CYSUR: The Mid & West Wales Safeguarding Children Board

Child Practice Review Protocol

APPROVED

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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