. They will all be 'index children' of that review.

Terms of Reference

5.17. Initial terms of reference will be submitted to the Chair of the Board based on information known at the time. It should be noted that the terms of reference are **a living document** and not set in stone. They may need to be amended, in the light of new information, at any point during the course of a concise review. The *Review Panel* will have responsibility for agreeing any variation to the terms of reference.

5.18. The final terms of reference (anonymised) will be included in the Child Practice Review Report at the completion of the review.

5.19. An exemplar of the terms of reference is included in Annex 2.

Review Panel

5.20. The *Review Panel* manages the review process and plays a key role in ensuring the learning is drawn from the case. Representatives should be appointed to the *Panel* from those agencies involved in the case, including adult services. The panel members should have working knowledge of the services but not have had direct involvement in the case. A multi-agency panel should always be convened, even where the case may involve only a single agency or a small number of agencies. Because the *Panel* is an integral part of the review process, it is essential that, once appointed, there should be consistency in *Review Panel* membership and in attendance at *Panel* meetings. Deputies should only be permitted in exceptional circumstances.

5.21. Services that have been involved with the child and family will be requested by the *Review Panel* to provide information of contact with the family by preparing an agency timeline of significant events (within a timescale agreed by the *Panel* – see 5.22 below) together with a brief analysis of relevant context, issues or events. Information about action already taken or recommendations by staff for future improvements in systems or practice may be included, if appropriate. The preparation of timelines and analyses should be undertaken by managers who have not had operational responsibility for the case but understand the service.

Timelines and genogram[10]

5.22. A **timeline** of a maximum of 12 months preceding the incident should be prepared. The 12 month timeline may be extended only if there are exceptional circumstances but as the focus of the review is on current practice, the timeline should in those cases be no longer than 2 years. The timeline may be extended to include decisions and action following the incident. Any extension of the time line should be agreed by the *Review Panel.*

5.23. Where there is significant background information or a previous incident, this can be included in the brief analysis accompanying the timeline. Family history is vitally important but the critical issue in a review is who was familiar with the family

[10] It was found during the pilots that the police service has software which produces high quality single agency and merged timelines and genograms which considerably assisted the effectiveness and efficiency of the work of the *Review Panels,* the reviewers and the learning events.

history, how it was shared within the professional network and how it was taken into account in current decision making.

5.24. A full and accurate **genogram** (also known as a Family Association Network in the police service) should also be prepared by the *Review Panel* as a means of clarification of family relationships. It should be used during panel discussions with the reviewer and be available for reference at all stages of the review process, although not included in the published report.

5.25. The *Review Panel* will produce a merged timeline of significant events from the individual agencies' timelines. The merged timeline, genogram and brief agency analyses will then be used by the *Review Panel* members and the reviewer to develop questions and ideas about what happened in the case. This initial understanding will inform the preparation of a learning event for practitioners and line managers to test out and further explore operational practice issues. The reviewer will also have access to and will read documentary and other relevant written material, as appropriate. During discussion, issues for clarification may arise and the *Review Panel* will ask services to respond; the terms of reference for the review may be amended or extended, as a result.

5.26. At any point in the course of conducting a concise review, the *Review Panel* and/or the reviewer may reach the conclusion that, from the analysis of timelines or other sources, the review does not meet the criteria for a concise review or the review cannot be conducted as laid out in the guidance. If the concise review is terminated, it will require the agreement of the *Review Panel*, a report to be written and presented to the *Panel*, the Chair of the LSCB asked to approve the action by the Chair of the *Panel*, and the Safeguarding Team of the Welsh Government notified.

Commissioning a Reviewer

5.27. The *Review Panel* will identify and commission a reviewer who must be independent of the case management and who may be a member of the LSCB, or a member of another Board, or from a neighbouring authority, or a person with relevant skills and experience as required by the case. Relevant experience may be determined by issues of language, ethnicity, religion or health, such as disability, or other factors instrumental to the circumstances of the case[11].

5.28. If the *Review Panel* considers that, given the circumstances of the case, it would be helpful to appoint another person to work with the reviewer, the appropriate commissioning arrangements should be made expeditiously.

5.29. When choosing a reviewer, it will be important to remember that the quality and experience of the reviewer is crucial to the quality of the outcome. The role requires a wide range of knowledge, skills and abilities which include a thorough knowledge of child protection systems, issues, responsibilities and practice, an understanding of multi-disciplinary working, an ability to enquire and communicate

[11] For example, organisations such as AFRUCA, *Africans Unite Against Child Abuse*, or AAFDA, *Advocacy After Fatal Domestic Abuse*, may be called upon to give advice, advocacy and expertise.

about practice with professionals and with children and family members, and skills in facilitating and managing group processes effectively. In appointing a reviewer, the LSCB will need to be satisfied that safe recruitment practices have been observed.

Engagement of children and family members in the review process

5.30. Engagement with family members and listening to their perspectives and experiences are essential to developing learning when a case is under review. Family members may include the child or young person, his or her siblings, parents, carers, grandparents or other significant family members (as appropriate to the case). They should wherever possible be informed of the review and their views incorporated into the review process. The *Review Panel* will need to consider how this can be most effectively achieved. This may best be done by contacting and talking to family members about the purpose of the review process and identifying with them the messages, perspectives or experiences they would want to contribute to practitioner learning at a learning event and what they might expect from the review.

5.31. How such contact is made will need to be discussed by the *Review Panel* and the reviewer. In some cases it may involve the lead professional or others who are working with the child and family. Experience has shown that the reviewer has an important role to play in meeting the child, siblings and other family members shortly before the learning event, if appropriate and the family so wishes, and carrying their messages into the event.

5.32. Children and young people have sometimes been excluded from making a contribution. Experience reinforces the importance for young people to be involved, to contribute in as small a way as they wish, to help them influence the learning of those involved in the review and to then have the opportunity to see and discuss the report and its findings at the conclusion of the review.

5.33. LSCBs should think creatively about how families can be engaged in the review and how explanatory information is provided to children and adult family members, taking account of age and of circumstances such as disability and first language. An example is given below.

A reviewer designed a leaflet for an adolescent to take to a discussion with the young person and leave at the end of the visit. It explained why a review was being held, how the review was carried out and what the reviewer's responsibilities were. Questions were included to help the young person contribute to the review and the reviewer left contact details on the leaflet for the young person to use if needed.

5.34. Careful arrangements need to be made for reporting back at the conclusion of the review and sharing the findings of the report. The reviewer and/or the *Panel* Chair may be the most appropriate persons to do this. Family members will vary in their response as to whether and how they would want to receive feedback, not necessarily face-to-face but by telephone or letter. The timing of sharing the content of the report will need to be carefully considered in relation to the date of publication and other sensitive issues for the family. Copies of the report should not be given to

family members to retain until it has been finalised, approved by the LSCB and published.

5.35. The feedback may have a number of functions according to the circumstances. It may provide reassurance or validation, help to draw a line or provide a turning point in a programme of care and treatment or it may bring distress or revive painful memories. In some circumstances, appropriate support from key professionals may need to be made available to the respective children or family members.

Learning event

5.36. The learning event is a critical part of the review. It ensures the voice of practitioners directly contributes to the review, that practitioners can hear the perspectives of the family during the event and, with other practitioners who have worked with the child and family, they are able to reflect on what happened and identify learning for future practice.

5.37. Practitioners and managers are expected to attend if asked. The *Review Panel* should think creatively about how relevant practitioners and line managers can be engaged in the review. In some instances it may be appropriate for more than one learning event to be held to ensure the contribution of key staff to the learning process. The *Review Panel* has responsibility for supporting the reviewer in carrying out an effective learning event. [12]

5.38. The *Review Panel* Chair will normally attend the learning event on behalf of the *Panel* to ensure that the questions and issues identified by the *Panel* are fully addressed. Should the Chair of the *Panel* be unable to attend, the LSCB Child Protection Co-ordinator or another suitable member of the Panel may attend.

5.39. At the conclusion of the learning event, the reviewer with the practitioners will identify single and inter-agency issues and practice learning points for consideration and further discussion by the *Review Panel*.

Child Practice Review Report

5.40. Following the learning event, the reviewer has responsibility for collating and synthesising the learning to date for discussion with the *Review Panel* in the form of a draft report, using the agreed template outlined in Annex 1. The reviewer also has responsibility for confirming that the learning process was undertaken appropriately.

5.41. The draft report should be succinct and focused on improving practice. It should include the circumstances which led to the review, the practice and organisational learning identified during the review, including highlighting effective practice, and considerations about what needs to be done differently to improve

[12] Training tools supporting the child practice review framework, including a practice guide on holding multi–agency practitioner learning events, are available on the Welsh Government website. http://wales.gov.uk/topics/childrenyoungpeople/publications/safeguard12/?lang=en

future practice. Actions should be identified that will bring about improvements in systems and practice, and should be specific, workable and affordable, and have clearly defined anticipated outcomes.

5.42. Meetings between the reviewer and the *Review Panel* combine important opportunities for professional challenge with quality assurance by *Panel* members. Practice issues originally identified by the *Panel* can be re-examined in the light of the reviewer's findings and the learning event, and there may be issues identified for further clarification either with practitioners or managers or the *Review Panel*. Once agreed, the anonymised draft child practice review report and an outline action plan will then be presented to the LSCB. A template (in Annex 1) has been provided for the child practice review report.

5.43. However, because a review has been held, it does not mean that practice has been wrong and the reviewer may conclude there is no need for change in either operational policy or practice.

5.44. The *Review Panel* will have responsibility for producing an anonymised summary of the merged timeline (the summary timeline should be included with the child practice review report when published).

Presentation of the Report to the Board

5.45. The draft report and an outline action plan should be presented to the Board by the Chair of the *Review Panel* and the reviewer. The presentation of the report is an important means of the Board maintaining a close relationship with practice. In order to carry out this role, when presenting the draft report to the Board members, the reviewer will need to take them through the detail of the timeline as well as the practice and organisational issues arising from the review. The role of Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development.

5.46. The Board may identify additional learning issues or actions of strategic importance for individual agencies or for the collective responsibility of the Board. These may be included in the final child practice review report or in the action plan, as appropriate.

5.47. The Review Panel and the reviewer will then complete the final report to reflect the range of learning identified. The Board has responsibility for accepting the report and providing direction regarding the proposed action plan.

5.48. The Chair of the Board will submit the report to the Safeguarding Team of the Welsh Government which will then draw in other parts of the Welsh Government and the Inspectorates Group as appropriate and consider if further action is needed. The Welsh Government will require the report at least two weeks before the proposed date of publication by the LSCB.

5.49. The finalised child practice review report together with the summary timeline will be published on the LSCB website for a minimum of 12 weeks. A reference on the website thereafter will indicate that the report may be available on request.

5.50. The review process will be completed as soon as possible but no longer than six months from the date of referral to the LSCB's *Review Sub-Group*.

Action Plan

5.51. *The Review Panel* and the reviewer will have responsibility for preparing an outline action plan, to accompany the draft child practice review report for presentation and discussion by the Board. The action plan should reflect the learning identified in the child practice review report, including where appropriate effective practice. The actions may be directed either at single agencies or require multi-agency action. The action plan should be outcome-focused and indicate how actions are intended to make a difference to local systems and child protection practice.

5.52. The finalised action plan should be prepared by the *Review Panel* and the reviewer reflecting discussion by the Board. This should be within four weeks of the LSCB consideration of the report, and sent to the Chair of the Board for signing off by the member agencies. It should then be sent to the Welsh Government. The action plan should have a clear focus on improving outcomes for children and their families

5.53. The action plan will be reviewed and progress will be monitored by the *Review Sub-Group* and reported to the Board. This must include dissemination of the report and action plan to local staff, as appropriate.

5.54. Action plans should lead to improvements in child protection practice and the Board will need to ensure they are carefully audited to see whether they have been carried out and with what effect, and whether they are achieving the intended outcomes.

5.55. The reviewer may be requested by the *Review Panel*, as part of taking forward the action plan, to undertake an event with staff groups either to disseminate what has been learned or to follow-up the impact on practice of changes being made as the result of learning from the review.

5.56. The *Training Sub-Group* and *Audit Sub-Group* will need to include any issues emerging from the concise review in the Board's future training and audit programmes or incorporated into the work programme of the Multi-Agency Professional Forums.

5.57. On completion of the work, the action plan will need to be signed off by the Board and a report made to the Safeguarding Team of the Welsh Government about the difference the actions taken have made to practice.

6. Extended child practice reviews

Criteria for an extended review

6.1. 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 care leaver under the age of 18[13]) 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[14] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for **extended reviews** are laid down in revised regulations, *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.*

Process for undertaking an extended review

6.2. **The same process for undertaking a concise review, as laid out in Section 5, should be followed for undertaking an extended review. There will be some additional issues to be addressed**.

6.3. The review process is represented as a flow chart (fig. 2 page 31).

6.4. On receiving a referral following the death of a looked after child where abuse or neglect is known or suspected, the LSCB should ascertain that the local authority has notified the Welsh Government and others in accordance with their duty under Section 20 of Schedule 2 of the *Children Act 1989*.

6.5. It should be noted that there may be matters which require negotiation and resolution by the *Review Sub-Group* before a *Review Panel* to manage the review can be put in place.

6.6. **More than one LSCB is involved:** where a referral received by the *Review Sub-Group* involves more than one LSCB, co-operation and careful planning

[13] *Care leaver* as defined by section 23A(2) of the *Children Act 1989*; section 19B(2) to Schedule 2 of that Act and Regulation 4 of the *Children (Leaving Care) (Wales) Regulations 2001* (s12189/2001(W1511)).

[14] 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* as set out in the new Regulations

between the respective *Review Sub-Groups* of those Boards will be required to agree the way forward (*Children Act 2004*, s.25 and s.28). The guiding principle should be that the LSCB in which the child is or was normally resident should take lead responsibility for conducting the review. In the case of a looked after child, the responsible authority should take lead responsibility for conducting the review, involving other LSCBs with an interest or involvement as appropriate. The decision reached on how the review will be handled should be reported to the respective Boards.

6.7. **More than one LSCB in different countries is involved:** where a referral received by the *Review Sub-Group* involves more than one authority in different countries within the United Kingdom, the principle of ordinary residency will determine which LSCB should take lead responsibility for undertaking a review. However, co-operation and careful planning may be required between LSCBs in order to agree how the respective review procedures will be followed and how any additional matters will be addressed by the review. These decisions may also need to involve the respective government departments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.

6.8. **Parallel investigations of practice are involved:** where the case gives rise to other parallel investigations of practice, for example, a domestic homicide review where a parent has been murdered, or a review of the provision of mental health services by Healthcare Inspectorate Wales following a homicide, or a Youth Justice Board Serious Incident Review, or a Prisons and Probation Ombudsman investigation where a child has died in a custodial setting, the chair of the LSCB should be informed (see Annex 1) and agree a way forward with the *Review Sub-Group*.

6.9. The *Review Sub-Group* should then liaise with those other bodies and agree the type of review and the lead responsibility for conducting the review. Depending on the circumstances of the case, there might be a joint review or additional questions might be added to the terms of reference. In these cases, it is quite likely there will be a focus on more than one member of the family, some of whom may be adults. The *Review Sub-Group* has an important responsibility to ensure the child or children's interests are always appropriately represented in other investigations of practice. The *Review Sub-Group's* recommendation on the way to proceed should be confirmed by the LSCB. At the conclusion of the review, if undertaken by another review body, the review report should always be considered by the LSCB and anonymised learning points relevant to the child or children should be published. An action plan should be put in place as required.

6.10. **Concurrent police investigations or judicial proceedings:** where the case is subject to police investigations or judicial proceedings, these should not inhibit the setting up of a child practice review nor delay the holding of a multi-agency learning event with practitioners. It is important that the purpose of the review process 'to support professional and organisational learning, to promote improvement in future inter-agency child protection practice' is understood and remains the focus.

6.11. **Relationship with other formal staff processes:** the review process is about practice learning. If any issues of individual staff training needs or staff

malpractice emerge during the course of an extended review, these matters should be referred back and managed through the relevant agency's own staff procedures.

6.12. Even where there are other formal processes or investigations underway, such as complaints procedures, there is no reason to delay undertaking a child practice review. A review is focused on learning to improve future practice and is not a quasi-process for dealing with complaints. LSCBs should consider how other processes may run in parallel with a child practice review and relevant learning resulting from the different processes should be shared.

6.13. **More than one index child[15]:** there may be cases where more than one child has died or has suffered serious harm as the result of abuse or neglect and each child is the subject of the same review, i.e. there are several index children of that review. The review process must consider each child's perspective and experience individually but ensure the learning arising from the children's circumstances is brought together in one comprehensive child practice review report at the conclusion of the review. It is important that the Chair of the Board is informed by the *Review Sub-Group* of each child to be included in the review in its recommendation for the way forward.

Additional issues to be addressed by the Review

6.14. In following the process for undertaking a concise review, as laid out in section 5, there will be additional issues to be addressed as part of an extended review and these will require additional external professional challenge.

6.15. An additional level of scrutiny will include consideration of the following issues in the preparation of the terms of reference and timelines, and during the learning event:

- 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 plan was implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan.
- The aspects of the plan that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding

[15] *Index child* is a term used to indicate the child who is the subject and focus of a review, to distinguish that child from other children who may also be involved. In some reviews, there may be more than one child who has died or been significantly harmed, and they may all be subjects of the same review. They will all be 'index children' of that review.

the effectiveness of the plan, including progress against agreed outcomes for the child. 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 (and this should include consideration of both organisational issues and other contextual issues).

6.16. Further relevant issues in relation to the circumstances of the case may also be identified by the *Review Panel* and/or the reviewers (see para 6.18).

6.17. The 12 month timeline (see para 5.22 **Timelines and Genogram**) may be extended, but only when necessary, to reflect the period of time the child was on the child protection register or was recently a looked after child. The timeline can be extended from 12 months to up to two years if circumstances so warrant but the focus of the analysis is on current practice and on the relevant child protection plan and/or looked after children's plan or pathway plan.

Review Panel

6.18. The *Review Sub-Group* will formulate the initial terms of reference for the extended review (an exemplar is contained in Annex 3) and will set up a multi-agency *Review Panel.* As with a concise review the *Review Panel* manages the review process and plays a key role in ensuring the understanding and learning from the case. The *Review Panel* will build on the initial terms of reference formulated by the *Review Sub-Group* and will develop questions and ideas about what happened in the case informed by the merged timeline[16] of significant events, the agency analyses and in the context of local knowledge. The terms of reference will either be further amended in the light of new information or *Review Panel* discussions and will need to be agreed with the reviewers when appointed.

Reviewers

6.19. Extended reviews will be undertaken by two reviewers. One reviewer will be appointed who is not involved in the case management but who has knowledge of the local context. The other reviewer will be appointed to contribute external professional challenge and relevant experience. Both reviewers will have responsibility for scrutiny of the additional issues to be addressed and will work jointly with the *Review Panel.*

[16] It was found during the pilots that the police service has software which produces high quality single agency and merged timelines and genograms which considerably assisted the effectiveness and efficiency of the work of the *Review Panels,* the reviewers and the learning events.

Learning Event

6.20. As with a concise review, a critical part of the extended review will be a learning event[17] which will be organised and facilitated by the two reviewers (see paras 5.36-5.39). The *Review Panel* and reviewer should think creatively about how relevant practitioners and line managers can be engaged in the review. In some instances it may be appropriate for more than one learning event to be held to ensure the contribution of key staff to the learning process. Practitioners and managers are expected to attend and participate in the process if asked. Reflection and confirmation of the learning points may be part of the learning event or a separate session may be held with the participants of the learning event at a later date.

Child Practice Review Report

6.21. Following the learning event, the reviewers have responsibility for collating and synthesising the learning to date for discussion with the *Review Panel* in the form of a draft report, using the agreed template outlined in Annex 1. The reviewers have responsibility for reporting on the additional issues for scrutiny and also have responsibility for confirming that the learning process was undertaken appropriately.

6.22. The draft report should be succinct and focused on improving practice. It should include the circumstances which led to the review, the practice and organisational learning identified during the review, including highlighting effective practice, and considerations about what needs to be done differently to improve future practice. Actions should be identified that will bring about improvements in systems and practice, and should be specific, workable and affordable, and have clearly defined anticipated outcomes.

6.23. The meeting between the reviewers and the *Review Panel* combines important opportunities for both professional challenge and quality assurance by *Panel* members. Practice issues originally identified by the *Panel* can be re-examined in the light of the reviewer's findings and the learning event and there may be issues identified for further clarification either with practitioners or managers or with the *Review Panel*. Once agreed, the anonymised draft child practice review report and an outline action plan will then be presented to the LSCB. A template (in Annex 1) has been provided for the child practice review report.

6.24. The reviewers and the *Review Panel* may conclude that practice in this case has not failed or been inappropriate and there may be no recommendations for changes in local operational policy or practice.

Presentation of the Report to the Board

6.25. The draft report and outline action plan will be presented by the Chair of the *Review Panel* and by the reviewers to the Board for its consideration. As with a

[17] Training tools supporting the child practice review framework, including a practice guide on holding multi–agency practitioner learning events, are available on the Welsh Government website. http://wales.gov.uk/topics/childrenyoungpeople/publications/safeguard12/?lang=en

concise review, the presentation of the report serves to connect Board members with current practice and organisational issues arising from the practice learning. The Board may identify learning issues or actions of strategic importance for individual agencies or that may come within the collective responsibility of the Board, for inclusion in the final review report or in the action plan, as appropriate.

6.26. The *Review Panel* and the reviewers will then complete the final report to reflect the range of learning identified. The Board has responsibility for accepting the report and providing direction regarding the proposed action plan.

6.27. The report will be submitted by the Chair of the Board to the Safeguarding Team of the Welsh Government who will then draw in other parts of the Welsh Government and the Inspectorates Group as appropriate and consider if further action is needed. The report will be required by the Welsh Government at least two weeks before the proposed date of publication by the LSCB.

6.28. The finalised child practice review report will be published on the LSCB's website for a minimum of 12 weeks, and thereafter reference will be made on the website to the availability of the report on request.

6.29. The review process is to be completed as soon as possible but no longer than six months from the date of referral to the LSCB's *Review Sub-Group*.

Action Plan

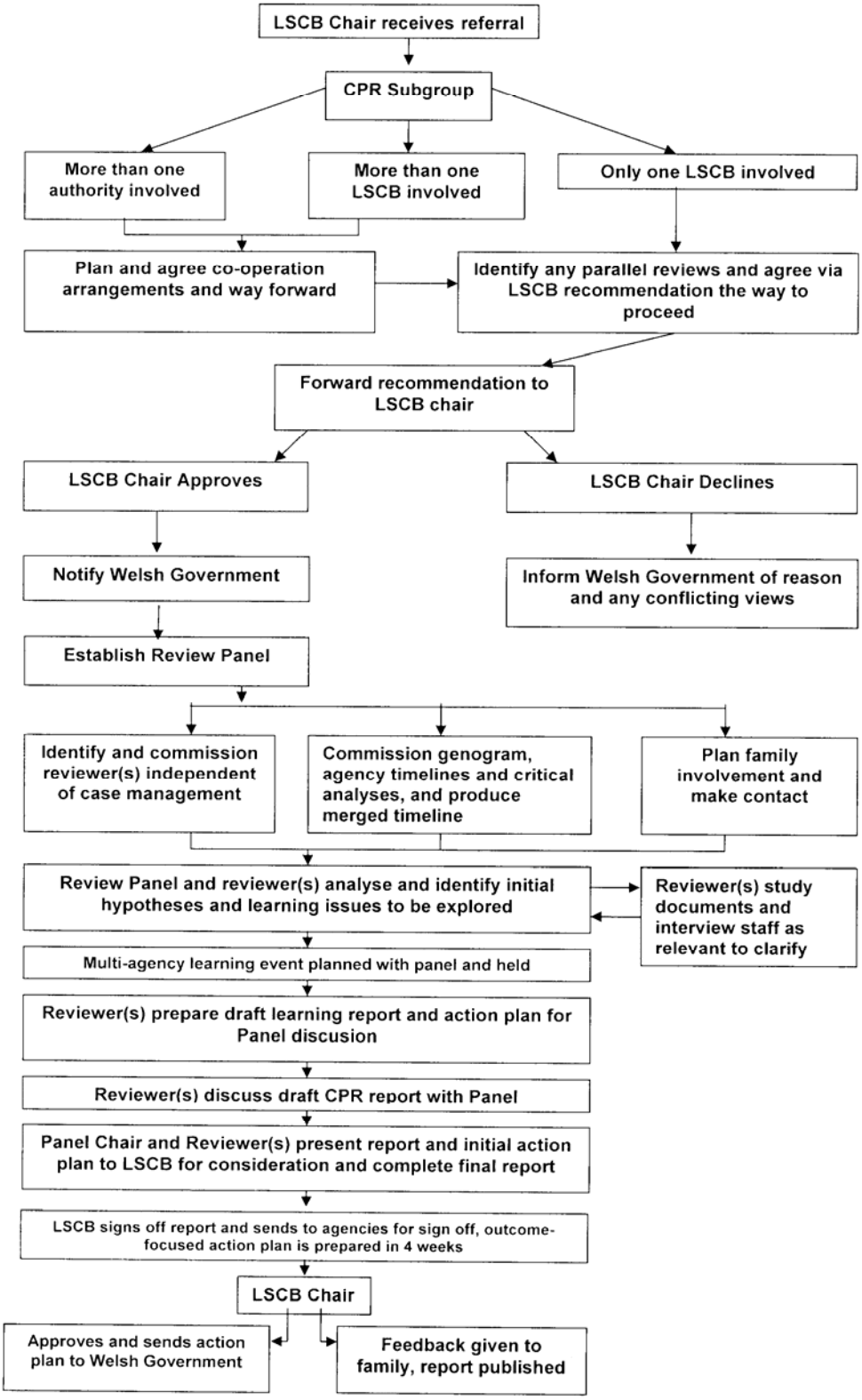
6.30. *The Review Panel* and the reviewer will have responsibility for preparing an outline action plan, to accompany the draft child practice review report for presentation and discussion by the Board. The action plan should reflect the learning identified in the child practice review report, including where appropriate effective practice. The actions may be directed either at single agencies or require multi-agency action. The action plan should be outcome-focused and indicate how actions are intended to make a difference to local systems and child protection practice.

6.31. A finalised action plan should be prepared reflecting this discussion within four weeks of the LSCB's consideration of the report, and sent to the Chair of the Board for signing off by the partner agencies. The action plan should have a clear focus on improving outcomes for children and their families.

6.32. The action plan will be reviewed and progress monitored by the *Review Sub-Group* and reported to the Board. This must include wide dissemination of the report and action plan to staff, as appropriate. Consideration will be required by the respective LSCB sub-groups of the critical learning points and how they will be incorporated into any changes in operational systems and practice, training and supervision, and in shaping priorities for future work undertaken by the Board.

6.33. Once the action has been completed, the action plan will be signed off by the Board and a report made to the Safeguarding Team of the Welsh Government and to the Inspectorates on the difference the actions have made to practice.

Fig. 2 Flowchart of child practice review process



7. Applying the child practice review process to historic abuse

7.1. It is the responsibility of the LSCB to determine whether a case meets the prescribed criteria for undertaking a child practice review. An LSCB may decide that a review is required in relation to a case involving historic organised or multiple abuse. The aim of such a review would be to examine what can be learned from past practice to ensure that current practice and organisational systems are strengthened and improved.

7.2. There is an expectation in Chapter 9, *Safeguarding Children Who May Be Particularly Vulnerable – Investigating organised or multiple abuse*[18] in the 2006 *Working Together* Guidance, that LSCBs will identify and learn lessons at the conclusion of an investigation of organised or multiple abuse (p.227):

- *put in place a means of identifying and acting on lessons learned from the investigation (e.g. in respect of policies, procedures and working practices which may have contributed to the abuse occurring) as the investigation proceeds, and*;
- *at the close of the investigation, assess its handling and identify lessons for conducting similar investigations in future.*

7.3. Historic reviews that meet the criteria for a child practice review should follow the principles, approach and process outlined in sections 1 to 6 of this guidance. Practice guidance is provided in Annex 3 about how such a review may be undertaken.

[18] 'Organised and multiple abuse may be defined as abuse involving one or more abuser and a number of related or non-related abused children and young people. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse', *Safeguarding Children: Working Together Under the Children Act 2004, s9.22, p.225*

Annex 1: Child Practice Review Templates

Template 1. Recommendation to Chair of LSCB from Review Subgroup

From: Chair of the CPR Subgroup – Name and Designation

To: Chair of the LSCB – Name and Designation

Re: Insert numerical case identifier **(to be used in all future correspondence-** *These are based on the year a CPR began. So, for example, the first CPR undertaken by Cardiff LSCB next year will be (Cardiff 1/ 2013)***)**

Date of Recommendation:

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.

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	☐
No review	☐
Alternative review process	☐
*Please specify or detail alternative review process, e.g. Homicide Review***:** …… ……	
Decision	
Unanimous	☐
Majority	☐

Rationale for Decision/Recommendation

This should include:-

- Guidance Criteria.
- Range of reviews considered.
- Alternative types of review considered to meet the case needs.
- How the needs of any other review will be incorporated into the terms of reference.
- If majority decision – explanation and outcome.

Proposed Initial Outline of Review

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

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

Police	☐		NHS Trust	☐	
Education	☐		Social Services	☐	
Probation	☐		Public Health Wales	☐	
Youth Offending	☐		CAFCASS Cymru	☐	
Local Health Board	☐		Other LSCB	☐	
Other (please specify if known or yet to be identified):			☐		

Agency identified to Chair Review Panel

Include name and designation if known

Police	☐		NHS Trust	☐	
Education	☐		Social Services	☐	
Probation	☐		Public Health Wales	☐	
Youth Offending	☐		CAFCASS Cymru	☐	
Local Health Board	☐		Other LSCB	☐	
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	☐
*State **rationale for choice** of Chair:*				

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

1. To examine inter-agency working and service provision for Child or Children X through defined terms of reference.

2. To seek contributions to the review from the child/children and appropriate family members and keep them informed of key aspects of progress.

---

3. Identify particular issues identified for further clarification including: (*List issues relevant to particular case.*)

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

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

6. The Panel Chair will inform the Chair of the LSCB and the LSCB subgroup of significant changes in the scope of the review and the TOR will be updated accordingly which will be updated in the TOR

7. The Chair of LSCB 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 LSCB Report.

8. The LSCB and 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 panel on issues relating to interviewing individual members of staff.

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 plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;
- the aspects of the plan 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 plan, including progress against agreed outcomes for the child. 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 (and 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:	£ …… (total)

Date of First Panel meeting (mm/mm/yyyy)	……

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 Coroners decision*				

Anticipated completed report date (mm/yyyy)	……..

To be completed by Sub Group Chair

Signature ……

Title ……

Date ……

Telephone number ……

Decision of the Chair of LSCB

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 ……

Date ……

Telephone number ……

In discussion with Chair of Sub group

Date information to be presented to LSCB ……

Date information sent to Welsh Government ……

For Welsh Government use only

Date information received …….. ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……..

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

Template 2. Child Practice Review Report

Child Practice Review Report

(insert name) **Local Safeguarding Children Board**
Concise/ Extended *(delete as appropriate)* **Child Practice Review**

Re: *insert numerical case identifier*[19]
xx LSCB 1/13

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

An *X* review was commissioned by *X LSCB* on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Child Practice Reviews. The criteria for this review are met under *x:*

(a succinct anonymised account of the circumstances which required a review to be held by the LSCB)

Practice and organisational learning

*Identify each individual **learning point** arising in this case (including highlighting **effective practice)** accompanied by a brief outline of the **relevant circumstances***

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

[19] These are based on the year a CPR **began**. So, for example, the first CPR undertaken by Cardiff LSCB next year will be (Cardiff 1/ 2013).

Improving Systems and Practice

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

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

Statement by Reviewer(s)

REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the 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)*	……	**Name** *(Print)*	……
Date	……	**Date**	……

Chair of Review Panel (Signature)	…….
Name *(Print)*	…….
Date	…….

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review process *To include here in brief::* • *The process followed by the LSCB and the services represented on the Review Panel.* • *A learning event was held and the services that attended.* • *Family members' had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

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

Template 3. Summary Timeline

Local Safeguarding Children Board *(insert LSCB name)*
Summary Timeline
Re: *insert numerical case identifier*

Type of activity	2011							2012										
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
Midwife Services																		
Health Visitor																		
Hospital Services																		
Police																		
Youth/criminal Justice																		
WAST																		
GP																		
Social Services																		
Housing																		
Education																		
Contextual issues																		

Detailed timelines were produced by the relevant services for the purposes of the review to assist the understanding of the complex interactions between events and services in this case.
This summary and partial timeline contains limited and anonymised details and is provided to supplement the outline of circumstances in the Child Practice Review report.

Annex 2: Terms of reference for concise and extended reviews - an exemplar

Terms of reference for an concise/extended child practice review (delete as appropriate)

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and LSCB.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child 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 learning event for practitioners and identify required resources.

For extended reviews ONLY. In addition to the review process, to have particular regard to the following:

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances? How did that knowledge contribute to the outcome for the child?
- Was the child protection plan (and/or the looked after child plan or pathway plan) robust, and appropriate for that child, the family and their circumstances?
- Was the plan 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? To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled?
- Were there 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?

- Were the statutory duties of all agencies fulfilled?

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and 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.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s 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 reviewer/s contact arrangements with the child 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, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the LSCB 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.

Tasks of the Local Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Review Panel complete the report and action plan.
- LSCB send to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on LSCB website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Annex 3: Undertaking a review in a case of historic organised or multiple abuse

1. The aim of a review following an investigation of a case of historic organised or multiple abuse, which meets the prescribed criteria for a child practice review, is to identify issues arising from past practice and to ensure learning has informed current practice so that improved systems are in place. The purpose is to promote improvement and learning and not to apportion blame. Any competency or disciplinary matters fall outside the remit of a review and they are a matter for individual agency disciplinary procedures.

2. The learning should be shared with those agencies and staff currently carrying responsibility for child protection action. Learning from the review should be used by the LSCB to assure the quality and robustness of agencies' current systems and practice in responding to any concerns, suspicions or allegations in relation to children and young people in schools, residential institutions or other forms of group care (in line with the UN Convention on the Rights of the Child and, in particular, Article 19[20]).

The review process

3. The review should examine how child protection agencies responded to disclosures of abuse and identify learning points from the processes followed and the decisions and actions taken in response to allegations. The review process will need to be flexible and challenging in order to capture relevant issues and take account of changes in staff and procedures that may have occurred in the intervening period. This can be done by a range of methods including examining records of meetings and other documentary sources, and individual interviews with staff and family members (as appropriate) to clarify information. The review should include a learning event held with relevant managers and practitioners.

4. The review should follow the principles, approach and process outlined in Section 5. The flowchart (Fig.2) of this guidance outlines the process to be followed.

Core tasks of the Review

5. The core tasks are as follows:

- To ensure current policy, procedures and practice of the named services and the LSCB have been informed by the issues and learning arising from the case, by examining:
    - decision making across agencies and through the whole authority as related to this case

[20] *UN Convention on the Rights of the Child, Article 19:*' State Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.'

- the extent to which decisions and actions were child-focused
- inter-agency working and service provision for the children concerned and their families

- To seek contributions to the review as appropriate or available from children and family members, and to provide them with feedback.
- To take account of the learning from parallel investigations or proceedings related to the case at the time of the incidents and subsequently.
- To hold a multi-agency learning event to identify where practice has already changed or should be different in future.
- To prepare a report of the review using the template in Annex 2 of this guidance.

Specific tasks

6. The review should be managed by a multi-agency *Review Panel* set up by the *Review Sub-Group* of the Board. The agencies represented on the *Review Panel* may be drawn from Education, Police, Health, Youth Justice, Social Services, Probation and Youth Services, together with the LSCB Co-ordinator. Experienced staff external to the authority may be included to provide additional expertise and challenge. The panel members should have working knowledge of the services but not have had direct involvement in the case.

7. The responsibilities of the *Review Panel* members during the review should be to:

- act as a link to their respective agencies to facilitate the work of the reviewers and keep their agencies informed of issues arising from the review in line with its organisational reporting arrangements;
- confirm or amend the terms of reference as required including time period to be reviewed;
- commission agency timelines and analyses of involvement;
- present their agency timeline and initial analysis to the panel;
- offer professional expertise and challenge to the practice identified in the merged timeline and agency analyses;
- identify issues to be explored in a learning event;
- following the learning event, the *Panel* should consider the learning issues identified when the report has been drafted by the reviewers;
- contribute to developing a report and action plan as required.

8. A timeline should be agreed by the *Review Panel* for the examination of records and other material.

9. The *Review Panel* should commission agencies to provide timelines of their involvement in the case and a succinct analysis of actions and practice from their agencies' perspective.

10. The *Review Panel* should appoint a reviewer (or reviewers), who is independent of the LSCB, in accordance with guidance for concise and extended child practice reviews. He/she will be expected to work closely with the *Review Panel* and be offered practical support by the LSCB Co-ordinator or a nominated panel member.

11. The reviewer/s should examine the individual agency timelines and analyses, and have access to relevant documentary evidence identified from the agencies involved, particularly any multi-agency documents. As needed, he/she should interview the agency representative who prepared the timeline to clarify information as well as draw on available guidance and reports.

12. When this has been completed, the reviewer/s with the *Review Panel* should formulate ideas and hypotheses, to be tested in a learning event, based on the key issues that have emerged through analysis of the merged timeline and summary reports.

13. A learning event should then be planned by the reviewer/s with the *Review Panel* bringing together key relevant staff from different agencies who would be currently involved in the handling and management of the multi-agency response to such concerns and in subsequent decisions and action that would have to be taken. Participants in the learning event should be identified and prepared. Particular care in planning the event is likely to be needed when it involves staff who may have been in post at the time of the matters under review, as well as staff newly appointed since then. The focus of the event should be on learning and not blame for what has happened in the past, and should be about identifying where practice has already changed or should be different in future. Although the review is likely to be about the processes to be followed, the reviewer/s need to ensure there is a child-focus throughout.

14. The reviewer/s with the *Panel* should consider and manage how any children's or family members' perspectives may be included and contribute to the learning event

15. The learning issues and conclusions from the event should inform discussion with the *Review Panel* and a draft child practice review report should be prepared by the reviewer/s for consideration and discussion with the *Review Panel*. The report together with an outline action plan should be presented to the LSCB. The preparation of a report should follow the template format (Annex 1).

LSCB tasks

16. A draft report should be presented by the Chair of the *Review Panel* and the reviewer/s to the Board for members to consider and approve the report. The role of the Board is to provide professional challenge and to consider the strategic

implications of the findings and future action for the Board and its constituent member agencies.

17. On approval of the final report by the LSCB, it should be sent to the agencies involved for sign off. The report will then be sent by the Chair of the LSCB to the Safeguarding Team of the Welsh Government. The learning outcomes should be published on the LSCB website, as outlined in Section 5.

18. The LSCB should consider the outline action plan prepared by the *Review Panel* and the reviewer/s. The action plan should identify the difference any action is intended to make to practice and how the LSCB will audit this in the future. The final action plan should be signed off by the LSCB within four weeks of the report and sent to the Welsh Government.