West Glamorgan Safeguarding Board

Practice Review
Multi – Agency Timeline Guidance

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Issue Date:	**2nd September 2020**
Review Date:	**2nd September 2022**

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Introduction

This guidance has been developed to support agency panel members in the development of their timelines and to support and ensure a robust review process overall.

A completed multi-agency timeline is instrumental to the Practice Review process and assists the panel in understanding the case, identifying key people to attend the learning event for the review and to best share any organisational learning points highlighted from the review.

Practice Review Multi Agency Timelines

A timeline is required specifically as a part of the Child Practice Review (CPR) / Adult Practice Review (APR) process and once amalgamated to a multi-agency timeline, is a useful tool to be used by the Practice Review Panel to assist in the analysis and understanding of a case, case related activity and decision making. A single agency timeline does not provide a complete picture of the family's life and circumstances, only combined multi-agency timelines can do this. In addition to the multi-agency aspect, the timeline format allows for the author to provide analysis of actions taken or decisions made as well as assisting the panel when lesson learning is being considered.

Attached to this document is the timeline template that will be used across all agencies, statutory or voluntary. Appendix 1

It is important for an appropriate person to complete the timeline for their agency. This does not have to be the panel member but there is an expectation that the person completing the timeline is independent of the case and has sufficient knowledge of the relevant information being included; if they are unsure they can refer to their panel member.

The panel member will be responsible for the development and content of their agency timeline which must include analysis and comments on practice, including where good practice is identified. Where panel members are not authors of their agency timeline, panel members must have full knowledge of timeline content and ensure timeline authors have not had operational responsibility of the case.

The Template (Appendix 1)

- **Column 1: Date –** DD/MM/YYYY
- **Column 2: Time –** 00:00
- **Column 3: Source of Information –** Where has this information come from e.g. Education, next door neighbour etc.
- **Column 4: Significant Event –** explain what has taken place e.g. child protection medical has taken place at the hospital and Paediatrician has concluded it was accidental/non accidental; or someone has moved into or out of the home address. Make sure you include who was there, who saw what / said what as far as is possible.
- **Column 5: Action Taken –** Summary of action taken e.g. what happened, referrals made, intervention.
- **Column 6**: **Analysis –** an analysis of the agency's view on whether there was any good practice, missed opportunities, whether the voice of the person was considered.

When To Complete A Multi – Agency Timeline?

When a decision is reached by the Practice Review Management Group (PRMG) that a Practice Review will be undertaken; relevant individual agencies will be required to access the child's/adult's record and submit a timeline. A preliminary scope/timeframe will be recommended by the PRMG

The Practice Review Panel will agree the scope/timeframe of the review and the dates for the completion of the timelines.

The Business Management Unit (BMU) will be responsible for merging the individual agency timelines into a multi-agency timeline.

What to Record in a Multi-Agency Timeline?

Timelines provide a key link in the chain of understanding. Setting out key events in sequential date order, they give a summary timeline of child, adult, carer and family circumstances, patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment.

Professionals need to consider what records can be used to inform their completion of the timeline. For example, this could include information from previous Child Protection Conference Minutes or assessments, GP records and hospital records, Local Authority, Education records and school records however this list is not exhaustive and each agency will have a variety of sources of information from which to contribute to the timeline.

A significant event is something that impacts, negatively or positively, on the child or adult. This will inevitably involve a professional decision and/or judgement based upon the child/adult's individual circumstances, It is important that a timeline **is not** a repeat of the records you hold for this child/adult, it should only include **significant events.** (See examples below)

Examples include:

- A significant observation during home visits e.g. the frequent presence of unknown adults, evidence of damage to the property, negative interactions between parent and child, poor home conditions found on visit etc.
- If timelines are to accurately reflect family circumstances, relevant/significant positive factors should also be recorded (e.g. families' engagement with professionals, child's presentation in school significantly improves etc.).
- Changes in policy, practice or legislation that impact on the child, adult or family.

It is essential that timeline authors/panel members use their professional judgement in identifying any significant events and in their critical analysis of their agency's involvement.

Acknowledgements

In completing this guidance and the accompanying template, the following were used as reference materials:

1. Social Services and Well Being (Wales) Act 2014
2. Working Together to Safeguard People Volume 2 – Child Practice Reviews (6.2 – 6.25)
3. Working Together to Safeguard People Volume 3 – Adult Practice Review (6.21 – 6.25)
4. Wales Safeguarding Procedures – Pointers for practice

Appendix 1: Timeline Template

Family Composition

Include every person living in the home, significant other family members e.g. father who lives elsewhere, other children living elsewhere.
Include dates of birth and addresses.

DATE	TIME	SOURCE OF INFORMATION	SIGNIFICANT EVENT	ACTION TAKEN	ANALYSIS/ COMMENTS
11 Jun 2019	23:15	Acute Clinical Team > Emergency department Morriston hospital Nursing Documentation Continuation Sheet	MC moved to cubicle for privacy and due to anticipated death. MC unresponsive, however, family attempting to feed and hydrate her. Nursing documentation indicates family not understanding that MC is end of life.	Medical registrar spoke to family to explain that MC'S health is poor and that the plan is to make MC comfortable.	Appropriate communication with family to advise relating to health needs and care.
12 Jun 2019	03:45	Acute Clinical Team > VA1 adult protection referral form	VA1 completed by staff nurse Swansea Bay UHB.	Comprehensive documentation relating to all injuries in addition to body maps included. VA1 not discussed with family.	Good quality referral made detailing injuries comprehensively. No evidence of any communication with family relating to Va1 documented in the notes,
12 Jun 2019	05:35	South Wales Police > South Wales Police Niche 1900211233	At 05.35hrs, 12th June 2019, SWP received a report from the Ambulance Service. They had attended the home of MC's son who together with his brother had requested medical assistance for their mother. Due to her	Intelligence checks identified the occupants of the address as MC and her sons. Only information of note was in 2004 that one of her Son's had admitted stealing from an elderly male while he was a	The response to this call was proportionate given the fact that the focus was on the presence of the weapons and not out of concern for MC. The ambulance crew had not voiced any concern about her care that

			condition, she was conveyed to Morriston Hospital. The attending ambulance crew noted that there was a box of guns and ornamental machetes hanging on the wall.	carer at a local care home. This was dealt with by way of home officer clear up as the victim did not want to make a complaint Upon attendance at the address the officers noted that the weapons were replicas and had not been used for some time as they were covered in dust.	might have resulted in a different approach. The information obtained as a result of the later call from the hospital would not have been readily available at this time.
12 Jun 2019	09:04	Swansea Social Services > Paris: referral	12/06/2019: Safeguarding referral received to Hub Services Central: DLM appointed to coordinate safeguarding process. Safeguarding referral made from Morriston Hospital. MC presented to hospital very emancipated, skeletal in appearance, extensive bruising all over her body, including several neurotic areas. Son indicated on admission that his mother MC had been deteriorating since Christmas and had been seen by the GP in February but had not been seen since. Son indicated that his mother had not been able to eat solid food for 7-10 days. Paramedics had indicated that the house was unkempt and unsafe floor boards. Police informed. 18/06/2019:	Strategy meeting, police highlighted that police investigation was underway before an adult at risk referral was made and indicated that there was an ongoing investigation to the Son. MC passed away while in hospital on the 14/06/2019	