**Cardiff &Vale Regional Safeguarding Board CPR 04/2016**

**Press Statements – Strict embargo until 11.30am, August 2, 2018**

**Important - Notes to Editors**
The birth family and the adoptive family are aware of the report, the outcome of the Child Practice Review and the recommendations contained within it.
They do not wish to comment any further nor answer any questions from the press or other media agencies.
They have asked that all press and media agencies respect their decision and privacy and do not intrude into their grief at this time, and going forward.

The Child Practice Review will be available online at 11.30am on Thursday, August 2, here https://www.cardiffandvalersb.co.uk/children/professionals-and-employers/child-practice-reviews/

Any Press enquiries – please tel: 02920872964

**Independent Review Statement**

Independent Chair of the Child Practice Review, Wendy Rose, said: "We must not forget that the tragic death of a child is at the heart of this review.

"The review has been a particularly difficult and emotional process for the child's birth family and for members of her adoptive family. Their contribution to the review has been valuable and greatly appreciated.

"For the vast majority of children placed for adoption, the outcome is positive and they go on to lead healthy and well-nurtured lives with motivated and committed parents. There was no indication that it would be any different for this child.

"In the tragic circumstances of this child's death, it is imperative that we learn from what happened to her. We have set out to do this by conducting a very thorough and independent review. We found that some systems and practices can be strengthened so that there can be confidence in the quality and standard of services offered to children placed for adoption and their families. Prompt and timely improvements have already been implemented by the agencies involved and the report recommends further action on which to build a strong and responsive children's service."

**Statement made at the press conference by RSCB representative Sarah McGill**

Thank you for coming here today for the publication of the Independent, Extended Child Practice review into the circumstances around the tragic death of little Elsie.

My name is Sarah McGill and I am here today on behalf of the regional safeguarding children board and also to chair this press conference.

The Child Practice review was commissioned by the Regional Safeguarding Children Board, in line with Welsh Government legislative requirements.

And...On either side of me are representatives of the key organisations involved in caring for Elsie, who are also members or advisors to the board.

I will introduce them to you shortly but… first….

I think it is important to say that **everyone** involved in Elsie's care has been deeply affected by her tragic Death and our thoughts and deepest sympathies are with members of her adoptive family and her birth family.

The Reviewers have met with members of both Families and the review outcomes have been shared with them.

I'm sure you will recognise that this will be a difficult time for them & they have **specifically** asked that their privacy is respected by the media today and in the future.

It's also important we remember that this tragedy is the result of the **actions** of the **individual** convicted of Elsie's murder.

We are not here today to go back over the criminal trial – but, in the terrible circumstances of Elsie's death, it is very important that we discover if any learning can be identified to improve systems and practice.

That is why this Independent Review was Commissioned and the regional safeguarding children board and all member organisations have welcomed its findings and recommendations.

The review has concluded that there was **no information** during the assessment of the adopted parents that could or would have predicted what happened to Elsie.

Indeed, all the professionals involved in Elsie's care reported a committed, motivated and caring family.

The review has found that assessment of the adoptive parents was **strong** and **robust** and was compliant with good practice standards.

**However** The review also found that there were areas of learning that should be acted upon to improve some systems and practices, particularly around timely sharing of information and data recording.

It also identifies occasions when there were missed opportunities to raise safeguarding concerns.

For this, all agencies involved in Elsie's care would like to sincerely apologise.

The conclusion of the review is that there **is** learning that should be acted upon to improve some systems and practices.

The report recognises the extensive actions that have already been implemented by the agencies involved and the review makes NINE further recommendations which are in the process of being progressed.

I would like to make clear that we are absolutely determined that implementing these recommendations will improve the way we do things, improve the way we protect children, and improve the lives of children in our care.

**Regional Safeguarding Board Statement**

In a joint statement, Co-Chairs of the Cardiff and Vale Regional Safeguarding Board, Lance Carver and Claire Marchant, said: "Everyone involved in Elsie's care has been deeply affected by her tragic death, and our thoughts and sympathies are with members of her birth family and her adoptive family.

"Ultimately, this tragedy is the result of the actions of the individual convicted of Elsie's murder, but key learning points have been outlined by the independent review and are being acted upon.

"The Child Practice Review is an opportunity to learn from the events leading up to Elsie's tragic death. This is not about revisiting the criminal trial.

"All of the Board members welcome the findings of the independent Child Practice Review. From what we have learnt through this review, we can improve future practice, and ensure the effectiveness of our services in protecting children.

"Changes have already been made in the organisations involved in Elsie's care and steps are now being taken to implement the further recommendations made by the independent review."

**Vale of Glamorgan Council Statement**

Lance Carver, Vale of Glamorgan Council Director of Social Services, said: "The Vale of Glamorgan Council welcomes the independent Child Practice Review launched after the tragic death of Elsie and is committed to learning lessons from its findings. The review found that the care planning and adoption assessment processes were followed correctly and were robust. As Director of Social Services, I acknowledge unreservedly that there must always be a thorough examination to learn lessons from such a tragic event and I fully accept the recommendations from the review.

"I do not underestimate the impact on those most closely affected and we have thoroughly considered our own processes whilst the independent review was taking place. As a result of this, a number of actions have already been implemented to strengthen the monitoring arrangements once a child has been placed for adoption. These changes include additional professional oversight over and above normal supervision methods, an enhanced visiting schedule, and ensuring the robust recording and sharing of information.

"The death of a child within an adoptive placement is incredibly rare, but made no less shocking or distressing by its infrequency. I would like to take this opportunity to express my deepest sympathy

to members of Elsie's birth and adoptive families. Implementing the recommendations of the independent review is a priority for the Council and one we take incredibly seriously.

**Cardiff and Vale UHB Statement**

Cardiff and Vale UHB Executive Nurse Director, Ruth Walker acknowledged the recommendations highlighted in the report. She said: "I would like to apologise to members of Elsie's birth and adoptive families and welcome this report to support our learning not only in health but from the multi-agency perspective. The report highlights key learning points and we have recognised these and made changes to current practice in response. In addition to this, the Health Board set up a Task and Finish Group who agreed additional recommendations to improve current practice and these are all on target to be achieved.

"The key changes to practice in line with the recommendations in the report include, children under 2 years of age who present with a fracture in A&E will now be included at the weekly formal safeguarding review. All children that are referred by the GP with a suspected bone fracture will be reviewed in A&E by a Paediatric Consultant. All x-rays of children taken in the trauma clinic are now reported by a Specialist Paediatric Radiologist. A revised pathway for health visitors has been developed to ensure that all safeguarding information regarding children looked after is shared with their lead paediatrician.

"Staff have been deeply affected by Elsie's very sad death and have been supported and remain engaged with all the learning and changes made."

**National Adoption Service Statement**

Suzanne Griffiths, Director for National Adoption Service for Wales, said: "The circumstances that led to this review are tragic and extremely rare. Our thoughts are with everyone affected. The National Adoption Service has been providing advice to the Cardiff and Vale Regional Safeguarding Children Board in relation to the independent review. We want to ensure adoption services across Wales have an opportunity to learn from these findings.

"The report concludes that key decisions regarding the approval of Elsie's adoptive parents and their subsequent matching with Elsie were thorough and robust. That finding notwithstanding, there is clearly a need to carefully consider the detail of the review and its recommendations so that policy and practice can be strengthened.

"In responding fully to the recommendations in the report, we will continue to work with the adoption collaboratives across Wales, voluntary adoption agencies and Welsh Government to strengthen safeguarding and adoption practice. The work we have already commenced, including on the review and support of children placed for adoption, will help us to do this, as will changes already made by the Vale, Valleys and Cardiff regional adoption collaborative, such as clearer guidance during pre-placement meetings; more detailed recording of visits; and discussion and sharing of safeguarding concerns.

"The adoption process has remained highly regulated since sweeping reforms were introduced in the 1980s. Adoption offers permanence and good outcomes for the vast majority of children who leave care in this way.

“The process of approving prospective adopters and placing children for adoption is necessarily thorough and detailed. It places a duty on professionals to make enquires and ask questions, in a sensitive and balanced way, in order to safeguard and promote a child's welfare.

“Since being established at the end of 2014, the National Adoption Service for Wales assumed responsibility for co-ordinating improvements to adoption services and advising the Welsh Government on policy and appropriate regulatory changes. We will continue to do that, informed by all the evidence and data available to us, including the findings and recommendations published today by the RSCB.”

**Frequently asked questions regarding the Board and Child Practice Reviews**

**What is the Regional Safeguarding Board?**
The Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (RSCB) is made up of statutory partners (Cardiff Council, Vale of Glamorgan Council, the University Health Board, Velindre Health Trust, South Wales Police and the Probation Services) and additional members including voluntary sector organisations as appropriate

**What is the role of the Board?**
The Cardiff and Vale RSCB oversees the effectiveness of interagency arrangements for safeguarding children from abuse across Cardiff and the Vale of Glamorgan. It forms an independent view of local safeguarding work and challenges where necessary

**When would the Board commission a Child Practice Review?**
In accordance with the Social Services and Well-Being (Wales) Act 2014, a Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development;

and,

the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

**What is the process involved in commissioning a Child Practice Review?**
The Board appoints a Review Panel comprising RSCB statutory partners, plus any other relevant agencies who may be involved in that particular case and the role of the Panel is to oversee the conduct of the review

**What is the purpose of a Child Practice Review?**
The purpose of a Child Practice Review is to identify learning for future practice

**Who carries out the review?**
Child Practice Reviews are carried out by independent reviewers, working closely together, who are appointed by the Review Panel and who have had no previous involvement in the case or its management

**What activity is undertaken in carrying out the Child Practice Review?**
In addition to considering a wide range of relevant documentation, reviewers engage directly with children and families wherever possible and appropriate, and their views are reflected in the final report. The contributions of the professionals and managers who have had involvement with the case also play a key part in understanding what took place and what might have been done differently. The review includes scrutiny of the actions taken by statutory agencies during the period of their involvement in the case and subsequently

**What happens if the Review identifies professional negligence and/or culpability?**

The Review is about learning and improving future systems and practice. If any issues of individual staff training needs or of staff negligence or malpractice emerge during the course of a Child Practice Review, the Chair of the Review Panel has responsibility for ensuring these matters are referred and managed by the relevant agency's own formal staff procedures.

**How does this differ from what happens in England?**
In England the role of the Child Practice Review is taken by a Serious Case Review. Prior to 2013, Wales followed the same arrangement as the England model of conducting serious case reviews to support multi-agency understanding and learning if there was serious harm to a child. However, on 1st January 2013, the new framework for Child Practice Reviews came into effect '*Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews*. In April 2016, the guidance *Social Services and Well-being (Wales) Act, Working Together to Safeguard People - Volume 2 – Child Practice Reviews* came into force. Child practice reviews aim to conclude learning and review more quickly and succinctly than serious case reviews. They typically conclude in 6-12 months and produce a 20-39 page report.

**What is the National Adoption Service?**
The National Adoption Service for Wales is the collaboration for the provision of adoption services across Wales. Since November 2014 it has brought together local authority adoption services into five regional collaboratives with co-ordination and leadership provided by a small central team and Director of Operations, with some functions for the management of children's cases remaining at local authority level. Voluntary adoption agencies operating in Wales are important partners in the collaborative as are other agencies such as health and education.

# Bwrdd Diogelu Rhanbarthol Caerdydd a'r Fro 04/2016

# Datganiadau i'r Wasg – Dan embargo llym tan 11.30am, 2 Awst 2018

**Pwysig – Nodiadau i Olygyddion**
Mae'r teulu biolegol a'r teulu mabwysiadol yn gwybod am yr adroddiad, canlyniad yr Adolygiad Arfer Plant a'r argymhellion sydd ynddo.
Nid ydynt am wneud sylwadau pellach nac am ateb unrhyw gwestiynau gan y wasg nac asiantaethau cyfryngol eraill.
Maent wedi gofyn i'r holl asiantaethau gwasg a chyfryngau barchu eu penderfyniad a'u preifatrwydd a pheidio â tharfu ar eu galar yn ystod y cyfnod hwn nac yn y dyfodol.

Bydd yr adolygiad arfer plant ar gael ar lein am 11.30am ar ddydd Iau, 2 Awst, yma https://www.cardiffandvalersb.co.uk/cy/plant/gweithwyr-proffesiynol-chyflogwyr/child-practice-reviews/

Unrhyw ymholiadau I'r wasg tel: 02920872964

**Datganiad yr Adolygiad Annibynnol**

Dywedodd Cadeirydd Annibynnol yr Adolygiad Arfer Plant, Wendy Rose: "Mae'n rhaid i ni gofio mai marwolaeth drasig plentyn sydd wrth wraidd yr adolygiad hwn.

"Mae'r adolygiad wedi bod yn broses anodd ac emosiynol iawn i deulu biolegol y plentyn ac i aelodau ei deulu mabwysiadol. Mae eu cyfraniad at yr adolygiad wedi bod yn werthfawr ac mae'n cael ei werthfawrogi'n fawr.

"I ran fwyaf y plant sy'n cael eu rhoi i'w mabwysiadu, mae'r canlyniad yn un positif ac maent yn mynd ymlaen i fyw bywydau iach a chael magwraeth dda gan rieni brwdfrydig ac ymroddedig. Doedd dim rheswm i gredu y byddai pethau'n wahanol i'r plentyn hwn.

"Yn wyneb yr amgylchiadau trasig sy'n gysylltiedig â marwolaeth y plentyn hwn, mae'n hanfodol ein bod yn dysgu gan yr hyn a ddigwyddodd iddi. Rydym wedi bwrw ati i wneud hyn drwy gynnal adolygiad trylwyr ac annibynnol iawn. Daethom i'r casgliad y gellid cryfhau rhai systemau ac arfer fel y gall pobl fod yn ffyddiog yn safon y gwasanaethau a gynigir i blant sy'n cael eu rhoi i'w mabwysiadu a'u teuluoedd. Mae gwelliannau prydlon ac amserol eisoes wedi'u rhoi ar waith gan yr asiantaethau sy'n gysylltiedig â'r achos ac mae'r adroddiad yn argymell rhoi camau pellach ar waith i sicrhau gwasanaeth plant cryf ac ymatebol."

**Datganiad a waned yn y Gynhadledd Wasg gan cynrychiolydd y BDPR: Sarah McGill**

Diolch am ddod yma heddiw i gyhoeddiad yr adolygiad Arfer Plant Annibynnol, Estynedig ar amgylchiadau marwolaeth drasig Elsie fach.

Fy enw i yw Sarah McGill a dwi yma heddiw ar ran y bwrdd diogelu plant rhanbarthol a hefyd i gadeirio'r gynhadledd i'r wasg hon.

Comisiynwyd yr adolygiad Arfer Plant gan y Bwrdd Diogelu Plant Rhanbarthol, yn unol â gofynion deddfwriaeth Llywodraeth Cymru.

Ac, ar y naill ochr i mi mae cynrychiolwyr y sefydliadau allweddol a fu'n rhan o'r gwaith o ofalu am Elsie, sydd hefyd yn aelodau neu'n ymgynghorwyr i'r bwrdd.

Byddaf yn eu cyflwyno i chi yn fuan, ond... yn gyntaf...

dwi'n credu ei bod hi'n bwysig dweud bod **pawb** a fu'n rhan o'r gwaith o ofalu am Elsie wedi'u hysgwyd gan ei marwolaeth drasig ac mae ein meddyliau a'n cydymdeimladau gydag aelodau o'i theulu mabwysiadol a'i theulu biolegol.

Mae'r adolygwyr wedi cwrdd ag aelodau'r ddau deulu ac mae canlyniadau'r adolygiad wedi'u rhannu gyda nhw.

Dwi'n siŵr eich bod yn deall bod hwn yn gyfnod caled iddyn nhw, ac maent wedi gofyn yn **benodol** i'w preifatrwydd gael ei barchu gan y cyfryngau heddiw ac yn y dyfodol.

Mae hefyd yn bwysig ein bod yn cofio bod y drasiedi hon o ganlyniad i **weithredoedd** yr **unigolyn** a gyhuddwyd o lofruddiaeth Elsie.

Dydyn ni ddim yma heddiw i edrych yn ôl ar yr
achos troseddol - ond, dan amgylchiadau ofnadwy marwolaeth Elsie, mae hi'n bwysig iawn ystyried a allwn ddysgu unrhyw beth i wella systemau ac arferion.

Dyna pam fod yr Adolygiad Annibynnol hwn wedi cael ei gomisiynu ac mae'r bwrdd diogelu plant rhanbarthol a'r holl aelod-sefydliadau wedi croesawu'r canfyddiadau a'r argymhellion.

Daeth yr adolygiad i'r casgliad na chafwyd **unrhyw wybodaeth** yn ystod y broses o asesu'r rhieni mabwysiedig a allai neu a fyddai wedi rhagweld yr hyn ddigwyddodd i Elsie.

Yn wir, soniodd yr holl weithwyr proffesiynol a fu'n rhan o ofal Elsie am deulu ymrwymedig, llawn cymhelliant a gofalgar.

Gwnaeth yr adolygiad ganfod fod yr asesiad o'r rhieni mabwysiadol yn **gryf** a **chadarn** ac yn cydymffurfio â safonau arfer da.

**Fodd bynnag**, gwnaeth yr adolygiad hefyd ganfod fod yna feysydd dysgu y dylid gweithredu arnynt i wella rhai o'r systemau ac arferion, yn arbennig o ran rhannu gwybodaeth a chofnodi data. Mae hefyd yn nodi achlysuron lle methwyd cyfleoedd i godi pryderon diogelu.

Am hyn, hoffai'r holl asiantaethau a fu'n rhan o ofal Elsie ymddiheuro o waelod calon.

Casgliad yr adolygiad yw y **gellir** dysgu o hyn ac y dylid gweithredu i wella rhai o'r systemau ac arferion.
Mae'r adroddiad yn cydnabod y camau mawr sydd eisoes wedi'u cymryd gan yr asiantaethau dan sylw ac mae'r adolygiad yn gwneud NAW argymhelliad pellach sydd yn y broses o gael eu gweithredu.

Hoffwn ddatgan yn glir ein bod yn hollol benderfynol, drwy weithredu ar yr argymhellion hyn, o wella'r ffordd rydym yn gwneud pethau, gwella'r ffordd rydym yn diogelu plant, a gwella bywydau plant yn ein gofal.

**Datganiad y Bwrdd Diogelu Rhanbarthol**

Mewn datganiad ar y cyd, dywedodd Cyd-gadeiryddion Bwrdd Diogelu Rhanbarthol Caerdydd a'r Fro Lance Carver a Claire Marchant: "Effeithiodd marwolaeth drasig Elsie'n ddwys ar bawb sydd wedi bod ynghlwm wrth ei gofal, ac rydym yn cydymdeimlo'n arw â'i theulu biolegol a'i theulu mabwysiadol ac yn meddwl amdanynt.

"Yn y pen draw, canlyniad gweithredoedd yr unigolyn a gafwyd yn euog o lofruddiaeth Elsie yw'r trasiedi hwn, ond mae'r adolygiad annibynnol wedi tynnu sylw at rai pwyntiau allweddol i'w dysgu ac mae camau gweithredu eisoes ar waith mewn ymateb.

"Mae'r Adolygiad Arfer Plant" yn gyfle i ddysgu gwersi yn sgil yr amgylchiadau a arweiniodd at farwolaeth drasig Elsie. Nid atgyfodi'r achos troseddol yw'r nod o gwbl.

"Mae holl aelodau'r Bwrdd yn croesawu canlyniadau'r Adolygiad Arfer Plant annibynnol. O'r hyn a ddysgwyd yn sgil yr adolygiad hwn, gallwn wella arfer yn y dyfodol, a sicrhau effeithiolrwydd ein gwasanaethau wrth amddiffyn plant.

"Mae newidiadau eisoes wedi'u gwneud yn y sefydliadau oedd ynghlwm wrth ofal Elsie ac mae camau i roi'r argymhellion pellach a wnaed gan yr adolygiad annibynnol eisoes ar waith eisoes yn mynd rhagddynt ."

**Datganiad Cyngor Bro Morgannwg**

Dywedodd Lance Carver, Cyfarwyddwr Gwasanaethau Cymdeithasol Cyngor Bro Morgannwg: "Mae Cyngor Bro Morgannwg yn croesawu'r Adolygiad Arfer Plant annibynnol a lansiwyd yn dilyn marwolaeth drasig Elsie ac wedi ymrwymo wrth ddysgu gwersi yn seiliedig ar y canlyniadau. Yn ôl yr adolygiad, dilynwyd y prosesau asesu cynllunio gofal a mabwysiadu yn briodol ac roeddent yn gadarn. Fel Cyfarwyddwr Gwasanaethau Cymdeithasol, rwy'n cydnabod yn llwyr fod rhaid cynnal ymchwiliad trylwyr bob amser i ddysgu gwersi yn seiliedig ar ddigwyddiad mor drasig â hwn ac rwy'n derbyn argymhellion yr adolygiad yn llawn.

"Rwy'n llwyr sylweddoli effaith y digwyddiad ar y rhai sy'n gysylltiedig â'r achos a buom yn ystyried ein prosesau ein hunain yn drylwyr tra roedd yr adolygiad annibynnol yn mynd rhagddo. O ganlyniad, mae nifer o gamau eisoes wedi'u rhoi ar waith i gryfhau'r trefniadau

monitro ar ôl i blentyn gael ei fabwysiadu.  Mae’r newidiadau hyn yn cynnwys sicrhau rhagor o oruchwyliaeth broffesiynol, yn fwy na'r dulliau goruchwylio arferol, amserlen ymweliadau estynedig, a sicrhau bod trefniadau cadarn ar waith ar gyfer cofnodi a rhannu gwybodaeth.

“Er bod marwolaeth plentyn mewn aelwyd fabwysiadol yn hynod brin, mae’n peri sioc a gofid mawr. Hoffwn fanteisio ar y cyfle hwn i fynegi fy nghydymdeimlad i aelodau teulu biolegol a mabwysiadol Elsie. Mae rhoi argymhellion yr adroddiad annibynnol ar waith yn flaenoriaeth i’r Cyngor ac un yr ydym yn ei hystyried o ddifri.”

**Datganiad BIP Caerdydd a’r Fro**

Mae Uwch-Gyfarwyddwr Nyrsio BIP Caerdydd a’r Fro, Ruth Walker, yn cydnabod yr argymhellion a amlygwyd yn yr adroddiad. Dywedodd: “Hoffwn ymddiheuro wrth aelodau teulu biolegol a mabwysiadol Elsie a chroesawu’r adroddiad hwn i ategu ein dysgu nid yn unig yn y maes iechyd ond o ran persbectif amlasiantaethol. Mae’r adroddiad yn nodi’r pwyntiau allweddol i'w dysgu ac rydym wedi cydnabod y rhain a newid yr arfer presennol mewn ymateb i hynny. Hefyd, mae’r Bwrdd Iechyd wedi sefydlu Grŵp Gorchwyl a Gorffen sydd wedi cytuno ar argymhellion ychwanegol gyda golwg ar wella’r arfer presennol ac mae'r rhain eisoes ar waith.

“Mae’r prif newidiadau yn yr arfer yn unol ag argymhellion yr adroddiad yn cynnwys: cynnwys plant dan 2 oed ag asgwrn wedi torri sy'n dod i'r Adran Damweiniau ac Achosion Brys yn yr adolygiad diogelu ffurfiol wythnosol. Caiff yr holl blant a atgyfeiria’r Meddyg Teulu ag asgwrn wedi torri eu hadolygu yn yr Adran Damweiniau ac Achosion Brys gan Ymgynghorydd Pediatrig. Caiff pob pelydr-x ar blant yn y clinig trawma ei gofnodi gan Radiolegydd Pediatrig Arbenigol. Mae llwybr diwygiedig i ymwelwyr iechyd wedi’i lunio i sicrhau y caiff yr holl wybodaeth diogelu sy’n ymwneud â phlant sy’n derbyn gofal ei rhannu â’u prif bediatregydd.

“Mae marwolaeth drist Elsie wedi effeithio’n ddwys ar yr holl staff ac maent wedi cael cymorth ac yn parhau i ymwneud â’r dysgu a’r newidiadau."

**Datganiad y Gwasanaeth Mabwysiadu Cenedlaethol**

Dywedodd Suzanne Griffiths, Cyfarwyddwr Gwasanaeth Mabwysiadu Cenedlaethol Cymru: “Mae’r amgylchiadau a arweiniodd at yr adolygiad hwn yn drasig ac yn brin iawn. Rydym yn meddwl am bawb y mae hyn wedi effeithio arnynt. Mae’r Gwasanaeth Mabwysiadu Cenedlaethol wedi bod yn rhoi cyngor i Fwrdd Diogelu Plant Rhanbarthol Caerdydd a’r Fro mewn perthynas â’r adolygiad annibynnol. Rydym eisiau sicrhau bod gwasanaethau mabwysiadu ledled Cymru yn cael cyfle i ddysgu gan y canlyniadau hyn.

“Daeth yr adroddiad i gasgliad y bu’r prif benderfyniadau ynghylch cymeradwyo rhieni mabwysiadol Elsie a’u paru ag Elsie yn drylwyr a chadarn. Wedi dweud hynny, mae’n amlwg bod angen ystyried manylion ac argymhellion yr adroddiad yn ofalus fel y gellir cryfhau’r polisi ac arfer.

“Wrth ymateb yn llawn i'r argymhellion yn yr adroddiad, byddwn yn parhau i weithio gyda'r sefydliadau mabwysiadu cydweithredol ledled Cymru, asiantaethau mabwysiadu gwirfoddol a Llywodraeth Cymru i gryfhau arfer diogelu a mabwysiadu. Bydd y gwaith yr ydym eisoes yn ei wneud, gan gynnwys ar yr adolygiad a chymorth i blant a roddir i'w mabwysiadu, yn ein helpu i wneud hyn, yn yr un modd â’r newidiadau a wnaed eisoes gan gydweithfa mabwysiadu’r Fro, y Cymoedd a Chaerdydd. Mae'r rhain yn cynnwys canllawiau cliriach yn ystod y cyfarfodydd cyn mabwysiadu; cofnodi ymweliadau yn fanylach; a thrafod a rhannu pryderon o ran diogelu.

“Mae’r broses mabwysiadu wedi parhau i gael ei rheoleiddio’n fanwl ers ei diwygio’n helaeth yn y 1980au. Mae mabwysiadu yn cynnig canlyniadau parhaol a da i ran fwyaf y plant sy’n gadael gofal fel hyn.

“Mae’r broses o gymeradwyo darpar fabwysiadwyr a rhoi plant i’w mabwysiadu o anghenraid yn drylwyr a manwl. Mae’n rhoi dyletswydd ar weithwyr proffesiynol i wneud ymholiadau a gofyn cwestiynau, mewn modd sensitif a chytbwys er mwyn diogelu a hybu llesiant plentyn.

“Ers ei sefydlu ar ddiwedd 2014, mae Gwasanaeth Mabwysiadu Cenedlaethol Cymru wedi bod yn gyfrifol am gydlynu’r gwaith o wella gwasanaethau mabwysiadu a chynghori Llywodraeth Cymru ar bolisi a newidiadau rheolaethol priodol. Byddwn yn parhau i wneud hynny, yng nghyd-destun yr holl wybodaeth a data sydd ar gael i ni, gan gynnwys y canlyniadau ac argymhellion a gyhoeddwyd heddiw gan y BDPRh.”

## Cwestiynau Cyffredin ynghylch y Bwrdd ac Adolygiadau Arfer Plant

**Beth ydy’r Bwrdd Diogelu Rhanbarthol?**
Mae Bwrdd Diogelu Plant Rhanbarthol Caerdydd a Bro Morgannwg (BDPRh) yn cynnwys partneriaid statudol (Cyngor Caerdydd, Cyngor Bro Morgannwg, Bwrdd Iechyd y Brifysgol, Ymddiriedolaeth Iechyd Felindre, Heddlu De Cymru a’r Gwasanaeth Profiannaeth) ynghyd ag aelodau ychwanegol gan gynnwys sefydliadau’r sector gwirfoddol fel y bo’n briodol.

**Beth ydy rôl y Bwrdd?**
BDPRh Caerdydd a Bro Morgannwg sy’n goruchwylio effeithiolrwydd trefniadau amlasiantaethol ar gyfer diogelu plant rhag cael eu cam-drin ledled Caerdydd a Bro Morgannwg. Mae’n ffurfio barn annibynnol ar waith diogelu lleol ac yn ei herio pan fo angen.

**Pryd byddai’r Bwrdd yn comisiynu Adolygiad Arfer Plant?**
Yn unol â Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014, mae’n rhaid i Fwrdd gynnal adolygiad arfer plant estynedig dan unrhyw un o’r amgylchiadau canlynol os oes achos o gam-drin neu esgeuluso yn hysbys neu’n debygol yn ardal y Bwrdd, a’r plentyn wedi

- marw; neu
- wedi cael anaf sy’n peryglu bywyd; neu
- wedi cael anaf difrifol a pharhaol sy’n effeithio ar ei iechyd neu ddatblygiad;

ac,

roedd y plentyn ar y gofrestr amddiffyn plant a/neu yn blentyn oedd yn derbyn gofal (gan gynnwys person sy’n gadael gofal dan 18 mlwydd oed) ar unrhyw ddyddiad yn ystod y 6 mis cyn

- dyddiad y digwyddiad y cyfeirir ato uchod; neu
- y dyddiad y mae awdurdod lleol neu bartner perthnasol yn nodi bod gan y plentyn anaf difrifol a pharhaol sy'n effeithio ar ei iechyd a'i ddatblygiad.

**Beth yw’r broses sydd ynghlwm wrth gomisiynu Adolygiad Arfer Plant?**
Mae’r Bwrdd yn penodi Panel Adolygu yn cynnwys partneriaid statudol BDPRh, yn ogystal ag unrhyw asiantaethau perthnasol sy’n gysylltiedig â'r achos dan sylw, a rôl y Panel ydy goruchwylio'r gwaith o gynnal yr adolygiad.

**Beth ydy pwrpas Adolygiad Arfer Plant?**
Pwrpas Adolygiad Arfer Plant ydy nodi pwyntiau i’w dysgu ar gyfer y dyfodol.

**Pwy sy’n cynnal yr adolygiad?**
Cynhelir Adolygiadau Arfer Plant gan adolygwyr annibynnol, sy’n cydweithio’n glos, a gaiff eu penodi gan y Panel Adolygu ac sydd heb fod yn gysylltiedig â'r achos neu'r gwaith o'i reoli o’r blaen.

**Pa weithgarwch a gyflawnir wrth gynnal yr Adolygiad Arfer Plant?**
Yn ogystal ag ystyried yr ystod eang o ddogfennau perthnasol, mae adolygwyr yn cysylltu’n uniongyrchol â phlant a theuluoedd pan fo’n bosibl ac yn briodol, ac mae eu barn yn cael ei chynnwys yn yr adroddiad terfynol. Mae gan gyfraniadau gweithwyr proffesiynol a rheolwyr sydd wedi bod yn gysylltiedig â’r achos hefyd ran allweddol i'w chwarae yn y gwaith o ddeall yr hyn a ddigwyddodd a pha bethau y gellid fod wedi'u gwneud yn wahanol. Mae’r adolygiad yn cynnwys craffu ar y camau a roddwyd ar waith gan asiantaethau statudol yn ystod y cyfnod yr oedden nhw yn gysylltiedig â'r achos ac wedi hynny.

**Beth sy’n digwydd os ydy’r Adolygiad yn nodi achos o esgeulustod proffesiynol ac/neu euogrwydd?**

Nod yr Adolygiad yw dysgu a gwella systemau ar arfer ar gyfer y dyfodol. Os ydy unrhyw fater yn ymwneud ag anghenion hyfforddiant staff unigol neu esgeulustod neu gamymddwyn gan staff yn codi yn ystod Adolygiad Arfer Plant, yna cyfrifoldeb Cadeirydd y Panel Adolygu ydy sicrhau y caiff y mater hwnnw ei gyfeirio at weithdrefnau staff ffurfiol yr asiantaeth berthnasol a'u rheoli ganddi.

**Ym mha ffordd y mae hyn yn wahanol i’r drefn yn Lloegr?**
Yn Lloegr, Adolygiadau Achosion Difrifol sy'n cyflawni rôl yr Adolygiad Arfer Plant. Cyn 2013, roedd Cymru yn dilyn yr un drefn â’r model o gynnal adolygiadau ar achosion difrifol a

ddefnyddir yn Lloegr i hybu dealltwriaeth a dysgu ar lefel aml-asiantaethol os cafodd plentyn ei anafu'n ddifrifol. Fodd bynnag, ar 1 Ionawr 2013, daeth y fframwaith newydd ar gyfer Adolygiadau Arfer Plant i rym 'Amddiffyn Plant yng Nghymru - Canllaw ar gyfer Adolygiadau Ymarfer Plant Amlasiantaeth'. Ym mis Ebrill 2016, daeth canllaw Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru), Gweithio gyda'n Gilydd i Ddiogelu Pobl - Cyfrol 2 - Adolygiadau Ymarfer Plant i rym. Nod adolygiadau arfer plant yw cwblhau'r gwaith dysgu ac adolygu yn gyflymach a chryno nag adolygiadau achosion difrifol. Fel arfer caiff y rhain eu cwblhau mewn 6-12 mis gan baratoi adroddiad 20-39 tudalen.

**Beth ydy'r Gwasanaeth Mabwysiadu Cenedlaethol?**

Cydweithrediad ar gyfer darparu gwasanaethau mabwysiadu ledled Cymru ydy Gwasanaeth Mabwysiadu Cenedlaethol Cymru. Er mis Tachwedd 2014 mae wedi dod â gwasanaethau mabwysiadu awdurdod lleol at ei gilydd mewn pum cydweithfa ranbarthol a gydlynir ac a arweinir gan dîm canolog bach a Chyfarwyddwr Gweithrediadau, gyda rhai swyddogaethau dros reoli achosion plant yn parhau i gael eu gwneud ar lefel awdurdod lleol. Mae Asiantaethau Mabwysiadu Gwirfoddol sy'n gweithredu yng Nghymru yn bartneriaid pwysig yn y gydweithfa yn ogystal ag asiantaethau eraill megis iechyd ac addysg.