Child Practice Review Report

South East Wales Safeguarding Children Board
Historical Child Practice Review

Re: SEWSCB 2 / 2017

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*

Legal Context

A Historic Child Practice Review was commissioned by South East Wales Safeguarding Children Board following the recommendations of the Practice Review Group convened on 17th July 2017.

In accordance with the Guidance for Multi-Agency Reviews the criteria for this review are met under section 5. The Terms of Reference for the review are at **Appendix 1.**

Circumstances Resulting in the Review

This review concerns a family with 4 children who were subject to neglect, physical abuse and sexual abuse.

Full care orders were granted in March 2015 and the Police Case closed in August 2015. However following a review by the Police the case was reopened and further disclosures of sexual abuse were made by the children in June 2016. A decision was made at this point that the case should be referred to the Case Review Group for consideration of a Child Practice Review.

The time period for the review was agreed as from 1st July 2012 to 8th August 2015, when the police initially closed the case.

The review period covers 3 years. During these years the children were aged between 4 and 11 years old. One child has a learning disability, and another required additional educational support. They lived with their parents. There was significant parental input from a paternal aunt and her husband.

Information was obtained prior to July 2012 to inform the review as the family had been known to Social services. Historical information recorded that the family were first referred to Social Services in 2004 noting that the parents required additional support and that they had learning difficulties. There were repeated referrals to Social Services prior to 2012 for poor home conditions, parents not coping, a burn to one child with a delay in seeking treatment, and bruising to the younger children. During this time the family received additional support from services including Home Start, a Parenting Group, and Family Support Services (FST). The children were supported under section 17 Children Act 1989 as a Child In Need.

During the period of the review there were 4 referrals to Social Services. In 2012 there was an anonymous referral alleging that the children were ‘having sex’, were unkempt and the parents were not coping. A check was made with one school and a previous referral which had been for bruising to the younger children was noted. The case was closed with no action taken.

Later in 2012 the youngest child presented to the GP with unexplained bruising, resulting in a Social Services referral. A strategy discussion took place between Police and Social Services. It was agreed that Social Services would undertake a joint Section 47 enquiry which included a child protection medical due to the extent of the bruises. This was a single agency investigation as no Police were available at the time, under the agreement that Social Services would contact the police if required. The Child Protection Medical confirmed that there was no explanation for the majority of the bruises seen. Mother and Aunt attributed the bruising to another sibling. The outcome was section 17 Children Act 1989 as a Child In Need with a programme of additional support over the next three months

for the family.

In 2014 a 3rd referral was made by the school. The youngest child had presented with bruising, telling the school that they had fallen off a wall. During initial enquires the Aunt indicated that the bruising could have been caused by the same sibling who was previously alleged to have harmed the child and the parents stated that it was from jumping into a pool. The parents were asked to take the child to the GP by the Social Worker and the child remained open on Child in Need Plan.

The child was taken to the GP 15 days later and found to have extensive bruising to various parts of their body. The GP made a referral to Social Services (4th referral) for unexplained bruising. A strategy discussion was held, which agreed a Joint Section 47 enquiry should be conducted by Social Services and police. The Child Protection Medical was undertaken by a paediatrician who confirmed that bruises were in excess of what you would expect to find in a typically developing child. In addition some bruising was of a pattern consistent with trauma caused by an object. The parents agreed that all the children should be voluntarily accommodated with their Aunt and Uncle, with a contract of expectations put in place.

During the Social Worker's assessment the Aunt was noted to undertake a parenting role and admitted disciplining the children by smacking them. Despite this it was agreed that the children should remain with the Aunt and Uncle until the Child Protection Conference. However, this plan changed and the children were returned to their parents prior to the Child Protection Conference being convened. It is unclear what safeguards were put in place on their return home. All Children were placed on the Child Protection Register under the category of neglect.

The day after the Case Conference the mother made an allegation of sexual harassment against the children's uncle. She also reported that he had asked for sex with one of the children. A joint section 47 enquiry between Police and Social Services was initiated and a decision was made for the child concerned to be interviewed at school. That child told the police that they had been ''touched'' by their uncle. All Children were removed under Section 20 arrangements and became Looked After Children. Full care orders were granted

in March 2015 and the Police Case was closed in August 2015.

Further disclosures of sexual abuse have been made by the siblings outside the period of the review, after the children had been removed and accommodated into local authority care. These allegations have been investigated by the Police.

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

As part of this Child Practice Review, a Learning Event was held engaging practitioners involved with the family.

The reviewers would like to thank all those who attended and for their contribution to the learning from this review.

It was acknowledged that as this is a historical review, practitioners felt that current practice would prevent some of the failings noted. For example at the time of the review, a structured programme of support was delivered by a partner organisation based on a referral. Now that partner organisation works to develop the plan with the social worker in a way that takes account of previous support and this allows for a more holistic approach.

The discussions and suggested learning from the learning event reflected the thinking of the panel.

Themes and learning points

There were four overarching themes identified which have informed the learning points from this review.

Theme 1 – Lack of assessment of the parents' ability to parent and protect their children.

The records refer to the parents as having special needs and or learning difficulties, but no formal assessment of their parenting was undertaken at that time. There is evidence that the mother had a support worker for a period of time but it is not clear who or what their role was. As part of the Family Court process the parents were formally assessed, and the father was found to have a mild learning disability. The mother has a low IQ but no learning disability. Up to this point there were a number of terms used that all indicated that the parents had limited educational ability, but no consistent term was used.

At the time of the second referral during the period of the review the outcome was that a letter was sent to the parents advising them to self-refer to support services. It is not clear if they would have been able to understand what support they were being offered.

There was no evidence that services working with this family tried to understand what this impairment meant for them as parents and their ability to parent four children, two of whom required additional educational support. An assessment of the parents, focusing on lifestyle, support mechanisms and ability to work with practitioners, would have helped practitioners to measure the parents' capacity to meet the children's needs. This would have allowed ongoing monitoring and tailored support in a way that could have enabled the parents to sustain change rather than requiring repeating cycles of support, as was the case.

Given that it is documented that the parents had additional learning needs there was an opportunity for assessment at an earlier stage by professionals working with this family. A formal assessment was not initiated until the Family Court Proceedings, and this was a missed opportunity. The parents themselves were vulnerable in particular the father who was found to have a mild learning disability. He would not have had the same ability to

understand and process information.

Learning Point 1

Any assessment should consider the learning needs of the parents and their ability to meet the needs of their children. Any intervention must take into account the results of the assessment.

Theme 2 – Information Sharing

Information sharing is highlighted as an area for concern in many reviews. Decisions regarding safeguarding concerns must consider the previous history. Agencies must share the key events with partners to allow informed decision making.

The All Wales Child Protection Procedures 2008 states that ‘’A chronology should be prepared by each agency involved, to take account of all the background information available.’’ The Procedures suggest that a chronology is used when undertaking section 47 enquiries.

While it is acknowledged that this family was in most cases supported under section 17 Children Act 1989 as a Child In Need, there were three Section 47 enquiries during the period of the review.

Locally there is practice guidance for staff that was developed in response to the Serious Case Review Children E published in 2010 by Caerphilly Safeguarding Children Board. The review concluded that professionals would have had a better understanding/ overview of the case if they had access to an up to date chronology, either single or multi agency. More recently, this guidance was revised in response to Child Practice Review (Cases H and J), which were published in 2015 and 2016. In this case agencies had listed previous involvement in their assessments but there was no evidence of this information being used to identify trends or patterns.

Practitioners at the learning event noted that decisions were made based on the referral at

the time and did not consider historical information about the family. There was no account given of previous involvement in decision making, and a chronology could have prompted further exploration of the impact of previous interventions and whether these had resulted in a sustained change in behaviour. This led to a cycle of ineffective interventions.

At the learning event it was noted that during the School Holidays there is no formal process in place for schools to provide information. There was a suggestion from the Educational representatives that a mechanism for school staff to make information available or otherwise contribute to enquiries during holiday periods is explored.

Since the period of the review practice has changed in that agencies providing structured support work more closely with Social Services, with programs developed jointly. In addition they would now consider previous involvement when planning programmes of support.

While this is encouraging, the panel could not be assured that the use of chronologies is embedded within practice.

Learning Point 2

Educational Authorities to consider how information about a child is made available during school holidays in relation to safeguarding enquiries.

Learning Point 3

SEWSCB to be assured that all assessments take account of historical information which informs that assessment.

<u>Theme 3 – Following The All Wales Child Protection Procedures 2008</u>

Decision Making

The first referral for the period of the review was an anonymous referral in 2012 alleging that the children were ‘having sex’ and they were unkempt and that the parents were not

coping. A check was made with one school and the previous referral reviewed and this was closed with no action taken. The lateral check relied on the school having no concern regarding possible sexual abuse but the school did highlight concerns regarding poor hygiene and the previous referral had been for bruising. Based on the information presented, an initial assessment was indicated using the All Wales Child Protection Procedures 2008.

The first episode of bruising in 2012 led to the children being supported under Section 17 Child In Need, although the Child Protection medical had confirmed that there was extensive bruising with no explanation. This met the threshold to proceed to Child Protection Conference rather than remain as a Child in Need.

The Aunt and Uncle were seen as protective factors for this family. The Aunt is noted as providing parenting and support. Following the Child Protection Medical in 2014 when all four children were moved to the care of the Aunt and Uncle their role in providing care was not considered as a possible cause or contributory factor.

The decision to move the children to the care of the Aunt and Uncle was based on a Police National Computer (PNC) check, Children's Services systems check and information shared resulting from the section 47 enquiry and concerns raised by health. The children remained with the Aunt and Uncle for a period of up to 6 weeks without any legal framework being applied.

The record keeping relating to these decisions should be clearly documented including a rationale. From the review there was no clear rationale documented for these decisions.

During the period of the enquiries the Aunt disclosed to the Social Worker that she had on occasion smacked the children. At a legal meeting this was discussed and it was agreed that the children remain in the care of the Aunt and Uncle. There is no evidence that this decision was challenged in that the children were placed with a family member known to have smacked them.

The Child in Need Plan for this period stated that the children should remain with the Aunt

and Uncle until after the Child Protection Conference to allow the programme of structured support to be completed. From the review it is not clear on which date the children were returned to their parents but it is clear that they had all returned prior to the date of the Child Protection Conference taking place. Neither of these decisions were challenged or considered as inappropriate.

For practitioners at the Child Protection Conference it would be difficult to challenge something that has already occurred. None the less if an action is outside of an agreed plan there should be a clearly documented reason for this.

At a minimum Police and Social Services must make available appropriately skilled staff to conduct a section 47 enquiry. Following the second referral in 2012 (first in the time period for bruising) it was agreed that there would be a joint section 47 enquiry, but this was conducted as a single agency enquiry as no police officers were available. Social services are able to challenge and there is a process in place but in this case this was not used.

The multiagency hub was established in 2018 where agencies involved in the screening of referrals are geographically co-located with access to their organisations information so that multiagency screening can occur more effectively. Practitioners felt that the hub has improved multiagency working.

Effective challenge should underpin how practitioners work. This can be done informally and if required there are formal routes such as SEWSCB Multi Agency Practice Guidance Resolving Professional Differences. If we are to ensure evidence based thinking then staff need to feel able to appropriately question colleagues regarding decisions. There was no evidence that challenge was considered in this case when process was not followed.

At the learning event some practitioners stated that they viewed Social Workers as experts and they did not have enough knowledge to understand what is required of them. This meant that they may not feel able to challenge for example during the Child Protection Conference. The Business Unit of the SEWSCB is developing training which will address this point.

Learning Point 4

SEWSCB to be assured that rationale for decision making is clear and recorded in line with the All Wales Child Protection Procedures 2008.

Learning Point 5

SEWSCB to ensure staff feel empowered to appropriately challenge colleagues as part of their practice, both within their agency and between agencies. Staff should have access to Child Protection Supervision.

Disguised Compliance

The family would always engage with services offered. From the point of the first referral in 2004 the family were referred to a number of agencies who provided a structured programme of support. During the time of the interventions services would note an improvement and their input would end and this led to a cycle of improvement then deterioration.

''Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Published case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance. The learning from these reviews highlights that professionals need to establish the facts and gather evidence about what is actually happening, rather than accepting a parent's presenting behaviour and assertions. By focusing on outcomes rather than processes professionals can keep the focus of their work on the child.'' NSPCC website. Disguised compliance: learning from case reviews Summary of risk factors and learning for improved practice around families and disguised compliance. 2014.

When the child allegedly fell off a wall (2014) there were three differing accounts provided, but no evidence that the parents or Aunt were challenged about the differing accounts they gave. At both Child Protection Medicals the same sibling was reported to be the perpetrator of the injuries by the parents and Aunt and this was accepted as a plausible account during the enquiries.

During the core assessment following this referral, the parents told staff that the child with the bruising had not been left unsupervised, which meant that the other sibling could not have been the cause. When staff challenged as to how, if this were the case, the bruising had occurred they did not respond. These parents used disguised compliance by targeting another sibling as the cause of the bruising.

''The rule of optimism means that we are likely to give clients too many chances which is an adverse outcome for children in far too many cases. It exposes them to ongoing instability as child protection comes and goes without achieving successful outcomes.'' Social Work Helper, 28 Jul 2014

At the learning event practitioners noted that practice had been influenced by the rule of optimism.

Learning Point 6

Professionals need to be able to recognise disguised compliance by parents or carers: professional curiosity and healthy scepticism should be promoted.

Understanding the role of the Paediatrician in the Child Protection Process

The All Wales Child Protection Procedures 2008 advise that when a medical examination is indicated that a Paediatrician should be included within the strategy discussion.

When the child fell of the wall, the account of the injuries was inconsistent. There was no paediatrician involved in the strategy discussion. The outcome of the section 47 enquiries was that they remain open under section 17 Child in Need and the parents were asked to take the child to the GP for advice regarding the bruising. The parents went to the GP 15 days later. The GP noted a significant number of bruises with no explanation and they made a referral to social services. This was the second occasion that the GP had seen this child with unexplained bruising and on both occasions they made a referral to social services. The bruising could easily have faded in this 15 day window with important

evidence lost. Moreover, the child was not safeguarded during this period.

Following the 2nd Child Protection Medical (2014) a decision was made for all four children to be entrusted into the care of the Aunt and Uncle. At this point there was no evidence that there was consideration that the other siblings may require a CP medical.

Learning Point 7

A Paediatrician should be included in strategy discussions when a medical examination is being considered.
When concerning bruising is identified, the child should be referred to a paediatrician for child protection medical in a timely fashion.

Multi-Agency planning following a disclosure of sexual abuse.

The NSPCC website cites Radford and colleagues (2011) *"Child abuse and neglect in the UK today notes that most sexual abuse isn't reported, detected or prosecuted. Most children don't tell anyone that they're being sexually abused. It's a crime that is usually only witnessed by the abuser and the victim.''*

Following the allegation of sexual abuse by one of the children there was no consideration for a multiagency assessment in relation to child sexual abuse which should include assessment by Paediatrician. As already described, a Paediatrician should be involved at the strategy discussion stage when an examination may be required. Of concern in this case is that at no stage was this considered.

Specialist services such as Sexual Assault Referral Centres (SARCs) provide a holistic assessment of the child and an opportunity for multiagency working. This can include police video interviews, paediatric forensic examinations, counselling and ongoing support through the criminal justice process.

The lack of involvement of the paediatrician at the strategy discussion stage meant that a paediatric assessment for the child was not considered. The allegation was managed as a

criminal act, and did not take into account the wider issues for those children.

The panel acknowledges that there are challenges in access to the SARC locally; however this does not negate the need to consider these services in cases of alleged sexual abuse.

Learning Point 8

SEWSCB must be assured that there is effective multi-agency planning in relation to disclosures of sexual abuse, to include liaising with a paediatrician and SARCs to support families through the investigation.

Learning Point 9

SEWSCB must have a clear pathway in place for access to SARC services.

Theme 4 – Achieving Best Evidence

After an allegation of Sexual Abuse was made the children were not interviewed using Achieving Best Evidence (ABE) guidance.

The Ministry of Justice Guidance on interviewing victims and witnesses, and guidance on using special measures 2011 states: *"The purpose of this guidance is to assist those responsible for conducting video-recorded interviews with vulnerable, intimidated and significant witnesses, as well as those tasked with preparing and supporting witnesses during the criminal justice process. The guidance incorporates best practice from local areas and the expertise of practitioners, charities and voluntary groups who support victims and witnesses at a local level."*

The guidance is clear that core to any interview is preparation. Factors such as where, who should be present and what is being asked should all be agreed before the interview takes place. From the review it is clear that there was no planning involved when interviewing these children, and none of these points were considered. The child interview took place at school, with no prior discussion between Social Services and the police; there were 4 adults

present, 3 of whom were males.

This guidance supports this approach for all vulnerable groups, including children, and suggests that with appropriate planning and support even younger children can be interviewed. In this case a decision was made that the Child with a Learning Disability would not be interviewed using this guidance. This was a missed opportunity.

During March 2016 Her Honour Judge Mifflin wrote to the Children's Commissioner for Wales with regard to a number of sexual abuse cases where the evidence presented by Social Services and Police fell below the required standard. One of these cases related to the subjects of this review. She requested that the Children's Commissioner look at copies of her judgements and refer on to the appropriate bodies. This letter was copied to the Chair of SEWSCB to ensure the concerns were discussed with Board members.

In early May 2016 the Children's Commissioner asked for assurance from SEWSCB that this concern was being addressed. In the intervening two months Police and Social Services leads had met and discussed a strategy to ensure that relevant frontline staff would all receive ABE awareness raising training. This was fully discussed at the May 2016 SEWSCB.

This process was further discussed at the next two SEWSCB meetings and assurances were given that this training had been completed for all frontline staff that would be involved in speaking with children directly. At this point the Chair of SEWSCB wrote to the Children's Commissioner to confirm the actions taken.

Learning Point 10

Police and Social Services must provide SEWSCB evidence that Achieving Best Evidence guidance on interviewing children has been implemented and fully embedded in their practice. The Quality Assurance Framework or equivalent framework will measure compliance of ABE Guidance.

Good Practice / Improvements already made

- Newport Safeguarding Hub Pilot commenced in 2018, which brings key organisations together at the screening stage has strengthened multi agency working.
- Barnardo's now has closer links with Social Services so that they are involved at the point of referral and will plan any support plan with the social worker taking account of previous interventions.
- School Nursing and Education recorded outcomes of Child Protection Conferences within records.
- GP on two occasions made referrals to Social Services. On both occasions this led to Child Protection Medicals and a Child in Need Plan on one occasion and Child Protection Plan on the second.
- Police and Children's Social Services have completed training in Achieving Best Evidence.

Improving Systems and Practice

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

Learning Point 1

Any assessment should consider the learning needs of the parents and their ability to meet the needs of their children. Any intervention must take into account the results of the assessment.

Learning Point 2

Educational Authorities to consider how information about a child is made available during school holidays in relation to safeguarding enquiries.

Learning Point 3

SEWSCB to be assured that all assessments take account of historical information which informs that assessment.

Learning Point 4

SEWSCB to be assured that rationale for decision making is clear and recorded in line with the All Wales Child Protection Procedures 2008.

Learning Point 5

SEWSCB to ensure staff feel empowered to appropriately challenge colleagues as part of their practice, both within their agency and between agencies. Staff should have access to Child Protection Supervision.

Learning Point 6

Professionals need to be able to recognise disguised compliance by parents or carers: professional curiosity and healthy scepticism should be promoted.

Learning Point 7

A Paediatrician should be included in strategy discussions when a medical examination is being considered.

When concerning bruising is identified, the child should be referred to a paediatrician for child protection medical in a timely fashion.

Learning Point 8

SEWSCB must be assured that there is effective multi-agency planning in relation to disclosures of sexual abuse, to include liaising with a paediatrician and SARCs to support families through the investigation.

Learning Point 9

SEWSCB must have a clear pathway in place for access to SARC services.

Learning Point 10

Police and Social Services must provide SEWSCB evidence that Achieving Best Evidence guidance on interviewing children has been implemented and fully embedded in their practice. The Quality Assurance Framework or equivalent framework will measure compliance of ABE Guidance.

REVIEWER 1	Ann Hamlet	**REVIEWER 2** ***(as appropriate)***	Kelly Turner
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		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	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Ann Hamlet	**Name** *(Print)*	Kelly Turner
Date	21/05/2019	**Date**	21/05/19

Chair of Review Panel (Signature)	
Name *(Print)*	Dr Alison Mott
Date	22/ 05/ 19

Appendix 1: Terms of reference

Child Practice Review process

To include here in brief:

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

Child Practice Review Process

The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government on 13th November 2017 that it was commissioning a Historical Child Practice Review in respect of a four siblings.

Reviewer: Ann Hamlet, Head of Safeguarding, Aneurin Bevan University Health Board

Reviewer: Kelly Turner, Child Protection Coordinator, Monmouth Children's Social Services

Chair of Panel: Dr Alison Mott, Designated Doctor, Public Health Wales

The services represented on the panel consisted of:

- Gwent Police
- Children's Services
- Adults Services
- Aneurin Bevan University Health Board
- Education
- Barnardo's

The Panel met regularly from October 2017 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

A Learning Event took place in April 2018 and was attended by the following agencies:

- Aneurin Bevan University Health Board
- Education
- Gwent Police
- Children's Services
- Adults Services
- Barnardo's

Family Members

Relevant family members were not informed that the review was taking place as there was an ongoing Police investigation. This meant that any meetings would have needed agreement from CPS and timings did not allow this. The panel felt that it was not appropriate to delay the process by waiting.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SCB Chair…….

Date circulated to relevant inspectorates/Policy Leads …….

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

Appendix 1

Terms of Reference
Historical Child Practice Review
In Respect of SEWSCB 02/2017

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child 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:
    - Ongoing Police Investigation
- Hold a learning event for practitioners and identify required resources.

In addition to the review process, to have particular regard to the following:

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

- To take account of any additional needs of the adults within the family, and whether these were these identified and addressed?

- To understand whether the additional learning needs of the adults in the family impacted on their ability to keep the children safe? Was there any assessment process to establish the extent of their learning difficulties?

- To explore issues connected with the Child Protection process from first point of disclosure to placement.

- To establish whether achieving best evidence guidelines were used to good effect.

- To examine the extent of professional challenge across agencies.

- To explore how professionals communicated with the children in the family and across agencies.

- To ensure that the review spans across adult and children arena.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.

- Agree the time frame for the review from 1st July 2012 to 8th August 2015.

- 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.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board 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.

Tasks of the Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Pane*l complete the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.