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Findings from a thematic analysis of Child Practice Reviews in Wales

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Background

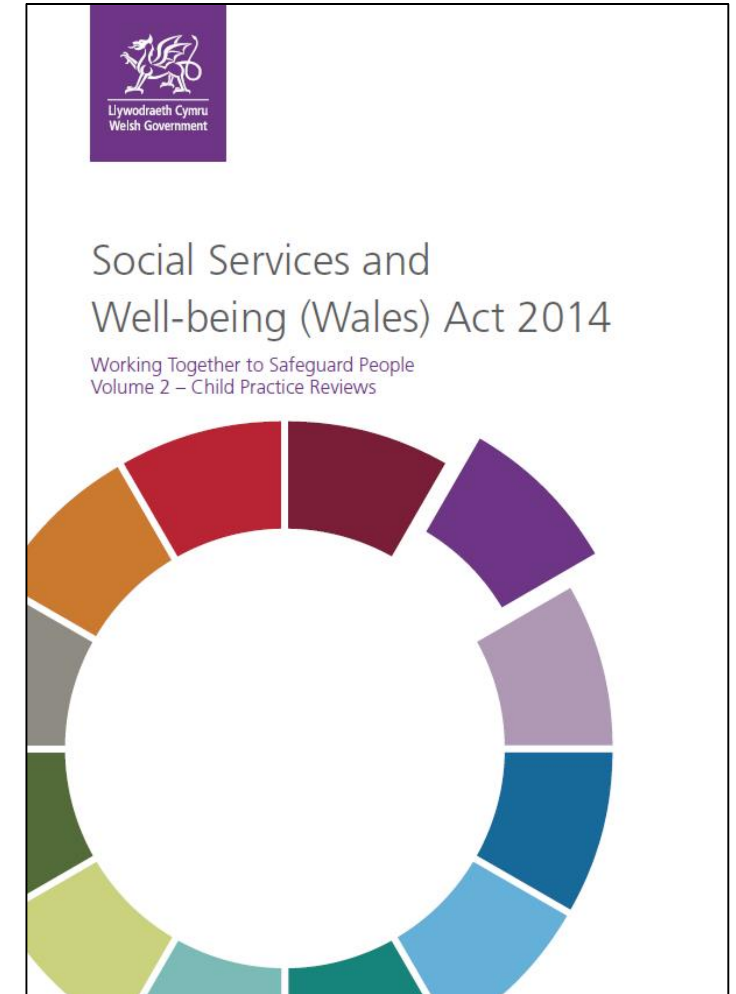
- Long history of 'learning from' Serious Case Reviews (SCRs) (see by Prof. Marion Brandon at UEA)
- Funded by the National Independent Safeguarding Board for Wales
- Build on previous review (Robinson, *et al.,* 2018) of:
  - Domestic Homicide Reviews (*n*=10)
  - Mental Health Homicide Reviews (*n*=6)
  - Adult Practice Reviews (*n*=4)
- This was the first 'learning from' research into the new CPRs

Child Practice Reviews

- Replaced Serious Case Reviews (SCRs) in 2013 following recommendations from the Care and Social Services Inspectorate for Wales (CSSIW)

- Contemporary guidance can be found in Working Together to Safeguard People Volume 2 – Child Practice Reviews (Welsh Government 2016)

- Review of implementation of CPRs took place in 2015



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When does a review take place?

Child Practice Reviews (CPRs) are undertaken by Regional Safeguarding Boards (RSBs) where abuse or neglect of a child is known or suspected to have taken place, and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; *and (see criteria for concise and extended reviews)*

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Concise and extended reviews

Concise	Extended
the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding (Welsh Government 2016: 4)	the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding (Welsh Government 2016: 5)
One reviewer required	Two reviewers required

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Historic and multiple abuse reviews

- Historic reviews can also be undertaken (guidance issues under Chapter 8 Welsh Government, 2016)
- There is also guidance on how reviews should be undertaken where instances of multiple abuse has occurred
- The criteria for historic and multiple abuse reviews is the same as those previously identified

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What did we do?

- Innovative, comparative and multi-disciplinary approach
- Thematic documentary analysis (*n*=20) using three disciplinary perspectives (triple coding):
    1) Criminology
    2) Legal
    3) Social work
- Focus groups with practitioners
- Survey with practitioners

Findings

Four substantive themes:

1) Hierarchy of knowledge
2) Information sharing and recording
3) Partial assessment
4) Voice of the child

Additional elements included:

- Challenges
- Maximising learning from CPRs

Hierarchy of knowledge (1)

- **Communities and families** –
  - Professional opinions were prioritied above community and family perspectives.
  - Within families hierarchies were often noted, with priority being given to adults priorities over children, and mothers over fathers.
  - Fathers often overlooked or not consulted
- **Inter-professional and multi-agency** –
  - Some evidence to suggest hierarchies between professions and agencies, but difficult to determine due to the language used in the CRPs (i.e. ‘professionals’ as a generic grouping)
  - Where professional disagreement and conflicts exist, more effective use is needed of conflict resolution processes

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Hierarchy of knowledge (2)

- **Objective vs. subjective** - Prioritising medical information, even when this is inconclusive and/or wider evidence exists
- **Tunnel vision** - A hierarchy of knowledge can lead ‘tunnel vision’, where certain attitudes are formed and then become hard to challenge (Munro, 2011). This can happen in groups as well as to individuals. Tunnel vision was noted to be an issue in practice, but hard to overcome, reinforcing earlier work (Robinson et al., 2018)

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Information sharing and recording

- Lack of understanding about information sharing in non-Child Protection cases. Advice from Lord Laming (2003) need to be adhered to

- Concerns about complaints led to practitioner reluctance to share information

- GDPR has led to confusion about information sharing

- Inter-agency information sharing hindered by:
  a) computer systems and IT infrastructure;
  b) varied approaches to information sharing;
  c) poor record keeping, inconsistency in language and a lack of chronologies

Partial assessment (1)

- **Familial context**
  - Focus on the individual without consideration of wider familial (and social) contexts
  - New partners were often not discussed or followed up
- **Large families**
  - Indication that children in larger families were being left in precarious situations
  - Concerns about: (i) separating children; (ii) costs; (iii) practical considerations (i.e. availability of placements, etc.)
- **Grandparents and wider family members** – Unrealistic and unfair expectations can be placed on grandparent and wider family member

Partial assessment (2)

- **Polarised representations of mothers ('good' or 'bad')** – lack of consideration of fluctuation
- **Supervision** – Often seen as an area of need, but risk of it being a panacea
- **Service disengagement** – Families and/or parents being off-rolled from services without consideration of wider safeguarding concerns
- **Examples of good practice** –
  - Practitioners being given time and space to manage complex cases
  - Continuity of workers being maintained (avoids discontinuous representation)

Voice of the child

- Voice of the child often not being considered in practice, including a lack of consideration child’s lived day-to-day experience
- Instances of children being spoken to in front of parents
- In large families the voice of each child is often not captured effectively (i.e. different experiences of each child)
- CPRs often unclear what they mean by ‘voice of the child’. Suggestion that Children’s Lived Experiences (CLE) might be a more useful way to frame this

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Challenges and learning

Challenges	Maximising learning
• Workload and supervision • Agile-working • IT difficulties • Data protection and safeguarding • Concise and extended reviews	• Context • Timelines and action plans • Lack of involvement in some dissemination events

Recommendations for practice

- Multi-agency training on data sharing and GDPR are needed
- Information sharing processes reviewed to ensure information is shared in effective format and timely manner
- Regional Safeguarding Boards (RSGBs) might want to consider reviewing supervision practice across agencies
- Consideration should be given to multi-agency and interdisciplinary supervision
- Practitioners should be given appropriate time to attend learning events

Recommendations for future CPRs

- A central registry of CPRs is coming (meaning CPRs will be available for longer than 12 weeks)
- Action plans should be attached to all CPRs
- More contextual information needed in CPRs to aid learning
- Creative methods needed for dissemination
- Reviewers to be given appropriate workloads to undertake CPRs
- Training needed to aid with consistency across CPRs
- Regular ‘learning from’ reviews is needed
- More clarity needed about concise and extended reviews

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Summary

- Unfortunately, some of these themes are not new… So how do we effect sustainable change?
- There are some examples of good practice highlighted in these CPRs, we should remember to learn from these too
- We need to look at embedding learning at micro, meso and macro levels

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1) How do these findings resonate with your experiences and observations?

2) How might practitioners make better use of CPRs to inform future practice?

3) What would need to happen for you to be able to use them more fruitfully?

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