Concise Child Practice Review Report

CYSUR 2/2020

Date report presented to the Executive Board:

24th January 2023

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Review Re:
CYSUR 2 2020

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 and West Wales Safeguarding Board, on the recommendation of the Child Practice Review Sub Group in accordance with the Social Services and Wellbeing [Wales] Act 2014[1], and accompanying statutory legislation in section 139 of the guidance in Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016)[2].

The criteria for this review are met under section 3.4 of the guidance, namely:

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 of 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[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 & Procedures) (Wales) Regulations 2015[4].

The purpose of the review is to identify learning for future practice. It involved practitioners, managers and senior officers exploring the detail and context of agencies working with a child and their family. The output of the review is intended to generate professional and organisational

[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 refeed to in S.28 of the *Children Act 2004* or body mentioned in s.175 of the *Education Act 2002*.
[4] The Safeguarding Board (Functions and Procedures) (Wales) Regulations 2015; Reg 4 (3)

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 on what needs to be done differently to improve future practice. (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016[5]).

Circumstances Resulting in the Review

The CYSUR 2 2020 Concise Child Practice Review was commissioned by CYSUR, the Mid and West Wales Safeguarding Board following a referral to the Child Practice Review sub group. This is a tragic situation that involved the sudden unexplained death of an infant (SUDI)[6] which occurred in the spring of 2019. The infant was almost 12 weeks old at the time of their death.

In the events leading up to the infant's death, the infant's teenage parents had been out with friends enjoying a night out whilst the infant was cared for by their grandparents and collected the next day by both parents who were tired and hungover. That night, the parents had friends to stay, one of whom was a 16-year-old child. After the last feed, the infant was settled in their Moses basket downstairs in the living room and both parents fell asleep on the sofa, one friend slept on a chair and the 16-year-old went up to bed. At some point during the night, the infant's mother woke up on the sofa and went upstairs to bed. The following morning, the infant's father woke up on the sofa and could not find the infant in the Moses basket. He found the infant in the corner of the sofa facing inwards, who was cold and lifeless. The infant's father called an ambulance, reporting that he thought he had killed his child. The emergency services attended and cardiopulmonary resuscitation (CPR) was attempted, however, sadly, 'Recognition of Life Extinct' was recorded by the first responders and the infant's death was later certified at the hospital.

In accordance with the procedures for a Professional Response to an Unexplained Death in Childhood (PRUDiC)[7], a meeting was held whereby the professionals agreed that a referral to the Child Practice Review subgroup should be made to ascertain any learning for agencies involved in this case.

A police investigation was immediately initiated and the infant's father was arrested at the hospital under suspicion of causing the infant's death through neglect, based on comments made during the initial report to the ambulance service. Toxicology tests found the father to be positive for various class A drugs at the time of the incident, however, it could not be established whether he was under the influence of such substances on the night of the infant's death. The pathologist concluded from their evidence that the case involved a sudden unexplained infant death. Co-sleeping[8] was highlighted, however, it could not be determined if this contributed to the infant's death.

The police enquiry concluded with no further action to be taken. The rationale was based on the lack of certainty around the cause of death and clear evidence of culpability. The case was considered by the Powys coroner and a narrative verdict was established which included *"(The child) died whilst co-sleeping with his father. The precise circumstances of which are unknown*".

[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)
[6] https://www.lullabytrust.org.uk/safer-sleep-advice/what-is-sids/

[7] Procedural Response to Unexpected Deaths in Childhood (PRUDIC) 2018
[8] Co-Sleeping – sleeping with baby on a bed, sofa or chair which can occur intentionally or unintentionally

Time Period Reviewed and Why

The maximum period of 12 months was agreed for this concise child practice review, covering the period between 20th May 2018 and 20th May 2019. The independent reviewer, panel chair and review panel felt it was beneficial to incorporate agency timelines for the parents as they were both open to the leaving care team at the time of the critical event. Therefore, the overall timeline reflects the work undertaken both individually and collectively as a family during this period.

The timeline, chronologies and analysis submitted by all agencies were discussed in detail during the panel meetings, at the learning event and have informed the learning included within this report.

Family History and Relevant Contextual Information

This information falls outside of the timeline and scope of the review, however, is considered to be relevant contextual information to help gain a better understanding of the context of which the event and infants death occurred.

Both parents experienced adverse childhood experiences (ACEs)[9] resulting in disrupted and chaotic childhoods with compromised parenting having been exposed to harmful levels of domestic violence, parental substance misuse and neglect, including several referrals to social services resulting in both being looked after by the Local Authority.

The infant's mother was subject to protective planning during her early to mid-teens. She was registered on the child protection register under the category of neglect and was looked after for a short period of time. Her background reflects a complex history of instability through disrupted living arrangements, as well as behavioural problems, self-harm and a single incident of attempted suicide. Child Sexual Exploitation (CSE)[10] and drug use were noted as concerns and plans were made to manage the risks via a Sexual Exploitation Risk Assessment Framework (SERAF)[11]. There was no evidence found in the records that showed the SERAF plan being formally ended, however, there were no risks of exploitation identified during the mother's pregnancy.

The infant's father was subject to a Full Care Order from his early childhood and this ended in 2017 when he turned 18. He was stable in Local Authority foster care until adolescence, when he became involved in low-level criminal activity and his long term placement broke down. In 2015, he returned to live with his mother before he went on to experience further instability, spending time sofa surfing and experiencing homelessness.

Historical files and records indicate leaving care support was not provided in accordance with statutory requirements with significant gaps, for example, there were no Pathway Plan Reviews undertaken between age 16 and 18. The provision of support was inconsistent and sporadic, resulting in difficult and distrustful relationships with professionals. Engagement with services improved just prior to father's 19th birthday, when he began to engage with his Personal Advisor, IRO and Pathway Plan Reviews. Ongoing concerns regarding father's emotional health linked to unresolved childhood trauma which had not been addressed and outstanding life story work from childhood are referenced and noted as part of these reviews.

[9] Adverse Childhood Experiences (ACEs) are stressful events during childhood that can have a profound impact on an individual's present and future health

[10] Welsh Government (2021) Working together to safeguard people: volume 7 – safeguarding children from child sexual exploitation (PDF). [Cardiff]: Welsh Government.

[11] SERAF refers to the risk assessment framework applied in practice at the time of this review

The infant's parents' support network consisted of the mother's previous foster carers, with whom she had maintained a relationship, and her parents. There had been no change recorded in the grandparents' lifestyles or recorded risks. At the time of the learning event, professionals were concerned that child protection concerns had been raised again within the infant's maternal family. The infant's parents were considered able to manage their relationships with their families independently and protect the infant from situations or individuals that could present a risk to them or their child.

Just prior to the review timeline, a Domestic Violence Disclosure Scheme application under Clare's Law[12] had been requested. An assessment found that the father did not have the relevant history of violence or domestic abuse to justify any formal disclosure. Police provided advice and guidance to the mother on keeping safe in relationships.

Organisational Context

It is important to consider and understand the organisational context in this case, as this extremely sad and tragic event occurred whilst the Local Authority was subject to an improvement plan following the Care Inspectorate Wales inspection in 2017[13].

> "*Children and young people do not appear to be well served by the current arrangements for accessing support services in Powys. A lack of assessment, care and support planning combined with an inconsistent approach to working in line with the child sexual exploitation guidance and the management of sexual exploitation and risk assessment framework process placed children at risk of harm. In addition, child protection processes did not always comply with statutory guidance with delays in investigations and assessments being undertaken and completion of statutory visits." (CIW 2018)*

Both case holding social workers for the infant were agency staff and are no longer employed by the department, therefore have not taken part in this review.

As a result of the improvements made in safeguarding practice within Powys since this inspection occurred, Powys County Council have been removed from enhanced monitoring and are no longer subject to a performance improvement plan. In September 2020, CIW found the local authority had made significant progress, with areas of strength identified in respect of leadership and management, partnership working and early intervention and prevention in children's services. This notable improvement in safeguarding practice in Powys must both be acknowledged as a reflection of the dedication of the Local Authority to address the shortcomings identified in the initial CIW inspection, and must also be borne in mind when reflecting upon the findings of this review which have occurred to safeguarding practice since the events captured within the timeline.

Circumstantial Summary

The infant was the first-born child for both parents, who at the time, were both teenagers. As stated, father was a category 3 care leaver, supported by a personal advisor (PA) and subject to Pathway Planning. The mother, although not technically eligible for leaving care statutory services, was supported via a Care & Well-Being care plan as a result of her identified need. At the time of the infant's death, the department were meeting their statutory responsibilities in

[12] Clare's Law has two functions which is 'right to ask' (ask about a partner's history regarding domestic violence from the police) and 'right to know' (police can disclose information to an individual if they deem it necessary).
[13] https://www.careinspectorate.wales/sites/default/files/2018-03/171017powyschilden.pdf

relation to their obligations under Care Leavers (Wales) Regulations 2015[14], in contrast to the two year period as previously identified where there were no statutory reviews undertaken.

During the period of mother's pregnancy and in the period leading up to the infant's death, a number of agencies and support services were being provided to the parents with varying degrees of engagement. Pathway plan reviews undertaken during this period note support from the PA being provided primarily via telephone contact to father and focussed upon 'developing frustration management strategies' and to 'think through his role as a father'. Although the subsequent Pathway Plan review noted an apparent improvement in father's maturity and ability to manage his emotions, he failed to attend an initial assessment at the Local Primary Mental Health Service in relation to concerns around his low mood, and was subsequently discharged for non-engagement. Records indicate none of the professionals involved were aware of this, and ongoing work with the PA and the pre-birth assessment continued to focus upon unresolved trauma and emotional regulation. Ongoing concerns regarding father's low mood are noted to be recorded throughout the full timeline. The father was known to Dyfed Powys Police for drug-related offending, and at the time was under investigation for possession and supply of class A drugs, with the outcome of a custodial sentence a realistic possibility. Throughout the timeline, 11 intelligence reports concerning the father's involvement in drug-related activity were logged by the police, 10 of which were actioned for internal information sharing only.

The parents were living in temporary accommodation and were being managed under homeless legislation. For a period of time, they were both in employment, appeared more settled and were being seen regularly by professionals. In August 2018, the young couple accepted a secure tenancy and moved to a new area. Unfortunately, following this, father lost his job and they fell into debt with mounting rent arrears. Several attempts to support the couple in resolving this were made throughout via telephone calls with no success. Home visits were not offered, which, on reflection, may have provided an opportunity for the housing officers to gain a fuller picture of the parent's financial situation. After several failed attempts by housing to establish a repayment plan, the arrears were eventually cleared by Children's Services, and the housing officers' direct involvement ceased.

In the months leading up to and immediately following birth, the infant's mother experienced a healthy pregnancy and straightforward birth. She engaged with all antenatal and postnatal visits and sought advice when needed. The couple lived in a Flying Start area and received home visits by the midwife and their Health Visitor. Whilst the infant's father was present for some appointments, the focus of the visit and conversations were centred around the mother. The infant's mother was offered universal antenatal classes focussing on preparing for the delivery, however it is not recorded whether she attended these or not. The enhanced elements of the Flying Start programme such as parenting programmes or Nursery Nurse support were not, however, offered during the antenatal or postnatal period.

The mother describes her baby to have been a very happy baby, who fed and slept well and enjoyed hearing music playing.

The infant's mother was seen alone on four occasions by the midwife during her pregnancy, with the routine domestic abuse enquiry completed during one of these visits, and no concerns were identified. SIDS advice was provided to the infant's mother on three occasions by the midwife and reiterated at three of the four postnatal visits as the infant's parents were observed not to be

[14] Care Leavers (Wales) Regulations 2015

following this, in that the room temperature was too high, the infant was observed wearing a hat inside and there were bumpers and toys in the Moses basket. Despite this, the infant was observed by the Health Visitor to be developing well and no other concerns noted.

A Care & Support meeting took place on 13th February 2019 and was attended by the midwife. A verbal handover took place between the midwife and the health visitor. Children's Services had not shared the minutes with health as would be expected, therefore the health visitor was not aware of the full extent of the concerns held by social services.

On 30th September 2018, Dyfed Powys Police responded to a call reporting concerns of a verbal domestic incident at the couple's home, where there was also recorded to be a strong smell of cannabis. This triggered a Domestic Incident Report to Children's Services and a decision to undertake a pre-birth risk assessment. The assessment recorded the father to have made progress in that he was applying coping strategies, however, his unresolved trauma and maladaptive behaviours to stress/challenge remained a concern and he continued to be advised to seek an appointment with the GP. As referenced previously, it was not known that he had already been closed to mental health services due to non-engagement. Irrespective of the positive progress noted, in November 2018, the Service Manager overruled the assessment authorised by the Team Manager, where the social worker recommended the family to be supported by preventative services, and considered a more in-depth assessment was needed that took into consideration and further explored the parents' complex adverse childhood experiences and how this may impact upon their own ability to parent. Unfortunately, there was a significant gap of 6 weeks between this decision being made and the parents being informed of the outcome, at which point the mother was 32 weeks pregnant.

Relationships between the parents and social services deteriorated significantly at this point, with both parents expressing frustration they were being given mixed messages by social workers regarding the outcome of the assessment, the future plan and what was expected of them. A month later, in mid-February 2019, the first Care & Well-Being planning meeting took place with the parents being introduced to their new social worker. The formal transfer was recorded to have occurred two weeks thereafter and the infant was born three days after that, on 28th February 2019. Following the birth, two social work visits took place in the first two weeks and the infant was next seen by the social worker at a Care & Well-Being planning three weeks later. Records show a significant gap of 6 months in total from the date of the completion of the pre-birth assessment in November 2018 to actually commencing the follow up-assessment, which did not commence until 16th April 2019, at which point the infant was 6 weeks old.

In early January 2019, at around 32 weeks pregnant, records indicate a MARF was actioned following police receiving intelligence regarding drug dealing from the parents' home address over the Christmas period. However, there is no record of the MARF on Children's Services records, and the Police did not follow this up. As a result, no strategy meeting was convened or any further action taken.

Records indicate continuing and escalating concerns regarding parents' lifestyle in the following weeks, in the latter stages of pregnancy and in the first weeks following birth, with reported smells of cannabis in the home noted by the social worker and health visitor during a joint visit, and reports made by the father to his PA regarding daily arguments in the home and missed health visitor appointments. The records do not support or indicate the parents were ever asked about

the smell of cannabis in the home or that the information shared with the PA was ever passed on or shared directly with the social worker.

On the 17th April, when the infant was 6 weeks old, a serious incident of domestic abuse occurred in which father assaulted mother whilst the infant was present in the room, and furniture was smashed. Both parents contacted their respective workers on the same day to report the incident, and the mother's well-being worker supported her to share the information with the infant's social worker, however, the parents' workers failed to submit a MARF, and the social worker failed to complete a strategy request form in line with the council's practice process. Therefore, this incident did not trigger a strategy meeting or Section 47 investigation[15]. A home visit was not undertaken by the social worker until a week later, in which the parents were noted to have ended their relationship, with mother advising professionals of her plan to not allow any unsupervised contact between the infant and father. The case continued to be managed via continuation of the in depth Pre-Birth Care & Well-Being Assessment, however, tragically, the infant died before the assessment concluded.

The infant was seen at 9 weeks for his routine developmental assessment on 2nd May 2019 where the Health Visitor noted a smell of cannabis and a decline in home conditions. Although the couple reported they were still in a relationship, they reported father was not sleeping in the home every night.

A further domestic incident regarding the parents was reported to Children's Services on 13th May concerning the mother screaming at the father whilst holding the infant. The infant's social worker was on annual leave, therefore, the duty worker spoke with the mother over the phone, who denied the allegation and explained a low-level argument had taken place. Again, this incident did not trigger a strategy meeting or Section 47 enquiry. In the following few days, the infant's mother reported to her well-being worker that the relationship was back on track and that things were going really well. The infant's father continued to sofa-surf with friends some nights and visited the family home after work to help out with the infant's care. A few days later on 20th May 2019, tragically, the infant died.

Other than the outcome of the first pre-birth assessment being overruled by the Team Manager, there is no clear evidence of management oversight or supervision of the infant's case, either in the timeline or the records.

Parents' involvement in the review

The family's views are an important element of the review, to enable professionals to learn from their experience of their involvement throughout the time period and to glean any learning to inform future practice. In this case, both parents contributed to the review, which the panel is extremely grateful for and acknowledges how difficult this will have been for them both. The Independent Reviewer, Panel Chair and Panel Members extend their thanks to both parents, who agreed to meet with the Independent Reviewer and the Panel Chair. The infant's father attended in person with support from his Personal Advisor, and the infant's mother was interviewed via telephone.

[15] The purpose of s47 (Section 47 Children's Act 1989) enquiries is to establish whether a child is suffering or is likely to suffer significant harm and requires intervention to safeguard and promote their well-being. It commences once a strategy discussion/meeting decides that the evidence indicates such enquiries are necessary.

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 member's perspectives, evidence about practice and its impact, contextual factors and challenges.

The following themes were drawn from the timeline, agency analysis and the learning event:

- Cumulative Risk Factors: *domestic violence, substance misuse and mental health*
- Children of Looked After Children & Care Leavers; assessment & support
- Co-sleeping
- Information Sharing

Theme 1 – Cumulative Risk Factors: *Domestic Violence, Substance Misuse & Mental Health*

The cumulative level of risk in the home environment, particularly the combination of escalating domestic abuse incidents, the unknown level of substance misuse, and the infant's father's emotional and mental health were not fully understood, with no one agency having the complete picture. The significant gap between the decision to undertake a more comprehensive pre-birth assessment and this starting resulted in missed opportunities to fully understand the risks, therefore no clear plan was in place at the time of the birth.

Professionals at the learning event highlighted that the professionals involved could have strengthened their professional curiosity[16]. The NSPCC's Domestic Abuse: learning from case reviews paper (2020)[17] outlined the importance of professionals not being too reliant on information from parents, and should exercise professional curiosity and remain curious about claims that domestic abuse is not taking place, and that practitioners need to be aware that victims and perpetrators may not recognise the relationship is abusive. The gaps in assessment and information sharing resulted in missed opportunities for a more comprehensive plan to be put in place which may have helped professionals understand, provide support and reduce the risks. The parents both reported the serious domestic incident to their respective workers, however, this did not result in a MARF, which would have been expected given the level of violence with the infant, then 6 weeks old, being present at the time. Both this incident and the one thereafter should have resulted in section 47 enquires which would have considered threshold for an Initial Child Protection Conference, with a future missed opportunity for multi-agency intervention and protective action to be considered.

Health colleagues identified three missed opportunities during the antenatal period for midwifery services to undertake the routine enquiry into domestic abuse required within the All Wales

[16] Professional Curiosity is a golden thread through Child and Adult Practice Reviews and is an essential part of safeguarding and a fundamental aspect of working together to keep children, young people and adults safe https://go.walsall.gov.uk/Portals/37/01%20Professional%20Curiosity%207%20minute%20briefing.pdf?ver=2020-06-18-133031-307 CYSUR's information page on Professional Curiosity page can be found here.

[17] NSPCC (2020) Domestic Abuse; Learning from case reviews; https://learning.nspcc.org.uk/media/1335/learning-from-case-reviews_domestic-abuse.pdf

Pathway[18]. Nevertheless, good practice was identified within the Health Visiting Service, with the routine enquiry being asked at 3 out of 4 visits, although each time this concluded as negative and no concerns noted. They suggested their internal processes for managing Domestic Incident Notifications (DIN) could be strengthened by providing clear, service specific guidance for practitioners to follow in response to the DIN and by looking at how the domestic violence questionnaire is asked again when an incident has happened and prompt the family to be contacted.

The learning event reflected professionals involved were overly optimistic about the infant's father's ability to address his periods of low mood independently, and the true extent of his reported cannabis use was unknown. Throughout the timeline, there were many examples of either the father saying he will attend the GP or professionals advising him to see the GP, however, his behaviour clearly indicated he was either unable or unwilling to manage this independently. Professionals felt his mental health and substance use could have been explored further and alternative approaches, such as substance misuse services, would have been appropriate. In this case, professionals attending the learning event felt those involved with the family relied too heavily on the parents' self-reporting, which they used to inform their assessments.

The NSPCC (2020) found the perception that mothers are responsible for the care and protection of their children led some practitioners to rely too heavily on a mother's ability to keep her child/ren safe from abuse. They found this was particularly the case if a father was absent or not engaged with services and highlighted if practitioners do not engage fully with the men in a child's life, a man's role in the family can be overlooked, meaning practitioners are unaware of the man's potential to protect or harm the child. This can be applied in this case as the review acknowledged that whilst the father was in telephone contact with his PA, he had not been seen by them or the social worker, and the mother's reassurances in maintaining the separation and supervised contact were accepted.

Similarly, The National Child Safeguarding Review Panel (NCSRP 2020)[19] in their thematic review identified missed opportunities to identify changing family circumstances due to overly optimistic assumptions about maintaining protective behaviours or in maintaining restricted contact arrangements, all of which can be applied appropriately in this case. Professionals at the learning event reflected it can be difficult to know how far to go when the victim does not feel ready to share information about the abuse they are experiencing, or other risks within the family and identified missed opportunities for professionals to exercise their professional curiosity throughout the pregnancy and following the birth whereby attempts to see the mother formally on her own were not made. It would have been appropriate for the family to be supported with developing a safety plan at the outset. As highlighted by the NCSRP, the 'what if' discussions with young mothers was seen to be more effective when considering information on risk situations.

In summary, whilst there are some examples of good practice, this is overshadowed by poor professional practice and a lack of management oversight on the infant's case, resulting in a failure to instigate child protection procedures on three separate occasions, particularly the serious domestic incident involving furniture being smashed. As discussed, all professionals involved

[18] The All Wales Ante Natal Domestic Abuse Pathway (Pathway) is a legal record of care provision which provides Midwives and Health Visitors with an evidence-based, structured approach to encourage disclosures of domestic abuse and to assess the level of risk faced by the woman and unborn child.

[19] National Child Safeguarding Review Panel (2020) out of Routine: A Review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm; https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

were overly optimistic and did not consider the cumulative risk factors i.e. teenage care leavers, poor childhood experiences, emerging and increasing concerns regarding drug use, domestic abuse and mental health. There was no clear plan in place for the birth or during the postnatal period, which could have been more robust around the infant's father's presence in the house and contact with the infant.

Identified Good Practice

Health:

The Health Visitor undertook the routine enquiry into domestic abuse with the mother on three occasions.

Parents' Perspective

Mother:

The infant's mother felt strongly that professionals should have intervened, despite her concealment of the domestic abuse going on and the true extent of the father's drug use and involvement with drug-related crime. Consequently, when the serious domestic abuse incident happened and she was no longer able to hide the abuse, she was expected to be able to safeguard the infant by herself. At that point specifically, the mother felt professionals should have supported her and acted further as she felt she could not be honest and ask for help through fear of her child being removed or repercussions from drug dealers.

Although the Health Visitor completed the domestic abuse screening, from the mother's perspective she had no information on domestic abuse and no advice on how to get out of the relationship. The main point the mother was keen to make for this review is that from her experience, when a person is in a domestic abuse relationship, they will say everything is fine and professionals should understand and expect this.

The mother's perception of the different assessments and levels of support available was confusing. She would have valued more information to understand the different processes and what this meant for her and her child e.g. Pre-birth; Care & Support; Child Protection; Care Proceedings.

Father:

Although not in the scope of the review, the father's perceptions of the poor and inconsistent support he received from Children's Services during his childhood and as a care leaver meant that he had no role model or opportunity to learn how to be in a relationship and the absence of his life story work clearly impacted on his ability to trust professionals. He also felt strongly that in his earlier teenage years, he was judged and treated by professionals as a criminal rather than understanding that his vulnerabilities could be exploited which compounded his lack of trust in the professional network around him and his feeling of being let down.

Learning

All Agencies

- All agencies to exercise professional curiosity in the work with families and respectfully question and triangulate information. All agencies to ensure an understanding of the complexities of domestic abuse, including coercive control[20] and how victims may conceal or deny abuse, together with the non-linear way in which abuse can occur/escalate[21] underpins practice.

Health:

- Consider strengthening the practice process for managing domestic incident notifications (DIN) by providing specific guidance for practitioners to follow in the receipt of the DIN.

Social Services:

- Internal systems and practice processes in respect of internal MARF submissions, screening and outcomes must be clear, robust and embedded in day to day practice
- It is essential that child protection procedures are understood by all operational officers across the Social Services Directorate.
- It is essential for all departments to work in partnership together to build trust and transparency with families.
- Safety planning should be central to the assessment work and undertaken with parents and families at the early stages of their involvement. Parents and families must be supported in understanding potential risk situations and what action they need to take to keep their children safe and protected from harm.

Theme 2 - Children of Looked After Children & Care Leavers; assessment & support

Children's Services knew both parents well; as mentioned, professionals were acutely aware of the father's mistrust of professionals and how this could manifest into angry outbursts, however, the PA worked hard to develop a positive relationship and keep in touch, which led to the father re-engaging with his pathway plan and IRO. Good practice was highlighted, with Children's Services going over and above their statutory duty for both parents, with the IRO involvement post-18 in respect of the father and a Care and Support plan in respect of the mother. There was some evidence of joint working between Children's Services Teams. The agency analysis identified the importance of the leaving care and assessment teams to work in partnership without losing the parents' trust. Roberts (2021)[22] undertook a Wales wide study on the outcomes, experiences and support to young parents in and leaving care and found leaving care practice could be strengthened with clear practice guidance and advice on circumstances that require a MARF, as well as managing the challenging dual roles and responsibilities of supporting young

[20] Coercive control refers to the psychological element of domestic abuse which consists of an ongoing set of behaviours designed to coerce the victim and maintain control over the victim It is thought by many experts in the field to underpin the majority of cases of domestic abuse (see, for example: Iain Brennan and Andy Myhill, 'Coercive Control: Patterns in Crimes, Arrests and Outcomes for a New Domestic Abuse Offence' 2021 62(2), BRIT J CRIMINOL 468–483)

[21] Charlotte Barlow and Sandra Walklate, 'Gender, risk assessment and coercive control: contradictions in terms?' 2021 61 BRIT J CRIMINOL 887–904

[22] Roberts, L. (2021) 'The Children of Looked After Children' Bristol University Press. https://www.exchangewales.org/supporting-parents-in-and-leaving-care-messagestocorporateparents/

people alongside safeguarding responsibilities. In this case, the serious domestic incident when the infant was 6 weeks old should have resulted in the leaving care team submitting a MARF.

The quality assurance and management oversight of the pre-birth risk assessment was highlighted as good practice. However, in addition to the missed opportunities resulting from the practice after that point, the timeline showed that leading up to and following the birth, professionals were at times working in isolation. Professionals highlighted the need for robust assessment around pre-birth, with the importance of involving midwifery and including them in that assessment from the start. In response to this tragic event, the Council developed a Pre-Birth Pathway[23] which has been endorsed by CYSUR, The Mid and West Wales Safeguarding Board and rolled out across the region.

Good practice was noted with the midwife and Health Visitor providing home visits; they each developed a good rapport with the mother and made the father feel included during their visits. However, opportunities for early intervention and prevention support were missed as no targeted or specialist support services were made available to the parents in either the antenatal or postnatal period. The enhanced Flying Start programme would have been appropriate given they were young parents and the father was a care leaver expecting their first baby, even more so as the cumulative risks were emerging. Particular focus on the father's involvement and preparing for fatherhood could have been strengthened.

The independent reviewer and panel chair identified good practice from Dyfed Powys Police in their response on the day of the infant's death. The rapid response to the critical incident meant appropriate support for the parents was provided swiftly and the father's mental health was a key consideration during the arrest and investigation, with appropriate referrals to mental health.

The review and learning event identified that close working relationships between housing officers and social workers naturally evolved as the departments were co-located. However, with a lack of formal strategy or policy, partnership or joint working approaches were heavily reliant on individual practice. Good practice was noted from the housing officer who was persistent with contacting the parents to address their rent arrears, however, this could have been extended further through home visits. Professionals at the learning event reflected a more formalised approach would have been beneficial as this would have provided a more holistic approach to housing related support. In response to the requirements set out in the Future Generations and Well-Being (Wales) Act 2015[24] and the Welsh Governments subsequent Hidden Ambitions Strategy (2018)[25] for social services and housing to work together to help plan a young person's move to independent living, the council is in the process of launching a revised practice approach which intends to see a more holistic view to the support provided, with members of housing working much more closely with Social Services.

The absence of specific policy and practice guidance in respect of working with young parents who are care leavers has clearly impacted on the professional response in this case in relation to referral, assessment and support. Whilst the pre-birth pathway policy developed in response to this tragic event goes some way to addressing the gaps, this is centred on assessment criteria. As identified by Roberts (2021), it is essential for responsibilities to be clarified and corporate parents to strengthen their responses to young parents in and leaving care. Therefore, it is

[23] Mid and West Wales Safeguarding Board Multi-Agency Pre-Birth Pathway (2020)

[24] Welsh Government (2015) Shared Purpose: Shared Future: Statutory guidance on the Well-being of Future Generations (Wales) Act 2015. Available at: https://gov.wales/well-being-future-generations-wales-act-2015-guidance

[25] Hidden Ambitions - Children's Commissioner for Wales (childcomwales.org.uk)

recommended that further policy and practice guidance is developed to bridge this gap and suggest that agencies consider developing a local response to The Charter[26] published by CASCADE (2021) which sets out the range of support that should be available to young people before and after they become parents, and that this information is readily available to them.

Identified Good Practice

Social Services:

- There is evidence that the Personal Advisor's tenacity was clear, as it was difficult to arrange home visits due to the infant's father's work commitments, and this approach secured a trusting relationship, which was the first time the infant's father felt positive about a support worker.
- The leaving care service went above and beyond their statutory duty for both parents with the provision of an IRO for the father and a Well-Being worker for the mother.
- Good level of quality assurance and management oversight of the initial pre-birth assessment.
- CYSUR, Mid and West Wales Safeguarding Board have developed and implemented a Pre-Birth Pathway in response to this tragic death.

Housing:

- Housing officers worked with the couple to try and maximise income to avoid action being taken to address rent arrears.

Health:

- Home visits were undertaken by the Midwife and Health Visitor.

Parents' Perspective

Father:

Although good practice has been highlighted in relation to the Police investigation, from the father's perspective, in contrast to the kindness and compassion showed by the officers who attended the family home, the arrest that followed was insensitive and showed no compassion. He feels very strongly that in similar situations where an investigation is clearly required and the person is willing to be interviewed, Police should not leave someone locked in a cell whilst the investigation is underway. The father's learning point for professionals from his perspective is for police officers dealing with a similar situation in the future is to ensure support is provided and to ask if the person in custody is okay.

Mother:

The mother advised she was not aware of all the support available to her either before or after her child died. Had the plans around them been more formal, she would have learned a lot more

[26]Roberts, L. (2021) The Charter; CASCADE & Cardiff University https://www.exchangewales.org/supporting-parents-in-and-leaving-care-messagestocorporateparents/

about parenting. Whilst acknowledging this may or may not have changed the outcome, looking back she feels this is a learning point for professionals.

Learning

All agencies:

- Practitioners and families need to be clear on what is required of them in terms of referral, assessment and support.
- Specific focus needs to be provided to ensure fathers, as well as mothers, are included in the antenatal and postnatal period to maximise opportunities to prepare for the transition to parenthood.

Housing:

- Housing officers to ensure tenancy and housing support services are readily accessed and where not, further actions to be put in place; consider increased home visits to establish current circumstances.
- At the time of the learning event, the Housing Department were in the process of launching a revised practice approach to their service, which aims to provide a holistic view and see housing and social services working much more closely together to ensure families have the right support around them.

Theme 3 - Co-sleeping

Co-sleeping could not be identified as the cause of death in this tragic case, and good practice was highlighted at the learning event in respect of the number of times safe sleep information was provided to the infant's mother. However, co-sleeping was highlighted by the pathologist as a contributing factor, therefore, the review felt it valuable to explore this theme, with a view to identifying any potential learning for future practice, as research tells us many incidents of SUDI are sadly preventable, and each one is a devastating loss for the family.

The Child Death Review Programme looked into the patterns and trends of child deaths in Wales between 2011 and 2022 found that from 2016, 170 were sudden and unexplained deaths, of which 137 (81%) were sudden unexpected deaths in infancy (SUDI). The review found the rate of SUDI in the most deprived areas was double that of children in the least deprived areas and co-sleeping in the presence of at least one risk factor i.e. parental alcohol, drug use or smoking were modifiable factors for SUDI, accounting for 48 of the 170 deaths (Public Health Wales, 2022).[27]

The National Child Safeguarding Review Panel (NCSRP)[28] in England commissioned a thematic review in response to SUDI which identified a commonality where domestic abuse, mental health and substance misuse were identified risk factors; all of which have been identified as the

[27]Public Health Wales (2022) Patterns and trends of child deaths in Wales 2011-2020 https://phw.nhs.wales/publications/publications1/patterns-and-trends-of-child-deaths-in-wales-2011-2020/

[28] National Child Safeguarding Review Panel (2020) out of Routine: A Review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm; https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

cumulative risk factors in this tragic case. Despite information on safe sleep being provided rigorously by Health professionals in this case, the parents were either, for a range of different reasons, unable or unwilling to receive or act on this advice. The NCSRP concluded that SUDI presents with all the hallmarks of safeguarding work and that it should not be left solely to Health professionals in their work or 'relegated to handing out a health leaflet' and needs to be embedded within respectful, relational based safeguarding practice' (NCSPR, 2020).

It is therefore recommended the CYSUR, Mid and West Wales Safeguarding Board consider the findings from the NCSPR (2020) review and undertake an evaluation of current practice in the Mid and West Wales region that provides a greater understanding of:

- Understanding the views of parents about safer sleep information
- Knowledge, understanding and skills of the workforce to promote safer sleeping within their role
- Multi-agency systems and processes and how recognition of unsafe sleep environments and risk of SUDI is incorporated into multi agency safeguarding work for responding to neglect; domestic violence; parental alcohol and substance misuse and mental health
- Workforce Capacity to develop and maintain support for parenting (including safer sleep) for highly vulnerable families
- Quality Assurance; how the board is assured about the effectiveness of the wok undertaken to promote safer sleeping and reduce risk of SUDI

.

Identified Good Practice

- Safe sleep advice was provided to the infant's mother on at least four occasions.
- A 7-minute briefing on safe sleep has been produced by Powys Teaching Health Board and adapted by CYSUR, The Mid and West Wales Safeguarding Board to raise awareness of SUDI and SIDS, and this has been circulated to multi-agency partners.
- Safer Sleep Standard Operating Procedure has been developed, along with a short training session for all professionals, including HB, LA, police and DA services, involved with families

Parents' Perspective

Father:

From the father's perspective, before social services became involved, a good relationship was developed with the midwife and Health Visitor and they were treated like a family. He felt included during their visits, however, he dipped in and out as the appointments were more focussed towards the mother, which in his view was natural and he "let them get on with it".

Learning

All agencies:

Situational risks and out of routine circumstances act together to increase the risk of SUDI. Multi-agency partners need to consider safe sleep within the context of wider safeguarding assessments, and consider that mothers and fathers who have identified risks stemming from

their backgrounds may find it difficult or impossible to engage with standard sleep safe messages (NCSPR 2020).

Theme 4 - Information Sharing

Whilst outside of the timeline and the remit of this review, the learning event considered the referral to the Domestic Violence Disclosure Scheme (Clare's Law Disclosure)[29] as this occurred a year before the pregnancy, when the mother was 17 years old. Police shared information with agencies and a decision was made for no disclosure to be made as, mentioned earlier, there was no relevant violence or domestic abuse history. However, professionals attending the learning event identified this as a potential early opportunity to consider alternative safeguards, as the couple were in a relationship and the infant's father was under investigation for drug-related offences, and could have triggered a formal review of the mother's CSE risks.

As previously stated, there were 11 separate intelligence logs to the Police throughout the timeline relating to the father's connection to the supply of drugs in the area. There was good evidence of these being scrutinised internally within internal governance processes which were followed and recorded. In the main, these were considered as single events and actioned for internal development and targeting purposes only. It would have been appropriate for the Police to have considered the history in their decision making process and shared the information with partner agencies who were involved with the couple in undertaking assessments and delivering antenatal care. This was highly likely to have met the threshold for a strategy discussion to consider whether threshold had been met for an Initial Child Protection Conference. The Police were proactive by submitting the MARF in January 2019, however, this should have been followed up within Police governance structures as Children's Services did not have a record on their systems. This meant the concerns were never followed up by the social worker undertaking the assessment and respective agencies unaware.

The handover process between midwifery and health visiting services could have been strengthened. A verbal handover occurred and key information from social services was not available on the health records, therefore the Health Visitor was not aware of all of the issues and risks in this case. During the home visit where concerns around cannabis use and a deterioration in home conditions was observed, the information should have been referred in via a MARF.

In summary, there were missed opportunities to identify changing family circumstances and difficulties in transferring information about the family and their social networks within and across agencies. As a result, there were at least 3 potential missed opportunities for a MARF to Children's Services and for a strategy discussion or meeting to take place whereby wider safeguarding information could have been shared. As outlined above, this may have led to an Initial Child Protection Conference whereby all information held on the family could have been shared and a decision for the infant to become subject to protective planning. It is important to stress here, this may not have changed the tragic outcome in this case, nonetheless, it could have provided a statutory footing for the infant to have been seen at a minimum of every 10 days.

The independent reviewer, panel chair and professionals involved in the learning event all expressed their disappointment and frustration that information sharing continues to feature as a

[29] This scheme gives any member of the public the right to ask the **police** if their partner may pose a risk to them. https://www.dyfed-powys.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/

theme, despite being identified during many serious case reviews and child and adult practice reviews. It is therefore a recommendation that CYSUR, The Mid and West Wales Safeguarding Board review the Information Sharing Policy and request all agencies reassure themselves respective information sharing policies and practice guides are up to date in line with current legislation, policy and procedures. It is also recommended an audit on staff training is undertaken on this subject in the context of safeguarding children and adults at risk.

Identified Good Practice

Dyfed Powys Police:

- All contacts and information received concerning the parents and those associated with them were recorded appropriately and internal decision making processes followed with clear lines of accountability and senior officer oversight

Learning

Dyfed Powys Police:

- Sharing police intelligence where criminality impacts on safeguarding which falls below the threshold for a statutory discussion
- Follow up strategy discussion where no acknowledgement is received within 7 days (WSP 2019)[30]
- Consider all historical information held when new intelligence is presented

Health Board**:**

- Improved communication between midwifery and health visiting services and more formal handover process
- Health staff could have considered the Resolution of Professional Differences Policy[31] when key information was not shared from social services to hold on file

Children Services:

- Ensure minutes from meetings and care plans are circulated to all agencies in line with local practice standards or where relevant, statutory timescales

The Learning

The learning identified in this case must be considered with acknowledgement to the organisational context outlined earlier in this report, noting the significant improvements to practice which have occurred locally resulting in the removal of enhanced monitoring and the closure of the performance improvement plan.

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

[30] Wales Safeguarding Procedures 2019

[31] Mid and West Wales Safeguarding Board Resolution of Professional Differences Protocol (2018)

- The production of a merged multi-agency timeline and agency analysis
- Learning events for professionals
- Interview with both parents
- Discussions within the review panel meetings
- Case record review
- Independent Reviewers and Chair's analysis
- Literature & Policy Review

The Learning Events

A number of key professionals are no longer working within the department, thus unable to take part in this review. A learning event was held in October 2021, and was well attended by practitioners, managers and senior managers of all the relevant agencies who were involved with the family. Whilst some were not directly involved, they were able to contribute through reflecting on the following key questions:

- What went well, what good practice have you identified?
- What do you feel did not go well, are there areas which concern you?
- What do you feel agencies could have done differently?
- What actions do you feel agencies need to take going forward, to ensure any learning informs future practice?
- Are there any other comments or observations you would like to make?

The following agencies were represented at the learning event:

- Health Board (Midwifery and Health Visiting)
- Local Authority Children's Services (Intake and Assessment Team / Care & Support Team / Leaving Care Team)
- Local Authority Housing
- Dyfed-Powys Police

The learning event was facilitated by the Independent Reviewer and the Panel Chair. As described above, the learning event considered the timeline of contacts and events for the period May 2018 to May 2019.

FINAL

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:

Recommendations:

1. It is recommended that further policy and practice guidance is developed to bridge the gap in respect of the professional responsibilities for referral, assessment and support provided to young parents in and leaving care and;

- It is recommended that all areas in Children's Services who support statutory childcare teams (including support to parents) to undertake action to assure themselves that an understanding of safeguarding responsibilities and the statutory duty to report concerns for children or adults at risk is embedded in day to day practice. This includes domestic abuse incidents and referrals for unborn children. These concerns should be formally reported through the submission of a MARF.

- It is recommended that Powys Children's Services review the process of recording and responding to MARFs on open cases to ensure they are formally recorded on the child's record.

- Agencies to agree a local response to The Charter published by CASCADE (2021) which sets out the range of support that should be available to young people before and after they become parents and that this information is readily available to them.

2. The CYSUR, The Mid and West Wales Safeguarding Board seek reassurance that:

- All agencies' internal information sharing policies and practice guides are up to date in line with current legislation, policy and procedures, and all staff are able to access ongoing training on this subject in the context of safeguarding children and adults at risk.

- Staff at Powys County Council review their internal systems and practice processes in respect of internal MARF submissions, screening practice and outcomes are clear, robust and embedded in day to day practice.

- Local Authorities' policy and practice guidance regarding strategy discussions is reviewed and where appropriate, extended to include safeguarding leads from Health.

- All agencies to review their internal transfer policies and procedures to ensure timely, fully informed handovers take place in operational practice.

3. Powys County Council to undertake a thematic quality of practice audit on pre-birth assessments and associated thresholds, to assure the Board that the Regional Multi-Agency Pre-Birth Pathway has been thoroughly and consistently implemented across the region.

4. Powys Teaching Health Board to review their internal processes for managing Domestic Incident Notifications (DIN) and strengthened by providing clear, service specific guidance for practitioners to follow in response to the DIN.

5. Dyfed Powys Police to review and improve the process for sharing police intelligence where criminality impacts on safeguarding which falls below the threshold for a statutory discussion.

6. CYSUR, Mid and West Wales Safeguarding Board and Health partners to consider the findings from the NCSPR (2020) review and undertake an evaluation of current practice in the Mid and West Wales region that provides a greater understanding of:

   - Understanding the views of parents about safer sleep information
   - Knowledge, understanding and skills of the workforce to promote safer sleeping within their role
   - Multi-agency systems and processes and how recognition of unsafe sleep environments and risk of SUDI is incorporated into multi agency safeguarding work for responding to neglect; domestic violence; parental alcohol and substance misuse and mental health.
   - Workforce Capacity to develop and maintain support for parenting (including safer sleep) for highly vulnerable families
   - Quality Assurance; how the board is assured about the effectiveness of the work undertaken to promote safer sleeping and reduce risk of SUDI

   CYSUR, The Mid and West Wales Safeguarding Board, along with Health partners, to seek to ensure that there is an effective local response to reduce the risk of SUDI to support local/regional multi agency learning and development in this critical area of work.

7. The CYSUR Training Sub-Group to review the learning from this report and consider any identified needs in in relation to the quality and delivery of safeguarding training available to regional multi-agency practitioners.

8. Local Authorities to review or develop a housing strategy for Care Leavers that ensures a holistic response and robust multi agency partnerships to ensure a joined up approach to meeting the support needs for individuals and families.

/Statement by Reviewer(s)			
Reviewer 1	Helen Goodridge	**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 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** N/A *(Signature)*	
Name *(Print)*	Helen Goodridge	**Name** *(Print)*	N/A
Date	06/02/2023	**Date**	N/A
Chair of Review Panel *(Signature)*			
Name *(Print)*	Chief Inspector Richard Yelland		
Date	09/02/2023		

Appendix A: Terms of Reference

Child/Adult 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.*

- Referral discussed in Local Operational Group
- Referred to Regional Child Practice Review Group – agreed criteria met for a Concise Child Practice Review
- Referral signed off by Chair of CYSUR
- Panel Chair and Reviewer identified
- Initial Panel held, Independent Reviewer confirmed
- 7 x Panel Meetings have taken place in total – Membership:

    1. Powys County Council; Children's Services & Housing
    2. Powys Teaching Health Board; Midwifery & Health Visiting
    3. Dyfed Powys Police

- Multi Agency Learning Event held in October 2021

Family declined involvement: No, both parents engaged with the process.

A telephone conference call was held with the infant's mother and a face to face meeting was held with the infant's father.

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
CIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix A – Terms of Reference for CYSUR 2 2020 Child Practice Concise Review

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/adult and family.
- Determine the extent to which decisions and actions were in the best interests of the child/adult 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 reviewers to work with the *Review Panel* in accordance with guidance for extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewers and Panel membership
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewers a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft child/adult practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the CPR Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 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

Tasks of the CYSUR Safeguarding Children Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking 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 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 / Volume 3 – Adult 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.

FINAL