Concise Child Practice Review Report

CYSUR 2/2017

Date report approved by the Board: 24th January 2019

Draft Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Child Practice Review Re:
CYSUR 2/2017

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*

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 young person was a 15-year-old child, whose body was found alone in the outdoors. The young person was thought to have died sometime during the night having attended an outdoor party where it was suspected that young people had been using illegal substances. A post mortem toxicology report shared at the Inquest indicated that the young person prior to their death had used cannabis and MDMA excessively.

In the immediate weeks prior to death, the young person had increasingly started to go missing from home. There had been some involvement from a number of agencies but there had been difficulties concerning the engagement of the young person and their family. However, the door had remained open at all times for the young person and their family to re-engage, or to call upon agency support, if needed. There was an awareness of substance misuse issues and poor school attendance and engagement.

In accordance with procedures, a Procedural Response to Unexpected Deaths in Childhood (PRUDiC)[6], meeting was held. It was the perspective of members at that meeting that based on the circumstances of the sudden death, and the history, there should be a referral under the Child Practice Review process.

Time Period Reviewed and Why

In a Concise Child Practice Review (CCPR), the learning is focused on the last twelve months of the young person's life and this coincided with the point at which the young person had left mainstream school and transferred to pupil support services. The timeline to be reviewed was from the 8th April 2016 to the 8th April 2017. However, in order to understand the necessary context, the learning process did take account of relevant historic information.

It should be noted that at the commencement of the review process, there was an ongoing Police investigation and the review process was adjourned on the 30th May 2018 to await the outcome of the Inquest for the young person, which took place on the 19th September 2018.

Young Person's Family History and Contextual Information

The young person was at no point ever in the care of the Local Authority (LA) or subject to a Child Protection Plan. The young person lived at home and was one of a large sibling group.

The young person was described by their family and a friend, to be a loving, loyal, articulate person who was popular with their peers, but who was unable to say 'no' or to walk away from situations. The young person liked cycling, football, drumming and rhythm music, alongside maths and art. The young person had a sense of humour, and was gentle and protective of their close friends. At times, the young person could be stubborn, hedonistic and ambivalent. But when the young person did engage their progress and awareness was positive.

By the time the young person was in Year 9, they had been assessed as being unable to cope in a mainstream setting. The young person was identified, as academically capable, but was demonstrating challenging behaviours and high levels of absenteeism. The young person could become aggressive at home and during the time line of the review, their mother had requested respite care, on two separate occasions. The family had felt unable to cope or manage the presenting situation.

The Local Authority Families and Children's Social Services (FCSS), had previously known the young person and their family. There had been some limited involvement with the Youth Justice

[6] Procedural Response to Unexpected Deaths in Children (PRUDIC).

and Preventions Service (YJPS) alongside other agencies. The Child and Family Assessment and Support Team (CFAST), Team Around the Family (TAF) had offered parenting advice and support, alongside access to other services, but parental engagement to address concerns was extremely limited. Within the family and by the young person's own admission, there was a general mistrust of agencies.

A Child Protection Strategy Meeting was held under the 'All Wales Child Protection Procedures 2008'[7] in November 2016, due to escalating concerns regarding the young person going missing, and reports of their substance and alcohol misuse. As a result, safeguarding actions were agreed with agencies and interventions of support were offered to the young person and their family.

Alternative education provisions were put in place, but the availability of suitable provision became ever more limited because of the young person's previous exclusions from wider educational opportunities mainly due to unacceptable behaviour and poor attendance.

By March 2017, the young person was only willing to engage in education for two hours per day. The young person would often arrive late and substance misuse was a significant issue affecting their participation.

A Strategy Discussion was held on the 7th April 2017 due to the young person having three further missing Police reports, with an outcome, to proceed to hold a Strategy Meeting under the 'All Wales Child Protection Procedures 2008'[8].

There were two Accident and Emergency attendances as a result of the young person sustaining accidental injuries in 2017. On the latter occasion, they were missing from home. Throughout the timeline of the review, there was substantive evidence of substance misuse, with the young person using cannabis and disclosing that they had tried MDMA (ecstasy).

Over the timeline of the review, there was an escalating number of contacts made with the Police, due to missing reports (6), incidents of suspected substance misuse and drug dealing (14), and other incidents of anti-social and risky behaviour, and causing disturbances to others (8).

Repeated attempts had been made by the YJPS to engage the young person, both on an individual basis and within a setting context, following referrals and Bureau[9] appearances.

There appeared to be limited, inconsistent engagement on the part of the family and the young person (going through the motions, no significant change at reviews despite significant input, parent agreeing with professionals regarding required changes but then no sustained effort into making changes work, parent aligning themselves with certain professionals)[10]. However, a lack of clarity and confusion existed by the family as to what agency offered which provision or service.

Additional agencies, such as Substance Misuse Services were involved with the young person. Their engagement followed a referral made by Families and Children's Social Services (FCSS). Following an assessment of the young person, harm reduction and information sessions were provided with some productive engagement.

[7] All Wales Child Protection Procedures 2008.

[8] All Wales Child Protection Procedures 2008

[9] The Youth Offending Team, as a model of pre court division, first established the 'Bureau' in Swansea. It has now been extended as a model, across most parts of Wales, as in Ceredigion. It aims to provide young people the opportunity to be diverted out of the criminal justice system and provide them and their parents/carers, with the opportunity to access support services that may be able to meet their needs. It is a partnership between the Police, Youth Justice Services, and is supported by the Community Safety partnership. Engagement of the young person is voluntary.

[10] Indicators of Disguised Compliance, adapted by Reconstruct from Peterborough LSCB, Warwickshire LSCB, Stoke on Trent LSCB. Reconstruct 'Working with Difficult Dangerous &Evasive Service Users' Staff Development Programme.

The young person's involvement with education was complex. The Pupil Referral Unit (PRU) had referred the young person to FCSS, due to concerns surrounding substance misuse, risky behaviour and non-attendance, which accelerated considerably towards the end of the young person's life.

The young person's behaviour had also become more challenging, threatening and aggressive. However, when there was service intervention, following referrals made, or assistance requested, the situation would then improve, but only for short periods.

TAF engagement with the family was well received and this continued throughout, with the family being able to access services on an open access basis. TAF was also significant in offering extended support to the young person's family and friends, following the young person's sudden death.

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.

Agencies that were Involved with the Young Person

The agencies involved are listed on page 12.

Multi-Agency Partnership Working

- The young person was substantively supported by a wide range of agencies who worked effectively within their agency protocols. However, the young person may have benefited from a more holistic, co-ordinated person centred planning approach based on their daily situation, particularly when signs of risky behaviour escalated.
- Multi-agency meetings were held on a regular basis, organised by TAF, with some relevant partner agencies in attendance, but the appropriate people were not always invited. Such meetings may have afforded further opportunities for holistic working with the young person to analyse, inform and risk assess the emerging picture.
- Situations arising with the young person were dealt with based on a reactive approach, as opposed to considering a longer-term outcome/plan; at the time of their death, there was no multi- agency plan in existence to manage the escalating risky behaviour.
- There were notable discussions, referrals, information sharing and actions agreed. However, when there was no engagement by the family or the young person, the case was closed. Yet the presenting risks, behaviours, absenteeism and escalations which had given rise to the initiation of meetings remained.
- Individual agency record keeping was strong. However, professionals attending the Learning Event realised how much additional information was available concerning the young person. They acknowledged that had this been shared more widely, the risks in the young person's situation might have been more accurately understood. This in turn could have resulted in a Multi-Agency Referral to Children's Social Services, which could have provided an opportunity to put in place an appropriate plan to try and address the risks.

Identified Good Practice

Efforts were made to continually offer support and engage with the young person and their family and when the young person / family became closed to services there was always the opportunity for them to re-engage; an open door policy was maintained.

Family / Friend's Perspective
The family were very appreciative of the role of agencies that supported them both prior to and after the young person's death. The substantial support offered to the young person was appreciated.

Learning
There is a need for agencies to explain clearly their role and available services to families using an appropriate and person centred approach that is pertinent to their needs and understanding. Information should be shared collectively with all agencies supporting a young person in an accurate and timely manner in order to inform holistic, multi-agency risk assessments and support plans with escalation to the use of Child Protection Procedures if necessary. 'Risky Behaviour Plans'[11] aligned to best practice, can be implemented which show accountability, contain parental involvement, emphasising within them the voice of the young person and are fair, open and transparent.

Supporting Families with Complex Issues

- The young person was identified as having complex emotional, social and behavioural needs.
- Limited, inconsistent engagement was a contributory factor in the learning. Positive change was recorded on occasions by agencies but was not sustained.
- The young person presented challenge and had a discursive approach at times when working with a professional. The difficulty appeared to be finding a break through which would ensure sustained voluntary engagement, leading to improvement.
- Professionals from the Learning Event considered very carefully their decisions regarding closure of the young person's case. It was felt that the decision to close a young person's case where non-engagement is a significant factor should always be agreed using a coordinated multi-agency approach.

Identified Good Practice
A comprehensive range of support was available to the family on an ongoing basis. There was extensive resource provision put in place by the Local Authority to enable the young person to access educational and other provision.

Identified Good Practice
The young person was listened to and their voice was heard when they engaged. There were examples of them being able to share confidential information around their feelings and actions within both the home and external settings.

[11] Risky Behaviour/ Management Plan should be based on: Appropriate use of information, an estimation of likelihood and impact based on an assessment grounded in the evidence and communication with relevant others. Risk Management Plans should be well matched to the risks identified, appropriately resourced and delivered with integrity. Cwm Taf Safeguarding Children Board Risk Taking Behaviour protocol, December 2014.

Family / Friend's Perspective
The young person often said that they had a good relationship with their mother. However, there were occasions when the family felt alone and unable to cope with the young person's presenting behaviours. It was felt that the young person was affected and influenced by their peer group. Respite care was requested but not provided as an option. It was not clear to the parent why this was the case.

Learning
Agencies need to communicate in such a way that families understand the rationale for decisions, especially when their needs, requests, and/or expectations cannot be met. Skills training should be put in place for professionals to further develop person centred communication in order to improve engagement.

Risky Behaviour Identification, Assessment, Acknowledgement and Management

- The young person demonstrated sustained risky behaviour associated with substance misuse and low-level criminality along with a number of triggers as highlighted by a neighbouring authority protocol[12] for Risky Behaviours. Not least of those triggers was that the young person was associating with an older peer group, all of whom were over the age of 18 years, and known to the YJPS. There had been three incidents in a fortnight where the young person had been out in the early hours of the morning in the few weeks prior to their death. There was no evidence of a co-ordinated multi agency response in place. An Asset risk assessment had been completed but this was on a single agency basis at a time when there were an escalating number of concerns being raised with the Police: concerns due to missing reports, suspected substance misuse, drug dealing and other incidents of anti-social and risky behaviours. It is likely that safeguarding actions including an Initial Child Protection Conference (ICPC) would have resulted from the Strategy Meeting that was to be held at the time of young person's sudden death.
- Substance misuse for the young person was significant. Not only was there cannabis misuse but there was also an episode where the young person had taken their parent's prescribed medication and had passed it on to another young person. There was also disclosure that the young person had tried MDMA.
- The young person presented challenge in discussion with professionals and they noted the young person to have 'a poor sense of danger'.
- Whilst the young person was referred to Substance Misuse support services, their disregard in relation to the negative impact of substance misuse was a significant cause of concern for professionals.
- The inquest revealed through the post mortem Toxicology reports that at some point prior to their death, the young person had used cannabis. Reports also indicated, excessive use of MDMA prior to their death. Leading to the medical cause of death being recorded as 'MDMA Toxicity' and the conclusion of the Coroner was a verdict of 'Misadventure'.
- There were a number of records relating to the young person's risky behaviour held by agencies, including occasions when a Multi-Agency Referral could have been submitted to Children's Services.
- There was evidence of the parent requesting drug testing of the young person due to their concern over substance misuse.

[12] Pembrokeshire Safeguarding Children Partnership, Children and Young People with Risk Taking Behaviours, Multi Agency Protocol (September 2015).

- 'The Guidance for Substance Misuse Education'[13] – July 2013, provides detailed information relating to the delivery of appropriate substance misuse education according to individual requirements and specific need alongside, substance misuse incident management, including support, legislation and good practice. This remains in place for use within educational and outreach settings. Emerging from the Learning Event was a need to review the implementation of this Guidance and for professionals, to look at alternative ways to engage young people and to make them aware of the risks associated with substance misuse and the longer-term implications, not only with regards to themselves, but also the wider impact on their families and communities.

Identified Good Practice

The good relationship that Substance Misuse Services and the YJPS managed to develop with the young person through persistence despite them at times not wishing to engage to address their problems.

Identified Good Practice

The establishment of the Ceredigion Harm Reduction Partnership in April 2017. The forum brought together senior personnel from a comprehensive range of agencies to:

- Share information on existing harm reduction strategies and draw them together into a combined multi agency strategy;
- Plan new co-ordinated harm reduction strategies, and following agreement, arrange for their implementation, as part of a co-ordinated multi–agency approach; and
- Provide updates on activities of the partnership to other relevant Boards and Forums.

Identified Good Practice

Agencies demonstrated innovative practice by arranging community meetings for the parents of the young people who were presenting with risky behaviour issues in the community. These meetings were accessible, inclusive and contributed to some successful outcomes.

Family / Friend's Perspective

The young person's behaviour particularly around substance misuse was becoming difficult to manage causing issues and risks within and outside the home. Whilst professional substance misuse agencies were involved, there was felt by the family and friends to be no help with the young person's substance misuse; 'there was not enough being done about it and more needed to be done'. The young person had to give their consent, whilst engaging voluntarily and they would not. Siblings felt that there should be more drugs raids in schools and there should be a review of drugs education. Parents also needed to be more aware and informed. The young person liked to be with their friends and family. However, the area in which they lived had limited opportunities for young people to engage in activities.

Siblings and friends felt that in the future it would be beneficial for other young people to hear the young person's story as a learning experience.

[13] Guidance for Substance Misuse Education, Welsh Government July 2013.

Learning

The Multi Agency Harm Reduction Group will need to review the pathways and information sharing protocols of agencies in order to ensure agency awareness around the submission of MARFs and to ensure consistency and ongoing awareness raising as part of inter-agency good practice.

Learning

CYSUR the Regional Mid and West Wales Safeguarding Board has initiated work on the drafting of a regional multi agency 'Risky Behaviour Protocol', which will help to support and inform the safeguarding of young people who present with risky behaviours.

Learning

Messages conveyed in the taught environment must also be shared with parents and carers to enable reinforcement in the home environment. There needs to be further training, through a range of forums with parents, agencies and young people also being trained to be 'supportive friends'.

Learning

There is a need for increased resources to be made available to work with young people in an outreach capacity at source, not waiting for young people to voluntarily engage with services. Through the Harm Reduction Partnership, new co-ordinated harm reduction strategies will be planned and implemented via multi agency partners.

Learning

There is a need to review the effective implementation of The Guidance for Substance Misuse Education[14]' within settings. Professionals, in doing so, should look at differing ways to engage young people, to make them aware of the risks associated with substance misuse and the longer-term implications, not only in regard to themselves but also the wider impact on families and communities.

Management of Absenteeism / Educational Provision

- Absenteeism from educational provision was a significant factor in the issues that arose with the young person. The young person was academically able and at the outset of the timeline was capable, with engagement, of achieving qualifications.
- The young person was at the PRU following a very difficult and challenging time at school. Over the timeline of the Review, the young person was in year 11 of provision.
- Despite a number of exclusions, limited provision and presenting challenges, learning services continued to work with the young person and their family to provide opportunities and manage absence in accordance with their procedures.
- Historic actions had been taken regarding the absenteeism of the young person (there had been previous truancy sweeps and warnings about the importance of attendance and the role of parental compliance in this regard). Consideration was given at the Learning

[14] Guidance for Substance Misuse Education, Welsh Government July 2013.

Event to the use of legislative powers in year 11 and when/ if they should be applied – there was a tendency not to apply them in current practice.

Identified Good Practice

The allocation of continued resources to support the individual needs and transportation of the young person to alternative educational provision. Attempts that were made to listen to the young person, and to source work experience/opportunities, appropriate to what they vocationally expressed interest in.

Family / Friend's Perspective

The family felt that things had gone 'downhill' after the young person's exclusion from mainstream school. They felt that the school should have maintained the young person on their roll, and not 'turned their back on them'. However, they also acknowledged the extensive support given to the young person by support services.

Learning

There is a need to consider carefully the management of absenteeism for learners in year 11 and discuss through professional practice review, how the legislative approach, can / is applied to improve attendance.

Learning

To consider a wider engagement of local agencies and educational / training providers in the delivery of an alternative curriculum, for hard to engage young people.

Missing Persons

- **'**Every missing episode should attract proper attention from the professionals involved with the missing person and they must collaborate to ensure a consistent and coherent response is given to the missing person on his / her return' ('Guidance on the management, recording and investigation of missing persons[15], Association of Chief Police Officers, 2005). In compliance with legislation and guidance when the young person went missing, the primary objective was consistently to locate them and return them either to education or to the family home.
- The timeline, illustrated effective interagency working in this regard, resulting in Strategy Meetings / Discussions, following the three missing episodes of the young person from home. Where occurrences of the young person going missing from education occurred, matters were dealt with, in compliance with the All Wales Child Protection Procedures and the All Wales Protocol for missing Children[16] – Children who Run Away or Go Missing from Home or Care, (2011).
- Both the Police and Social Services were involved in transporting the young person home.
- Appropriate interviews / debriefs occurred when the young person was located within the required timescales. There were occasions when the parent of the young person was unaware that they were missing.

[15] Guidance on the Management, Recording and Investigation of Missing Persons, ACPO 2005.

[16] All Wales Protocol for Missing Children, All Wales Child Protection Procedures Review Group, July 2011.

Families Perspective
The young person would not tell their parent where they were staying; they would text and just say that they were 'staying with a friend.'

Learning
It was known by some agencies that a group of young people were moving around hostels, houses and hotels; agencies could have considered co-ordinated interventions and taken more direct action to resolve the situation.

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:

There was substantive practice put in place by agencies to support the young person, to endeavour to understand their needs, to recognise their abilities and to assist them with their engagement. The following learning has been identified to inform practice and systems improvement for the future:

Learning 1: All Agencies should action and Implement the Regional Safeguarding Board's Risky Behaviour Protocol within an agreed timescale following its publication.

Learning 2: All Professionals to be aware of the thresholds for the submission of Multi - Agency Referral Form[17] (MARF) as defined by the CYSUR, 'The Right Help at the Right Time for Children, Young People and their Families', Regional Thresholds & Eligibility Support document 2017. Utilising them, holistically, to report and share safeguarding concerns in a timely manner, enabling a targeted response to presenting / escalating issues.

Learning 3: To further develop individualised alternative educational provision / planning, taking into consideration wider multi agency curriculum / pastoral support offer, where appropriate, which reflects the individual needs of a young person.

Learning 4: To ensure that education absenteeism procedures are equally applied for all pupils of statutory school age.

[17] Multi Agency Referral Form (MARF) CYSUR Mid & West Wales Regional Safeguarding Board 2017. ' The Right Help at the Right Time' FOR Children, Young People and their Families. Regional Thresholds and Eligibility for Support Document. A Mid and West Wales Collaboration, April 2017.

Learning 5: Schools and the PRU to review compliance, with the 'Guidance for Substance Misuse Education'[18] (July 2013), in their annual safeguarding audits. Ensuring that children, young people and parents are aware of the procedures for dealing with substance misuse incidents and understand the implications for them, if young people are engaged in such activities. All local schools should be accepting of input from Barod and enable them through their annual campaigns to raise awareness of the issues associated with substance misuse.

Child Practice Review Process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A Learning Event was held and services that attended*
- *Family members had been informed, their views sought and represented throughout the Learning Event and feedback had been provided to them.*

At the PRUDiC meeting, it was the perspective of members that based on the circumstances of the sudden death and the young person's history that the matter should be referred for consideration under the Child Practice Review Process. The matter was considered at the Local Operational Group (LOG), with a recommendation made to the Chair of the Regional Safeguarding Board. The Chair approved that a Concise Child Practice Review should be undertaken.
The services represented on the Review Panel were as follows:

- Team Around the Family (TAF);
- Wales Ambulance Services NHS Trust (WAST);
- Police;
- LA Families and Children's Social Services;
- Health;
- Education;
- Youth Justice Prevention Service (YJPS); and
- Substance Misuse Services.

An Independent Reviewer was commissioned. Who was, in accordance with the guidance, independent of the case management and who had the relevant experience, abilities, knowledge and skills as required by the case.

In accordance with the guidance, a Learning Event was held on the 7th February 2018, facilitated by the Independent Reviewer, attended by professionals from the following agencies:

- Team Around the Family (TAF);
- Wales Ambulance Services NHS Trust (WAST);
- Police;
- LA Families and Children's Social Services;
- Health;
- Education;
- Youth Justice Prevention Service (YJPS); and
- Substance Misuse Services.

[18] Guidance for Substance Misuse Education July 2013 Welsh Government.

The young person's family were fully engaged with the Review process. They were spoken to, during December 2017, by the TAF Co-ordinator and then subsequently written to by the Independent Reviewer. A meeting with the Independent Reviewer and the family joined by a close friend of the young person followed. The family's views, recollections and feelings, were then conveyed at the Learning Event, by the Independent Reviewer and included within the learning; they were also taken into consideration as part of this report. The family have received updates through the Review process and have been offered a further meeting with the Independent Reviewer prior to the publication of the Concise Child Practice Review.

The Learning Event afforded the professionals concerned the opportunity to consider their involvement, practice, assessments and decision-making processes that concerned the young person's life. They were able to consider the following questions, using the methodology of 'Signs of Safety'[19] :

1. What were the areas of practice that went well and were there any areas of good practice that could be identified?
2. What did agencies feel had not gone well?
3. What would agencies do differently (reflecting on their decision-making, assessment /professional practice) and what have they learnt as a result?
4. What are the actions that agencies will now take going forward, to ensure their learning informs their future practice and systems delivery?

Evaluations from the Learning Event recorded a very successful event, where learning had taken place at both a service and individual professional level. Actions to improve services and practitioner working were identified and reflected in the Review.

Family declined involvement: No

[19] Turnell Andrew & Edwards Steve: Signs of Safety (A Solution and Safety Orientated Approach to Child protection Casework), USA, WW Norton & Company, 1999.

Statement by Reviewer(s)			
Reviewer 1	Maxine Thomas	**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: • 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, 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, 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)*	Maxine Thomas	**Name** *(Print)*	……
Date	……	**Date**	……
Chair of Review Panel …… *(Signature)*			
Name *(Print)*	……		
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 2/2017 (CCPR)

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 time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete the Proposed Initial Outline of Review document, which includes information regarding the 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 1998*[20] when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR Sub Group:

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

Tasks of the CYSUR Safeguarding Children Board:

- Inform Welsh Government of the Board's commissioning of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored

[20] Key Principles of the Data Protection Act 1998

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.