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Os yn galw gofynnwch am - If calling please ask for

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CABINET
Dydd Mawrth, 19eg Medi, 2017

P E C Y N A T O D O L

1.	**ADRODDIAD DIOGELU CHWARTEROL GWASANAETHAU PLANT AC OEDOLION**

Ystyried adroddiad gan y Cynghorydd Sir Stephen Hayes, Aelod Portffolio ar faterion Gofal Cymdeithasol Oedolion a'r Cynghorydd Sir Rachel Powell, Aelod Portffolio ar faterion Gwasanaethau Plant.

(Tudalennau 1 - 78)

Mae'r dudalen hon wedi'i gadael yn wag yn fwriadol

CYNGOR SIR *POWYS* COUNTY COUNCIL.

CABINET EXECUTIVE
19 September 2017

REPORT AUTHOR:	**County Councillor Stephen Hayes** **Portfolio Holder for Adult Social Care** **County Councillor Rachel Powell** **Portfolio Holder for Children's Services**
SUBJECT:	**Adult & Children's Safeguarding Update Report Q1 2017/18**
REPORT FOR:	**Information**

1. Summary

1.1 The purpose of this report is to provide cabinet with an update in respect of safeguarding children and adults in Powys for Quarter 1 of 2017/18. This report contains both adults and children's safeguarding information and Regional Update.

To discharge the Mid & West Wales Safeguarding Board's (MAWWS) objectives effectively, there is one Board for Children (CYSUR) and one for Adults (CWMPAS) with cross-cutting issues managed jointly across both. There is a live new website update for public and professionals (www.cysur.wales).

1.2 The Adult Safeguarding team continues to receive increased enquiries and referrals during this quarter. We have continued to strengthen our partnership working seeking to improve practice under the guidance of the Powys Local operation Group Adults, (PLOGA). It is our intention, during our next meeting of the PLOGA, in September 2017, to undertake an adult review. This will inform our learning as a multi-agency group going forward.

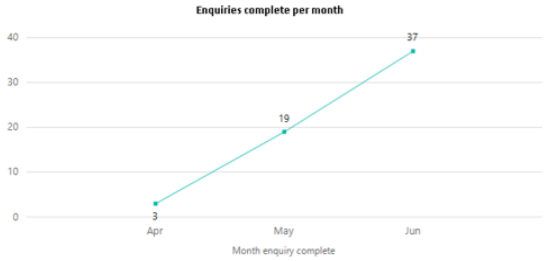
2. Proposal

Adult Services

2.1 Due to the system change for Draig to WCCIS, there was a delay in achieving reports in the new format. As a result we are actively working with our business partners to ensure we are collecting and able to report data appropriately. There have been some challenges to the data collection and reporting within WCCIS for quarter 1. Business Insight Centre has now completed the building of adult safeguarding reports and have commenced work on improving data for Adult Social Care as a whole. This information will be available for officers going forward.

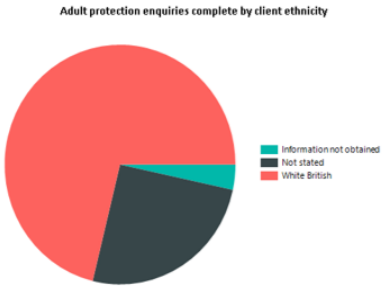
Blue and Underlined data can be selected to reveal detail

	Within Timescale		Completed Outside Timescale		Total
2017 Year Total	39	66.10%	20	33.90%	59
Total	39	66.10%	20	33.90%	59



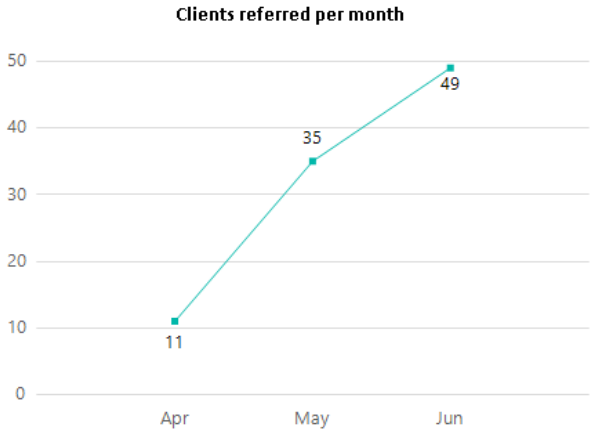
Client Age Range

	17 or under	18 to 64	65 and over	Total
Information not obtained	0	2	0	2
Not stated	3	2	10	15
White British	0	20	22	42
Total	3	24	32	59



The above table represents the number of enquiries closed within 7 working days. Work continues with the Corporate Insight Centre to continue to make some changes in relation to reporting. We have consulted with our regional partners and are working towards a collaborative and consistent approach as to how we record decision making in relation to Adult Safeguarding enquiries.

	No. of Clients referred
Apr	11
May	35
Jun	49
Total	95



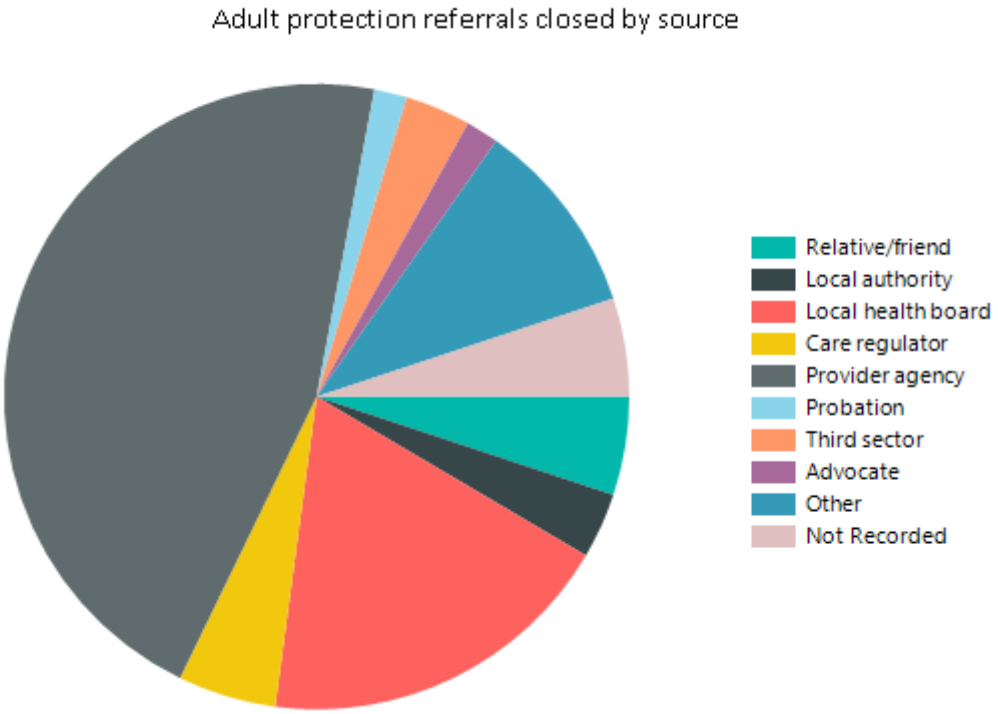
The above table reflects the number of referrals received by the Safeguarding Team for Q1. There continues to be a steady increase in referrals on a month by month basis. This is due to an increased awareness and single point of referral.

Adult Protection complete enquiries analysis

Setting of Alleged Abuse	Adult Protection	
Own Home	25	44.07%
Community	3	5.08%
Care home setting	14	25.42%
Health setting	5	10.17%
Not Recorded	3	5.08%
Other (please specify)	6	10.17%
Total	56	100.00%

The above table shows the setting for the alleged abuse The continues to be a theme to reflect that the majority of the referrals received are in relation to individuals within their own home, followed by individuals who are placed in a care home setting.

Source of Enquiry	Adult Protection	Disability Team North	Disability Team South	Ystrad Older People Integration Team	Percentage of Referrals
Relative/friend	3	0	0	0	5.08%
Local authority	2	0	0	0	3.39%
Local health board	10	0	1	0	18.64%
Care regulator	3	0	0	0	5.08%
Provider agency	25	1	0	1	45.76%
Probation	1	0	0	0	1.69%
Third sector	2	0	0	0	3.39%
Advocate	1	0	0	0	1.69%
Other	6	0	0	0	10.17%
Not Recorded	3	0	0	0	5.08%
Total	56	1	1	1	100.00%



2.2 **Policies and Procedures Sub Group Update**

- Adult Threshold Document

Work remains on-going in respect of the Regional Threshold Document for Adults. (Senior Service Manager for Adult Safeguarding in Carmarthenshire) is leading on this project on behalf of the Board. One development day has taken place with a second date scheduled for later in the year.

- Mental Health Protocol

Ceredigion have led on the development of a Regional Protocol for Parents with Mental Health Difficulties. The final draft has been completed, was approved by the Executive Board in July and is now available on the Board's website (appendix 1).

- Adult Multi Agency Referral Form (MARF)

A draft adult MARF was approved by the last Policies & Procedures Group. This will run as a 3 month pilot across the region with effect from 4th September. A review of the pilot will take place in January 2018. This has been disseminated throughout the organisations. Copies of this document are available on the Board's website and included as appendices 2 and 3 for your convenience.

Practice Review Sub Updates

- Adult Practice Review (APR) Sub Group

There remains one ongoing regional Adult Practice Review. The process has been delayed due to ongoing legal complications. The final version of the Regional Adult Practice Review Protocol was agreed at the last Executive Board and available on the Board's website (appendix 4). We are working towards reviewing a safeguarding case to present at the next PLOGA.

National Safeguarding Week (NSW) 13-17th November 2017

- Regional Programme of NSW Events

A regional Task & Finish Group has been established to develop a regional programme of events for National Safeguarding Week that will be ratified at the October Exec Board. Several regional meetings have been arranged to discuss and plan our regional programme. Key points are:

- A communication package will be produced based on this programme so that all areas know what is happening where and this can be given to individual agency's media teams. This will include some English/Welsh translated phrases and press releases for use by all organisations.
- Activities and events should be carried out by all partner agencies to show the multi-agency participation of the Board.
- Where possible, thought should be given to activities that cut across both children and adults during the week.

All Safeguarding Board Business Units across Wales have agreed some outline 'All Wales' themes for National Safeguarding Week (appendix 5). There will be a rough theme for each day within the scope of safeguarding and each Regional Safeguarding Board has agreed to take the lead on a theme. The idea is that the 'lead' Safeguarding Board will share resource on their theme – like leaflets or information that can be used by the other areas during that theme.

Children's Services

2.3 **Inspection**

There has been notification received of CSSIW core inspection of children's services in this period the findings of which will be available in Q2. This was a 2 week Inspection which took place over July and early August. Inspectors reviewed a number of children's files and interviewed staff and managers from PCC and senior officers from Partner organisations to assess the

effectiveness of services to vulnerable children. The report will be available in September – date yet to be confirmed.

2.4 Child Practice Reviews

There have been 2 new referrals for Child Practice Review over the reporting period. One is for consideration by the Powys Local Operational Group before referral to the Safeguarding Board. The second involves a review of practice where a young person who had been in the care of the authority some years ago and who had subsequently committed suicide. The family has been in discussion with the Authority asking the safeguarding Board to undertake a review to ensure we collectively understand why this happened and to incorporate any lessons learned into our policies and practice.

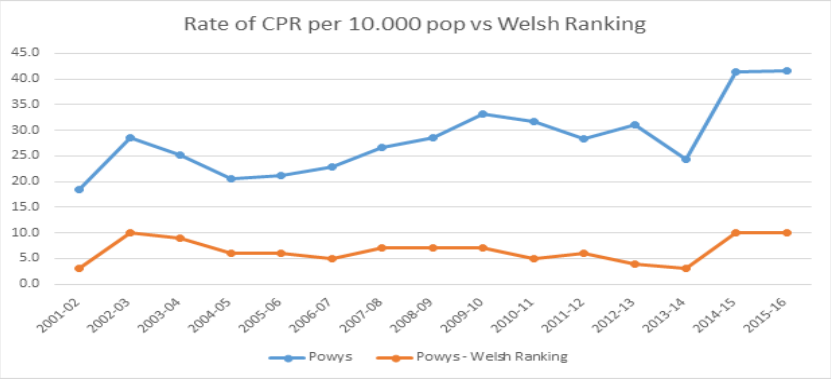
2.5 Quality Assurance

A Quality Assurance and Performance strategy and audit planner has been introduced and implemented this may require review following inspection feedback. Regular case file and themed audits are undertaken. The findings from these audits are disseminated across the service to enable learning and improvements in practice and service delivery. Monthly Children's Services management meetings monitor the actions arising from the audit findings. This will include findings from the recent inspection.

We are developing and implementing a quality assurance framework to help the authority assess progress and impact of its service this will be monitored through service dashboards moving forward.
Children's services undertook a number of audits in addition to its usual practice in preparation for the inspection. These showed practice of inconsistent quality, with some examples of good practice.

A number of areas were identified in preparing data for the inspection where reports can be developed to improve data accuracy and therefore making tracking of case quality easier.

2.6 Trends in Child Protection (CP) registrations



The trajectory of CP registrations in Powys continues to indicate an increasing trend. This increase continues to reflect the national picture from Welsh Government published statistics and requires some further analysis to ensure we are responding to safeguarding concerns appropriately and that Child Protection Plans are effective.

We are investigating this trend and reviewing through a range of measures including working with the Regional Safeguarding Board (CYSUR) on clarifying levels of needs to inform the actions moving forward. This will ensure that we provide a service that safeguards children and we will continually review the rationale for those children on the child protection register.

2.7 **Safeguarding Children**

The total number of referrals received into children's services from 1st April 2017 to 30th June 2017 is 861. This is a clear reduction in the last two quarters of the year. This may suggest that the introduction of the care and well-being assessment into Powys People Direct, as well as additional collaborative work and alternative support mechanisms with partner agencies in supporting vulnerable families, may have prevented escalation and the need for intense intervention. We will keep this under review to ensure we are supporting vulnerable children in a timely way.

The highest number of child protection referrals continue to be from the Police, they referred 39% of all child protection referrals during the year, followed by education with 23%.

The numbers of Section 47 (Child Protection) enquiries remains steady with 182 being completed in Q3 and 165 in Q4.

2.8 **Missing Children and Child Sexual Exploitation (CSE)**

A regional and local multi-agency CSE action plan has been developed and monitored through CSE working group and reported through the Local Operational Group and to the Regional Safeguarding Board.

The Multi Agency Child Sexual Exploitation (MACSE) meetings chaired by the local authority are now meeting on a bi-monthly basis to monitor the SERAF tool and those children and young people identified as potentially at risk of sexual exploitation.

Child Protection Register

The table below shows child protection registrations on a quarterly basis.

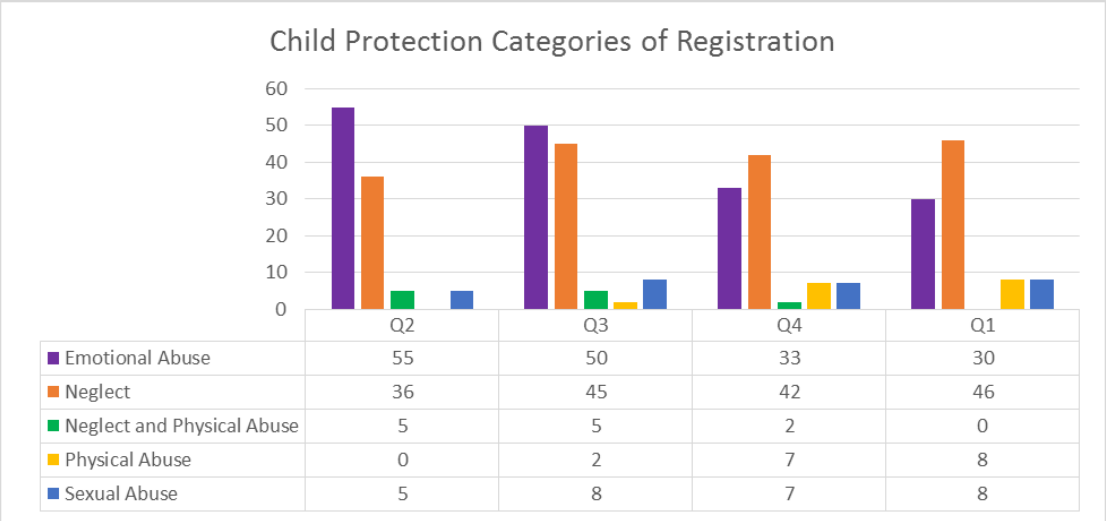
30/09/2016	31/12/2016	31/03/2017	30/06/2017
101	110	91	92

The table below further analyses the register as at 30th June 2017 and shows breakdown by allocated team.

Team	No.
Welshpool	12
Newtown	30
Radnor	23
Brecon	27
Children with Disabilities	0

A similar number of children are subject to Child Protection Plans but the distribution of the children has changed quite significantly with reductions in numbers in Welshpool and increased numbers in Newtown. There were small reductions in the Radnor and Brecon teams. No children from the children with disabilities team being subject to a child protection plan at the end of this period.

The chart below displays the number of children on the register as at 30th June 2017 split by category of registration.



	Q2	Q3	Q4	Q1
Emotional Abuse	55	50	33	30
Neglect	36	45	42	46
Neglect and Physical Abuse	5	5	2	0
Physical Abuse	0	2	7	8
Sexual Abuse	5	8	7	8

Neglect is the highest category of abuse. In Q3 and Q4 you can see a shift towards a decrease in the number of children registered under emotional abuse and an increase in the number being registered under the category of neglect.

During Q1 there were 32 Initial Child Protection Conferences that resulted in 87.5% of children being registered. There were 62 Review Child Protection Conferences at which 56.5% of children were deregistered.

Regional Update

Policies and Sub group update

The Right Help at the Right Time (Children's Threshold and Eligibility for Support) document has now been completed. It was agreed and ratified at the last Executive Board.
The Policies & Procedures Sub Group has a number of on-going work-streams and a number of key regional policies are actively under development. The main areas of focus in the coming quarter will include finalising the Elective Home Education Protocol. The first development day for this has taken place and a second development day is scheduled for July to complete this piece of work. Work is also on going on a regional FOI protocol.

Regional Training Sub Group Update
The all-age group has agreed a short term training plan which will deliver on some immediate actions. One of which is to arrange and deliver a regional training event on working with challenging, difficult and evasive families. A pilot regional training event has been scheduled to take place in Carmarthen on the 5th and 6th June which will be delivered by Reconstruct with the intention being each organisation should further commission and roll this out to larger staff numbers within their own individual organisations.
Six multi-agency regional training sessions are in the process of being delivered by the Gwella project worker, Giselle Moran, on working with children who display sexually harmful behaviour. Initial feedback received has been very positive.
A development day for the Training Sub Group and members has been scheduled for 19th May to pull together a long term training strategy.

Regional Child Practice Review Sub Group
There were no new referrals to the last Sub Group and there are no on-going regional child practice reviews. It has been agreed that when the CPR Sub group recommends that a MAPF should be undertaken, this will return to the local area for completion and will exit the CPR Sub Group. Progress of any on-going MAPFs will be tracked and reported as part of the regional QA framework. Any action plans will remain local action plans opposed to regional ones. The business unit will audit MAPFs as part of their function and identify any common themes that may need a regional approach or work. The regional CPR protocol for has now been agreed and ratified by the Executive Board (appendix 6).

Pembrokeshire have agreed to lead upon the development of a regional MAPF framework.

CSE and SERAF Review
A national review of CSE guidance including the definition of CSE and a review of the SERAF tool is under way. CASCADE research facility attached to Cardiff University has been commissioned by Welsh Government to undertake this review. As part of this process six national focus groups have taken place in each Safeguarding Board area across Wales with input from practitioners and managers on a multi–agency basis. The event in Mid and West Wales took place on 30th March, facilitated jointly by the business unit and Dr Anne Crowley from CASCADE at Dyfed Powys Police Headquarters. This was attended by practitioners and mangers from all four local authorities

and the key statutory partners. The national review and accompanying recommendation will be concluded by the end of May.

- **CPR/APR Training**

The Welsh Government are working on rolling out new national training for CPR/APRs which will consist of some generic online training materials and some more specific direct training for Independent Reviewers. A specific meeting has been arranged with Regional Safeguarding Board Managers to take place on the 23nd May to discuss and plan in more detail.

- **Information Sharing and Ownership**

The National Independent Safeguarding Board has formally raised the issue of ownership of information within the context the governance and responsibilities in relation to information sharing for Safeguarding Boards. Ruth Henke is leading on this from the National Independent Safeguarding Board and is completing a report to advise Welsh Government. This is likely to recommend guidance needs to be issued to strengthen and clarify parameters, legal ownership and responsibilities.

- **SAIT Tool**

This tool and process remains under review and the Welsh Government are now giving serious consideration to starting afresh with the procurement of a new tool.

- **Child Death Reviews**

Discussions are on-going with the National independent Safeguarding Board as to whether Regional Safeguarding Boards should have more robust oversight of Child Death Reviews.

Regional Board Annual Report
The board annual report has been included with this report (appendix 7).

3. Options Considered / Available

3.1 Not applicable.

4. Preferred Choice and Reasons

4.1 Not applicable.

5. Impact Assessment

5.1 Is an impact assessment required? No

6. Corporate Improvement Plan

6.1 Safeguarding is everybody's business and links to objectives within the Corporate Improvement plan.

7. Local Member(s)

7.1 Not applicable.

8. Other Front Line Services

Does the recommendation impact on other services run by the Council or on behalf of the Council? Yes

If so please provide their comments:

The Powys Local Safeguarding Group engages with frontline staff/services through its child protection fora. Both the PLOG and PLOGA have active training programmes co-ordinated by the local authority and attended by staff from all agencies. The Safeguarding team give advice and information to managers and staff working with children and adults' at risk from all sectors.

9. Communications

Have Communications seen a copy of this report? Yes

Have they made a comment? Communications officers from the People Directorate have contributed to the development of the CYSUR website, and continue to promote the work of the regional board. Officers supported and promoted a positive campaign with both public and private sector organisations during Safeguarding week, and will continue to support and promote Safeguarding Week in November 2017.

10. Support Services (Legal, Finance, Corporate Property, HR, ICT, Business Services)

10.1 Legal – no comment received.

10.2 Finance - The Finance Business Partner notes the content of the report re safeguarding matters.

10.3 Corporate Property – The Professional Lead notes the contents of the report.

10.4 HR – no comment received.

10.5 ICT – no comment received.

11. Scrutiny

Has this report been scrutinised? No

If Yes what version or date of report has been scrutinised?

Please insert the comments.
What changes have been made since the date of Scrutiny and explain why Scrutiny recommendations have been accepted or rejected?

11.1

12. Statutory Officers

13. Members' Interests

The Monitoring Officer is not aware of any specific interests that may arise in relation to this report. If Members have an interest they should declare it at the start of the meeting and complete the relevant notification form.

Recommendation:	Reason for Recommendation:
That Cabinet accepts the safeguarding update in line with its safeguarding responsibilities.	**Safeguarding is everyone's business and this report provides assurance to Cabinet of work that is underway both locally and regionally on important safeguarding matters.**

Relevant Policy (ies):			
Within Policy:	**Y**	**Within Budget:**	**Y**

Relevant Local Member(s):	**All**

Person(s) To Implement Decision:	**Agency representatives**
Date By When Decision To Be Implemented:	**N/A**

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Background Papers used to prepare Report:

Multi agency Protocol for Safeguarding Children affected by Parents who are experiencing Mental Ill Health

CYSUR: THE MID AND WEST WALES SAFEGUARDING CHILDREN BOARD

Version	Revision Date	Author	Date approved by Board	Review Date
V1	3/5/2017	Produced by Sian Howys and Donna Prichard, Ceredigion Social Services in consultation with a local Task and Finish Working Group and members of the Policies and Procedures Sub group.	n/a	n/a
V2	17/5/2017	Policies & Procedures Sub Group	13/7/17	13/7/19

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1. Introduction.

1.1 The overarching aim of this Protocol is to ensure that children[1], including unborn children of parent(s) [2] experiencing mental ill health [3] receive appropriate support, safeguarding and protection.

1.2 All agencies have a collective responsibility to safeguard and protect children. This requires effective communication and coordination of multi -agency services to children and their families at both strategic and operational levels. This may include Adults and Children Social Services, Health, Education, Police, Probation and the Voluntary Sector. This Protocol provides a framework for joint working to ensure that children living with adults who are experiencing mental ill health are adequately safeguarded and supported within the Mid and West Wales Region

1.3 The Protocol is specifically intended for all professionals and staff members who work within Adult Mental Health and Children Services. It complies with the requirements of the Children Act 2004, The Social Services and Well-being (Wales) Act 2014 and the related safeguarding statutory guidance, Working Together to Safeguard People, The Mental Health (Wales) Measure 2010, Mental Health Act 1983 (and 2007 Amendments), and the All Wales Child Protection Procedures (2008).

1.4 All agencies need to ensure that they work together in partnership with parents and in the best interest of children. It is recognised that there may be, at times, a perceived conflict of interest between the needs of the child(ren) and the needs of parents who are experiencing mental ill health. However, if a child is at risk of abuse or is suffering or is likely to suffer significant harm[4] , the welfare and well-being of the child is paramount and the All Wales Child Protection Procedures 2008 must be followed.

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[1] A 'child' is defined here as a person under **18 years** of age.

[2] For reasons of clarity, the term 'parent' refers to those persons with significant child care responsibilities, whether or not they may be the biological parent. The term 'parent' is defined more by parental role and responsibility than by familial or genetic bonds.

[3] The term 'mental ill-health' will be used in the remainder of this document for reasons of brevity, notwithstanding its associations with the medical model. It includes addiction as described in section two.

[4] The Children Act 1989 introduced **the concept of significant harm** as the threshold that justifies compulsory intervention in family life in order to protect children. Significant harm is defined in the legislation as ill treatment or the impairment of health and development. It describes the effects of sexual, physical, emotional abuse or neglect, or a combination of different types. There are no absolute criteria on which to rely when judging what constitutes significant harm. A single, serious event of abuse, such as an incident of sexual abuse or violent assault, might be the cause of significant harm to a child. However, more frequently significant harm occurs as a result of a long-standing compilation of events, which interrupt, change or damage a child's physical and psychological development. The significant harm resulting from the corrosive effect of long-term abuse is likely to have a profound impact on the future outcomes for the child.(All Wales Child Protection Procedures Definition)

[5] See Working Together to Safeguard Children Vol 1 for a definition of relevant partners and types of abuse.

1.5 All agencies should be aware that The Social Services and Well-being (Wales) Act 2014 introduced new statutory duties on 'relevant partners' to report both children and adults who are at risk along with new definitions of what is meant by a child and an adult at risk and of the categories of abuse and neglect. When a child has been reported under Section 130 of the Act, the local authority **must** consider whether there are grounds for carrying out an investigation under section 47 of the Children Act 1989.

1.6 It should be understood, that not all parents who experience mental ill health are abusive or neglectful. Many parents with mental ill health can provide safe and effective care for their children if they have good positive support networks and if they can access appropriate advice and support in the community.

1.7 The Social Services and Well-being (Wales) Act 2014 places a strong emphasis on the duty to work in partnership with parents and children and to provide early help, advice and prevention strategies which build on peoples' strengths and address what matters to them.

1.8 This document should be read in conjunction with the legal framework of *The Children Act (1989 and 2004), The National Health Service and Community Care Act (1990),* the *Mental Health Act 1983 and amendments (2007),the Mental Health (Wales) Measure (2010)* and the *Human Rights Act (2000),* and relevant operational policies relating to children's and mental health services and in particular in conjunction with the Safeguarding Children Standards for Adult Mental Health (2015) published by Public Health Wales.

2. The purpose of the Protocol

2.1 The purpose of the Protocol is to set out the responsibilities of agencies and practitioners for sharing information and working together when there is a concern that a parent's mental ill health compromises his/her parental capacity and places his/her children in need of care and support and/or at risk of harm including the unborn child. It is based on the principle that regular multi agency cooperation and communication will lead to informed assessments, effective planning and better outcomes for children and families.

2.2 The Protocol's key message is that all mental health agencies providing services to adults who may have parental and child care responsibilities must regard protecting and safeguarding the welfare and well-being of children as the most important consideration.

2.3 The aim is to facilitate coordinated responses from Children and Family Services, Mental Health, Primary Care Services and Partner Agencies. This response is to include joint assessments of families where there are child protection concerns and the parent has significant problems in relation to their mental health.

2.4 It aims to maintain effective communication between Children and Family Services, Mental Health, Primary Care services and Partner Agencies.

2.5 It aims to facilitate the early identification of those children who are experiencing or may be at risk of experiencing harm as defined in the All Wales Child Protection Procedures and statutory guidance so that support can be offered to prevent the escalation of risk.

3. Scope of the Protocol.

3.1 For the purpose of this protocol, an adult with mental ill health is defined as:

- An individual who is experiencing mild to moderate mental ill-health such as anxiety disorders, mild to moderate depression, psychosocial, behavioural or emotional difficulties or memory impairment
- An individual who is experiencing severe mental ill-health such as schizophrenia or other (enduring or transient) psychosis, bipolar disorder, severe affective disorder, severe eating disorder, dementia or personality disorder.

4. Sharing information and confidentiality.

4.1 The Children Act 2004, section 28, places a statutory duty on Local Authorities, Police, Probation, NHS bodies, YOS, Prison Governors, Training Centre Directors, British Transport Police and contracted services. To make arrangements to ensure they carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children.

4.2 Professionals and staff providing services to adults and children will be concerned about the need to balance their general duty towards their service users and their duties to protect children from harm. Confidentiality is an important factor in enabling service users to engage confidently and honestly and all agencies should support the requirement to maintain confidentiality as far as possible. The personal information given by a service user should not be shared with others without consent, unless the safety of the service user or other vulnerable person may otherwise be put at risk. The general principle enshrined in professional and ethical codes of conduct, and in human rights and data protection legislation, acknowledges an individual's right to privacy but also enables disclosure and sharing of information in certain appropriate circumstances, such as when there is a concern regarding the welfare of a child.

4.3 In cases where there are concerns that a child is, or might be at risk of significant harm, this will always override a professional or agency requirement to keep information confidential. Research and experience from child death reviews have repeatedly shown that in order to safeguard a child from abuse and/or neglect professionals and staff must share information in a timely manner about the child's health and development and exposure to possible harm. It is critical that information is shared about a parent whose needs may compromise their ability to care adequately for the child, and those who may pose a risk of harm.

4.4 The main provisions on disclosure of information for professionals and practitioners are:

- The common duty of confidence;
- Human Rights Act 2000;
- Data Protection Act 1998.
- The Children Act 1989,
- Children Act 2004,
- The Crime and Disorder Act 1998.
- The Social Services Well-being (Wales) Act 2014

4.5 The common law and statutory restrictions do not prevent the sharing of personal information with other professionals and practitioners as long as:

- The service user and/or those likely to be affected give their consent;
- The public interest in safeguarding the child's welfare or well-being overrides the need to keep the information confidential; or
- Disclosure is required under a court order or other legal obligation.

4.6 The legislation therefore recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others. It is good practice that when concerns about a child's safety require a professional or staff member to share information without consent, he/she should tell the person that they intend to do so, unless it would place the child or others at greater risk of harm.

4.7 It is good practice for a professional or staff member requesting information from another agency to explain:

- What kind of information they require;
- Why they require it;
- What they will do with the information, and,
- Who else might need to be informed if there are continuing concerns about the child.

4.8 In circumstances when a child is considered to be at risk of abuse or neglect professionals and staff members may be asked to provide information either verbally or in a written report, for the purpose of;

- A proportionate or specialist assessment of the child's circumstances,
- Completion of Section 47 enquiries
- Provision of information and advice to parents
- Provision of preventative services and targeted intervention for a child and their family
- Informing decision making at a Child Protection Conference
- Completion of Court reports

Please note that this is not a definitive list

4.9 The professional or staff member to whom the request for information is made should consider:

- Whether there is a perceived risk or likely risk of abuse or neglect to a child;
- Whether they have relevant information to contribute;
- Whether the information is confidential, or in the public domain, or could be better provided by another agency
- What information the service user has given permission to share;
- How much information needs to be shared in order to reduce the risk of harm to the child/ren.

5. Standards for professionals and staff members in Mental Health Services, Children services and other agencies.

5.1 Professionals and staff in adult mental health services should make themselves aware of service users who are parents and/or pregnant, and/or hold parental responsibility and/or have children living with them.

5.2 Professionals and staff in children services should be aware of parental mental health issues so as to be sure of an informed assessment and to ascertain whether the parents they work with are known to or would benefit from mental health services.

5.3 Multi agency training should be arranged under the Safeguarding Children Board in order to ;

- Facilitate the early identification of children at risk of harm and to develop skills in undertaking multi agency assessments and to promote effective collaboration and communication between agencies.

- Improve staff awareness of mental health issues and child protection.

6. The role and responsibilities of mental health services in safeguarding and promoting the welfare of children.

6.1 Mental health services within the region will need to ensure that their service users are made aware that any identified child protection concerns in relation to children will be shared with the appropriate agencies.

6.2 As part of all mental health assessments each episode of treatment whether at an inpatient unit or in the community, the mental health professionals will:

- Routinely record/confirm whether the adult being assessed is a parent or has a significant caring role for a child.

- Establish and record details of the children, the parenting arrangements and what agencies are currently involved.

6.3 Following assessment, professionals should routinely inform midwifery, health visiting or school nursing service as appropriate. If the initial referral was not from the GP, primary care should be notified of any concerns which may impact upon an adults parenting or caring capacity (Appendix 1). There will be a need to reassess at each further contact.

6.4 Where professionals suspect a child or an unborn child is experiencing or is at risk of experiencing abuse or neglect, the referral process must be followed in line with the All Wales Child Protection Procedures. An appropriate child protection referral should not be delayed because a diagnosis has not yet been made in relation to the adult's mental health. (See flow chart Appendix 2)

6.5 If mental health service professionals and staff members have concerns about the welfare or well-being of a service user's child, for instance in relation to their safety, their health and/or education and/or development they should seek parental consent in order to make a referral to the appropriate agency.

6.6 All adult mental health service professionals and staff must make a referral to Children Services in accordance with local arrangements in their area of the region.

6.7 It is good practice to gain parental consent as long as asking for consent from parents is not likely to increase the risk of harm to a child. When considering making a referral, agency professionals and staff members should ask themselves the following questions:

- What parenting information, support and advice is required in order to prevent a risk of harm to the child?
- What impact are the parental mental health issues having/likely to have on the child's well-being?
- How vulnerable is the child/children?
- How extensive is the concern/problem?
- Are the concerns/problems long standing or part of a repeated pattern?
- What is likely to happen if action is delayed or not taken?

- What protective factors/strengths are in place?

6.8 The agency professional or staff member should provide a completed Multi-Agency Referral Form (MARF) which provides information about the family and household circumstances and the identified concerns.

6.9 When considering making a referral you should ask if there may be circumstances where a referral would prevent harm and where early intervention or targeted prevention could prevent risk from escalating. Parental consent is required in these circumstances.

6.10 All verbal referrals should be directed to the local Children's Single Point of Access and should be confirmed in writing within 24 hours.

6.11 In addition, it is important for professionals and staff to distinguish between issues of evidence and seriousness. It is often difficult to obtain clear evidence to substantiate a professional/staff member's concerns, but this should not be taken as a signal that the situation is not potentially serious.

6.12 All mental health service professionals and staff members should assist social services professionals in undertaking assessments. This is undertaken by contributing relevant information from assessment materials and attending and reporting to Child Protection Conferences and related meetings. This will be undertaken in accordance with information sharing and confidentiality requirements.

7. The role and responsibilities of social services in safeguarding and promoting the welfare of children.

7.1 When the Social Services Department receive a referral or report about the children of a parent experiencing mental ill health, a decision will be made about accepting the referral within 24 hours and the referrer will be informed within 7 days of the outcome. If the referral is accepted, an assessment will be undertaken within 42 days by the allocated Social Worker. The child will be seen and their views taken into account as part of the assessment. The main task is to gather and analyse information from as many sources as possible in order to decide subsequent actions. The assessment will include a preliminary risk assessment based on an analysis of identified strengths and vulnerabilities and where there are grounds for concern that a child is at risk of harm, a Strategy Discussion or Strategy Meeting will be held to consider the need for child protection enquiries in accordance with the All Wales Child Protection Procedures.

7.2 All Agency professionals and staff when notified of an assessment will gather and contribute relevant information about the child and parents.

7.3 Other agencies working with children may be able to provide information about:

- The child's age and stage of physical, social and emotional development;
- The child's educational needs;
- The child's health and health care needs;
- The emotional impact on the child of frequent and/or unpredictable; changes in adults' mood and behaviour;
- The child's perception of parental mental health issues.

7.4 Following the completion of the assessment a decision will be made if the child is a child in need of care and support, and if so, a Care and Support Plan will be formulated and reviewed. This may require that further specialist or detailed proportionate assessments are undertaken. It is important that both children services and mental health services and other agencies involved with the child and family share ownership of the Child in Need of Care and Support Plan.

7.5 Should this assessment identify an adult who requires a Care and Support Plan, a referral should be made to the relevant service.

7.6 In the event of a child being considered to be at risk of harm, Child Protection Section 47 enquiries will be undertaken and a proportionate assessment will be completed from which a decision will be made whether an Initial Child Protection Conference should be convened.

7.7 The Initial Child Protection Conference must be undertaken within 15 working days from the date of the Child Protection Strategy Discussion/Meeting, and agencies will therefore have limited time in which to prepare and share their report with the family and send it to the Conference Chair within two working days prior to Conference. If a child's name is placed on the Child Protection Register a Protection Plan is made and agencies in contact with the child and/or parents will be required to attend Child Protection Core Group meetings and the Review Child Protection Conference.

7.8 As mental ill health can be very complex and often involves a relapsing condition, it is essential that when involvement ceases from Children Services or from Adult Mental Health Services that this decision is communicated to all

involved agencies. It is important to ensure that there is at least one agency providing universal services such as health and education having continuing contact with the child who can remain vigilant for any reoccurrence of signs of difficulties.

7.9 Professionals working within adult mental health services must ensure that their care planning includes explicit details about issues and interventions required to help their clients in their parenting role. Consideration must be given to the adults' role as a parent and the impact of their mental ill health on their parenting capacity and subsequently on their children. This should also consider the wishes and feelings of the child regarding the parent's illness.

7.10 Where there are issues about children's welfare or well-being, discharge plans must involve and be agreed by all professionals working with the family. Discharge planning needs to be robust to ensure that the child's physical and emotional needs are met.

8. Risk Factors

8.1 It is estimated that mental illness or mental health difficulties will affect 1 in 4 people at some time in their lives. Many children will grow up with a parent who, at some point will experience mental illness. Most of these parents will have mild or short-lived illnesses which will usually be treated by their General Practitioner. Some children live with a parent who has a long term mental ill health condition

8.2 Recent research has highlighted the adverse effects of childhood trauma which can result in long term health, educational, social and relationship difficulties. Parental mental ill health has been identified as one of the main stressful experiences that can adversely affect the environment in which children live. Research shows that some of the most harmful family environments for children include a combination of parental mental illness, alcohol/substance abuse and domestic abuse.

8.3 The strong associations between exposure to adverse childhood experiences (ACEs) and vulnerability to various kinds of harm including substance use, unintended teenage pregnancy, violence, mental illness and physical health problems in adulthood mean the children of those affected by ACEs are at increased risk of exposing their own children to ACEs. This is often referred to as the 'cycle of violence'. Consequently, preventing ACEs in a single generation or reducing their impact on children can benefit not only

those individuals but also future generations across Wales.

8.4 The need for agencies to work together to ensure targeted effective prevention measures progressing through to remedial intervention and child protection planning is key across the continuum of need as set out in the Regional Thresholds Protocol, The right help at the right time. See Appendix 3

8.5 Research also shows that the risk of harm to children is more likely to escalate if children;

- Are separated repeatedly from a parent who needs to go into hospital
- Feel unsure of their relationship with the parent with a mental illness
- Are not being looked after properly
- Are being hit or mistreated (more likely if the parent suffers from alcohol or drug problems or has personality difficulties)
- Are looking after a sick parent, or are taking care of their siblings
- Are being bullied or teased by others
- Hear unkind things being said about their parent(s)
- Live in poverty, poor housing or have many changes of home address
- Witness a lot of arguments or violence between their parents
- Live with carers who have a history of not complying with treatment / medication

8.6 Research examining the links between child care and mental illness has shown the latter to be a significant factor when considering the safety and welfare of the child. At the very least it is likely that the quality of parent - child interaction is affected. Active consideration needs to be given to supporting the adult's parenting capacity in order to meet the needs of their child(ren).

9. Assessment.

9.1 The Framework for the Assessment of Children in Need and their families provides the foundation for the systematic assessment of children and families. The Framework embraces three key areas: the child's developmental needs; parenting capacity and wider family and environmental factors.

9.2 All staff working with adults who experience mental ill health must consider the needs of the child(ren), giving consideration to the domains of the Assessment Framework (Appendix 1).

9.3 Information should be gathered, collated and recorded in such a way that it supports a process of analysis. The Assessment should include clear summaries in which both strengths and difficulties are identified in each of the

three domains (‘family and environmental factors’, ‘parenting capacity’ and ‘child’s developmental needs’).

9.4 Planning for the assessment should address the following issues – (see Appendix 2 in Mental Health Standards)

- Who will be involved in the assessment, including family members?
- Who will undertake which parts of the assessment?
- Whether there are any communication difficulties, and plans for how they will be overcome
- Which questionnaires and scales will be used, and by whom?
- What aspects of the assessment have already been undertaken?
- Whether there are any sources of information about the child(ren) or their family not previously contacted
- Whether the consent of the child’s parents has been given and, if not, how it will be gained
- Where the assessment will be conducted
- How the information will be recorded
- Who will be involved in the analysis and how it will be done
- What the timescales are for each stage
- Whether any specialist assessments are required
- Who will undertake direct work with the child(ren)?
- How family members and children will be involved in the assessment
- Whether the assessment needs to ‘co-opt in’ any members with particular areas of knowledge and skill e.g. forensic assessments, Psychiatrists, Psychologists.

9.5 This protocol does not suggest that mental health workers should carry out full assessments of children; rather that the domains of the Assessment Framework provide a useful basis for considering children’s needs and that they should be considered routinely in the assessment of adults with mental health problems. Adult mental health professionals will be particularly valuable in assessing the impact of the parent’s mental health in the ‘parenting capacity’ domain. Any impact should be reflected as part of the care and treatment plan and any actions agreed with the patient/parent.

9.6 Children are often frightened or worried about their parent's illness or behaviour and will show signs of distress. Some children withdraw into themselves, become anxious and find it difficult to concentrate on their school work. They may find it very difficult to talk about their parent's illness or their problems at home, which may prevent them from getting help. Children are sometimes ashamed of their parent's illness and worry about becoming ill

themselves. Some children may emulate aggression they witness at home, leading them into conflict with other children, teachers or other authority figures.

9.7 Preschool children can display behavioural difficulties such as poor feeding, behaviour, toileting and sleeping issues.

9.8 The impact of poor maternal ill health on the development of the unborn child should be not underestimated.

10 Care and Treatment Planning and reviewing.

10.1 In this context, the Adult Mental Health Services Care and Treatment Plan is the 'jointly agreed plan', which is derived following consideration of the holistic assessment of the family's needs, with the child's needs being of paramount importance.

10.2 Following the Joint Planning Meeting, each Care and Treatment Plan will identify clear objectives, responsibilities and review dates.

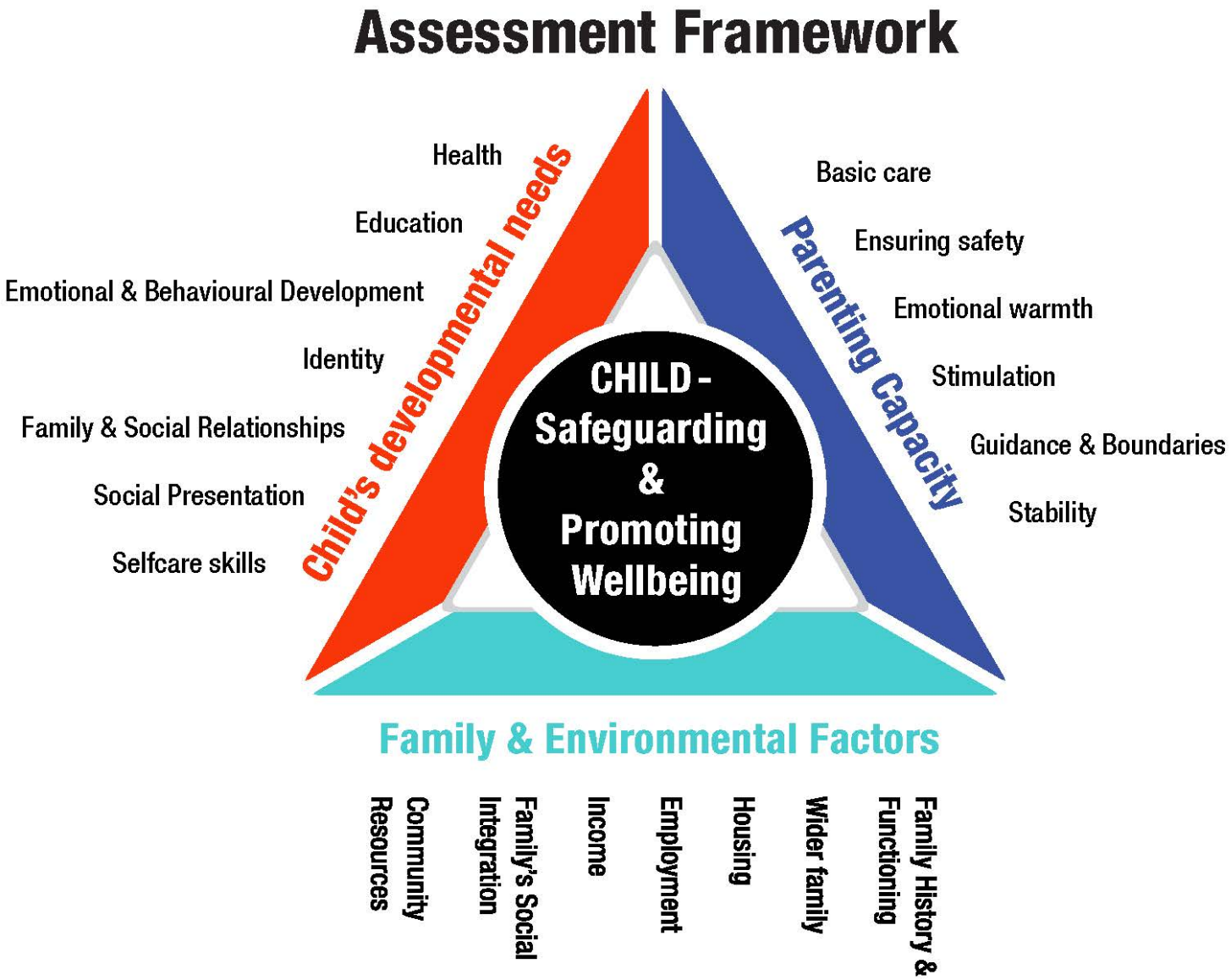
10.3 It is essential that there is good communication and joint planning to support appropriate and integrated service responses. Consultation should always occur between families and teams on significant changes in Care Plans and on the planned closure of a case. Children Services should always be informed if there are any significant changes in a family which may impact on parenting, for example, if a parent or carer leaves the household, leaving the other parent who suffers from mental illness with sole care of the children. Equally, Children Services must always be informed if there are plans to discharge a parent / carer from acute psychiatric care.

10.4 In cases where there is not an allocated Social Worker or Care Coordinator for the parent, the relevant Team Manager or designated deputy from the Mental Health Service will provide advice and consultation to Children Services along with undertaking the liaison function.

10.5 Alternatively if there is not an allocated Social Worker for the child(ren), the relevant Team Manager or designated deputy from Children Services will provide advice and consultation to the Mental Health Team.

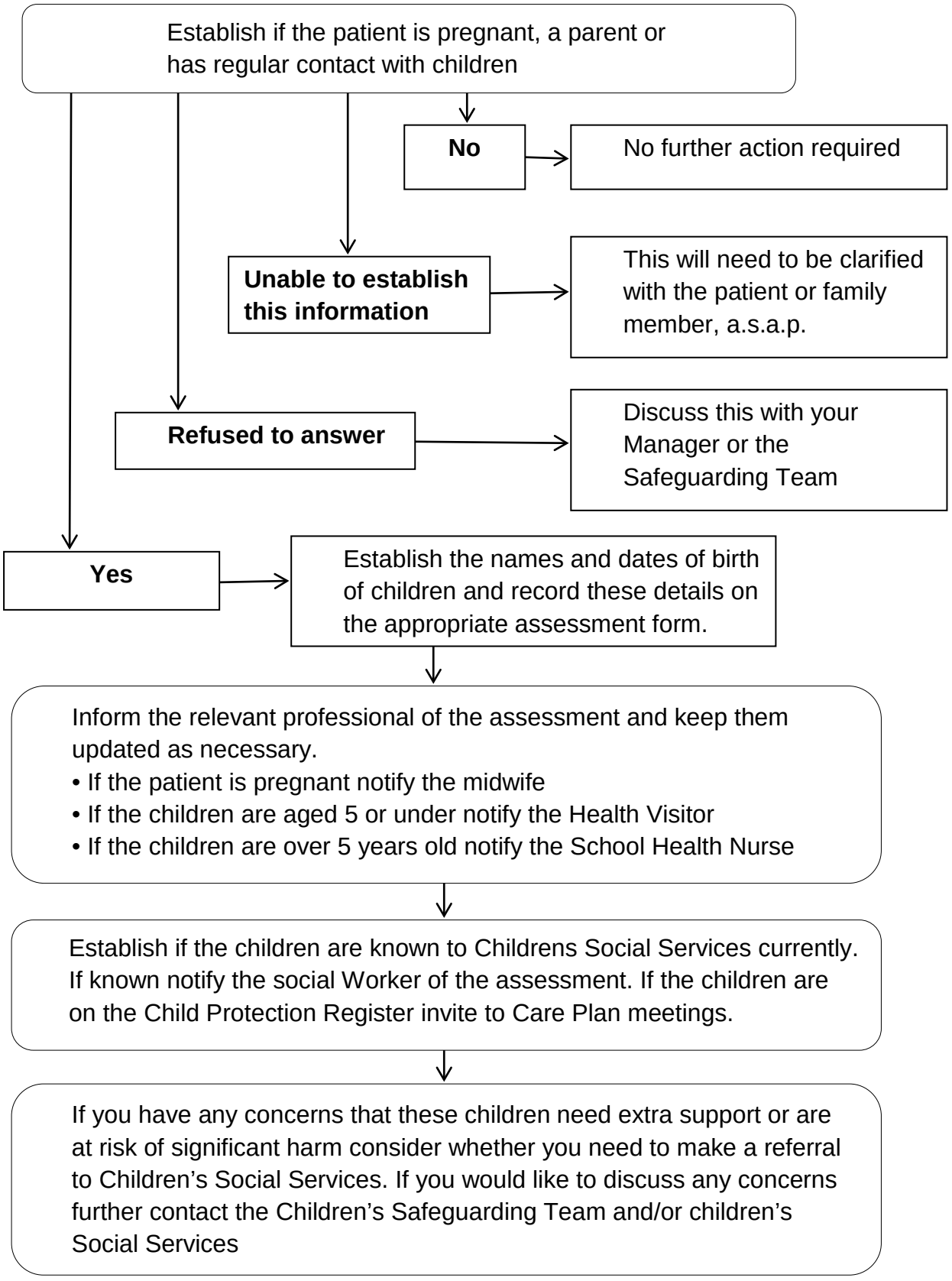
10.6 A number of professionals from a variety of agencies may be involved including Primary Care, Education, Police, Probation and the Voluntary Sector. Consideration must be given to securing multi-agency representation at Joint Planning Meetings.

APPENDIX 1: Assessment Framework



APPENDIX 2:

SAFEGUARDING CHILDREN FLOWCHART FOR MENTAL HEALTH SERVICES



Taken from Safeguarding Children Standards for Adult Mental Health, Public Health Wales, originally adapted from a chart devised by Cardiff and Vale University Health Board

APPENDIX 3:

Continuum of Need as produced in the Regional Threshold & Eligibility for Support Protocol.

Mae'r dudalen hon wedi'i gadael yn wag yn fwriadol

DYFED POWYS ADULTS AT RISK MULTI-AGENCY REFERRAL FORM (MARF)

DETAILS OF PERSON MAKING REFERRAL:					
Name:		**Agency:**		**Date:**	
Telephone:	**Email:**		**Signature:**		

SUBJECT OF REFERRAL: *(Adult at Risk)*					
Surname:	**Forename(s):**		**Other names used:**		
Client/Patient ID Number:		**NHS Number:**		**Marital Status:**	
DOB:	**Age:**	**Gender:**	**Ethnicity:**	**Preferred Language:**	**Need Interpreter:** Yes / No
Adult at Risk's current address: **Adult at Risk's normal residence if different to above, including post code:**				**Post code:** **Telephone:**	
Other adults or children at the property:				**Are they considered also at risk?** Yes / No / Don't know	
GP's Name:	**Surgery Address:**			**Telephone:**	

MAIN CLIENT GROUP: *(Adult at Risk)*		
Elderly Mentally Infirm ☐ Older Person ☐ Visual Impairment ☐ Hearing impairment ☐	Learning Disability ☐ Functional Mental Health ☐ Organic Mental Health *(eg. Dementia)* ☐ Physical Disability ☐	Substance Misuse ☐ Communication difficulties (*please specify*): Other (*Please specify*):
Any other relevant information regarding the client's health status:		

Tudalen 33

IF THERE ARE IMMEDIATE CONCERNS FOR AN ADULT AT RISK, A REFERRAL SHOULD BE MADE IMMEDIATELY BY TELEPHONE TO THE ASSESSMENT SERVICE / DUTY TEAM. IN SUCH CASES THIS FORM SHOULD THEN BE COMPLETED AND SENT TO THE ASSESSMENT SERVICE / DUTY TEAM THE SAME WORKING DAY IN ACCORDANCE WITH ALL WALES PROCEDURES.

ADDITIONAL INFORMATION ABOUT THE SUBJECT BEING REFERRED *(Adult at Risk)*	
Normal care needs of the person being referred, if known: **Who provides this:**	**Why can the adult at risk not protect themself?**
Does the adult at risk have/need an advocate? Yes / No **Give details:**	**What action has been taken to safeguard the adult at risk?**

CAPACITY / CONSENT	
Is the adult at risk subject to legislative powers, such as DoLS, MHA or Power of Attorney? Yes / No **Specify:**	**Is there any evidence to suggest that the adult at risk lacks mental capacity to consent to this referral?** Yes / No
Next of Kin / Person with legal responsibility / Adult at risk's chosen representative (*delete, as appropriate*):	**If the adult at risk has capacity, do they consent to their information being shared with other agencies?** Yes / No
Relationship:	**Is there an overriding reason to share this concern without consent?** (*e.g. a crime has been committed, others may be at risk)* Yes / No **If yes, please explain why:**
Address: **Telephone:**	
Is the adult at risk aware of the referral? Yes / No **If not, please explain why:**	**Has the adult at risk been informed that their information will be shared without consent, where necessary?** Yes / No

Signature of Adult at Risk (or person with legal responsibility) consenting to referral: ……..……..……

Name: **Date:**

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ABOUT THE ALLEGED ABUSE:

Type of alleged abuse: (*tick all relevant boxes*)
Physical ☐ Sexual ☐ Emotional/Psychological ☐ Financial/Material ☐ Neglect ☐

Where did the alleged abuse occur?
Own Home ☐ Care Home - Residential ☐ Care Home – Nursing ☐ Care Home – Respite ☐ Relative's Home ☐
Supported Tenancy ☐ Hospital ☐ Hospital – Independent ☐ NHS Trust Group Home ☐ Home of Perpetrator ☐ Day care ☐
Educational ☐ Sheltered Accommodation ☐ Hospice ☐ Public Place ☐ Other ☐ - Please State:

Is the abuse: Historical ☐ Current ☐

Additional risks/concerns? Racial Abuse ☐ Domestic Abuse ☐ Substance Misuse ☐

REASON FOR REFERRAL / NATURE OF CONCERNS: *(including how and why those concerns have arisen, if known)*

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DESCRIPTION OF ALLEGED ABUSE OR INJURIES:

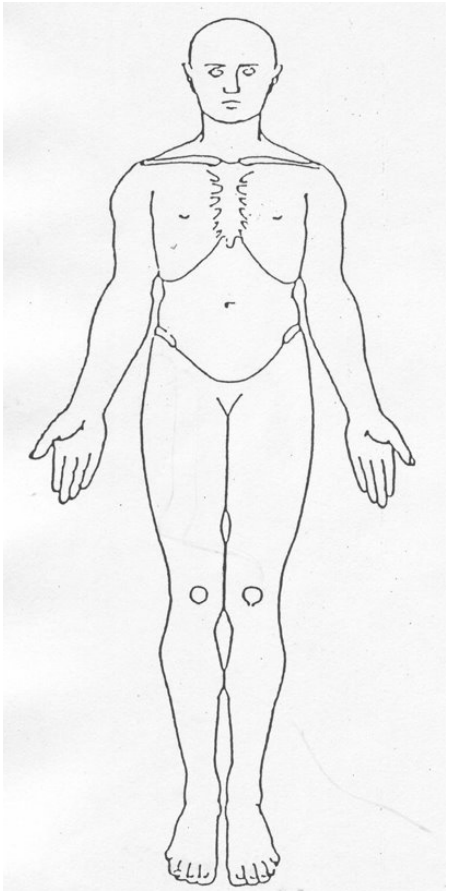
Please provide details of any injuries, marks, bruising, wounds etc:

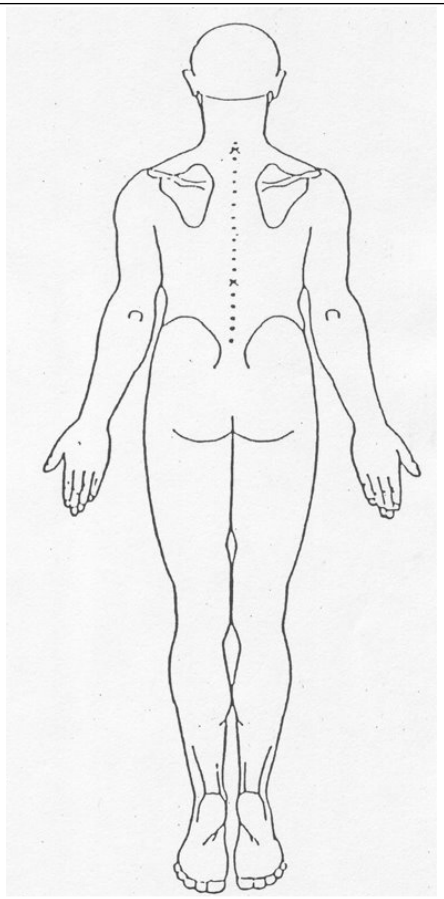
Please use this section to identify the position of any marks, bruising, wounds etc – *for electronic referrals, drag circle over area & relate number to description of injury above.*

1

2

3





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5

6

ABOUT THE PERSON(S) ALLEGEDLY RESPONSIBLE FOR THE ABUSE:			
Unknown at present:		**More than one alleged perpetrator?** Yes / No (*Add details to additional information box on next page)*	
Name:		**Address:** **Telephone:**	
DOB:	**Age:**	**Relationship to Alleged Victim:**	
Perpetrator's Employing Agencies: (List all known)			**Volunteer?** Yes / No
Is the alleged perpetrator an adult at risk? Yes / No / Don't know **If the alleged perpetrator is an adult at risk, do they have capacity to understand their actions?** Yes / No / Don't know			
Is alleged perpetrator a child? Yes / No / Don't know	**Is alleged perpetrator aware of the referral?** Yes / No / Don't know	**Is alleged perpetrator known to Social Services, Health or Police?**	

ABOUT THE PEOPLE WHO WITNESSED THE INCIDENT(S):						
Name of Witness	**Address, inc Post Code**	**Telephone no.**	**Relationship to victim (if any)**	**Is witness a child?**	**Is witness an adult at risk?**	**Is witness aware of referral?**

WHO HAS RAISED THE CONCERN?					
Name	**Address, inc Post Code**	**Telephone no.**	**Relationship to victim (if any)**	**Occupation / Employer**	**When was the disclosure made**

Does the reporter wish to remain anonymous? Yes / No
If yes, explain why: *(excludes professionals)*

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ADDITIONAL INFORMATION:

VIEWS OF THE SUBJECT:

What are the views and wishes of the adult at risk? What would the adult at risk like as an outcome to this referral? What would they like to happen?

Guidance Notes

An "Adult at risk" is a person aged 18 years or over who

- Is experiencing or is at risk of abuse or neglect and
- Has a need for care and support and
- As a result of those needs is unable to protect himself against the abuse or neglect or the risk of it

Adults at risk may have or may lack mental capacity to make specific decisions. The Mental Capacity Act 2005 specifies that:

"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"

A person is assumed to have capacity unless he/she is assessed as unable to do any one of the following:

- Understand the information relevant to the decision; or
- Retain information; or
- Use or weigh that information as part of the process of making the decision; or
- Communicate their decision (whether by talking, using sign language, writing etc)

NOTE: Be aware of information security when sharing or emailing this completed document and ensure you adhere to data protection principles and boundaries of confidentiality.

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DYFED-POWYS MULTI-AGENCY REFERRAL FORM – Supporting Information

IF THERE ARE IMMEDIATE CONCERNS FOR AN ADULT AT RISK, A REFERRAL SHOULD BE MADE IMMEDIATELY BY TELEPHONE TO THE ASSESSMENT SERVICE / DUTY TEAM. IN SUCH CASES THIS FORM SHOULD THEN BE COMPLETED AND SENT TO THE ASSESSMENT TEAM / DUTY TEAM THE SAME WORKING DAY IN ACCORDANCE WITH PROTECTION OF VULNERABLE ADULTS PROCEDURES.

CARMARTHENSHIRE REFERRALS: • Email: cat@carmarthenshire.gov.uk • IAA service on 0300 333 2222 *by Minicom on: 01554 756741 or by SMS: 07892 345678 or make a referral through our website www.carmarthenshire.gov.uk*	**CEREDIGION REFERRALS**: • During Office Hours: Contact Centre – Tel: 01545 574000 Fax: 01545 574002 • E mail: contact-socservs@ceredigion.gov.uk • Outside of Office Hours: Emergency Duty Team – Tel: 0845 6015392
PEMBROKESHIRE REFERRALS: • During Office Hours: Adult Safeguarding Team – Tel: 01437 776056 (no fax facility) • Email: adult.protection.team@pembrokeshire.gov.uk • Outside of Office Hours: Emergency Duty Team – Tel: 08708 509508 [doctors on call answering service take social services calls for out of hours]	**POWYS REFERRALS**: Powys People Direct: • Tel: 01597 827666 • E mail: people.direct@powys.gov.uk

Guidance for Referral

Working together to Safeguard People – volume 1 – Introduction and Overview (s.28) states:

28. Practitioners must share information in accordance with the Data Protection Act 1998 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so. In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the professional deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others.

29. Any personally identifiable information should be shared in accordance with the Wales Accord on the Sharing of Personal Information (WASPI). WASPI is a framework for all Welsh public, independent and third sector organisations. It underpins effective collaboration across organisations, helps overcome perceived barriers and enables staff to share information safely and legally. More information on WASPI can be found via the following link: http://www.waspi.org/. HM Government – Information Sharing: guidance for practitioners and managers highlights:-

3.41 It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You must make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied (except as described in 3.43). There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action - the information shared should be necessary for the purpose and be proportionate.

3.42 There are some circumstances in which sharing confidential information without consent will normally be justified in the public interest. These are:

- when there is evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm; or
- when there is evidence or reasonable cause to believe that an adult is suffering, or is at risk of suffering, serious harm; or
- to prevent significant harm to a child or serious harm to an adult , including through the prevention, detection and prosecution of serious crime.

3.43 An exception to this would be where an adult with capacity to make decisions (see paragraph 3.30 [of Information Sharing: guidance for practitioners and managers]) puts themself at risk but presents no risk of significant harm to children or serious harm to other adults. In this case it may not be justifiable to share information without consent. You should seek advice if you are unsure.

If you have any comments in regard to inaccuracy or additions to this supplementary information or the actual MARF, please contact the Mid & West Wales Safeguarding Board Business Unit at CWMPAS@pembrokeshire.gov.uk

Mae'r dudalen hon wedi'i gadael yn wag yn fwriadol

CWMPAS: The Mid & West Wales Safeguarding Adults Board

Adult Practice Review Protocol

APPROVED

Version	Revision Date	Author	Date approved by Board	Review Date
V1	7/6/2017	Business Unit – based on CPR Protocol	n/a	n/a
V2	19/6/2017	APR Sub Group	13/07/2017	13/07/2019

Context

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

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

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

- Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People Vol. 3 – Adult Practice Reviews
- PRUDiC Protocol
- SSWB (Wales) Act Part 8 Code of Practice on the role of the Director of Social Services (Social Services Functions)
- Adult Practice Review Sub Group Terms of Reference (*January 2017*)
- Local Operational Groups (LOGs) Joint Terms of Reference (*April 2017*)

The Purpose of Practice Reviews

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

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

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

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

Practice reviews are not part of any disciplinary process or inquiry relating to individual practitioners. Where information emerges during any practice review which indicates

disciplinary action would be appropriate, this should be undertaken separately to the practice review and in line with the employing organisations disciplinary procedures. These processes may be conducted at the same time but should be separate. In some cases it may be necessary to immediately evoke disciplinary action in order to protect other adults from harm or suffering.

Safeguarding other adults

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

Concise Reviews

A Safeguarding Board **must** commission a concise adult practice review where an adult at risk who has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health.

Extended Reviews

A Safeguarding Board **must** commission an extended adult practice review where an adult at risk, who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- Died; or
- Sustained a potentially life threatening injury; or
- Sustained serious and permanent impairment of health.

Referring a Case for Consideration for a Practice Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Role of the Regional Adult Practice Review Sub Group

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

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

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

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

The Role of the Local Operational Groups

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

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

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

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

The Role of the Regional Safeguarding Board Business Unit

The role of the Regional Safeguarding Board Business Unit is to support the Regional Adult Practice Review Sub Group, Board Chair and Executive Board in their respective identified roles. The Regional Safeguarding Board Business Unit will be a central point of contact for all cases across the region in respect of cases referred for consideration for APRs. This will enable a clear audit trail to be developed across the region which can support the Board in

having regional oversight of referrals and outcomes; and to ensure learning from APR reviews are disseminated in a robust and timely manner.

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

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

Multi-Agency Professional Forums

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

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

Parallel Reviews or Inquiries

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

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

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

Complaints or Disputes arising from Practice Reviews

CWMPAS: The Mid & West Wales Safeguarding Adults Board will continue to follow guidance issued by Welsh Government *'Working Together to Safeguard People – Volume 3: Adult Practice Reviews'* for processing regional practice reviews.

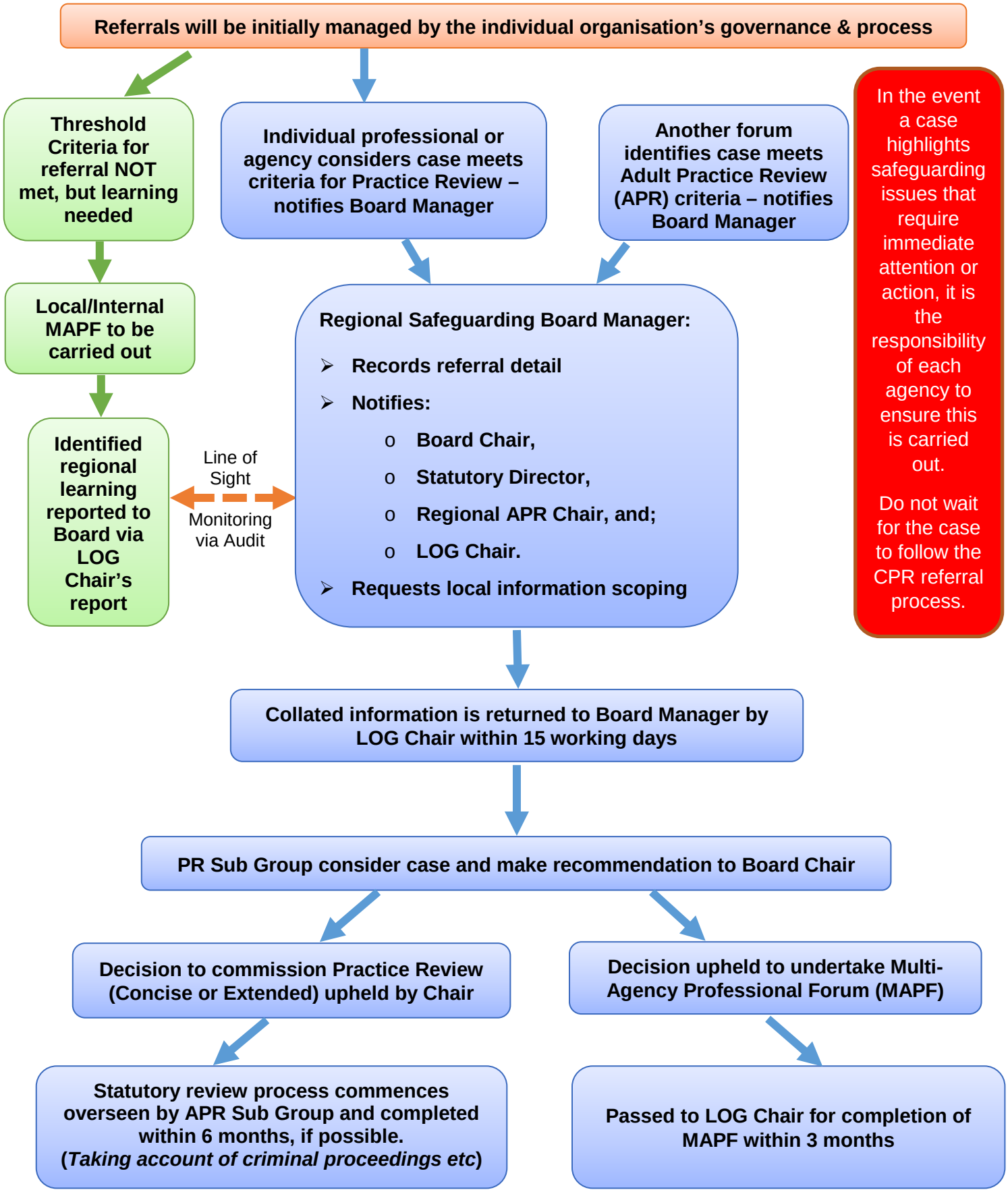
Any complaints or disputes received will be processed following the Board's complaints policy.

Annex List

- **Annex 1** APR Process Flow Chart
- **Annex 2** Referral to CWMPAS Adult Practice Review Sub Group for consideration to undertake an APR (Template)
- **Annex 3** Recommendation to Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group (Template)
- **Annex 4** Decision of the Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group (Template)
- **Annex 5** Proposed Initial Outline of Review & Terms of Reference (Template)
- **Annex 6** APR Report (Template)

Annex 1:

Practice Review Flowchart



Annex 2:

Referral to CWMPAS Adult Practice Review Sub Group for consideration to undertake an APR

Ref: CWMPAS */2017 (*********)

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

From: **Date discussed at LOG:**

Date of APR Sub Group:

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

Rationale for Request.

Any other relevant information

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

To be completed by referring agency:

Name: Designation:

Contact details:

Annex 3:

Recommendation to Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group

From: xxxxx, Chair of the APR Sub Group

To: xxxxx, Chair of CWMPAS Executive Board

Ref: **CWMPAS */2017 (**********)**

Date of APR Sub Group:

Brief outline of Case

Recommendation	
The APR Sub Group has considered this case and recommends that it meets the criteria for:	
A Concise review	☐
An Extended review	☐
If the criteria are not met for the above reviews, what alternative review process will be undertaken:	
Multi-agency professional forum	☐
No review	☐
Alternative review process	☐
Please specify or detail alternative review process e.g. Domestic Homicide Review: …… ……	

Decision		
Unanimous	☐	
Majority	☐	(Number balance of votes……..)

Rationale for Decision/Recommendation

This should include:

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

Annex 4:

Decision of the Chair of CWMPAS Regional Safeguarding Adults Board from CWMPAS Adult Practice Review Sub Group

Re: CWMPAS */2017 (**********)

Date of APR Sub Group:

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

Signature:

Title: Chair

Date:

Telephone Number:

In discussion with Chair of Sub Group

Date information to be presented to MAWWSB ……..……

Date information sent to Welsh Government ……

Annex 5:

Proposed Initial Outline of Review
(This is an initial outline which will need to be updated as the review proceeds)

Re: CWMPAS */2017 (**********)
Date of APR Sub Group:

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

0-6 months	☐	**6-12 months**	☐

Rationale for time period

More than 12 months	☐

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

Agencies involved in the case being reviewed

(*Include name and designation if known*)

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

Agency identified to Chair Review Panel

(*Include name and designation if known*)

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

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

Terms of Reference for Concise / Extended Adult Practice Review

(Insert Reference for Review)

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

- To examine inter-agency working and service provision for individual x through defined terms of reference.
- To seek contributions to the review from the individual/individuals and appropriate family members and keep them informed of key aspects of progress.
- To identify particular issues for further clarification. (*List issues relevant to particular case.*)
- To produce a report for publication and an action plan.

Core tasks

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

Indicative Roles and responsibilities:

- The Board Co-ordinator will be responsible for maintaining links with all relevant agencies, families and other interests.
- The *Review Panel* Chair will inform the Chair of the Board and the Board sub-group of significant changes in the scope of the review and the terms of reference will be updated accordingly
- The Chair of the Board will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Final Board Report.
- The Board and *Review Panel* will seek legal advice on all matters relating to the review. In particular this will include advice on:
    - terms of reference;
    - disclosure of information;
    - guidance to the *Review Panel* on issues relating to interviewing individual members of staff.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Adults Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Panel* completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- 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

In working with sensitive information in relation to an adult 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 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.

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

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

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

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

Appointment of Reviewer Independent of the Case Management

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

Review Independent of the Case Management – Extended Review

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

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.
- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

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

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

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

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

Anticipated completed report date	……..

To be completed by APR Sub-group Chair:

Signature ……..

Title ……..

Date ……

Telephone number ……

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

For Welsh Government use only

Date information received …….. ……..……..……..……..

Date acknowledgment letter sent to Board Chair ……

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

☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

Annex 6:

Adult Practice Review Report

Mid & West Wales Safeguarding Adults Board

Concise/ Extended *(delete as appropriate)* Adult Practice Review

Re: CWMPAS */2017 (Local Area)

Brief outline of circumstances resulting in the Review

To include here: -

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

An … review was commissioned by … Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Adult Practice Reviews. The criteria for this review are met under *x:*

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

Practice and organisational learning

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

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

Improving Systems and Practice

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

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

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as***	
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 individual or family, nor have I 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 individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	.....
Name *(Print)*		**Name** *(Print)*	.....
Date		**Date**	.....

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

Appendix 1: Terms of reference

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 the services that attended.* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
☐ Family declined involvement

Appendix 2: Summary timeline

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to Board Chair ……....

Date circulated to relevant inspectorates/Policy Leads …….

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

Mae'r dudalen hon wedi'i gadael yn wag yn fwriadol

SAFEGUARDING WEEK 13-17th NOVEMBER 2017				
DATE	**AWARENESS WEEK**		**THEME**	**LEAD BOARD**
MONDAY 13th NOVEMBER	**ALCOHOL AWARENESS / FINANCIAL CAPABILITY / ANTI BULLYING/ SELF CARE**	**World Kindness Day**	**COMMUNITY ENGAGEMENT**	**Western Bay**
TUESDAY 14th NOVEMBER			**MODERN SLAVERY**	**Cwm Taf**
WEDNESDAY 15th NOVEMBER		**Blue Wednesday (Cancer Depression Awareness)**	**MENTAL HEALTH AND RESILIENCE**	**North Wales**
THURSDAY 16th NOVEMBER			**CYBER SECURITY**	**Mid & West Wales**
FRIDAY 17th NOVEMBER			**DOMESTIC ABUSE**	**South East Wales**

Mae'r dudalen hon wedi'i gadael yn wag yn fwriadol

CYSUR: The Mid & West Wales Safeguarding Children Board

Child Practice Review Protocol

APPROVED

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

Context

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

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

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

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

The Purpose of Practice Reviews

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

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

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

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

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

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

Safeguarding siblings and other children

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

Concise Reviews

A Safeguarding Board **must** undertake a concise child practice review in any of the following cases where, within the board area, abuse or neglect of a child is known or suspected and the child has;

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health or development; **and**

The child was neither on the child protection register nor a looked after child in the 6 months preceding-

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

Extended Reviews

A Board must undertake an extended practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has;

- died; or
- sustained a potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; **and**

The child was on the child protection register and/or was a looked after child (including a person who has turned 18 years of age, but who was a looked after child) on any date during the 6 months preceding -

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

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

Referring a Case for Consideration for a Practice Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Role of the Regional Child Practice Review Sub Group

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

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

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

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

The Role of the Local Operational Groups

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

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

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

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

Multi-Agency Professional Forums

If a decision is made by the Regional Child Practice Review Sub Group and upheld on behalf of the CYSUR Board by the Board Chair that a Multi-Agency Professional Forum (MAPF) is

the most appropriate review mechanism; responsibility for this process will lie with the relevant Local Operational Group.

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

The Role of the Regional Safeguarding Board Business Unit

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

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

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

Parallel Reviews or Inquiries

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

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

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

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

Complaints or Disputes arising from Practice Reviews

CYSUR: The Mid & West Wales Safeguarding Children Board and CWMPAS: The Mid & West Wales Safeguarding Adults Board will continue to follow guidance issued by Welsh Government *'Working Together to Safeguard People – Volume 2: Child Practice Reviews* and *Volume 3: Adult Practice Reviews'* for processing regional practice reviews.

Complaints or disputes will only be heard when it is regarding one of the following aspects of a practice review and within the below timescale:

- The decision regarding as to whether a case meets the criteria for a practice review or;
- The way a practice review is managed or overseen.

A complaint or dispute must be received within 28 calendar days of publication of the review.

The following process will apply:

Stage One – within 15 working days (from date of complaint)

In the first instance the complaint should be made in writing to the Regional Safeguarding Board Manager who will attempt to informally resolve it.

Stage Two – within 25 working days (from date of complaint)

If resolution is not reached through informal discussion at Stage One level within 15 days, the complaint will be escalated to the Board Chair who will discuss the complaint with the Director of the relevant agency or nominated representative for example the Executive Board member to agree how the matter is to be investigated.

If resolution is not reached at Stage Two within 25 days, an independent person with the appropriate knowledge of the practice review process will be commissioned to resolve the issue. This panel may consider written representation from agencies involved and the complainant if considered appropriate.

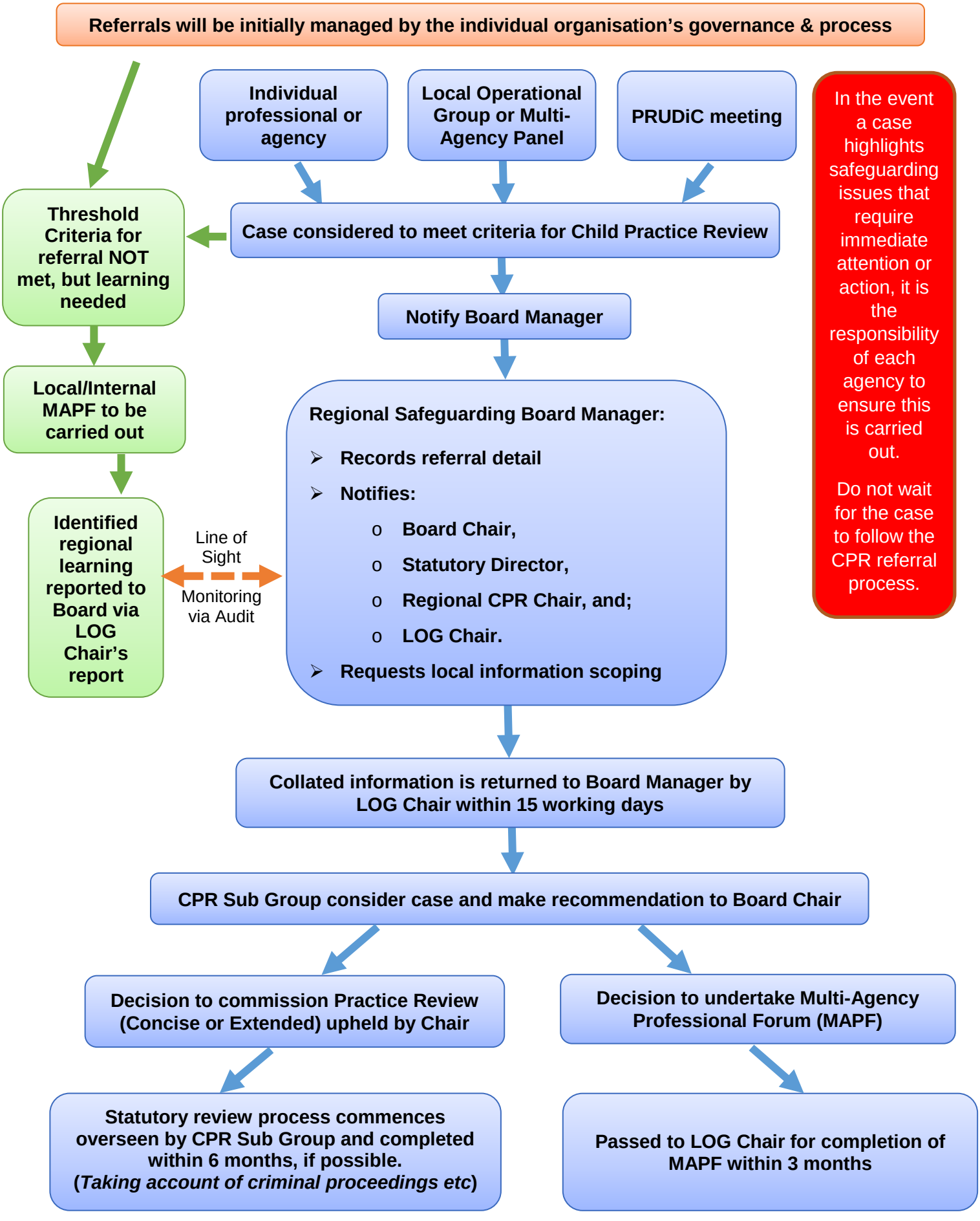
Who Can Complain

- Immediate family member, such as a parent, sibling or grandparent,
- Those with Parental Responsibility, or;
- Carers; such as foster carers or those with whom the child has resided as part of a court arrangement or who has provided accommodation as part of a Care and Support plan, or;

Any professional who has had significant direct involvement with the child with the agreement of and who is supported by their agency can complain using the Resolution of Professional Differences Protocol.

Complaints can consider concerns about the way in which a practice review is managed or overseen, it cannot however consider or deal will any complaints regarding the scope, outcome conclusions or recommendations of a review, or the conduct of any professional. These matters should be dealt with via the individual agency's formal complaints procedures or via the Resolution of Professional Differences Protocol.

Child Practice Review Flowchart



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