Welsh Government

Protecting Children in Wales

Arrangements for Multi-Agency Child Practice Reviews: Draft Guidance

For Consultation (4): December 2011

Contents

1. Preface

1.1. This draft practice guidance is being issued for consultation and is accompanied by a set of consultation questions. It sets out the proposed new arrangements for Multi-Agency Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected. Feedback from consultation will inform the final practice guidance as well as the future review of *Safeguarding Children: Working Together Under the Children Act 2004*[1]*.* It is anticipated that the new arrangements will be ready to be implemented in Wales in April 2012, following necessary amendments to the *Local Safeguarding Children Boards (Wales) Regulations 2006.*

1.2. The review process outlined in the draft guidance is about learning from practice in order to achieve improvements in multi-agency child protection practice. The guidance includes an annex (Annex 1) which is a guide for reviewers who will be organising and facilitating practitioner-focused multi-agency learning events under the new arrangements. It is hoped this guide will give practical assistance to those undertaking the new tasks of reviewers. In Annex 2, there is a set of templates to assist in streamlining communication and reporting during the process of a Child Practice Review. As the approach in Wales is building on existing good multi-agency practice by LSCBs, Annex 3 and 4 contain examples of how multi-agency learning events can be set up.

1.3. The guidance is addressed to all Local Safeguarding Children Boards (LSCBs) and partner agencies. The overall purpose of reform of the present serious case review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, responsibility for which is managed by LSCBs. It puts in place a system for Multi-Agency Concise and Extended Child Practice Reviews that are fit for purpose in circumstances of serious incidents resulting from abuse or neglect. These changes are expected to lead to new learning which can support a process of continuous improvement in inter-agency child protection practice.

1.4. The new framework has a number of important features which mark it out from the present serious case review system:

- it involves agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability;
- it has the potential to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different professionals with whom they work;
- it strengthens the accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need;

[1] Welsh Assembly Government (2006) *Safeguarding Children: Working Together Under the Children Act 2004.* Cardiff: Welsh Assembly Government.

- it recognises the impact of the tragic circumstances of non-accidental child deaths or serious harm on families and on staff, and provides opportunities for serious incidents to be reviewed in a culture that is experienced as fair and just by all concerned;
- it takes a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases;
- it allows a more constructive use of resources than in the current system and works to shorter timescales;
- it uses the learning from other related review processes and increases compatibility with different review systems;
- it focuses on key learning identified through the review process which results in relevant recommendations and action to improve future practice, recorded in anonymised reports which are published by LSCBs.

1.5. Further amendments to the arrangements proposed in the practice guidance will be required in due course following implementation of new Safeguarding and Protection Boards announced by the Deputy Minister for Children and Social Services in October 2011. However, this requires a new legal framework which will be part of a *Social Services (Wales) Bill* to be brought forward in 2012.

1.6. During the development of the practice guidance, the proposed new arrangements have been subject to extensive discussion and feedback, including a workshop of key stakeholders from across Wales held in June 2011. The proposals for child practice reviews have been tested by three Local Safeguarding Children Boards and other pilots are being planned. One Local Safeguarding Children Board held a multi-agency learning event in circumstances of serious neglect that did not meet the criteria for a serious case review or the new Concise Review, and three Local Safeguarding Children Boards, in agreement with the Welsh Government, have piloted or are in the process of piloting a Multi-Agency Concise or Extended Child Practice Review. They have all made an invaluable contribution to developing the detail of the guidance, and have confirmed the efficiency and effectiveness of the approach.

1.7. In parallel to this consultation the Welsh Government is considering what processes it will follow upon receipt of the recommendations produced by a Child Practice Review.

2. Principles underpinning the new arrangements

2.1. The new framework is underpinned by a set of principles to guide LSCBs, their constituent members and other community partners in their responsibilities for learning, reviewing and improving local child protection policy and practice, and to guide LSCBs in setting up new arrangements for multi-agency child practice reviews:

- professionals in all services working with children and families in the local area are given the assistance they need so they can undertake the complex and difficult work of protecting children with confidence and competence;
- organisational cultures, and the processes that underpin the culture, are experienced as fair and just, and promote supportive management and work environments for professionals;
- a positive shared learning culture is an essential requirement for achieving effective multi-agency practice;
- a culture of transparency is created that:
    - provides regular opportunities to address multi-agency collaboration and practice, and multi-agency learning, reflection and development;
    - has processes for learning and reviewing that are flexible and proportionate and are open to professional and public challenge;
    - takes account of the wishes and views of children and families in individual cases;
    - provides accountability and reassurance to children, families and the wider public;
    - identifies promptly the need for systemic or professional changes and ensures timely action is taken;
    - shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally and nationally;
- the work of learning, reviewing and improving local multi-agency child protection policy and practice is audited and evaluated for its effectiveness.

2.2. The principles underpinning the new framework are in accord with the Articles of the *Convention on the Rights of the Child* [2] and can be found similarly reflected in the statutory instruments and guidance of other relevant bodies for their systems of reviews, investigations and tribunals[3].

[2] UN Convention on the Rights of the Child, ratified by the United Nations, 20 November 1989.
[3] For example, The Tribunal Procedure (Upper Tribunal) Rules 2008, s.2; Jordan v UK (2003) EHRR 2 – 'minimum standards' for an article 2 investigation.

3. Learning and reviewing framework

3.1. The learning and reviewing framework has been developed with the intention that LSCBs and their constituent members provide an environment in which practitioners and their agencies can learn from their casework. The framework, underpinned by the principles in section 2, consists of a foundation for learning of Multi-Agency Professional Forums and, in clearly specified circumstances, Multi-Agency Child Practice Reviews that are either Concise or Extended.

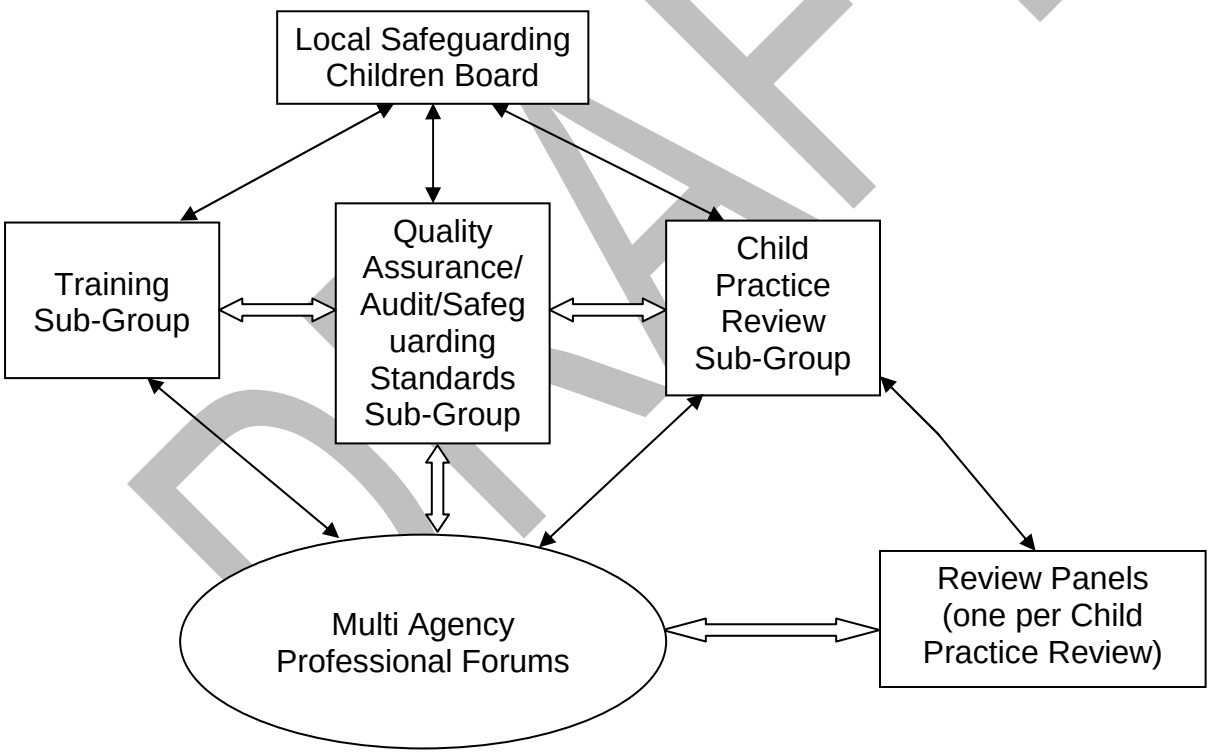
3.2. In summary, the framework consists of several inter-related parts, to be laid down in revised *Local Safeguarding Children Boards (Wales) Regulations 2012*:

- **Multi-Agency Professional Forums:** an LSCB annual programme of multi-professional learning events for practitioners and managers, primarily to examine multi-agency case practice and findings from child protection audits, inspections and reviews, to improve local knowledge and practice and to inform the Board's future audit and training priorities.
- **Concise Reviews:** a multi-agency review of practice in circumstances where a child has died, or has been or was in danger of being seriously harmed as the result of abuse or neglect **and was not** on the child protection register within the last six months and was not a looked after child or a care leaver under the age of 18. The review engages with relevant children and families in so far as appropriate and seeks to include their perspectives, and it involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner-focused learning event is held, conducted by a reviewer independent of the case management, to examine recent practice, using a systems approach. At the conclusion of the review, there is an anonymised Child Practice Review Report which is to be submitted to the Welsh Government and published by the LSCB. The process will be completed as soon as possible but no more than six months from a referral from the Board to the *Review Sub-Group.*
- **Extended Reviews:** a multi-agency review where a child has died, or has been or was in danger of being seriously harmed as the result of abuse or neglect **and was** on the child protection register within the last six months or was a looked after child or a care leaver under the age of 18. It follows the same process and timescale as a Concise Review, engaging with relevant children and families, in so far as they wish and is appropriate, and involving practitioners and managers throughout. There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) in place for the child or young person. The review is to be undertaken by two reviewers working closely together, one of whom will bring an external perspective and who will have responsibility for the scrutiny of how the statutory duties of all relevant agencies were fulfilled. An anonymised Child Practice Review Report is to be submitted to the Welsh Government and published by the LSCB.

Implications for Local Safeguarding Children Boards

3.3. Achieving improvement in safeguarding policy and practice is a core business of LSCBs. Boards have responsibility for establishing Child Practice Reviews, for signing off the agreed report and action plan when a Child Practice Review has been completed, and for implementing necessary changes in local policy and practice. These responsibilities require committed, well functioning and strongly led Boards and the full support of agencies represented on the Boards. They also require active partnership with other community services that are not Board members but working locally with children and families.

3.4. In order to achieve the objectives of the learning and reviewing framework, there will need to be certain functions in each Local Safeguarding Children Board to deliver them. The structure and purpose of the Board's standing sub-groups or sub-committees will need to reflect the core business of the Board, ensure appropriate cross representation, and fully co-ordinated processes and programmes of work between the sub-groups. The inter-relationships that need to be developed for the implementation of the new learning and reviewing framework are represented in the diagram below:



A systems approach

3.5. It has been agreed that the approach to be taken in multi-agency child practice reviews should be a systems approach i.e. the focus should be on the multi-agency professional practice in relation to a particular child(ren) and family, with the aim of identifying underlying issues that are influencing practice more generally[4].

[4] Munro, E. (2011) *The Munro Review of Child Protection.* London: The Stationery Office, p.64.

3.6. Two particular systems-based approaches in use currently are *Root Cause Analysis* and the Social Care Institute for Excellence (SCIE) systems model, *Learning Together*[5]*.* The Healthcare Inspectorate Wales (HIW) expresses its commitment to the importance of structured investigation and supports the use of *Root Cause Analysis*, developed and adapted for the NHS from the field of engineering[6]. In reviews conducted by HIW, an expert review team is established, information is gathered from various sources and then sorted and analysed with key staff from the relevant agencies, further analysed with a variety of techniques, and a conclusion reached about the systems or processes which might be put in place to prevent further occurrences.

3.7. It has been recognised that there are a range of methods, techniques and skills which can be efficient and effective in reviews and investigations, according to the nature of the matter to be investigated, its extensiveness and any constraints of time or other resources[7].

3.8. Critical to any choice of method is that it must be fair and just, flexible and proportionate, inclusive as a process but rigorous and accountable in examining the practice of services which carry child protection responsibilities. These are features of the approach being adopted in Wales. The approach is firmly embedded in the responsibilities of LSCBs and has at the heart of a Child Practice Review a multi-agency learning event which brings relevant practitioners and practice managers together to explore with the reviewer(s) of that case the detail and context of agencies' work with a child and family, and from which learning for future practice can be drawn.

[5] Fish, S., Munro, E. and Bairstow, S. (2009) *Learning together to safeguard children: developing a multi-agency systems approach for case reviews.* London: Social Care Institute for Excellence.
[6] Healthcare Inspectorate Wales (2008) *Report of a review in respect of Ms A and the provision of Mental Health Services, following a Homicide committed in October 2005*, Annex C. Cardiff: Healthcare Inspectorate Wales, 46.
[7] Healthcare Inspectorate Wales (2008) *Report of a review in respect of Ms A and the provision of Mental Health Services, following a Homicide committed in October 2005*, Annex C. Cardiff: Health Inspectorate Wales, p.46.

4. Multi-Agency Professional Forums

4.1. Multi-Agency Professional Forums are the foundation of the learning and reviewing framework and the need for Multi-Agency Professional Forums will be laid down in the revised *Local Safeguarding Children Boards (Regulations) Wales*. The forums are, therefore, an integral part of LSCBs' functions. They require a work plan flexible enough to deal with relevant new issues as they arise. Responsibility for their establishment may fall to an existing sub-group, such as *Quality Assurance* (also known in some Boards as *Audit* or *Safeguarding Standards Sub-Groups* or *Sub-Committees*) or the *Training Sub-Group*, or a specific sub-group may be established for the purpose. The activities will inevitably be closely related to those of other sub-groups of the Board, including the *Child Practice Review Sub-Group,* and require appropriate cross-membership of sub-groups and good exchange of information.

4.2. The forums have two main purposes – case learning events and exploration of learning from audits, inspections and reviews – but they can also be used to provide other important opportunities for local multi-agency practitioner and manager learning:

- **Case Learning:** Discussion, consultation and reflection for practitioners, managers or core groups, using a systemic approach to examining and analysing individual current or no longer active cases. These may include complex cases where there have been good outcomes, current cases that have become stuck or cases which are causing professional concern that do not meet the criteria for Concise or Extended Child Practice Reviews;
- **Dissemination of findings from multi-agency child protection audits:** (See suggested topics below), and from child practice reviews, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

Learning from multi-agency child protection audits

Topics for local child protection audits and for multi-agency workshops to explore the audit findings, suggested by Rhondda Cynon Taff LSCB:

- Children who have been on the child protection register for more than 2 years.
- Children who have been deregistered in the last 12 months.
- Children subject of child protection conferences but not registered.
- Children with repeat registration within 12 months.
- Children on the register who were subject to a Child in Need Plan up to 12 months prior to registration (likely to be neglect due to parental problems).
- Working with uncooperative service users.
- Children who go missing.
- Looked after children subject to a strategy meeting.
- Children on the register subject to further strategy meetings or who should have been subject to further strategy meetings.

4.3. The learning from these forums may require local action through changes in operational policy, protocols, service delivery and practice, and this should occur promptly and without delay. It is expected that if at any time a higher level of concern is identified that would fit the criteria for a Concise or Extended Review, then the case should be referred to the *Child Practice Review Sub-Group* for consideration and action.

4.4. The forums should be facilitated events, undertaken in environments that provide safe, professional support and professional challenge, with a clear set of working principles or processes so that staff know what to expect and the confidentiality of any case material is respected. The forums considering cases that do not fall under the criteria for a Concise or Extended Child Practice Review may use the same processes as used in those reviews for learning from a case. They may also use a range of creative methods already familiar in training and continuing professional development, such as multi-agency supervision, appreciative inquiry or sculpting, as appropriate. The practice learning should be captured and used for dissemination more widely to staff, and should inform the Board's annual review of its Business Plan.

4.5. The forums should allow assessments, decision making and practice to be explored openly with each other by staff. However, if any issues of individual staff training needs or staff malpractice emerge during the course of a Multi-Agency Professional Forum, these should be managed through the relevant agency's own staff procedures.

4.6. Where the learning from these forums is of wider relevance, the messages will need to be conveyed to agencies locally and the process managed by the relevant standing sub-group of the LSCB.

4.7. The effectiveness of these forums will be dependent on the commitment of senior agency representatives on the LSCB and dependent on local agency support in enabling professional staff to make use of these learning opportunities.

4.8. The programme of work will require resourcing by the LSCB, evaluating to ascertain whether the programme is valued and found effective by staff, and assessed for its impact on local child protection practice by the *Quality Assurance Group*, to be reported back to the LSCB on a regular basis.

4.9. There are examples where this approach is already being developed by some LSCBs in Wales and experience of what has worked well can be shared between Boards. For example:

Caerphilly Safeguarding Children Board has had an established multi-agency consultation process since 2009, initiated by practitioners, which brings together key staff to look at cases that are, for example, stuck or difficult, and provides reflective supervision. It has been successful in building understanding of the need for multi-agency responsibility for work with families. A flow chart suggesting how this might work is contained in Annex 3.

A case review learning event was held for practitioners to consider a serious case of neglect by Torfaen Safeguarding Children Board, which did not reach the criteria for a Concise Review. It identified key learning points and messages for the Board. More importantly, it was valuable because it was experienced as a non-threatening, constructive session and empowering for practitioners. It allowed other agency perspectives to be explored and better understood, and to build relationships between agencies. The process highlighted the positive work that the family and practitioners had been doing, and showed the progress already made. An example of the terms of reference for such a multi-agency learning event is set out in Annex 3.

Rhondda Cynon Taff Safeguarding Children Board has set up Multi-Agency Practitioner Forums, with the intention of holding at least three multi-agency workshops a year for focused practice learning from audited cases and a fourth for disseminating learning from case reviews based on the Child Practice Review model. These events may involve at least 50 practitioners from different services at anyone time.

4.10. The use of Multi-Agency Professional Forums in Wales will, therefore, be building on some longstanding prior experience and be drawing on existing developing good practice.

5. Concise Child Practice Reviews

5.1. The criteria for Concise Reviews will be laid down in revised *Local Safeguarding Children Boards (Wales) Regulations 2012*. They should be undertaken in cases **where abuse or neglect of a child is known or suspected and:**

- a child dies and was not on the child protection register; or within the looked after children system, or a care leaver under the age of 18, **or**
- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical or emotional health or development (this may include cases where a child was subjected to serious sexual abuse) **and *was not*** on the child protection register, or within the looked after children system, or a care leaver under the age of 18.

The process for undertaking a Concise Review

5.2. A referral is received by the Chair of the LSCB who forwards it to the *Child Practice Review Sub-Group (or Sub-Committee)* which will be a standing group in each LSCB. Any member of the Board, agency or practitioner can raise a concern about a case which may lead to a referral to the *Review Sub-Group*.

5.3. Where a referral received by the *Review Sub-Group* involves more than one LSCB, co-operation and careful planning between the respective *Review Sub-Groups* of those Boards will be required to agree the way forward (*Children Act 2004*, s.25, s.28). The guiding principle should be that the Local Safeguarding Children Board in which the child is or was normally resident should take lead responsibility for conducting the review. The decision reached on how the review will be handled should be reported to the respective Boards.

5.4. Where a referral received by the *Review Sub-Group* involves more than one authority in different countries within the United Kingdom, the principle of ordinary residency will determine which LSCB should take lead responsibility for undertaking a review. However, co-operation and careful planning may be required between LSCBs in order to agree how the respective review procedures will be followed and any additional matters to be addressed by the review. These decisions may also need to involve the respective government departments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.

5.5. Where the case gives rise to other parallel investigations of practice, for example, a domestic homicide review where a parent has been murdered, or a Youth Justice Board Serious Incident Review, or a Prisons and Probation Ombudsman investigation where a child has died in a custodial setting, the *Review Sub-Group* should liaise with those other bodies and agree who will take the lead on the relevant review process. Depending on the circumstances of the case, there might be a joint review or additional questions might be added to the terms of reference. The *Review Sub-Group* has an important responsibility to ensure the child or children's interests are appropriately represented in other investigations of practice. The *Review Sub-Group's* recommendation on the way to proceed should

be confirmed by the LSCB. At the conclusion of the review, if undertaken by another review body, the review report should be considered by the LSCB and an action plan put in place if required.

5.6. The *Review Sub-Group's* decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Board, with the following information:

- a brief outline of the circumstances of the case;
- the reasons for holding a concise review;
- the proposed terms of reference;
- a timeline for the review;
- an assessment of the likely communication and media issues, as known at the time.

5.7. A template has been provided for this submission to simplify the process, ensure consistency and provide a report for informing the Welsh Government. The Welsh Government should be informed of every case recommended by the *Review Sub-Group* for a Concise Review, including those where the lead LSCB may be in another country, and should be informed of the outcome of the recommendation.

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

5.9. If the decision is yes, the *Review Sub-Group* will establish a multi-agency *Review Panel* to manage the review. The pilots have demonstrated the value of a multi-agency panel even where the case may involve only a single agency or a small number of agencies.

5.10. **Timelines and genogram**[8]

- A **timeline** of a maximum of 12 months preceding the incident should be prepared. The 12 month timeline may be extended only if 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. Any extension can only be agreed by decision of the *Review Panel.* Where there is significant background information or a

[8] It was found during the pilots that the police have software which produces high quality single agency and merged timelines and genograms which considerably assisted the effectiveness and efficiency of the work of the *Review Panels,* the Reviewers and the learning events.

previous incident, this can be summarised in the brief analysis accompanying the timeline.

- A full and accurate **genogram** (also known as a Family Association Network in the police service) should also be prepared as a means of clarification of family relationships by the *Review Panel,* and used during the learning event, although not included in the published report.

5.11. Services that have been involved with the child and family will be requested by the *Review Panel* to provide information of contact with the family with an agency timeline of significant events, together with a brief analysis of the situation and recommendations, if appropriate. (These will replace the current requirement for agency reviews, known widely as Independent Management Reviews.) The agency timelines will then be compiled into a merged timeline (defined by a template). The *Review Panel* will manage the process and produce a merged timeline. This will be used by the *Review Panel* to develop initial ideas about what happened in this case in preparation for the learning event and to amend the terms of reference for the review, if required. An anonymised summary of the merged timeline should be included in the published Child Practice Review Report.

Terms of Reference

5.12. It should be noted that the Terms of Reference are a live document and may need to be amended at any point during the course of a Concise Review.

Contribution of family members

5.13. The perspective and experience of family members, such as the child or young person, his or her siblings, parents, carers, grandparents or other significant family members (as appropriate to the case), should wherever possible be incorporated into the review process and the Review Panel will need to consider how this can be most effectively achieved. This may best be done by contacting and interviewing family members about the messages or questions they would want to contribute to the learning event. How such contact is made will be discussed by the *Review Panel* and the reviewer when appointed and may involve in some cases the practitioner or other professionals working with the child and family. Reviewers may play an important part by meeting the child and family members shortly before the learning event, if appropriate and the family so wishes, and carrying their messages into the event. Arrangements will need to be made, as appropriate, for reporting back to family members the conclusion of the review (as laid out in the guide in Annex 1).

5.14. The *Review Panel* will identify and commission a reviewer who must be independent of the case management and who may be a member of the LSCB, or a member of another Board, or from a neighbouring authority, or a person with relevant skills and experience as required by the case. Relevant experience may be determined by issues of language, ethnicity, religion or health, such as disability, or other factors instrumental to the circumstances of the case[9]. When choosing a reviewer, it will be important to remember that the quality and experience of the

[9] For example, organisations such as AFRUCA, *Africans Unite Against Child Abuse*, or AAFDA, *Advocacy After Fatal Domestic Abuse*, may be called upon to give advice, advocacy and expertise.

reviewer is crucial to the outcome. The role requires a wide range of knowledge, skills and abilities which includes a thorough knowledge of child protection systems, issues, responsibilities and practice, an understanding of multi-disciplinary working, an ability to enquire and communicate about practice, and skills in facilitating and managing group processes effectively (see Annex 1).

5.15. The detailed process for reviewing a case through a multi-agency practitioner learning event is laid out in Appendix 1, *Reviewer's Guide for Organising and Facilitating Practitioner Focused Multi-Agency Learning Events.* The learning event is a critical part of the review process, and practitioners and managers are expected to attend if asked.

5.16. At the conclusion of the learning event, the reviewer with the practitioners will identify key single and inter-agency issues and learning points to be included in the Child Practice Review Report for consideration by the Board and its partner agencies. This may include future targeted work with wider staff groups. After the report has been accepted by the Board, the reviewer may be requested by the *Review Panel*, as part of the action plan, to undertake an event with staff groups either as part of disseminating what has been learned or to follow-up the impact of changes upon practice.

Child Practice Review Report

5.17. At the completion of the review, the reviewer will have responsibility for completing an anonymised Child Practice Review Report, for submission to the *Review Panel.* The reviewer should follow the template in Annex 2. The report should be succinct and focused on improving practice. It should include the circumstances which led to the review, the practice and organisational issues identified during the review, and the conclusions reached. Conclusions should be relevant to bringing about improvements in practice and should be specific, workable and affordable, and have clearly definable outcomes. However, because a review has been held, it does not mean that practice has been wrong and the reviewer may conclude there is no need for change in either operational policy or practice. The reviewer will identify the conclusions and learning points for discussion with the *Review Panel* which then has the task of constructing an action plan.

5.18. The Report should be presented to the Board by the Chair of the *Review Panel* and the reviewer. The Board has responsibility for accepting the report and approving the action plan.

5.19. The Chair of the Board will submit the report with its conclusions and action plan to the Safeguarding Team of the Welsh Government which will then draw in other parts of the Welsh Government and the Inspectorates Group as appropriate and consider if further action is needed. The Welsh Government will require the report at least two weeks before the intended date of publication by the LSCB.

5.20. The report will be published on the LSCB website for a minimum of 12 weeks, with a reference on the website making the report available thereafter on request.

5.21. The process will be completed as soon as possible but no longer than six months from the date of referral to the LSCB's *Review Sub-Group*.

5.22. The action plan will be reviewed and progress will be monitored by the *Review Sub-Group* and reported to the Board. This must include dissemination of the report and action plan to local staff, as appropriate.

5.23. Conclusions and action plans should lead to improvements in child protection practice and will need to be carefully audited to see whether they have been carried out and with what effect, and whether they are achieving the intended outcomes. Work by Handley and Green for NSPCC[10] and Warlock for *Local Government Improvement and Development and the London Safeguarding Children Board*[11] provide some useful ideas and tools to assist *Audit Sub-Groups* in this task.

5.24. The *Training Sub-Group* and *Audit Sub-Group* will need to include any issues emerging from the Concise Review in the Board's future training and audit programmes or incorporated into the work plan of the Multi-Agency Professional Forums.

5.25. The review process is about practice learning. If any issues of individual staff training needs or staff malpractice emerge during the course of a Concise Review, these matters should be managed through the relevant agency's own staff procedures.

5.26. The action plan will need to be signed off by the Board and a report made to the Welsh Government about the difference the actions taken have made to practice.

[10] Handley, M. and Green, R. (2004) *Safeguarding through audit. A guide to auditing case review recommendations.* London: National Society for the Prevention of Cruelty to Children (NSPCC).
[11] Local Government Improvement and Development & London Safeguarding Children Board (2011) *Improving local safeguarding outcomes: Developing a strategic quality assurance framework to safeguard children.* London: Local Government Improvement and Development.

6. Extended Child Practice Reviews

6.1. The criteria for **Extended Reviews** will be laid down in regulations and follow the same process as **Concise Reviews** but have additional issues to be addressed as part of the review and require additional independence from an external perspective in undertaking the review.

6.2. The criteria for Extended Reviews are that they should be undertaken in cases **where abuse or neglect of a child is known or suspected and:**

- a child dies **and** was on the child protection register or had been on the child protection register within the last six months or was within the looked after children system or was a care leaver under the age of 18; or
- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical or emotional health or development (this may include cases where a child has been subjected to serious sexual abuse) **and *was*** on the child protection register or had been on the child protection register within the last six months, or was within the looked after children system or was a care leaver under the age of 18.

6.3. The process for undertaking an Extended Review should follow that of Concise Reviews, as laid out in section 4, but with some additional elements.

6.4. An additional level of scrutiny will include consideration of the following issues in the preparation of the terms of reference and timelines, and during the learning event:

- Whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child.
- Whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.
- Whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan.
- The aspects of the plan that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (and this should include consideration of both organisational issues and other contextual issues).

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

6.5. The 12 month timeline should be extended, when necessary, to reflect the period of time the child was on the child protection register or was recently within the looked after children system or a care leaver. It can be extended from 12 months up to three years if circumstances so warrant but the focus of the analysis is on current practice and on the relevant child protection plan and/or looked after children's plan or pathway plan.

6.6. The *Review Sub-Group* will formulate the initial terms of reference for the Extended Review and set up a multi-agency *Review Panel.* The *Review Panel* will build on the initial terms of reference formulated by the *Review Sub-Group* and will be informed by ideas about what happened from study of the merged timeline of significant events and in the context of local knowledge. The terms of reference will either be further amended in the light of new information or *Review Panel* discussions and will need to be agreed with the reviewers when appointed.

6.7. Another additional element of Extended Reviews is that they will be undertaken by two reviewers. There will be a reviewer appointed by the LSCB (a decision which may be endorsed by the Chair of the LSCB on behalf of the Board) to contribute an external perspective and relevant experience and to have particular responsibility for scrutiny of the additional issues to be addressed. A second reviewer will be appointed who is not involved in the case management but who has knowledge of the local context. Both reviewers will be appointed to work together and with the *Review Panel.* As part of the Extended Review, there will be a learning event which will be organised and facilitated by the two reviewers. The learning event is to be conducted in accordance with the guide for organising and facilitating such events (Annex 1). Reflection and confirmation of the learning points may be part of the learning event or a separate session may be held with the participants of the learning event at a later date.

6.8. Following the learning event, a Child Practice Review Report will be written by the reviewers, which will follow the outline of the template in Annex 2, and be submitted to the *Review Panel*. The second reviewer will have particular responsibility for reporting on the additional issues for scrutiny and will also have responsibility for confirming that the learning process was undertaken appropriately. There may be a debriefing or feedback session with the *Review Panel*.

6.9. The reviewers may conclude that practice in this case has not failed or been inappropriate and there may be no recommendations for changes in local operational policy or practice.

6.10. The report and action plan will be presented by the Chair of the *Review Panel* and the reviewers to the Board for its acceptance and approval of an action plan.

6.11. The report will be submitted by the Chair of the Board to the Safeguarding Team of the Welsh Government which will then draw in other parts of the Welsh Government and the Inspectorates Group as appropriate and consider if further action is needed. The report will be required by the Welsh Government at least two weeks before the intended date of publication by the LSCB.

6.12. The report will be published on the LSCB's website for a minimum of 12 weeks, with a reference on the website making the report available thereafter on request.

6.13. The process is to be completed as soon as possible but no longer than six months from the date of referral to the Local Safeguarding Children Board's *Review Sub-Group*.

6.14. The action plan will be reviewed and progress monitored by the *Review Sub-Group* and reported to the Board. This must include wide dissemination of the report and action plan to staff, as appropriate. Consideration will be required by the respective LSCB sub-groups of the critical learning points and how they will be incorporated into any changes in operational policy and practice, training and supervision, and in shaping priorities for future work undertaken by the Board.

6.15. The action plan will be signed off by the Board and a report made to the Welsh Government and to the Inspectorates on the difference the actions taken have made to practice.

6.16. As in Concise Reviews, these reviews are a learning process. If any issues of individual staff training needs or staff malpractice emerge during the course of an extended review, these matters should be managed through the relevant agency's own staff procedures.

Annex 1

Reviewer's Guide for Organising and Facilitating Practitioner Focused Multi-Agency Learning Events

December 2011

Contents

1. Introduction

1.1. The learning and reviewing framework is intended to provide an environment in which practitioners and their agencies can learn from their casework. It is important, therefore, that attention is given to creating the conditions for learning from the very beginning of the process and not just focusing on the learning event itself.

1.2. Reviewing serious cases can raise much anxiety in individuals and organisations and in turn anxiety can block learning and lead to defensiveness and an inability to reflect. The Reviewer as facilitator has an important role in the management of this anxiety and so early identification of who is to undertake the role of Reviewer is crucial in order that they can engage at an early stage in the process alongside the Review Panel. This means that when practitioners gather for the Learning Event they will be better able to review, reflect and participate.

Creating the conditions for learning

1.3. Learning is about progress, about developing and moving forward. This framework brings people together in groups to work collaboratively, to share ideas and to enhance understanding. The group, therefore, has to be an effective entity in order that the task can be achieved.

1.4. Ensuring effectiveness requires several preconditions[1]. Firstly, the individuals who make up the group need to feel safe in order that they can begin to open up and connect with other group members. If safety and openness are features of the group then a modicum of trust will build between participants which will lead onto achieving the real work of the group that of appropriate and constructive questioning and challenge which will result in the development of ideas and action plans.

1.5. The creation of feelings of safety is a key starting point that can begin to happen from the very start of the review process. Clarifying objectives, setting out purpose and being transparent about expectations all help to minimise defensiveness and manage the inevitable anxiety within organisations, systems and individuals.

1.6. The building of trust within a group and the move towards challenge and change is not necessarily a linear process. At any point trust within the group can be lost for any number of reasons. Facilitating the process therefore requires constant monitoring of the group and sometimes a rebuilding of safety to restore openness and communication.

The Reviewer

1.7. The guidance specifies that the Reviewer must be independent of the case management, may be a member of the LSCB or a member of another Board, or from

[1] Professional Development Group, University of Nottingham in Charles, M with Stevenson, O (1990) *'Multidisciplinary is Different'* University of Nottingham.

a neighbouring authority, or a person with relevant expertise as required by the case. In the event of an Extended Review two Reviewers are required; one who is independent of the case management but who has knowledge of the local context and a second reviewer who will bring an external perspective, is independent of the board, has relevant expertise and who will have particular responsibility for scrutiny of the additional issues arising from the statutory responsibilities of the agencies.

1.8. The role of the Reviewer is a multi-faceted one as it includes managing the task, facilitating the process, managing and facilitating the learning of the group and producing a Child Practice Review Report.

1.9. It follows, therefore, that the role requires a wide range of knowledge, skills and abilities which includes:

- The knowledge and skill base of their own profession.
- A thorough knowledge of child protection systems, issues and practice.
- The roles and responsibilities of practitioners, organisations and services within the inter-agency safeguarding network.
- The capacity to share all of the above. In other words the ability to 'talk practice'.
- An understanding of the nature of multi-disciplinary working.
- An understanding of how adults learn.
- An understanding of group dynamics.
- Skills in facilitating and managing group process.
- The ability to shape an event but also to work in the moment with what participants bring to the group.

1.10. Extended reviews require two Reviewers who, in addition to the knowledge, skills and abilities listed above, also have to think about how they will work alongside one another. If they have never worked together before then this will mean spending some time getting to know one another in terms of knowledge, skills and styles as well as thinking about who will do what in order to ensure effective facilitation.

2. Preparation

2.1. At this stage of preparation leading up to the learning event, there are four main areas that the Reviewer has to concentrate on and they are:

- Engaging with and working alongside the Review Panel.
- Gaining an in-depth understanding of the situation under review.
- Beginning to connect with those who are to participate in the learning event.
- Planning the event itself with regard to structure and methods of facilitation.

2.2. Careful preparation is crucial in terms of promoting a learning environment, managing anxiety and paving the way for 'success'.

2.3. Once the Reviewer has been identified and commissioned then a meeting with the Review Panel should be set up to think about how the Reviewer works alongside the group and to discuss and plan the next steps. The agenda will include:

- Revisiting the terms of reference and making any adjustments if necessary.
- Making decisions about time-lines and summaries in terms of which agencies and services, who will be approached to complete them and the deadline for submission.
- Thinking about how family members will be contacted to see if they wish to contribute to the review and speak to the Reviewer and deciding who is best placed to make this initial approach.
- Consideration of the learning event itself in terms of possible participants; date; venue and duration. Most events will probably take a day on average. However, some might be successfully completed in half a day and occasionally very complex situations may need to be extended over two days. If the latter is the case then thought should be given whether these should be sequential or not. Two consecutive days, whilst intense, would ensure a continuous thread of themes and learning. A gap between the days gives an opportunity for further thought and preparation by the participants.

The stage of clarification

2.4. Timelines and summaries should be sent to the Reviewer as soon as possible after the deadline for submission. This will allow the Reviewer time for a first reading to identify main points, note what 'strikes' them about the situation and to see whether or not there are any gaps in information or any lack of clarity. It is also an opportunity to think about who should be part of the learning event.

2.5. The next step is a second meeting of the Reviewer with the Review Panel, also involving the authors of the timelines if they are not already Review Panel members. The agenda for this meeting should encompass:

- Clarifying and filling gaps in the information presented in the timelines and summaries as far as is possible. It should be recognised that it might not be possible to know some things until the learning event itself.
- Confirming who should attend the learning event and encouraging Review Panel members to approach these people informally before they receive a letter of invitation.
- Confirming date, venue and duration of the event and who will be present in the role of note-taker.
- Confirming if and how family members are to be approached to contribute to the review.

2.6. The first contact that the Reviewer has with the participants in the learning event is via the letter of invitation. It is recommended that this is kept short and simple but makes clear that there is an expectation of attendance and offers the opportunity for direct contact with the reviewer if someone has additional questions and queries about the event. It is also helpful if people are given a structure around which to prepare as they will need to revisit their contact with the child who is the subject of the review. A sample letter of invitation at Appendix 1a suggests they think about their involvement in terms of:

- Assessments.
- Decision making.
- Actions.
- Interaction with other professionals and services.
- Areas of good practice.
- Areas where there could be some improvements.

2.7. At this stage of becoming acquainted with the specifics of the situation, the Reviewer will need to give thought to how to structure the learning event and this is considered in more detail in the next section.

2.8. If family members who are relevant to the situation wish to contribute to the review by meeting with the Reviewer, then it is best done before the learning event so that family members' thoughts and opinions can be woven into the programme for the day and inform any conclusions and action plans. Family members can include parents, carers, grandparents, the child, the child's siblings and any other significant people.

2.9. The Learning Event will need to capture discussions and contributions and so it is important to identify a note taker for the event. Ideally this would be someone who is skilled in taking accurate minutes, who has an understanding of the territory but who will not actively participate in the process [DN to be expanded].

3. The event

Purpose

3.1. The purpose of the learning event is to bring together key staff to reflect and learn from what has happened in order to improve practice in the future. Using a systems approach the emphasis will be on understanding what happened, considering why some assessments and decisions were made and how and what can be learned for the future. A systems approach does not stop at the point when faults in professional practice have been identified, it moves on to explore the interaction of the individual with the wider context to understand why things developed in the way they did[2].

3.2. It follows, therefore, that in order to meet these objectives attention to the setting is important. The venue as well as the structure of the day must facilitate the process and so it needs to be arranged in such a way that participants can see one another and develop a conversation together. Rooms laid out in boardroom style or horseshoes or circles should assist this, together with space to move in and out of small group and sub-sets and walls or display boards where time lines and flips can be pinned up.

Structure

3.3. A learning event is different from a traditional training event in that it requires the facilitator to work in the moment with the material generated by the group rather than follow a set programme of inputs and structured exercise. However, in order for the event to have some coherency, for participants to engage with and work on the task in hand and arrive at some conclusions, it does need shape and structure without being over-structured.

3.4. Thinking about the stages in the group dynamic provides a guide to the overall structure of the day. Heron's model[3] (see Appendix 1b) highlights the need to break through the initial defensiveness of the group, to 'warm' them up in order that they can connect and communicate with one another and begin to be productive and work on the task in hand. Endings are equally important, so that learning and actions can be identified for participants to take away and use in their ongoing work and plans formulated to develop practice and services more generally.

3.5. This guide has already talked about the need to address possible defensiveness and begin to generate safety early in the process but careful attention to the beginnings of the learning event continues this. So an introduction to the event should cover the following areas:

- Introductions to the facilitator(s) and the note taker.

[2] Fish, S., Munro, E., & Bairstow, S. (2008) *Learning together to safeguard children: developing an inter-agency systems approach for case reviews,* London: SCIE.
[3] Heron, J (1989) *The Facilitators Handbook* London. Kogan Page.

- A round of introductions to the participants specifying their role and a brief initial explanation of why and when they were involved in the situation under review.
- Clarification of purpose and process of the event.
- Setting some working principles or ground rules for the event and checking that everyone agrees with them. An example of Working Principles can be found at Appendix 1d.
- Setting out an overview of the situation under review and the questions to be addressed by the learning event encapsulated in the terms of reference.
- Drawing attention to the timelines.

3.6. Once the scene has been set and the purpose clarified then the learning event moves into the main task which is one of identifying key points, looking at who did what, when and why and highlighting assessment and decision making.

3.7. To begin this process and building on the initial introductory round, participants can be invited to 'tell the story' of their involvement with the situation, specifying what they did and when this happened. This is best done sequentially with reference to the merged timeline so that the Reviewer can facilitate each contribution in order of events.

3.8. As the story unfolds it will be important to ask participants to differentiate between their thoughts and actions at the time and the wisdom of hindsight afforded by a retrospective reflection. In other words it is about exploring the question 'why did we do that then?' and following it up with 'could we have done it differently and what would have helped us to do so?'

3.9. As the discussion and thinking develops within the group the Reviewer should ensure the following areas are covered:

- Were the risks in the situation identified and understood?
- How were family members engaged with?
- What were the family's views at the time and what are they now?
- How did the professionals work together?
- What went well? This is about identifying good practice and what facilitated that good practice.
- What could have been done better and why did it not happen at the time?

3.10. To help people make sense of their learning and to keep moving through the process it is important that at appropriate points in the event the Reviewer pauses and summarises the discussion. This will also assist in the identification of emerging learning points.

3.11. Attention has already been drawn to the importance of well structured endings to a learning event. At this final stage there are several aspects that need to be covered which include both individual and group learning, learning about the situation under discussion and learning about the process, together with strategies to ensure all of this can be put into practice. The tasks to be completed at this final stage are, therefore:

- To summarise the key learning points about the situation under review.
- To broadly agree the content of the learning output.
- To outline the next steps.
- To give participants an opportunity to think about their personal learning from the day and how to take it forward.
- To engage in some evaluation of the learning event as a whole including checking out how participants feel about the process. A sample evaluation form can be found at Appendix 1e.

3.12. To work through all the stages of the learning event and arrive at an outcome requires the Reviewer to give some thought to styles and modes of facilitation. Heron's model[4] (see Appendix 1f) suggests three approaches, all of which are valid depending on the task in hand and how the group is managing that task.

3.13. Beginning the learning event requires strong leadership from the facilitator in terms of setting the scene and clarifying the process. This is the facilitator in hierarchical mode or leading from the front. As the event gets underway and discussion develops then the facilitator may move into co-operative mode, very much working alongside the group. Participants themselves may suggest a way of working and so for a time the group is leading with the facilitator in a supportive role. It is important that the facilitator is able to move through each of these modes, as appropriate, to suit the needs of both the programme and the group. So, for instance, if the group becomes stuck or discussions go off at a tangent then the facilitator will need to move back into hierarchical mode in order ensure things get back on track.

3.14. If a learning event is to taker place over more than one day, or one continuous session then there will need to be some flexibility in terms of where to break. Reconvening for the second part of the event will also require some careful recapping and reminding of what has emerged so far in order to help participants back into the learning and the reflection.

Methods

3.15. To help the group think about and make sense of a situation together necessitates the learning event having shape and structure, but it also calls for a variety of materials and methods to assist discussion and sense-making. Both the terms of reference and the merged timeline should be visible and available to

[4] Heron, J (1989) *The Facilitators Handbook* London. Kogan Page.

participants. The timeline could be pinned up around the walls. If the situation under review contained particular issues such as neglect then it might be helpful to take along some useful references to aid thinking.

3.16. There are a variety of methods which can be employed including:

- Focused questions to guide discussion and trigger thinking.
- Dividing into small groups with specific areas to consider. To capture discussion the subsets can be asked to record the main points on flips.
- Large group discussion to identify the significant events in a situation from the merged timelines, then smaller subsets looking at each of these events to think about:
    - What actions were taken.
    - Why were they taken.
    - What else could have been done at the time.
    - Why did it not happen?
- Facilitators' feeding in their thoughts of what 'struck' them when reading timelines and summaries as a means of generating discussion.
- Asking the group to identify a piece of good practice and analyse its component parts.
- Having blank sheets of flip paper on the wall to note down significant learning points as they arise or any ideas for subsequent actions.
- Using 'post its' to add any additional significant events to the merged timeline as they are uncovered.

3.17. The above is not an exhaustive list and flexibility is essential in their use as some methods might not suit some groups. It is suggested that facilitators go prepared with a 'tool-kit' of methods so that if something is not working they have other things to fall back on.

4. After the event

Preparation of the Child Practice Review Report

4.1 After the learning event the task of the Reviewer is to collate and synthesise all the material from the learning event. This will include the record taken by the note taker and any flips produced by the group, as well as their own impressions and understanding of what emerged through the event. The learning points resulting from the learning event then have to be transformed into a Child Practice Review Report using the agreed template outlined in Appendix 2 of the Practice Guidance.

4.2 Once a summary of the learning points has been completed it should be shared with participants for comments.

4.3. In the light of feedback from participants there may need to be some amendment to the Child Practice Review Report before the Reviewer meets with the Review Panel to go through it.

Presentation to Local Safeguarding Children Board (LSCB)

4.4 The Child Practice Review Report has to be presented to the Local Safeguarding Children Board for agreement and action. Such a presentation should include some description of the learning event itself in terms of participants, process and impact. This will help in terms of developing the framework.

Debrief

4.5 Thought should be given to a process of debriefing for the participants in the learning event, for family members who may have contributed to the review and for the Reviewer(s) and the Review Panel.

4.6 With regard to the participants in the learning event, it might be too complex to reconvene, but it might be helpful if Review Panel members took responsibility for feeding back to people within their agency or service area.

4.7 At the point that family members were first approached, before the learning event, the issue of feedback should have been raised. Some might prefer another visit to explain what has happened and what recommendations have been made and what actions are to be taken, others might think a phone call or a letter sufficient.

4.8 As this is a new framework for reviews and LSCBs are learning through doing, it would be very helpful if the Reviewer could meet with the Review Panel to reflect on the overall process of the review.

Appendix 1a

Sample Letter of Invitation to the Learning Event

Dear

Learning Event in respect of Child …..
Date:
Venue:

A new framework for multi-agency child practice reviews is currently being developed to reform the present serious case review system. The development of this framework has been endorsed by all the constituent members of the Local Safeguarding Children Board and therefore there is an expectation of participation.

One of the features of this new framework is that it involves agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future.

In line with this new development a Concise/Extended Review is being undertaken with regard to Child ……. The review process uses a systems approach whereby the focus is on multi-agency professional practice with the aim of identifying underlying issues that are influencing practice more generally.

As part of this Concise/Extended Review terms of reference have been constructed and time-lines prepared, but at the heart of the Review is the Learning Event. It is this to which you are invited as you were involved with Child ……. and his/her family and consequently you have something to contribute to the overall learning.

The Learning Event

The Event is to be held at …….. on ……. starting at ……. and finishing at …….. Lunch will be provided.

The event will identify key single and inter-agency issues, learning points and issues for consideration by the LSCB. The event will be facilitated by ……. who will adopt a systems approach and structure the day to help participants reflect, think and learn together in a safe environment.

The family are to be approached to see if they would like to meet with the Reviewer before the event, in which case any comments and observations they might wish to make can be woven into the discussions and reflections on the day.

After the event the Reviewer will compile a short report or learning output. You will have an opportunity to look at this in draft form and make comments before its final submission to the Board.

Preparation for the event

It would be helpful if you could give some thought to your involvement with Child ….. and his/her family thinking specifically about:

- Assessments.
- Decision making.
- Actions.
- Interaction with other professionals and services.
- Areas of good practice.
- Areas where there could be some improvements.

To help you with your preparation you will also receive the following documents:

- The Terms of Reference of this Concise Review.
- A copy of the Welsh Government's draft guidance of the Framework for Multi-Agency Child Practice Reviews.

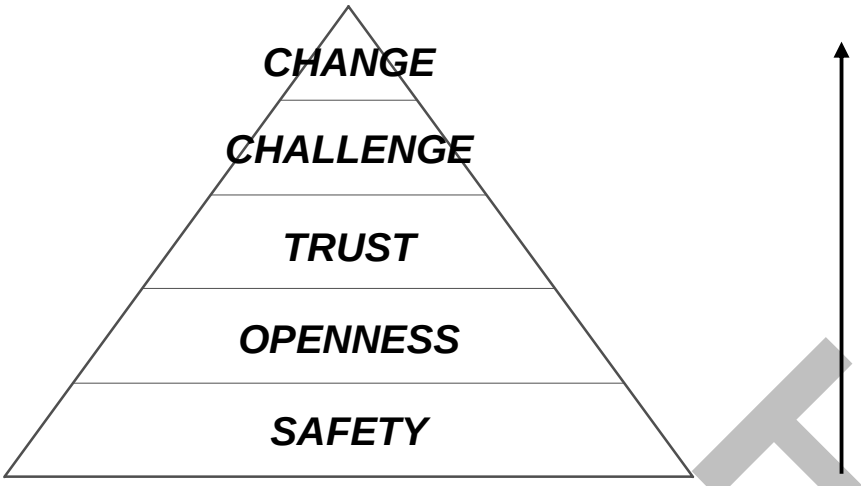
We very much look forward to working with you at the Learning Event and hope you find this new approach constructive and helpful. In the meantime if you have any queries or need further clarification please do not hesitate to contact us.

[Let us know if you are able to attend – response on a reply slip?]

Kind regards

Appendix 1b

Preconditions for Building Effective Group Relationships



SAFETY In any situation where personal, professional or organisational change is at stake, the issue of safety is fundamental to the effective working of a group. Without this, group members will be withdrawn and defensive and the main personal agenda for each participant will be personal survival. Conversation will be at the trivial, social level while people explore the motivation of others and the potential threat to themselves.

OPENNESS Only when people feel safe will they to begin to move from projecting a purely impersonal public persona to revealing a more human image of themselves. Once this process begins, group members become able to be open and honest, both with each other and themselves. They are able to share feelings and emotions and become open about their own personal/professional agendas and issues they care about.

TRUST With this sharing emerges a feeling of trust in other members of the group. Once people can be relied on not to laugh, disparage or take advantage, then people will be very much more willing to take risks, both in what they attempt themselves and in how they interact with others, knowing that what they say will not be taken in the wrong spirit.

CHALLENGE In this trusting environment, group members can become truly challenging, in the sense of "constructive confrontation". Procedures, behaviour, perceptions can all be examined and reviewed. Correlation (or the lack of it) between motivation and the effect of behaviour can be checked out and fed back.

CHANGE As a direct result of such trusting and constructive encounters, genuine and permanent change or co-operation can then be expected.

Professional Development Group, University of Nottingham in Charles, M with Stevenson, O (1990) *'Multidisciplinary is Different'* University of Nottingham.

Appendix 1c

Stages in the Group Dynamic

WINTERTIME:

The ground may be frozen and the weather stormy.

This is the stage of defensiveness, usually at the outset of a group.

Trust is low and anxiety is high.

SPRINGTIME:

New life starts to break through the surface crust.

This is the stage of working through defensiveness. The group is underway, trust is building and anxiety is reducing.

SUMMERTIME:

There is an abundance of growth and the sun is high.

This is the stage of authentic behaviour where the group is working hard and meeting its aims and objectives. Trust is high and anxiety is a spur to growth and change.

AUTUMN:

The fruit is harvested and stored; the harvesters give thanks and go their way.

This is the stage of closure. As the group draws to a close the members gather in and review the fruit of their learning and prepare to transfer it to life in the wider world outside.

Heron, J (1989) *The Facilitators Handbook* London. Kogan Page.

Appendix 1d

Working Principles for the Learning Event: an example

1. Each member of the group has a valid contribution to make which will be valued and listened to.

2. Where there are differences in views, these will be heard sensitively or questioned in a way which is constructive and enabling to the process of the group and its objectives.

3. We are all striving to challenge and address oppressive practices in our work and the whole group will share responsibility for addressing oppressive behaviour or language in a way which is sensitive and constructive.

4. Participants will support the principle of confidentiality about personal feelings or issues which are shared during our work together.

5. Naïve questions will be considered the norm.

AND ……. ????? What else do *you* need to agree in order to participate fully and effectively?

Appendix 1e

Sample Evaluation Form

Name:

Job Title/Role:

Date of Learning Event:

1. **Did this learning event meet its objectives?**

2. **How do you rate this event?**

3. **What did you find most helpful?**

4. **What did you find least helpful?**

5. **Is there any learning from this event that you intend to take back into your work?**

6. **Any other relevant comments or suggestions for improvement?**

Thank you for your participation and your assistance

Appendix 1f

Modes of Facilitation

❖ The hierarchical mode

Here the facilitator directs the learning process and does things for the group. This is leading from the front by thinking and acting on behalf of the group. Thus the facilitator decides on the objectives and the programme, interprets and gives meaning, challenges resistance, manages group feelings and provides structures for learning.

❖ The co-operative mode

Here the facilitator shares power over the learning process and manages the different dimension **with** the group. The facilitator enables and guides the group to become more self-directing and their view, though influential, is not final but one amongst many. Outcomes are always negotiated and learning processes are devised through collaboration.

❖ The autonomous mode

Here the facilitator respects the total autonomy of the group and does not do things for them or with them, but gives them freedom to find their own way, exercising their own judgement without any intervention on the facilitator's part. The bedrock of learning is unprompted, self-directed practice. It is not about the abdication of responsibility but rather the subtle art of creating conditions within which people can exercise full self-determination in their learning.

Heron, J (1989) *The Facilitators Handbook* London. Kogan Page.

Annex 2

Child Practice Review

Recommendation to Chair of LSCB from CPR Subgroup

Additional function:- Sub group initial scoping doc for panel
Notification of Welsh Government
Audit trail
Initial TOR for the panel

From: Chair of the CPR (Subgroup) – Name and Designation

To: Chair of the LSCB – Name and Designation

Re: Insert Case identifier **(to be used in all future correspondence)**

Date of Recommendation:

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

Recommendation The CPR Subgroup has considered this case and recommends that it meets the criteria for a:	
Concise review	☐
Extended review	☐
If the criteria is not met for the above reviews, what alternative review process will be undertaken:	
Multi-Agency Professional Forum	☐
No review	☐
Alternative review process	☐

*Please specify or detail alternative review process, eg Homicide Review***:**

……
……

Decision	
Unanimous	☐
Majority	☐

Rationale for Decision/Recommendation

This should include:-

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

Proposed Initial Outline of Review

(This is an initial outline which will need to be updated as the review proceeds.)

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

0-6 months	☐	6-12 months	☐	12-24 months	☐

***Rationale for time period*:**

More than 24 months	☐

If more than 24 month -As this is outside timeframe recommended in guidance please specify rationale

Agencies involved in the case being reviewed

Include name and designation if known

Police	☐		NHS Trust	☐	
Education	☐		Social Services	☐	
Probation	☐		Public Health Wales	☐	
Youth Offending	☐		CAFCASS Cymru	☐	
Local Health Board	☐		Other LSCB	☐	
Other (please specify if known or yet to be identified):			☐		

Agency identified to Chair Review Panel

Include name and designation if known

Police	☐		NHS Trust	☐	
Education	☐		Social Services	☐	
Probation	☐		Public Health Wales	☐	
Youth Offending	☐		CAFCASS Cymru	☐	
Local Health Board	☐		Other LSCB	☐	
Other (please specify if known or yet to be identified):			☐		

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

Core Issues to be addressed in the Terms of Reference of the Review will include:

1. **To examine inter-agency working and service provision for Child or Children X through defined terms of reference.**

2. **To seek contributions to the review from the child/children and appropriate family members and keep them informed of key aspects of progress.**

3. Identify particular issues identified for further clarification including: (*List issues relevant to particular case.*)

4. To produce a report for publication.

5. The LSCB Co-ordinator will be responsible for maintaining links with all relevant agencies, families and interests.

6. The Panel Chair will inform the Chair of the LSCB and the LSCB subgroup of significant changes re the scope of the review and the TOR will be updated accordingly which will be updated in the TOR

7. The Chair of LSCB will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Final LSCB Report.

8. The LSCB and Panel will seek legal advice on all matters relating to the review. In particular this will include advice on:

   - Terms of Reference;
   - Disclosure of Information;
   - Guidance to the panel on issues relating to interviewing individual members of staff.

Appointment of Review Independent of the Case Management

Is an independent reviewer to be appointed?	Yes	☐	No	☐
Is the name and designation of independent reviewer known?	**Yes**	☐	No	☐

*If **yes** please state nominated designation of Independent Reviewer plus any additional information):*

Review Independent of the Case Management – Extended Review

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

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

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

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

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

Date of First Panel meeting (mm/mm/yyyy)	……

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

Anticipated completed report date (mm/yyyy)	……..

To be completed by Sub group Chair

Signature ……

Title ……

Date ……

Telephone number ……

Decision of the Chair of LSCB

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

Signature ……

Title ……

Date ……

Telephone number ……

In discussion with Chair of Sub group

Date information to be presented to LSCB ……

Date information sent to Welsh Government ……

For Welsh Government use only

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

Date acknowledgment letter sent to LSCB Chair ……

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

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

Annex 2

LSCB Child Practice Review Report **Re:** *Insert case identifier*	
Concise Review	☐
Extended Review	☐

Brief outline of circumstances resulting in the Review *To include here:-* • *Circumstances resulting in the review.* • *Time period reviewed and why.* • *Summary/Timeline of significant events to be added as an annex as appropriate.*

Practice and organisational issues identified **What did we learn?**
(from the 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)

Conclusions and Learning points from the Review What do we need to do differently? How will this improve future practice?			
Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
Set text to be added		*Set text to be added*	
Reviewer 1 *(Signature)*	……	**Reviewer 2** *(Signature)*	……
Name *(Print)*	……	**Name** *(Print)*	……
Date	……	**Date**	……

Appendix 1: Terms of Reference.

Appendix 2: Summary timeline (*Currently no standard template*).

Appendix 3: Arrangements for the Review.

Appendix 1

Terms of reference for the Review

In the case of an **Extended Review** issues to be addressed to include:

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

Appendix 3

Multi Agency Learning Event process *The process include length of event, services attendance etc.*
Engagement of Family members *Family perspective /messages informing the review*
☐ Family declined involvement

For Welsh Government use only

Wording to be Confirmed

Date information received ……

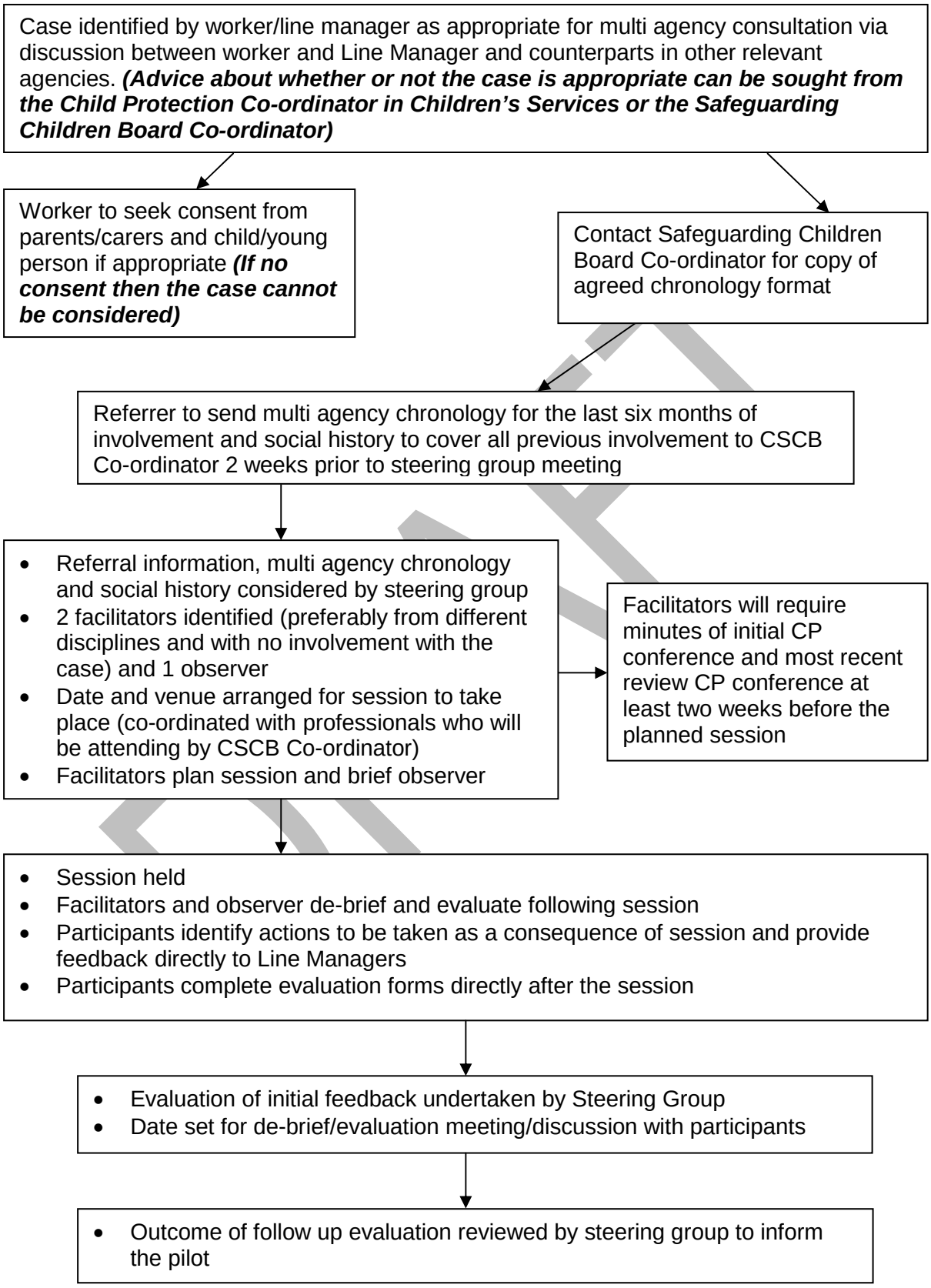
Date acknowledgment letter sent to LSCB Chair ……

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

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

Annex 3

Multi Agency Consultation Model – Process Flow Chart



Annex 4

LSCB Case Review Event (CRE)

Terms of reference

The CRE is undertaken on behalf of the LSCB .The purpose of the event is to examine interagency practice in order to highlight areas of good practice and to establish whether there may be learning from the case.

Methodology

- A summary of the case to be presented to the Case Review Group (CRG).
- CRG to establish those agencies with case involvement.
- Members of the CRG to use an agreed template to create a timeline of significant events for each agency for the time period December 2009-November 2010.
- Agency timelines to be merged into a single interagency timeline.
- Timeline to be used to identify key practitioners and relevant managers to be invited to a case review event.
- CRG to plan and coordinate the case review learning even, as an approach to examine practice.
- CRE to be facilitated by members of the CRG independent of case management or supervisory responsibilities.

CRG to agree on key objectives for learning event:

- Were there indicators of neglect that were not identified/acted upon? If so, can this be understood?
- Were professionals in agreement about the actions that needed to be taken and the timeliness of these actions?
- Were there opportunities that would have allowed for an earlier action to secure the safety and wellbeing of the children concerned?
- What good practice can be identified?
- Are there any lessons that may be learnt by the practitioners involved?
- Are there any messages from this case that need to be communicated more widely – what are these and what actions need to result?

Facilitators to produce a learning outcome report for the LSCB along with a plan of any agreed actions. Report should also be shared with the Regional Improving Practice Group to ensure wider learning across the region where this is necessary.

The process will be completed within 3 months.