
# Concise Child Practice Review Report

# CYSUR 5/2017

**Date report presented to the Board: 11th April 2019**

**Child Practice Review Report**

**CYSUR: Mid & West Wales Safeguarding Children Board**

**Concise Child Practice Review Re:**
**CYSUR 5/2017**

## Brief outline of circumstances resulting in the Review

### Legal Context

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

The criteria for this review are met under Chapter 6, *Concise Child Practice 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 (LA) or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

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

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and a family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations about what needs to be done differently to improve future practice. (*Working Together to Safeguard People – Volume 2 – Child Practice Reviews* (Welsh Government, 2016[5]).

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

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

**Circumstances Resulting in the Review**

The children who are the subject of this review are, at the request of the family, to be known as Child A and Child B.

Following a safeguarding referral by a New-born Hearing Screener, Child A, a four week old baby boy, was found to have injuries that were potentially life threatening and could have a serious and permanent impairment of his health or development. Child B, the two and a half year old sister of Child A, had injuries which were neither life threatening nor had the potential for serious and permanent impairment of her health or development.

Following the safeguarding referral to Social Services, a Joint Section 47 investigation[6] commenced and the children were placed in the care of the Local Authority (LA). These children now live with their maternal grandparents under a special guardianship order[7].

Child A sustained multiple injuries. These included a fracture to the skull, bi-frontal haemorrhage contusions, bruising, scratches, a torn labial frenulum, fractures to ribs as well as healing fractures to left radius, left femur and left tibia. Although it was not possible to accurately date when all the injuries were sustained, it was found that the majority occurred within two weeks of being identified, on 3rd February 2017. Child B had a healing wrist fracture, and scratches and bruises to her face; although these were not considered to be inflicted.

The Family Court judgement concluded that the children's mother was the perpetrator of the injuries to Child A. The injuries to Child B were found to be not inflicted and therefore no perpetrator was identified.

The Family Court process identified that the children's mother had a significant learning disability. A capacity assessment placed her in the lowest 1% of the population, with an IQ of 53 and a reading age of 6 years. A parenting assessment concluded that mother had deficits in 95% of the skills assessed, and therefore very limited parenting capacity.

The psychological report for the children's father found that he had borderline capabilities, including an IQ of 76 which places him in the lowest 5% of the population. The assessments describe the father's 'indifference' to his responsibilities as a parent, his failure to see visible injuries to Child A and the mother's limited ability to cope with managing two children.

The judgement concluded that the injuries to Child A were as a result of their mother's difficulties in coping with everyday life rather than any cruel or indifferent actions. The Police did not pursue any criminal charges.

**Time Period Reviewed and Why**

In a Concise Child Practice Review (CCPR), the learning is focused on a twelve month period. The Review Panel chose the period 2nd March 2016 to 2nd March 2017 in order to capture the mother's pregnancy and the month following the safeguarding referral. However, in order to understand the necessary context, the Learning Events and the Independent Reviewer have taken account of relevant historic information.

[6] All Wales Child Protection Procedures 3.7 (2008)
[7] Adoption and Children Act 2002

**Children's Family History and Contextual Information**

Prior to this incident, neither Child A nor Child B were known to Social Services, and were therefore never in the care of the LA or subject to a Child Protection Plan (CPP).

Child A and Child B lived with their mother and father. Their parents met in January 2013 and they lived in a large city in England. When Child B was born in July 2014, the family (mother, father and Child B) lived with the maternal grandparents, who were very involved in supporting the day to day life of the family and in the parenting of Child B. There were two short periods when the family had lived away from the maternal grandparents. These were when mother, father and Child B had lived with extended family, and a second time when the mother and father had split up, and mother and Child B had resided in a flat for less than two weeks. It is important to note that, up to this point, the mother's and father's ability to parent without support was relatively untested.

In March 2015, mother, father and Child B moved to the Mid and West Wales region. The paternal grandparents had moved there in November 2014 and, following a split from the children's mother, the father moved to live near his parents. The mother followed him with Child B after a period of two weeks. The mother's move to Mid and West Wales was unplanned, and happened whilst the maternal grandparents were away on holiday. They returned home and were shocked to find the mother and Child B had moved. The maternal grandparents and extended family remained in England, and they visited the family regularly on weekends and during school holidays. The maternal grandmother maintained daily contact by telephone.

It proved difficult to obtain a historic context of what was known of the mother's learning disabilities. The maternal grandparents reported that the mother had one-to-one support throughout education and that they thought that she had a statement of educational needs.[8] However the family, as part of the subsequent Family Court proceedings, could find no documented evidence of the statement.

It is also known that, following the birth of Child B, the mother experienced postnatal depression. Health records detail General Practitioner (GP) support in England and Mid and West Wales related to this. Whilst in England, the mother was referred to mental health services but did not engage. The children's mother stopped taking anti-depressants for postnatal depression with GP support, in February 2016.

It has been confirmed that the family were not known to Social Services during their time living in England.

The family had limited engagement with services in Mid and West Wales, and were known only to the following agencies and support setting:

- GP
- Midwifery Services & Obstetrics
- Health Visiting
- Paediatric Services
- Nursery for Child B

[8] A Statement is a document which sets out a child's SEN and any additional help that the child should receive. The aim of the Statement is to make sure that the child gets the right support to enable them to make progress in school. https://www.gov.uk/children-with-special-educational-needs

The identification of the practice and organisational learning has been drawn from the following key elements of the review:

- The production of a merged multi-agency timeline & agency analysis
- Three Learning Events
- The maternal family's perspective
- Discussions within the Review Panel meetings
- Consultation with Nursery staff
- Case record review
- Independent Reviewer and Panel Chair's analysis

Learning points have been identified throughout the review process. It is important to note that these points are identified with the benefit of hindsight. Any learning should contribute to improving future practice and ensure services are robust in protecting children. The section below identifies the themes emerging from the review and the learning that can be gained from them.

**Provision and Communication across Health Services**

- The family were known to four departments/specialities within health services agencies (GP, Midwifery, Health Visiting, Paediatrics)
- The midwifery services were provided across two different Health Boards.
- The mother was a regular attendee at the GP's surgery with Child B. Visits were, on average, twice every three weeks, mainly for minor childhood illness or ailments which predominantly only required reassurance to the mother by health professionals, rather than treatment.
- A real risk to Child A was sudden infant death due to overwrapping. On the day of the safeguarding referral, the New-born Hearing Screener observed Child A in his pushchair with a hat pulled down over his head and face. There were two covers on the pram plus a coat over the top. Thirteen days prior to this, Child A was found in a similar state by a Community Midwife, he was in his pushchair with a blanket covering him completely, including his head, with a rain cover and a coat over the top. The Community Midwife removed Child A and found him to be hot. The Community Midwife discussed at length the risks of sudden infant death and suffocation, and these concerns were passed to the Health Visitor as part of the discharge from midwifery services. The Health Visitor and GP notes both recorded a clinic visit a week later, where Child A was again observed as overwrapped and hot.
- The mother and Child A were discharged from Community Midwifery services on a Friday. During the discharge visit, the Midwife had safeguarding concerns as Child A had been seen as being overwrapped. A telephone message was left by the Community Midwife for the Health Visitor detailing the safeguarding concern - this message was not received until the following Monday.
- The Health Visitor offered an enhanced service to the mother of Child A and B because of the mother's past history of post-natal depression and her decision to stop medication for depression prior to becoming pregnant. The review has considered if the focus on post-natal depression meant that the wider context and risks posed by the mother's level of parenting capacity were missed.
- The Independent Reviewer and Panel Chair explained the learning ethos of the review to agencies, with a clear emphasis on the importance of openness, collaboration and constructive discussions. Certain elements of the review were occasionally challenging and sensitive for agencies and staff who had contact with the family. At times during the review it has been apparent that there are differences in systems, policy and procedure between health professionals and Health Boards, which have resulted in professional challenge and differences.

**Identified Good Practice**

- The GP's surgery had identified and discussed the mother's need for reassurance.
- The mother and Child A were provided with a good level of both antenatal and postnatal Midwifery service, in line with procedure. The number of postnatal visits were above average.
- The Midwifery notes from the Health Board for the birth of Child B in England were called, and an analysis of them placed on the mother's file.
- Good practice was evident during the pregnancy, with regard to the completion of domestic violence routine enquiries.[9]
- An enhanced Health Visiting service was provided, including nursery nurse support because of the mother's history of postnatal depression. The mother had a positive relationship with her Health Visitor and trusted her. The Health Visitor offered the mother advocacy and also reviewed Child B in the nursery setting.
- A new-born hearing screening home visit for Child A was offered, due to the mother not attending the new born hearing screening appointment.
- Following the safeguarding concerns raised by the Community Midwife on discharge, the Health Visitor offered the mother advocacy and also reviewed Child B in the nursery setting.

**Family Perspective**

- The mother was complimentary about the services she received from Midwifery, Health Visiting and the GP; she felt they offered her a good level of support.

**Learning**

- If the Health services involved with this family had shared information with each other, it is possible that the level of this family's vulnerabilities could have been identified and specialist advice, guidance and services obtained. Following the Learning Event, the GP surgery is now considering (with their multi-disciplinary team) extending their register currently used to highlight elderly and/or frail patients to cover wider vulnerabilities across all ages.
- The discharge of the mother and Child A from Midwifery services on a Friday with ongoing safeguarding concerns was considered unsafe. If the family had remained open to Midwifery over the weekend, then follow-up visits could have occurred until Health Visiting services opened on the following Monday.
- There was a missed opportunity to make a safeguarding referral related to overwrapping. This should have been actioned on the second occasion it was noted.
- The enhanced Health Visiting services were focused on postnatal depression. It is possible that if there had there been a more holistic approach to the family, they could have identified the level of this family's vulnerabilities and obtained specialist advice, guidance and services.
- It is vital that Health services are able to develop a culture of challenge and learning between professions and different Health Boards. This will enable them to work towards service improvements and, consequently, better outcomes for service users.[10]

[9] All Wales Pathway Antenatal Routine Enquiry into Domestic Abuse Minimum Standards
[10] The 2016 Challenge: A Vision for NHS Wales

**The mother had a learning disability and limited capacity, the implications of this for her parenting was not fully recognised by professionals.**

- It is important to make the point that having a learning disability and/or limited capacity does not make someone a poor parent. Moreover, there are many examples of good and safe parenting by people with a learning disability and/or limited capacity. The aim is to ensure the right support and services are in place to ensure parenting in a safe and positive manner.
- At the practitioners' Learning Events, professionals who knew the mother found it difficult to accept the low level of her capacity assessments, due to her presentation.
- During their visit to the children's mother, the Independent Reviewer and Panel Chair found that the children's mother had developed effective masking techniques when she did not understand a question. It was only after further discussions that the level of her capacity to understand became evident. Both the Independent Reviewer and the Panel Chair observed how, in a short interaction/appointment, it could be missed.
- The children's mother reported to the Community Midwives that she had not understood what was said to her at the booking-in appointment, as the professionals were speaking in Welsh. Further enquiries have since revealed that this was not the situation.
- One of the Community Midwives suspected that the mother had limited understanding, and contacted the Health Visitor on two separate occasions to ascertain whether she could understand information and instructions. She was subsequently reassured by the Health Visitor that she could understand.
- The Nursery staff had not established within the setting that the mother had a learning disability or limited capacity to understand; their perception was that the mother was very quiet and shy. There was one occasion when she was unable to give them her telephone number correctly. She was also arriving early in cold weather with Child B, often without appropriate clothing.
- The GP's surgery had recognised that the mother needed regular reassurance with regards to the health of Child B.
- The Midwives reported that they do not know enough about capacity and learning disabilities, and their impact on pregnancy and parenting. They feel that they should have more training, tools and knowledge of support services available. They commented that training is often directed by national agendas rather than local need.
- Record keeping was not always clear. It was noted that, across all agencies, there were times when a concern was highlighted but there was insufficient detail or context, i.e. is the concern self-reported, is it professional opinion, what are the actions and by whom.

**Identified Good Practice**

- The Community Midwife did ascertain the mother's level of understanding with the Health Visitor on two separate occasions.
- The Police took into account the outcome of the Family Court proceedings when considering whether criminal proceedings were appropriate.

**Family Perspective**

- The maternal grandparents explained how they supported the mother in her daily life and parenting of Child B.
- The maternal grandparents were in daily contact and visited regularly after the move to Mid and West Wales. They felt that the children's mother was managing well with the support of the children's father and the paternal grandparents.
- The Independent Reviewer and Panel Chair felt that over a long period of time, the maternal grandparents have subconsciously developed their own behaviours and coping strategies to compensate for the mother's learning disability. This could have made it difficult for them to see the risk in relation to the mother's parenting capacity.

- The children's mother reported that she thought she was managing fine, and confirmed she had not raised any concerns with the children's father, her parents, the paternal grandparents, or any professionals.
- The children's mother told the Independent Reviewer and the Panel Chair that she would have liked to have had more support and help from the children's father. The children's father was always working, and worked through his paid paternity leave and did not offer assistance.
- The children's father had substantively more capacity to parent safely than the children's mother. Had he played a more supportive and active parental role, the risks to Child A and Child B would have reduced. It is unclear how involved the paternal grandparents were; but if they had had more involvement, this could also have added some safety.

**Learning**

- It is not always immediately obvious that someone has limited capacity or a learning disability. The children's mother has developed life skills and coping strategies that enabled her to mask the level of her understanding. It is only by spending time with her that this becomes apparent.
- It is suggested that, with a little more professional curiosity and time, all of the agencies who had known this family could have identified that the children's mother had a learning disability and limited capacity. If this had been the case, then specialist advice, guidance and services could have been identified at an earlier stage.
- A Community Midwife suspected the mother was not able to understand what was being conveyed to her. On two occasions she checked this out with the Health Visitor, whom she felt knew the mother better. The Midwife told the review that, with the benefit of hindsight, she wished she had followed her instincts and made a safeguarding referral herself.
- It was not known by agencies that the parents' ability to parent independently was relatively untested.
- Staff reported they do not feel they have enough training and information relating to parental capacity and learning disabilities. Health employ a specialist Community Learning Disability Nurse, and have safeguarding leads. These staff, alongside the learning disability specialists in Adult Social Services, would have been able to give advice and guidance to support the professionals involved with this family.

**The importance of knowing how to make and respond to a safeguarding referral**

- It has been suggested that by making the safeguarding referral when she did, the New-born Hearing Screener may have saved Child A's life.
- The response to the referral by the Police and Children's Social Services was immediate, and appropriate safeguards were taken that day, with the children placed in foster care.
- Police used the Health Visitor's relationship with the mother to gain entry to the household.
- The Social Services chronological analysis highlighted that they did not gather all of the required information for the strategy discussion. It has also been established that there should have been a strategy meeting following the discussion to bring together all the relevant agencies involved to share information.

**Identified Good Practice**

- The New-born Hearing Screener used her training and gut instinct and made a safeguarding referral at the right time.
- The subsequent safeguarding response was immediate and followed correct procedures to keep Child A and Child B safe.
- Children's Social Services used the protocol for non-mobile babies to inform their decision to undertake a child protection medical.

- The mother trusted the Health Visitor and this relationship assisted the Police and Social Services in gaining access to the parental home.

**Family Perspective**

- Child A and B's maternal grandparents expressed their shock when they were informed about the safeguarding referral and injuries. They described an initial period of complete denial and an inability to understand how this had occurred.

**Learning**

- Ensuring that all staff and agencies have basic safeguarding training; keeping this up to date and knowing how to make a safeguarding referral helps to save children's lives.
- The protocol for bruising in non-mobile babies was helpful in progressing the safeguarding referral and subsequent actions.[11]
- Strategy discussions held under the All Wales Child Protection Procedures[12] should be strengthened to involve all agencies who are involved with the child. Police safeguarding information should be gathered in respect of parents. Strategy discussions should consider information requests from previous LAs. Strategy meetings should be held to bring together multiagency information.

**Appropriate and Timely Agency Reviews Following a Critical Incident**

- The Midwives told the Independent Reviewer and Panel Chair that this was the first time they had been spoken to following the injuries to Child A. Collectively they felt that there should have been some sort of debrief and agency learning in a timelier manner. The GP made the same observation. We have heard from the Review Panel and the managers' Learning Event that there was a debrief and data review. It remains unclear, however, why the Midwives and GP were not aware of, or involved, in these processes. The Independent Reviewer and Panel Chair had concerns that Health services have waited for the outcome of the Child Practice Review process before exploring any agency learning. Agencies should, wherever possible, undertake any immediate remedial learning to improve services and practice, and not wait for the publication of a Child Practice Review.
- The proposal to submit a referral for a Child Practice Review was discussed at the Local Operational Group (LOG) on three occasions, before progressing to the regional sub-group for final recommendation. There are no records of the discussions or decision-making in the LOG. The original referral to the regional sub-group was of a poor standard, and the person presenting it did not have any knowledge of the case. The referral therefore had to be brought back on a subsequent occasion for consideration.
- Police feedback at the Learning Event noted that there had been some difficulties in obtaining Family Court material to review for evidence that might have been relevant to the criminal investigation. This had been in part due to a lack of awareness of how to obtain the records by the investigators and some challenges around legal services provision within Dyfed-Powys Police at the time. The investigators remarked that they had good communication and advice from the Crown Prosecution Service, however they declined to make a charging decision until after the outcome of the Family Court Hearing, prolonging the outcome of the criminal inquiry. Police also commented with regard to a national shortage of Expert Medical Witnesses who will provide evidence on the causation of injuries for both Family and criminal courts.

[11] SGP005 Bruising in Non Mobile Babies Under 1 year old, Guidance for Health Professionals

[12] All Wales Child Protection Procedures 3.7 (2008)

**Learning**

- All agencies should be clear about lead responsibilities to ensure they are able to support staff to debrief following a critical incident, and make any required changes promptly. This should not wait for a Child Practice Review process.
- LOGs should ensure there are minutes that accurately detail the discussions and decision-making relating to review referrals. Referrals to the sub-group should be of a standard to ensure they can be discussed and reviewed by the professionals present. Referrals should be presented by a senior manager who is knowledgeable concerning the circumstances under review.
- Dyfed-Powys Police legal services should provide guidance and training to officers concerning the use of, and how to obtain, Family Court material where pertinent to a criminal investigation.

**Improving Systems and Practice**

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

**Learning 1:** Training and awareness raising on learning disabilities and learning difficulties, their effect on parenting capacity and pregnancy is provided for Midwives and Health Visitors.

**Learning 2:** Systems are put in place to improve the communication between GPs, Midwives and Health Visitors, in order that they are able to share information on vulnerable people and develop a holistic view of the best way to support them.

**Learning 3:** A review of Midwifery discharge procedures is undertaken to consider good practice standards for when there is an ongoing safeguarding concern.

**Learning 4:** All agencies to ensure that they are promoting and providing appropriate levels of safeguarding training so that all staff, volunteers and contractors are able to make safeguarding referrals confidently.

**Learning 5:** All agencies to ensure that they have systems and procedures in place to review any critical incidents/near miss episodes and identify immediate learning in a timely manner.

**Learning 6:** Safeguarding Board and Child Practice Review Sub-group to be confident that partner agencies have effective management systems and resources in place to ensure learning reviews (CPR, APR and MAPF) are carried out to the required standard .

**Learning 7:** Development and implementation of a regional protocol for Injuries in Non-Mobile Babies.

**Learning 8:** Safeguarding Board to develop a tool that can be used by all partner agencies to promote the value of professional curiosity and information sharing in keeping children safe.

## Child Practice Review Process

### Child Practice Review Process

The Child Practice Review referral in respect of Child A and Child B were considered at the LOG on three occasions in 2017 before progressing to the Regional Child Practice Review sub-group. The referral was discussed in September 2017, but did not have adequate detail. Therefore further information was requested, and the referral returned to the sub-group in January 2018, resulting in a recommendation to the Chair of the Regional Safeguarding Board for a Child Practice Review to be undertaken. The Chair subsequently approved this recommendation in February 2018, confirming that a Concise Child Practice Review should be undertaken.

The services represented on the Review Panel were as follows:

- Police
- LA Children's Social Services
- LA Adult Social Services
- Health (2 Health Boards)
- Regional Safeguarding Board

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

### Learning Events

Three Learning Events were held during January 2019. They were jointly facilitated by the Panel Chair and the Independent Reviewer.

Learning Event number one for practitioners was attended by the following agencies:

- Community Midwives

Learning Event number two for practitioners was attended by the following agencies:

- Police
- LA Children's Social Services
- LA Adult Social Services
- Health (2 Health Boards) (GP, Midwifery and Health Visiting)
- Regional Safeguarding Board

Learning Event number three for managers was attended by the following agencies:

- LA Adult Social Services
- Health (2 Health Boards) (Midwifery and Health Visiting Community Leading Disability Services)
- Regional Safeguarding Board

In addition, the Independent Reviewer conducted a telephone consultation with staff representing the Nursery setting that Child B attended. This was undertaken because it came to light that, following the Learning Events, they had not been invited as originally planned.

The Learning Events allowed the professionals concerned the opportunity to consider their involvement, practice, assessments and decision-making processes. The following questions were used to facilitate discussions and identify learning:

| |
|---|
| 1. What went well, what good practice have you identified? |
| 2. What do you feel did not go well, are there things that concern you? |
| 3. What do you feel agencies could have done differently? |
| 4. What actions do you feel that agencies need to take going forward, to ensure any learning informs future practice? |

Evaluations and feedback for all three Learning Events were very positive.

The Panel Chair and Independent Reviewer have experienced significant challenges in respect of the completion of this Child Practice Review. This has been in the context of a lack of appropriate and adequate practical support from the Local Authority, as well as an absence of robust senior management oversight of the progress and management of the review. This lack of engagement has had the potential to compromise the quality of the review, and the completion of the review within the agreed timeframe. It has required persistence and a formal intervention by the Chair of the Board to ensure professional standards have not been compromised.

**Family Engagement**

Engagement with the father of the children and the paternal grandparents

The paternal family were contacted twice during the review by a Social Worker who knew the family well. Initially they agreed to meet with the Panel Chair and Independent Reviewer, but they later declined to meet. Following the second request to meet, the family confirmed that they felt that they did not want to be involved because they did not want to 'drag up the past and relive it all again'.

The Independent Reviewer and the Panel Chair subsequently wrote to the father and the paternal grandparents to explain the following:

- Why there was a review and how it would be conducted
- The role of the Independent Reviewer and Panel Chair
- The learning event
- Report timescales

They gave the father and the paternal grandparents a list of five questions they wanted to ask, and asked them if they would be willing to respond in writing. A follow-up letter was sent in February 2019, but no response has been received. Their views are therefore not represented in this report.

The Independent Reviewer and Panel Chair have also offered to visit the father and the paternal grandparents to share this report with them prior to publication.

Engagement with the mother of the children and the maternal grandparents

The children's mother and maternal grandparents agreed to meet with the Independent Reviewer and Panel Chair, and a visit took place in January 2019 at the grandparents' home in England.

In preparation of the visit, a letter was sent to both the children's mother and the maternal grandparents. Again, this letter explained why there was a review, how it would be conducted, the role of the Independent Reviewer and Panel Chair, the Learning Event and the report. They were also given a list of questions the Independent Reviewer and Panel Chair wanted to ask prior to the visit.

The visit was very positive. The Independent Reviewer and Panel Chair met with Child A, who was a delightful, lively toddler. Child B was in school and not present for the visit; but they were shown family photos of her, a lovely little girl. Initially they met with the maternal grandmother and grandfather, and later with the children's mother. They had the support of a Social Worker from the LA who knew the family well.

The Independent Reviewer and Panel Chair found all of the family members to be open and engaging. They presented as open, honest and thoughtful in their responses, and are grateful for the opportunity to contribute to this review. Their perspectives and responses were shared at the Learning Events and, where appropriate, are included in the section on Practice and Organisational Learning. The family also gave the Independent Reviewer and Panel Chair a beautiful photograph of Child A and Child B to use at the Learning Event. This was well received by those attendees who knew the family.

The Panel Chair had experience and training in interviewing in line with Achieving Best Evidence[13] with children, vulnerable adults and adults with learning difficulties. This provided the skills to communicate effectively with the mother so she was able to understand information provided to her and to answer questions she understood. Over time the mother's learning disability and ability to understand the questions became more apparent. The Independent Reviewer and Panel Chair were left with a good understanding of how well the children's mother could present and mask her disabilities. Both felt that this was a learned behaviour/coping strategy rather than someone trying to be evasive.



[13] Achieving Best Evidence in Criminal Proceedings – Ministry of Justice 2011

| Statement by Reviewer(s) | | | |
|---|---|---|---|
| **Reviewer 1** | Diane Beacroft | **Reviewer 2** *(as appropriate)* | N/A |
| **Statement of independence from the case** *Quality Assurance statement of qualification* | | **Statement of independence from the case** *Quality Assurance statement of qualification* | |
| I make the following statement that prior to my involvement with this learning review:<br>• I have not been directly concerned with the child or family, or have given professional advice on the case.<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge, experience, and training to undertake the review.<br>• 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:<br>• I have not been directly concerned with the child or family, or have given professional advice on the case.<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge, experience, and training to undertake the review.<br>• 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)* | Diane Beacroft | **Name** *(Print)* | …… |
| **Date** | …… | **Date** | …… |
| **Chair of Review Panel** …… *(Signature)* | | | |
| **Name** *(Print)* | Elaine Bendle | | |
| **Date** | …… | | |

**For Welsh Government use only**

Date information received: *(date)*

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

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

| Agencies | Yes | No | Reason |
|---|---|---|---|
| CSSIW | | | |
| Estyn | | | |
| HIW | | | |
| HMI Constabulary | | | |
| HMI Probation | | | |

**Appendix 1** **Terms of Reference for CYSUR 5/2017 (CCPR)**

## Terms of Reference for Concise Child Practice Review

## CYSUR 5/2017 (Powys Concise CPR)

- **Nominated Safeguarding Lead** – David Johnston, Interim Head of Children Services, Powys
- **Review Panel Chair** – DI Elaine Bendle, Dyfed Powys Police
- **Independent Reviewer(s)** – Diane Beacroft, Pembrokeshire County Council

**Core tasks:**

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

**Specific tasks of the Review Panel:**

- Identify and commission a reviewer to work with the *Review Panel* in accordance with guidance for concise reviews.
- Agree the timeframe.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewer and Panel membership.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewer 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 contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft Child Practice Review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the CPR Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of

the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

**Specific tasks of the CPR Sub Group:**

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

**Specific tasks of the CYSUR Safeguarding Children Board:**

- Inform Welsh Government of the undertaking of a CPR.
- Adhere to timescales for completion, as per statutory guidelines.
- Receive and formally approve the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Send the report 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 Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

**Information Sharing and Confidentiality**

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

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

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

- In working with sensitive information in relation to a Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
  - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
  - The disclosure of information outside of the Panel beyond that which is

agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

- If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
- However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.