Concise Child Practice Review Report

CYSUR 1/2019

Date report presented to the Board:

16th July 2024

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Review Reference:
CYSUR 1 2019

Brief outline of circumstances resulting in the Review

To include here:

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

Legal Context

A Concise Child Practice Review was commissioned by CYSUR, the Mid and West Wales Safeguarding Children Board, on the recommendation of the Child Practice Review sub-group in accordance with the Social Services and Wellbeing [Wales] Act 2014[1], and accompanying statutory legislation in section 139 of the guidance in Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016)[2]. The criteria for concise reviews are laid down in The Safeguarding Boards (Functions & Procedures) (Wales) Regulations 2015[3].

The criteria for this review are met under section 3.4 of the guidance, namely:

A Board must undertake a Concise Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- Died; or
- Sustained potentially life-threatening injury; or
- Sustained serious and permanent impairment of health of development; **and**
- the child was neither on the Child Protection Register nor a Looked After Child on any date during the 6 months preceding

- The date of the event referred to above; or

- The date on which a Local Authority or relevant partner[4] identifies that a child has sustained serious and permanent impairment of health and development.

The purpose of the review is to identify learning for future practice including highlighting effective practice. It involved practitioners, managers and senior officers exploring the detail and context of agencies working with a child and their family.

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)
[3] The Safeguarding Board (Functions and Procedures) (Wales) Regulations 2015; Reg 4 (3)
[4] Local Authority or relevant partner means a person or body referred to in S.28 of the *Children Act 2004* or body mentioned in s.175 of the *Education Act 2002*.

Circumstances Resulting in the Review

The Concise Child Practice Review (hereafter The Review) concerns a baby who, in 2018, sustained unexplained and potentially life-threatening injuries whilst in the care of, and living with, his biological parents and maternal grandmother. At the time of this incident, the baby was no more than five weeks old.

The baby was initially taken to hospital with concerns in relation to a chesty cough. When examined, he was found to have a head injury which the parents were unable to explain. Numerous further significant injuries were noted, including several fractures. These injuries were deemed unexplained and not consistent with accidental injuries. The biological parents and maternal grandmother were subsequently arrested as potential perpetrators, due to the baby being in their care over the time period of the incident.

Following respective criminal proceedings, the biological mother pleaded guilty to assault / ill treatment / neglect / abandoning a child to cause unnecessary suffering / injury and was sentenced to ten months imprisonment wholly suspended for twenty-four months. The biological father pleaded guilty to assault / ill treatment / neglect/abandoning a child to cause unnecessary suffering/injury and was sentenced to three years imprisonment. He is currently on Probation, under licence until 2025. The maternal grandmother was charged with assault / ill treatment / neglect and abandoning a child/young person to cause unnecessary suffering/injury. However, no evidence was offered by the Crown Prosecution Service, and the case did not progress to criminal trial.

At the point of adoption, the baby was making positive progress and regained his eyesight, but still struggled to meet his developmental milestones. Some of the issues he experienced included delayed standing up, head banging and pulling his hair. He was supported weekly by a Physiotherapist, Speech and Language Therapist and a Play Therapist. There were also concerns that he did not use his left side as much as his right side, and struggled with food intake. Professionals currently remain unclear what the impact of the injuries will be.

Time Period Reviewed and Why

The Welsh Government guidance, Working Together to Safeguard People, Volume 2 – Child Practice Reviews (2016)[5] states that, for The Review, a timeline of a maximum of twelve months preceding the identified incident should be prepared and agreed by the multi-agency Child Practice Review Panel. This also includes a genogram as a means of clarification of family relationships, and agency analysis focussing on their respective agency involvement during the identified time period, which includes any actions undertaken prior to The Review commencing, or that which remains in progress.

For this Review, it was agreed by the Child Practice Review Panel that the time period to be covered should be from 19 March 2018 to 24 December 2018 inclusive. This timeline comprises the multi-agency work undertaken both individually and collectively and was merged as one integrated multi-agency timeline. There is one entry referred to which falls slightly outside of this time period; this was agreed to be included by the Panel as it provides relevant and helpful clarification of an important process that links to the rationale for The Review.

The rationale for agreeing to begin the time period from 19 March 2018 was that this was the date the Mum first presented as an early pregnancy contact under NHS Trust (Surrey and Sussex).

[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)

The rationale for agreeing to conclude the time period on 24 December 2018 was that this was the date the baby was discharged from Powys Teaching Health Board into foster care.

The timeline, chronologies and analysis submitted by all agencies were discussed in detail during the Panel meetings, at the learning event, and informed the themes and learning included within this report.

Family history

This baby is the first child of both parents.

The baby's Mum was aged 20 years and Dad 18 years, respectively, when their baby was born.

Mum was raised by, and resided with, her stepdad in West Sussex until August 2018. Her Mum (maternal grandmother to the baby) and stepdad agreed this would be in everyone's best interests due to some difficulties the maternal grandmother was experiencing, including homelessness and substance misuse, which required her to move to Wales.

Dad also resided in West Sussex until he moved to Wales with the baby's Mum in August 2018. Information from Surrey and Sussex NHS Trust states that Mum presented as supported by her partner (Dad). They planned to live with maternal family and appeared well supported by professionals.

Both parents were not raised by their respective biological parents, and both experienced complex childhoods and trauma. Mum experienced childhood adversities, including physical, sexual, and emotional abuse. She also exhibited some concerning behaviours, such as taking an overdose and self-harming. There was no domestic abuse disclosed by either parent.

Summary of agency involvement with the family

The baby's Mum, at thirty weeks pregnant, and Dad moved to Wales from West Sussex because Mum wanted to be with her Mum (maternal grandmother) and have her baby in Wales.

Upon relocating to Wales, Mum registered with the necessary medical professionals and was supported by a local midwife.

Concerns were first shared with Powys Local Authority Children's Services on 09/12/18 when the Emergency Duty Team (EDT) were contacted by the Duty Paediatrician in Princess Royal Hospital. The baby was taken to hospital earlier that afternoon with concerns about a chesty cough. When examined he was found to have a head injury that the parents were unable to explain. A strategy discussion was held, and a Section 47 investigation was triggered.

The following day, an initial safeguarding medical took place at which the baby's injuries and findings were deemed unexplained, and not consistent with accidental injuries given the young age of the baby, who was not mobile[6].

The baby was discharged from hospital into foster care and Court proceedings were initiated.

It was established that the information gathered within the Court process reflected Mum's poor mental health. Mum was referred to the General Practitioner (GP) and the Community Mental Health Team (CMHT), and prescribed medication when the baby was two and a half weeks old.

[6] Mid and West Wales Procedure for the Management of Suspected Injuries in Non-Mobile Children

The CMHT completed an assessment which advised a referral for Counselling, a Consultant Psychiatrist outpatient appointment, to continue with her medication and to attend the GP again if necessary.

Although outside the time period for the Review, it should be noted that on 16/01/19, an underlying disorder was ruled out as a possible cause for the baby's injuries.

For the time period covered, the baby and/or his family were supported by, and had involvement with, the following agencies:

Surrey and Sussex NHS Trust: Midwifery

Contact began on 19/03/18 when Mum registered for maternity care. Six appointments were attended in person between 19/03/18 and 05/06/18, with two telephone appointments held thereafter between 05/06/18 and 11/09/18. The last contact was 11/09/18 when Mum advised she had returned to Wales.

Powys Teaching Health Board Midwifery services

Mum self-referred on 23/09/18 at 32 weeks, her care and treatment were Consultant-led, and labour was induced at 37 weeks' gestation, as the baby was not growing sufficiently. He was in hospital for the first week post-birth and prescribed antibiotics upon discharge from hospital at seven days old, and into the care of the Community Midwives.

The Community Midwife noted low mood in mum on days eight and nine, and reported on day ten that the low mood was moving towards depression; the Edinburgh Postnatal depression score[7] was 23. A score above 13 indicates a high risk or likelihood of depressive illness and requires further clinical assessment and diagnosis. An appointment to see the GP was made for the following day, and the GP made a referral to the Adult Mental Health Team.

Powys Teaching Health Board Health Visiting Service

Generic Health Visiting service commenced when the baby was eighteen days old (referenced as two-week old contact). There was a verbal handover from the Midwife to the Health Visitor (HV) and the HV was advised of Mum's history of anxiety pre-pregnancy and that she had been commenced on Sertraline (anti-depressant). The baby was seen naked at weeks two and three.

At the three-week-old contact, the HV records document that Mum was feeling unwell, and the medication (anti-depressants) was changed the same day at her GP appointment. The baby was twenty-six days old at this visit. He was not weighed at three weeks as the Midwives had weighed him a few days prior to the HV's visit.

The HV recorded that the maternal grandmother was doing most of the baby's care at the four-week-old visit as Mum was unwell. The HV weighed the baby at this visit and was positive about the contact between the baby and his Mum.

At the five-week-old contact (forty days old), the baby was seen by the Consultant Neonatologist at the Princess Royal Hospital, Telford. The Consultant Neonatologist documented that the baby appeared well, making progress and there were no concerns. At the HV appointment, two days later, the HV recorded a scratch below the right nostril.

[7] Assessment | Diagnosis | Depression - antenatal and postnatal | CKS | NICE

Hitherto this point, the HV had not reported any other marks on the baby or that he was distressed. The HV documented that baby was wide awake and wanting a feed, and that there was good interaction between Mum and baby.

The parents declined for the baby to be weighed at this contact as this was undertaken when he attended the hospital. Mum also reported she was feeling better, and the medication continues to suit her. The next HV appointment was arranged for twelve days later, with Mum's appointment with the Psychiatrist scheduled for the following day.

Princess Royal Hospital, Telford

The baby was admitted to hospital via ambulance on 09/12/18 with bronchiolitis. He was six weeks old and, on examination, was found to have swelling to his leg and head. A child protection medical was undertaken on 10/12/18, from which the provisional skeletal survey report listed significant and multiple injuries.

Powys Local Authority Adult Services (Mental Health and Disabilities)

A mental health assessment was completed in respect of Mum on 23/11/18. The information within the assessment highlights low mood and a propensity to lose her temper easily (but has felt like this since she was a teenager). There were no delusions, hallucinations or other unusual thoughts, no signs of self-neglect and no current thoughts of harming herself or others.

The outcome of the assessment was for Mum to be referred for counselling and a consultant psychiatrist out-patient appointment. Additionally, for Mum to continue with her medication and to visit her GP if necessary.

Parents' involvement in the review

The family's views are an important element of the review, to enable professionals to learn from their experience of their involvement throughout the time period and to glean any learning to inform future practice. Both biological parents were approached to obtain their views. This proved unsuccessful. However, the Reviewer and Panel Chair met with the maternal grandmother prior to the Learning Event. This proved successful in obtaining detailed views from one of the baby's main carers for the duration he was in the family home. Therefore, it should be noted that, in the next section, the representation of the family's views is limited only to that of the maternal grandmother.

Panel Reflections and Analysis of Multi-Agency Involvement and Intervention with the Family

The Panel's reflections and analysis of agencies' intervention with the family have concluded that a more robust assessment of the family's situation pre-birth may have identified the need for the offer of formal care and support post-birth. Although it is acknowledged it is recorded parents engaged with antenatal appointments on the whole, and no concerns were identified regarding their care and interaction with the baby post birth, a triangulation by professionals of all the information available, taking into consideration the parents' complex history (including their difficult and complex childhoods), mother's history of concerning behaviour and presenting mental health needs could have identified the need for higher level of support post birth. This could have included, for example, the offer of an enhanced maternity pathway and pre-birth assessment, which may have provided an opportunity for a better understanding of the grandmother's views

and opinions of their ability to care for a newborn baby, and a better understanding of father's complex history and what role he may play in the care of his child.

Practice and Organisational Learning

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

The following 2 learning points were identified from the timeline, agency analysis and learning event:

Learning point 1 – The use of professional curiosity by practitioners

Family's views:

The maternal grandmother relayed that agencies appeared to focus on the immediate presenting issues and may have been better served, or at least informed, by listening to her views, as she was significantly involved in caring for the baby.

Practitioners' views:

All agencies agreed that, although evident in some instances, professional curiosity could have been better in some aspects of the agency involvement with the family. The completion of a pre-birth assessment would have provided opportunities to obtain further information in relation to the familial dynamics and history and therefore informed the appropriate care, referrals and support.

Learning:

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family, rather than making assumptions or accepting things at face value. Curious professionals will spend time engaging with families on visits, be open to the unexpected and incorporate information that does not support initial assumptions into their assessment of what life is like for the child or adult in the family. All agencies should ensure that professional curiosity is routinely used by their practitioners in all their work with families.

Learning point 2 - The importance of familial history in referrals, assessments and interventions, with specific reference to the father's role

Family's views:

The maternal grandmother commented that practitioners seemed to overlook the role and background of the biological father, and its potential significance in the care and interventions provided.

Practitioners' views:

Powys Teaching Health Board referred to the importance of giving due consideration to the father, if he is present, as a member of the family and not separate from the assessment process. Although present for the Health Visitor appointments, more attention and analysis could have been paid to the father, his role in the family and with the baby.

Learning:

Every family should be offered an holistic assessment of need as outlined in the Healthy Child Wales Programme.[8] The programme underpins the concept of progressive universalism and aims to identify a minimum set of key interventions to all families with pre-school children, irrespective of need. For some families there will be a need to increase intervention to facilitate more intensive support; this includes professional assessment of a family's resilience, which not only looks at the development of the child, but considers the whole setting and wider influences such as social, economic and environmental factors, and whether the child and family need additional support to address areas of concern.

Effective practice

There are several examples of effective agency and practitioner practice for this review:

Powys County Council – Children's Services

In respect of the baby, Child Protection processes were appropriately followed, and occurred well within timescale. Additionally, placement searches commenced immediately so they were sourced prior to discharge and a smooth transition occurred.

Powys County Council – Mental Health & Disabilities

The referral from the GP was triaged by the duty worker the same day. A further discussion was held at the multi-agency 'hub' meeting and allocated for assessment with duty worker.

Mum was referred for primary counselling and ongoing support from psychiatry outpatient appointments. This was undertaken to help support Mum, and she was receptive to this referral. Initial assessments were shared with Children's Services and Powys Teaching Health Board Safeguarding Unit (Children's). It should be noted that these interventions occurred after the injuries were inflicted.

Dyfed-Powys Police

Information was accurately and promptly shared internally and externally. Prompt action and safeguarding was undertaken on receipt of information regarding non-accidental injury from partner agency.

Surrey and Sussex NHS Trust

Identified physical and mental health challenges of the patient. Recognised and treated a deterioration in maternal mental health.

Powys Teaching Health Board

Telephone contact is documented between the Powys and Surrey and Sussex Midwifery Teams following the move to Wales at 32 weeks gestation, to ensure effective handover of care.

Hospital staff enabled the father to stay to support mum while the baby needed to stay in hospital. All advice around the safe care of the newborn was given prior to discharge from the

[8] An overview of the Healthy Child Wales Programme (gov.wales)

hospital and at the Health Visitor birth visit. This included safe sleeping and risks of smoking around baby and advice against bed sharing.

Appropriate support was offered to mum as the signs of her low mood became apparent. This included visits from the Midwife and a plan to support the family, completion of the Edinburgh Post Natal Depression Scale, seeking advice from a senior midwife following the high score, and referral to the GP for medication and the CMHT for assessment.

The Learning Event

A multi-agency learning event was held in November 2022, and was well attended by practitioners, managers and senior managers of all the relevant agencies who were involved with the family. Whilst some were not directly involved, they were able to contribute through reflecting on the following key questions:

- What went well, what good practice have you identified?
- What do you feel did not go well, are there areas which concern you?
- What do you feel agencies could have done differently?
- What actions do you feel agencies need to take going forward, to ensure any learning informs future practice?

The learning event was facilitated by the Independent Reviewer and the Panel Chair. As described above, the learning event considered the timeline of contacts and events for the period 19 March 2018 to 24 December 2018 inclusive. The family's views were also woven into the discussions.

Improving Systems and Practice

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

Recommendations:

1. The Board and its member agencies should ensure that professional curiosity is consistently and effectively applied by all practitioners across adults and children's services in their practice when working with families.

2. The Board and its member agencies should ensure that safeguarding referrals, assessments, and interventions include, reference and reflect the complete familial picture, always including the father.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>Reviewer 1</td><td>Simon Watts</td><td>Reviewer 2 (as appropriate)</td><td>Not applicable for this Review</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">I make the following statement that prior to my involvement with this learning review:

• I have not been directly concerned with the child or family or have given professional advice on the case.
• I have had no immediate line management of the practitioner(s) involved.
• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</td><td colspan="2">I make the following statement that prior to my involvement with this learning review:

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<tr><td colspan="2">Reviewer 1.
(Signature)</td><td colspan="2">Reviewer 2 Not applicable for this Review.....
(Signature)</td></tr>
<tr><td colspan="2">Name Simon Watts……
(Print)</td><td colspan="2">Name Not applicable for this Review……
(Print)</td></tr>
<tr><td colspan="2">Date 5th September 2024</td><td colspan="2">Date Not applicable for this Review ….</td></tr>
<tr><td colspan="4">Chair of Review Panel
(Signature)</td></tr>
<tr><td colspan="4">Name Jayne Butler ……..
(Print)</td></tr>
<tr><td colspan="4">Date 5th September 2024</td></tr>
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Child Practice Review Process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

- The referral for consideration of a Child Practice Review was discussed in the Powys Local Operational Group. This referral was agreed to progress to the CYSUR Child Practice Review sub-group for consideration of a Child Practice Review.
- The referral was duly discussed in the CYSUR Child Practice Review Sub Group. Agreement was reached that the criteria was met for a Concise Child Practice Review, which was then recommended to the Chair of CYSUR.
- This recommendation was ratified by the Chair of CYSUR to undertake a Concise Child Practice Review.
- A multi-agency Child Practice Review Panel was formed. Services represented on the Panel:
    1) Surrey and Sussex NHS Trust: Midwifery.
    2) Dyfed-Powys Police.
    3) Powys Teaching Health Board: Midwifery, Health Visitor, Maternity, Neonatal, Paediatrics, GP, CMHT, Accident and Emergency Doctor.
    4) Powys County Council: Social Care Mental Health and Disabilities.
- Panel Membership, Terms of Reference and time period for the review to cover agreed.
- Amalgamated agency timeline and analysis completed and agreed.
- Family contact undertaken for the purposes of the review, their views obtained and represented in the Learning Event. Feedback was then provided to them.
- Learning Event held. Services in attendance:
    1. Surrey and Sussex NHS Trust: Midwifery.
    2. Dyfed-Powys Police.
    3. Powys Teaching Health Board: Midwifery, Health Visitor, Maternity, Neonatal, Paediatrics, GP, CMHT, Accident and Emergency Doctor.
    4. Powys County Council: Social Care Mental Health and Disabilities.

For Welsh Government use only

Date information received: …… *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……*(date)*

Agencies	Yes	No	Reason
CIW			
Estyn			
HIW			
HMI Constabulary			

HMI Probation			

Annex A – Terms of Reference for CYSUR 1 2019 (Powys) Child Practice Concise Review

Terms of Reference for Concise Child Practice Review
CYSUR 1/2019 (Powys)

- **Nominated Safeguarding Lead** – Holly Gordon
- **Review Panel Chair** – Det Supt Jayne Butler
- **Independent Reviewer(s)** – Simon Watts

Core Tasks:

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

Specific tasks of the Review Panel

- Identify and commission an Independent Reviewer to work with the Review Panel in accordance with guidance for extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewer and Panel membership.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the Independent Reviewer a learning event for practitioners, to include identifying attendees, preparing and supporting them pre- and post-event, and arrangements for feedback.
- Plan with the reviewer contact arrangements with the individual and family members, where possible, prior to the learning event.
- Receive and consider the draft child practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft report and an outline action-plan and make arrangements for presentation to the Child Practice Review sub-group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- Review Panel members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the Practice Review Sub Group:

- Agree and approve draft Terms of Reference for each case recommended for a review.
- Agree conclusions from the draft report, an outline action plan and make arrangements for presentation to the Safeguarding Board for consideration and agreement.
- Monitor Child Practice Review action plans to ensure all recommendations are carried out

on behalf of the Safeguarding Board.

Tasks of the CYSUR Safeguarding Children Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a Child Practice Review.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final Child Practice Review report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or action-plan.
- Confirm arrangements for the management of the action plan by the Practice Review Sub Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on the CYSUR Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the CYSUR Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

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

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

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

- In working with sensitive information in relation to a Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews / Volume 3 – Adult Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
    - However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.