BWRDD Diogelu Gogledd cymru / north wales Safeguarding BOARD	**CASE REFERENCE** **ECPR Gwynedd 1 2015**

Concise Review	☐
Extended Review	☑
MAPF	☐

Review Process

Circumstances Resulting in the Review

1. A Multi-Agency Professional Forum (MAPF) was originally commissioned by the North Wales Regional Safeguarding Children's Board (NWRSCB) on the recommendation of the Regional Child Practice Review Sub Group in accordance with 'Safeguarding Children, Working Together under the Children Act 2004 and All Wales Child Protection Procedures 2008'

2. However, following the first meeting of the MAPF Panel it was agreed, that in light of the children having been subject of a Child Protection Plan and having sustained possible permanent impairment of health or development, an Extended Child Practice Review (ECPR) should be undertaken (Local Safeguarding Children's Boards (Wales) Regulations 2006 as amended 2012).

3. The purpose of the review was to:

   - Establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguarding children
   - Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result
   - As a consequence, improve inter-agency working and better safeguard children
   - Identify examples of good practice

4. This review was undertaken following a finding of fact that 2 young children had been deliberately given methadone by either or both of their parents.

   The background to this family includes a mother who was known to Substance Misuse Service (SMS) and was on a methadone programme over a sustained period of time. Whilst there had been no concerns raised with Social Services regarding the care of the older child, it became apparent during the second pregnancy that parental substance misuse was becoming more chaotic and parents were withdrawing from agency involvement. However, SMS continued to provide services.

   Father had a history of substance misuse and police intelligence suggested that he was dealing controlled substances in the local area. Father also received support from SMS.

5. During the second pregnancy there was a referral to Social Services and an Initial Assessment (IA) undertaken which assessed the child/unborn as being Children in Need (CIN) and a plan of intervention was developed.

Following birth, the second child developed symptoms of drug withdrawal as a consequence of mother's substance misuse in pregnancy. Relevant multi-agency support was put in place as part of a CIN Plan.

Parental engagement with agencies as well as the parent's ability to consistently prioritise the needs of the children became an increasing concern throughout agency involvement.

6. At the end of December 2013 developmental delay in the children was identified as a concern and enquiries into the cause of this began.

7. In spring 2014 both Children's names were placed on the Child Protection Register (CPR) under the categories of Neglect and Emotional Abuse and the Public Law Outline (PLO) process was subsequently instigated.

During this time there was significant input by Health by virtue of Speech and Language Therapy (SALT), and Flying Start which tried to effect parental change.

8. Following lengthy concerns and investigations the concerns regarding the older child's developmental delay had increased by autumn 2014. There were also ongoing concerns about chaotic parental substance misuse and at this point the children were removed from the care of their parents due to a suspicion that the children had deliberately been given methadone/opiates by their parents.

9. A clinical psychological report was commissioned as part of the court proceedings and this recommended that the children should be tested for substances as it appeared that they were exhibiting behaviour indicative of substance withdrawal and formal testing took place

The Clinical Psychologist had had previous experience of children having been deliberately given substances by their care givers and so she was able to draw comparisons with the children's behaviours. The report raised the possibility that one or both of the children had been administered methadone, either as a way of sedation to reduce difficult behaviours, or as a way of preventing withdrawal symptoms

The children's hair samples proved positive for opiates and therefore a criminal investigation was instigated. It was believed that the children had been given opiates and/or methadone both whilst they were on the CPR and subject to an Interim Care Order (ICO) whilst placed with their parents.

Methodology:

10. The methodology employed was as follows:

- A review Panel was convened with a Chair
- Two independent reviewers were appointed
- Timelines were developed from each agency identified and these were amalgamated into a composite timeline
- A summary/analysis from each service was produced
- Due to the ongoing Police investigation the Senior Investigating Officer from NWP advised that we could not hold a traditional Learning event with professionals so interviews were

undertaken on 15 September 2015 where the reviewers and chair met with all identified professionals separately in order to reflect upon their involvement with this case
- A series of focussed analytical Panel discussions took place
- A draft Review Report was produced with recommendations and presented to the Panel on Monday 23 November 2015.

Practice & Organisational Issues Identified

Narrative:

Risk Assessment/Analysis

11. In October 2012 Social Services received a referral from the Substance Misuse Service (SMS) when mother was 26 weeks pregnant. A management decision was made to undertake an Initial Assessment (IA) as the referral did not trigger a concern about significant harm.

    The management decision indicates that further information needed to be gathered during the IA from SMS given the referral was 'so vague and gives no detail regarding parental capacity'. This vagueness was not felt to be uncommon in referrals and raised the question of the quality of referrals being received by Social Services from professionals. The 'vagueness' in this case led to a management decision to open this case as CIN rather than Child Protection (CP) as the referrer had originally intended.

12. The IA concluded that both the child and the unborn were assessed as CIN. The team manager commented that "further deterioration in parental capacity due to substance misuse will likely lead to the children being at risk of harm. Further assessment and child in need planning is required" but it is not clear if further assessment was undertaken.

13. The Initial Assessment was weak as it lacked checks with all statutory agencies including the Police. Safeguarding Children: Working Together under the Children Act (8.59) states that all relevant information (including historical information) should be taken into account as part of the Initial assessment. If an analysis of the historical information had been available, a more informed risk assessment could have been completed and identified future behaviours at an earlier stage

14. The reviewers are aware that the Social Care Manager does not feel that it is a reasonable expectation to have a chronology on all CIN cases; however chronologies are considered a key tool to aid reflection and analysis both in real time and after the event. Research also suggests that chronologies promote early identification of patterns of events and may have indicated behaviours which were key in this particular case.

15. During the individual interviews with professionals it was evident that Social Service professionals were not consistently clear about when a Pre Birth Assessment should be instigated. A Pre-Birth Assessment may have been more appropriate given that the All Wales Child Protection Procedures (AWCCP) 3.3.1., Working Together to Safeguard Children (Chapter 8), require the child to be seen as part of the Initial assessment which is not possible for an unborn. A Pre Birth Assessment would lend itself better to assessing the vulnerabilities particular to an unborn/new baby

A Pre Birth Assessment was undertaken by Health in accordance with their Pre-Birth Assessment Policy however these assessments are not consistently applied to all pregnancies. They are usually completed for those with some 'predisposing factors' as identified in the Health Pre Birth Assessment Policy (Health Pre Birth Assessment by Midwife/Health Visitor)

The process and timing of Pre Birth Assessments by all agencies needs to be reviewed in order that there is some synergy and sharing of appropriate information at an early stage to inform case management decision making and planning.

Across North Wales there are inconsistent approaches between Social Care Departments as to when to accept pre-birth referrals from partner agencies. Some areas will accept early referrals in order to try to effect parental change where necessary and some authorities will request a referral to be re-presented at 24 weeks. An agreement needs to be reached in order to provide a consistent approach.

In this case the panel and reviewers were keen to understand the interface between the Health and Social Care pre-birth assessments, in particular how they are coordinated and triggered, and whether one informs the other. It was identified that there is currently a lack of consistency across the region regarding Pre Birth Assessments. This review makes no recommendations in this regard as we are aware that this is being addressed via an ongoing piece of work commissioned on a regional basis.

16. SMS identified a Health and Safety risk to staff and made a decision based on the aggression of father not to visit alone. Despite this decision the children remained in the household. In the reviewers' opinion when a situation is deemed too risky for professionals to attend alone, this must give rise to significant concerns of the risks posed to the children in the household, and should trigger a review of the level of risk presented to the children.

Professional Judgement

17. During the interviews with practitioners we heard from several professionals who referred to their 'gut instincts' that something was wrong, for example, the manager involved in one of the strategy meetings acknowledged that in hindsight she has been persuaded by the social worker that the children should remain with parents but had a 'gut instinct' that this was not appropriate. Whilst professionals may not be able to act on 'gut instinct' it is helpful in this type of case to consider what 'gut instincts' are and look for evidence that might support or discount that professional instinct. This should be done through supervision and opportunities for reflective practice.

18. This case in particular has highlighted the need for objective supervision and the importance of 'fresh eyes'. There were at least two occasions when new workers were introduced to the family and immediately raised concern, this could be indicative of a collusive relationship with a family but other issues such as workers being 'groomed' by parents should also be explored and challenged.

Dealing with Complex Parents

19. This case has undoubtedly involved professionals dealing with a challenging family with complex and wide ranging needs spanning professional disciplines. In addition, key professionals have had to seek to engage and form a professional relationship with very

challenging parents, whilst maintaining the ability to appropriately challenge non-compliance and recognise 'disguised compliance'.

20. There was a good example of a key professional appropriately and robustly challenging the parents in this case, but this was not a consistent theme. When dealing with complex parents, there is a need for constant and consistent challenge from professionals to demonstrate and support the overriding shared objective to safeguard children.

    This need for consistent challenge also applies to professionals challenging one another regarding their decision making when there is a lack of agreement between agencies. During the 'interviews with practitioners' it became apparent that on more than one occasion professionals were uncomfortable with decisions being made by other agencies but did not pursue this. There was not a culture across agencies of professional challenge acting as an effective check and balance to uni-lateral decision making.

21. It is acknowledged that in some professional disciplines the need to establish a strong relationship with service users is absolutely vital. This is particularly true of disciplines such as the Substance Misuse Service where there is a reliance on voluntary engagement. This poses a challenge when it comes to enforcing professional boundaries. During this review there seemed to be a reluctance by SMS to make a safeguarding referral, and when it was made, there were internal processes (e.g. Professionals meeting) followed which could have undermined efforts to safeguard. It was also true that the need to maintain effective engagement with parents was cited by one of the social workers as a reason for dealing with this case as Child in Need and it not being escalated to Child Protection.

22. It is important that workers have a clear understanding of their professional role, and are absolutely clear regarding boundaries in respect of safeguarding at the outset of their relationship with service users. Those boundaries must be clearly and consistently enforced throughout, regardless of any potential adverse effect on the professional relationship with parents.

    Professionals should have regard to the paramount principle at all times to ensure that the child's welfare takes precedence over the professional's relationship with their clients.

23. It is certainly evident that professionals as a collective had been slow to identify lack of parental compliance. There is a need for agencies to ensure adequate training is provided to front line staff in relation to strategies for dealing effectively with complex/challenging parents, and to recognise and appropriately address issues of non or disguised compliance at an early stage.

Inter-Agency Communication

24. It is clear from the timeline that police were receiving a great deal of intelligence regarding this family's activities throughout the time when agencies were actively involved and seeking to fully understand the risks. Lots of intelligence was being generated regarding the drug related activities of father, and these intelligence logs clearly had safeguarding implications and would have added to the safeguarding picture.

    Very few of the intelligence logs were shared with partner agencies. There may have been good reason why this was the case but it is fair to say that any such decision not to share

must have a sound rationale. It is felt that the Police need to examine their internal processes to ensure that there are no gaps in the sharing of intelligence relevant to safeguarding.

25. On a similar note, one significant incident on the time-line was when a pre-planned warrant under the Misuse of Drugs Act 1971 was executed at the family's home address. This was one of two potential opportunities to ensure a joined up approach was taken by agencies. Despite this there was no thought given to engaging with partners, particularly Social Care, to ensure a coordinated strategy with safeguarding at the forefront of everyone's minds. It is felt that Police need to examine their internal processes to ensure a more coordinated approach with partners when conducting pre-planned operations with potential safeguarding implications.

There was concern raised that both children reportedly slept throughout this police operation, and although a CID16 Child Protection referral was subsequently submitted, due to delay this did not represent the most timely sharing of safeguarding concerns. Police need to reiterate the need for officers to ensure positive and timely action is taken to support safeguarding.

There has been much discussion and analysis by the panel regarding the challenges to effective information sharing that an ongoing case such as this gives rise to. This is especially the case when there is much professional involvement from a number of agencies over a prolonged period. That said, the panel was of the view that along the time line there were key events critical to effective information sharing e.g. a formal multi-agency meeting such as a strategy meeting, or core group meeting. In this case there were missed opportunities where information with safeguarding implications was not shared at such forums and as a result any strategy or decisions made were not made on firm foundations.

Given the increasing workloads and pressures of time on staff, it is vital that such multi-agency meetings are seen as 'golden opportunities' to ensure a coordinated informed plan based on current, relevant, and accurate multi-agency sourced information. Such meetings, chaired by the appropriate level of independent senior Social Care staff need to be attended by key representatives from relevant agencies that are fully prepared and take an active part in the discussion to enable key safeguarding decisions to be made.

27. Great concern has been expressed that urine test results were not shared at multi agency meetings even though they were known to SMS. This happened on a number of occasions over a five month period including at a key point in this case - the strategy meeting just prior to the baby's discharge home from hospital. Even issues impacting on the culture of the family were known to SMS but not communicated to other agencies. In addition, on occasion, information was shared but not appropriately contextualised, for example, when urine test information was shared by SMS it was not put in a context relevant to safeguarding.

In this case there seems to have been over reliance on the actual urine sample results and not enough emphasis on the application of professional judgement of the results in the safeguarding context. A key aspect of this case was the point at which mother refused to allow the youngest child to provide a sample for analysis. Such behaviour is indicative of a parent not prioritising the child's safeguarding needs, and should have rung alarm bells and acted as a trigger for escalation.

28. During the review it was identified that the Housing Department were a particularly useful source of information whose presence at any such meeting was valuable and only added to the safeguarding picture. It is recommended that Housing are invited routinely to multi-

agency meetings regarding complex families such as this who are likely to be well known to local authority or independent housing providers.

29. During the interviews with practitioners it was identified that certain relevant professionals within health were not getting timely access to key safeguarding documents specifically the CP conference minutes. This became apparent during the interview with the SMS Doctor who reported being heavily reliant on a verbal briefing from the SMS key worker before meeting with the parents to review their medication.

Inter-Agency Knowledge

30. Due to the prevalence of substance misuse within our communities and the associated impact on safeguarding it must be anticipated that those agencies involved in safeguarding will be exposed to parents who misuse substances. Professionals need to be familiar with associated terminology and there needs to be a shared understanding of what terms actually mean.

Having reviewed the timeline in this case, it became apparent that differing terms were being used by professionals interchangeably, and the same terms were being used to mean different things. This adds to confusion and can lead to decisions being made on the basis of erroneous assumptions.

This hypothesis was tested during the 'interviews with practitioners' by asking each professional what their understanding of the term 'occasional drug use' was. This term was selected as it appeared at various points in records as a term used by professionals in this case.

Without exception each professional provided a completely different definition of their understanding of the term. The risks associated with this confusion are obvious.

31. The Adfam Report 2014 : Medications in Drug Treatment: Tackling the Risks to Children, which reviewed and summarised the key findings from 17 serious case reviews involving the ingestion of drugs by children highlighted the increased risk of babies and young children being doped by parents who themselves misuse substances. There have been previous reported instances of substance misusing parents deliberately administering controlled substances to their children in North Wales. Despite this, and although it is not suggested that symptoms of doping were missed by professionals in this case, the possibility of there being such a risk does not appear to have featured in professionals' thinking when assessing the prevailing risks.

Due to the fact that reported cases are rare, it is fair to say that deliberate doping of children by parents was not on the radar of professionals in this case until highlighted by the clinical psychologist following concerns regarding significant developmental delay becoming apparent in the older child. It is imperative that professionals keep an open mind and 'think the unthinkable' when assessing safeguarding risks to children with parents who misuse substances. Front line professionals from all agencies involved in child safeguarding need a heightened awareness of the risks, triggers and warning signs.

32. The reviewers findings in this case are consistent with the key findings highlighted in the Adfam Report 2014 below:

- Review highlighted a lack of awareness and understanding among non-drug service professionals of the risks around Opioid Substitution Treatment
- Many professionals found the very idea of intentional administration a difficult one to accept, and were reluctant to believe that their clients could behave in such a way.
- A common finding was that practitioner's missed or minimised risk factors during the family's contact with services
- Professionals in these cases took an overly optimistic view of the parent's progress, and many involved 'disguised compliance' on the part of the parents who were able to manipulate or deceive services into believing they were making positive changes
- Professional Curiosity and Challenge is a specific heading in the Adfam report
- The concepts of healthy scepticism and 'respectful uncertainty' were seen as vital in cases where children come to harm from ingesting OST drugs
- Many of the SCRs found a failure to share relevant information
- How learning from SCRs inform practice was also highlighted as an issue

SMS- Specific Learning

33. During the panel discussions and the 'interview with practitioners' a gap was identified within Health. Substance Misuse Service are not making use of the corporate safeguarding supervision available from the safeguarding team within their own organisation this may have highlighted an increased concern due to the fact that both parents were open to SMS services. It is felt that plugging this gap would enable specialist support and advice to be accessed by key Health professionals, and is likely to lead to better outcomes for children. This is thought to be particularly useful given the aforementioned conflict in the SMS worker's role.

34. On a practical note the circumstances in this case give rise to questions regarding what measures can be put in place to minimise risk to children of substance misusing parents i.e. safe storage within the home and whether these substances should be in the home at all

Multi Agency Learning

It should be noted that 'Supporting Children, Supporting Parents: A North Wales Multi Agency Protocol' details required practice by all agencies providing a service to families misusing substances. The protocol is a framework to ensure that safeguarding children takes precedence. Unfortunately the reviewers could find no reference to the protocol either in the documentation reviewed or in discussions with the professionals involved in the case. It would not appear that the protocol has been complied with in this case.

Conclusion

35. There is growing empirical evidence to support the concept that parents can and do harm their children by deliberately doping them and this is an emerging theme throughout the country.

36. This case acts as a reminder of the importance of timely information sharing between agencies and ensuring objective oversight and robust planning arrangements are in place.

37. Similar to one of the key findings in the Adfam Report 2014 this case highlighted that professionals took an overly optimistic view of parents progress which delayed escalation to Child Protection Procedures

39. The most significant learning arising from this case is the need for workers to 'think the unthinkable'. None of the professionals involved in this case had considered that the parents may have been deliberately giving the children drugs and as such an opportunity to protect these children was missed.

40. Also of concern is that a protocol designed to safeguard children in these specific circumstances was not adhered to or even apparently considered

41. It should be acknowledged that cases involving complex families require an ongoing support by several agencies continue to present to information sharing and planning

Improving Systems & Practice

In order to promote the learning from this case the review identified the following Learning Points for the North Wales Safeguarding Children Board and its member agencies:

42. Professionals involved in potential child abuse cases must have their awareness raised to enable them to think the unthinkable. They must consider that children may have deliberately given illegal substances such as methadone and should be trained in the signs and symptoms arising from this.

43. There has been a great deal of concern raised in this case that SMS did not share relevant information with Social Services which would have had a direct impact upon their risk assessment . There is a need therefore for SMS to receive training and clarification about when and how to share information appropriately.

44. For Social Services, the strategy meeting at the point of discharge was a key opportunity and internal mechanisms must be reviewed to ensure that appropriate and sufficient challenge is in place when chairing these meetings

45. Dealing with complex and often challenging parents is difficult for many professionals and in this case there was an over optimism in relation to the parents willingness and ability to change. Further training is required to adequately equip professionals to manage complex parents

46. It has been identified that NWP held relevant information/intelligence regarding this family which was not shared. Police must review its processes for the timely sharing of information which may impact on safeguarding.

47. It is recommended that the 'Supporting Children, Supporting Parents: A North Wales Multi Agency Protocol' is reviewed and updated to include specific signs and symptoms to help workers identify when parents are deliberately doping their children.

48. In light of the failure of agencies to follow the 'Supporting Children, Supporting Parents: A North Wales Multi Agency Protocol' consideration should be given to agencies reviewing their processes and providing reassurances to the RSCB about how they have disseminated and implemented the protocol.

49. This case has also highlighted the value of chronologies in considering families in the context of their history in order to predict future behaviours. Chronologies were also raised in the Derbyshire SCR (Nov 2013) which involved a death of a child of substance misusing parents. A key finding was that there was a failure to take consideration of the history of both parents to inform a sound assessment of the risks

50. Multi-agency substance misuse training needs to include information on what urine test results in such cases actually mean, and what associated behaviours among children and parents should raise safeguarding concerns.

51 It is recommended that Health examine their internal processes to ensure that key professionals receive safeguarding information in a timely way

Statement by Reviewer

REVIEWER

Statement of independence from the case
Quality Assurance statement of qualification

I make the following statement that
prior to my involvement with this learning review:-

- I have not been directly concerned with the child or family, or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
- **The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.**

Reviewer 1 (Signature)		**Reviewer 2 (Signature)**	
Name (Print)	**DI Simon Williams**	**Name (Print)**	**Francine Salem**
Date	**09/03/2016**	**Date**	**26/02/2016**

Chair of Review Panel (Signature)	
Name (Print)	**Rachel Shaw**
Date	**26/02/2016**

Annex 1: Terms of Reference

TERMS OF REFERENCE

EXTENDED CHILD PRACTICE REVIEW

GWYNEDD 1 / 2015

INTRODUCTION

- This Extended Child Practice Review has been commissioned by the Chair of the Regional Safeguarding Children Board on the recommendation of the Regional CPR Group on 12th June 2015 in accordance with Safeguarding Children: Working Together under the Children Act 2004' guidance and AWCPP 2008 which have been adopted by the North Wales RSCB. On 6th February 2015 there had been a recommendation by the Regional CPR Group that a MAPF should be undertaken.
- When the merged timeline was created the Panel was advised by the Business Manager to consider whether or not this case meet the threshold for an ECPR and therefore the matter was returned to the Regional CPR Group on 12th June and the recommendation was changed.
- A Multi – Agency review panel and review Panel chair has been identified by the Regional CPR Group and independent reviewers have been nominated to undertake the review; DCI Simon Williams of North Wales Police & Francine Salem Service Manager Wrexham County Borough Council. Rachel Shaw, Public Health Wales was appointed as the Chair of the Review panel will regularly report progress to the regional CPR Group
- Business Manager will be responsible for governance arrangements for the retaining of documentation.

PANEL

Rachel Shaw	**Chair of the Panel**
Simon Williams	**Reviewer** **Detective Chief Inspector , North Wales Police**
Francine Salem	**Reviewer** **Service Manager, Wrexham County Borough Council**
Panel members	
Detective Inspector, **North Wales Police**	
Senior Manager for Safeguarding and Quality, **Gwynedd Children Services**	
Early Years Coordinator, Early Years Unit, **Gwynedd Children Services**	
Clinical Nurse Specialist Safeguarding, **BCUHB**	
Consultant Acute and Community Paediatrics, **BCUHB**	
Neighbourhood Services Manager, **Cartrefi Cymunedol Gwynedd Cyf**	
Head of Operations - North Wales, **CAFCASS Cymru**	
Head of Programme & Consultant Psychiatrist, **SMS, BCUHB** (for part of the Review only)	

Safeguarding Lead Mental Health **CPG, BCUHB** (for part of the review to replace Head of Programme and Consultant Psychiatrist SMS BCUHB)
Consultant Nurse, **Substance Misuse Service, BCUHB** (for part of review only to replace Head of Programme and Consultant Psychiatrist SMS BCUHB)

PURPOSE

- To establish whether there are lessons to be learnt about the way in which local professionals and agencies work together to safeguard children.
- To identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.
- As a consequence improves inter agency working and better safeguard children.
- Identify examples of good practice.

TERMS OF REFERENCE

The terms of reference agreed for this review are:-

1.	**The following agencies will provide a timeline of actions taken by each agency during the 12 month preceding the event (7/11/14-1/11/13)** • **Gwynedd SSD** • **Health Visitor** • **Paediatrics** • **SMS** • **Early Education** • **Police** • **CAFCASS Cymru**
2.	**A summary/analysis of each agency's involvement will also be produced by the above services. This will include additional background information from outside the timescale for the review as well as initial analysis of the key issues involved, an indication of further issues for consideration by the Reviewer and any recommendation if appropriate.**
3.	**Other services may be asked to provide a timeline following review of the information provided.**
4.	**Determine whether decisions and action taken in the case comply with local and national policies and procedures.**
5.	**To examine inter-agency working and service provision for the child.**
6.	**To determine the extent to which decisions and actions were child focused**
7.	**To consider whether previous relevant information or history about the children and/or family members was known and taken into account in professionals' assessments, planning and decision making in respect of the child, the family and the circumstances. How did this knowledge contribute to the outcome for the children?**

8.	**To consider whether the Child Protection Plan and looked after child plan was robust and appropriate for that child, the family and the circumstances.**
9.	**To consider whether the plan was implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development of the multi agency plan.**
10.	**To identify what aspects of the plan worked well and those that did not work well and why?**
11.	**To identify the degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child**
12.	**To determine whether the respective statutory duties of agencies working with the child were fulfilled?**
13.	**To identify any obstacles or difficulties in this case that prevented agencies from fulfilling their duties (organisational issues and other contextual issues)**
14.	**The Reviewer is to consider contact with the family, to apprise them of the review, ascertain the degree of involvement they want in the review and keep them informed of key aspects of progress.**
15.	**If any features of the case, indicates that any part of the review process should involve or be conducted by an independent party this should be referred immediately to the Review Chair and Regional CPR Chair.**
16.	**Identify any parallel investigations (for example, disciplinary , inspectorate investigations) of practice and determine if a co-ordinated approach will address all the relevant questions.**
17.	**To hold a learning event for practitioners and to liaise closely with North Wales Police and Crown Prosecution Service in relation to hosting the learning events and discussion points at the event.**
18.	**The Reviewer will produce a succinct Review Report with learning points and issues in accordance with 'Protecting Children in Wales 2012'.**
19.	**The Reviewer will share the findings of the review with the family.**
20.	**The Review Panel will identify the learning points and issues and will consider all actions if required**
21.	**The Review Report will be presented by the reviewer and Chair of the review panel to the Regional CPR Group and NWSCB.**
22.	**The Chair of the NWSCB will be responsible for making all public comment and response should there be any media interest concerning the review until the process is completed. Also consider whether there is a need for the public disclosure of information.**
23.	**The Regional CPR group and the Review Panel will seek legal advice on all matters relating to the review as necessary. In particular this will include advise on:-** **TOR** **DISCLOSURE** **TIMESCALES** **DATA MANAGEMENT** **A Legal Advisor from Conwy County Council will be the Panel's legal advisor**
24.	**Panel Members will destroy all notes/paperwork relating to the review once the process has finished. All information relating the review will be stored by the Business Unit. Information will be stored securely and in accordance with their retention and data protection policies.**
25.	**All correspondence will be sent by e mail and will be password protected or sent via a secure e mail system. The use of initials or any other personal information that contravenes data protection guidance will not be used to identify the child or family outside of secure communication channels.**

26.	**Panel members will not share information with any third party without the permission of the Chair.**

Version 1: 29/6/15