**CHILD PRACTICE REVIEW REFERRAL FORM**

The information provided in this referral will be used to decide whether a case should be the subject of a Child Practice Review or a Multi-agency professional forum.

Before submitting this referral, please ensure the following has been completed:

* Pages 12 and 21 from the ‘Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People: Volume 2 – Child Practice Reviews’ <https://socialcare.wales/cms_assets/hub-downloads/Working_Together_to_Safeguard_People-_Volume_2_____Child_Practice_Reviews.pdf> has been read and the referrer is satisfied that this case meets the criteria for a review
* The referrer has provided as much detail as possible on this case

The Child and Adult Practice Review (CPR/APR) Sub Group will consider this referral and forward recommendations to the Co-Chairs of the Cardiff and Vale Regional Safeguarding Children Board (C&V RSCB) who will ultimately make the final decision on what type (if any) review is convened.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF THE REFERRER** | | | | | | | | | | |
| **Name & Role of Referrer:** |  | | | | | | | | | |
| **Agency:** |  | | | | **Date of Referral:** | | | |  | |
| **Email Address:** |  | | | | **Tel number:** | | | |  | |
| **DETAILS OF THE CHILD** | | | | | | | | | | |
| **Name of Child:** |  | | | | | | | | | |
| **Address:** |  | | | | | | | | | |
| **Previous Addresses of the Child** *(last two years)***:** |  | | | | | | | | | |
| **Date of Birth:** |  | | | | **Date of Death/Incident:** | | | |  | |
| **Name, Address and DOB of Parent(s):** |  | | | | | | | | | |
| **Name, Address and DOB of Sibling(s):** |  | | | | | | | | | |
| **RATIONALE****FOR****REFERRAL** *(please include details of the event that lead to the referral and why this case meets the criteria for a Child Practice Review)* | | | | | | | | | | |
|  | | | | | | | | | | |
| **PLEASE COMPLETE THE FOLLOWING CHECKLIST** | | | | | | | | | | |
| **Has the child died?** | | | | **Yes** | |  | **No** | | |  |
| If no, has the child sustained potentially life threating injury, or; has the child sustained serious and permanent impairment of health or development? | | | | **Yes** | |  | **No** | | |  |
| If yes, please provide details and cause of death (if known): | | | | | | | | | | |
| **Was abuse or neglect potentially associated with the event detailed above?** | | | | **Yes** | |  | **No** | | |  |
| **Was abuse or neglect suspected prior to the event detailed above?** | | | | **Yes** | |  | **No** | | |  |
| **Has the Child been on the Child Protection Register in the last 6 months?** | | | | **Yes** | |  | **No** | | |  |
| **Has the Child been a Looked After Child in the last 6 months?** | | | | **Yes** | |  | **No** | | |  |
| **DETAILS OF ANY OTHER REVIEWS/INVESTIGATIONS REQUESTED OR UNDERTAKEN** *(please write N/A if this does not apply):* | | | | | | | | | | |
|  | | | | | | | | | | |
| **OTHER AGENCY INVOLVEMENT** | | | | | | | | | | |
| **Do you know of any involvement of other agencies?** | | | | **Yes** | |  | **No** | | |  |
| **AGENCY** | | **PLEASE TICK IF INVOLVED** | **AGENCY** | | | | | **PLEASE TICK IF INVOLVED** | | |
| **Police** | |  | **Children’s Services** | | | | |  | | |
| **Education** | |  | **Public Health Wales** | | | | |  | | |
| **Local Health Board** | |  | **CAFCASS Cymru** | | | | |  | | |
| **National Probation Service** | |  | **Housing** | | | | |  | | |
| **Wales Community Rehabilitation Company** | |  | **Fire Service** | | | | |  | | |
| **Youth Offending Service** | |  | **Welsh Ambulance Service NHS Trust** | | | | |  | | |
| **Other** | |  | **Third Sector Agencies** *(please detail below)* | | | | |  | | |
| Please give details of any other agencies involved: | | | | | | | | | | |
| **OVERVIEW OF AGENCY INVOLVEMENT** *(completion of this is the responsibility of CPR/APR Sub Group members)* | | | | | | | | | | |
| **Children’s Services:** | | | | | | | | | | |
| **Education:** | | | | | | | | | | |
| **CMHT/CAMHS:** | | | | | | | | | | |
| **Health:** | | | | | | | | | | |
| **Police:** | | | | | | | | | | |
| **National Probation Service:** | | | | | | | | | | |
| **Wales Community Rehabilitation Company:** | | | | | | | | | | |
| **YOS:** | | | | | | | | | | |
| **Other** *please specify***:** | | | | | | | | | | |
| **TO BE COMPLETED BY THE CHAIR OF THE C&V RSB CPR/APR SUB GROUP** | | | | | | | | | | |
| **Date of CPR/APR Sub Group** | | | |  | | | | | | |
| **Criteria met for Extended CPR** | | | | **Yes** | |  | **No** | | |  |
| **Criteria met for Concise CPR** | | | | **Yes** | |  | **No** | | |  |
| **Other review considered** | | | | **Yes** | |  | **No** | | |  |
| **Recommended alternative review** |  | | | | | | | | | |
| **REASONS FOR DECISION** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Signature of CPR/APR Sub Group Chair** | **Date** | | | | | | | | | |
|  |  | | | | | | | | | |

The referrer should give as much detail as possible on this referral and will be invited to a CPR/APR Sub Group meeting to present their referral.

This referral should be submitted to the C&V RSB Business Unit on [CardiffandValeRSB@cardiff.gov.uk](mailto:CardiffandValeRSB@cardiff.gov.uk)

It is the responsibility of the C&V RSB CPR/APR Sub Group member, once they have received the referral from the C&V RSB Business Unit, to ensure their agency has given a detailed summary if involved in this case.

The C&V RSB Business Unit will notify the referrer of the final decision.