Findings from a thematic analysis of Child Practice Reviews in Wales

Dr Alyson Rees

School of Social Science Cardiff

University

Dr Roxanna Dehaghani

School of Law and Politics Cardiff University

Dr Thomas Slater

School of Social Science Cardiff

University

Dr Rachel Swann

School of Social Science Cardiff

University

Professor Amanda L Robinson

School of Social Sciences

Cardiff University

Background

This research project was commissioned by the National Independent Safeguarding Board to push forward the intellectual agenda and learning that can be achieved from a systematic analysis of Child Practice Reviews (CPRs). Furthermore, this research provides an opportunity to maximise the value from such reviews; these are costly investments and are potentially underutilised as learning resources. The current study builds upon an earlier study of adult death reviews, funded by the National Independent Safeguarding Board (see Robinson, Rees and Dehaghani, 2018). A range of cross cutting themes were identified (faulty assessment, tunnel vision, crossing boundaries, hoodwinking and privileged knowledge) and these will be considered alongside the findings of this report.

CPRs became a statutory requirement in Wales in 2013, replacing Serious Case Reviews (now only in England). Wales took an innovative step in moving away from Serious Case Reviews. The new process stemmed from the Care and Social Services Inspectorate Wales report - *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews* (Welsh Government, 2009). 'The overall purpose of the reform to the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which Local Safeguarding Children's Boards and partner agencies hold responsibility' (Welsh Government, 2012:1).

A key element of the CPR framework has been the introduction of two different type of reviews known as 'concise' and 'extended', depending on the circumstances involved. Concise reviews take place where the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding (WG, 2012:5). Historic reviews can also be undertaken in certain circumstances (see Annex 3, Welsh Government, 2016). All CPRs must be approved by a Regional Safeguarding Children's Board (RSCB) and then submitted to Welsh Government. CPR reports then appear on RSCB's websites.[1]

A recent review into implementation CPRs was undertaken on behalf of Welsh Government (Welsh Government, 2015). Findings focussed on the implementation of the CPR Framework, including decision-making, time and resources, practitioner involvement and effective dissemination. However, there is no prior research on the

---

[1] Contemporary guidance on CPRs can be found in *Working together to safeguard people – Volume 2 – Child Practice Reviews* (Welsh Government, 2016) (issued under section 145 of the Social Services and Well-being (Wales) Act 2014).

content and themes emerging from CPRs. One of the most recent and directly relevant studies available is an analysis of Serious Case Reviews (the English equivalent to CPRs), which identified the following themes: assessment and thresholds, hearing the voice of children and families, communication and information sharing (Sidebotham et al., 2016). Other syntheses of reviews into deaths and serious incidents have shown the importance of: increased training for healthcare professionals; improved risk assessment and improved responses to those with complex needs; missed opportunities for safeguarding children and improved record keeping (Neville and Sanders-McDonagh, 2014; HIW, 2016; Sharps-Jeff and Kelly, 2016). The current study aims to identify the key themes from CPRs, and compare these to learning from other types of reviews (DHRs, APRs and MHHRs), in order to generate new knowledge to improve future inter-agency practice. It is hoped that findings from this research will help improve practice amongst those charged with undertaking reviews and inform the governance arrangements going forward for reviews and inspections taking place in Wales.

Methodology

The overall approach to this study is qualitative, involving the thematic coding of reviews complemented by focus group discussions with practitioners from across Wales.

<u>Sample</u>

The sample of reviews to be coded was provided by the NISB. A total of 20 Child Practice reviews - completed between 2014 and 2019 - were triple coded by the research team from legal perspective, an academic perspective (criminology) and practitioner perspective (social work). The project team was assembled to deliver a robust, multi-disciplinary overview of CPRs in Wales. One of the CPRs was a historic review that had been promoted by disclosures made by the index child whilst incarcerated. Nine of the CPRs were undertaken as a result of a child death, with causes of death ranging from factors associated with medical and/or other forms of neglect (including lack of supervision), filicide (i.e. killing of a child), and suicide. It was unclear in one of the CPRs (13) whether a child had died. Other reviews were prompted by a range of adverse events with concerns ranging from sexual abuse/exploitation, physical abuse (often by a parent or partner of a parent) and neglect. Emotional abuse was present in many of the cases but did not seem to feature as a primary reason for a CPR to take place. Unsurprisingly, many of the CPRs identified that young people had been subject to a number of different forms of abuse, often over protracted periods of time.

An overview table of the sample, containing key details of each review, is contained in Appendix A.

Coding framework

A method and framework to identify key themes was established by the research team. Briefly, this involved reading and discussion of three CPRs by four researchers (law, academic and two practitioners), which then enabled the development of a coding framework. Researchers were asked to identify up to five key themes under each of the following categories: Residence/circumstances of child; Perpetrator/s (if there was one); Other demographic information; Characteristics of abuse; Agency performance – Children's Services; Agency performance – Health (Including CAMHs); Agency performance – Education; Agency performance – Police; Agency performance – Other (including third sector); Multi-agency partnership working; Identification of good practice; Key recommendations going forward; Comments on quality of CPR; Other comments (e.g. from an academic, practitioner or legal perspective).

As per the research specification, each review was thematically coded by each member of the coding team. This resulted in coding being undertaken from an 'academic', 'practitioner' and 'legal' perspective (i.e. a minimum of three sets of coding per review). Weekly team meetings over a five-week period were used to discuss batches of reviews. After the coding was completed, the results were combined into a single Excel database, containing the coding from every team member, so that these could be evaluated for their similarity and points of divergence. Ultimately, this exercise revealed only small differences, even though the research team was notionally assembled to bring three different perspectives to the coding. This is discussed later in the report.

From the coding exercise, a group of four cross-cutting themes was identified plus an additional aspect of key structural challenges and procedural issues, to provide the structure for the focus group discussion. These four themes were subject to a validity check through the discussion and feedback provided by the practitioner focus groups. An overview table depicting how the themes relate to each CPR review is provided in Appendix B.

Focus groups

Focus groups were undertaken to discuss the identified themes and gain feedback on potential interpretation of their meaning. Participants for focus groups were identified by the NISB. One focus group was held in North Wales (Wrexham) and one in South Wales (Cardiff). The information was not sent out by NISB until a relatively late stage and as a result there were only two attendees at the Wrexham focus group; ten participants attended the Cardiff group. Both focus groups lasted two hours. As so few were able to attend the Wrexham focus group a summary of the emerging themes was sent out via NISB to those who could not attend to garner their thoughts about whether

these resonated with practitioners' experience and to gather comments on CPRs more generally.

Invitations to participate in a brief online survey to gather background information were sent to practitioners registered to attend one of the two focus groups. Eleven responses were received. Participants occupied a variety of practice, managerial and strategic roles within police, Social Services, probation and health. Participants were asked to indicate their level of experience with each type of review (no experience; have read this type of report; have participated by providing evidence or information; have had overall responsibility for the process; have had strategic responsibility for ensuring that recommendations are implemented). All participants had some level of knowledge and/or experience with CPRs.

Many of the comments in the survey related to the need to review the difference that recommendations have made and the impact of action plans:
- 'Actions need to be measurable and not a wish list'
- 'Monitoring of learning outcomes, ensuring that recommendations are accepted at a strategic level and are trickled down to operational staff'
- 'Where themes emerge then particular training or action needs to be taken to address the issue'

Some respondents commented on the need for wider dissemination of CPRs: • 'Regional Safeguarding Boards could do more to promote learning from all reviews and research, audit the effectiveness of implementation of recommendations and develop a culture of continuous improvement in safeguarding and child protection practice across all agencies'
- 'Prompt completion and publishing of reviews. Wider dissemination of the reviews and findings. Wider participation in the learning events by multi agency staff. Opportunities for multi-agency training, shadowing roles etc.'

Others noted the resource and time implications of the CPR process:

- 'I am aware of [problems] in our region: problems finding chairs and reviewers due to capacity within agencies and timescales being stretched due to ongoing police investigations'
- 'Resource implications for agencies providing reviewers, chairs and panel members'
- 'Practice Reviewers: are they qualified, [do they] have the right experience?' There was some consistency across survey respondents and several of the themes of workload and dissemination were identified in the analysis of the

CPRs. Although the focus groups were not recorded, notes were taken at the time and then consolidated immediately afterwards into a written account of the key themes. This information was then supplemented by an opportunity for all participants to provide feedback via a short survey afterwards.

<u>Limitations</u>

A brief comment on the study's limitations is necessary, before proceeding to the main findings. Firstly, the sample was a convenience sample provided by the NISB. It does not necessarily provide a representative sample of CPRs that have been carried out in Wales. However, they were chosen with a view to ensuring a wide geographic spread of cases within Wales, and to illustrate the diverse range of issues that tend to be found in such reviews. Although the NSPCC estimates that 29 CPRs have been completed to date, which means the sample analysed here represents about two thirds of the total, further research with a larger sample is needed to substantiate our findings.

Findings

The four cross-cutting themes identified from the coding exercise and confirmed by the focus group discussion are discussed in the sections that follow.

Theme 1 – Hierarchy of Knowledge

From reading the CPRs it was evident that some knowledge was privileged (CPRs 1, 3, 4 5, 6, 7, 9, 10, 11, 12, 14, 15, 16, 17 and 18), and this resonates with a theme identified in our previous research (Robinson et al., 2018) whereby professional knowledge was seen to take precedence over personal knowledge. Certain professional views were privileged above others in this study as well, although this was sometimes difficult to determine, as reports often referred to 'practitioners' or 'professionals' generically. This theme resonated with the focus group participants who highlighted difficulties in managing differences when, for example, a medical professional says there is no or insufficient evidence of child abuse, but the nonmedical professional believes otherwise. The decisions of professionals (e.g. medical diagnosis or an arrest/charge) were seen to be based on 'objective' knowledge, which was seen to be superior to the 'subjective' judgements or opinions of paraprofessionals, family, and community members. The views of professionals were listened to and privileged above those of parents; for example, parents worried about their son who went on to kill himself (CPR 10). The views of community members were seen to be less reliable and therefore less influential (e.g. when they made their concerns for a child known to agencies, see CPRs 16, 18). There was

broad agreement in one of the focus groups that community referrals are not always given appropriate credence.

This hierarchy of knowledge led to 'tunnel vision', where certain attitudes are formed and then become hard to challenge (CPRs 1, 4, 11) (Munro, 2011). Further to this, the focus groups identified that the potential for tunnel vision could arise in group contexts. For example, practitioners collectively constructing narratives about the situation of a family can create the potential to overlook new evidence that challenges the original narrative. Tunnel vision was noted to be an issue in practice, but hard to overcome, reinforcing earlier work (Robinson et al., 2018).

In addition to a hierarchy of knowledge with professionals at the top, there was a hierarchy within families. There was a sense that adults were listened to (CPRs 11, 12 and 15) and believed more than children (see also themes 3 and 4 below). Furthermore, the views of mothers tended to be privileged over both children and fathers (CPRs 5, 14 and15). The focus groups identified that fathers were often absent from discussion and intervention in practice. As a result of an 'assumed' absence of fathers, the onus of care was often placed solely with mothers or grandparents (CPR 3) in practice. However, attempts were made to involve fathers in CPRs (CPR 15).

Finally, it is inevitable that interdisciplinary and multi-agency working will at times result in different opinions about the risks posed to the welfare of a child. Where professional disagreements exist, it is essential that both practitioners and managers across agencies utilise resolving professional differences protocols. This was absent in the cases reviewed (CPRs 5, 10 and 17). These processes should not be seen as punitive or adversarial, rather they represent a space for professionals to discuss concerns in an open forum. These need to be utilised more readily to effectively explore concerns and identify what actions are needed by different agencies going forward.

Theme 2 - Information sharing/recording

Information sharing was regularly noted to be an area for improvement in the CPRs. Specifically, professionals were often noted to be unsure about when they could, or should, share information without consent in instances where support to a family was not taking place under the auspices of a safeguarding concern (i.e. non-child protection) (CPRs 1, 2, 3, 4, 6, 7, 9, 11, 14, 15, 16, 17, 19 and 20). As Lord Laming (2003) noted in the Victoria Climbie inquiry, the sharing of information in such circumstances is permissible so long as a clear justification exists and is carefully recorded. Concerns about complaints being made over inappropriate sharing of information, and/or a belief that other agencies were already aware of the information, were both cited as reasons details were not being shared. The focus groups were both

alert to issues around information sharing and it was noted to be an ongoing and complex issue. The concerns about information sharing were noted both within and across agencies in different reviews, however, some types of problems were more consistent and problematic than others, for example, in CPR 6 information was not shared well between hospital and community staff, which placed the young person at higher risk despite the GP and health visitors being particularly proactive in following up on missed appointments. In CPR 11, a young person was only able to engage with CAMHS in their new area due to the input from their GP, because a CAMHS to CAMHS referral did not appear to have taken place. In CPR 7, concerns were raised about the sharing of information between substance misuse services supporting the mother and other agencies.

Concerns about information sharing within and across organisations were also noted between adult and children Social Services departments (CPR 19). Where concerns were raised for the welfare of a parent, checks were not always being made with adult services about any children they may have (CPR 9) (see also theme 3).

In one family (CPR 2) of 6 children, the mother was pregnant with a seventh child. Two children had been adopted, and two had been fostered. Some of the children were fostered out of county and there was no sense that each child was part of the same family; information was not shared across local authorities. When working with large families it is essential that multi-agency working takes place to meet the needs of children both individually and collectively. Different IT systems can serve to complicate information sharing; this was particularly acute for large families who were as a result sometimes required to attend multiple appointments for different children in different places at the same time (CPR 1).

The lack of access to information was something that could be hindered by Children Services' failure to pass on information to other agencies in a timely manner. For example, in CPRs 15 and 16 Social Services were noted to have failed to pass on information received from the police[2] to other agencies. Equally, Children Services did not always alert other agencies that they were withdrawing support to a child(ren)/family; this has the risk that it may give those agencies still working with a child(ren)/family a false sense of security and/or lead to further breakdowns in communication going forward. Perhaps most worryingly, CPR 2 and 4 both noted poor information sharing between Children Services departments in different local authorities. In the former, a family had been in receipt of support from both agencies at different points in time, hindering access to historic information that is often essential for effective risk assessment. With regards to the latter, out of county placements resulted in essential information for safeguarding the welfare of the child was missing.

---

[2] It should be noted that the police were consistently noted to be proactive in providing information to children services, although there was a tendency to rely on children services to disseminate information to other agencies.

The problems from 'crossing boundaries' were also found in our previous study (Robinson et al., 2018).

In addition to concerns about sharing information, our analysis also identified issues with approaches to recording information, including: (i) record keeping; (ii) consistency of language; and, (iii) chronologies. Producing accurate and clear records was regularly identified as an important skill across professions. When information is shared, or a referral is made, both the referrer and the referee must record this (CPR 3). In CPR 3 it was noted that referrals made by phone were not followed up in writing within two working days as expected. In CPR 5 information passed to Social Services was not always seen or recorded as a referral. Practitioners across agencies need to be clear about what constitutes a referral, how it is logged and what happens as a result of this. This is particularly important where a referral has been made by one agency, but no further action was felt necessary by the receiving agency. These decisions need to be recorded and communicated, to avoid agencies having to chase to find out what action (if any) has taken place.

Multiple CPRs (2, 4, 7 and 17) noted that inconsistent language use across agencies can lead to adverse outcomes of children. Specifically, loose terminology regarding home conditions in cases of neglect can hinder understandings of risk and impact on court processes (i.e. poor or inconsistent evidence). Equally, different terminology across agencies can lead to confusion and inappropriate assumptions about risk. In CPR 7, a lack of consistency around substance misuse was noted as being problematic in multi-agency working. Confusion can result not only from word choice but also by the use of acronyms. Working across multiple systems creates opportunities for misunderstanding. For example, CPR 4 noted that multiple risk assessments around sexual exploitation existed across agencies. The name of assessments and their purpose was not clear across agencies and this served to impinge on effective multi-agency working.

Theme 3 –Partial assessment

The theme of partial assessment was prevalent (CPRs 1, 2, 3, 4, 5, 6 ,7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20) and reinforces findings from our previous study. In CPRs we found similar problems such as practitioners sometimes evaluating people as individuals without due regard for their domestic/family context (CPRs 1, 3, 4, 9 and 20), which is particularly problematic for children. For example, individuals with drug and alcohol problems (CPRs 1, 6, 7,11 and19), mental ill-health (CPRs 2,5,12,14 and 18) or unspecified health difficulties (CPRs 8, 9 and 16) might also be parents, but this was not routinely considered, nor the impact on any children evaluated or addressed (CPRs 1, 2 and 9). Taking an individualistic approach meant that the views of all professionals and services involved were not joined up (e.g., where concerns were raised about the welfare of an adult, there was not always a check to see if they were

parents, and subsequently opportunities for intervention may have been missed) (CPRs 7 and 11). Practitioners need to ask more about new partners, particularly where there is a history of domestic abuse (CPR 2).

It was also difficult for the readers of the CPRs to get a picture of the whole situation. In some cases, the research team could not tell whether adult services were involved (CPR 16). It is not always clear who the child(ren) were living with at the time of the incident that triggered the review, or whether they had siblings (CPRs 12, 16, 18, 20).

As also identified under theme 4 below, there is a need to be child-centred and to consider all the children and each child's view, so the whole family is represented and all agencies involved are present (CPR 11, 15, 17 and 18). The Welsh Government Guidance (2016) also stipulates that where there is more than one index child (who has suffered serious harm as a result of the abuse or neglect), 'the review process must consider each child's perspective and experience individually' (see 6.12, Welsh Government 2016). Practitioners also need to consider how additional/special needs might impact on parenting abilities (CPR 6).

The onerous impact of caring for numerous children was not always recognised. Several CPRs involved large families: CPRs 1 (4 children), 2 (6 children), 3 (7 children), 6 (5 children), 17 (5 children) and 20 (unknown, states 'large sibling group'). In addition, it was not apparent that practitioners were seeing children with special needs as especially significant stressors within a large family (CPR 6). This may add more of a stressor to a large family, than for a one or two child grouping. Multiple and complex health needs of children in large families may far more difficult for the family to respond to. In one case the workers seemed to have unrealistic expectations of grandparents, primarily the grandmother, who was looking after 2 children, looking after her daughter, whilst also being responsible for overseeing the other 4 children (CPR 3).

A focus group identified that with large families there will likely be a tendency for services to try and keep children at home for as long as possible (i.e. avoid entry into care). The focus group suggested that this was due to: (i) financial costs; (ii) practical consideration (i.e. availability of foster care placements); and, (iii) separating children/best interests of young person. There is a risk of higher thresholds being seen as acceptable for large families.

Mothers in particular (as well as families), seemed to be polarised as either good or bad, rather than having an appreciative understanding of human beings for whom it is normal to have a range of actions and behaviours that can both good *and* bad. This is evident in a range of characterisations of parents as generally negative, i.e. 'challenging', 'un-cooperative' and/or feigning compliance. Such views can lead to practitioners not adopting a sufficiently strengths based approach that recognises the abilities (and not just the deficits) of the parents. Conversely, professionals may share overly optimistic views about individuals and their abilities and thus not provide

appropriate and proportionate support. Such polarised views fail to recognise that parents may have fluctuating abilities due to their life experiences (CPRs 3, 4, 5, 6, 7, 9, 10, 17, 18, 19).

This labelling of mothers and families as either good or bad, believed or dismissed, (Goffman, 1961) rather than a sense of fallibility/continuum of capability, appears to be linked to professionals' perceptions of being hoodwinked (CPRs 1,2,5) or being overly or unduly optimistic (CPRs 3, 6, 17). This binary representation of parents extended to understandings of families as being 'good' or 'problematic'. This served to obscure and limit effective understanding of situations and/or management of interventions.

Another area of complexity for health services in particular seems to focus on service disengagement. Where a child was not being brought for appointments, or where there is no engagement with a service, then the closure of any case should be accompanied by questions about the wider welfare of the child (CPRs 6 and 18). In CPR 18 a family was 'off-rolled' from their GP practice despite the mother having PTSD and there being a long history of welfare concerns for the children. Closing cases in these circumstances increases vulnerability. Clear protocols for checks within and across agencies are needed at the point of services withdrawing. Having an up to date knowledge of the services which continue to be involved with a family is important for effective assessment and safeguarding of the child.

Despite the pressures placed upon workers, some examples of good practice were also identified. In CPRs 4 and 5 the high complexity of the work was recognised by a manager and accommodated via a reduced caseload [3]. In both these cases, a consistent worker was identified as being beneficial to both children/families and the workers. By avoiding instances of discontinuous representation (changing workers) (see McConville et al, 1994), it was possible for practitioners to gain a more detailed understanding of situations being experienced by those they are working with which led to better assessments.

Theme 4- Voice of the child

Children's voices or the perspective of the child were sometimes missing and/or not always central to practice (CPRs 1, 2, 9, 10, 11 and 18).The CPRs often did not really consider the experience from the perspective of children/young people. In this respect, the reviews seemed iterative of practice.

It was often not clear whether children had been spoken to in the process of the CPR, or how directly practitioners worked with children in practice (CPRs 1, 2, 9, 10, 11, 18

---

[3] For CPR 4 both the police and social services ensured that workers had reduced caseloads. In CPR 5 a reduced caseload was only identified for the social worker.

and 19). There were instances where children had been spoken to, but this had been in front of their parents, which would not give them a safe place to disclose their experiences (CPRs 2 and 11). Children were not always being linked up, for example, children who had been fostered or adopted elsewhere were not listened to regarding their experiences (see also Theme 3) (CPR 2). Any practice observations of children were lacking in description to give a sense of the experience of the child (CPR 2). In CPR 9, which related to home schooling, the children were completely invisible to all professionals. For a variety of reasons, it was not always possible for young people and/or their families to be consulted as part of the CPR process. Nevertheless, it would have been useful to have at least some reflection on the day-to-day lived experience of the child in every CPR. The guidelines for CPRs state 'The review [should] engage directly with children and family members as they wish and is appropriate' (WG, 2012 Guidance; SSWBA 6.3,3 6.34, WG, 2016). CPRs 18 and 19 did explicitly mention the need to give voice to the child, which we commend as good practice.

Large families inherently mean more work for practitioners (CPRs 1, 2, 3, 6, 17, 20 all had four or more children). For example, a family of seven will mean seven separate reports and care plans. Time and space is needed for practitioners to manage large families. Equally, practitioners need to guard against losing sight of the needs of individual children within these cases. Practitioners need to be alert to how and when information should be copied between children and the potential impact this may have on the voice of the individual child(ren). Data systems do not support working with large families. Specifically, information may be copied across cases and the needs of individual children may be lost in the process.

Participants in the focus groups highlighted that the contemporary guidance on CPRs (2012; 2016) could more readily emphasise the importance of capturing the voice of the child. Although it should be noted that under 6.34 of the current guidance, RSGBs are asked to think 'creatively' about how families can be engaged with reviews. However, it was also acknowledged that any suggestion that a reviewer must meet with children needs to be tempered with consideration of the appropriateness of the situation' (i.e. consideration of reliving trauma, etc.). As Preston-Shoot (2018: 12) highlights, 'clearly, a balance must be struck between protecting the anonymity of families and ensuring that professionals and their organisations are held accountable and that learning can be disseminated and used to inform future practice'.

There was a consensus in the focus groups that the CPR should record whether the child was spoken with and if not, why and how and where the child's voice /experience appears. 'Children's lived experience' (CLE) was seen as a better term by those in one of the focus groups, to acknowledge the wider range of ways of seeing and working with children, rather than 'voice of the child', as this relies on children's ability to speak and be heard. CLE shifts away from children's vocal articulation and repositions the focus on sound professional practice.

Challenges to the CPR framework

Challenge 1-. Workload and supervision

Through the CPRs repeated mention was made of the working conditions of practitioners across agencies (CPRs 1, 5, 6, 7, 15 and 17). The increase in workloads in Social Services has been identified by the Welsh Local Government Association (WLGA) (BBC, 2018) as a source of anxiety and stress for practitioners. Issues with the retention of social workers in Children Services is well established, and the CPRs confirmed that this continues to be an acute issue for contemporary practice in Wales. In addition, Social Services departments - who often assume the lead role in the safeguarding of children - were recognised to be under particular pressure. With diminished resources, social workers are often only working with the most acute need and this is often reflected in the form of complex cases. Further to this, it is often the responsibility of Social Services to facilitate and record multi-agency meetings and multi-agency work. As one focus group participant remarked, 'the buck [responsibility] stop[s] with them [social workers]'. Workload issues are recognised within CPRs as having a significant impact on practice.

Training opportunities and supervision were often cited as areas for development (CPRs 4, 5, 6, 7, 10, 12, 16 and 18). Supervision comes in many forms and can have multiple functions (Carpenter, *et al.*, 2013). Whilst more clarity about the form and function is needed in CPRs, it is apparent that supervision is not being prioritised in contemporary practice.

Challenge 2- IT difficulties

These were seen to hinder timely and effective information sharing. Health services in particular were noted to have highly fragmented systems (e.g. General Practitioners' (GP)[4] computer systems sit outside of wider systems used by health services (CPRs 1, 8, 14 and 17) meaning that information sharing necessitated extra steps). A diversity of different software packages combined with different databases meant that in many instances not all of the information discussed in the learning events was known to all agencies.

The introduction of WCCIS database was felt to be positive, but access to this system is variable by region and agency. Local authority and health boundaries often seemed to pose barriers for the ready exchange of information, even in instances where the same software packages were being used (i.e. two local authorities may be using the same software but their databases are not accessible across organisations – it seems

---

[4] GPs were also noted to be absent from some of the learning events. This was often noted to be due to high workloads and/or a lack of understanding about the purpose and role of a CPR. Please see CPRs 1 and 17.

that the ability to share or send information across databases proved problematic). However, we should be mindful that databases are only as good and the information they contain and practitioners need to be mindful of their responsibility to produce clear and accurate records.

Challenge 3- Data protection and safeguarding

The implementation of the General Data Protection Regulation (GDPR) (and the associated Data Protection Act 2018), was felt to have added a further layer of complexity to effective multi-agency work on safeguarding. Training across agencies was felt to be needed to address some of the anxieties being exhibited by practitioners from across Wales on this issue.

Challenge 4 –Concise and extended reviews

The research team could not readily discern the difference between concise and extended reviews, especially since they are often the same length. The focus groups also identified that some areas routinely require two reviewers for all CPRs irrespective of type, further blurring the boundary between the two. Concise reviews often served as a learning opportunity for new reviewers to gain experience under the tutelage of a more experienced reviewer, rather than the type being determined by the nature of the case.

Challenge 5- Agile-working

With the rise of agile working, accurate record-keeping is felt to be of particular importance. Practitioners increasingly work in a range of diverse settings and are reliant on information held on databases to guide their thinking.

Agile-working was not seen as universally bad in focus groups, however, there was a concern with declining opportunities for support and learning that comes with not being physically present and working with and around other professionals to share information and learn from each other. This was particularly but not exclusively important when talking about junior members of staff. The increasing expectation that social workers work alone is considered to have negative implications because of the reduction in group and peer supervision opportunities and ultimately could be potentially 'dangerous'.

Maximising learning potential from CPRs –Consistency and status

There was a wide range of quality across the CPRs as identified by the research team, and this was also identified in the focus groups. Consistency is thus an issue. Expertise was a recurring theme throughout the focus group discussion. The idea that panel members are not typically as senior or experienced in the process as with the previous process (SCRs) was seen as problematic in terms of the quality, but more worryingly with regard to the status of CPRs. Thus, for some, CPRs are seen to be occupying a lower status in terms of their rigour and utility compared to SCRs and DHRs.

– Lack of context

In a minority of cases the readers struggled to make sense of the context surrounding the CPRs because of the limited information provided. Endeavouring to apply the learning without context was challenging and it raises questions about how useful these might be to practitioners from different areas attempting to learn from them.

The guidelines require that CPRs cover a maximum of 12 months preceding the event (see 6.22 in Welsh Government, 2016). In some instances, this renders a very limited picture for the reader. It should be noted that in a small number of cases the CPR was extended to cover in excess of 12 months[5]. It was also widely reported in one of the focus groups that panel members do not include recommendations in reports that are already 'known', a practice linked to the limited dissemination of the reports, which is often confined to local areas. CPRs were identified by the focus group participants as being too inward-looking, in terms of focussing on the (very) local rather than regional or national impact.

It was suggested by some of those present in one of the focus groups who had chaired CPRs that practice was to avoid 'airing any dirty washing'. This has been further understood by some panels/boards as needing to strip out context in the CPRs; hence why some of them include little/no information. Not all of those attending the focus group agreed with these points.

- Timelines and action plans

Some of the reviews did include timelines or chronologies and this was found to be particularly helpful, although not recommended in the Guidance (Welsh Government, 2016). Not all CPRs that we received included action plans, and it is important that action plans are attached to and stored with the reviews. Questions were also asked within focus groups as to why, if there is a commitment to wider and longer-term

---

[5] In exceptional circumstances a timeline of up to two years can be provided (see 6.22 of Welsh Government, 2016).

learning beyond the immediate local context, some boards upload CPRs for only the minimum statutory period. In both focus groups the complexity of obtaining multiagency chronologies was discussed. Here, the issues related not just to technological barriers, but also to staff time, content and co-ordination.

- **Lack of involvement in some dissemination events**

This was noted in the CPRs, the participant surveys, and the focus groups. The pressures placed upon staff may be impacting attendance at CPR learning events due to workload and sickness (CPRs 1, 2 and 3). That key individuals did not participate in the learning event clearly undermines the potential of the learning event to have meaningful engagement. Indeed, 6.38 of the Welsh Government (2016) guidance identifies that both practitioners and managers are expected to attend if invited. The guidance goes on to advise that reviewers should 'think creatively about how relevant practitioners and managers should be engaged in the review' (see 2.68 of Welsh Government, 2016), and suggests that in some instances it may be appropriate to have more than one event. In some areas it seems to be routine practice to hold separate practitioner and manager events; it is unclear why it has developed in this way, and whether more shared learning would be achieved by bringing all professionals at differing levels together.

Discussion

Our analysis of this sample of CPRs provides an 'aerial' view that has revealed patterns and cross-cutting themes that could not have been discerned from reading a single review, although there are undoubtedly benefits from exploring individual reviews and taking more of a 'worm's eye view'.

A distinctive aspect of this research was to have a research team from three different disciplines – criminology, law and social work (academic, legal and practice) – code and analyse the data. Different backgrounds enabled a range of perspectives to be brought to the analysis and helped the team to avoid 'silo thinking' and the privileging of one particular discipline over another. This approach also facilitated the corroboration of findings through triangulation. Future research taking a similar approach might benefit from having an additional coder from a medical discipline (e.g. mental health or medical professional).

The research team independently identified similar themes from each of the review documents. These themes resonated with the participants in the focus groups. When comparing the themes from the CPRs with those of the previous study undertaken into adult reviews (Robinson et al., 2018), some of the same themes emerged across both samples, regardless of whether the review was a CPR, DHR, APR or MHHR. These included the hierarchy of knowledge and partial assessment, demonstrating these

issues are not confined to working with adults or with children, but routinely emerge in both spheres of professional practice. Indeed, that these are organised as separate entities poses a challenge for holistic assessments that consider the whole family rather than individuals separately. These different professional 'planets' hinder effective safeguarding across teams, settings, and disciplines (Hester, 2011). Problematic information-sharing is another prominent feature of both studies, as well in numerous other studies (Neville and Sanders-McDonagh, 2014; HIW, 2016; Sharps-Jeff and Kelly, 2016; Sidebotham et al., 2016).

The two studies also identified that some themes are indeed distinctive to practice with adults or with children. For example, the possibility of 'hoodwinking' was revealed as an important consideration when working with adults experiencing domestic abuse, mental ill-health or substance misuse. This points to the importance of professionals being skilled and confident to appropriately challenge the perspective being voiced by adults. In contrast, the current study found the problem was more to do with accessing the child's 'voice' or experience in the first place. The key focus on children's views and lived experiences must be repositioned as the central focus for CPRs.

Whilst the CPR has been reviewed previously, this was mainly to consider the implementation, two years post its inception, focussing on the level of awareness of CPR, decision making, time and resource issues (Welsh Government, 2015). This current study is reviewing the themes from reading across 20 CPRs some five to six years after inception. Thus, we had a very different purpose and are therefore likely to come to some different conclusions.

There were some excellent examples of good practice, such as information sharing that was effective, and organisations working together extremely well in practice as well as during the CPR (CPRs 4, 5).

Whilst the aim of the change to the CPR model 'was to take a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases' (WG guidance; 2012), it may be that learning is somewhat compromised by this overly pared-down approach. Our findings from reading the Adult Practice Reviews was similar in that APRs were similarly found to be 'often devoid of background detail, which is difficult for those outside of the situation to follow, although they can convey helpful analysis and learning points for those involved' (Robinson et al., 2018).

The lack of inclusion of 'known' recommendations and wider detail might in part be the result of the stated purpose of the CPR which focuses on responsibility and learning at a local level. 'The overall purpose of the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which Boards and partner agencies hold responsibility (see 1.3 of Welsh Government, 2016).

This approach seems at odds with attempts to promote broader, national learning from these reviews.

More consideration of fathers in assessment is needed, and if their voice or views are absent, it needs to be stated why this is the case. Discussions in focus groups highlighted that the North Wales Safeguarding Board previously worked with the Fatherhood Institute to build in practice changes that aimed to improve engagement with fathers. This included making sure that fathers were routinely being copied into correspondence and were invited to meetings. Unfortunately, the effect was not felt to be sustained in contemporary practice. Few specialist services exist to work with fathers. Focus group participants noted NSPCC Caring Dads previously used to be a productive service but is no longer running.

One feedback from a focus group noted the benefits of coming 'together with others undertaking reviews, discussion regarding process and exploration of common themes' and noted that (they) 'would like to have opportunity to do this again, its [sic] helpful in getting unity, plus support as it can be a lonely task'. It maybe that the facilitation of regular meetings for reviewers would be helpful.

Chronologies and genograms need to be created by practitioners, regularly updated and accessible for everyone working across organisations in practice (to include children who have been adopted or fostered in another local authority). Timelines and genograms are also specified in the Guidance documentation for CPRs- 'A full and accurate genogram should be prepared by the review panel. It should be used during panel discussions, and be available for reference at all stages of the review process, although '*not included in the published report*' (see Welsh Government, 2012:19; 6.24 of Welsh Government, 2016). Details of circumstances around a child and genograms may need to be available to practitioners (and potentially researchers) after the learning event if full learning is to be gleaned.

The quality and scope of the CPRs was found to differ markedly. Some reports were of far better quality in terms of their level of detail and analysis than others, and writers of reviews may benefit from more training, a consistent standard and benchmarking. Unpredictable variability both within reviews was also highlighted as a barrier to learning. One major area highlighted by the survey respondents and in the focus groups was workload issues and lack of qualified, available staff with capacity to undertake the reviews. This iterates the workload issues outlined in challenge 1 which identified workload as being a major difficulty for all professions in times of cuts and austerity. There would seem to be high level of support for increased training and workload relief for those involved in CPRs. Multi-disciplinary training on GDPR for all Safeguarding boards is clearly warranted.

Gwynedd local authority was noted to have a risk assessment tool that was built into supervision processes and had been found to be helpful to practitioners; RSGB might wish to consider identifying and mapping supervision practices and tools across

agencies in their areas. Consideration should also be given for multi-agency supervisions sessions.

Our previous research (Robinson et al. 2018) suggested a number of ways in which the reviewing process could enhance the likelihood of wider, deeper learning. In the previous study, many of the focus group participants expressed a desire for a more centralised, proactive, structured approach to facilitate learning from reviews, which is specific to Wales. This would also seem to be the case for CPRs, as a lot of dissemination issues were identified. There is no complete Welsh repository for such reviews, although one is currently in development.

Recommendations [6]

The evidence contained in this report suggests a number of recommendations, which are listed below.

To improve the outputs and impact of conducting reviews in Wales, we recommend that:

1. CPRs be deposited in a central repository (e.g. the one currently being established at Cardiff University) to promote the accessibility of completed reviews to facilitate learning pan Wales. Each review should be indexed according to the issues arising within it, so that others working in the same area may benefit from this easily accessible information.
2. For the learning to be maximised to a pan Wales audience, more details need to be included in CPRs (as a minimum, what happened and which organisations were working with the family).
3. A regular publication of the major themes emerging is produced and disseminated widely in order to enhance learning across Wales. This should occur at least biannually and adopt the robust methodological approach used here (i.e. thematic coding of multiple types of reviews by an interdisciplinary team).
4. The use of creative methods is explored to disseminate the messages from the reviews, for example, the use of 'webinars'. These could provide excellent opportunities for teaching and learning and could form the basis of team or inter-disciplinary supervision.
5. Multi-disciplinary training on GDPR is provided to all RSGB boards (and the NISB).
6. CPRs be uploaded on Safeguarding Board websites for more than 12 weeks.
7. CPRs always be published with the attached action plan

---

[6] http://upsi.org.uk/projects-2/2019/1/14/qtyhf5xsczuiuwjsubnb4z9tam0quk

8. More clarity provided with regard to the distinction and purpose of the concise and extended reviews.

9. Additional training to improve the consistency of the quality of review is developed for and completed by all those charged with undertaking reviews in Wales. This needs to include a focus on involvement of the child, engagement with fathers, timelines/chronologies, genograms, cooperation, responsibilities, and information-sharing by different agencies contributing to reviews. Regular meetings of CPR chairs and reviewers to be convened.

10. The training for CPRs (2016) be revisited with regard to repositioning and ensuring the child is centre stage and how the voice of the child might be presented where they cannot be spoken to. At the very least reviewers need to identify whether children have been spoken to and, if not, specify the reasons for this.

11. There should be clear workload relief, to enable reviewers the time to conduct high quality reviews and for people to attend learning events.

12. RSGB might wish to consider identifying and mapping supervision practices and tools across agencies in their areas.

13. Consideration should also be given for multi-agency supervisions sessions.

We anticipate that improving the process and the outputs in these ways will increase the status of the CPR, resulting in improved _outcomes_ (i.e. practice across agencies will be improved through practitioners having better access to relevant learning from reviews taking place in Wales, with the ultimate aim to reduce the number of incidents requiring reviews over the longer-term).

As a final note, we would like to acknowledge that we feel privileged to have had access to these CPRs, each of which has proved illuminating for our future work. We are also very grateful to the busy professionals who conduct these reviews and to those who took time to participate in the focus groups, surveys and feedback.

References

British Broadcasting Corporation (BBC) 2018. Children's social services in Wales 'near crisis'. Available at: https://www.bbc.co.uk/news/uk-wales-43951732 (Accessed 11.03.19)

Carpenter, J., Webb, C., Bostock, L. and Coomber, C., 2012. *Effective supervision in social work and social care*. Bristol: Social Care Institute for Excellence.

Carpenter, J., Webb, C.M. and Bostock, L., 2013. The surprisingly weak evidence base for supervision: Findings from a systematic review of research in child welfare practice (2000–2012). *Children and Youth Services Review*, *35*(11), pp.1843-1853.

Forrester, D., Maxwell, N., Slater, T. and Doughty, J. 2017. *An evidence-based review of the risks to young people who are home educated*. Available at: http://safeguardingboard.wales/wp-content/uploads/sites/8/2017/11/2017-11-14Home-Education-Report-Final-13.10.17.pdf (Accessed 10.01.19)

Lord Laming 2003. *The Victoria Climbe Inquiry: report of an inquiry by Lord Laming*. Available at: https://www.gov.uk/government/publications/the-victoria-climbieinquiryreport-of-an-inquiry-by-lord-laming (Accessed 10.01.19)

McConville, M., et al. 1994. *Standing Accused: The Organization and Practices of Criminal Defence Lawyers in Britain*. Oxford: Clarendon Press.

Neville and Sanders-McDonagh, 2014 Preventing domestic violence and abuse: common themes and lessons learned from West Midlands' DHRs. http://www.westmidlandspcc.gov.uk/media/346463/13-spcb-11-sep-14domestichomicide-reviews-research-appendix-1.pdf .

Patrick, R. 2017. *For whose benefit? The everyday realities of welfare reform*. Bristol: Policy Press.

Preston-Shoot, M. 2018. What is Really Wrong with Serious Case Reviews?. Child Abuse Review, 27, pp.11-23.

Robinson, Rees and Dehaghani, 2018) , *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews*. Project Report. Cardiff: Cardiff University).

SharpJeffs, N. and Kelly, L. (2016). Domestic Homicide Review (DHR) Case Analysis. http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf.

Webb, C.M. and Carpenter, J., 2011. What can be done to promote the retention of social workers? A systematic review of interventions. *British Journal of Social Work*, *42*(7), pp.1235-1255.

Welsh Government. 2016. *Social Services and Well-being (Wales) Act 2014: Working together to safeguard people. Volume 2 – Child Practice Reviews*. Available at: https://gov.wales/docs/dhss/publications/161111cpr-guidanceen.pdf   (Accessed 11.03.19)

APPENDIX A

Descriptive table to provide a snapshot of each review and overview of the sample.

	Region	Date signed or Publication	Period of review Concise or extended	Child details	Event/s	Broader circumstances of the case
CPR1	Western Bay Safeguarding Children Board	19/04/2018	01/07/2014-31/07/2016 Extended	Age and gender unknown Living with 3 siblings and mother	House fire Neglect	Mother known substance misuse. On/off relationships with fathers (2) of children
CPR2	Western Bay Safeguarding Children Board	07.08.18	Period of review unclear (baby died in Spring 2017) Concise	Male, aged 8 months	Mother awoke to find baby blue/white, stiff and unresponsive.	Lived with mother, Father not living with mother. Four other maternal siblings not living with mother. Baby and elder sister sharing bed with mother. Mother had been drinking alcohol prior to and on night of baby's death. Ambulance called. Baby announced dead on arrival at hospital.

| CPR3 | Western Bay Safeguarding Children Board | No date recorded | 01/06/2013- 17/07/2014 Concise | Female, age unclear | Child with special needs died of peritonitis. (Day of death noted between Christmas and New Year in 2014). Could not be concluded that child died due to neglect. | Living with mother. Father seems not to live with child. Maternal grandparents supervising mother's care of four youngest (including index child). Mother with learning difficulties, struggled with parenting. Seven children from four relationships. Eldest child lives with paternal family. Two of elder children live with maternal grandparents. |
| CPR4 | Western Bay Safeguarding Children Board | No date recorded | Period of review unclear Extended | Female, 12Y (Start), 15Y (during) | Beyond parental control. Evidence of CSE - one perp in prison but child is in love with perp. | Lived with maternal grandmother, mother and aunt in family home. Often cared for by relatives. Biological father only met once. Father of sibling referred to as father. |

CPR5	Cardiff and Vale	16/01/2018	01/07/201201/07/2014, Extended	Female, 6y10m (FC)	At nursery and at school - soiling, sexualised behaviour, aggression towards other children.	Living with mother. Mother worked as escort from home. Often left in care of male friends of mother who bathed and delivered/collected child to/from nursery and school. Mother - depression, low mood, parenting
						deficits. Mother blamed inherited paternal MH. Mother failed to meet child's health needs. Mother and partner later arrested but NFA by CPS. Physical and sexual abuse could not be ruled out. Reports from child suggested sexual assault.

CPR6	North Wales	Approved January 2017	01/07/201201/07/2014, Extended	Male, 11Y	Death by asthma attack. Delay in presentation for medical assistance and not given appropriate medicine in preceding days. Failure of parents to meet health needs.	Child eldest of 5. Mother and father separated. Mother co-hab with partner (father to 5th child). Child witness to DV; inconsistent/neglectful parenting; lack of app nurture and care; parents resistant to help/support; history of failure to ensure reg attendance at school or health apts. Previous child protection register on two occasions. Mother presented unkempt and smelling of alcohol (at hospital).

CPR7	North Wales	09/03/2016	Period of review unclear, Extended	Age and gender unknown	2 children given methadone deliberately.	Parental substance misuse more chaotic and withdrawal from agency involvement during second pregnancy. Mother substance misuse. Father also substance misuse and police intelligence to suggested dealing controlled substances in area. 2nd child - drug withdrawal symptoms. Concerns re developmental delay.

CPR8	Cwm Taf	No date recorded	Period of review unclear, Concise	17 months, gender unknown	Child fallen down stairs: investigation - serious non accidental injury.	Prior to death only normal health services involvement
CPR9	Mid and West Wales	07/07/2016	Thirteen months prior to Dec 2011, Concise	Male, 8 years	Gross anaemia, dental abnormalities, soft tissue haemorrhage in lower legs. No evidence of any medical input regarding deterioration. Neglect - vitamin C deficiency.	Living with mother, father and older sibling. Child home educated.

CPR10	Mid and West Wales	25/01/2018	Period unclear, Extended	Male, 17 years old, almost 18	Death by hanging (suicide)	Living in foster care under LA. Under LA care from 2 years old due to severe physical and emotional abuse and neglect. Child - Attachment Disorder & aggression. Child had been adopted by Mr & Mrs A but they, by the time he was aged 10, were unable to cope with him (earlier concerns re suitability of As from As and professionals). Experiencing anxiety re pathway plan to independence.
CPR11	South East Wales	27/06/2018	1992 (birth) to 2007 (Social Services referral), Historic review	Male, adult at time of review	J sexually abused by father. J also perpetrator of abuse.	Child J youngest child with 3 sisters aged 12, 7 and 6 at time of his birth. Parents split before his birth and father moved with new partner and her 10Y son (on CP Reg). Family known to statutory services: emotional abuse and distress, mother's alcoholism, J's behaviour at school, conflict between parents. Historic - child J aged 15Y when he committed a sexual assault.

CPR12	South East Wales	20/06/2016	04/03/2014 - 03/03/2015, Concise	Female, aged 16	K found hanging in bedroom closet (fatal hanging). Had previously attempted suicide.	Living with mother. Had spent 7 months in foster care in 2009. K was open case with CAMHS. At time of death, not engaging directly. Earlier non-fatal hanging - questioned child re self-harm and contacted mother. Initial denial of self-harm, This relayed info to Children's Services.
CPR13	Western Bay	No date recorded	14/01/2013 – 14/01/2014 (covering antenatal period), Concise	Female, aged 4 months	History of vomiting and being floppy, serious injuries to neck, thoracic and lumbar parts of her spinal cord, fractured ribs, fractures to both tibiae and numerous bruises and grazes over her body. Father perpetrator.	Parents and baby living with extended family

CPR14	Western Bay	No date recorded	Period unclear, Concise	Female, aged 17 months	3 weeks of sustained vomiting. A number of injuries, believed to be non-accidental. Police instigated criminal proceedings but mother stated that	living with mother, mother separated from father (DV), with new partner (DV), not clear that mother and partner living together
					child had fallen and she (mother) had not sought help because she panicked.	
CPR15	Western Bay	8.12.14	21/05/2012 – 21/05/2013, Concise	Possibly 6 months old, gender unknown	Emergency admission to hospital. Unexplained bi-lateral bruising to face and a bleed in the head between the brain and the skull	Family home: mother, older sibling and mother's new partner

CPR16	Western Bay	18/12/2015 (Chair signature)	08/201208/2013 (12 month preceding incident), Historical information also recorded in Appendix, Concise	Male, 11 years old	Numerous injuries, indicating physical abuse: slap mark to left side of face and bruising on parts of body Child had suffered previous incidents of physical and emotional abuse (known through assessment,	Living with mother and step father and three younger half siblings. Injuries brought to attention through member of the public.
					conducted during review)	

CPR17	Western Bay	8.12.14	Autumn 2010 to Autumn 2012, Extended	Child born 2010 but age otherwise unknown/unclear. Gender unknown, Extended	Neglect. Index child with significant complex needs. Child's needs not being addressed by parents. Child and siblings - neglect.	Eldest child assaulted by stepfather.

CPR18	Cardiff and Vale	August 2018	18/04/201525/02/2016, Extended	3 years old, Gender unknown	Neglect - child hanged by soft toy, found by sibling. Mother later fled scene with child and older sibling.	Living with mother and older sibling. Father had no overnight contact Little food, dead flies in kitchen, makeshift kitchen in bedroom - not due to mother but symptomatic of neglect, poor supervision. Mother health concerns, father substance misuse
CPR 19	Cardiff and Vale	11/10/2018	01/01/2014 – 10/01/2016, Extended	4/5Y (start), 6/7Y (end), Gender unknown/unclear	Neglect of health and developmental needs and education by mother. Mother's boyfriend sexually abused child.	Mother longstanding substance misuse problems during pregnancy and 1st 6 y of child's life. Child: exposure to mother's substance misuse, criminal activity and to domestic abuse. School: attendance, punctuality, presentation and poor dental health. Poor developmental and educational progress. Teeth decayed; 10 extracted. Mild/moderate difficulty in understanding spoken language.

CPR20	Mid and West Wales	24/01/2019	08/04/201608/04/2017, Concise	15 years old, gender unknown/unclear	Body was found alone in the outdoors. Possible death overnight - attending outdoor party - cannabis and MDMA.	living with family, large number of siblings. YP with complex needs. YP frequently going missing. Alcohol and substance misuse.

APPENDIX B

	Brief title/summary	Theme 1 – Hierarchy of knowledge	Theme 2 – Information sharing/ recording	Theme 3 – Partial Assessment	Theme 4 – Voice of the Child
CPR 1	House fire Neglect	Yes	Yes	Yes	Yes
CPR2	Mother awoke to find baby blue/white, stiff and unresponsive.		Yes	Yes	Yes

CPR3	Child with special needs died of peritonitis. (Day of death noted between Christmas and New Year in 2014). Could not be concluded that child died due to neglect.	Yes	Yes	Yes	Yes
CPR4	Beyond parental control. Evidence of CSE - one perp in prison but child is in love with perp.	Yes	Yes	Yes	
CPR5	At nursery and at school - soiling, sexualised behaviour, aggression towards other children.	Yes		Yes	
CPR6	Death by asthma attack. Delay in presentation for medical assistance and not given appropriate medicine in preceding days. Failure of parents to meet health needs.	Yes	Yes	Yes	Yes
CPR7	2 children given methadone deliberately.	Yes	Yes	Yes	

CPR8	Child fallen down stairs: investigation - serious non accidental injury.			Yes	
CPR9	Gross anaemia, dental abnormalities, soft tissue haemorrhage in lower legs. No evidence of any medical input regarding deterioration. Neglect - vitamin C deficiency.	Yes	Yes	Yes	Yes

CPR10	Death by hanging (suicide)	Yes		Yes	Yes
CPR11	J sexually abused by father. J also perpetrator of abuse.	Yes	Yes	Yes	Yes
CPR12	K found hanging in bedroom closet (fatal hanging). Had previously attempted suicide.	Yes		Yes	
CPR13	History of vomiting and being floppy, serious injuries to neck, thoracic and lumbar parts of her spinal cord, fractured ribs, fractures to both tibiae and numerous bruises and grazes over her body. Father perpetrator.				
CPR14	3 weeks of sustained vomiting. A number of injuries, believed to be non-accidental. Police instigated criminal proceedings but mother stated that child had fallen and she (mother) had not sought help because she panicked.	Yes	Yes	Yes	
CPR15	Emergency admission to hospital. Unexplained bi-lateral bruising to face and a bleed in the head between the brain and the skull	Yes	Yes	Yes	

ID	Description				
CPR16	Numerous injuries, indicating physical abuse: slap mark to left side of face and bruising on parts of body Child had suffered previous incidents of physical and emotional abuse (known through assessment, conducted during review)	Yes	Yes	Yes	
CPR17	Neglect. Index child with significant complex needs. Child's needs not being addressed by parents. Child and siblings - neglect.	Yes	Yes	Yes	Yes
CPR18	Neglect - child hanged by soft toy, found by sibling. Mother later fled scene with child and older sibling.	Yes		Yes	Yes
CPR19	Neglect of health and developmental needs and education by mother. Mother's boyfriend sexually abused child.		Yes	Yes	Yes
CPR20	Body was found alone in the outdoors. Possible death overnight - attending outdoor party - cannabis and MDMA.		Yes	Yes	Yes