Child Practice Review Report

Cardiff and the Vale of Glamorgan Safeguarding Children Board

Extended Child Practice Review C&V LSCB02/2014

Brief outline of circumstances resulting in the Review

To include here: -

- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal Context:
This Extended Child Practice Review has been commissioned by Cardiff and Vale of Glamorgan Local Safeguarding Children Board. The criteria for this Review were met under section 6.1 of Guidance for Arrangements for Multi Agency Child Practice Reviews (WG 2013)

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

(a) died; or
(b) sustained potentially life threatening injury; or
(c) sustained serious and permanent impairment of health or development

and

The child was on the Child Protection Register and/or was a Looked After Child (including a care leaver under the age of 18) on any date during the 6 months preceding:

- the date of the event referred to above
- the date on which the Local Authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for extended reviews are laid down in revised regulations, The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.

Circumstances Resulting in the Review:

This Extended Child Practice Review (ECPR) was commissioned following a recommendation from the Child Practice Review Subgroup of the Cardiff and Vale Safeguarding Children Board. It considers the circumstances of a young girl who was and remains subject of a Care Order to the Local Authority and had been placed in a residential care home out of Wales. Prior to this she had been in a residential care home in Wales as well as having been looked after in a number of foster placements. She was vulnerable in a number of ways: she was/is subject to a statement of educational needs; her behavior was unpredictable and made her vulnerable as she often went missing from her placements. She could be challenging and uncooperative and she did not appear to have close relationships with her peers and was in many ways was considered immature for her age.

Her younger sibling is also the subject of a Care Order to the Local Authority and for some time they were in a foster placement together. Apart from her younger sister the child has two half-brothers, both older than her. Contact with her birth family, particularly with her parents is not consistent. She does have a close bond with her maternal grandmother. She can be very resourceful and it was to her grandmothers 'she ran to' when she went missing from her placement in England taking a day on one occasion and two days on another to make her way to her grandmothers address.

A feature of this young person's behavior throughout the period of this review was her propensity to 'go missing/run away' from her placements. On occasions she would return to her placement of her own free will, albeit the police were frequently involved.

As a direct consequence of the relationships she was allowed to form with other young people in the latter residential care home, led to her being vulnerable to sexual abuse and exploitation which resulted in her being subjected to two separate sexual attacks upon her with the latter being a rape which resulted in her being hospitalised

Children Services had adopted their agreed tendering processes when attempting to locate a placement for the child. They were satisfied that the residential care home where the child was placed was appropriate to meet all of her needs. Following the attacks which she had been subjected to whilst being a resident at that home, Children Services had no reason to believe that the care home itself was not a suitable placement for her. However following a communication from a Police Force in England with Children Services, they voiced their concerns about the placement, explaining the risks involved in returning the child to the home. During the discussion the police mentioned that if a decision was made to return the child they would invoke their Powers of Police Protection. Children Services clearly listened to and assessed the information received from the police regarding the risks posed to the child within the care home setting. As a consequence of that discussion together with the information in respect of the attacks on the child a further risk assessment was conducted by Children Services. From that assessment Children Services decided to apply for and was successful in obtaining a three month Secure Order to place the child in secure accommodation for her own safety.

She has since been placed in a residential care home in West Wales with three other children, including her younger sister. She is settled and making progress, and having contact with her family.

The Child Practice Review Sub Group first raised this referral in January 2014. Following that meeting the Chair of that subgroup made contact with the relevant LSCB in England concerning the referral.

Representatives at a subsequent meeting were satisfied, that due to the Looked After Children status of the child the criteria for an Extended Review of the child was met. Further dialogue also took place between Cardiff and the Vale LSCB and the relevant LSCB in England and by the meeting dated 17th November 2014 it was noted and accepted that it is the responsibility of the placing authority to undertake the Child Practice Review due to their accountability for the welfare of the child. As a consequence on that same day it was decided that the CPRSG would recommend to Cardiff and the Vale LSCB that an extended child practice should be commissioned as a consequence of the multi-agency involvement with the child. Agencies involved from the English region have fully engaged in the CPR process.

At the first meeting of the Child Practice Review Panel (CPRP) it was agreed that the scope for this ECPR would be for the two years leading up to the event which triggered this review i.e. from 16th October 2011 to 16th October 2013, it is acknowledged there was a significant delay in commencing this review.

The Terms of Reference for the Review can be found at Appendix1

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

The Learning Event

There were a number of themes identified through the work of the Panel and during the event.

The Learning Event was attended by 13 practitioners in addition to the Panel Chair, the two reviewers and the LSCB Business Manager. With permission of the participants the Learning Event was recorded to enable the Reviewers to ensure discussions and decisions are accurately reflected in this report.

The following practitioners were in attendance.

- 2 Looked after Children Nurses
- 2 Police Officers from South Wales Police
- Team Manager for Looked After Children 14+ team.
- Team Manager Children's Services
- Social Worker for the Child
- 3 Representatives from Education
- 2 Police Officers from the Police Force involved from England
- An English Local Authority's Children Services

The views of the young person

The Reviewers met with the young person in her current placement in a residential home in Wales prior to the Learning Event to seek her views as to the services provided to her.

The child was seen in the lounge. She sat curled up in an armchair but did make eye contact.

She told the reviewers:

She was annoyed at the number of times she was moved although she understood it was to keep her safe and she didn't mind being so far away from home. She was happy that she was now in a placement with her sister, as when she was placed elsewhere she missed her sister and wasn't allowed to see her or phone her Nan.

She demonstrated an understanding of her inappropriate behaviour and said she was treated well when she was held in police custody.

She told us she was annoyed when she was placed out of area that her Social worker was never available to talk to and she was never visited by her, and that she

wanted to see her family more. She spoke very positively about her current social worker.

The Reviewers also met with the maternal grandmother at her home prior to the Learning Event to seek her views of the services provided to her granddaughter:

She consider that it was wrong that her grand-daughters had been separated when in foster care and considered that to do so was not in their best interests. She was upset that once her granddaughter was placed out of area she never saw her, she didn't know what was going on, professionals never contacted her and it wasn't until the child ran away that the family were first made aware of the 'sexual exploitation issues'.

She found contact with her grandchildren stressful as it was supervised and she hadn't been told this was going to happen. She noted that her granddaughters had had no contact with the extended family (cousins, etc.) saying they don't know who their family are.

She confirmed that all correspondence to the girl's mother is sent to her (grandmother's) address, but that she does not get communication in her own right so never knew what was going on as her daughter didn't tell her much.

During the discussions of the timeline the Practitioners noted the following:

- There was a varying level of knowledge in regard to the number of times the police had been involved due the child going missing, etc.
- School (Cardiff) appeared to be a place of stability.
- The young persons' behaviour in school was inconsistent, sometimes conforming and not at others. She could be unpredictable.
- Her personal appearance was very important to her but not always age appropriate.
- The 'Barometer of concern was considered to be 'medium to high'.
- In school she spent a good deal of time in the 'Nurture Class'.
- She did not meet the criteria for the acute services which were provided by (therapeutic) CAMHS what she required was a therapeutic service which CAMHS did not offer. It was noted that there had previously been a CAMHS Nurse who could have provided the necessary service but that service came to an end when the two LA merged. Practitioners identified that in their opinion a significant number of Looked After Children actually require a service that is no longer available. It was also the practitioner's view that it is often the carer that needs the support to manage children with difficult behaviours and again this is no longer available.
- The separation from her sibling had a major impact on her, albeit her sibling felt she was being held back by the index child.
- Practitioners felt that the introduction of a mobile phone for this particular child at that time may have been an unwise decision as suddenly she had 'lots of friends'.

- Concerns escalated from January 2013 onwards when the young person became very 'disengaged'.
- The legal duty to always find a school place for a child is not easy in reality especially with out of county placements.
- Health professionals identified they do not always get informed when a child is moved out of county.
- There was little understanding of the tendering process for Out of County Placements by partner agencies other than the Local Authority.
- Concerns about the quality of information transferred in relation to health when a child moves as Looked After Children Nurses do not do this themselves.
- If the child is not statemented there can be a delay in sharing information
- Lack of an All Wales Notification Process for transferring children out of county, the police being aware of the 1st out of County Placement but not the 2nd which impacted on the information sharing.
- Issue raised around moving a child from one area where there is a service provision to another area where this not i.e. Caterpillar Service.
- Lack of clarity of between what was fact, observation, allegation and opinion
- Dealing with the surface issues and not drilling down to the cause of the child going missing this may be appropriate to be carried out by someone independent. Practitioners identified it would have been beneficial if there had been a process for 'missing person debriefs'. Statutory guidance on children who go missing from home (s.7 Local Authority Act 1970 paragraph 69 and accompanying flow chart places an obligation on the Local Authorities to offer an independent return interview. Whilst this is applicable in England it does not appear to be the same in Wales. The All Wales Protocol on Missing Children Paragraph 6.4 is not as prescriptive and states that the interviewer could be a police officer, social worker, teacher or independent person. This can be confusing and all agencies need to be aware of those differences.
- Looked After Children Nurse triggered a SERAF (Score 36).
- There was confusion between agencies with regard to whether a CSE strategy meeting had taken place.
- Lack of family involvement in Looked After Children Reviews.
- Young person had four changes of placement in a very short time.
- The out of area placement was seen as an appropriate placement having had a good Ofsted report albeit from a police perspective the number of young people who went missing from the placement was disproportionally high and No SERAF undertaken there. (NB: Although this provision remains open it no longer specialises as a placement for children at risk of CSE.)
- There is a need for clear and well understood communication pathways.
- Professionals expressed their concerns about appropriate adults being available to juveniles in custody (especially out of hours).

Effective practice in inter-agency collaboration

- There were appropriate links between foster carers and the pastoral care team
- Her learning difficulties were widely acknowledged and appropriate support was offered.

- Police Force involved in England noted they have a missing person's co-ordinator so when a child is placed who causes concern re missing episodes there is a central person who is the link.
- There was effective communication between Forces as well as agencies at the point of the child being reported as missing and as a consequence of that communication as well as the effective intelligence systems the child was recovered expeditiously.
- Whilst the separation of the siblings in this case may have proved not to have been the best course of action, there was clear evidence of significant consultation between representatives from all agencies to ensure that the decision was well informed and would stand scrutiny having considered the impact that it would have on both children.
- There is evidence from the initial disclosure of the rape allegation of a thorough and robust investigation where the child's needs were met by effective protocols being adhered to as well as the effective communication between the three Police Forces involved which led to a prompt and effective arrest of the perpetrator.
- The effective communication between the English Police Force and Cardiff Children Services with regard to the accommodation in England not being a suitable placement for the child. The police in that area were so concerned about the placement that they confirmed they would be invoking Powers of Police Protection in respect of the child if she was returned. Children Services listened and risk assessed the entire situation and as a consequence a Secure Care Order was obtained to allow the child to be placed into secure accommodation thereby ensuring that she was kept safe.
- When the child was placed into an out of county placement in the South Wales Police area there was evidence of good communication and information sharing between the Missing Person Co Coordinator in South Wales Police and the South wales Police officers in the placement area which evidences that providing agencies know about the placements appropriate measures can be put into place to respond accordingly. This was evidenced in the missing episodes.

Improving Systems and Practice

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

During the course of the Learning Event the practitioners engaged in an open and proactive manner. A number of learning points were identified which have led to the following actions being identified. Most of these learning points hinge on the importance of appropriate and timely information sharing. It needs to be noted, information sharing has frequently been identified as a failure in numerous reviews of the Serious Case Review process over the last two decades.

Understanding the tendering process for Out of County Placements and whether there is a choice/making the right choice

There was a lack of understanding across agencies in this regard and the Local Authority identified that when an out of county placement is put out to tender it may be that there is just one placement that tenders rather than there being a choice.
It was noted that as far as the residential placement this child had had both local to Wales and out of county, none of them were represented at the Learning Event and this was because they are no longer in existence. It was also noted these placements are usually private businesses. It is essential that the services provided when looking for placements for children meet the needs of the child. This child needed a therapeutic placement but the out of area placement was not such a placement albeit claimed to be as they had access to a peripatetic therapist. It is noted that The Local Authority have already undertaken a Review of this establishment

Before a child is placed there should be pre-placement multi -agency discussions with that area. It was identified that children's services would not as a matter of course speak to the police into the receiving area, it is suggested this should be part of the process as The Police Force where the child was placed knew how many children went missing from that residential home. If this had been known by Cardiff if is likely this child would not have been placed there.

Sharing information about a child who has had episodes of 'going missing'

This young person had had numerous episodes of going missing when she was resident in the Cardiff and Vale area, when such a child is placed out of county it is essential these behaviours are drawn to the attention of the receiving area.

Review the role of the missing person's co-ordinator

Consideration should be given to reviewing the roles and responsibilities of the four Missing Persons Co-ordinator across South Wales Police and it is recommended that this is done through discussion with the English Police Force involved, the other Welsh Forces and the National College of Policing to ensure a more corporate approach and to have an understanding of the different levels of interventions/processes in the respective areas.

The importance of effective transfer of information when a child is placed out of area and there are concerns in relation to being vulnerable to sexual exploitation

CSE procedures in Wales came into force towards the end of 2012. But the receiving placement stated they didn't have any information from Cardiff in relation to this young person's vulnerability. It needs to be noted the CSE procedures are an enhancement of the existing child protection procedures.

However Cardiff LA did send information to the Residential Care Home Management Team in the receiving area, but not to the home itself which identified a communication issue between the Residential Care Home, Management Team and the home. During the Looked After Children Review general issues had been discussed but not specific details such as the number of missing episodes when the young person was in Cardiff.

A history of 'missing' should be actively shared with the receiving placement. (Similar to a MAPPA Process - again if effective multi agency transfer meetings (MATMS) take place such behaviours should be disclosed.

The importance of following through with assessments when concerns have been raised about the possibility of (sexual) exploitation

The timeline identified a number of occasions when professionals had made reference to their concerns that this young girl was vulnerable to exploitation yet these concerns did not lead to a full assessment of risk or any identified action plan to address the risks

Risk assessing giving a young vulnerable person a mobile phone

This young person, who was known to display vulnerable behaviours, was given a mobile phone as a 'present/reward'. This should have been discussed with her key worker and properly risk assessed.

Keeping family members who are considered as significant to the child appropriately informed of plans when they do not hold parental responsibility

The child's maternal grandmother was a significant person to this young girl, and as identified earlier, was the person she ran to on two occasions from her out of area placement. It was made clear during the discussion the reviewers had with the grandmother she did not understand the rationale for supervised contact or have any real understanding of the Care Plan or indeed why the child was subject to a Care Order. When this was explored during the Learning Event the reason given for this was because grandmother did not have parental responsibility albeit it was acknowledged she was a significant person in the child's life. It was also noted the child's mother did not always actively involve herself in meetings convened in relation to her children. Therefore it was unlikely she would keep the grandmother informed about the children's situation. When working with family members who are difficult to engage, it is important agreements are put in place to enable appropriate information can be shared with significant family members.

The need to take a holistic approach when considering changes of placement.

The implications of all agencies need to be discussed when considering out of county placements. In particular the educational need for a child is fundamentally important and it has been highlighted that the legal duty to always find a school place for a child is not easy in reality. Education need to be engaged in the decisions making process around out of county placements to ensure that there is an appropriate provision for the child and to allow for a smooth transition.

Looked After Children Nurses should receive notifications in advance to be able to comply with good practice and share information regarding out of area placements

There is not An All Wales Notification Process for the transferring of notes and or information and as a consequence it is incumbent upon Children Services to notify the

Looked After Children Nurse of the decision around changes in placement. This would allow the Looked After Children Nurse to effectively notify their counterparts in the placement area, as well as transfer the notes. This happened when the child was moved into the South Wales placement due to the effective communication but this failed when she moved to the placement in England.

The Voice of the Child

It is important that when decisions are being made in respect of the placements and the support and care for children that there is clear documented evidence that their own views and concerns are also being considered and addressed.

Independent De Briefs with regard to children who go missing and are identified as being vulnerable to CSE.

There is evidence from this case and from previous reviews that many children do not engage with the police following missing episodes and as a consequence there could be missed opportunities for effective intelligence gathering to protect the child and identify perpetrators of CSE. There is a clear need for this type of service provision to be put into place to establish if it will enhance the safeguarding around children.

Making use of 21st century technology

It is suggested, communication could have been enhanced if more use was made of available technology such as using skype calls/video conferencing, as face to face communication can be more effective than emails and phone calls.

Review the single point of contact for referrals of Out of County Placements

The learning event identified that there is a need for Local Authorities to have a single point of contact for the referring and receiving of information concerning Out of County Placements with the responsibility of acknowledging receipt of the same. This would ensure a smooth, effective and informed transfer of the child. This would also enhance the ability for partner agencies to access information should a concern be identified around an out of county placement child. The Local Authority have confirmed to the reviewers that there is a process that has been in place since 2007, this is a purely administrative function. The review identified that there was a need for the practitioners involved in the care of the child to be aware of that process and what information is shared, to enable them to effectively assess the ongoing needs and risk for the child which was absent in this case.

Strengthen approaches to supporting placement stability.

It was noted this young girl had a number of foster placement across the South Wales area prior to being transferred out of area. Each time she was moved it was because here behaviour was difficult for the carers to manage and on occasions after a move the child would decide she wanted to go back to the previous placement. The number of different placements was not conducive to the child's best interests. There is a need for appropriate and effective planning involving the child. There should be more

consideration given to exploring the need for extra support to the current placements to deal with the identified issues rather than solving the problem by moving the child.

Review of the All Wales Protocol for Missing Children

The All Wales Protocol for Missing Children is not prescriptive around whose responsibility it is to ensure that a missing child is interviewed and or offered an independent interview following his/her return unlike the procedures in England. This can lead to confusion especially with the cross border issues with missing children. This needs to be addressed in any subsequent revision of the procedures as otherwise everyone will think someone else is doing it.

Statement by Reviewer(s)	
REVIEWER 1 Daphne Rose Designated Nurse Safeguarding and Looked After Children Safeguarding Children Service Public Health Wales	**REVIEWER 2** Susan Hurley Independent Protecting Vulnerable Person Manager South Wales Police
Statement of independence from the case *Quality Assurance statement of qualification*	**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**.**	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)* … Daphne Rose. ……	**Reviewer 2** *(Signature)* *S. Hurley* S. M. Hurley
Chair of Review Panel *(Signature)* **Name** *(Print)* **Date**	Peter Greenhill Peter Greenhill 16.03.2015

Appendix 1: **Terms of Reference**

Index Child: Born 1999

The specific tasks of the Review Panel

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

- Agree the time frame for the review including any necessary reference to any significant background information or previous incident.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Child Practice Review Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken.

- The Panel determined that the appropriate agencies to be engaged in this review and therefore participate as members of the review panel are:

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the Reviewer/s a Learning Event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback. Based upon the timeframe within which the Panel will conclude the review and the Learning Event will be scheduled for the 9th July 2015.

- Plan with the Reviewers contact arrangements with the child and her family members prior to the event. Advice will be sought about how to engage with the child subject to the review and any relevant family members.

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

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Child Practice Review Sub Group and the LSCB for consideration and agreement. (It is proposed that the report will be shared with the Child Practice Review Sub Group at its meeting scheduled for 8th September 2015 and at the LSCB meeting scheduled for 30th September 2015). It is proposed that the final report will be signed off by the end of September 2015 and submitted to Welsh Government in October 2015 at least 15 days prior to publication.

- Following the acceptance of the Child Practice Review Report by Cardiff and Vale Safeguarding Children Board and Welsh Government the Reviewers will make arrangements with the child and family to share the report with them before it is published on the Boards website

Scope of Review:

At the first Panel meeting it was agreed that the start date for the scope of the review would be on16th October 2011 – 16th October 2013. The Panel commissioned the following:

Chair of Panel - Peter Greenhill
External Reviewer - Daphne Rose
Internal Reviewer - Susan Hurley

Panel Members:

Cardiff and Vale of Glamorgan LSCB Partner Agencies:

Health: Cardiff and Vale University Health Board
Children Services: Cardiff Local Authority
Vale of Glamorgan Local Authority
Education Services: Cardiff Local Authority
Vale of Glamorgan Local Authority
South Wales Police

English region's LSCB Partner Agencies:

LSCB
Social Care
Police
NHS Foundation Trust
Learning and Achievement

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and LSCB.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a Learning Event for practitioners and identify required resources.

In addition, as this was an extended review, the Panel will have particular regard to the following:

- Was previous relevant information or history about the child and/or her family members known and taken into account in professionals' assessment, planning and decision-making in respect of the children, their family and their circumstances? How did that knowledge contribute to the outcome for the child?

- Was the child protection plan/looked after child plan for the child) robust and appropriate for the child and her circumstances?

- Was the plan for the child effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan(s)?

- What aspects of the plan(s) worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan(s), including the progress against agreed outcomes for the child?

- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?

The tasks of the Local Safeguarding Children Board

- To consider and agree any Board learning points to be incorporated into the final report or the action plan. This will take place no later than the scheduled meeting of the LSCB on 30th September 2015.

- To send the Final Report and Final Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government. This will be scheduled to take place in October 2015.

- To confirm arrangements for the management of the multi-agency action plan by the Child Practice Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- To plan the publication of the report on the LSCB website. The date of publication will be confirmed by the Chair of the LSCB Board.

- To agree dissemination process to agencies, relevant services and professionals.

- The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2 Summary Timeline

Appendix 3: Child Practice Review process

To include here in brief:

- *The process followed by the LSCB and the services represented on the Review Panel;*
- *A Learning Event was held and the services that attended.*

Family members' had been informed, their views sought and represented throughout the Learning Event and feedback had been provided to them.

The Panel met on 6 occasions with relevant personnel from the receiving region joining the Panel by telephone conference. Following the first Panel meeting timelines were produced by agencies and merged.

The young person and her family were offered the opportunity to meet with the Reviewers before the Learning Event so their thoughts and feelings about the way agencies worked with them would be considered at the Learning Event. The Reviewers met with the young person's Grandmother at her home, and with the young person in her accommodation.

The Learning Event was attended by 15 professionals who had been involved or worked with the young person. The timeline was used to inform the Learning Event where practitioners worked together to consider how effective the interagency working had been. They considered whether there needs to be changes in working practice to better protect children, or whether there had been missed opportunities to protect the young person from the abuse she suffered. The maternal grandmother and young person's thoughts, feelings and opinions that were shared with the reviewers were insightful and were shared at the appropriate points during the Learning Event and influenced the learning outcomes.

The Reviewers produced a draft report which was considered by the Panel. The final report was recommended to the Child Practice Review Subgroup and the Reviewers presented the Report to Cardiff and Vale SCB on the 30/9/15 the Chair of receiving region's SCB was in attendance.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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