Findings from a Thematic Multidisciplinary Analysis of Child Practice Reviews in Wales

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In this paper, we report findings from a qualitative, multidisciplinary analysis of 20 Child Practice Reviews (CPRs) (previously Serious Case Review) in Wales. The reviews were analysed from three different disciplinary perspectives: law, criminology and practice (social work). The following cross-cutting themes were identified from our coding of the reviews: (i) hierarchy of knowledge, where certain sources of knowledge were privileged over others; (ii) information sharing/recording, where deficiencies of sharing or recording of information were evident; (iii) partial assessment, where certain assessments were not always holistic; and lastly, (iv) voice of the child, where the experience or perspective of the child was not always considered. In addition, our analysis revealed a range of challenges to the CPR process as implemented. This paper is the first to explore themes emerging from (Welsh) CPRs and is also the first to do so from a multidisciplinary perspective. We conclude by highlighting the recommendations for practice, such as the need for greater learning pan-Wales, regular publication of the major themes emerging from CPRs and the need for deposit of CPRs in a central repository to facilitate learning from reviews.

Key Practitioner Messages:

- There is an urgent need for multidisciplinary training on contemporary data protection requirements as per the General Data Protection Regulation for all safeguarding boards.
- Creative methods are required to disseminate the messages from Child Practice Reviews more widely.
- Child Practice Reviews should be deposited and indexed in a central repository to facilitate learning across Wales.
- Guidance and training for Child Practice Reviews should be revisited, so that the child is repositioned at the centre of the process and the voice of the child is heard.

Key Words: child abuse; child death; child protection; safeguarding children; information sharing

'Report[s] findings from a qualitative, multidisciplinary analysis of 20 Child Practice Reviews… in Wales'

Introduction

The first formal review in the UK of the death of a child from abuse or neglect arose from the scandal of Dennis O'Neill who, in 1945, was 'boarded out': the practice of placing abandoned or neglected children in the long-term care of a family for a weekly allowance as an alternative to the workhouse or orphanage (Hopkins, 2007). This led to the Monckton four-day inquiry and report (Home Office, 1945) and death reviews of all types have developed since this time. New statutory requirements, introduced in the 1990s and 2000s, have significantly contributed to an 'inquiry culture', thus prompting death reviews to become 'much more a feature of public life' (Nash and Williams, 2008, p. 134).

Statutory reviews in the form of Child Practice Reviews (CPRs) in Wales, and Child Safeguarding Practice Reviews in England, were introduced in 2013 and late 2019, respectively, as replacements to the former Serious Case Reviews (SCRs). SCRs had been the centre of debate for some time (Garboden, 2011), but Wales was the first to make the innovative change and provide a positive, proportionate and flexible response to child tragedy. Wales has also subsequently introduced the Social Services and Well-being (Wales) Act 2014, which has sought to transform care and support services.

The new process for CPRs stemmed from a Care and Social Services Inspectorate Wales (CSSIW) (now Care Inspectorate Wales (CIW)) report entitled *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews* (Welsh Government, 2009). Reform to the review system was said to have the overall purpose of promoting 'a positive culture of multi-agency child protection learning and reviewing in local areas, for which Local Safeguarding Children Boards (see Annex 3, Welsh Government, 2016) and partner agencies hold responsibility' (Welsh Government, 2012, s. 1). In this way Wales was aiming to move away from a blame culture:

> 'The shift in terms of language, from "serious case review" to "practice review", echoed the shift in culture; the overall purpose was to promote a positive culture of multi-agency learning and practice improvements and to generate local learning.' (Manole and Glasgow, 2019, p. 1)

The introduction of two different types of review, known as 'concise' and 'extended', formed a key element of the CPR framework. In the circumstances where the child was neither on the child protection register nor was a looked-after child on any date during the six months preceding the review, a concise review is conducted (Welsh Government, 2012, s. 5). Otherwise, an extended review will be conducted. Under certain circumstances, historic reviews can also be undertaken. Regional Safeguarding Children Boards (RSCB) are responsible for commissioning and approving CPRs (Welsh Government, 2016, ch. 6.28). The reviews must then be submitted to the Welsh Government, but no accessible archive is currently maintained. The reports of the CPR will then appear on RSCB's websites for a minimum of 12 weeks (see Welsh Government, 2016 for contemporary guidance on CPRs; see also Social Services and Well-being (Wales) Act, 2014, s. 145).

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A review of the implementation of CPRs was undertaken in 2015 (Welsh Government, 2015) and examined the CPR Framework, including decision-making, resources and time, involvement of practitioners and effective dissemination. There is, however, no prior research on CPRs relating to the content of the reviews; and existing published reviews of the former SCRs in Wales are now dated (see Brandon *et al.*, 1999, 2002). Analyses by Brandon *et al.* (2020) and Sidebotham *et al.* (2016) of SCRs in England are the most directly relevant studies to this paper. These analyses identified a range of significant themes including: (i) assessment and thresholds; (ii) hearing the voices of children and families; (iii) communication and information sharing; and (iv) multiagency and interdisciplinary working practices. Other themes arising from analyses of reviews into deaths and serious incidents have included: (i) increased training for professionals; (ii) improved risk assessment and improved responses to those with complex needs; and (iii) missed opportunities for safeguarding children and improved record keeping.

Aims

The current study aimed to identify key themes from CPRs and compare these to learning from other types of review in Wales (Robinson *et al.*, 2018; Robinson *et al.*, 2019). The ambition was that this research would help improve practice, provide learning for those given the responsibility of undertaking reviews and inform any future governance arrangements for reviews and inspections that may occur in Wales.

Methods

The approach taken within this study was qualitative and involved a multidisciplinary thematic coding of reviews. This was then complemented by focus groups with practitioners from across Wales. The sample of reviews to be coded was provided by the Wales National Independent Safeguarding Board (NISB). Twenty CPRs – completed between 2014 and 2019 – were triple- and in some cases quadruple-coded by the research teams from differing disciplines. These disciplines were: (i) legal; (ii) criminology (providing an 'academic' perspective); and (iii) social work (thus, providing 'practitioner' perspectives).

We had undertaken a similar exercise in 2018 coding other Welsh death reviews (Robinson *et al.*, 2019). For this research, we introduced two new members to the research team to ensure that we were not 'blindfolded' by our own tunnel vision (Robinson *et al.*, 2019); in other words, limited by finding only what we expected to see. Out of the 20 CPRs, one was a historic review, which had been prompted by disclosures of abuse made by the index child while incarcerated. Nine of the CPRs concerned the death of a child; in these reviews the cause of death ranged from medical or other forms of neglect (including lack of supervision), filicide and suicide. In one of the CPRs (CPR 13) it was unclear whether the child had in fact died. Other reviews involved various forms of abuse – such as sexual abuse/exploitation or physical abuse (often by a parent or partner of a parent) – or neglect. Emotional abuse, while

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present in many of the cases, did not seem to be the primary reason to conduct the CPR. In a number of the CPRs, perhaps unsurprisingly, young people had been subject to different forms of abuse, often over protracted periods of time.

The research team collaboratively established a method and framework to identify key themes. This involved researchers initially reading and discussing three CPRs. This then informed the coding framework, which included the following coding categories: (i) residence/circumstances of child; (ii) perpetrator/s (if there is one); (iii) other demographic information; (iv) characteristics of abuse; (v) agency performance – children's services; (vi) agency performance – health (including Child and Adolescent Mental Health Services); (vii) agency performance – education; (viii) agency performance – police; (ix) agency performance – other (including third sector); (x) multiagency partnership working; (xi) identification of good practice; (xii) key recommendations going forward; (xiii) comments on quality of CPR; and (ix) other comments (e.g. from an academic, practitioner or legal perspective).

Each member of the coding team then thematically coded each review. This, therefore, resulted in a minimum of three sets of coding per review, with coding being undertaken from the three differing perspectives. Once the coding was complete, the results (containing the coding from every team member) were combined into a single Excel spreadsheet. This was done so as to evaluate the similarity and points of divergence between team members. While the research team was notionally assembled to bring three different perspectives to the coding, ultimately the exercise revealed only small differences, and a total of four cross-cutting themes were identified. Also identified were key structural and procedural issues. These provided the basis and structure for the subsequent focus group discussions, with the feedback from the practitioner focus groups providing a validity check and an opportunity to consider how themes could possibly be interpreted. An overview table depicting how the themes relate to each CPR review is provided in the appendix (see Appendix 1 in the online Supporting Information).

Participants for focus groups were identified by the NISB, with one focus group being held in north Wales (two attendees – a summary of emerging themes was sent out via the NISB to other participants within the north Wales area for practitioners to provide comments), and another in south Wales (10 attendees). Each focus group lasted two hours. Practitioners who had registered to attend one of the two focus groups were invited to participate in a brief online survey to gather background information and 11 responses were received. These were diverse groups holding practice, managerial and strategic roles within police, social services, probation and health. Participants were also asked to indicate their level of experience with CPRs: (i) no experience; (ii) have read this type of report; (iii) have participated by providing evidence or information; (iv) have had overall responsibility for the process; and (v) have had strategic responsibility for ensuring that recommendations are implemented. All participants had some level of knowledge and/or experience of CPRs.

Ethics

CPRs are publicly available documents that have to be uploaded on to the relevant safeguarding board website and remain there for a minimum period

of 12 weeks. Information accessed was therefore already in the public domain. All of the CPRs had already been stripped of contextualising information, with the effect that individuals and families were already anonymised at the point of our thematic analysis. The CPRs came from across Wales. So as to add an additional layer of anonymity, we have opted, in this article, not to refer to the locality of the CPRs. All comments from focus groups were anonymised by role and name, thus it would not be possible for anyone outside to determine the identity of any respondent. The research design was reviewed and agreed on by the School of Social Sciences' Research Ethics Committee, Cardiff University.

Findings

Four cross-cutting substantive themes were identified from the coding exercise and confirmed in the focus group discussions. In addition, a range of challenges to the CPR process as implemented was identified as a fifth theme.

Theme One – Hierarchy of Knowledge

From reading the CPRs, it was evident that, in 15 reports, some forms of knowledge were privileged over others. This resonates with a theme identified in our previous study (Robinson *et al*., 2019) whereby professional knowledge was seen to take precedence over personal knowledge (Preston-Shoot, 2018). This theme also resonated with the focus group participants, who highlighted difficulties in managing professional differences. The decisions of professionals (e.g. medical diagnosis) were seen to be based on 'objective' knowledge, which was seen to be superior to the 'subjective' judgements or opinions of para-professionals, family and community members (Preston-Shoot, 2018). All professionals were listened to and their concerns privileged above those of parents; for example, in one CPR, the parents expressed concerns about their son and he later ended his life. The views of community members were seen to be less reliable and therefore less influential (e.g. when concerns about a child known to agencies were raised). There was broad agreement in one of the focus groups that community referrals are not always given appropriate credence. This hierarchy of knowledge often led to 'tunnel vision', where certain attitudes are formed and then become hard to challenge, especially by those lower in the hierarchy (Findley, 2012; Munro, 2011).

In addition to a hierarchy of knowledge, with professionals at the top, there was a hierarchy within families. There was a sense that adults were listened to and believed more than children (see also themes three and four below). Furthermore, the views of mothers tended to be privileged over both children and fathers. The focus groups identified that fathers were often absent from discussion and intervention in practice. As a result of an 'assumed' absence of fathers, the onus of care, in practice, was often placed solely with mothers or grandmothers in practice (Dunkerly, 2017).

Finally, it is inevitable that interdisciplinary and multiagency working will, at times, result in different opinions about the risks posed to the welfare of a child, with few mechanisms to resolve them. While interdisciplinary and multiagency working can be difficult to manage, it is important that an array

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of views are acknowledged and respected. It is also advisable that potential resolution mechanisms are developed to ensure that agencies can work together effectively.

Theme Two – Information Sharing and Recording

'Information sharing was regularly noted to be an area for improvement in the CPRs'

Information sharing was regularly noted to be an area for improvement in the CPRs, as has been found elsewhere (Brandon *et al.*, 2008; Brandon *et al.*, 2012; Brandon *et al.*, 2020; Sidebotham *et al.*, 2016). Specifically, professionals were often noted to be unsure about when they could, or should, share information without consent in instances where support to a family was not taking place under the auspices of a safeguarding concern (i.e. non-child protection). As Lord Laming (2003) noted in the Victoria Climbié inquiry, the sharing of information in such circumstances is permissible so long as a clear justification exists and is carefully recorded. Concerns about complaints being made over inappropriate sharing of information, and/or a belief that other agencies were already aware of the information, were both cited as reasons why details were not being shared. The focus groups were both alert to issues around information sharing and it was noted to be an ongoing and complex issue exacerbated by the introduction of the General Data Protection Regulation (GDPR) (European Parliament and Council of Europe, 2016) and the Data Protection Act 2018.

In one family of six children, the mother was pregnant with a seventh child. Two children had been adopted, and two had been fostered. Some of the children were fostered out of county and there was no sense that each child was part of the same family; information was not shared across local authorities. When working with large families it is essential that multiagency working takes place to meet the needs of children both individually and collectively (Culliney *et al.*, 2014). Different IT systems, both within and across agencies, can serve to complicate information sharing; this was particularly acute for large families who were, as a result, sometimes required to attend multiple appointments for different children in different places at the same time.

'Access to information was sometimes hindered by Children's Services' failure to pass on information to other agencies in a timely manner'

Access to information was sometimes hindered by Children's Services' failure to pass on information to other agencies in a timely manner. For example, in two CPRs, social services were noted to have failed to pass on information received from the police to other agencies. Equally, Children's Services did not always alert other agencies that they were withdrawing support to a child(ren)/family; this has the risk that it may give those agencies still working with a child(ren)/family a false sense of security.

Another area of complexity, for health services in particular, was service disengagement. Where a child was not being brought in for appointments, or where there is no engagement with a service, then the closure of any case should be accompanied by questions about the wider welfare of the child. In one case, a family was 'off-rolled' from their GP practice despite the mother having post-traumatic stress disorder and there being a long history of welfare concerns for the children. Closing cases in these circumstances increases vulnerability (Preston-Shoot, 2018). Clear protocols for checks within and across agencies are needed at the point of services withdrawing.

We also identified issues with approaches to recording information. These tended to focus on three key areas: (i) record keeping; (ii) consistency of language; and (iii) chronologies. Producing accurate and clear records was regularly identified as an important skill across professions (Hardy, 2017). When information is shared, or a referral is made, both the referrer and the referee must record this. In one case, information passed to Children's Services was not recorded as a referral. This is particularly important when a referral has been made by one agency, but no further action was felt to be necessary by the receiving agency. These decisions need to be recorded and communicated in order to avoid agencies having to chase to find out what action (if any) has taken place.

In four CPRs, it was noted that inconsistent language was used across agencies. Specifically, loose terminology regarding home conditions in cases of neglect can hinder understandings of risk and can impact on court processes (e.g. poor or inconsistent evidence). Equally, different terminology across agencies can lead to confusion and inappropriate assumptions about risk (Fisher and Frey, 2013). Confusion can result not only from word choice but also by the use of acronyms. Working across multiple systems creates opportunities for misunderstanding; for example, it was noted that multiple risk assessments around sexual exploitation existed across agencies. The name of assessments and their purpose was not always clear across agencies and this served to impinge on effective multiagency working.

Theme Three – Partial Assessment

Partial family assessment arose as a result of practitioners sometimes evaluating people as individuals without due regard for their wider domestic/family context, which is particularly problematic for children. For example, individuals with drug and alcohol problems, mental ill-health or unspecified health difficulties might also be parents, but this was not routinely considered, nor the impact on any children evaluated or addressed. Taking an individualistic approach meant that the views of all of the professionals and services involved were not joined up (e.g. where concerns were raised about the welfare of an adult, there was not always a check to see if they were parents and, subsequently, opportunities for intervention may have been missed).

The onerous impact of caring for numerous children was not always recognised in assessment, especially in times of austerity. Six of the CPRs involved large families: one family had seven children, one had six children, two families had five children, one had four children, and exact numbers for one family were unknown, although a 'large sibling group' was noted. In addition, it was not apparent that practitioners were viewing children with special needs as significant stressors within a large family (Tanner and Turney, 2003); this may add more stress to a large family than to a one- or two-child grouping. Multiple and complex health needs of children in large families may be far more difficult for the family to respond to. A focus group identified that, with large families, there will likely be a tendency for services to try and keep children at home for as long as possible (i.e. avoid entry into care). This is due to: (i) financial costs; (ii) practical consideration (i.e. availability of foster care placements); and (iii) separating children/best interests of the child/young person.

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Mothers in particular (as well as families) seemed to be polarised as either good or bad rather than being understood as human beings, for whom it is normal to have a range of actions and behaviours that can be both good *and* bad. This was evident in a range of characterisations of parents as generally negative, i.e. 'challenging', 'uncooperative' and/or feigning compliance. Such views can lead to practitioners not adopting a sufficiently strengths-based approach that recognises the abilities (and not just the deficits) of the parents. Conversely, professionals may share overly optimistic views about individuals and their abilities and thus not provide appropriate and proportionate support (Kettle and Jackson, 2017). Such polarised views fail to recognise that parents may have fluctuating abilities due to their life experiences and ongoing challenges. This binary representation of parents extended to understandings of families as being 'good' or 'problematic'. This polarisation potentially served to obscure and limit effective assessment, understanding of situations and management of interventions.

Theme Four – Voice of the Child

Children's voices or the perspective of the child were sometimes missing from CPRs and/or were not always central to practice. Despite this being often mentioned by the CPRs as an area for learning, it seems that the CPRs often failed to clearly consider the experience from the perspective of the child, and did not always embrace a child-friendly approach themselves. In this respect, the reviews seemed iterative of practice (Ferguson, 2017).

It was not always clear whether children had been spoken to in the process of the CPR, or how directly practitioners worked with children in practice. There were instances where children had been spoken to, but this had been in front of their parents, which would not give them a safe place to disclose their experiences. Familial links were not always being made between children; for example, in one CPR, children who had been fostered or adopted elsewhere were not listened to regarding their experiences (see also theme three). In addition, practice observations of children were lacking in description to give a sense of the experience of the child. In another case, which related to home schooling, the children were completely invisible to all professionals (see Monk, 2004). For a variety of reasons, it was not always possible for young people and/or their families to be consulted as part of the CPR process. Nevertheless, it would have been useful to have at least some reflection on the day-to-day lived experience of the child in every CPR. The guidelines for CPRs state 'The review [should] engage directly with children and family members as they wish and is appropriate' (Welsh Government, 2012, Guidance; Welsh Government, 2016, s 6.33, 6.34). Two of the CPRs did explicitly mention the need to give voice to the child, which we commend as good practice.

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Large families inherently mean more work for practitioners (Lacovou and Berthould, 2006; Willitts and Swales, 2003). For example, a family of seven will mean seven separate reports and care plans. Time and space is needed for practitioners to manage large families. Equally, practitioners need to guard against losing sight of the needs of individual children within these cases. Practitioners need to be alert to how and when information should be copied between children and the potential impact this may have on the voice of the

individual child(ren). Data systems do not support working with large families. Specifically, information may be copied across cases and the needs of individual children may be lost in the process.

Participants in the focus groups highlighted that the contemporary guidance on CPRs (Welsh Government, 2012, 2016) could more readily emphasise the importance of capturing the voice of the child, although it should be noted that, under section 6.34 of the current guidance (Welsh Government, 2016, p. 17), regional safeguarding boards are asked to think 'creatively about how families can be engaged in the review and how explanatory information is provided to children'. It was also acknowledged that any suggestion that a reviewer must meet with children needs to be tempered with consideration of the appropriateness of the situation (e.g. consideration of the impact of reliving trauma, etc.).

There was a consensus in the focus groups that the CPR should record whether the child was spoken with and, if not, why and how and where the child's voice/experience appears. 'Children's Lived Experience' (CLE) was seen as a better term by those in one focus group, to acknowledge the wider range of ways of seeing and working with children, rather than 'voice of the child', as this relies on children's ability to speak and be heard. CLE shifts away from children's vocal articulation and repositions the focus on sound professional practice.

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Theme Five – Challenges to the CPR

In addition to the four substantive themes discussed above, our analysis revealed a number of challenges to effective practice and the CPR process, which are discussed below: lack of detail; workload and supervision; data protection and safeguarding; agile working; and dissemination.

First, it was apparent that much contextual detail had been stripped out of many of the CPRs, which negatively impacted on potential learning. In part, this was because of confidentiality, and also the fact that the local safeguarding boards would have knowledge of the case details of a CPR and felt these did not need to be repeated. This, however, means that learning by professionals from outside of the locality may be limited. As Preston-Shoot (2018, p. 12) highlights:

> 'Clearly, a balance must be struck between protecting the anonymity of families and ensuring that professionals and their organisations are held accountable and that learning can be disseminated and used to inform future practice.'

Context is evidently integral to understanding how a recommendation has been reached, and how it might be operationalised.

An additional challenge was the difficult working conditions of practitioners in many agencies, which was repeatedly mentioned in the CPRs. The increase in workloads in Social Services has been identified by the Welsh Local Government Association (BBC, 2018). Issues with the retention of social workers in Children's Services is well established, and the CPRs confirmed that this continues to be an acute issue for contemporary practice in Wales. In addition, Social Services departments were recognised to be under particular pressure. With diminished resources, social workers are often only working

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with the most acute need and this is often reflected in the form of complex cases. Despite the pressures placed on workers, some examples of good practice were also identified. In two CPRs, the high complexity of the work was recognised by a manager and accommodated via a reduced caseload. In both these cases, a consistent worker was identified as being beneficial to both children/families and the workers. Supervision was often cited as an area for development. Supervision comes in many forms and can have multiple functions (Carpenter *et al.*, 2012, 2013). It was apparent that supervision was not being prioritised in the practice described in these cases.

The implementation of the GDPR (European Parliament and Council of the European Union, 2016) and the associated Data Protection Act 2018 was felt to have added an additional challenge. As indicated in the focus groups, this requirement has added a further layer of complexity, and therefore confusion among many practitioners, thus hindering effective multiagency work on safeguarding. This led to practitioners becoming more anxious about their responsibilities and potentially more reluctant to share information, even when it was necessary and appropriate to do so.

With the rise of agile working in social work (Jeyasingham, 2019), accurate record-keeping is felt to be of particular importance. Practitioners are increasingly reliant on information held on databases to guide their thinking; partial or missing information poses a challenge both to effective practice generally and carrying out CPRs specifically. Agile working was discussed in the focus groups and, while it was not seen as universally bad, there was a concern that opportunities for reflection, support and learning that come with being physically present and working with and around other professionals (to share information and learn from each other) were greatly diminished. The increasing expectation that social workers work alone is considered to have negative implications because of the reduction in group and peer learning and tacit conversations that can inform practice decisions.

A final challenge revealed by our analysis is the poor dissemination of CPRs. Currently, CPRs are only accessible on individual RSCB websites for a minimum period of 12 weeks. There is currently no national repository in Wales and so CPRs cannot be routinely reviewed for cross-cutting themes, nor can they be considered in the context of recommendations from other death reviews (Robinson *et al.,* 2018). Clearly, CPRs are resource-intensive and their availabililty should be enhanced so that learning can be maximised.

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Limitations of the Study

The sample was a convenience sample provided by the NISB. It does not necessarily provide a representative sample of CPRs that have been carried out in Wales. However, CPRs were chosen with a view to ensuring a wide geographic spread of cases across Wales, and to illustrate the diverse range of issues that tend to be found in such reviews. Further research is necessary to substantiate the findings presented here, drawing on a complete sample. While the Welsh Government stores all CPRs, no overall list is readily available. However, the NSPCC (with whom we liaised and who attempt to keep a list of reviews) estimates that, since the inception of the CPR in 2013, 29 had been completed. If the NSPCC list is anywhere near accurate, our

sample of 20 would be around two-thirds of the total. We were cognisant that CPR documents are primarily designed for practitioners and not for research purposes and so could be open to misinterpretation in light of the decontextualisation mentioned previously. The focus groups aimed to address these risks of misinterpretation so that we could test out themes and have these validated.

Discussion and Implications for Practice

A distinctive aspect of this study was to have a research team from three different disciplines code and analyse the sample of reviews. This ensured a range of perspectives were brought to the analysis, which helped to avoid silo thinking and the privileging of one discipline over the other. The following substantive cross-cutting themes were identified: (i) hierarchy of knowledge, where certain sources of knowledge were privileged over others; (ii) information sharing/recording, where deficiencies of sharing or recording of information were evident; (iii) partial assessment, where certain assessments were not always holistic; and, lastly, (iv) voice of the child, where the experience or perspective of the child was not always considered. These resonate with our earlier study, as well as with previous research. Our identification of similar substantive themes across different types of review, including those carried out for both adults and children, highlights the seeming intractability of some issues (e.g. hierarchies of knowledge, faulty or partial assessments, poor information sharing). Yet we should be cautious in assuming that these seemingly intractable issues are static in nature; indeed, it is apparent that these issues are inherently contextually, temporally and culturally bound. In short, there is no 'one size fits all' solution. Constant reflection in practice and an evolving empirical evidence base are essential for enhancing contemporary practice.

In addition, our analysis revealed a number of challenges to the CPR process, and points to ways in which they could be overcome. For example, it is vital that more contextual information be included in CPRs so that wider learning beyond that in the local area can take place, including across and outside of Wales. Child death reviews are costly and time intensive and it is essential that findings from them can be easily accessed. In our previous study of adult death reviews in Wales, which did not include CPRs (Robinson *et al*., 2018), the same themes of partial assessment and privileging knowledge (including tunnel vision) were identified. This demonstrates the importance of learning from *across* different types of review (Robinson *et al*., 2018). In the last study, many of the focus group participants expressed a desire for a more centralised, structured approach to facilitate learning from reviews. As a result, a Welsh repository is currently under development with a task group taking this forward (https://crimeandsecurity.org/feed/wsr), so that overall cross-cutting, 'aerial' learning can take place on a larger scale. CPRs will be placed in this repository alongside other death reviews; each review will be coded according to the issues arising within it, so that others working in the same area may benefit from this easily accessible information. A UK-wide or global repository might be a useful resource for professionals in the future. Accessibility to a repository of reviews would allow for a wide range of creative methods to

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engage and disseminate messages from the reviews. These could provide excellent opportunities for teaching and learning and could form the basis of team or interdisciplinary workshops.

Of particular concern was the confusion and reticence that GDPR (European Parliament and Council of European Union, 2016) has created and it would seem that multidisciplinary training on GDPR is essential for all practitioners in the UK, especially those sitting on regional and local safeguarding boards.

Effective support is required for those managing large caseloads, possibly via supervision. Supervision is at its most effective when accompanied by a supportive culture and effective management. We are concerned that it should not be seen as a general panacea to more systemic and resource issues.

More consideration is needed regarding the difficulties faced by large families as this is an area that is rarely discussed within the literature, and could helpfully form the basis of a future study. While large families are relatively rare, according to the Office for National Statistics Labour Force Survey (2019), the total number of one-family households in Wales was estimated to be 764 000. Of these, the number who had three or more dependent children was 37 000 (4.82%). Across the UK, the total number of households is estimated to be 19.2 million and, of these, 1 217 000 have three or more dependent children (6.34%).

Lastly, and most importantly, training for those involved in CPRs needs to be regularly revisited with a reconsideration of how the child's lived experience might be presented, especially where they cannot be spoken to, and how to reposition the children involved to centre stage.

Acknowledgements

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Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article.