

Cardiff and Vale of Glamorgan
Regional Safeguarding Boards

Child Practice Reviews

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Caerdydd a Bro Morgannwg
Byrdd Diogelu
Oedolion Rhanbarthol
CaFBDOR
C&VRSAB
Cardiff & Vale of Glamorgan
Regional Safeguarding
Adults Board

Bwrdd Diogelu
Plant Rhanbarthol
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National Findings

Learning from Reviews

1 April 2018 to 31 March 2019

Analysis of Emerging Themes from
Child Practice, Adult Practice and
Domestic Homicide Reviews in Wales

NHS Wales Learning from Reviews
National Safeguarding Team

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- Between 1 April 2018 and 31 March 2019, there were **16** published reviews in Wales. This comprised of:
 - 3 Domestic Homicide Reviews
 - 7 Child Practice Reviews
 - 6 Adult Practice Reviews

National Themes

- Record Keeping and Information Sharing

Discrepancies in record keeping and information sharing practice, omissions, lack of clarity and detail, failure to share relevant information with others, inconsistent quality of information recorded.

- Long Term Neglect and Complex Cases

Unrealistic expectations, lack of coordination and joined up health services, confidence to effectively manage families and secure their engagement, cases allowed to drift with a lack of management oversight.

- Voice of the Child

Importance of seeing, hearing and observing the child; complexities in managing parents needs deflected attention from the child, importance of capturing the 'voice' of very young children including those with speech/language delay.

National Themes

- Disguised Compliance and Professional Optimism

Skilful strategies used by parents to allay professional concerns and diffuse intervention, professional optimism, false sense of security, lack of professional curiosity.

- Supervision and Professional Vulnerability

Poor management oversight, high caseloads, lack of adequate supervision.

- Risky Behaviour and Holistic Risk Assessments

Exclusion from school, going missing, escalating concerns, unpredictable and challenging behaviour which professionals felt unable to manage.

- Care Planning and Supporting Older People

Lack of care-coordination packages, anecdotal concerns, lack of documented evidence to indicate concerns had been acknowledged/explored by the placing authority, lack of joined up health services and coordination.

C&V Reviews Themes

Common Themes	Volume	References
Planning/Assessment/Review	5	CPR 1/2013, CPR 2/2014, CPR 9/2014, MAPF 2/2015 APR 2/2017;
Staff Development	5	CPR 1/2013, CPR 9/2014, MAPF 2/2015, CPR 9/2014 APR 2/2017;
Communication and Information Sharing	6	CPR 2/2014, CPR 3/2016, CPR 04/2016, CPR 2/2016 APR 2/2017; APR 4/2017
Voice of Child	5	CPR 02/2014, CPR 9/2014, MAPF 2/2015, CPR 3/2016 CPR 2/2016
Raising Awareness	1	MAPF 2/2015

C&V Reviews Themes

Common Themes	Volume	References
Disguised Compliance	3	CPR 3/2016, CPR 2/2016
Decision Making	2	CPR 9/2014, CPR 3/2016
Record Keeping	3	CPR 3/2016, CPR 4/2016 CPR 2/2016

C&V Reviews 2019-2020



Established CPR/APR sub group with good attendance and appropriate membership

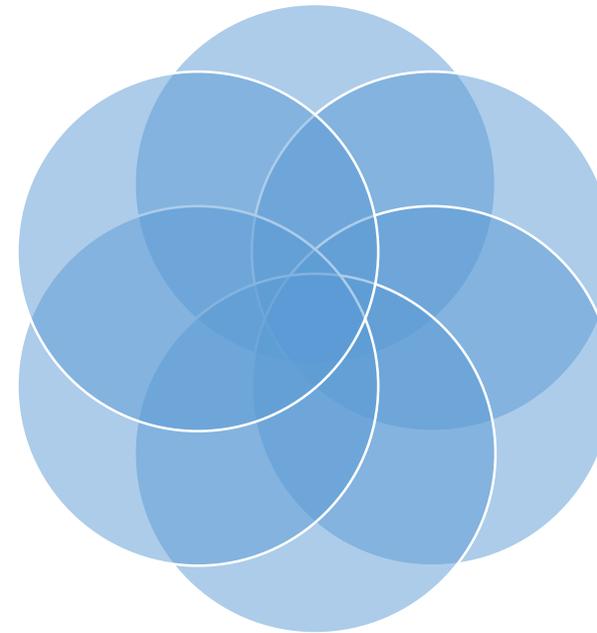
First APR Published, with positive feedback on content and learning from WG

Rolling Programme of CPR/APR Awareness Sessions – overview of what reviews are; who can refer; criteria (Business Unit)

Training has resulted in increased pool of reviewers and chairs

Shadowing opportunities (APR/CPR)

Two days reviewer training delivered in January 2020 by Barbara Firth. Half day 'train the trainer' sessions



C&V Reviews Forward Planning 2020 - 2021

More robust system of monitoring and dissemination of learning: Learning Framework, 7 minute briefings, Safeguarding 'Keeping you informed/alerts' and themed events

Closer interface with other review mechanisms i.e. RCA's,

Pool of trained/experience
Chairs/Reviewers

Connectivity with other sub-groups in dissemination of learning and monitoring of action plans/recommendations

All organisations represented on board will be required to submit plan of how learning has been embedded and recommendations taken forward