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Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Executive Summary Report

of the Investigation into an Allegation Made Under the Public Interest Disclosure Act in October 2013

Ceredigion County Council

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Introduction

Background to the Public Interest Disclosure Act Allegation

1. The Local Safeguarding Children Board (LSCB) of Authority B decided to conduct a Serious Case Review (SCR) following the death of a child who had lived in their area. Authority B's LSCB began the SCR process in February 2012 and in September 2012 decided that information should be sought from Ceredigion County Council. The information sought was in connection with one of the child's parents. The terms of reference for the SCR were provided to Ceredigion County Council with the request for an independent management review (IMR) to be completed within a specified time frame. This time frame had been set previously in agreement with other agencies who were also contributing to the SCR.

2. The Allegation made under the Public Interest Disclosure Act is that Ceredigion County Council failed to complete the required IMR in accordance with the relevant statutory guidance *Safeguarding Children : Working Together under the Children Act 2004.*

Focus of the Investigation

3. Following receipt of the allegation made under the Public Interest Disclosure Act (PIDA) it was determined by the Care and Social Services Inspectorate Wales (CSSIW) that a focused investigation was in order. The investigation would consider the actions taken in commissioning and completion of the IMR and would not focus on the content and quality of the IMR.

The specific questions to be addressed were:

a) What were the actions taken in commissioning and completing the IMR?

b) Was the IMR completed in accordance with the statutory guidance?

The Investigation Process

4. The investigation was undertaken by a CSSIW sessional inspector between December 2013 and February 2014.

5. In September 2013 the LSCB of Authority B decided that the SCR should be suspended due to external factors with the result that all IMRs, including that of Ceredigion County Council, were also to remain suspended until further decisions had been made by the LSCB. This

investigation therefore focuses on events between September 2012 and September 2013.

6. During the time period covered by this investigation revised statutory guidance in Wales was introduced to replace Serious Case Reviews with Child Practice Reviews from 1st January 2013. Whilst this change may have influenced thinking the LSCB was still conducting a SCR up until the decision was made to suspend it in September 2013.

Findings

7. The investigation found examples of good practice as well as omissions and shortfalls in Ceredigion's County Councils actions in completing the IMR. Good practice included the prompt commissioning of the initial IMR; the IMR author was provided with the terms of reference and the necessary documentation and took decisions about whom to interview. An appropriate person acted as liaison between the IMR author and the commissioning LSCB. The report was completed within the very short timescale and sent to the LSCB by the requested date. These actions showed diligence and positive joint working.

8. The investigation also identified some shortfalls and omissions in the process in particular in relation to interviewing key members of staff and data gathering and analysis. These shortfalls could have been addressed in early December 2012 in order to ensure that the Statutory Guidance was followed and due process observed. This would have ensured that the SCR writer's group could consider the possible significance of information that had not been included and analysed initially. Opportunities for feedback and learning were not identified and acted on at this stage.

9. Shortfalls in responding speedily and effectively to concerns raised by one of the interviewees were also found. The concerns, which later became the impetus for the complaint included concerns about the interview process, the failure to provide a record of the interview and a failure to include some information that the complainant believed to be significant and without which the IMR would be incomplete. The CSSIW investigation concluded that these were substantial concerns that could have been responded to and their significance evaluated in detail immediately after they were raised in order to ensure due process was followed.

10. The investigation found evidence that senior officers made on-going attempts to resolve the concerns and challenges in the six months after the first IMR was submitted in November 2012. These actions showed a commitment to collaborative working at a senior level. However, it was difficult to see how the different roles and responsibilities of senior officers were being co-ordinated to ensure that there was also effective overall management of the IMR. The decision by the Chief Executive to seek legal advice as to the necessity for a new IMR showed a commitment to ensure that statutory guidance was followed.

11. In addition, despite two further revisions to the IMR in May 2013, following external legal advice being received, some of the initial omissions and shortfalls continued. The revisions were informed by revisiting documentation only and no interviews were held meaning that all of three of the IMRs were signed off by the Authority without key people being interviewed in person and interviews recorded. Therefore, due process was not followed and the opportunity for more detailed exploration and analysis of possible significant information was missed.

Conclusions and Recommendations

The purpose of an IMR as set out in *Safeguarding Children*:*Working Together under the Children Act 2004* is two fold:

- To provide information to Local Safeguarding Children Boards in a consistent format to help with preparing an overview report (paragraph 10.28).

- To '*look openly and critically at individual and organisational practice'.* The reason for this is '*to see whether the case indicates that changes could and should be made and if so identify how these changes should be brought about* (paragraph 10.25).

- While the Statutory Guidance does not address possible challenges to an IMR this investigation has demonstrated that for an IMR to fully meet the stated purposes it needs to be as comprehensive, considered and appropriate to the circumstances. When Ceredigion County Council were made aware of concerns of a member of staff about the adequacy of

the IMR, prompt action should have been taken to address the concerns.

It is recognised that Ceredigion County Council cannot do anything further with the IMR whilst the SCR process is suspended. It will be for Authority B and their LSCB to decide what the next steps will be and when this is decided Ceredigion County Council can then respond accordingly. In the meantime it is recommended that:

- An update and interim feedback session for staff involved be arranged as per the Statutory Guidance.
- If the SCR is re-instituted and Ceredigion County Council resumes the compilation of the IMR, it must ensure that key staff are interviewed in person and interview notes provided to them as required by the Statutory Guidance.
- Lessons from this investigation for organisational practice (including safeguarding practice), management, communication and engagement need to be identified and action taken to implement the learning.