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Risk, Response and Review: Multi-Agency Safeguarding

A THEMATIC ANALYSIS OF CHILD PRACTICE REVIEWS IN WALES 2023

FULL REPORT
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Please note: A separate **Briefing Report** is also available.

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Preface

The authors of this thematic review appreciate that the events which led to the tragic outcomes for the young people concerned are deeply distressing for all those involved. This includes the young people themselves, their friends and families, the practitioners working alongside them, and the reviewers. We are grateful for all their contributions.

It is acknowledged that these reviews represent a minority of safeguarding scenarios; that is, those that led to the requirement of a CPR. As such, it is advised that the findings should not be taken out of context and automatically generalised as being representative of wider safeguarding practice. In these circumstances, it is recognised that multi-agency safeguarding may not have worked as effectively as it should have, for a variety of reasons. Whilst it is not guaranteed that changes in practice would have changed the outcomes for these young people and their families, it is crucial to reach a full understanding of what occurred, to ascertain any learning from the circumstances surrounding these reviews. Having interviewed many practitioners working within safeguarding, including a national evaluation of the multi-agency safeguarding arrangements within Wales, the authors would like to pay tribute to the passionate and dedicated practitioners and managers, who regularly go above and beyond in their duty to support children, young people, and families. It is well established that the working landscape within the safeguarding arena is incredibly challenging, arguably more so than ever. Key factors including significant cuts in funding, coupled with unprecedented demand for safeguarding support and intervention, have contributed to considerable pressures being placed upon service delivery across agencies. Moreover, it is understood that there are persistent challenges in retaining a "burned out" workforce and recruiting for these roles.

The purpose of a Child Practice Review (CPR) 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". This thematic analysis seeks to understand the recurring themes across CPRs, to highlight the following:

- Trends in child and family characteristics within CPRs
- Intelligence and information held by agencies in contact with the child and/or family
- Barriers, challenges, and what worked well within the safeguarding identification and responses.

Whilst this requires an in-depth, reflective, and at times uncomfortable analysis of these critical incidents, there is no intention to bring adverse attention to any individual practitioner, agency, or area of practice. Each of the individual CPRs, whilst acknowledging the tragic harms and outcomes that occurred, was also able to identify good practice within some of the professional and agency responses. The aim is to learn where challenges exist, where and how good practice can be used to develop and guide opportunities for a more effective way of identifying and responding to safeguarding concerns. This will ultimately minimise the harms being perpetrated and maximise the dissemination of learning across Wales.

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Contents

Preface 3
Figures 5
Introduction 6
Child Practice Reviews (CPRs) 6
Wales Safeguarding Arrangements 7
Previous CPR key findings 7
Aim of the current review 9
Methodology 10
Data 10
Coding and Analysis of CPRs 10
Results 11
Descriptive information of CPRs 11
Section One. Risk Factors: Index Child and Family Characteristics within CPRs 11
Parental/Caregiver risk indicators 13
Index Child vulnerabilities 13
Inferential Analysis of Index Child and Family Characteristics 14
Section Two. Response: Multi-Agency involvement 16
Descriptive Analysis 16
Thematic Analysis of Response: Multi-Agency Involvement and Learning 18
Section Three. Review: Quality of CPRs 29
Descriptive Analysis 29
Thematic Review of Quality Factors within CPRs 31
Discussion 34
Strengthening Collective Safeguarding Responsibility 34
Deep Dive: Missed Health Appointments 36
Recommendations 37
1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS 37
1.1. Multi-Agency Partnership Training: 37
1.2. Professional Curiosity: 37
1.3. Prioritising Support and Supervision for all practitioners: 37
2. RECOMMENDATIONS FOR AUTHORITIES AND BOARDS 38
2.1. Threshold Uncertainty, improving Decision-Making, Agreement and Challenge: 38
2.2. Working towards a unified health record. 38
2.3. Measuring Effectiveness within Safeguarding Arrangements 38
3. RECOMMENDATIONS FOR POLICY MAKERS 38
3.1. CPRs Quality Assurance 38
3.2. Development of Automated Safeguarding Referral/Report Portals 39

3.3. Review of the 'Not Brought' Protocol to maximise this policy into practice. 39
3.4. Recording and Guidance relating to neglect and home conditions 39
3.5. Implementation of the 12Cs as a Guidance Framework and Audit Toolkit 39

Concluding Remarks **40**

References **41**

Appendices **42**

Appendix 1. Flowchart of Child Practice Review Processes 42
Appendix 2. CPR examples of Risk Indicators 43
Appendix 3. Index Child and Parental/Carer Correlations 44
Appendix 4. Diagram of Safeguarding Pathways 46
Appendix 5. Network of (dis)Connections across Services/Agencies/Organisations 48
Appendix 6. Example Template: Child Practice Review Report 50
Appendix 7. Detailed Recommendations: The Child Practice Review Report and Process 54
7.1. Additional detail to be added to the CPR Template 54
7.2. Review and Amendments to the CPR Terms of Reference 'Core Tasks' 54
7.3. Review of required timelines from referral to Sub-Group to Completion of CPR 55

Figures

Figure 1. The six Local Health Boards in Wales 7
Figure 2. Number of CPRs across RSBs 11
Figure 3. Recorded Parental/Carer risk indicators within CPRs 13
Figure 4. Recorded Index Child(ren) vulnerabilities within CPRs 13
Figure 5. Visual Representation of co-occurring parental/carer risk indicators 15
Figure 6. Visual Representation of co-occurring index child vulnerabilities 15
Figure 7. Agencies/Organisations that had engaged with index family/child within CPR 17
Figure 8. Frequency of Recommendations made within CPRs 17
Figure 9. Health Complexities 26
Figure 10. Model of CPR Quality and Consistency 31
Figure 11. Model of Multi-agency Connections, Considerations and Complexities 35

Tables

Table 1. Type of harm recorded to index child 11
Table 2. Age of index child 12
Table 3. Age of index child (LCSPR categories) 13
Table 4. Significant Correlations between Parental/Carer Risk Indicators 14
Table 5. Breakdown of Previous Children's Services history 16
Table 6. Themes across Multi-Agency Involvement and Learning 18
Table 7. Range of dates captured within CPRs 29
Table 8. Descriptive information of CPRs by RSB. 30
Table 9. Timelines included within the CPR Review Period. 30
Table 10. Timelines included within the CPR Review Period. 31

Introduction

CHILD PRACTICE REVIEWS (CPRs)

In accordance with The Safeguarding Boards (Functions and Procedures) (Wales) Regulations (2015), Regional Safeguarding Children Boards (RSBs) have a statutory responsibility to undertake multi-agency Child Practice Reviews (CPRs) in circumstances of a significant incident where abuse or neglect of a child is known or suspected. The key purpose of CPRs is to identify any steps that can be taken by RSB partners or other bodies, to achieve improvements in multi-agency child protection practice.

Welsh Government guidance, the Social Services and Wellbeing (Wales) Act 2014 – Working Together to Safeguard People Volume 2 – Child Practice Reviews, states that there are two types of reviews within CPRs:

1. Concise Reviews[1]

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**

For Concise Reviews, the **child must not** have been 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.

2. Extended Reviews[2]

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.

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

Any agency, practitioner and Safeguarding Board member can raise a concern about a case which they feel has met the criteria for a CPR. This concern should be raised to the RSB Business Manager, which is then forwarded to the CPR Subgroup for consideration. If the criteria for an APR/CPR is met, then a recommendation to hold a review is made to the RSB Children's Chairs. Ultimately, the decision as to whether the case meets the above criteria rests with the respective Board Chair, as advised by the CPR subgroup. The CPR process is defined in the SSWB (Wales) Act (2014): Working Together to Safeguard People Volume 2 – Child Practice Reviews guidance (p.29). This can be found in Appendix 1.

As part of the review process, cases considered by the CPR Subgroup may agree that the criteria for a Child/Adult Practice Review have not been met. This may result in the case being considered by the Multi-Agency Professional Forum to enable a more 'proportionate approach than required by CPRs' (Working Together to Safeguarding People, Vol 2, 2016, p.4) whilst still ensuring the identification and sharing of lessons learnt. In such cases a recommendation can be made to hold a MAPF review.

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[1] Criteria for Concise Reviews can be found within Chapter 6 of the SSWB Act (2014) Working Together to Safeguard People Vol 2.
[2] Criteria for Extended Reviews can be found within Chapter 7 of the SSWB Act (2014) Working Together to Safeguard People Vol 2.

WALES SAFEGUARDING ARRANGEMENTS

The Welsh Assembly Government's One Wales Strategy (Health in Wales, 2021) reorganised the structure of NHS Wales creating single local health organisations responsible for delivering healthcare services within a geographical area, rather than the Trust and Local Health Board system. This resulted in six Health Boards and three NHS Trusts in Wales (see Figure 1). These six Local Health Boards (LHBs) have responsibility for the planning and delivering of healthcare services in their local area.

Figure 1. The six Local Health Boards in Wales[3]

The Social Services and Well-Being (Wales) Act 2014 came into force on the 6th of April 2016. The Act allows service users to have more control over the care and support they require as well as carers being allowed to have equal input around the type of support available for those they care for. The Act emphasises the creation of good effective partnership and collaboration. The focus of the Act is on the 'people approach', promoting people's independence to give them a stronger 'voice and control' (NISB, 2021a). The purpose of the Act is to integrate and simplify the law to allow for greater consistency and clarity to those working with individuals who require all forms of care and support. Moreover, early intervention and prevention are part of the core principles of the Act.

In addition, the Wales Safeguarding Procedures (2021) detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect. The Procedures are intended to help practitioners apply the SSWB (Wales) Act (2014) and statutory guidance Working Together to Safeguarding People and help standardise practice across all of Wales and between agencies. It is important to note that these procedures are intended to guide safeguarding practice for all those employed in the statutory, third (voluntary) and private sector in health, social care, education, police, justice and other services. They are applicable for all practitioners and managers working in Wales – whether employed by a devolved or non-devolved agency (NISB, 2023).

PREVIOUS CPR KEY FINDINGS

A previous commissioned review completed by Cardiff University in 2019 and later published in Child Abuse Review (Rees, et al., 2021) **examined 20 Child Practice Reviews in Wales**. Four key themes were extracted from their thematic analysis including:

(1) Hierarchy of knowledge.

(2) Information sharing/recording.

(3) Partial assessments

(4) Voice of the child.

Regarding the theme Hierarchy of knowledge, the review found that there were 'some forms of knowledge were privileged over others' (Rees et al., 2021, p.145). This Hierarchy of knowledge was described as present when professionals' views had taken precedence over family or community concerns. This was also noted within to be an issue within families themselves, with attention and credit given to adults within family units, compared to children and young people, with this hierarchy often placing mothers' thoughts and self-reports at top and fathers often absent.

Theme two of Information sharing and recording, (a reoccurring learning point noted in most reviews of safeguarding practice) discussed the issues about understanding consent and this hindering sharing of information. It was noted within the review that information was 'sometimes hindered by Children's Services failure to pass on information in a timely manner; (p. 146). Examples such as sharing information received from police to other agencies supporting the family, with examples also given about notifications of withdrawing support of Children's Services not well communicated. Identification of information sharing within health where children were missing appointments, lack of engagement with a service and closure/removal of support without wider consideration of the welfare of the child were highlighted. Key areas were identified as 1) Recording keeping, 2) Consistency of language and 3) Chronologies. This was exemplified in a CPR describing issues in recording, inconsistent

[3] https://safeguardingboard.wales/find-your-board/

language of home conditions within neglect cases. This was found to hinder understanding of risk and subsequent decision making.

Linked to the previous themes, theme three identified an issue with Partial assessments with the analysis indicating individualistic rather than whole family approaches to assessments. Examples were given around identified mental ill-health, or drug and alcohol problems where focus is on the adults, with less consideration of the child. The impact of large families and sibling groups were noted, particularly where there are additional needs within the family (such as complex health needs).

The final theme of Voice of the child were highlighted as either absent or not always 'central to practice' (p. 148). Adopting a more child-friendly approach was not always seen within the CPRs, with observations lacking in description in understanding the daily lived experience of the child within the home. This was further expanded regarding those children being home schooled, and those within larger families. Focus on the Children's Lived Experiences (CLE) was seen as a preferred term to 'voice of child' to ensure the capturing of their day-to-day life.

Rees et al's. (2021) review also identified a range of challenges within the CPR process. These highlighted issues in:

- Lack of detail: the balance of providing context to help other areas understand the key factors and learning to be taken from the review process. This was seen to be challenging due to the need to balance the anonymity of families.
- Workloads and supervision: noted the increased and unmanageable workloads particularly within Social Services, compounded by issues of retention, meaning acute/critical needs are prioritised. This also makes supervision to be more ad-hoc and not effectively used for new staff who require additional support.
- Data protection and safeguarding: challenges with the implementation of GDPR and the Data Protection Act (2018) with this adding further confusion and creating barriers to effective, collaborative working. Anxieties were reported amongst professionals and their ability to share information.
- Agile working: this centred on reliance of information held on data bases, which is often partial or missing, but also in terms of time/capacity to engage in reflection, support and learning as part of a team. Concerns were raised about lone working expectations within Social Work, whereas many stated the benefits in peer learning, agile discussions to help with their professional practice and provide essential support.
- Dissemination of CPRs: with challenges noted in the accessibility of CPRs only being available of Regional Safeguarding Boards websites for a minimum period of 12 weeks. It was noted that with no central repository, this limits the ability for larger scale reviews in identifying key overlapping themes across Wales.

Key recommendations centred on the need for multi-agency training in GDPR across RSBs to ensure understanding of the ability to share information (as per Lord Laming, 2003 inquiry) where clear justification exists. Consideration of how to develop more creative ways to share findings from CPRs, which was linked to a need for a central repository to help facilitate this learning. A final key message from the review was to ensure that the child is 'repositioned at the centre of the process and the voice of the child is heard' (p.141), with additional training likely to be required in helping to achieve this.

A recent publication of **Local Child Safeguarding Practice Reviews (LCSPRs)** in England completed by The Child Safeguarding Practice Review Panel (2022) reviewed 84 LCSPRs, with additional data from 22 local child safeguarding partnerships through questionnaires and focus group discussions. The report highlighted that the median length to complete an LCSPR after the rapid review was 58 weeks, outside the statutory requirement of 26 weeks, with one case taking 2.5 years. Conclusions further emphasised the well-known concerns regarding the effectiveness of safeguarding practice are undermined by serious resource shortages. Some of the additional key messages centred on:

- Promoting cultures in giving staff confidence to ask questions, to be able to give and receive challenge (professional challenge).
- Need for practitioners to have access to proper support and resources, particularly regarding specialist services for families and children.
- Working with families who display 'reluctant and sporadic engagement' and those that displayed disguise compliance.
- Details of the day-to-day experience of the practitioner were not visible within reports. Recording the challenges will help to understand the context of decision making within particularly challenging and complex situations.
- Racial, ethnic, and cultural identities to be given appropriate weights when exploring the child(ren) in safeguarding responses and within reviews. Additional awareness raising of the interactions with other adversities in working with families.
- High quality reviews were noted as containing the voices of the family and young people

within them, with these contributions analysed alongside the information within the review.

- Wide variations in review reports in terms of style of writing, length, use of evidence, analytical detail, and clarity of learning, with this seen to be contingent on the individual author and their expertise.
- Ability to convert recommendations by the safeguarding partnership into SMART action plans, with an understanding of the limited likely action from ‘macro level’ recommendations that were seen as beyond the control of the partnership. This linked to preferences of learning to be disseminated by 7-minute briefings (or similar) and videos (YouTube).

There is a plethora of additional work that has focussed on key areas highlighted within CPRs, such as **neglect**. The NSPCC (2022) learning from case reviews highlighted overlapping vulnerabilities within neglect cases, including factors such as parental domestic abuse, drug and alcohol misuse, parental mental health issues, young parents, social isolation, financial issues linked to housing and poverty, and children with complex health needs and/or disabilities. Indicators of neglect were noted as tooth decay, repeated episodes of head lice, accidental injuries, poor school attendance, missed health appointments and unsuitable home environment, amongst others. The challenges noted in effectively responding to neglect cases were seen as multiple, and often overlapping across services. This made identifying the level of neglect and level of harm being caused, challenging, with one key challenge noted as professional desensitisation and normalisation.

Further reports have focussed on child maltreatment when there is a **medical cause of death**. Garstang et al (2021) conducted a review of these 23 children noted to have died unexpected in 20 cases, with maltreatment contributing to their death in 18 out of 23 cases. They conclude that all the Serious Case Reviews (SCRs) recorded indicators of abusive or neglectful parenting, with evidence of cumulative harms prior to their death. Therefore, whilst the child was identified as having an incurable medical issue, the ‘maltreatment that often exacerbated the medical issue could have been prevented’.

AIM OF THE CURRENT REVIEW

The purpose of a CPR 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”. This Thematic Review seeks to further the evidence base through a National Review of 33 CPRs. This review aims to understand the reoccurring themes across CPRs, to highlight:

- Trends in child and family characteristics within CPRs
- Intelligence and information held by agencies in contact with the child and/or family
- Barriers, pressures, and challenges which may impact upon safeguarding identification and responses.

The aim is to minimise harms being perpetrated on children by understanding where challenges and barriers in multi-agency safeguarding exist, to facilitate a more effective safeguarding response. As part of the process in analysing the CPR data, the analysis is divided into three key stages:

- **Risk: Index Child and Family Characteristics within CPRs**

This includes descriptive information to identify trends within the child and family characteristics and risk indicators. Additional inferential analysis has used Phi correlational analysis and PROXSCAL, a multidimensional scaling technique, to explore any potential co-occurrence of risk indicators across the index child and family.

- **Response: Organisational and Agency Involvement Prior to the Index Incident**

This includes descriptive information to identify which organisations and agencies were aware of the child and/or family members prior to the index incident. This stage also includes the thematic analysis of the CPR multi-agency learning and response.

- **Review: Quality of CPRs**

Given that the information contained within the CPRs aims to act as a key facilitator to drive learning, change, and action, it is important to explore the CPR reports themselves, in terms of structure, content, and adherence to the CPR processes as per Working Together to Safeguard People Volume 2 (2016). This was also highlighted as an important factor by previous national reviews (Rees et al., 2021).

Finally, this review seeks to feed into the core aims of the National Independent Safeguarding Board Wales in their mission to:

1. Ensuring that Safeguarding Boards are effective
2. Reporting on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales; and
3. Making recommendations to the Welsh Ministers as to how those arrangements could be improved.

Methodology

DATA

Child Practice Reviews (CPRs) across Wales were provided to the review team by email from the National Independent Safeguarding Board (NISB) Wales. The information was either provided via a hyperlink direct to the Regional Safeguarding Board (RSB) website to download the CPR report, or as an embedded pdf within the main document. The first stage of reviewing the sample aimed to ensure that none of the CPRs had been included in Rees et al.'s previous reviews (2019, 2021). Additionally, the research team checked each of the RSB websites and identified two extra CPRs that had been published but were not provided as part of the NISB's list. This gave a final sample of 33 CPRs to review.

Two members of the team were responsible for initial coding of the data. This required extracting basic information contained within the CPR, such as the RSB area, date of index incident, review timeline, and whether the CPR was conducted as a Concise or Extended review. This identified that the sample included a wide range of dates relating to the index incident, with one CPR incident occurring in 2013. A detailed methodology and descriptive overview is detailed within the Results section of this report.

CODING AND ANALYSIS OF CPRS

In developing the coding framework, three CPRs were selected across different RSBs that included at least one concise and one extended CPR. These were read and coded and initial key themes identified which were then discussed and explored. This process identified three broad areas for the coding framework: Child and Family Characteristics; Organisational and Agency Involvement up to point of index incident and the Quality of the CPR itself. Additional codes were then identified deductively based on key concepts and indicators identified in relevant literature, with the approach also using an inductive approach to identify patterns within the data. The two researchers worked independently (both are academics, with one a previous qualified social worker) and came together at completion of five cases to discuss and compare coding and to assess levels of agreement and formalise a coding strategy for the remaining CPRs. All themes were derived accumulatively which were refined and modified until the finalised themes were established. CPRs were then re-analysed in accordance with the thematic framework to ensure that the existing themes captured all the coding information. A third reviewer was available to consult if there was disagreement, however, this was not required with discussions leading to agreements on key themes. Each of the reviewers used excel to analyse data then merged into one main file. This file contained mainly open qualitative responses under each code. Within the Organisational and Agency Involvement, three key themes were identified from the analysis, with subthemes within these, which are detailed in Section 2.

Further analysis sought to examine the frequency of the codes created to capture the frequency and presence of key factors, such as key child and family characteristics. These were coded as either present, or not known. This dichotomous approach to coding was deemed most appropriate given that the coding was solely reliant on the information provided within the report. For example, a CPR may not mention domestic abuse, or alcohol misuse, but the absence of this may not reflect the reality of that lived experience. Therefore, any descriptive analysis needs to ensure caution on any findings reported. Once appropriate codes were transformed, the data was transferred to SPSS v.21. Using SPSS, the data was explored using descriptive analysis across child and parental indicators, as well as other key information such as recommendations highlighted within each CPR.

To examine the relationships between the individual vulnerabilities, Phi-coefficients were conducted. Only vulnerabilities which occurred in more than two cases were included in this analysis. A Phi coefficient of .7 or above indicated a Very strong correlation, .4-.7 a Strong correlation and .3-.39 a Moderate correlation. Phi-coefficients, however, only report the relationship between two vulnerabilities. To explore the relationships between all the vulnerabilities simultaneously, PROXSCAL a multi-dimensional scaling technique, was used to represent these relationships on a spatial plot such that the closer the distance between two vulnerabilities the higher their correlation. Clusters or themes of co-occurring vulnerabilities can then be identified. Only vulnerabilities which had significant Phi-coefficients were included in this analysis.

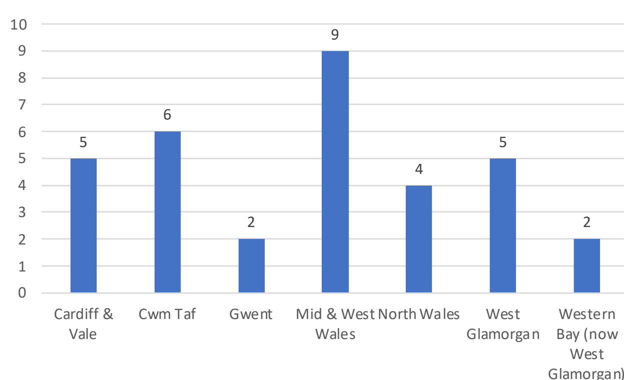
As data has been coded from CPRs it may be possible that vulnerabilities were present but not recorded. In accordance with previous studies using archival data (Almond et al, 2022, Bonny et al. 2016) the measure of association selected for the PROXSCAL analysis, Lance and Williams, does not increase the association between vulnerabilities if they are both non-occurrences. PROXSCAL provides a measure of stress or goodness of fit between the resulting plot and the observed data. The lower this stress measure the more accurate the plot represents the correlation matrix. A good fit is considered to be between 0 and 0.15 (Stalans, 1995).

Results

DESCRIPTIVE INFORMATION OF CPRs

In total 33 CPRs were identified and shared with the Research Team. Figure 2 below shows that there was a good distribution of CPRs across most of the 6 Regional Safeguarding Boards (RSBs). It is worth noting that Western Bay is now within West Glamorgan Regional Safeguarding Board, which takes West Glamorgan up to 7 CPRs within this review. Gwent, however, had the lowest number of CPRs, with only 2 provided to the team.

Figure 2. Number of CPRs across RSBs



Out of the 33 CPRs, a third (11, 32.3%) were conducted as **Extended CPRs**, with most (21, 63.6%) were **Concise**. One CPR was noted as historical. Out of the 11 Extended CPRs all had 2 reviewers that signed and dated the review, except for one review, which only had 1 reviewer sign the final report. This was noted to be an issue with the 2nd reviewer becoming unavailable at the final report stage of the process.

28 out of the 33 (84.8%) CPRs recorded the main (index) incident date relating to the child occurring after implementation of the **Social Services and Wellbeing Act (SSWB) Act 2014**. With the implementation date of the Act being 6th April 2016. This means 5 (15.2%) of the CPRs index incident occurred had the index incident occur prior to 6th April 2016.

The **Wales Safeguarding Procedures (2019)** guidance was launched in November 2019; however, implementation was initially set for all RSBs by April 2020. Due to Covid-19, this was extended to June 2020. However, most RSBs were already implementing parts of the Safeguarding Procedures from November 2019. For context, only 8 (24.2%) of the CPRs recorded the index incident as occurring after the Safeguarding Procedures were launched (Nov, 2019). The majority took place (N = 25, 75.8%) prior to this guidance being implemented.

When examining the Timeline Review Periods within the CPRs, 5 out of the 32 (15.2%) included a period that was subject to **Covid-19 pandemic restrictions** which may have impacted on services and responses by agencies at that time. However, we have taken this Covid-19 timeline wider by using the date of incident and final sign off date of the CPR, 21 CPRs would have been at least part completed when there was likely to be Covid-19 restrictions (63.6%) in place. This may have impacted on the CPR process in various ways such as limited access to professionals, family, and friends to engage with the CPR (although remote options were available), the issues of reduced workforce and availability of reviewers likely decreased during Covid-19 restrictions with reviewers all practicing professionals.

SECTION ONE. RISK FACTORS: INDEX CHILD AND FAMILY CHARACTERISTICS WITHIN CPRS

From the 33 CPRs, 21 resulted in the death of the index child (63.6%). Just over a third (N = 12, 36.4%) were recorded as resulting in either potentially life-threatening injury or sustained serious and permanent impairment of health and development. Furthermore, when looking at the type of index incident that led to the CPR, Table 1 below highlights the types of incidents recorded within the CPRs. Suicide was the highest type of harm recorded as the index incident, followed by the Other category. Five cases within this category were medical/health related and were found to be noted as natural causes due to issues such as heart conditions, diabetes, etc. One case was noted as a drug overdose at a party and was not concluded as suicide (or misadventure).

Table 1. Type of harm recorded to index child

Type	Frequency	Percent
Suicide	7	21.2
Other (e.g., medical/ health issues)	6	18.2
Non-Fatal Physical Abuse	5	15.2
SUDI	4	12.1
Non-Fatal-Neglect	3	9.1
Fatal-Physical Abuse	2	6.1
Child Sexual Abuse – Intrafamilial	1	3.0
Child Sexual Exploitation – Extrafamilial	1	3.0
Fatal-Neglect	1	3.0
Non-Fatal-Emotional Abuse	1	3.0
Not Known	1	3.0
Total	33	100

Regarding the **gender of any index children**, 11 of the CPRs did not provide this information. For the 22 that did, this was seen as 11 females and 10 males, with one as both genders due to including more than one index child. Additionally, Table 2 and 3 below provides a summary of the **ages of the index child subject to the CPR**. Seven CPRs were noted as missing information regarding the age of the child (22.6%). This was due to two of the CPRs (CPR9 and CPR11) having multiple victims over various ages that were not specified in the report. Additionally, CPR11 was a historical case of Child Sexual Abuse where the victim, now an adult adult, reported their abuse by their father against her and her sister throughout their childhood. Five of the other CPRs did not provide any information about the age of the index child.

Out of the 24 CPRs that did provide the age of the child, the highest frequency of age was under 1 years at 41.7% (N = 10). However, given that 7 out of the 10 under 1years were aged 0-3 months, this indicates a higher rate of index incidents occurring within this age group for the CPRs analysed. Hence the importance of breaking age down further than under 1. There was noted low frequencies within the 6-10 and 6-12 years, with frequencies increasing after this age (13+ years, N = 5).

Table 2. Age of index child

Age category	Frequency	Percent
0-3 months	7	21.2%
4-6 months	1	3.0%
7-9 months	1	3.0%
10-12 months	2	6.1%
13 months – 2 years	3	9.1%
3-5 years	4	12.1%
6-12 years	1	3.0%
13-17 years	6	18.2%
18 years[5]	1	3.0%

Table 3. Age of index child (LCSPR categories[4])

Age category	Frequency	Percent
Under 1 years	10	30.3%
1-5 years	8	24.2%
6-10 years	1	3.0%
11-15 years	3	9.1%
16+ years	4	12.1%

The patterns seen in **age are likely linked to the trends seen in type of injury**. Out of the seven 0-3 months index babies, four of these were recorded as Sudden Unexpected Death in Infants (SUDIs) (57%). With two recorded as Non-Fatal Neglect, and one 'Other' due to Medical/Health Complications from birth. The 13-17 years age group recorded 4 out of 6 (80%) of cases as suicide (or misadventure), with one case as Child Sexual Exploitation (Extra-Familial) and another as 'Other' due to drug overdose at a party. Those aged 3-5 years were more varied, with no trends in type of harm recorded for this age group with this broken down across: Fatal Physical Abuse, Non-Fatal Neglect, 'Other' from medical/health complications, and one where no information on type of harm was recorded.

Out of the 33 cases, 75.8% (n = 25) recorded that the child subject to the review also had a **sibling** (including half siblings). Only 5 cases involved an only child (15.2%). Of those 24 cases that recorded detail on siblings, 9 of these were recorded as including a **half-sibling** (37.5%). 28 of CPRs recorded if the family unit of the index child was living had 3 or more children within it, with 15 (45.5%) recording a large sibling group. It was also noted the child subject to the CPR was the **youngest child** in 14 out of the 21 cases that recorded this information (66.6%).

It was noted that 15.2% (N = 5) found the mother of the index child was in relationship/living with a partner that was **not the biological father**, with 19 cases (57.6%) stating this was not the case (either both biological parents, or single parent with no partner). For 9 cases it was not possible to gain this information.

Just under half of the CPRs (N = 16, 48.5%) noted **domestic abuse** as a key factor within the history or current circumstances. This could either be a parent of the index child was directly suffering domestic abuse with the index child potentially witnessing the abuse, but this also related to historical notes of domestic abuse of parents (e.g., they suffered domestic abuse as a child themselves). Over half of CPRs noted the presence of **substance misuse and/or alcohol misuse** by parents/carers of the index child or was noted as present in the older index children (N = 18, 54.5%). Within these 18 cases this was most likely to be noted as cannabis use (N = 8, 44%).

[4] Age Categories that were utilised in the recently published The Child Safeguarding Practical Review Panel Annual Report 2021: Patterns in practice, key messages and 2022 work programme: [Child Safeguarding Practice Review Panel: annual report 2021 – GOV.UK (www.gov.uk)]

[5] One 18-year-old was included as CPR due to being on Child Protection Register up to her 18th birthday (which was shortly prior to her death) and also a care leaver in receipt of a Pathway Plan.

Parental/Caregiver risk indicators[6]

Although caution should be noted following the descriptive information due to consistency in reporting information[7], Figure 3 highlights the noted **risk indicators for parents/caregivers** of the index child subject to the review. This noted that **drugs/alcohol issues** (N = 15) were noted as the highest frequency within CPRs, followed by identified **mental health issues** (N = 13) and there being **domestic abuse** present in the current relationship (N = 13). Three of the 33 reviews highlighted that at least one parent/caregiver of the index child was themselves a Looked After Child.

Figure 3. Recorded Parental/Carer risk indicators within CPRs

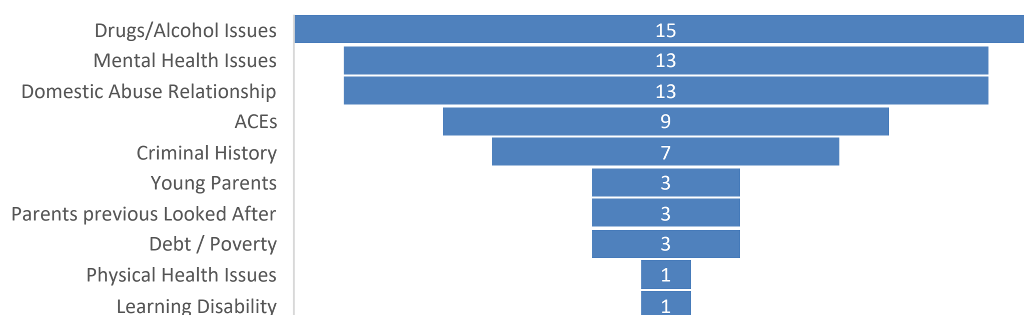
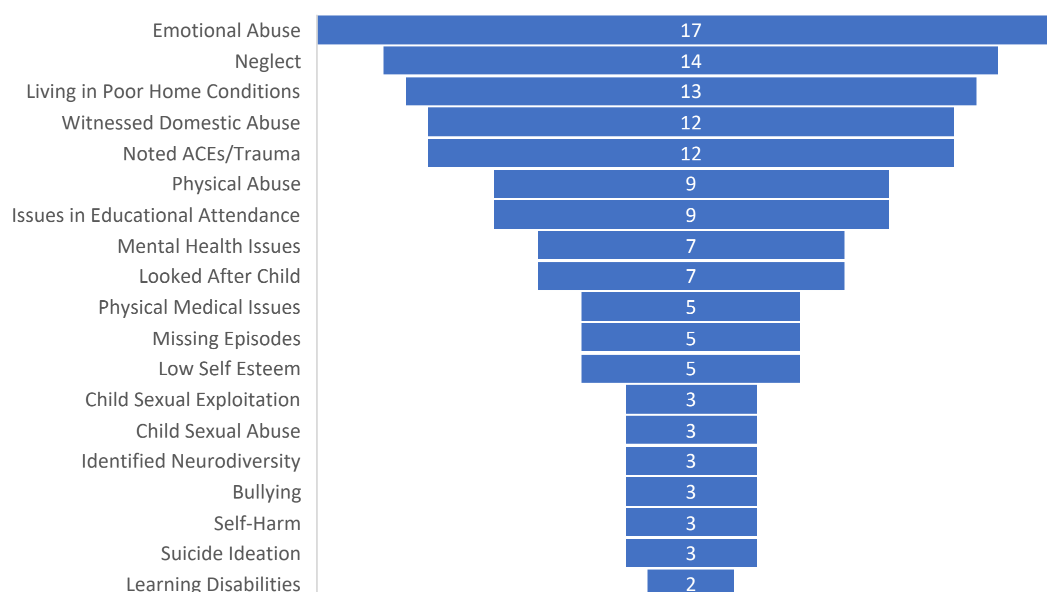


Figure 4. Recorded Index Child(ren) vulnerabilities within CPRs



Index Child vulnerabilities[8]

Similarly, several key indicators were noted for the index child(ren) subject to review. Again, caution should be noted in interpreting these figures due to reliance of information within the CPR . Exploring the recorded index child vulnerabilities, they were most likely to have noted to be experiencing emotional abuse (N = 17), followed by neglect (N = 14), poor home conditions (N = 13) and were actively exposed to ACEs (N = 12) and domestic abuse (N = 12).

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[6] It is important to note that coding of the presence of a child vulnerability means this was recorded in some way by a service/agency/organisation within the timeline of the review. For example, a parent noting their experience of domestic abuse after the index incident with no services aware of this experience would not be coded as a relationship domestic abuse as coding was based on what information key agencies had available at the time of decision making.

[7] Absence of a vulnerability may not necessarily mean this was not present within the circumstances of the parent/carer, with coding based on the detail provided within the review.

[8] It is important to note that coding of the presence of a child vulnerability means this was recorded in some way by a service/agency/organisation within the timeline of the review. For example, discovering poor home conditions after the index incident would NOT be coded as poor home conditions, as coding was based on what information key agencies had available at the time of decision making.

Inferential Analysis of Index Child and Family Characteristics

The following analysis explored the relationships across the index child and parental/carer characteristics and risk indicators. Phi Coefficients were used as this is a measure of association between two binary variables. In interpreting Phi Coefficients, .7 or higher indicates a very strong positive relationship. .4 – .69 strong positive relationship, .3 to .39 moderate positive relationship.

Taking the parental/carer risk indicators first, Table 4 highlights the correlations between each of the factors. The strongest positive correlation was found between parental ACEs and parental Mental Health Issues (Phi = .76, $p < .006$). Many of the risk indicators correlated with each other, with 5 of the indicators (MH, Criminal History, ACEs, Domestic Abuse Relationship and Young Parents) significantly correlated with 6 other indicators.

For child vulnerabilities, there were also several significant associations between the indicators, with the Bonferroni adjusted value set at $p < .003$. Appendix 3 outputs highlights only those with significant associations, with learning disabilities removed due to low frequency (N = 2). Caution should be noted when interpreting these findings, given that the ages of the index child subject to the review ranged from 35 minutes old to 18 years old. The younger age of the index child would automatically remove the likelihood of presence of some key indicators. For example, babies and younger children are unlikely to have recorded factors such as child sexual exploitation, bullying, suicide, missing episodes, and so on. However, analysis indicated that out of the 16 significant correlating factors, mental health issues and ACEs in the index child were significantly correlated with 12 other factors. These two factors were those factors most likely to be co-occurring with other factors within the index child's circumstances. This was closely followed by those noted as Looked After children (10 significant correlations) and missing episodes (10 significant correlations). Interestingly, even though poor home conditions were reported in 13 cases, this was only significantly positively correlated with physical medical issues.

Finally, the associations between Index Child and Parental/Carer risk indicators were examined using Phi Coefficients. Concerns were noted in examining the parental/carer indicators against child vulnerabilities, due to the issues in the large variance of age within the children, which resulted in many negative associations (due to the lack of presence in the child factors due to age, e.g., significant negative correlations between parental drugs/alcohol issues with index child Mental Health, Low Self Esteem).

Table 4. Significant Correlations between Parental/Carer Risk Indicators[10]

Parental/Carer Indicators	Mental Health	Drugs/ Alcohol Misuse	Criminal History	ACES	Domestic Abuse Relationship	Young Parents	Previous Looked After
Mental Health Issues		.51***	.49***	.76***	.62***	.39*	.39*
Drugs/Alcohol Misuse	.51***		.42*	.53***	.51***	.35*	
Criminal History	.49***	.42*		.51***	.64***	.35*	.61***
ACES	.76***	.53***	.51***		.48***	.52***	.52***
Domestic Abuse Relationship	.62***	.51***	.64***	.48***		.39*	.39*
Young Parents	.39*	.35*	.35*	.52***	.39*		.63***
Previous Looked After	.39*		.61***	.52***	.39*	.63***	

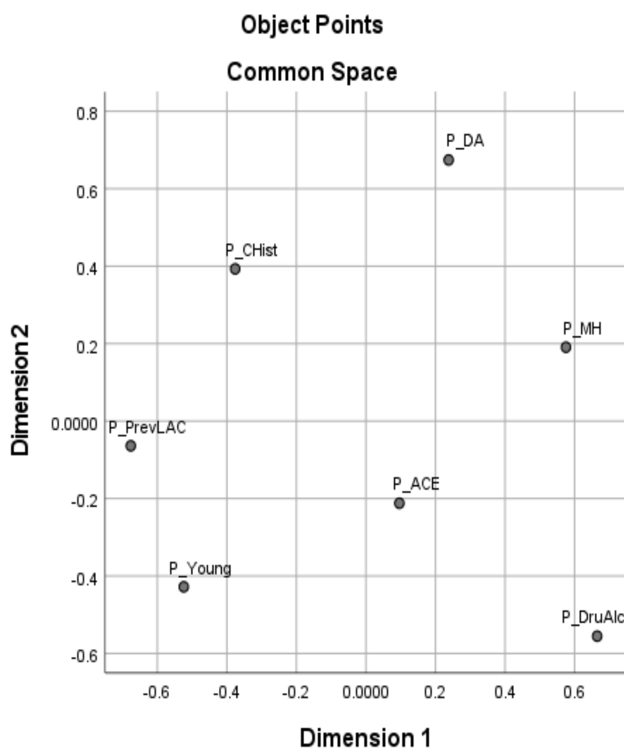
[10] *p <.05, **p <.01, ***Bonferroni correction p <.006

Multidimensional Scaling Analysis: PROXSCAL

To explore the relationships between all the vulnerabilities simultaneously, PROXSCAL a multi-dimensional scaling technique, was used to represent these relationships on a spatial plot such that the closer the distance between two vulnerabilities the higher their correlation. Clusters or themes of co-occurring vulnerabilities can then be identified. Only vulnerabilities which had significant Phi-coefficients were included in this analysis.

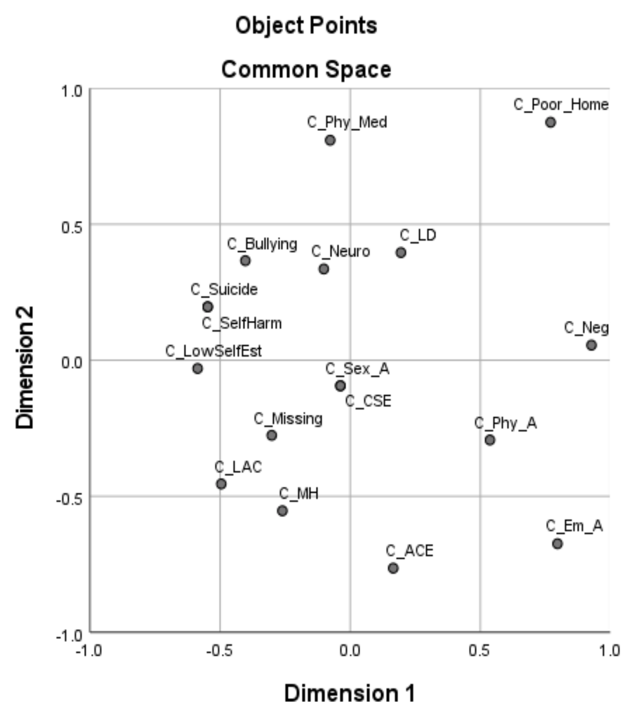
A PROXSCAL analysis was carried out on 7 parental vulnerabilities across 33 child reviews. The stress (normalized raw stress) value for the two-dimensional solution was 0.008, indicating an excellent fit between the PROXSCAL plot and the original association matrix (Stalans, 1995). Figure 5 examining the parental/carer risk indicators highlights a lack of co-occurring factors that cluster closely together but may indicate those parental/carer factors on one dimension that indicate their historical traumatic / emotional experiences from being a Looked After Child themselves, the experiences of ACEs as a child and now being a young parent. With the other factors of criminal history and domestic abuse indicating more behavioural manifestations of these experiences, and mental health issues with drug/alcohol misuse indicating more internal manifestations.

Figure 5. Visual Representation of co-occurring parental/carer risk indicators



A PROXSCAL analysis was carried out on 17 child vulnerabilities across 33 child reviews. The stress (normalized raw stress) value for the two-dimensional solution was 0.03, indicating a very good fit between the PROXSCAL plot and the original association matrix (Stalans, 1995). Figure 6 below shows that there was more evidence of co-occurring vulnerability factors for the Index Child within the CPRs. These factors were seen to cluster around those that were more internally experienced by the child, such as self-esteem issues, suicide ideation, neurodiversity issues, learning difficulties, and then those vulnerabilities and experiences inflicted upon the child such as neglect, physical abuse, and emotional abuse.

Figure 6. Visual Representation of co-occurring index child vulnerabilities



SECTION TWO. RESPONSE: MULTI-AGENCY INVOLVEMENT

Descriptive Analysis

Given a third (N =11) of the CPRs were completed as Extended CPRs, the very nature of these means that the index child was on the **Child Protection Register and/or was a Looked After Child** on any date during the 6 months preceding the event (index incident). Out of these 11 cases, 7 cases were noted as involving a Looked After Child and 3 were recorded as on the Child Protection Register. One Extended review was a historical report from an adult reporting their child sexual abuse by their father as a child and was therefore not included in further analysis.

Table 5. Breakdown of Previous Children's Services history.

Previous CS history	Frequency
Referral but did not meet CS threshold	18 (54.5%)
Looked After Child	7 (21.2%)
Child Protection Register	4 (12.1%)
Not known	2 (6.1%)
Adopted	1 (3.0%)
Excluded[11]	1 (3.0%)
Total	**33**

Out of the 33 cases that were reviewed in terms of the previous Children Social Services history, it was identified that over half of the cases were referred from some agency to Children's Social Services, or equivalent Multi-Agency Arrangements (such as MASH) with concerns regarding the child and/or family, with 54.5% (N = 18) but were stated as **not meeting threshold for any Children's Service intervention/action/support** (whether this be step-up, intervention/support). For one of these cases, the father of the index child was previously Looked After by the local authority but had been closed and he was in his 20s. However, there were records of several PPNs (Public Protection Notice[12]) relating to the home address with concerns of domestic abuse, with MASH[13] (Multi-Agency Safeguarding Hub) referrals closed relating to father as it was recorded that the mother of the baby did not reside with the father (which was later to be found to be inaccurate). Queries with the mother failed to consider the domestic abuse concerns that were recorded and were noted in the CPR to be over-reliant on the mother's self-report and ability to keep her and the baby safe.

Further examination noted that out of the 11 Extended Reviews that had identified the index child as either a Looked After Child or on the Child Protection Register in the 6 months preceding the index incident. **Nine were actively subject to these statutory involvement** at the time of the index incident. Of the two cases that were not active at the time, one of these cases involved an index child that had removed from the CP register 2 months prior to his death. The other had just turned 18 years with her Looked After status removed – she died 2 months after her birthday.

Agency/organisational awareness

Out of the 32[14] CPRs, **only two were not known to Children's Social Services** regarding the index child or family. These two cases did not record any safeguarding concerns with any other statutory services either. This means that **94% (N = 30) recorded at least one referral/notification to Children's Services as highlighted within the CPR[15]**. This did include examples such as CPR 25 which involved twins, where one twin was in hospital for a planned surgical admission. Hospital staff submitted several referrals/reports to the Emergency Duty Team due to behaviour of mother (cannabis smell, not visiting child on ward, partying whilst in hospital accommodation, smell of alcohol and slurring words, presentation of child on arrival). Two weeks later a Child Protection meeting was held and it was decided that the case would be closed, and support would be provided by Flying Start.

Figure 7 highlights that after Children's Services, Police were the service most likely to be aware of the family subject to the CPR (N = 20) followed by Health Practitioners across Midwifery/Health Visiting and GPs. There were also a high number that were known to Mental Health Services (N = 14).

[11] CPR 11 was historical CSA reported as an adult.

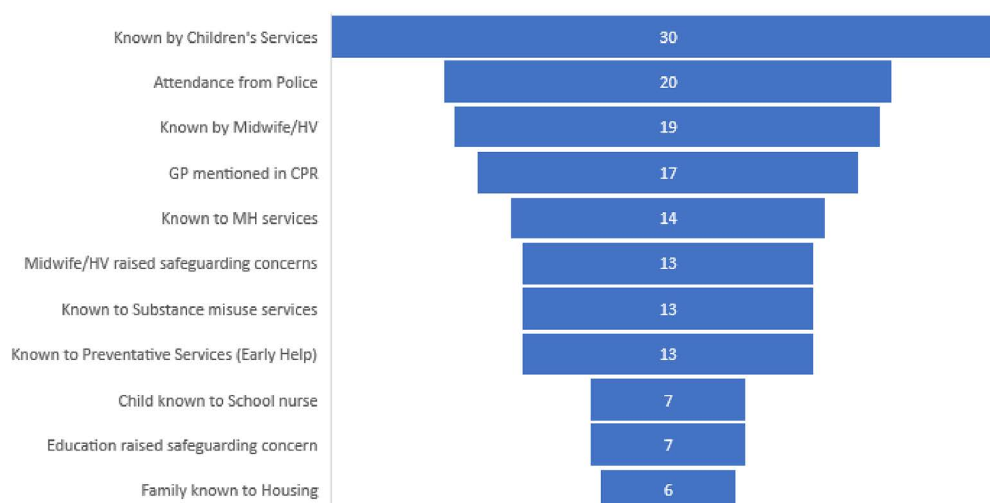
[12] A PPN is an information-sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response (HMICFRS, 2023).

[13] MASH refers to Arrangements that allow organisations with responsibility for the safety of vulnerable people to work together. Organisations work alongside each other, share information and co-ordinate activities, often through co-locating staff from the local authority, health agencies and the police (HMICFRS, 2023b)

[14] CPR 11 was historical CSA reported as an adult.

[15] Note: this was coded as present if there was any mention of referral to Children's Social Services in the CPR report, which could have included historical information outside the timeline of the review, but deemed relevant to the review. This could also relate to siblings and not the index child as noted within the example.

Figure 7. Agencies/Organisations that had engaged with index family/child within CPR

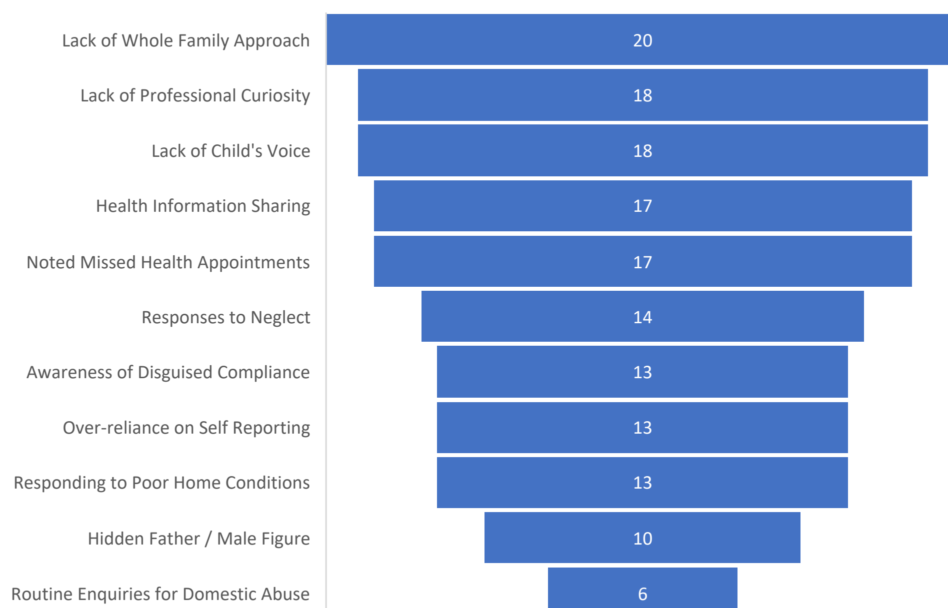


Key recommendations noted within CPRs

The CPRs made key recommendations, and these were coded according to their specific wording. For example, if the CPR did not note 'Professional Curiosity' specifically this was coded as absent, even if the report may have been suggestive of this. Similarly, this was found regarding hidden and/or ignored father/ male figures. Whilst many reports did specifically mention this as an issue regarding the index incident, this was also noted as absent in any considerations within some CPRs itself. Again, it is important to note that the researchers were reliant on the information contained within each CPR for coding. Overall, many CPRs had recommendations that relate to a **lack of whole family approach** within its decision, support, and action (N = 20).

Lack of or **need for increased professional curiosity** was also in high frequency (N = 18), with this likely to be increasing in frequency with more recent reviews due to it being a preferred term of phrase. Additionally, **lack of the child's voice** (N = 18) was noted in many CPRs. Many CPRs had a subheading that dedicated a section to this, reminding readers of key legislative responsibilities when working with families to actively engage and record the daily lived experience of the child. Interestingly, **issues with Health agencies sharing information** were noted as occurring at a high frequency (N = 17) alongside **recorded missed health appointments** – with these two issues certainly linked. These were often centred on Midwives, Health Visiting Service and GP Practices inability to share information due to different systems being used by each and a lack of collaborative meetings to share concerns such as missed appointments.

Figure 8. Frequency of Recommendations made within CPRs



Thematic Analysis of Response: Multi-Agency Involvement and Learning

> *"In adding all of the factors together, a more worrying picture emerges".*

The second section of the report will provide an analysis of themes which reoccurred throughout the CPR reviews, regarding multi-agency learning opportunities. These themes will relate to Practitioners and Agencies themselves, and crucially, the Structures and Processes which underpin their safeguarding activity. The themes will reflect the whole safeguarding process including the identification of potential safeguarding concerns and the response of safeguarding concerns. Given that the safeguarding process is usually multi-layered, often complex, and rarely linear, it is pertinent to understand how the system is operating at the different points. The themes will explore the safeguarding challenges which exist within and between various agencies when seeking to reach a holistic understanding of a child's life. It will also identify some examples of good practice highlighted within the CPRs.

Table 6. Themes across Multi-Agency Involvement and Learning

1. Practitioner and Agency Challenges	1.1 Assessing Needs and Risk: Clarity and Challenge	Transparency
		Professional Curiosity, Self-Report Reliance and Disguised Compliance
	1.2 Consideration of Co-occurring Harms and Historical Relevance	Previous Trauma and Agency In-volvement
		Accumulation and Interaction of Risk factors
		Remit and Safeguarding Lens
	1.3 Whole-Family Focus	Siblings
		Parental Unmet Needs
		Limited understanding and inclusion of fathers
	1.4 Child's Voice: Capturing, Recording, Utilising	Engagement, Exploration and Re-cording
		Utilising Child's Voice to Influence Decision-making and Action
2. Structures and Process Barriers	2.1 Escalation and Referral Process Ambiguity	
	2.2 Pathway and Coordination of Safe-guarding Responsibility	
	2.3 Health Organisational Complexity	
3. Wider Influences on practice and processes	3.1 Workforce Issues	
	3.2 Covid-19 Pandemic	
4. Identified Good Practice		

1. Practitioner and Agency Challenges

Within the analysis there were themes which reflected challenges regarding the practice of various agencies. This includes assessing the needs and risks of families and ensuring clarity, in addition to the role of challenge. It acknowledged the consideration of co-occurring harms and historical relevance, the need to adopt a whole family focus and capturing, recording, and utilising the child voice.

1.1. Assessing Needs and Risk: Clarity and Challenge

Key subthemes were identified from the CPRs within the theme of assessing needs and risk, with these identified as transparency between services and families and the need for increased 'Professional Curiosity' amongst practitioners. This also linked with CPRs noting an over-reliance on self-reporting and greater awareness needed of 'disguised compliance'.

Transparency

There were concerns regarding how transparent individuals and families found practitioners were when they were discussing safeguarding concerns in relation to risks and needs. This included clearly communicating concerns and ensuring that these concerns are understood, in addition to clarifying what was expected of families within the safeguarding process. CPRs highlighted that for some families, they were unsure of what different assessments were for and what support could be offered. Other families felt that the purpose of agency involvement was unclear or that concerns were not explained and *"therefore felt that there had been an element of dishonesty"* which impacted their ability to work with the local authority. Reviewers spoke about the need for practitioners to be supported to *"have frank and open conversations in relation to risk"*. CPRS highlighted there was a need to have *"a joint understanding of risk"*, in relation not only to Social Services but within other sectors such as Education, whereby one mother noted that she would have preferred the school to share their concerns with her first, before escalating. Where Health Visitors explained the child protection process to families, it was felt to be beneficial. For example, one CPR noted how a mother described her good relationship with her Health Visitor and stated they were *"more helpful than Children Services in explaining the court process since the children have been in care"*.

Professional Curiosity, Self-Report Reliance, and Disguised Compliance

Professional Curiosity was a term highlighted frequently within CPRs. This concept was referenced twenty years ago within the Lord Laming Report in relation to Victoria Climbie Enquiry and termed as 'respectful uncertainty' referring to practitioners engaging in *"critical evaluation of information that they are given"* (2003, p205)[16]. There were suggestions from CPRs that on occasion, practitioners accepted a self-reported version of events from families when safeguarding concerns were shared with them, and that this resulted in *"gaps in risk assessments and specialist skills around interrogating and analysing evidence"*.

In some instances, it was noted that there was a *"failure to make adequate enquiries with other agencies in response to expressed concerns and referrals"* and that there was a lack of questioning concerning a presented version of events put forward by a family. For example, when a family stated that safeguarding referrals made by neighbours, with whom they did not get along with, were malicious, there was opportunity for further exploration to determine if this was the case. Professional Curiosity was also raised in relation to understanding a change in behaviour for a child and exploring potential reasons for this. For example, when a child begins acting out of character, this could be symptomatic of a wider issue which could be explored in ascertaining a broader picture of the daily lived experience for that child. CPRs highlighted that there is a need to triangulate sources of information to ensure that a full understanding is reached and to prevent decision-making on any safeguarding referral being *"influenced by an overreliance on parental self-reporting"*, and that *"professionals should consider information from all available sources"*. When concerns are presented, it is crucial to attempt to seek information through liaising with other agencies, whether this is regarding different aspects of family life or different members of the family to ascertain that all important full picture.

The term 'Professional Curiosity' is ambiguous and does not fully acknowledge the potential organisational and structural barriers which may undermine the ability to exercise any such 'Professional Curiosity'. Whilst it is entirely credible that families are being honest in their accounts, it is also possible that this may not be the full picture and part of safeguarding responsibility is to be openminded to alternative scenarios and narratives in safeguarding decision-making. However, this requires practitioners to have the confidence to challenge when they need to and to be skilled at considering the family as a whole. There must be steps taken to validate accounts, such as liaising with partner agencies and crucially, this requires the

[16] The Victoria Climbie Inquiry: report of an inquiry by Lord Laming - GOV.UK (www.gov.uk)

practitioner having the time, space, and capacity to undertake this activity. Whilst this is within the role of Social Services, whose duty it is to assess risk, this is more complicated when other agencies are involved with families who may be working with one family member, under a specific remit. For example, there could be uncertainty in the remit of agencies such as Education or Substance Misuse teams and their role and capabilities in exploring and investigating any alternative narratives to the ones presented by the person they are working with. CPRs noted that there *"needs to be a better understanding of the roles and responsibilities of agencies supporting the family, in order for the right information to be shared"*. There is also confusion on how far to progress any such 'curious' issues and where to refer them in the absence of evidence to substantiate any possible risks:

> *"Further work is needed to support practitioners to work with confidence, particularly in 'grey' areas of professional uncertainty where concerns exist, sometimes long-standing, but where the threshold for statutory intervention is not met".*

The observation that practitioners must exercise more Professional Curiosity would need further investigation regarding how this curiosity is encouraged, facilitated, and embedded into practice. The lack of curiosity could suggest that practitioners may not have the confidence or competence within these situations to question or challenge, or the experience to consider alternative narratives to the accounts being put forward by families. It could also be that there is a lack of capacity in having adequate resources to comprehensively respond to referrals. There are also potential structural barriers in coordinating information-sharing pathways. For example, facilitating dynamic and informal relationships between practitioners across agencies, access to other agency databases, or routine mechanisms for sharing information between agencies.

Alongside Professional Curiosity, there were examples whereby CPRs observed that there was 'Disguised Compliance' by the family, in that they engaged 'just enough' to ensure that it appeared that there were cooperating with agencies. A significant example of this was through parents missing appointments either for themselves in relation to their needs such as mental health or substance use, or wider health appointments for their children. Whilst some of these missed appointments were documented within organisations such as Health Visitors and GPs, this information was not always shared more widely to ascertain if this was a safeguarding concern and how it could potential contribute to a bigger picture.

> *"Professionals should be reminded to ensure that numerous missed health appointments (where the child was not brought) are considered a potential 'red flag', which requires appropriate consideration and follow-up"*

One CPR noted how rigorous assessments of adoptive parents had been undertaken by practitioners which concluded that there was no reason to suspect parents of any wrongdoing. In scenarios such as this when injuries go on to occur to a child, it is likely to be more challenging to consider a potential alternative narrative than a counter one put forward by parents. This crystallises the need for all relevant information to be shared between agencies, particularly when a child is open to Children's Services with isolated injuries, as this helps build a full picture.

1.2. Consideration of Co-occurring Harms and Historical Relevance

When assessing familial safeguarding harms, some CPRs highlighted there was an absence of a full understanding of potential co-occurring harms which may have added valuable context to the immediate presenting concern. These can include any previous trauma or safeguarding agency involvement, the accumulation and interaction of various risk factors. When considering historical, current and continuingly changing co-occurring harms, it is important to overlay individual and agency remit in viewing these through a safeguarding lens.

Previous Trauma and Agency Involvement

Co-occurring harms and historical concerns for children and or family members are sometimes unknown to agencies. At other times they might be known, but not fully explored alongside presenting concerns. Following on from the observation of practitioners not always fully utilising 'Professional Curiosity', CPRs often noted that the full picture of a family's situation was not always given due consideration thus *"risk assessments in relation to referrals had been too heavily weighted on episodic events"*. Having a comprehensive understanding of previous information could provide opportunity to exercise 'Professional Curiosity' as to the wider picture, or alternative narrative could be. In some examples there was a focus upon the presenting issue, such as complex health needs for a child, when the potential impact of the extensive family history may have provided insight into the family's ability to manage the health condition and promote safeguarding.

When it was identified that there was a potential safeguarding concern for families, CPRs noted that on occasion, referrals were treated in isolation and responded to the current episode event and

"did not consider previous contacts, or historical information from other sources" which could have been relevant to the case. In many instances families were known as having *"low-level neglect concerns"* and therefore the threshold for statutory safeguarding intervention was not met. Other examples noted that the child themselves had significant history of adverse childhood experiences (ACEs) or local authority involvement which *"did not appear to have been considered when assessing the levels of potential harm which a young person may be at risk from"*. Additionally, the CPRs rarely mentioned if other forms of support were triggered in the absence of meeting thresholds for statutory intervention. This is true for the young people and children themselves but also the parents. In some examples, the young parents of the children who had tragically died, had previously experienced extensive trauma and adverse childhood experiences, alongside significant previous involvement with Social Services and other agencies, throughout their childhood.

> *"Given the pertinent information and history of both parents, that were held by key agencies, such as both adults' adverse childhood experiences, there were missed opportunities to undertake a robust assessment of the needs of the children and of family members"*.

Accumulation and Interaction of Risk factors

When risks or safeguarding concerns are identified and are presented to Social Services, for a variety of reasons, these concerns are not always enough to meet a threshold for statutory intervention. There were examples when an accumulation of risk factors of concerns can provide a 'cumulative effect' of risk which is not always duly considered. One such example was the use of cannabis. It may be that cannabis use by parents has no/little impact upon that parent being able to keep their child safe from harm, however, when there are other co-occurring concerns alongside this, such as examples of potential neglect, the impact of cannabis use could be more significant. One CPR noted *"the lack of any exploration of the children's experiences and how the poor home conditions, the parental substance misuse, and neglect they experienced, impacted on their safety, health and overall well-being"*. However, a CPR identified that the domestic abuse included the parents being teenage care leavers with concerns over drug-use and mental health, which were not fully considered alongside the domestic abuse incidents. This could have compounded the perceived level of risk and subsequent support required.

> *"Social Services viewed these referrals in isolation and not cumulatively, resulting in the safeguarding risk not being considered significant enough for further on-going assessment, with limited feedback regarding the outcomes of referrals given to the referrer"*.

Remit and Safeguarding Lens

Although it is mandated that 'safeguarding is everyone's responsibility', the CPRs illustrated that in practice, situations are not always considered through a safeguarding lens. For example, in one case a family was left without central heating for 9 months and no agency referred this to Social Services as a safeguarding issue. Other examples within Health include continued missed health appointments and one example of a mother accessing over and above the recommended amount of prescription drugs in pregnancy. Another CPR noted a doctor stopping a parent's medication without considering the impact of this. Similarly, there is a balance to be had for families engaging with support from Early Intervention/ Prevention services. Parents rightly have influence over the areas of support which they feel they need, however, issues relating to safeguarding concerns for children must not become overshadowed, for example, *"losing some focus and understanding of the impact of their behaviours on the child's and the unborn's needs"*.

The acknowledgement of historical concerns, in addition to co-occurring and accumulating harms illustrates how safeguarding concerns are not linear but indeed fluid and dynamic. Safeguarding concerns can vary in nature and severity but there must be consideration of the interaction between different risk factors, past, present and potential future, allowing for a holistic viewpoint to be sought. Alongside an acknowledgement that this viewpoint can be evolving and requires continuous monitoring.

1.3 Whole-Family Approach

It is widely acknowledged that when responding to unmet need and protecting children, there must be support for the whole family. Whilst this is relatively undisputed as a concept, there are challenges around the practice of implementing a whole-family approach. This can be related to agency and practitioner role and remit, in addition to structural barriers and thresholds for intervention. The CPRs showed that there were challenges in agencies maintaining a whole-family approach in three key areas, which requires a collective safeguarding responsibility and holistic response. First, in understanding the lived experience and impact upon siblings alongside the child who has been identified as at risk, particularly those living in the same household. Second, the responsibility to ensure that parents unmet needs are addressed due to the potential impact of these unmet needs on parenting ability. Third, it was highlighted that a reoccurring theme across CPRs

was the focus on mothers within families and the limited understanding and inclusion of fathers.

Siblings

From an identification of harm perspective, although certain agencies work with specific children within the family and not always whole sibling groups, there would usually be an awareness of siblings. Therefore, other agencies could be consulted, to share information and reach an understanding of what family life is like for the children in that household. When responding to safeguarding concerns, it was evident in some CPRs that safeguarding interventions were focussed on potential harm to a particular sibling, when arguably the cause of concern was the parenting ability and environment with potential for all children in that environment to be at risk of harm. This was evident in one example where there were concerns for an unborn child and where there was limited engagement with the mother, yet there is no record of any contact with the 8-year-old sibling to ascertain their lived experience at home and further understand potential risk.

Parental Unmet Need

Whilst the welfare of the child is paramount and the protection of children places them at the heart of any safeguarding assessments and investigations, the parents' ability to keep their child safe can be impacted through their own unmet needs and challenges. For example, particular risk factors such as parental mental health problems, substance misuse, previous trauma or ACEs, or a lack of support can impact upon the parents' capacity to ensure their children's safety. Within the CPRs there was an acknowledgement that some parents were experiencing challenges and support was offered or put in place. However, it was unclear whose responsibility it was to monitor the engagement and progress, with consideration of any impact and the day to day lives of the child(ren). There is potential disconnect between assessing information relating to parental needs and follow-up of actions relating to this, alongside the likely impact upon the child and their environment.

Similarly, when there were different practitioners and agencies involved with both parents and children within the same family, there was not always a whole-family approach. Some agencies and organisations were not invited to multi-agency meetings, therefore, unable to share information even though they were in contact and often working with family members. Even within organisations such as Social Services there were challenges in ensuring that whole-family focus. CPRs highlighted that there was *"opportunity to improve systems for communication between Adult and Children Services where there are identified vulnerabilities for both children and adults within the same family"* highlighting variance internally within organisations such as areas of fragmentation between Adult's and Children's Social Services. This is despite a willingness from practitioners to work in partnership with each other. IT systems do not always prompt joint-working between departments promoting an ad-hoc response which *"can be considered to have undermined practitioners' efforts to consider [the child] and [mother's] behaviour in a wider context"*.

Limited Understanding and Inclusion of Fathers

It was identified that within some CPRs there was more of a focus on the risk factors related to the mother and her ability to meet the children's needs and keep them safe, rather than the father or male figures within a child's life. It was noted that regardless of whether a male resides with children or not *"if it appears that they are, or will be, involved in parenting, there should be active attempts to engage with them [mother's partner/ father]"*. When fathers contributed to CPRs in some instances there were examples whereby they stated feeling side-lined by practitioners and not made aware of their concerns. Similarly, in another CPR it was highlighted that *"the social worker's proportionate assessment did not attach any significance to [child's] mother's reference to his father being care experienced or to his possible offending history"*. Recommendations in CPRs stated that practitioners must be aware of gender cultures that the mother is automatically the primary care giver, as even if this assumption is correct, the father can still have a significant role to play in a child's life. There are examples whereby specific training has now been undertaken to include fathers in assessments and interventions.

1.4. Child's Voice: Capturing, Recording, Utilising

Capturing the child's voice was a reoccurring theme within most CPRs. Themes were identified around engaging and capturing the child's voice but also ensuring that a child or young person's view are recorded and how this is utilised for future decision-making and how outcomes are shared with a young person, in relation to their wishes.

Engagement, Exploration and Recording

A consistent thematic finding across many CPRs was the absence of the child's voice. Challenges were highlighted within practice of engaging with the child and exploring their experiences of daily family life and recording this. The absence of a child's voice was evident throughout the safeguarding process, including at an identification level, whereby individual referring agencies had potential safeguarding concerns regarding children and families. It was also evident at the response stage. First, when referrals were submitted to Social Services and subsequent enquiries and assessments

were made to ascertain if concerns met a threshold. These enquiries on occasion focussed on a phone call with parents only. Second, when a child was receiving safeguarding support or interventions, such as when on the child protection register or living in local authority care. For children who were considered at risk from harm it was noted that although home visits to the child had taken place *"there was little understanding of the children's lived experiences, and the voice of the child was absent"*. This highlights the purpose of capturing a child's voice and perspectives and acknowledges that seeing a child may not be the same as fully understanding their lived experience day to day. It is understood that families can be dynamic and complex, but it is key not to let the child's voice become 'overshadowed' by these complexities to the point that there is limited reality of what a child's lived experience is.

There are also additional considerations when a child is non-verbal or very young. CPRs suggested that where there are siblings for a child who is at risk of harm, speaking to them and ascertaining their experiences in the family home and their perspectives of what life is like for their sibling, could be beneficial. However, there was little mentioned or documented in relation to discussions that took place, or plans made to address how an understanding of day-to-day life for the child would be ascertained in these difficult circumstances. It is acknowledged that Covid-19 pandemic- restrictions proved to be a substantial barrier when attempting to make meaningful contact with children (see theme 3 for further details).

Utilising Child's Voice to Influence Decision-making and Action

Once a child's voice was captured, there were challenges in utilising this voice and it was unclear how the child's wishes were responded to and incorporated into plans and taken forward. For example, in some CPRs there was limited evidence of how to action it or how to respond to what young people have expressed, either where positive influences could be made or where wishes could not be accommodated, what the conversations surrounding this looked like. For example, when a young person noted that they wanted contact with a sibling, reviewers found *"there is no documented evidence to state how this was dealt with and whether the child had been seen to discuss the decision"* or any details of progression with this request and future planning. Other examples which documented the wishes and feelings of children did not show any further development from this. For example, a case of a child living in local authority care discussed career aspirations but there was no subsequent mention of how or if this was progressed and provides support to the observation that *"that assessments were often completed during initial visits but not seen as an ongoing continuing process"*. Other CPRs acknowledged that a child's voice is not static and that the *"evolving view"* should be captured, recorded and considered.

2. Structures and Process Barriers

Within the analysis there were themes which reflected challenges regarding the structures and processes of safeguarding, which are designed to underpin and facilitate practice. These findings highlighted gaps and barriers within some structures and processes such as threshold uncertainty, ambiguity within the escalation and referral process, the pathways and coordination of safeguarding responsibility and the complexity of Health organisations.

2.1. Escalation and Referral[17] Process Ambiguity

Section 130(4) of the Social Services and Well-being (Wales) Act 2014 defines a 'child at risk' as a child who: a) is experiencing or is at risk of abuse, neglect, or other kinds of harm; and b) has needs for care and support (whether or not the Local authority is meeting any of those needs)[18]. Safeguarding referrals/reports to Social Services are required to have as much information as possible to ensure a comprehensive decision can be made. However, referring agencies and report makers are sometimes not fully aware of a holistic picture of family life or access to this information. However, based upon the information they do have, they are duty bound to share concerns if a child is at potentially risk. There were examples within the CPRs whereby referring agencies shared information several times, but it was not deemed to meet a threshold for further assessments. There were also instances when referrals were not made, despite there being potential risks of harm to children. Where there was disconnect between agencies making referrals and these being assessed as not reaching the threshold for statutory intervention, where referrers are still concerned then they are encouraged to escalate further, if differences cannot be resolved. This level of challenge was also noted to be encouraged if partner agencies felt that the safeguarding response was not meeting the child's needs to keep them safe *"where a Care and Support Protection plan is not keeping the child safe all involved professionals have a responsibility to challenge using existing*

[17] It is acknowledged that since the implementation of the Welsh Safeguarding Procedures (2019) that there have been terminology changes and that 'Report' has been adopted in place of 'Referral'. In addition, the term 'Report Maker' which refers to the person making a referral. However, given these CPRs range from 2013 to 2021, the terms are used interchangeably.

[18] working-together-to-safeguard-people-volume-5-handling-individual-cases-to-protect-children-at-risk.pdf (gov.wales)

processes". The responsibility to challenge is applicable for all agencies.

Threshold[19] uncertainty was noted across services *"there can be misconception about the roles and responsibilities of statutory and non-statutory services which includes lack of clarity regarding threshold criteria for access to each service"*. Ambiguity can also arise if there are no changes in circumstances after an assessment or decision has been made by Social Services. For example, the initial referral may conclude that the neglect does not meet a threshold for statutory intervention, but the referring agency continues to feel that the concerns round neglect remain. When agencies have referred a child to Social Services for neglect concerns, but it has not reached a threshold for intervention, CPRs noted that agencies should *"continue to refer to Children Services should neglect concerns persist"*. However, when the circumstances have not changed then this can result in uncertainty as to whether to re-refer.

> *"Education practitioners at the learning event confirmed that Social Services had been contacted on a previous occasion when Mother had presented in a similar way and this had not met the threshold for any intervention. They stated that as the circumstances had not changed since the previous contact, they did not consider that this incident posed any additional risk".*

There were also examples whereby simply sharing information with Social Services was considered sufficient, unsure as to whether a formal referral is required *"it is unclear if the school nurse thought her contacting Children Services was a 'referral' to the department"*. In the CPRs there were examples of information being shared as a referral but *"no evidence of any formal record"* or *"no records of this action being undertaken"*, suggesting there is uncertainty in how to make a referral and what a referring agency should expect by way of feedback or receipt of this referral. This is a key consideration when determining responsivity of acting upon a safeguarding issue.

Other challenges regarding referrals included the timing of submitting referrals, such as last thing on a Friday afternoon, whereby a case was not followed up until after the weekend, consequently leaving a child at risk all weekend. If there are concerns accumulating or remain persistent without sustained improvement, even without a significant decline in circumstances, then regular consultation should be encouraged between referring agencies such as Education, to Social Services to respond to concerns before the crisis point of Friday afternoon. This would allow for coherent plans to be put in place to manage risk through a collective safeguarding response. Areas whereby there are 'Resolution for Professional Differences' procedures in place have a potential mechanism for escalating concerns if referring agencies are unsatisfied with cases not being deemed to hit a threshold. However, this requires agencies and practitioners to have the awareness and confidence to use this. Whilst Social Services are often the lead agency for safeguarding responsibility, all agencies have a duty to identify and respond to safeguarding concerns by following their own protocols. Similarly, CPRs noted that there needs to be more consistent feedback provided to referrers when a referral does not meet the threshold to guide future action and enable them to understand any decision making.

Within organisations themselves, there was noted uncertainty around escalating safeguarding concerns internally and a lack of confidence in challenging decisions from senior members of staff with one CPR noting *"staff shared a culture of not challenging colleagues in a more senior role"*. This highlights that even with Escalation of Concerns protocols in place, it requires promotion and utilisation of such protocols and a positive working culture and relationships is using this.

2.2. Pathway and Coordination of Safeguarding Responsibility

Whilst there are longstanding observations that information sharing needs to be more robust, appropriate and more frequent, the structures and infrastructure which support (or indeed, inhibit) this information sharing are often inadequate. Many CPRs noted how the full picture of risk was unknown as information was not shared readily or efficiently within and between agencies and sectors. What became evident when reviewing the CPRs was that forums, pathways and infrastructure which are required to facilitate the sharing of information and coordinate multi-agency safeguarding concerns, were unclear, particularly in the absence of Social Services being the lead agency.

> *"The lack of 'soft' information sharing ability, such as incidents of a child wetting themselves in school and a child's involvement with preventative services. Agencies shared that there is often information that would assist decision making not known to Children's Services decision makers, as it is held on other agencies systems and has not met the threshold for a Child Protection referral".*

[19] It is acknowledged there are debates with the term 'thresholds', within this review it is used to describe a decision-making process in determining next steps and access to service intervention/response at a particular point in time.

When safeguarding concerns were raised, the CPRs noted that ownership and the monitoring of these concerns was not always followed through. This was noted to be particularly difficult when there were incidents of a child moving out of a local authority area, which presented challenges exchanging information but also monitoring progress and the subsequent ownership of who is responsible for coordinating support. However, even when a child remained in one area, there were examples of actions from assessments not being viewed as ongoing, particularly when there were numerous agencies and practitioners involved.

It was also noted on occasion, it can be difficult to manage the ongoing coordination when different practitioners and agencies were involved in the same sector, for example, collaboration between Fostering and Adoption teams or between Adult's Services and Children's Services. Health examples include a lack of understanding of follow-up procedures and coordination between Paediatrics, GPs, between each other and wider agencies, such as Education in relation to missed appointments. This illustrated confusion over which agency was required to take charge of individual pieces of information and investigate further. There were also examples of assumptions being made that when a family is known to Social Services that this involvement is current, with responsibility aligned to them as the lead agency. However, the case may not open to them at that time and they may not be aware of any presenting concerns.

One CPR noted how *"guidance should be developed to assist agencies to identify an individual to co-ordinate a plan when there is more than one agency involved"*. This supports the argument that infrastructure to facilitate this coordination is unclear or underutilised and potentially a barrier in operationalising a collective safeguarding responsibility. There can be confusion over practitioner confidence, competence and resource capacity, when determining which agency is best suited in taking the lead. This whole-family, multi-disciplined approach can be problematic when a practitioner's role aligns to a specific remit such as an Education or a Health issue and where consent is required to work with the family (see Appendix 4 Diagram of Safeguarding Pathways). Examples were given when separate agencies shared concerns about a family to Social Services, yet no further action was taken. In this scenario where it may not have met the statutory intervention threshold, there is a duty for the referring agency to follow-up concerns. However, there is confusion surrounding how to progress this duty. For example, how agency ownership is operationalised to effectively implement a multi-agency plan and coordinate activity to further enable sharing accumulative information concerns, to gather a holistic, and crucially, an evolving picture. CPRs noted with hindsight that sharing information at an earlier stage could change decision-making *"if information about the concerns leading to the referrals and the action taken had been shared between agencies, then questions around the decision to step-down to the Early Intervention Service may have been raised"*. However, a key barrier is the logistical structures and infrastructure which are not in place to share accumulative information, with a CPR noting that *"information sharing platforms that support multi-agency information sharing being absent or not compatible"*. The practical logistics of a shared IT system within and between agencies, are well understood and were recently evidenced within the All-Wales Shaping the Future of Multi-Agency Safeguarding Arrangements (McManus et al., 2022). The evaluation identified that the majority of LAs using WCCIS reported that they were forced to spend significant time making the system work for them; yet there were still issues in the accuracy of data extracted and functioning issues, such as when upgrades or changes were required. Not all agencies had access to the database and some only had read only, therefore, alternative methods of information sharing were required alongside this. The importance of having a safeguarding data system that allows practitioners to easily see the chronology of their service user/referral is essential. Our safeguarding IT systems are still being reported as deficient in being able to provide this essential safeguarding function.

The nature of multi-agency working requires agencies to work together in a timely manner. Delays in carrying out assessments can present challenges when agencies are still working with individuals and families but are unsure of any progress from other agencies. In addition, feedback from assessments and ensuring that the outcomes for this are reviewed, recorded and utilised to influence future decision making is a challenge. Waiting lists for support from different sector agencies, for example mental health or therapy, can influence how other agencies work with families whilst waiting for this support. It also requires coordination to monitor and review the impact of any multi-agency support and to ascertain how this influences future support plans.

2.3. Health Organisational Complexity

As a fundamental, universal service, Health featured significantly in many CPRs. Although there are commonalities across Health services, it is imperative to understand the complexities within the sector. Health is segregated by diverse roles, remits and specialised knowledge. It is governed by complex structures, management and organisational identities, and it is operationalised

by fragmented IT systems. Within the CPRs there were numerous examples of how information was known to various Health professionals but not routinely shared *"health practitioners held a number of important pieces of information in respect of the family that could have assisted with decision making"*. This is complicated further by some records being electronic and some manual. Whilst practitioners have a duty to share safeguarding information, isolated, singular pieces of information may not be regarded as a safeguarding concern, yet there is currently limited infrastructure which can support a standardised, consistent, and efficient methods of sharing information. The CPRs

Figure 9. Health Complexities

Adult's Health Needs Touch Points

Child's Health Needs Touch Points

demonstrate challenges in sharing information particularly between GPs surgeries, Midwives and Health Visitors. Some examples noted that had their Health department, be it a GP surgery or Midwifery, had access to information held by another Health agency, it could have influenced their assessments or offer of support. As there are different IT systems, it is difficult to share information routinely without requesting it and then waiting on additional permissions and access. When verbally sharing information, there is variability in which practitioners are invited to safeguarding meetings with GP surgeries and how much safeguarding is embedded into GP surgeries with *"some GP practices hold regular safeguarding meetings, this is not common to all practices"*.

When coordinating specialist health professional involvement outside of universal services, such as within specialist mental health, the opportunity to have an integrated Health service was also problematic. For example, there were challenges in ensuring contributions from a Psychiatric Nurse, formed part of a comprehensive assessment to explore the impact of parental mental health on parenting capacity. Sharing different agency health records electronically can be difficult, due to ensuring emails are secure. The infrastructure to ensure that all health information is centrally available, is not the case as ultimately, the *"Health Board does not have a single patient record"*.

Figure 9 (see page 26) highlights that Health is not a single unified organisation. Aspects of the system operate separately, presenting logistical challenges to aligning and coordinating services. The GP surgery is potentially the most likely single health commonality across family members, where key information could be collated and understood. However, the demands and variability in GP partnerships and structures are acknowledged.

3. Wider Influences on Practice and Process

In addition to the themes identified in relation to Practitioners and Agencies, as well as Structures and Processes themselves, there are wider influences which can impact upon how practice and processes operate. The contextual information surrounding workforce issues such as challenges in recruiting and retaining an experienced and stable workforce will no doubt impact upon how agencies can deliver effective services. The Covid-19 pandemic and the restrictive measures which were put in place to address it significantly affected the visibility of families and individuals who may have required safeguarding support.

3.1. Workforce Challenges

There was a clear need for any support with individuals and families to be grounded in relational approaches and building trusting relationships is key to partnership working. When discussing difficulties of engaging with young people, to hear their voice and discuss safeguarding concerns, the impact of a young person having *"6 social workers during his last period of child protection registration"* cannot be underestimated. Having to relive a traumatic experience and trust numerous professionals with such vulnerability and maintain engagement is understandably challenging. CPRs noted there is an absence of staff who are sufficiently experienced to respond to some of the safeguarding concerns. The constraints which were faced by some agencies due to the demand for their service and staffing levels was not always known. One CPR highlighted how crucially *"there is a clear theme of working environments under pressure that does not enable and create organisational conditions that support such complex work"*.

Good supervision was noted to be essential in reviewing safeguarding concerns for practitioners, across all agencies and can avoid the drift of cases and keep them focussed on outcomes, as well as reinforcing the importance of record keeping. Specialist areas of training were also noted to be key to ensure practitioners have the most up to date knowledge to respond to complex safeguarding concerns.

3.2. Covid-19 Pandemic

The Covid-19 Pandemic and the restrictive measures which were implemented presented significant challenges across all agencies. The closure of schools had significant ramifications on the visibility of children, particularly those who were living in vulnerable circumstances. Despite some children who were known to services being allowed to attend school, this offer was not always taken up. The operational changes across wider organisations and the scaling back of face-to-face contact limited the contact to support individuals and families and resulted in some families becoming far less visible to services. Changes in policies and risk assessments meant that practitioners were under immense pressure to balance the risk of Covid-19 with other safeguarding concerns. Although policies were created and adopted, including technological developments and new ways of working, the picture was an ever evolving one. Covid-19 was noted as a potential barrier regarding families displaying ‘Disguised Compliance’ and it was highlighted that practitioners lacked confidence in challenging families use of Covid-19 anxieties as a barrier to engage with services. Whilst this is a challenge in ordinary times, this in the context of unprecedented lockdowns will have placed a significant source of stress on practitioners, who were also operating within resource pressures of high levels of staff absence, due to illness and self- isolation rules.

4. Good Practice

Whilst there were examples of challenges in delivering an effective safeguarding response, within the majority of CPRs there were examples of good practice. In relation to understanding and representing the Child's Voice, CPRs praised Advocacy Services who were *"extremely well positioned to intervene and enable the multi-agency group to hear and act"* on a child's views. Within individual agencies, examples included the Police providing an experienced officer to interview a child, to ensure their voice was heard and understood. Examples within Children's services identified social workers creative methods to engage children, such as bringing a Rubik's cube when a child has expressed an interest in them.

When adopting a whole-family focus, there were examples of joint visits between Adult's Services and Children's Services, to ensure a consistent understanding of a family's situation was ascertained. Consideration of the impact of separating siblings was noted as being discussed between agencies to establish a robust evidence base for decision-making *"to ensure that the decision was well informed and would stand scrutiny having considered the impact that it would have on both children"*. There were examples of agencies not only responding to presenting needs of a child at risk, but also reflecting upon historical information and the potential current impact. This example ensured the needs of parents were considered and offered appropriate, individual parental support from a Leaving Care Team, with a father being provided with support of an Independent Reviewing Officer and a Wellbeing-worker offered to support a mother. This support demonstrated by the Leaving Care team was highlighted as *"above and beyond their statutory duty"*.

When considering the needs of the whole-family and addressing potential co-occurring harms, there were examples of Housing officers working with families to maximise their income and avoid rent arrears. CPRs noted that there were instances in Children's Services whereby practitioners demonstrated Professional Curiosity by continuing to review and check information, *"to try and make sense of the complex 'history' of this family"*. Other examples showed that efforts were made to understand the situation of wider family members with contact sought from other Local Authority areas, to ascertain a holistic view of the family's situation.

4.1. Social Services

From a response perspective, it was noted by a CPR that *"at the point where the information in the safeguarding referral became known, agencies acted effectively and promptly to safeguard the child"*. Within Social Services, there were examples of good practice around assessments with examples noting there was an *"accurate and concise assessment of the risks, needs and resources"* and others stating that the assessments were of high quality and would *"stand up to scrutiny"*. Other descriptions of assessments described how they offered local authority and other partner agencies *"the chance to take stock and to form a tight co-ordinated team around child"*. There were examples whereby statutory visits were noted as being completed on time in accordance with procedures and guidelines. CPRs highlighted joint visits to families between agencies, such as Children's Services and the School Nurse. Social Services showed an understanding that families may need continued support once they were no longer at the threshold for statutory support and so transitionary service delivery for the family was sought by a social worker from a preventative service, Resilient Families. A CPR noted how there is a need to support staff working with complex and traumatic cases and there are systems being developed to acknowledge this.

4.2. Health

There were examples of good safeguarding practice highlighted within Midwifery such as ensuring that there was completion of Domestic Violence Routine Enquiries and the transferring of notes from England to Wales. Much was noted about the good practice of Health Visitors, such as their wide delivery of support, such as providing housing support and ensuring families understood the Child Protection process. CPRs noted parents being offered Advocacy Services and that Health Visitors were mentioned as having good relationships with families, not only allowing them to offer health related support but also allowing access into the home for support from other agencies. There were examples of Information sharing working well between Health Visitors and other services such as School Nurses, notably with the two professionals meeting informally to discuss joint cases, which allowed for sharing of information on siblings, generating that full family picture. Health Visitors were also noted to liaise with GPs and make referrals to Social Services and actively seeking updates on cases. There was also an example of a prompt alert being shared by the hospital to Health Visiting Services to make them aware of any attendance there, again creating a full picture.

In the wider field of Health, diligence and professional curiosity was observed in key professionals such as Pharmacist, who drew attention of the frequent and excessive repeat prescriptions dispensed to a mother in the months leading up to the pregnancy. Another example included a New-born Screener who *"used her training and gut instinct and made a safeguarding referral at the right time"* which initiated

safeguarding procedures. Emergency Call Handlers and Ambulance Crew were also praised for their high standard of skills and conduct. CAMHS were mentioned in a CPR for their prompt appointment to see the child within 28 days of referral and ensuring their assessment was collaborative and the outcome communicated to the family, the Referrer, and the GP. The importance of the GP as a key safeguarding partner was recognised and in one CPR it was noted that there are now weekly meetings at a GP surgery whereby *"safeguarding is a permanent topic on the agenda"*.

4.3. Education

Within Education, there were examples of schools being proactive in submitting referrals for support for children and for wider family support, for example to Early Intervention services. There were examples of schools understanding the wider picture of what is going on for the child and being flexible with families regarding policies on attendance and lateness.

When one school did have concerns, there were examples which showed good pastoral support with a CPR highlighting that children knew how and where to access appropriate support from teaching staff, wellbeing staff and external counsellors. Good practice highlighted when schools spoke to families to share concerns and other schools showed creativity in trying to contact parents such as via telephone, letters and offering meetings. During the Covid-19 pandemic, there were examples of schools being proactive in consistently trying to keep in touch with children. With regards to recording of information, a CPR highlighted the school database being utilised to ensure any safeguarding concerns were captured. The Education Welfare Service was also noted to have an in-depth log detailing their interactions with a family they were working with.

4.4. Police

There were cases whereby the Police were identified as displaying good practice such as examples of providing a sensitive and timely response to families. It was observed that Police demonstrated good communication within force, such as escalating of concerns from a Police Community Support Officer to senior colleagues. There were also examples of joint working between forces, such as when a child went missing, in addition to collaboration with other agencies when there were wider safeguarding concerns. Other examples included the Police providing detailed historical information for Child Protection conferences to set context, as well as being vocal in articulating where they felt a case needed to be escalated. It was also noted that in relation to MARAC, there was *"robust decision-making and recording of the police with regard to the MARAC process thereby preventing duplication"*.

SECTION THREE. REVIEW: QUALITY OF CPRs

Descriptive Analysis

In examining the quality of CPRs, a key factor that was likely to impact on this was the efficiency of the CPR process from point of referral to the CPR Sub-Group and final sign off and publication of the CPRs report. This first section explores the various dates recorded within the CPR process.

The **date range of CPRs varied**. With the earliest dates recorded for the CPR index incident being as far back as 2013, and most recent in 2021. Similarly, final signatures and date of signature provided within the CPRs ranged from 2015 to 2023. There were **four CPRs that were not signed/dated** or included a publication date (12.9%). One CPR (CPR 33) did not include a date of the index incident, nor the dates of the review period. As noted in Table 7, the earliest timeline period captured was from 16/10/2011 to 16/10/2013, with the most recent timeline from 01/03/2020 to 31/07/2021.

Table 7. Range of dates captured within CPRs

	Earliest date	**Latest date**
Date of Index Incident	16/10/2013	31/07/2021
Date of signature (sign off)	16/03/2015	09/02/2023
Start date of Review Timeline Period	16/10/2011	01/03/2020
End date of Review Timeline Period	16/10/2013	31/07/2021

The number of days and months between the date of index incident and the date of signature of completion of the report were provided for all but 4 CPRs.	
Lowest:	444 days / 14.60 months
Highest:	2017 days / 66.31 months
Average:	Mean = 937/32 days (SD = 350.14) / 30.82 months (SD = 11.51),
	Median = 854 days / 28.08 months

When breaking down these key factors across the RSB areas, Table 8 below shows some differences across the RSBs, particularly as Gwent's 2 CPRs that were reviewed seem to suggest less of a backlog of CPRs with their earliest incident being in 2020. This is compared to areas such as Cardiff and Vale with their earliest incident date being 2013 and North Wales 2015. To note there was no rationale given as to why this CPR had not been included in previous thematic reviews and was provided to the research team as part of this National Review.

Table 8. Descriptive information of CPRs by RSB						
RSB Area	**No. Concise**	**No. Extended**	**Earliest Incident Date**	**Latest Incident Date**	**Av. No of days (mean)**	**Av. No of months (mean)**
Cardiff & Vale	2	3	16/10/2013	05/02/2018	1032.75	33.95
Cwm Taf	4	2	01/03/2018	31/07/2021	813.60	26.75
Gwent	2	0	14/09/2019	01/08/2020	763.0	25.08
Mid & West Wales	6	3	02/03/2017	20/05/2019	984.38	32.36
North Wales	3	1	29/07/2015	01/10/2020	1091.0	35.87
West Glamor-gan	3	2	06/07/2017	01/10/2020	889.0	29.22
Western Bay	1 (+1 historical)		27/08/2016	01/11/2017	807.0	26.53
Total/Average	**21 (+1 historical)**	**11**	**16/10/2013**	**31/07/2021**	**937.32**	**30.82**

The Social Services and Well-being (Wales) Act 2014, Working Together to Safeguard People (Vol 2) – Child Practice Reviews (CPRs) regarding the **timeline period** covered in the CPRs (Concise and Extended) states:

> *'A timeline of a maximum of 12 months preceding the incident should be prepared. The 12-month timeline may be extended if only there are exceptional circumstances but as the focus of the review is on current practice, the timeline should in those cases be no longer than 2 years. The timeline may be extended to include decisions and action following the incident' (noted under 6.22 for Concise CPRs and similarly worded for Extended CPRs under 7.23 and 7.25 to reflect the period the child was on the child protection register or was recently a looked after child)'.*

For the 32 CPRs that included a **review timeline period** just under half (N = 14, 43.8%) were based on a 12-month period preceding the index incident, as per the guidance, with 2 slightly less than 12 months[20]. Over a third of CPRs included a timeline that was between 13-24 months (34.4%) and 5 went beyond the maximum period of 2 years[21] (15.6%). Out of the 16 CPRs that did include a timeline period exceeding 12 months, 13 provided a clear rationale as to why this was required. Only 3 (18.8%) did not give a reason for this extended timeline.

Table 9. Timelines included within the CPR Review Period		
Months included within Review Period	**Frequency**	**Valid Percent**
Less than 12 months	2	6.3%
12 months	14	43.8%
13-24 months	11	34.4%
More than 2 years	5	15.6%
Total	**32**	**100%**

The Working Together to Safeguard People (Vol 2) states that *'The review process will be completed as soon as possible but not normally longer than six months from the date of referral to the Board's Review Sub-Group'.* However, only 17 out of the 33 CPRs (51.5%) recorded when the initial referral was received by the CPR Sub-Group. With only 14 recording both the referral date and date CPR was signed off (completed). Table 10 below shows that on average (median) it was **20.7 months that CPRs took from referral to the CPR Sub-Group to completion of the CPR report**. This was significantly longer than the 6 months stipulated within the guidance. The maximum time recorded from Referral to Sub-Group was 36 months within CPR14 noting that there were significant delays due to changes in Chair and Reviewers during the review process (shortest was 13.5 months).

[20] One at 9 months, and the other a 11-month period.

[21] This is the official Review Timeline Period as per the CPR and not included historical information provided as context/background.

The average time **from index incident to the Sub-Group Referral was 4 months**. CPR25 was noted as being 38 months within this process. However, this was due to the case initially recorded as an accidental death of a child, with a police investigation resulting in the charge of the mother with neglect manslaughter. The case was re-referred to the Sub-Group at point of charge, 3 years after the index incident.

Furthermore, there was an **average (median) of 18.6 months from index incident to the date of the Learning Event**. As noted within some CPRs, the delay from index incident to the Learning Event created challenges where practitioners were often unable to recall why they made certain decisions relating to the family. This was seen to create barriers in extracting key decision-making, learning and action.

Table 10. Timelines included within the CPR Review Period

Time in Months	Mean/ SD	Median/ Range	Frequency
From Referral to Sub-Group – Sign-Off	21.63 / 6.64	20.7 months / 22.9 months	14
From Index Incident – Sub-Group Referral	7.46 / 9.87	4 months / 37.4 months	17
From Index Incident – Learning Event	20.29 / 9.38	18.6 months / 33. 8 months	23

Thematic Review of Quality Factors within CPRs

There was variance in how CPRs were presented, formatted, and structured and differences in which information was selected to be included. To ensure that the collective learning from the CPRs is maximised, an analysis was undertaken to identify areas of good practice and limitations within the CPRs provided for this evaluation.

Figure 10. Model of CPR Quality and Consistency

1. Comprehensive Background Context

Whilst the background information leading to the review should be anonymous and as succinct as possible, there are key points which should be included, but were often missing within CPRs. Where there are concerns around confidentiality and anonymity, it could be considered that there are two versions, one of which is redacted and not freely available within the public domain.

1.1. Age and Gender of Child:

This is paramount when understanding the context of the circumstances around the event. For example, if talking about underage sex of a young person, it is pertinent to understand how old this young person is. It also is beneficial for understanding the situation from a child development perspective and to contextualise what other agencies roles would have been at this point in a child's life. It is worth noting that given the lack of information about age and gender, only 3 CPRs mentioned the ethnicity of the child (2 were noted as Welsh white heritage, and the other as 'mixed race' with no further information).

1.2. Family Dynamic:

Given the importance of family circumstances, it is key to have a clear understanding of the young person's family dynamic. The best CPRs clearly noted which significant adults were parents and caregivers to the child and the siblings and their ages. This provided context to the child's family life experience.

1.3. Date of Significant (index incident) Event:

Whilst this can usually be taken as the end date of the review period, it would be helpful and accurate to have this date mentioned in the introduction so that any subsequent timelines have a clear journey and are interpreted appropriately considering these dates.

1.4. Chronology of Significant Events:

Although it is suggested that all CPRs include this in their appendix, few were present. This is key to having oversight of what occurred for the young person, at what point in time and what the response was by relevant agencies. This allows for a more accurate understanding and context as to what would be expected to happen in response to an event and what did occur and why.

2. CPR Process and Contributors

It was noted on some CPRs who the chair, external and independent reviewers were and their role which provided helpful context to understand who was conducted the review. It is also important that the CPRs are signed and dated. A publication date would also clarify the timeframe from when the significant event happened and to understand what changes have happened since then.

2.1. Multi-agency Panel:

It is helpful to understand which agencies were represented on the panel and which attended the learning event and whether these were strategic representatives or operational representative.

2.2. Consultation with Young Person and/ or Family Members:

This was variable across CPRs. Whilst each CPR is different, it should be clear across all CPRs which family members (not a generic “family members”) were consulted and if they participated. It should also be clear as to what their contributions were. In some reviews it was not possible to ascertain the perspectives of family members, despite the CPR noting that they had been consulted. The best CPRs integrated the family or young person’s voice across the various sections of the CPRs allowing the reader to clearly see what this contribution was. Where ascertaining the child’s voice can be difficult, consulting with siblings or peers can be useful to understand their perspectives, where appropriate.

2.3. Practitioner Contributions:

Given each CPR is an account of various agencies contributions of who was working with the child and family, it was unclear from many CPRs which specific agencies or practitioners had contributed to the review and in what format. For example, if a drugs and alcohol service or a GP for example, were working with a family, what was their contribution to the review:

- Written account of involvement by Agency
- Interview or discussion of involvement with Agency
- Agency’s involvement discussed indirectly by another agency

2.4. Objectives of the Review:

Some CPRs had a Terms of Reference which clearly stated what the CPR hoped to achieve and what would be included in the process. Terms of Reference which included the Purpose and Principles as well as Core Tasks were helpful to understand what was specifically trying to be achieved as part of the CPR.

2.5. Key dates identified:

As shown in the analysis as the start of Section 3, the ability to understand how relevant the learning is to other areas across Wales require clear identifiable date. This will provide much needed context to some of the decision-making and responses within the review. This should include as a minimum:

- Initial referral of the index incident received by the CPR Sub-Group and any decision making from this. This should include if there has been repeated referrals prior to agreement for a CPR to be commissioned.
- Date of Index incident, alongside the review timeline. This should include an explanation of the timeline rationale, particularly if this is over 12 months (as required per the Working Together to Safeguarding People Vol 2 requirements).
- Date of Learning Event and any prior briefing events held before this.
- Signature and date at the end of the report by the Reviewer(s) and Chair.
- Publication Date. Some CPRs had this clearly on the front cover of their report.

2.6. Scrutiny, Debate and Challenge:

To optimise the learning of the CPR there should be opportunity to discuss and debate the CPR findings to ensure the quality is assured and scrutinised. This could be facilitated through the CPR Panel or through wider contributions from the RSB members. Noting if and how this took place would provide additional rigour of any findings and recommendations of the CPR.

3. Structure and Clarity, with Critical Analysis (Addressing Objectives)

For learning to be maximised, CPRs require a clear structure, inclusion of agency involvement, alongside evidence of critical analysis that addresses the objectives within the Core Tasks, as well as additional objectives identified. This allows for clear, actionable, and accountable recommendations to be presented as a core deliverable of the CPR process.

3.1. Structure:

The best CPRs were structured in a chronological order providing a clear, logical understanding of the circumstances. When dates are not provided as part of context, history, and involvement in agencies, the chronology becomes confusing and difficult to piece together any building picture of risk/harm the child was exposed to.

3.2. Clarity of Agencies involvement:

To ascertain where there are challenges within the safeguarding system there needs to be attention to detail when providing oversight into what happened during a case. For example, if a CPR mentions 'Health' referral, which agency does this refer to in Health? One example noted *'some agencies held information about self-harm and suicide ideation'* with no further information. This limits the learning, and potential training inputs that need to be done with that service and area.

There needs to be a written rationale as to why key agencies have not been included within the review. For example, in one CPR, the index child was of school age, but there was no mention of Education to understand their engagement with school and what this significant area of a child's life was like. Yet the CPR clearly noted within this particularly review that Education were part of the review panel and even provided a timeline of their involvement with child.

3.3. Critical Analysis:

Reflection and analysis on multi-agency decisions and actions in some CPRs were assessed as limited. For example, when decisions had been made which were unexpected or questionable, there was often limited narrative to unpick the reasons for decisions, which could be related to the case itself but also a wider issue such as staff shortages or demand pressures. To maximise the learning, it would be helpful to further understand the reasons behind decisions, not to appoint blame but to provide context and ensure learning is maximised. Like some of the cases themselves, in some CPRs there was a focus on mothers' role and less detail concerning the father, which require further commentary. Good Practice examples clarify what worked well in a case and if any learning in these areas can be replicated elsewhere.

3.4. Addressing Objectives:

In the Terms of Reference included (within each CPR), there were key objectives in which the CPR was trying to address, such as:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board and reasons why this is not the case.
- Examine the effectiveness of inter-agency working and service provision for the child and family and contextual factors involved
- Determine the extent to which decisions and actions were in the best interests of the child and outcome focused and reasons underpinning these decisions and actions

However, not all CPRs fully answer this explicitly. A conclusion would be valuable in summing up learning, not just the key findings and themes, but how they align and interact with the objectives[22].

4. Clear, Actionable, Accountable Recommendations

Recommendations need to be structured to have clear accountability and are actionable. It is beneficial to structure the recommendations in aligning them to which agencies they are attributed, for example, which sector. It is also helpful to clarify whether recommendations are strategic and would require further consultation, planning or development or whether they are operational based and could be actioned more quickly. It is also helpful to identify and list any changes which have already been made since the significant event.

[22] See Recommendations for further information (Appendix 7).

Discussion

STRENGTHENING COLLECTIVE SAFEGUARDING RESPONSIBILITY

Many families within the CPRs were noted as complex, with overlapping risk indicators that were seen to be co-occurring across the parental/carer and child environment and as such require a multi-agency response. Whilst there are challenges relating to silo practice, an overriding feature noted across all sections of analysis was a lack of infrastructure available to facilitate collaboration, both within key sectors (e.g., Health – GPs, midwives, health visitors; Education – schools, nurseries, including school nurses) and across them. The review of CPRs identified challenges in working with the child and their family, whilst also considering the wider environmental factors. The challenges of a whole-family approach are compounded by the significant complexity and therefore potential disconnect within and across practitioners from different sector agencies, many of whom do not have the remit to respond to whole-family need.

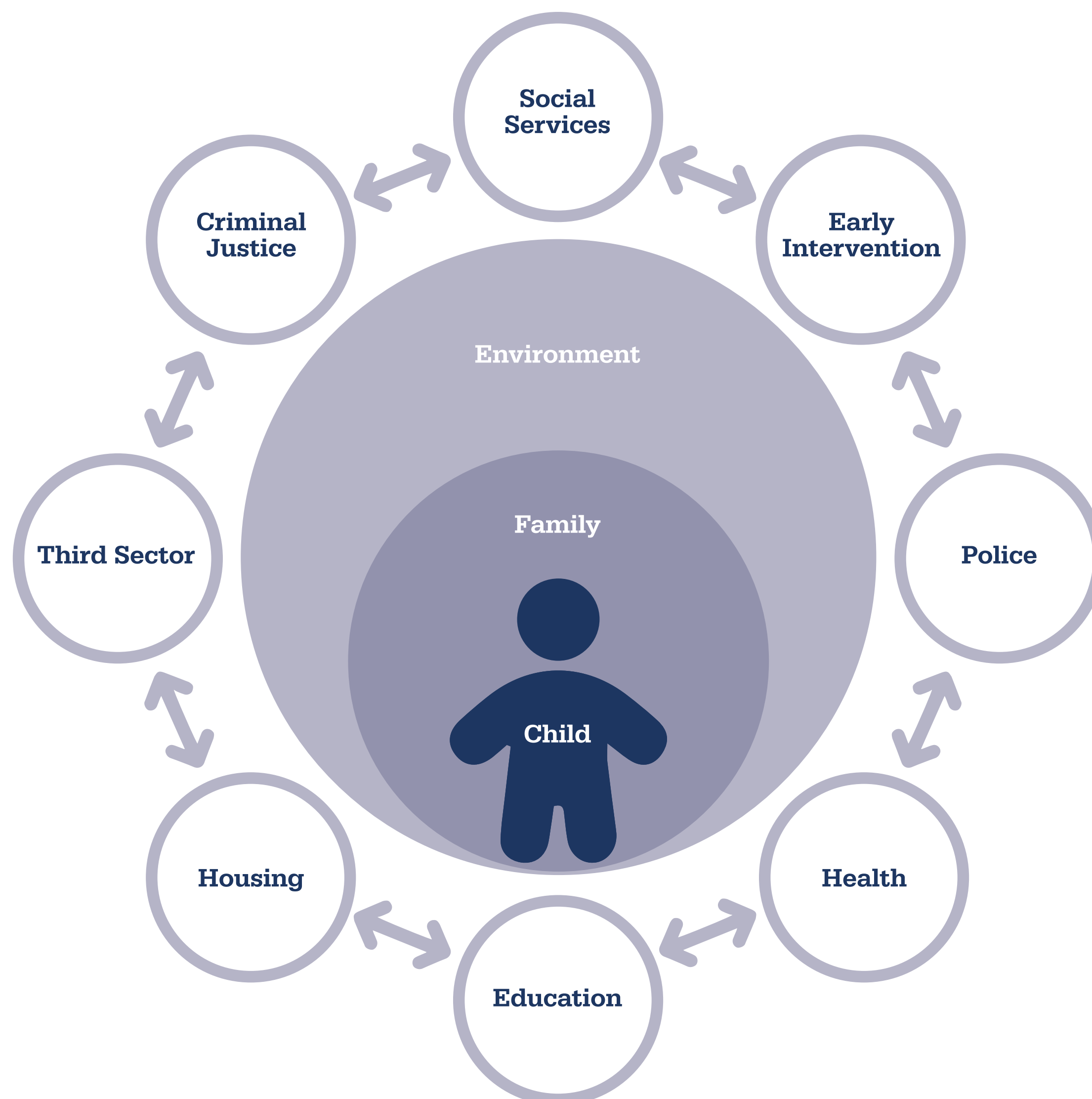
There are key issues in understanding how agencies can work together to generate a **collective safeguarding responsibility**. The reality of safeguarding is that it is not a linear journey and the number of potential agencies who are involved with any one young person, family member or their environment, is often underestimated. Moreover, the assumption that there are compatible organisational remits, with direct pathways for these agencies to collaborate, is not always well founded. Whereas some agencies have a long-term presence in a child, or family member's life, others are time-limited; not to mention the number of practitioners who may work for any one agency due to instability in workforces. The Model of Multi-agency Connections, Considerations and Complexities (Figure 11 – see page 35) illustrates the various elements a multi-agency response is required to consider. The inner circle highlights the balance required to focus upon the child themselves, understanding their daily lived experience, in addition to that of their siblings and parents. The complexities lie in the potential unmet needs and constant interactions of these needs among the family as a whole. The child and the family also reside in the context of their environment, whereby there could be wider societal and neighbourhood issues around poverty, discrimination, social unrest, fragmented communities, and so on. All of which can potentially impact a child's daily lived experience.

Although safeguarding is everyone's responsibility, the remit of those practitioners working with the child, in addition to those working with their family and those focussing on the wider environment, generates opportunity for disconnect. Routine exchanges of information exchanged between any number of practitioners working with a family are not always readily available and therefore collaboration is imperative. It is pertinent to note that safeguarding concerns are often fluid and not static. Concerns and risk factors co-occur, accumulate and evolve. The requirement for any agency or practitioner to have a 'full picture' is by its very nature challenging; hence the need for agencies to work in partnership with practitioners, both within their sector and across sectors. While this is not a new phenomenon, it remains an area of ongoing challenge. Crucially, it also requires practitioners having the **capacity within their workload** and adequate time and space to be able to carry out their jobs effectively, to **fulfil this safeguarding responsibility**. Without this, implementation of any recommendations will remain challenging.

To work in partnership, practitioners rely upon structures and processes which underpin, support, and facilitate their safeguarding practice. Within Social Services there is a duty to assess risk to determine if the threshold[23] for statutory intervention has been met; this requires an assessment of the whole family and the ability of the parents to keep the child safe. Whilst there are procedures that apply when a child has reached the level for statutory intervention, many incidents occur in which safeguarding concerns are not felt to have met that threshold. At this point there may be an option of a full family support offer from Early Intervention and Prevention services, but this is consent led and families may decide not to engage. If a family does not engage with family support, individual sector agencies such as Health, Education, and Police often continue to work or interact with families, but their day-to-day remits are specific to their agency. Practitioners are asked to be 'Professionally Curious' and question what the bigger picture of the situation could be; to not rely on self-report and to be aware of disguised compliance, by considering an alternative narrative

[23] As previously noted, we acknowledge debates with the term 'thresholds', within this review it is used to describe a decision-making process in determining next steps and access to service intervention/response at a particular point in time.

Figure 11. Model of Multi-agency Connections, Considerations and Complexities



to what is being presented. However, this not only demands confidence in ability and competence in skills; it also assumes that there is underpinning infrastructure to pursue and act on potential concerns within the capacity of the practitioner's individual role and organisation. Organisations themselves, as well as LAs and RSBs, have a responsibility to promote, facilitate, and review any such change in practice. A recommended framework in being able to help review, evidence and improve multi-agency safeguarding effectiveness is The Collective Responsibility Model (12Cs), developed from the Shaping the Future of Safeguarding project (Ball & McManus, 2023).

'Safeguarding is everyone's responsibility' is a much-agreed objective for all practitioners, however, translating this statement into Collective Safeguarding Responsibility practice is difficult. Analysis of the CPRs shows that a significant challenge in identifying and responding to safeguarding concerns is trying to obtain a full picture from all key agencies to determine severity of harm and impact. This is achieved by different agencies (as illustrated within the outer circle of the model) continually sharing relevant information regarding the child and the family members, with other agencies working with that family, so that a holistic picture can be ascertained. The challenge is that often there is no logistical support structures within these organisations or between them, to allow for this routine exchange of accumulative information; nor is there a lead coordinator to collate and review the evolving picture. Appendix 5 takes the Model of Multi-Agency Connections, Considerations and Complexities further by producing a sequence of figures highlighting the individual agency complexities and connections that need to be considered when developing a holistic picture.

Deep Dive: Missed Health Appointments

A key feature within the CPRs was missed health appointments, with reference to the Not Brought Policy needing to be followed and actioned. The Was Not Brought Protocol details what actions should follow when a child is not brought to a health appointment(s), based on the premise that failure to attend *could* be an indicator of a family's vulnerability, which may require support. However, the existence of any policy is of limited value if there is no infrastructure to facilitate recording and notification. Many of the findings of this review echo those of previous research, policy, and guidance, which have identified challenges of *'information sharing'* within multi-agency safeguarding working (Rees et al., 2021; The Child Safeguarding Review Panel, 2022; NSPCC, 2022). Currently, there are significant challenges with information sharing, even when aware of the specific type of information to be shared, such as missed health appointments. This is because we do not have the ability to specifically:

- Code (record) this key information (e.g., missed health appointments) clearly, easily searchable and extractable, particularly when it becomes a concern (trigger point).
- Notify other agencies of this information (share information).
- Collate this key information and overlay it with other child/family/environment information to understand the wider child/family circumstances.

This raises some key questions over what is to be done with the information held by one professional or organisation as typified below:

- Where in their system can they accurately log this information (a missed appointment)?
- At what point does this create a trigger (e.g., two missed appointments)?
- Who do you send/share the information with once the trigger is met?
- Who is the central coordinator to share information with, particularly when not subject to any Child Protection procedures?
- Who is responsible for collating this information, to potentially see trends of missed appointments (visibility/engagement) across a range of services?

What happens next? How is this one aspect of intelligence overlayed with other potentially relevant information/intelligence? How is this fed back to the initial professional or organisation regarding their involvement with the child/family, to be part of decision making on next steps?

CPR19: Missed Health Appointments

Child was two years old when found unresponsive at home. Had severe medical issues, but there were also a number of concerns and referrals made to Children's Services regarding the mother's associations within a household that had substance misuse. This was alongside health practitioners across a range of services recording missed health appointments by the mother for her child. The care coordinator was within Flying Start and they were unaware of any missed appointments. The CPR notes that no single professional within or outside of health had any oversight to risk assess the implications of the increasing number of missed appointments. Was noted as being seen in isolation by each department including the Health Visitor, hospital admissions (planned), Emergency Department, and Therapy.

Breaking this 'information sharing' issue into a specific type of intelligence (e.g., missed health appointments) highlights the practical and real barriers being faced by practitioners, where additional training and awareness raising of key trends to record is likely to be limited in resolving this issue. Within Health there is no one patient record or shared IT systems to see across Health services or across family members. This is without considering the multiple layers of intelligence alongside the 'missed health appointments' that can build a more accurate picture, including factors such as poor home conditions, police domestic abuse attendances. Currently, our safeguarding infrastructures fail to record and centralise this intelligence – there is no coordinator or central hub receiving these 'softer' intelligences, which ultimately are identified as key risk factors when critical incidents occur, as noted within this review.

Recommendations

This review has highlighted several key recommendations that should be considered and taken forward aimed at:

1. Recommendations for Practitioners and Managers
2. Recommendations for Authorities and Boards
3. Recommendations for Policy Makers (National)

As commissioners of this review, we call upon the National Independent Safeguarding Board (NISB) Wales to consider and review how best to take forward.

1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS

For those professionals and agencies who work within safeguarding, our review highlighted several areas to consider:

1.1. Multi-Agency Partnership Training:

We recommend that regular multi-agency training ensures common understanding, facilitates regular discussions of different agency perspectives and strengthens roles and expectations in recognising and managing safeguarding concerns. This can help to overcome collaboration barriers and enable more proactive responses where there is uncertainty about decision-making regarding thresholds for intervention, agency expectations and individual responsibilities. Training should specifically address:

- Understanding the child's voice as the daily lived experience of the child within their environment, how to best record, appropriately share and utilise within decision-making and interventions.
- Undertaking a 'Whole Family' approach and developing competent and confident workforce in applying 'Professional Curiosity'. Practitioners need to be clear on individual agency responsibilities and the processes and pathways for collating intelligence in identifying emerging risk. This includes co-occurring and interacting risk factors and with an understanding of the dynamic impact of past, present and potential risks in the continuing assessment of harm and risk.
- Key thematic areas in case studies of neglect and poor home conditions, which were identified as key interacting risk factors within the analysis, as well as within wider reports. Training should explore the roles and responsibilities of different agencies, but also the real-life challenges in transferring knowledge and theory into practice to identify pathways of interventions and support.

1.2. Professional Curiosity:

We recommend that strategic discussions are initiated at LA and RSB level which focus on how Professional Curiosity is encouraged, facilitated, and embedded into practice as a shared approach within and between all relevant professional agencies. Issues around agency expectations and limits within sectors and roles can be addressed in training. However, more clarity is required to explore how is curiosity embedded, supported, reviewed, and monitored for maximum and continued effectiveness.

- The Collective Responsibility 12Cs Framework[24] may help guide LAs and RSBs regarding how different agencies can work together to ensure that there is collective safeguarding between practitioners and the agencies they are governed by. This will enable a better understanding of expectations on professional curiosity across the safeguarding agencies, to maximise its effectiveness.

1.3. Prioritising Support and Supervision for all practitioners:

Managers should ensure there is clarity on expectations for formal safeguarding supervision for relevant practitioners. This should include details on the frequency, duration and objectives of supervision and demonstrate an understanding of how this will be internally reviewed and monitored.

- RSBs must be assured that regular and effective supervision is taking place across sectors, which may require, for example, returned reports from relevant agencies to the RSBs. This monitoring will provide confidence that supervision across safeguarding partners is purposeful, impactful and of sufficient quality. Supervision should also seek to include how best to facilitate collaboration with key partners.
- Managers should also seek to provide and review informal opportunities for practitioners to access safeguarding support.

[23] Available upon request.

2. RECOMMENDATIONS FOR AUTHORITIES AND BOARDS

For those organisations responsible for the delivery of safeguarding, our review highlighted several areas to address:

2.1. Threshold Uncertainty, improving Decision-Making, Agreement and Challenge:

Whilst we acknowledge there are debates with the term ‘thresholds’, within this review it is used to describe a decision-making process in determining next steps and access to service intervention/ response at a particular point in time. This review identified the need for:

- Multi-agency Threshold guidance should be agreed regionally to clarify expectations and as a point of reference for practitioners when making safeguarding referrals. Areas of concern, often subject to ambiguity and different interpretations, for example neglect, should be addressed. This should also include clear pathways for progressing concerns and challenging decisions should a safeguard concern remain after a threshold decision has been reached.
- Local polices and protocols relating to managing emerging or escalating concerns and resolving professional differences should provide transparent and accessible pathways and processes. This should be referenced in the Multi-agency Threshold guidance and monitored as part of internal reviews.

2.2. Working towards a unified health record.

This review has highlighted the key, but complex, nature of Health agencies within safeguarding. Whilst acknowledged as challenging, urgent work is required to further drive the facilitation of a unified health record. This requires:

- Bringing information from a range of Health services such as GP surgeries, Midwifery Services and Health Visitors is particularly vital in identifying emerging safeguarding concerns and supporting practitioners in having a whole family focus. In the absence of shared IT systems, there needs to be mechanisms for routine information sharing and relationship development between these practitioners to enable prompt and regular information sharing.
- To address the complexity of the NHS and its divisions we recommend the development of a nationally led Safeguarding Health Working Group, with stakeholders to consider the barriers and opportunities for collaboration and effective information sharing of low level and emerging safeguarding concerns.
- Any working groups should seek to liaise with the Department for Education (DfE) regarding their pilot work to improve multi-agency information sharing using a ‘Consistent Child Identifier[25]’.

2.3. Measuring Effectiveness within Safeguarding Arrangements

Clearer evidence is required from RSBs/ LAs in demonstrating the effectiveness of their multi-agency safeguarding arrangements.

- RSBs and Local Authorities are encouraged to adopt the Collective Safeguarding Responsibility Model: 12Cs. The 12Cs model details 12 components across “Practitioners and Agencies” as well as “Structures and Processes”. This will help to identify challenges and inform more targeted work, as well as identify best practice.
- RSBs need to improve transparency in meeting the recommendations of CPRs. Each RSB CPR completed should be subject to internal annual review (e.g., as part of annual audits/ corporate safeguarding reports). Given all CPRs provide a list of recommendations and required actions, the RSB should seek to collate all recommendations and actions required to improve safeguarding responses. This process should seek to identify common themes, share lessons and to better understand the improvements required across the region.

3. RECOMMENDATIONS FOR POLICY MAKERS

For those individuals responsible for shaping the continued development of our approach to safeguarding, our review highlighted several areas to address:

3.1. CPRs Quality Assurance[26]

This review undertook detailed analysis of the CPRs themselves, including the quality of the report and adherence to processes within guidance and legislation. Recommendations highlight that:

- CPRs should complete the ‘core tasks’ aspect of the review process, as defined by the terms of reference. See Appendix 7 and the full list of recommendations relating to the CPR report and process and the template provided in Appendix 6. This template should be adopted to ensure detailed information is consistently provided within CPRs.

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1168239/Improving_multi-agency_information_sharing.pdf

[26] Fuller details of the recommendations regarding the Child Practice Review Report and Process to help facilitate changes in practice are detailed in Appendix 7

- The timelines from case referral to sub-group to report completion should be reviewed. Many CPRS took more than double the suggested 6 months. Expectations must be managed and challenges acknowledged for future review processes.
- Moving towards the Single Unified Safeguarding Review (SUSR) process in Wales, these recommendations should be considered by The National Steering Group to improve the quality and optimise learning across all multi-agency reviews.

3.2. Development of Automated Safeguarding Referral/Report Portals

Given the complexities identified within safeguarding agencies and organisations that circle the family unit (see Figure 11 – Model of Multi-Agency Connections, Considerations and Complexities), alongside the various potential Safeguarding Pathways (see Appendix 4), prioritisation should focus on building automated portals for professional safeguarding concerns to be received, reviewed and managed. This would enable increased opportunities for effective information sharing of softer intelligence and concerns.

- In receiving notifications of submissions alongside unique referral reference numbers it would encourage follow-up from referrers regarding any decision making and feedback. This would increase capabilities in searching and collating information on a child, wider family and household in determining a holistic picture of concerns raised.
- We note that this would require additional resource to implement and would need to work within current systems and pathways, such as MASHs/Safeguarding Hubs and Information, Advice and Assistance (IAA) front door processes.

3.3. Review of the 'Not Brought' Protocol to maximise this policy into practice.

The 'Not Brought' Protocol was identified in many CPRs as requiring further implementation into practice. Whilst acknowledging the information-sharing issues identified within this review in capturing a holistic picture of concerns (see Discussion), there were concerns regarding premature closing of support due to non-attendance without consideration of sharing information.

- A national 'Not Brought' protocol for all agencies needs to be developed to sit across RSBs; this should allow for a clear pathway of action, specifying the roles and responsibilities of each agency that is notified of information, should it require actioning. Examples have been identified within dentistry in response to the link between dental decay and neglect (British Dental Association, 2020)[27].

3.4. Recording and Guidance relating to neglect and home conditions

Several CPRs identified issues with practitioners being unsure what detail was required to be reported to ensure accurate capturing of information. As per other recommendations within this review, the impact on all family members needs to be considered in these assessments and recording.

- Safeguarding records should detail the various, cumulative, and continuing concerns raised, what action was taken, and the longevity of any changes made. This would allow for increased application of current guidance such as the All-Wales Safeguarding Procedures; All-Wales Practice Guide on Safeguarding Children from Neglect (2021).
- RSBs should seek to review how neglect and concerns regarding home conditions are recorded, and who takes ownership and responsibility for these concerns, using their ability to extract information identifying escalating and/or continuing lack of progress from relevant agencies.
- Authorities should seek to develop multi-agency infrastructure nationally, to promote the sharing of softer safeguarding intelligence and to build a more accurate understanding of harms being recorded.
- Wider and more consistent use of the Information Advice and Assistance system may also offer a route to develop this.

3.5. Implementation of the 12Cs as a Guidance Framework and Audit Toolkit

While there are infrastructures in place in some areas to support joint working, at certain points in the safeguarding process such as within MASH, this is limited and does not provide an effective multi-agency shared IT system accessible to all potential agencies that may be working with a child or family. Moreover, it would not necessarily detail historical and current interactions and interventions. Therefore, consideration must be given to how agencies can facilitate collaboration, joint-working and instil a collective responsibility for safeguarding. The Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023)

[27] https://bda.org/advice/Documents/WNB-implementation-guide-AW.pdf

was developed as part of the National Evaluation Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales (McManus et al., 2022).

- We recommended that this model be implemented to support existing Guidance Frameworks, and Audit Toolkits across RSBs and LAs to help demonstrate any measures adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.
- Implementing the 12C framework would require RSBs/ LAs to respond to each of the 12Cs in turn to evidence what has been put in place or is planned to be implemented, to address this area. There is also an option to grade progress made within each of the 12Cs, which can be reviewed annually and monitored.

Concluding Remarks

The CPRs reviewed represent a minority of safeguarding scenarios. Throughout our wide portfolio work in multi-agency safeguarding, we have seen countless examples of dedicated professionals going above and beyond to support children, young people and their families. In the face of unprecedented demand, funding cuts and recruitment challenges, it's vital that we acknowledge their valuable contribution in keeping children safe.

Many of the findings of this review echo those of previous research, policy, and guidance, which identified challenges within multi-agency safeguarding working. We hope that this thematic analysis provides a deep dive into the underlying factors which underpin these challenges, as well as highlighting the complex task of translating policy into practice.

The implementation of effective multi-agency safeguarding is achieved by ensuring a collective safeguarding responsibility is enabled and maintained across relevant agencies. Whilst our review revealed several critical issues that require urgent prioritisation, it also highlighted examples of good practice which should be recognised and commended. Practitioners and leaders across agencies are working tirelessly and continuously with families to provide a robust safeguarding response and achieve positive outcomes. Effective safeguarding requires adequate resource to invest in a workforce who are confident, competent and supported to deliver a quality service response.

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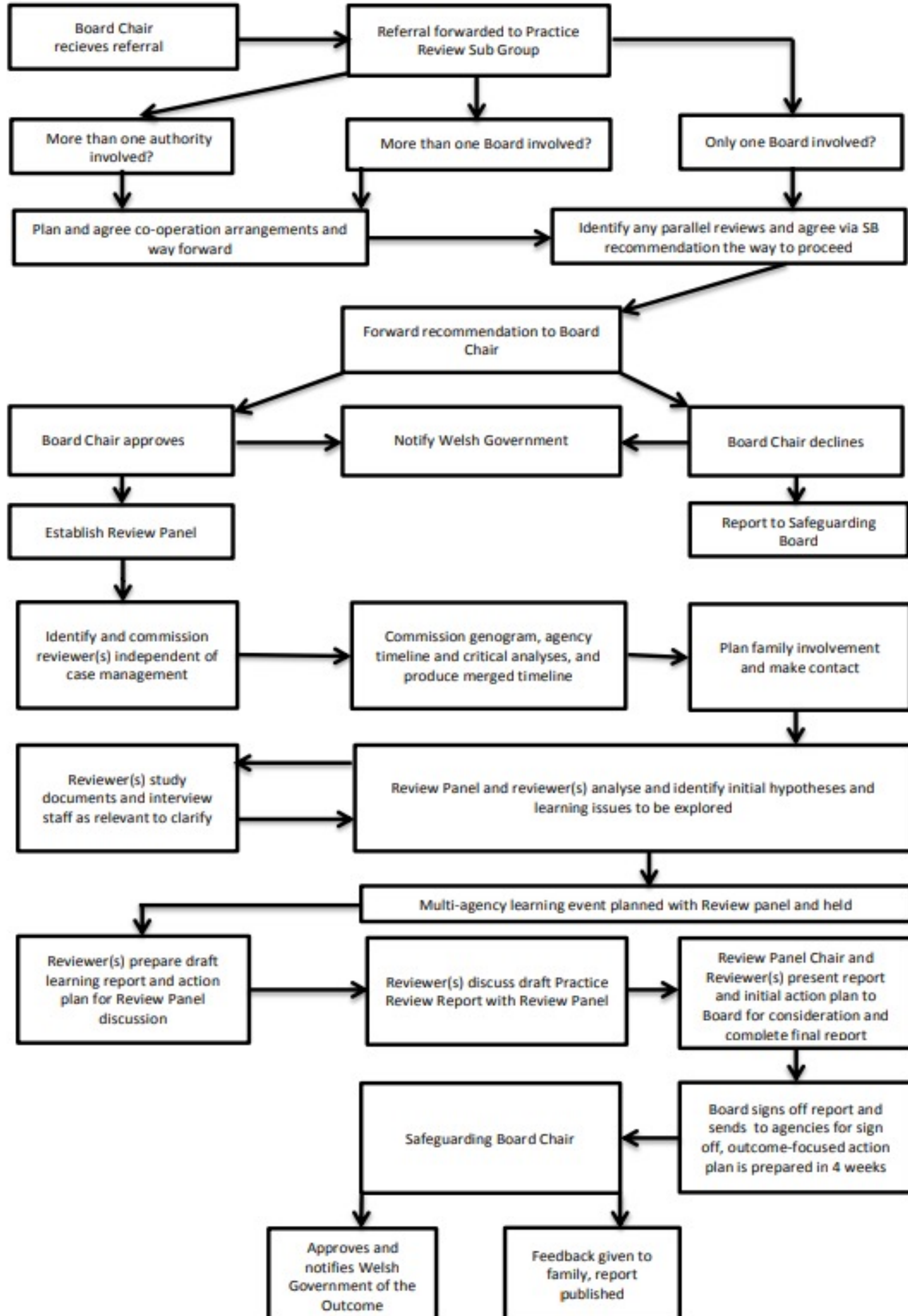
Appendices

APPENDIX 1. FLOWCHART OF CHILD PRACTICE REVIEW PROCESSES



APPENDIX 2. CPR EXAMPLES OF RISK INDICATORS

CPR Case Examples of high frequency risk indicators for parental/carers:

Alcohol/Drug misuse:

- CPR 12: HV and Midwife noted cannabis smell on visits and Father of child was under police investigation for serious drug offences (Class A Drugs). Positive drug test result on Father when he found the baby unresponsive after co-sleeping and waking to find the baby in the corner of the sofa.
- CPR 8: YP was noted to have been using illicit drugs since the age of 14 years (heroin, cocaine, speed, ecstasy, amphetamines, and cannabis). Was only able to control drug use when in secure accommodation. Index YP was 18 years old at time of death which was recorded as natural causes due to mismanagement of diabetes. However, this also coincided with her being Looked After since the age of 10 and at the time of her death was in Local Authority arranged accommodation in a licenced flat on a Pathway Plan with agency support.

Mental Health Issues:

- CPR 3: Mother of index child was diagnosed with post-natal depression of younger sibling (Index Child was aged 5 years old at time of death). The GP also noted a history of depression and borderline personality disorder. Mother was referred to the Community Resource Team, with a later referral to early help. There was no further information provided on engagement with these services.
- CPR 13: 4yo was found unresponsive at home (does not provide further details). Was noted to have been referred to the Crisis Mental Health Team and was assessed as very low risk of neglecting children, harm to others. The results of the assessments were found to not be available at a follow up GP appointment. Mother did not attend a follow up appointment where she was due to be fully assessed by a psychiatrist. No action was taken by any health professionals for non-attendance and mother was discharged from service.
- CPR 17: the CPR notes that some agencies held information about self-harm and suicide ideation risks but does not state which agencies held this, just that this information was not shared. The index YP is a 16-year-old with cause of death as suicide, who was also a Looked After Child in an unregistered placement at the time of his death.
- CPR 12: (12-week-old baby: SUDI). Noted that the father failed to attend an initial assessment at Local Primary Mental Health Service in relation to concerns raised by Health Visitor for low mood. Was discharged for nonengagement. Records revealed none of the professionals working with the family were aware of the Father being discharged.

Domestic Abuse

- CPR 16: CPR details that within the year preceding the child's death, there were 9 PPNs relating to domestic abuse at the household. After several incidents the mother was noted as a 'repeat victim'. She was risk assessed at each incident as Standard Risk, and therefore information was not shared across agencies that had knowledge of other concerns. Index incident was recorded as SUDI (3-month-old baby).
- CPR 30: CPR noted that there had been Police attendance to household regarding domestic abuse incidents between older sibling of index child and her boyfriend. Whilst there were actions taken to risk assess the circumstances for the sibling, this did not include the index child as part of these assessments to understand the household environment (Index child: age unknown, cause of death: suicide).

APPENDIX 3. SIGNIFICANT CORRELATIONS BETWEEN INDEX CHILD VULNERABILITIES[28]

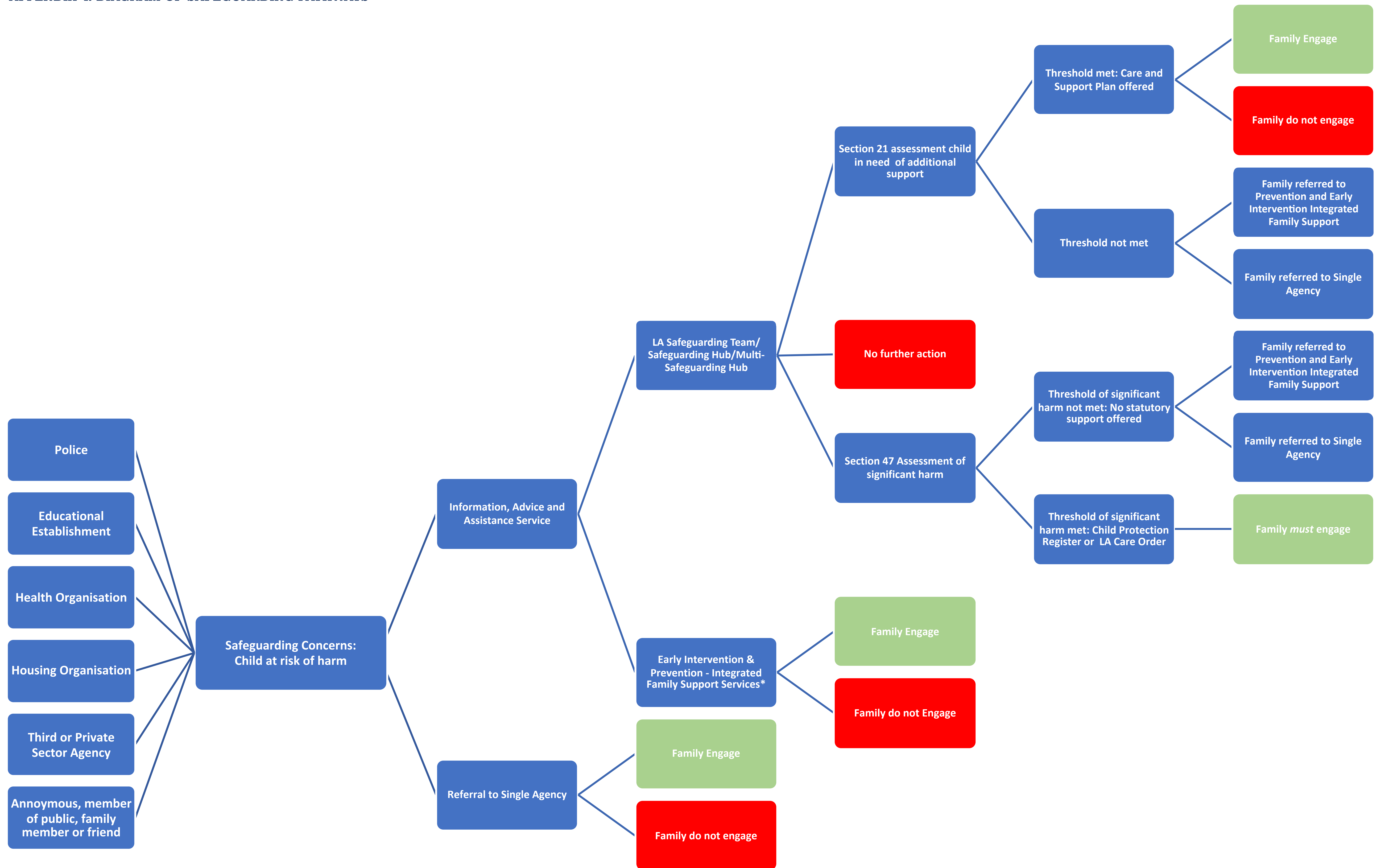
Significant Correlations between Index Child Vulnerabilities[28]

	Neglect	CSE	Emotional Abuse	Physical Abuse	Sexual Abuse	MH Issues	Physical Medical	Neuro-diversity	Looked After	Bullying	Self harm	Suicide	Missing episodes	ACEs	Low Self Esteem	Poor Home Conditions
Neglect			54 ***	.37 *				.37 *								
CSE				.56 ***	1 ***	.44 *			.66 ***				79 ***	.46 **	.36 *	
Emotional Abuse	.54 ***			.60 ***		.37 *								.61 ***		
Physical Abuse	.37 *	56 ***	60 ***		.56 ***				.40 *				.37 *	.41 *		
Sexual Abuse		1 ***		.56 ***		.44*			.66 ***				.79 ***	.46 **	.36 *	
MH Issues		.44 *	.37 *		.44 *			.56 ***	.67 ***	.56 ***	.56 ***	.56 ***	.47 **	.70 ***	.75 ***	-.46 **
Physical Medical																.35 *
Neuro-diversity	.37 *					.56 ***				.63 ***				.39 *	.45 **	
Looked After		.66 ***		.40 *	.66 ***	.67 ***					.56 ***	.56 ***	.65 ***	.56 ***	.55 ***	-.46 **
Bullying						.56 ***		.63 ***			63 ***	63 ***		.39 *	.75 ***	
Self-Harm						.56 ***			.56 ***	.63 ***		1 ***	.40 *	.40 *	.75 ***	
Suicide						.56 ***			.56 ***	.63 ***	1 ***		.40 *	.40 *	.75 ***	
Missing Episodes		.79 ***		.37 *	.79 ***	.47 **			.65 ***		.40 *	.40 *		.42 *	.46 **	-.38 *
ACEs		.46 **	61 ***	.41*	46**	.70 ***		.39 *	.56 ***	.39 *	.40 *	.40 *	.42 *		.52 ***	
Low Self-Esteem		.36 *			.36 *	.75 ***		.45 **	.55 ***		.75 ***	.75 ***	.46 **	.52 ***		
Poor Home Conditions						-.46 **	.35 *		-.46 **				-.38 *			

[28] *p <.05, **p <.01, ***Bonferroni correction p <.003

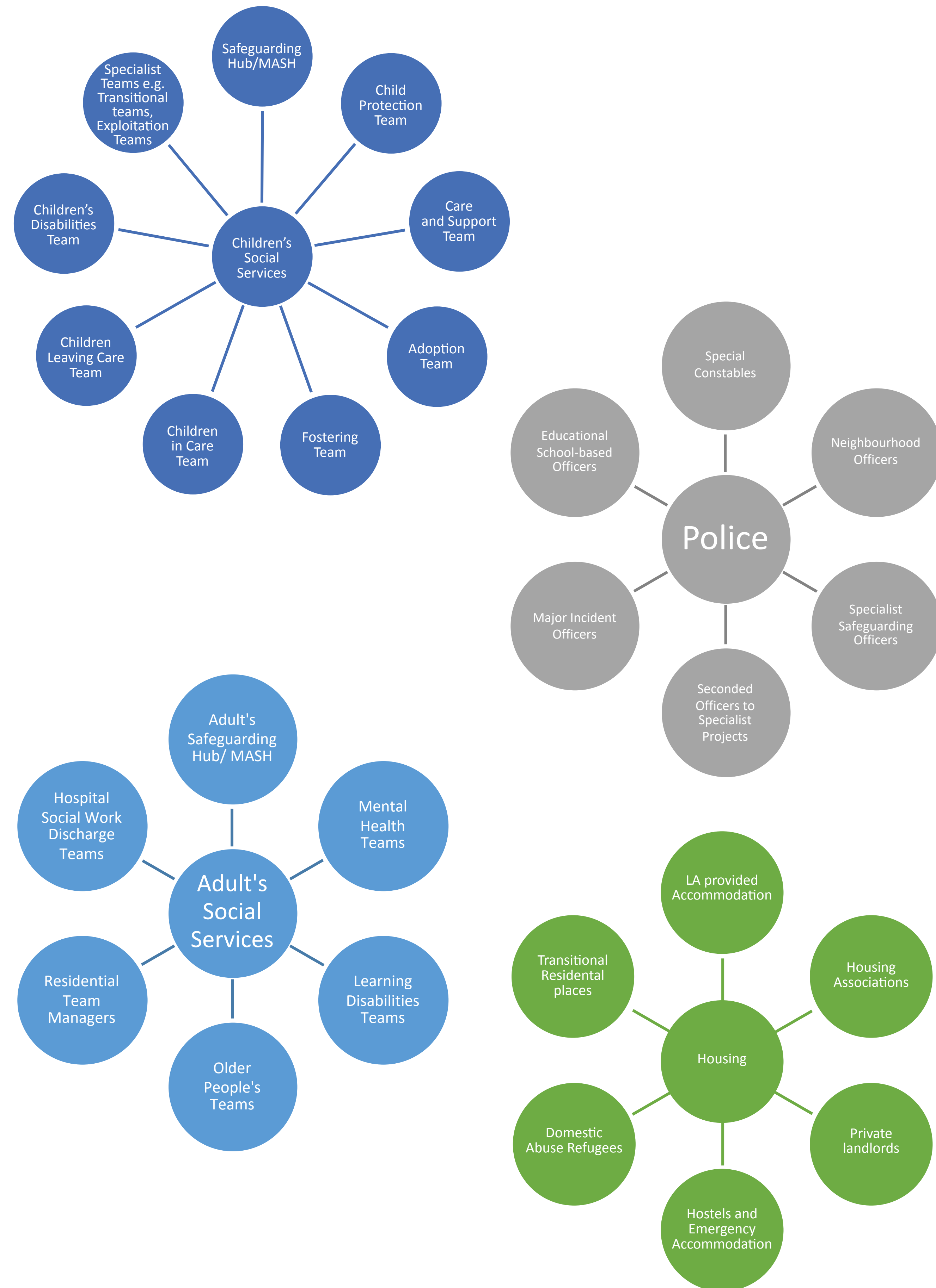
CHILD PRACTICE REVIEWS IN WALES

APPENDIX 4. DIAGRAM OF SAFEGUARDING PATHWAYS



CHILD PRACTICE REVIEWS IN WALES

APPENDIX 5. NETWORK OF (DIS)CONNECTIONS ACROSS SERVICES/AGENCIES/ORGANISATIONS



Early Intervention
Families First
Team Around the Family
Flying Start
SPACE (Single point of Access Child Wellbeing)

Early Intervention
Families First
Team Around the Family
Flying Start
SPACE (Single point of Access Child Wellbeing)

Probation
Probation Teams
Youth Justice Teams
Prisons
Youth Secure Accommodation

Education
LA Primary Schools
LA Secondary Schools
Private Schools
Colleges (Further Education)
University (Higher Education)
Alternative Education Provision
Specialist Educational Need Schools
Pre-Schools and Nurseries
Education Welfare

Third Sector
Youth Work Activities
Local Specialist Support Charities (child/adult)
National Specialist Support Charities (child/adult)

APPENDIX 6. EXAMPLE TEMPLATE: CHILD PRACTICE REVIEW REPORT

Child Practice Review Report

(insert name) **Safeguarding Children Board**

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

Re: insert numerical case identifier

xx SCB 1/16

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 *X* review was commissioned by *X SCB* on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Child 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 SCB)

Comprehensive Circumstances Context (some information could be included in a redacted version):

- **Circumstances:**
  Succinct anonymised account if the circumstances that led to event
  Must include relevant narrative and relevant family history
  Must include key information such as age of the child, dates of significant events
  Consider a redacted version if compromises anonymity

- **Scope of the Review Panel:**
  Review Dates:
  Publication Date:
  Chair of Panel: NAME and AGENCY
  Independent Reviewer: NAME and AGENCY
  External Reviewer: NAME and AGENCY
  Panel Multi-agency Representation:

- **Objectives:**
  Set of questions and objectives taken from the Terms of Reference agreed by the Review Panel that the review will seek to analyse and conclude how they have answered this.

- **Family Tree** of young person including ages of children (if appropriate)

- **Agency Involvement in the CPR:**
  List of agencies or practitioners who were involved with the family and details of how they contributed to the review e.g.

Agency/ Practitioner	Contribution to Review
Social Worker	Discussion
Health Visitor	Written Report

- **Timeline of significant events (as Annex)** (for child and family)

DATE	EVENT	AGENCY RESPONSE

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)

- Learning Points: ideally in chronological order, coherently embedded in a narrative with constructive critical analysis of decisions taken and subsequent actions and underpinning reasons, including contextual factors and workforce constraints.
- Family members perspectives clearly, visibly and explicitly documented, ideally regarding each learning point. If not, a sperate section should be added **Family Members Perspectives** where reviews can detail who has been contacted, the response of the family members and any comments. Where it has not been possible (or appropriate) to include family/friends, this should be stated. Any information extracted from family members/friends should seek to understand the daily lived experience of the index child and any circumstances that may help understand events leading up to the index incident.
- Relevant Research and legislation which aligns to issues and themes raised in account.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB 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)

- **Actioned Changes in Systems and Practice**

Changes already implemented after significant event, before review was complete. This may include

- **Actions agreed from Learning Review Panel**
- **Clear, Actionable and Accountable Recommendations for Practice and Systems**

(primary/ secondary/ tertiary)
(local/ national/regional)
(Immediate/ requires planning/ further consideration)

Recommendation	Agency	Strategic	Operational

<table>
<tr><th colspan="2">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td>REVIEWER 2 (as appropriate)</td></tr>
<tr><td>Statement of independence from the case
Quality Assurance statement of qualification</td><td>Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td>I make the following statement that prior to my involvement with this learn-ing review:-

• I have not been directly con-cerned with the child or family, or have given professional advice on the case

• I have had no immediate line management of the practition-er(s) involved.

• I have the appropriate recog-nised qualifications, knowledge and experience and training to undertake the review

• The review was conducted ap-propriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference</td><td>I make the following statement that prior to my involvement with this learning review:-

• I have not been directly concerned with the child or family, or have given professional advice on the case

• I have had no immediate line management of the practitioner(s) involved.

• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review

• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference</td></tr>
<tr><td>Reviewer 1
(Signature) ....

Name
(Print) ....

Date ....</td><td>Reviewer 2
(Signature) ....

Name
(Print) ....

Date ....</td></tr>
<tr><td>Chair of Review Panel
(Signature) ....

Name
(Print) ....

Date ....</td><td></td></tr>
</table>

APPENDIX 1: TERMS OF REFERENCE

Core Tasks[29]:

Objectives of Review:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board and reasons why this is not the case.
- Examine the effectiveness of inter-agency working and service provision for the child and family and contextual factors involved.
- Determine the extent to which decisions and actions were in the best interests of the child and outcome focused and reasons underpinning these decisions and actions.
- Seek contributions to the review from appropriate family members and detail their response to being invited to participate. Clearly list these contributions within the review and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a multi-agency learning event for practitioners (and/ or managers) and identify required resources. Detail who was at the Learning Event.

APPENDIX 2: SUMMARY TIMELINE

Child Practice Review process
To include here in brief: • The process followed by the SCB 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.
• Key dates clearly summarised, including referral to CPR Subgroup, date of index incident, date(s) of any learning events and completion of the CPR process and report. • Learning Event detail should include dates, who attended, who did not attend (that is relevant to the index incident). Summary of discussions with any identified key learning, recommendations and actions. • Detailed section on family engagement (non-engagement). Who was asked? How were they offered to engage? Summary of their engagement and how it was included within the CPR analysis.
☐ Family declined involvement

For Welsh Government use only			
Date information received			
Date acknowledgment letter sent to SCB Chair			
Date circulated to relevant inspectorates/Policy Leads			
Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

[29] Please note the Key Recommendations within this report regarding the review and development of Core Tasks within the CPR process.

APPENDIX 7. DETAILED RECOMMENDATIONS: THE CHILD PRACTICE REVIEW REPORT AND PROCESS

7.1. Additional detail to be added to the CPR Template

As identified in Section 3 Analysis, there were key elements of the CPR report that were missing, lacked detail, with some good practice examples taken from various parts of the reports to build a more comprehensive list of requirements to include. This will aid the consistency in detail, critical analysis, and importantly the learning to be shared and implemented from this. Figure 10 within Section 3 Analysis, along with the additional requirements that have been added to the current Template Report (see Appendix 6) should be reviewed across the RSB to agree a national template (with additional pointers). These recommendations of minimal requirements within the CPR report should also be considered as part of the development and piloting within the Single Unified Safeguarding Review (SUSR) template and reports.

7.2. Review and Amendments to the CPR Terms of Reference 'Core Tasks'

Annex 2 within Working Together to Safeguard People (Volume 2) provides Terms of Reference that are included in all published CPRs, usually as part of their Appendix. This includes specifically defined "Core Tasks" that are required to be completed as part of the CPR process. Evidence from this review highlighted the high levels of variability in the structure and detail provided within CPRs (Section 3 Analysis). This suggests the wording within these Core Tasks needs to be strengthened or expanded:

1. Minimum standards

There needs to be a review and agreement on minimum standards of information to be included within a CPR. A template is currently used by RSBs across Wales; however, as outlined within Section 3, there were variances in the level and quality of information provided, which impacted on the understanding and learning that could be taken forward. Appendix 6 highlights key information that should be included to ensure that the context of the CPR is fully understood, allowing maximum opportunity for meaningful and practical learning. Appendix 6 shows an example of a CPR template with examples of good practice on what should be included. When a minimum standard of information to be included has been decided, where these factors are absent from a review, a rationale must be explicitly stated on the CPR as to why they were not included.

2. Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board

Upon reviewing the CPRs, it was difficult to determine if this Core Task was addressed within each report. Extracting this question out specifically as a subheading that clearly articulates the response, including the evidence that has contributed to the conclusion, would allow a wider understanding and learning to be extracted from this.

3. Examine inter-agency working and service provision for the child and family

Whilst some CPRs addressed this question in specific headers, not all could do so effectively. Good CPRs used headers relating to specific agencies in terms of their involvement and response to the child/family, and then brought these together as a conclusion. Setting this Core Task as a specific subheading within the report would again allow for greater extraction and dissemination of learning. Good CPRs were also able to provide a comprehensive merged agency chronology as part of this analysis into inter-agency working. This is recommended to be included within the main report if possible; many CPRs referred instead to a timeline. However, this was either too high-level to gain any insight into inter-agency awareness and responses, or it was referred to within the appendices but was not part of the report (and therefore not available to view).

4. Determine the extent to which decisions and actions were individual focused

This key Core Task links to the findings within this report regarding the need for whole-family approaches to intelligence gathering, decision making, and responding to safeguarding concerns. We recommend that Figure 11 be utilised to examine the extent to which these decisions and actions were individual and silo focused. Again, a subheading is required to ensure this is specifically addressed within the report, as individual/silo decision making is a recommendation within most CPRs/SCR reviews and therefore requires the necessary attention to understand how to implement this and share any challenges and good practice.

5. Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress

Simply "seeking contributions" is allowing some CPRs to fall short of what should be desired as good practice. There was evidence that some CPRs not only included a specific subheading detailing their engagement and most importantly the voices of the family members, but also used their voices

at appropriate points across the whole CPR. This enabled the lived-experience voice to be present as an alternative and challenging voice throughout the report, allowing increased critical analysis of all the information provided within the review. Therefore, CPRs should provide a specific subheading detailing who contributed, how they contributed, and what they had to say, with efforts (where appropriate) to feed this in throughout the analysis of the review. Where it is not possible or appropriate to engage with family or friends, this should be clearly articulated, and the limitations should be noted in terms of the review. As with the previous Core Task, engagement with appropriate family members should consider wider family members such as siblings, who were noted within this review as absent regardless of the acknowledgement of them as potentially likely to provide insight.

6. Take account of any parallel investigations or proceedings related to the case

The issue of parallel investigations was noted in some reviews as causing more challenges and delays in the completion of the CPR process. The Terms of Reference must provide additional, specific guidance on expectations when parallel investigations are occurring, to ensure that reflection, learning, and action are not delayed. Importantly, CPRs should specifically state whether there were any parallel investigations. When there were significant delays from referral to sub-group to publication, it was difficult for us to understand if there were parallel investigations that were omitted from the report.

7. Hold a learning event for practitioners and identify required resources

Mention and engagement with Learning Events varied greatly across the CPRs. Some merely provided a date and list of agencies that attended. However, there was good practice identified in those that included a list of roles and agencies that clearly aligned with those involved with the child/family. This was furthered by clear articulation of what was discussed at the event and the learning/challenges identified from this. Some CPRs had even pulled out actions that had already been identified and addressed due to the Learning Event. This Core Task should ensure that the detail of the Learning Event includes all the above information.

Importantly, it should be noted that most of the CPRs took well over 12 months[30] to complete (from receipt of referral from the Board to the Review Sub-Group to completion of the report). As identified within the early review of the implementation of the CPR Framework (Welsh Government Social Research, 2015), some CPRs within this review stated that practitioners were unable to meaningfully contribute to Learning Events due to the time that had passed.[31] They were unable to recall why they had made or not made decisions, or else they had moved roles and struggled to attend. A further addition to the Learning Event Core Task should also ensure the requirement of an interim reflection event (as held within some CPRs) as soon as possible after a critical incident has occurred, to try and capture some of the learning to implement more expediently.

7.3. Review of required timelines from referral to Sub-Group to Completion of CPR

Working Together to Safeguard People (Volume 2) states that for both Concise and Extended reviews, “The review process will be completed as soon as possible but not normally longer than six months from the date of referral to the Board’s Review Sub-Group”. Our analysis showed that in all but one case, CPRs took over 12 months to complete from the date of referral to the CPR Sub-Group to the sign-off of the report. The longest period recorded was 36 months. Expectations need to be managed to maximise learning and action from these critical incidents, whilst acknowledging the various challenges in completing the CPR process: lack of suitable reviewers, parallel investigations, and complex incidents taking more time to review. It is recommended that some key activities within the Core Tasks should be prioritised, such as holding an Interim Reflection Event as soon as possible after receipt of referral to the Sub-Group, with discussions and any actions recorded to share with reviewers as part of the more formalised Learning Event.

Consideration of the practical realities of the time needed to complete the reviews is likely to present further delays within the SUSR process. The existing delays in the CPR processes could be impacted further when there may be numerous parallel processes to be considered. There is also a potential need for more omnicompetent reviewers, to undertake a variety of reviews. It is yet to be seen how this will affect the availability of a pool of reviewers, alongside the well-established challenges of workloads and availability of experienced staff. Since this information is reported to the Welsh Government (notification of a CPR and completion of a CPR), it is recommended that these required notifications are monitored (in terms of adherence to dates) and discussed with key leaders across NISB and RSBs going forward. This may identify further slippage in the expected progress and timely completion of reviews.

[30] This review identified an average of 20 months from referral to Sub-Group to completion of the CPR.
[31] This review identified an average (median) of 18.6 months from index incident to Learning Event.

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