Protecting Children Briefing Paper

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The Welsh Child Practice Review

This briefing presents the main features of the Child Practice Review Framework developed in Wales. The Framework consists of formal, multi-agency review processes carried out on behalf of the Local Safeguarding Boards[1], to identify lessons from particularly complex or difficult cases. Whilst there is a high degree of similarity between practice reviews for adult protection and child protection, only the latter will be addressed in this briefing.

The need for change

Wales replaced its process for conducting 'serious case reviews'[2], following a 2009 report of the Care and Social Services Inspectorate Wales which found that the process had become ineffective in improving practice and inter-agency working.

New arrangements were developed through a process of extensive consultation, testing and piloting, which led to a new 'practice review' framework being rolled-out across Wales in January 2013 and transposed into national guidance. (Welsh Government, 2015)

Underpinning features

The shift in terms of language, from 'serious case review' to 'practice review', echoed the shift in culture – the overall purpose was to promote a positive culture of multi-agency learning and practice improvements.

PRINCIPLES of the Child Practice Review Framework

- Professionals are given the assistance they need to undertake the complex and difficult work of protecting children with confidence and competence.
- A positive shared-learning culture is an essential requirement for effective multi-agency practice.
- Organisational cultures and processes are experienced as fair and just, and promote supportive management and work environments for professionals.
- A culture of transparency is created that, among other things, provides accountability and reassurance, has processes open to professional and public challenge, engages with and includes the perspectives of children and families.

[1] The Safeguarding Adults Boards and Safeguarding Children Boards in Wales are multi-agency local bodies, the latter being tasked to promote the welfare of children and young people at local level, similar to 'Child Protection Committees' in Scotland.
[2] The processes similar to 'serious case reviews' (England and Wales) are called 'significant case reviews' in Scotland.

Some significant features of the Welsh Child Practice Review Framework include:

- The involvement of agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future;
- The potential to develop competency and more confident multi-agency practice in the long term;
- The focus placed on accountability and not on culpability;
- A recognition of the impact of the tragic circumstances of non-accidental child deaths or serious harm on families and on staff, providing opportunities for serious incidents to be reviewed in a culture that is fair and just;
- Strengthen accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need;
- A more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases. (Welsh Government, 2016, pp. 1-4)

Criteria for and types of child practice review

Criteria

Child practice reviews take place following a significant incident where abuse of a child is known or suspected and the child has died, sustained a life threatening injury or serious and permanent impairment of health or development.

Two types of review – concise and extended

Concise:	Extended:
Specific criteria: The child was neither on the Child Protection Register nor a looked after child on any date during the 6 months preceding the significant event or the date on which the permanent impairment was identified.	**Specific criteria:** The child was on the Child Protection Register and/or was a looked after child, including a care leaver under the age of 18 on any date during the 6 months preceding the significant event or the date on which the permanent impairment was identified.
Undertaken by: one reviewer, independent of the case, according to the guidelines (there were however cases with two reviewers).	**Undertaken by**: Guidelines recommend two reviewers, independent of the case (implementation has also seen one reviewer only). **Additional element**: it considers the Child Protection Plan (e.g. robustness, effectiveness of implementation, monitoring and review, strengths and weaknesses).
Both:	
Managed by: a Review Panel, with representatives from those agencies involved in the case, with working knowledge of the services but without direct involvement in the case. **Timeline**: normally, up to 12 months preceding the incident, given that the focus should be on current practice; however, exceptional circumstances might require a longer timeline, recommended (but not limited) to be up to 24 months, and could also include decisions and actions following the incident. The Framework, specifically adapted, can also be used for historic reviews or specific incidents. **Length**: the process should be completed as soon as possible; but usually within six months, as the guidance recommends. (Welsh Government, 2016, pp. 12-29)	

Whilst the terms 'concise' and 'extended' might create the expectation that the first could be less complex, hence shorter and not as resource demanding as the other, it is useful to note that the above criteria do not refer to the complexity of the case, but to the child being or not on the Child Protection Register or looked after. Moreover, an evaluation of the Framework found little difference between the two types in terms of resources, with an average of 12 months required for completion. The final reports were found to have similar length, content and recommendations. (Welsh Government, 2015, pp. 20-29)

The Welsh approach is sometimes described as a tiered review model. However, a more complex case does not necessarily imply an 'extended' review, as long as the child was not on the Child Protection register or looked after.

Multi-Agency Professional Forums

The Forums are facilitated events for practitioners and managers from different agencies, set up by each Safeguarding Board as part of their continuous programme of active learning:

- To improve local knowledge and practice, including the quality of work with families and strengthening the ability of services to keep children safe;
- To examine practice and support case learning, which might include complex cases where there were good outcomes, current cases that have become stuck or cases that do not meet the criteria for any of the two types of child practice review;
- To disseminate findings from child protection reviews, audits and inspections;
- To provide opportunity for reflective learning, consultation and supervision;
- To inform future audit and training priorities. (Welsh Government, 2016, pp. 9-11)

Learning framework

The identification of the practice and organisational learning is drawn from:

- Production and analysis of merged timelines and genograms (Police software was found to be very useful).
- Analysis of case records;
- Planned and facilitated Learning Event(s):
    - Facilitated by the reviewer(s), to examine current case practice within an agreed limited timeline and using a systems approach.
    - Practice reviews will always have a Learning Event for practitioners who have been working with the child and family, and their managers.
    - Learning Events for senior managers were also organised during some practice reviews and proved useful (Firth, 2019).
- Family perspectives: practice reviews engage directly with children and family members, if they wish and as appropriate.
- Discussion at Review Panels (several meetings take place during a review).
- Reviewers' analysis and literature review. (Welsh Government, 2016)

> The Learning Event is a centrepiece of the Practice Review Framework: *"there was consistent support for the Learning Event which was felt to be a quality product, supporting the emphasis of a learning culture for practitioners and managers across agencies"* (Welsh Government, 2015)

Outputs

The final report

- Is approved and published by the local Safeguarding Children Board and must appear on their website for at least 12 weeks;
- Is submitted to the Welsh Government, at least two weeks before the proposed date of publication by the Board. (Welsh Government, 2016, pp. 19, 27-28)

The action plan

- Finalised within four weeks of the final report; its aim is to lead to improvements in child protection practice;
- The implementation of the action plan must be regularly reviewed and progress should be reported to the Safeguarding Children Board;
- The Safeguarding Children Board must ensure action plans are being carefully audited;
- The Safeguarding Children Board must submit a report to the Welsh Government on the differences the actions have made to practice, for information purposes. (Welsh Government, 2016, pp. 5-6, 19-20, 28)

Note: The role of the Welsh Government also includes receiving notifications from local Boards about the intention of conducting a practice review, but it does not hold a quality assurance, monitoring or directive role, which falls under the responsibility of local Boards (Welsh Government, 2015, p. 6).

Implementation of the Framework – key learning

Implementation in Wales

A 2015 evaluation, commissioned by the Welsh Government, looked at the first years of implementation of the Child Practice Review Framework and found that transition happened at a different pace across Wales, with adaptations of the guidelines sometimes occurring (e.g. flexibility regarding the number of reviewers).

The majority of the stakeholders consulted during the evaluation were clear that they preferred 'child practice reviews' to 'serious case reviews', describing the new process, especially the Learning Event, as a positive change, that brought a new ethos, drove reflective learning and offered a form of therapeutic support for practitioners. The involvement of families was also found to be positive, bringing considerable value to the process.

> There was a general sense that the reviews are very different from what went before, more proportionate, succinct and focused, and gave a voice back to practitioners, without a loss of focus on improving practice; the change *"has resulted in a palpable move away from a blame culture to one that supports learning"* (Welsh Government, 2015)

In terms of limitations or areas for improvements, the Welsh evaluation identified the following:

- The processes took significantly longer than expected (12 months on average, compared to six recommended by the guidelines). Closely connected was the need of having the same people in the Review Panels throughout the duration of the process, which raised concerns for the capacity of staff at all levels to coordinate diaries and allocate the time and resource required for good quality reviews. This led to recommending partner agencies to build in capacity and support all staff involved in reviews.
- Where it was the case, the external investigations (such as criminal proceedings or disciplinary issues) and the child practice reviews were not considered closely aligned, with implications for local boards (sometimes asked to suspend the review process), professionals and families (sometimes not being able to be part of the practice review).
- A wider dissemination of the learning taking place within the Learning Event was recommended, as a number of stakeholders feared the risk that this would be retained mostly by those directly involved in the event.
- Whilst the 'multi-agency professional forum' was designed as an alternative for cases not meeting the criteria for child practice reviews, as well as a platform for learning from positive cases and practice reviews, limited information in this respect was available.
- Similarly, considerable improvement was recommended in the wider dissemination of learning at regional and national level and across reviews. The extent to which child practice reviews result in actual changes to practice remained an area for further evaluation. (Welsh Government, 2015)

Wider implementation and adaptation

Several local boards in England, as well as Jersey, have been using the Child Protection Review Framework. Amongst them is Lancashire Safeguarding Board whose experience allowed a comparison with the 'traditional' approach. Significant advantages of the Welsh model were found – the reports were shorter in length and retained rigour and clarity, being also significantly less resource intensive (commissioned at one third of the cost of the 'traditional' English approach). The Practitioner Events were well received and found to enable inclusivity, support and co-production.

There was however a wide agreement that the recommendations and the action plans left room for improvement, particularly in terms of their implementation, irrespective if they were produced through the Welsh approach or the 'traditional' one. A note of caution is nevertheless necessary, as the governance and accountability function of partner agencies was sometimes described as problematic. (Kingston at all, 2018)

> Overall, the Welsh Framework was *"well received as an evolving work in progress, with on-going adaptations and flexibility key to its success"* – reviewers adapted the methodology, for example by incorporating a short chronology in the final report to provide more clarity around the circumstances of the case. (Lancashire Safeguarding Boards, 2018)

Discussion

The different evaluations of the Welsh Framework confirmed its advantages in terms of quality of reports, costs and a change in ethos and culture from blame to learning, with flexibility and adaptability being key to implementation. Evidence shows that dissemination alone is insufficient for change to happen – further understanding is thus needed of the wider system that has to be in place to maximise learning and implement the change identified through reviews. This would also include aspects of strengthened governance and accountability, as well as adequate support for reviewers (including in relation to training and continuous development for their role) and partner agencies to facilitate the right conditions for learning.

Similar to Wales, Scotland has been looking at ways of strengthening the learning culture, including in relation to 'initial case reviews' and 'significant case reviews'. Based on the findings of the Child Protection Systems Review, the Scottish Government became interested in exploring the extent to which the Welsh Child Practice Review Framework could inform improvements in the Scottish review processes, as mentioned in the Recommendation 8 of the Child Protection Systems Review (Dyer, Scottish Government, 2017). The recommendation was fully adopted by the Scottish Government's Child Protection Improvement Programme, in March 2017. The recommendations regarding initial and significant case reviews are being progressed, on behalf of the National Child Protection Leadership Group, by CELCIS and the Care Inspectorate, in partnership with key agencies and bodies.

References

Care and Social Services Inspectorate Wales (2009*), Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews*.

Dyer, C., Scottish Government (2017), *Protecting Scotland's Children and Young People: It is Still Everyone's Job. Child Protection Systems Review*, Edinburgh.

Firth, B. J., (2019), *Undertaking SCRs the Welsh Model*, presentation given for Aberdeen City Child Protection Committee, March 2019 (unpublished).

Firth, B. J., Welsh Government (2012), *Child Practice Reviews: Guide for Organising and Facilitating Learning Events*, Cardiff.

Hill, L. (2016), 'Background Paper Three: Significant and Initial Case Reviews', *Scottish Government Child Protection Systems Review: Child Protection Committees, Child Protection Registers & Case Conferences, and Significant and Initial Case Reviews*, CELCIS, University of Strathclyde.

Kingston, P., Eost-Telling, E., Taylor, L., Lancashire Safeguarding Boards (2018) *Comparing safeguarding review methodologies*

Scottish Government (2017), *Child Protection Improvement Programme Report*, Edinburgh.

Scottish Government (2015), *National Guidance for Child Protection Committees: Conducting a Significant Case Review*, Edinburgh.

Scottish Government (2014), *National Guidance for Child Protection in Scotland 2014*, Edinburgh.

Social Services and Well-being (Wales) Act 2014

Welsh Government (2016), Social Services and Well-being (Wales) Act 2014: Working Together to Safeguard People Volume 2 – Child Practice Reviews. Part 7: Guidance on Safeguarding, Cardiff.

Welsh Government (2015), 'Review of the implementation of the Child Practice Review Framework', *Social Research No. 45*, Cardiff.

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