Learning together from a thematic review of regional CPRs & MAPFs

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Croeso

Diolch i chi am y wybodaeth, y sgiliau, yr empathi a'r cryfder rydych chi'n eu rhoi i'r gwaith bob dydd.

Ar adeg o angen cymhleth cynyddol ac adnoddau prin, diolch am eich arweinyddiaeth

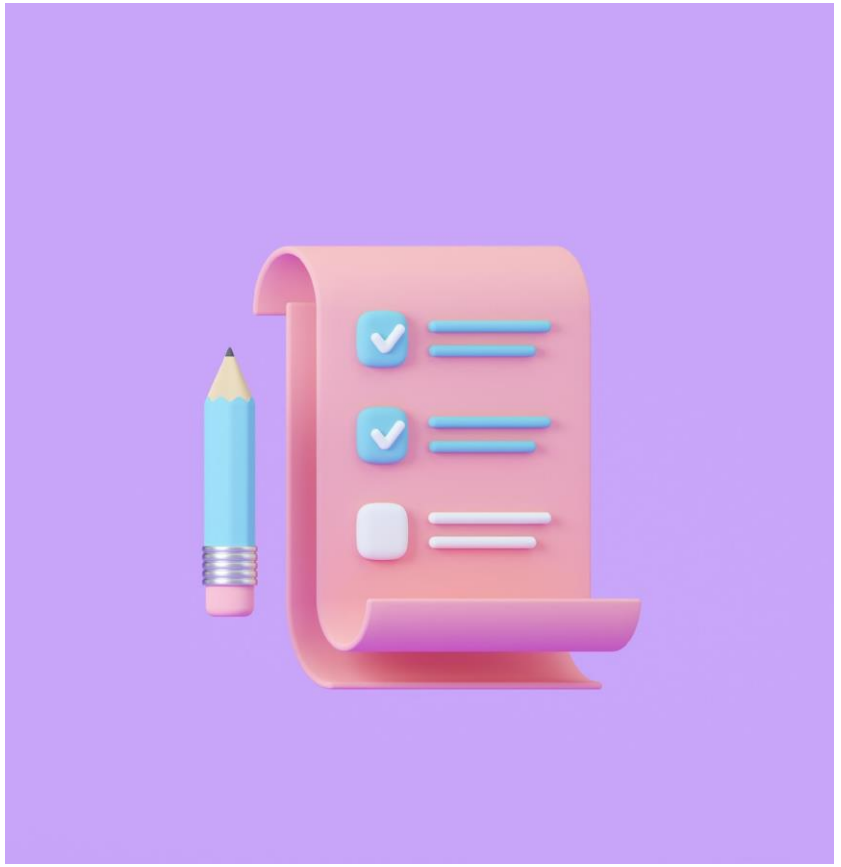
Welcome

Thank you for the knowledge, skill, empathy and strength you bring to work each day.

At a time of increased complex need and scarce resources, thank you for your leadership.

Content for today

- CPR Process, Structure and Action Plans
- CIW Rapid review of CPA / JICPA overview report
- Cardiff University Thematic Report 2019
- Manchester Metropolitan University Thematic Report 2023
- Analysis of Mid and West Wales CPR's & MAPFs
- Activity – Padlet
- Not Just A Thought
- Take Away Points
- Actions and Resources



Child Practice Reviews

- Generate professional and organisational learning and promote improvements / transparency
- Working Together to Safeguard People Volume 2 – Child Practice Reviews
- The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.
- Clear criteria for Extended / Concise CPR's:

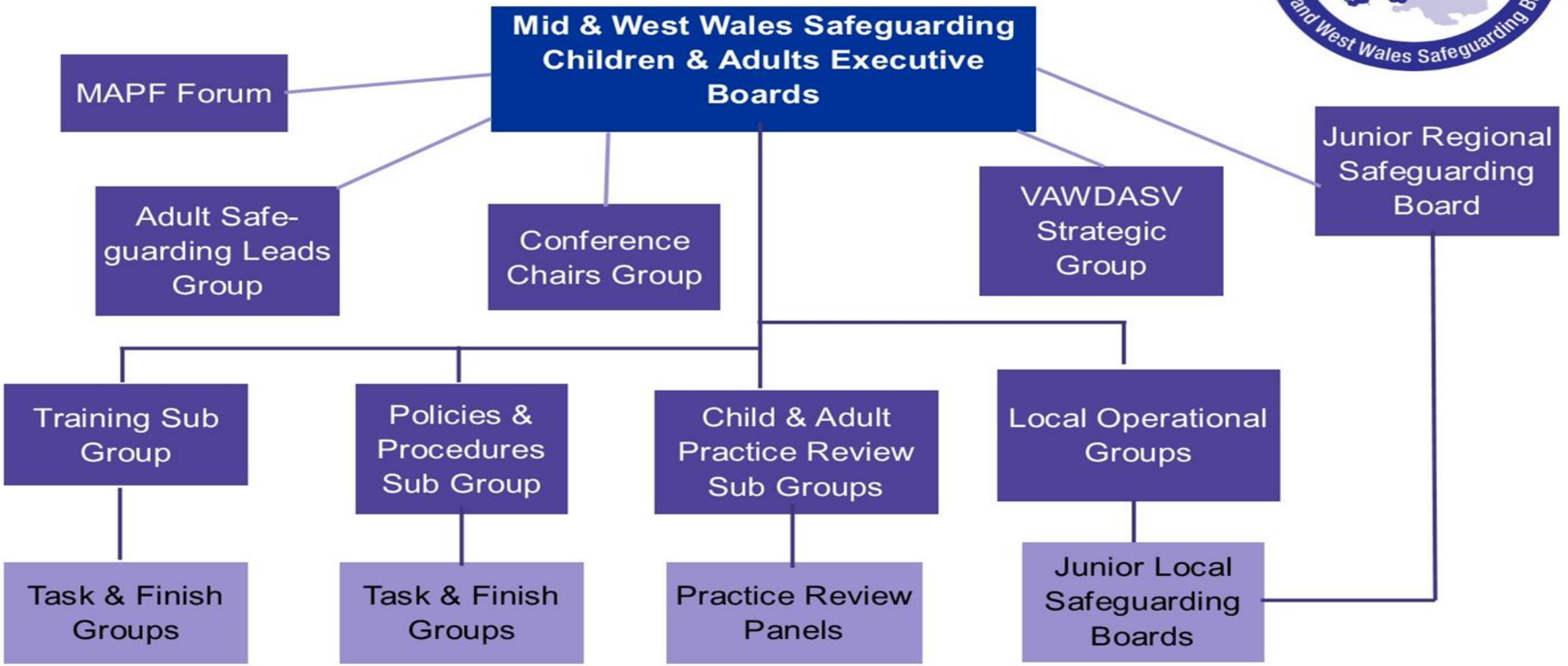
when a child has died; or sustained potentially life-threatening injury; or sustained serious and permanent impairment of health or development; **and**

the child was neither on the child protection register nor looked after on any date during the 6

months preceding the date of the event; or the date on which its identified that a child has sustained serious and permanent impairment of health and development. (Concise CPR)

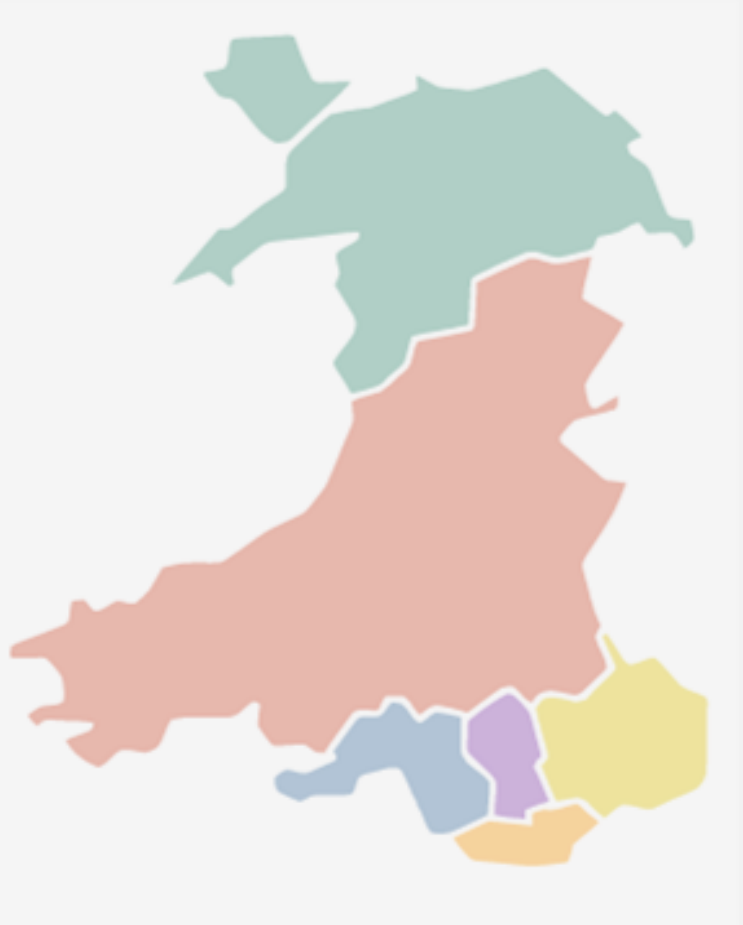
"Abuse of children is not a disease entity but a pattern of behaviour and like all such patterns it has a multiplicity of paths by which it is reached." (Scott, 1973)

Mid and West Wales Safeguarding Board Structure



CPR Process

- Referral
- Reviewer(s)
- Panel – membership, TOR, Timeline, genograms
- Family contributions
- Combined multi-agency chronology
- Learning event
- Completion of draft report
- Presentation of report to CPR Sub Group
- Presentation of report to Executive Board
- Publication



Action Plans

- Report recommendations inform a regional Action Plan
- Approval by the Review Panel and the Board
- Monitoring by the Practice Review Sub Group and Local Operational Groups
- Actions can be local, regional and/or national
- Completed plan formally closed down by Executive Board
- New action plans are drafted with consideration to previous plans completed

Wider Dissemination of Learning

In addition to the targeted work which flows from Action Plans, learning from reviews is also shared via the below mechanisms:

Rapid Review of Child Protection Arrangements (2023)

Led by CIW involving HIW and Estyn

The review considered the extent to which current processes ensure that children who are registered or deregistered from the CPR are protected from harm.

Findings:

Information sharing between agencies needs improving. The lack of a central information sharing IT platform is compounding this.

Workforce instability and vacancy gaps across organisations involved in child protection is impacting.

There should be a consistent approach across Wales to ensure the voice of the child is heard.

Rapid Review of Child Protection Arrangements (2023)

- Referrers must gain feedback. If this isn't received they must contact CS again within 7 days.
- Multi Agency training should be developed to include core group member responsibilities.
- All agencies should ensure representation at strategy meetings, conferences and core groups.
- Meetings should start with the child's story and hear their voice.
- Children must be invited to meetings
- Assessments should include all household members, the role of partners and those outside of the household.
- All agencies should contribute to a safety plan between the decision to go to conference and the conference occurring.
- All agencies should evaluate the effectiveness of escalation and challenge

Overview Report: Joint Inspection of Child Protection arrangements 2019-2024

Key inspectorates carried out joint inspections in each of the 6 regional safeguarding boards (RSBs) between 2019 and 2024.

The inspections reviewed the:

- response to reports of abuse and neglect at the point of identification
- quality and impact of assessment, planning and decision-making in response to safeguarding notifications and referrals
- protection of children aged 11 and under at risk of abuse and neglect
- protection of children and young people at risk of exploitation
- leadership and management of child protection
- effectiveness of the multi-agency safeguarding partner arrangements in relation to this work

Overview Report: Joint Inspection of Child Protection arrangements 2019-2024

highly committed and motivated professionals

Range of models - beneficial models focus on what needs to change and are strengths based

Demand and capacity

Overlap with rapid review – Thresholds, multi-agency audits and integrated ‘front doors’

Suitable systems are in place to facilitate effective partnership working

Cardiff University Analysis of CPR's (2019)

Key Findings

(1) Hierarchy of knowledge

(2) Information sharing / recording

(3) Partial assessments

(4) Voice of the child

Recommendations

- Ensure understanding of the ability to share information
- A need for a central repository to help facilitate this learning
- Ensure the child is 'repositioned at the centre of the process and the voice of the child is heard'
- Information_sharing_advice_practitioners_safeguarding_services.pdf
- https://cysur.wales/resource-hub/
- Ending physical punishment in Wales

Risk, Response and Review: Thematic Analysis of 33 Child Practice Reviews (CPRs) in Wales 2023

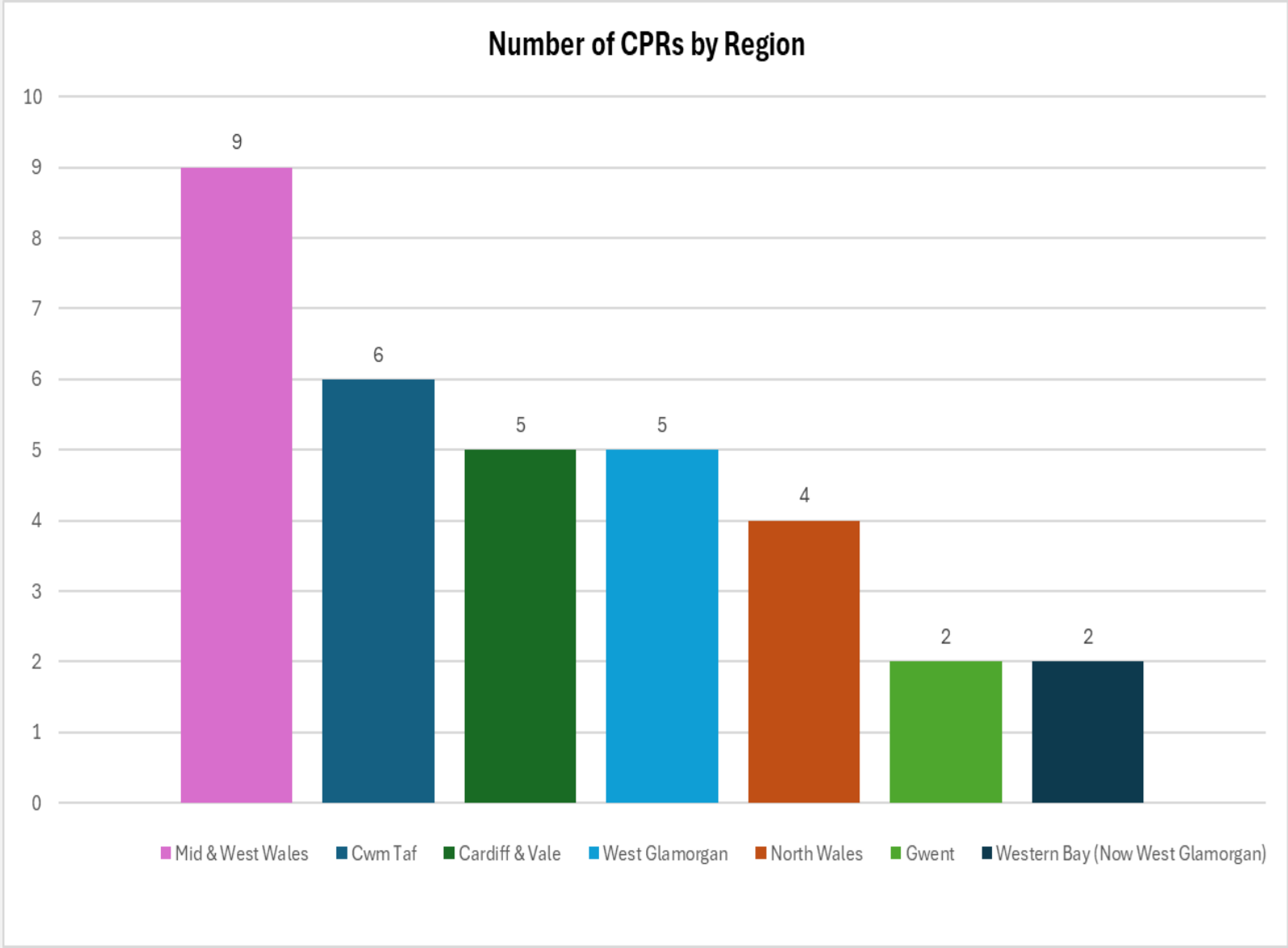
Led by Professor McManus, Manchester Metropolitan

It sought to understand recurring themes across to draw out:

Trends in child and family characteristics

Intelligence and information held by agencies

What worked, barriers and challenges



Risk Findings: Descriptives

Two thirds of CPRs were **prompted by a child's death.**

Suicide, other medical/health issues and non-fatal physical abuse were the **most common incidents.**

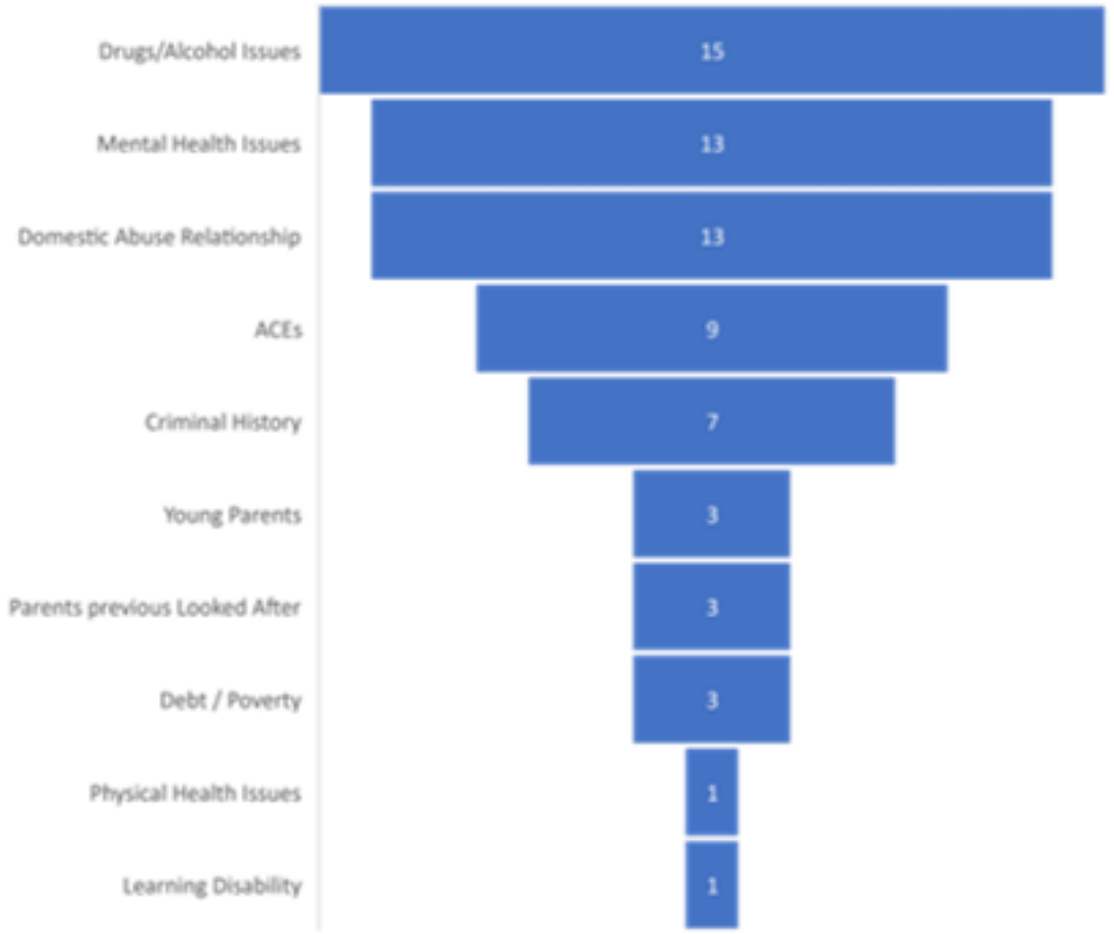
1/5 of the children were up to 3 months old when the incident occurred, while a fifth were 13 years old and over.

3/4 of the children had a **sibling**. Of these, a third had **half-siblings** and two thirds were the youngest in the family.

45% recorded a large sibling group (3 or more children). Child subject to the CPR was youngest child in 66% of 21 cases.

McManus et al 2023

Children's most common vulnerabilities were emotional abuse, neglect and living in poor home conditions.



Most common parental/carerrisk factors were drugs/alcohol misuse, mental health issues and domestic abuse relationship.

McManus et al 2023

Learning Points

Threshold Uncertainty:

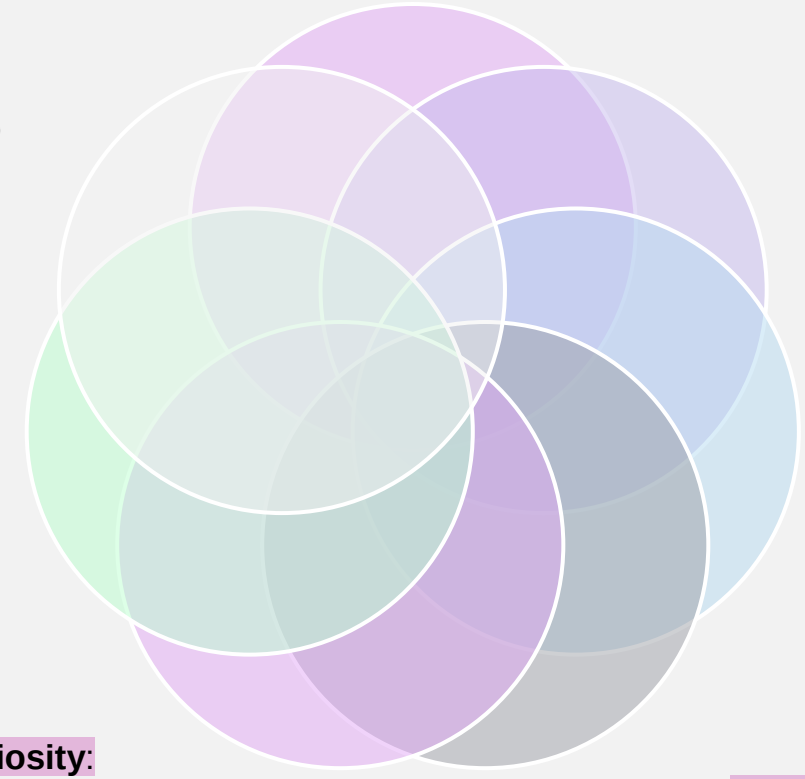
Inconsistent thresholds for intervention and lack of clarity among agencies sometimes lead to delayed or inadequate responses.

Focus on the Child's Voice:

Practitioners are encouraged to prioritise understanding a child's lived experience and integrating this perspective into assessments and decisions.

Missed Health Appointments:

A pattern of uncoordinated responses to missed appointments suggests the need for a unified health record system to flag potential risks.



Multi-Agency Collaboration:

Strengthening information-sharing, especially among health services, social care, and education, is essential for cohesive safeguarding responses.

Disguised Compliance and Reliance on Self-Reports:

Families occasionally exhibit minimal compliance, which can mask risks. Agencies are cautioned against over-relying on self-reports without triangulating information.

Professional Curiosity:

There is an emphasis on the need for practitioners to question information critically rather than rely solely on self-reported accounts, to fully understand and address safeguarding risks.

Workforce Challenges:

High caseloads, limited training, and staff burnout can compromise the quality and consistency of safeguarding efforts.

Education Schools proactively referred children and families for support, often to Early Intervention services. Good pastoral support was evident, with children knowing how to access help from staff and external counsellors. Schools also communicated concerns with families and creatively reached parents via calls, letters, and meetings. During Covid-19, schools worked hard to stay in touch with children. Safeguarding was thorough, with concerns logged on school databases, and the Education Welfare Service maintained detailed records of family interactions.

Health Midwifery showed good safeguarding practices, including completing Domestic Violence Routine Enquiries and transferring records between England and Wales. Health Visitors provided wide-ranging support, such as housing advice and guiding families on Child Protection, with good family relationships enabling home access for multi-agency support. Health Visitors collaborated with School Nurses and GPs and promptly referring cases to Social Services. Hospitals also alerted Health Visitors about relevant visits. Health professionals demonstrated vigilance, such as a Pharmacist spotting excessive prescriptions and a newborn screener making a timely safeguarding referral. Emergency services and CAMHS were praised for their responsiveness, and GPs were recognized as vital partners, holding weekly meetings with safeguarding as an essential agenda item.

Police showed effective internal communication, such as escalating concerns from Community Support Officers to senior staff. There were examples of inter-force collaboration, particularly in missing children cases, and joint work with other agencies on safeguarding. The Police also provided thorough historical information for Child Protection conferences and proactively pushed cases for escalation when needed. Regarding MARAC, decision-making and records were robust, preventing duplication.

Within **Social Services**, assessments were praised for being accurate, concise, and of high quality, capable of withstanding scrutiny. They provided local authorities and partners the opportunity to form a coordinated team around the child. Statutory visits were completed on time, and joint visits by agencies like Children's Services and School Nurses were highlighted. Social Services recognized the need for ongoing support for families beyond statutory thresholds, with a social worker seeking transitionary services from Resilient Families. A CPR also emphasised the importance of supporting staff in complex cases, with systems being developed for this.

Analysis of Regional Practice in Mid and West Wales

Data

4 MAPFs and 7 CPRs between 2017 and 2021 relating to children and young people age from infancy through to 19 years of age.

The types of harm identified include:

- Bullying
- Coercive control
- Domestic violence
- Drug and alcohol abuse
- Emotional and psychological abuse
- Extreme religious beliefs
- Neglect
- Physical abuse
- Sexual abuse
- Social isolation

Pre-Covid Reviews

CYSUR 3 2017 MAPF Report baby left in the care of a non-familial male suffers a serious non-accidental brain injury.

CYSUR 6 2018 Concise CPR Physical abuse from father towards children including threat to kill, previous concerns of neglect, alcohol use and the children's isolation.

CYSUR 7 2018 Concise CPR Unexpected death of a 14-year-old boy by misadventure.

CYSUR 2 2019 MAPF Report Examined the history of a 19 year old's childhood Concerns chronic neglect, domestic abuse, and alcohol misuse.

CYSUR 4 2019 Extended CPR regarding intra-familial sexual abuse (incest) of two generations of children and adults.

CYSUR 2 2020 Concise CPR Examined the sudden unexplained death of an infant when co-sleeping with their father.

CYSUR 4 2020 Extended hybrid CPR the serious harm suffered by a child in a fostering context during a respite placement.

CYSUR 5 2020 MAPF Report Domestic violence and substance misuse and decisions made regarding a previously looked after child.

Post COVID-19 Reviews

CYSUR 1 2021

Concise CPR

Death of an infant following an unprovoked and violent attack by mother's male partner.

CYSUR 2 2021

MAPF Report

Examined the death by suicide of a 17 year old.

CYSUR 3 2021

Concise CPR

Examined the death of a 16 year old with spina bifida who died in a chronic state of neglect.

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.

The closure of schools had significant ramifications on the visibility of children, particularly those who were living in vulnerable circumstances.

Changes in policies and risk assessments meant that practitioners were under immense pressure to balance the risk of Covid-19 with other safeguarding concerns.

Practitioners lacked confidence in challenging families use of Covid-19 anxieties as a barrier to engage with services.

Practitioners, who were also operating within resource pressures of high levels of staff absence, due to illness and self- isolation rules.

Emerging Themes

Advocacy & Empowerment (Individual & Structural)

Communication

Escalation

Recording

Voice of the Child

Individual Advocacy & Empowerment

The importance of advocacy for children to make their voices heard and empower them to be involved in their care support and protection.

Empowerment was a feature both for parents, children and employees. In particular challenges arose when considering how to advocate for children who are home educated or socially isolated.

Several reports made reference to the need for practitioners to be empowered to escalate concerns when they observe non-engagement from parents or when children‘s are at risk.

Implications were for staff to be supported and trained to ask difficult questions and to escalate matters to management if they remain unresolved.

A focus on professional curiosity but also the need for managerial supports and does managerial training needs to be improved to support staff?

Staff should feel confident to report concerns without retribution and a culture that supports whistle blowing is essential to identify risks at an early stage.

Structural Advocacy & Empowerment

Local authority children's services were overstretched resulting in high workloads and low morale. Austerity has impacted resources creating fragility in the region’s safeguarding abilities. Funding for staff recruitment needs, an increase in care coordinators is needed.

Guidance is needed for Heads of Service to request additional funding and should be readily available and understood.

A lack of appropriate fostering placements placed increasing demands on fostering services.

Policies are a key resource and several reports suggested that internal funding policies to ensure adequate resources should be improved policies that support the training of practitioners.

Local health organisations to review policies relating to concealed pregnancy policies of working with families with complex needs to ensure that policies related to care and support assessments comply with relevant codes of practise.

CPR’s provide a quality assurance systems are in place and effective to oversee improvements a review of the process for recording and responding to multi agency referral forms to improve consistency.

Communication

The report's detailed the critical role of effective and timely communication in safeguarding practises.

Good communication included building trusting relationships to facilitate effective support.

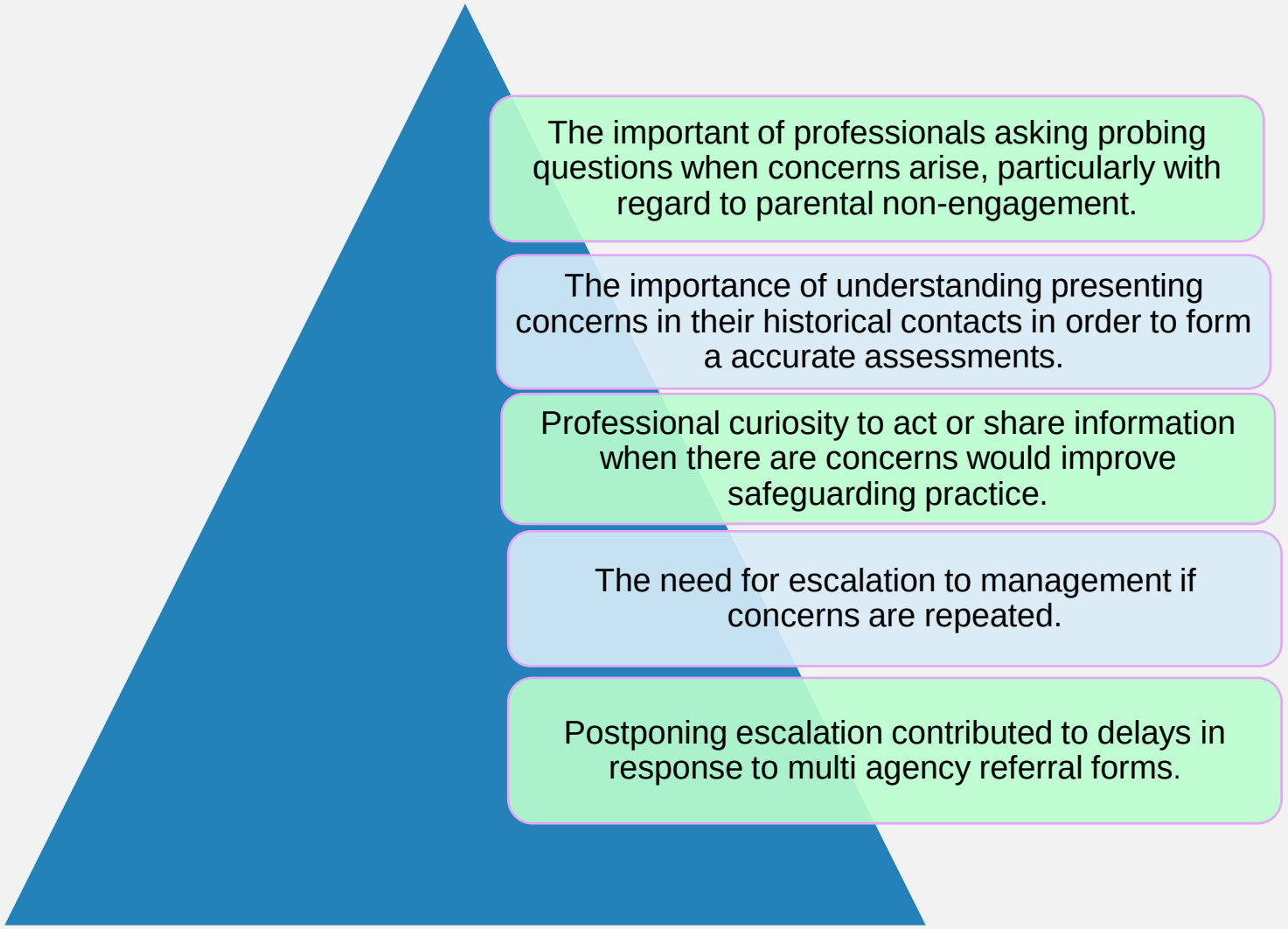
Poor communication was associated with missed opportunities for interventions which increased the risks for children.

The need for enhanced interagency communication and clearer information sharing process is was a consistent finding within the reports.

Recommended improved collaboration and clearer information-sharing pathways between Welsh and English services.

Inconsistent transition planning between child and adult services. There was a lack of coordination between agencies and insufficient involvement of the family in planning process.

Escalation



The important of professionals asking probing questions when concerns arise, particularly with regard to parental non-engagement.

The importance of understanding presenting concerns in their historical contacts in order to form a accurate assessments.

Professional curiosity to act or share information when there are concerns would improve safeguarding practice.

The need for escalation to management if concerns are repeated.

Postponing escalation contributed to delays in response to multi agency referral forms.

Recording

Across the reports there is a clear emphasis on the need for accurate, detailed and timely case recordings to support effective safeguarding practises.

Poor recording included being incomplete vague terminology and unclear references to family members. At times case notes were not entered onto electronic systems, in a timely manner.

At times there was no clear chronology of events or a genogram to illustrate family relationships which added to the difficulties of understanding the risk factors around the child.

The reports suggest a need for improved training and adherence to the recording standards of each agency.

Poor documentation can lead to gaps in understanding the child's needs and the context within which they exist and can ultimately affect the quality of care and the intervention provided.

When recordings were made they did not always adequately capture the complexity of the situation.

On occasion the service ceased to be delivered without proper investigation leading to missed opportunities to see and assess children and engage with the family.

Voice of the child (1)

The reports highlight the importance of understanding and including children's views and experiences when making decisions.

Reports highlighted the absence of a clear mechanism to capture some children's wishes and feelings in particular about their care and support.

At times there was a lack of documentation about the child's voice and wishes and so the child's perspective on their health and well-being was not known and could not be shared because it was not recorded.

A failure to capture the child's voice, at times contributed to misunderstanding about needs and circumstances.

Voice of the child (2)

At times when children were expressing their views there was a systemic failure to ensure that these views were clearly recognized and implemented an planning to meet their social health and education needs.

The lack of consistent inclusion of the views of children in decisions that are made about them is a concern.

Children being empowered to self advocate means they can be represented in assessments and interventions.

Systemic change is needed to ensure children are not only heard but actively involved in the decisions about their lives.

Good Practice

Practitioners showed persistence, making repeated home visits and providing flexible educational options.

Engagement of families in the review process, valuing their perspectives and feedback.

Collaborative work with social services, including evidence gathering and addressing housing instability.

Significant efforts by practitioners to engage families through home visits.

Active engagement with families occurred through regular updates and meetings.

Effective information sharing between agencies noted in certain instances.

Activity - Padlet

Interrogating compliance and curiosity

- Not Just A Thought

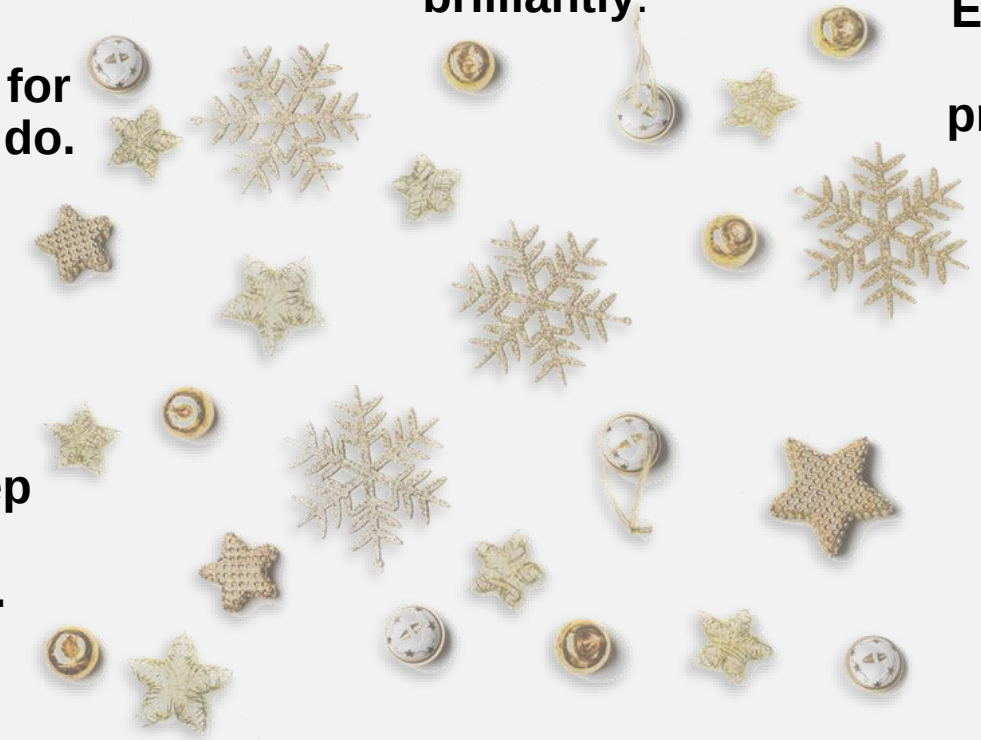
Not just a thought - Centre for Applied Health Research

Key Take Away Points

You are doing brilliantly.

We are grateful for you and all you do.

Embrace children's ability to co-produce knowledge and solutions.



Every day is a school day, keep reflecting and disseminating.

When the going gets tough reach out for support from colleagues and managers.

Strengthen interagency working, when you do it, it makes a real difference.

Consistently practice self-care.

Outputs of Action Plans and Thematic Learning

- Professional Curiosity Training Package
- Training animation focused on child voice and lived experience
- Was Not Brought Policy and Training
- Training and guidance centred on information sharing
- Development of the regional Rapid Response model
- Pre-Birth Pathway
- Protocol for Injuries in Non-Mobile Babies
- Guidance on Working with People Difficult to Engage
- Provision of specialist training in relation to complex CSA
- High-Risk Behaviours Policy/Procedure (Self-Neglect and Hoarding)

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