

Neutral Citation Number: [2023] EWHC 299 (Admin)

Case No: CO/4393/2021

**IN THE HIGH COURT OF JUSTICE**  
**KING'S BENCH DIVISION**  
**ADMINISTRATIVE COURT**

Cardiff Civil Justice Centre  
2 Park Street, Cardiff, CF10 1ET

Date: 20 February 2023

**Before:**

**HIS HONOUR JUDGE KEYSER KC**  
**SITTING AS A JUDGE OF THE HIGH COURT**

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**Between:**

**THE KING**  
**on the application of SARAH POLLOCK** **Claimant**  
**- and -**  
**CYSUR: MID AND WEST WALES**  
**SAFEGUARDING CHILDREN BOARD** **Defendant**  
**-and-**  
**PEMBROKESHIRE COUNTY COUNCIL** **Interested Party**

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**Owain Rhys James** (instructed by **Watkins & Gunn**) for the **Claimant**  
**Gwydion Hughes** (instructed by **Carmarthenshire County Council**) for the **Defendant**  
**Christian Howells and Laura Shepherd** (instructed by **Pembrokeshire County Council**) for  
the **Interested Party**

Hearing date: 10 February 2023  
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**Approved Judgment**

This judgment was handed down remotely at 2 p.m. on 20 February 2023 at a hearing without attendance by counsel, by circulation to the parties or their representatives by email, and by release to the National Archives.

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HIS HONOUR JUDGE KEYSER KC

## **His Honour Judge Keyser KC:**

### **Introduction and Summary**

1. The claimant is the mother of Child M, who in April 2012 took her own life at the age of 14. An inquest in June 2015 reached a conclusion of suicide. Before the inquest, a Serious Case Review into the death was carried out by the (now defunct) Pembrokeshire Safeguarding Children Board (“PSCB”), and the Serious Case Review resulted in January 2014 in the creation of an Overview Report (“the Report”). An Executive Summary of the Report was published on 24 January 2014, but the Report itself has never been made available to the claimant. In these proceedings the claimant challenges the decision of the defendant (“CYSUR”), made on 6 September 2021 and communicated to the claimant on 6 October 2021, not to disclose the Report to the claimant (“the Decision”). Permission to bring the claim was given by HHJ Jarman KC, who by a judgment dated 26 July 2022 with the neutral citation number [2022] EWHC 1899 (Admin) also resolved certain disputed issues, finding that the Decision was indeed taken by an operational sub-group of CYSUR and not, as CYSUR had argued, by the interested party (“the Council”) and holding that the proceedings had been brought promptly and in time.
2. Since Judge Jarman KC gave his judgment, CYSUR has filed Detailed Grounds of Resistance, which do not address the particular grounds of challenge raised by the claimant but contend that the Decision was *ultra vires* because CYSUR had no copy of the Report, no control over a copy of the Report and no statutory power to release a copy of the Report to the claimant. Although the Detailed Grounds concede that the Decision ought therefore to be quashed, CYSUR’s position at the hearing has been that the Decision can simply be ignored and the claim ought to be dismissed. For essentially the same reasons as those advanced by CYSUR, the Council contends that the claim ought to be dismissed.
3. The initial question, accordingly, is whether CYSUR had any power to accede to the claimant’s request for a copy of the Report. Only if that question is answered in the affirmative do the specific grounds of review advanced by the claimant fall for consideration. I shall address that question after providing a survey of the relevant legislative history and a short account of the relevant facts. My conclusion, for the reasons set out below, is that CYSUR had no power to accede to the claimant’s request for a copy of the Report and that the claim must accordingly be dismissed.
4. For their clear and helpful submissions I am grateful to Mr James, Mr Hughes and Mr Howells, who appeared with Miss Shepherd, counsel respectively for the claimant, CYSUR and the Council.

### **The Statutory Framework**

#### *The position until 31 December 2012*

5. The Serious Case Review in respect of Child M’s death and the consequent production of the Report were carried out by PSCB as a Local Safeguarding Children’s Board (“LSCB”), pursuant to the statutory regime in sections 31 to 34 of the Children Act 2004 (“the 2004 Act”) and the Local Safeguarding Children Boards (Wales) Regulations 2006 (“the 2006 Regulations”).

6. The provisions of the 2004 Act included the following:

*“31 Establishment of LSCBs in Wales*

(1) Each local authority in Wales must establish a Local Safeguarding Children Board for their area.

(2) A Board established under this section must include such representative or representatives of–

(a) the authority by which it is established, and

(b) each Board partner of that authority, as the Assembly may by regulations prescribe.

(3) For the purposes of this section each of the following is a Board partner of a local authority in Wales–

(a) the chief officer of police for a police area any part of which falls within the area of the authority;

(b) a local probation board for an area any part of which falls within the area of the authority;

(ba) the Secretary of State in relation to his functions under sections 2 and 3 of the Offender Management Act 2007, so far as they are exercisable in relation to Wales;

(bb) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a Board partner of the authority;

(c) a youth offending team for an area any part of which falls within the area of the authority;

(d) a Local Health Board for an area any part of which falls within the area of the authority;

(e) an NHS trust providing services in the area of the authority;

(f) the governor of any secure training centre within the area of the authority (or, in the case of a contracted out secure training centre, its director);

(g) the governor of any prison in the area of the authority which ordinarily detains children (or, in the case of a contractedout prison, its director).

(4) Regulations made under subsection (2) that make provision in relation to a Board partner referred to in

subsection 3(a) to (c), (f) or (g) may only be made with the consent of the Secretary of State.

...

(9) Two or more local authorities in Wales may discharge their respective duties under subsection (1) by establishing a Local Safeguarding Children Board for their combined area (and where they do so, any reference in this section and sections 32 to 34 to the authority establishing the Board shall be read as a reference to the authorities establishing it)."

*"32 Functions and procedure of LSCBs in Wales*

(1) The objective of a Local Safeguarding Children Board established under section 31 is—

(a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

(2) A Local Safeguarding Children Board established under section 31 is to have such functions in relation to its objective as the Assembly may by regulations prescribe (which may in particular include functions of review or investigation).

(3) The Assembly may by regulations make provision as to the procedures to be followed by a Local Safeguarding Children Board established under section 31."

*"34 LSCBs in Wales: supplementary*

(1) The Assembly may by regulations make provision as to the functions of local authorities in Wales relating to Local Safeguarding Children Boards established by them.

(2) A local authority in Wales and each of their Board partners must, in exercising their functions relating to a Local Safeguarding Children Board, have regard to any guidance given to them for the purpose by the Assembly.

(3) The Assembly must obtain the consent of the Secretary of State before giving guidance under subsection (2) at any time after the coming into force of any of paragraphs (a) to (c), (f) or (g) of section 31(3)."

7. The following provisions of the 2006 Regulations are relevant<sup>1</sup>:

*“3. Functions of a Board in relation to its objective*

(1) A Board is to have the following functions in relation to its objective under section 32 of the 2004 Act —

...

(b) to take steps whose aim is to raise awareness throughout the Board's area of the need to safeguard and promote the welfare of children and to provide information about how this might be achieved;

(c) to develop policies and procedures whose purpose is to co-ordinate what is done by each representative body for the purposes of safeguarding and promoting the welfare of children within the area of the Board, including policies and procedures in relation to—

(i) information sharing;

(ii) actions, including thresholds for intervention, to be taken where there are concerns about a child's safety or welfare;

(iii) the recruitment and supervision of persons who work with or have regular access to children;

(iv) the safety and welfare of children who are privately fostered.

...

(e) to undertake ‘serious case reviews’ in accordance with regulation 4;

...

(h) to disseminate information about best practice in safeguarding and promoting the welfare of children amongst the representative bodies and such other persons as the Board sees fit;

(i) to undertake research into safeguarding and promoting the welfare of children”.

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<sup>1</sup> All Welsh legislation exists in both English and Welsh versions, which have equal status. In this judgment I cite only the text of the English versions. In argument it was not suggested that the Welsh versions bore any different meaning.

“4. *Serious case reviews*

(1) A Board must undertake a review (a ‘serious case review’) in accordance with this regulation in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected, and—

- (a) a child has died, or
- (b) has sustained a potentially life-threatening injury, or
- (c) has sustained serious and permanent impairment of health or development.

...

(3) The purpose of a serious case review is to identify steps that might be taken to prevent a similar death or harm occurring.

(4) In carrying out a serious case review, a Board must—

(a) ask each representative body to provide the Board with a written report of its involvement with the child who is the subject of the review, unless the Board is of the opinion that such a report is unnecessary in the circumstances;

(b) following receipt of each report referred to in subparagraph (a), produce a written report (referred to in these Regulations as an ‘overview report’) that—

(i) identifies steps to be taken to reduce the risk of a similar death or harm occurring; and

(ii) recommends the time by which, and identities the persons by whom, those steps should be performed;

(c) produce an anonymised summary of each overview report and make it available for inspection at the Board’s principal office.

(5) The Board must provide the National Assembly for Wales with a copy of—

(a) each report provided by a representative body in accordance with paragraph (4)(a) above;

(b) each anonymised summary; and

(c) each overview report.

(6) The Board must provide each representative body with a copy of

(a) each anonymised summary; and

(b) unless the Board considers it inappropriate, each overview report.”

(The expression “representative body” was defined by regulation 1 to mean “a body who has appointed a person to act as its representative on the Board”.)

“5. *Representatives*

(1) A Board must include the following as representatives of the children's services authority—

(a) the authority's lead director for children and young people's services or some other officer directly accountable to the director who is of sufficient seniority to represent the authority instead of the director;

(b) unless the authority's lead director for children and young people's services is—

(i) the director of social services, the authority's director of social services or some other officer directly accountable to that director who is of sufficient seniority to represent the authority instead of that director;

(ii) the chief education officer, the authority's chief education officer or some other officer directly accountable to the chief education officer who is of sufficient seniority to represent the authority instead of the chief education officer;

(iii) the officer appointed by the authority with responsibility for the discharge of its functions under Part VI or VII of the Housing Act 1996,

some other officer directly accountable to that person who is of sufficient seniority to represent the authority instead.

(2) A Board must include the following as representatives of the children's services authority's Board Partners—

(a) in respect of the chief officer of police for any police area any part of which falls within the area of the Board, an officer who—(i) holds at least the rank of Inspector; and (ii) whom the chief officer has charged with responsibility for safeguarding and promoting the welfare of children;

(b) in respect of a local probation board for any area any part of which falls within the area of the Board, the Chief Officer or some other officer directly accountable to the Chief Officer who is of sufficient seniority to represent the Board instead of the Chief Officer;

(c) in respect of a youth offending team for an area any part of which falls within the area of the Board, the team's manager or the manager's deputy;

(d) in respect of a Local Health Board ('LHB') for any area any part of which falls within the area of the Board —(i) the LHB's lead officer for children and young people's services or some other officer directly accountable to the lead officer who is of sufficient seniority to act as the LHB's representative instead of the lead officer; (ii) a registered medical practitioner charged with specific responsibilities in relation to the protection of children within the area of the LHB; and (iii) a registered nurse charged with specific responsibilities in relation to the protection of children within the area of the LHB;

(e) in respect of an NHS Trust providing medical services in the area of the authority, other than the Welsh Ambulance Services NHS Trust, the Trust's lead executive director for children and young people's services or some other officer directly accountable to him or her who is of sufficient seniority to act as the Trust's representative instead of the lead executive director;

(f) in respect of the governor of any secure training centre within the area of the Board (or, in the case of a contracted out secure centre, its director), the governor's (or director's) deputy or an individual of higher rank; and

(g) in respect of the governor of any prison in the area of the Board which ordinarily detains children (or, in the case of a contracted out prison, its director), the governor's (or director's) deputy or an individual of higher rank.

(3) The representatives in paragraph (2) are hereby prescribed for the purposes of section 31 (2) of the 2004 Act."

*"7. Functions of Local Authorities in relation to their Boards etc*

(1) A local authority must provide a member of its staff to provide administrative services to the Board.



(2) The records of a Board (in whatever form) are to be treated as if they were records of the local authority.”

8. In September 2006 the Welsh Assembly Government published Guidance within the terms of section 34(2) of the 2004 Act. It might be noted that the obligation in that subsection to have regard to guidance was imposed not on LSCBs but on local authorities and their Board partners (that is, as defined by section 41(3)) “in exercising their functions relating to a Local Safeguarding Children Board”. The preface to the Guidance reflected the incidence of the obligation:

“Chapters 4 to 10 of this guidance are issued under Section 34 of the Children Act 2004, which requires a local authority in Wales and each of their Board partners, in exercising their functions as relating to a Local Safeguarding Children Board, to have regard to any guidance given to them for that purpose by the National Assembly for Wales with the consent of the Secretary of State. This means that they must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.”

For present purposes, the relevant part of the Guidance is Chapter 10, “Serious Case Reviews”. Sections 10.8 and 10.9 set out the purpose of Serious Case Reviews:

“10.8 The purpose of serious case reviews carried out under this guidance is to identify steps that might be taken to prevent a similar death or harm occurring and in so doing, to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence;
- improve inter-agency working and better safeguard children; and
- identify examples of good practice.

10.9 Case reviews are not enquiries into how a child died or who is culpable, that is a matter for Coroners and Criminal Courts respectively to determine, as appropriate.”

Section 10.32 provided in part:

“10.32 On receiving an overview report the LSCB should:

- ...
- clarify to whom the report, or any part of it, should be made available;

- disseminate report or key findings to interested parties as agreed;
- ...
- provide each representative body with a copy of the anonymised summary and unless the Board considers it inappropriate the overview report.”

That section, though not entirely free of ambiguity, appears to assume that LSCBs had power to disseminate Overview Reports to persons other than the recipients mentioned in regulation 4 of the 2006 Regulations. (See also sections 10.35 and 10.36, which refer to the provision of information to interested parties; this seems to be meant in distinction from the provision of the overview report itself, tending to confirm that section 10.32 does have release of the overview report in mind and not merely the provision of information.)

9. The statutory scheme set out above was swept away by successive reforms. The first reform did not affect the existence and composition of LSCBs but, with effect from 1 January 2013, abolished Serious Case Reviews and replaced them with Child Practice Reviews. The second reform, which took effect on 6 April 2016, abolished Child Practice Reviews and replaced them with largely similar Practice Reviews; more importantly, it abolished LSCBs (including PSCB) and replaced them with Safeguarding Children Boards (one of which is CYSUR). I shall consider these reforms in turn.

*The position from 2013 to 5 January 2016*

10. First, with effect from 1 January 2013, the Local Safeguarding Children Boards (Wales) (Amendment) Regulations 2012 (“the 2012 Amendment Regulations”) revoked regulation 4 of the 2006 Regulations and replaced it with a new regulation 4A:

*“4A. Child practice reviews*

- (1) A Board must undertake child practice reviews in accordance with this regulation.
- (2) The purpose of a child practice review is to identify any steps that can be taken by Board partners or other bodies to achieve improvements in multi-agency child protection practice.
- (3) A Board must undertake a concise 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—
  - (a) (i) died; or (ii) sustained potentially life threatening injury; or (iii) sustained serious and permanent impairment of health or development; and,

(b) the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding [specified dates].

(4) A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse of a child is known or suspected, and the child has—

(a) (i) died; or (ii) sustained potentially life-threatening injury; or (iii) sustained serious and permanent impairment of health or development; and,

(b) the child was on the child protection register and/or was a looked after child on any date during the 6 months preceding [specified dates].

(5) In undertaking a child practice review the Board must—

(a) ask each representative body to provide the Board with information in writing about its involvement with the child who is the subject of the review;

(b) ensure that the perspective of the child who is the subject of the review is obtained and that the child's perspective contributes to the child practice review process, so far as practicable and appropriate to the circumstances of the case;

(c) ensure that the perspectives of members of the family of the child who is the subject of the review are obtained and that these perspectives contribute to the child practice review process, so far as practicable and appropriate to the circumstances of the case;

(d) hold a multi-agency learning event following receipt of the written information referred to in sub-paragraph (a);

(e) in the case of a concise child practice review, ensure that the multi-agency learning event referred to in sub-paragraph (d) is organised and facilitated by a single reviewer appointed by the Board;

(f) in the case of an extended child practice review, ensure that the multi-agency learning event referred to in sub-paragraph (d) is organised and facilitated by two reviewers appointed by the Board;

(g) ensure that any reviewer referred to in sub-paragraph (e) or (f) is independent of direct involvement in case

work or case management in respect of the child who is the subject of the review;

(h) produce a child practice review report which recommends action to be taken following the multi-agency learning event;

(i) ensure that the child practice review report does not reveal the identity or whereabouts of the child who is the subject of the review or the child's family;

(j) produce an action plan detailing action to be taken by the representative bodies to implement the recommendations of the child practice review report;

(k) provide the child practice review report and action plan to the Welsh Ministers;

(l) make the child practice review report publicly available;

(m) undertake periodic progress reviews on the implementation of the action plan;

(n) provide a written report to the Welsh Ministers following any progress review referred to in subparagraph (m), reporting on progress in implementing the action plan and the impact on child protection policy and practice in Wales;

(o) have regard to any guidance given to it by the Welsh Ministers, in exercising its functions under this regulation.”

11. Three observations may be made about this reform. First, there was no change to the existence or composition of the LSCBs. As they had formerly been responsible for Serious Case Reviews, so now they were responsible for Child Practice Reviews. Second, the scope of the reviews was quite different, as was the required degree of openness and transparency: compare regulation 4(3)-(6) with regulation 4A(2), (5). Third, the Amendment Regulations 2012 did not contain any transitional provisions concerning deaths occurring, or Serious Case Reviews commenced, before 1 January 2013. In the present case, PSCB continued with the Serious Case Review that had commenced in 2012, even though the provisions relating to such a review had been repealed long before it concluded the review. For the claimant, Mr James suggested that PSCB ought instead to have converted the review into a Child Practice Review, though he accepted that it was not now open to the claimant to challenge the procedure adopted. In the circumstances, the matter does not fall for my decision. However, I think that PSCB was probably right to take the course it did and I incline to the view that the determinative factor was the date when the review was commenced. A review commenced in January 2013 in respect of a death in December 2012 ought, I think, to have been a Child Practice Review, because there

was no statutory provision for any other form of review. On the other hand, it seems sensible that a Serious Practice Review that was nearing completion as at the end of 2012 should be completed as such, rather than that a new process should be commenced. If it is necessary to identify a particular date as determining which regime applies, the logical choice seems to me to be the date of inception of the review. As I say, no decision on this point is required.

*The position after 5 April 2016*

12. With effect from 6 April 2016 the institutions and procedures established by the 2004 Act and the 2006 Regulations, as amended were replaced upon the coming into effect of Part 7 of the Social Services and Wellbeing (Wales) Act 2014 (“the 2014 Act”) and the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (“the 2015 Regulations”). Section 134 of the 2014 Act replaced LSCBs with Children Safeguarding Boards. CYSUR is a Children Safeguarding Board under section 134. Regulations 3 and 4 of the 2015 Regulations replaced Child Practice Reviews by Concise Practice Reviews and Extended Practice Reviews. Part 7 of the 2014 Act was brought into force by article 2 of the Social Services and Well-being (Wales) Act 2014 (Commencement No. 3, Savings and Transitional Provisions) Order 2016, and sections 31 to 34 of the 2004 Act were repealed by regulation 218 of the Social Services and Well-being (Wales) Act 2014 (Consequential Amendments) Regulations 2016. None of the savings or transitional provisions in either of those measures related to LSCBs, Serious Case Reviews, Overview Reports or Child Practice Reviews.

13. The following provisions of the 2014 Act are relevant:

*“134 Safeguarding Children Boards and Safeguarding Adults Boards*

(1) Regulations must set out those areas in Wales for which there are to be Safeguarding Boards (‘Safeguarding Board areas’).

(2) Each of the following is a Safeguarding Board partner in relation to a Safeguarding Board area—

(a) the local authority for an area, any part of which falls within the Safeguarding Board area;

(b) the chief officer of police for a police area, any part of which falls within the Safeguarding Board area;

(c) a Local Health Board for an area, any part of which falls within the Safeguarding Board area;

(d) an NHS Trust providing services in the Safeguarding Board area;

(e) the Secretary of State to the extent that the Secretary of State is discharging functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;

(f) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a Safeguarding Board partner in relation to the Safeguarding Board area.

...

(6) A Safeguarding Board must include—

(a) a representative of each Safeguarding Board partner mentioned in subsection (2) in relation to the Safeguarding Board area, and

(b) a representative of any other person or body specified in regulations as a Safeguarding Board partner in relation to the Safeguarding Board area.

(7) Regulations under subsection (6)(b) may only specify a person or body as a Safeguarding Board partner if that person or body exercises functions under an enactment in relation to children in Wales or, as the case may be, adults in Wales.

...

(9) A Safeguarding Board may include representatives of such other persons or bodies, being persons or bodies mentioned in subsection (10), as the Board considers should be represented on it.

(10) Those persons or bodies are persons and bodies of any nature who or which exercise functions or are engaged in activities relating to children or adults (as the case may be) in the Safeguarding Board area in question.”

“135 *Functions and procedures of Safeguarding Boards*

(1) The objectives of a Safeguarding Children Board are—

(a) to protect children within its area who are experiencing, or are at risk of, abuse, neglect or other kinds of harm, and

(b) to prevent children within its area from becoming at risk of abuse, neglect or other kinds of harm.

...

(3) A Safeguarding Board must seek to achieve its objectives by co-ordinating and ensuring the effectiveness of what is done by each person or body represented on the Board.

(4) Regulations must—

(a) provide for a Safeguarding Board to have functions relating to its objectives (including, for example, functions of review or investigation);

(b) make provision as to the procedures to be followed by a Safeguarding Board;

(c) specify when and how children or adults who are, or may be, affected by the exercise of a Safeguarding Board's functions must be given the opportunity to participate in the Board's work.”

14. Regulation 3 of the 2015 Regulations provides:

“3. *Functions of Safeguarding Boards*

(1) Paragraph (2) specifies the functions of—

(a) a Safeguarding Children Board in relation to its objectives under section 135(1) of the [2014] Act ...

(2) The functions are—

(a) to cooperate with other Safeguarding Boards and the National Board with a view to—(i) contributing to the development and review of national policies and procedures for Safeguarding Boards, (ii) implementing national policies and procedures recommended by, and guidance and advice given by, the National Board;

(b) to raise awareness throughout the Safeguarding Board area of the Board's objectives and how these might be achieved;

(c) to undertake relevant reviews, audits and investigations;

(d) to review the efficacy of measures taken by the Board to achieve the Board's objectives;

(e) to make recommendations in light of those reviews, to monitor the extent to which those recommendations are carried out and to take appropriate action where it is shown that the Board's objectives are not being fulfilled;

(f) to disseminate information about those recommendations to other appropriate Safeguarding Boards and the National Board;

(g) to facilitate research into protection of, and prevention of abuse and neglect of, children or adults at risk of harm;

(h) to review the training needs of and promote the provision of suitable training for persons working to achieve the Board's objectives;

(i) to arrange and facilitate an annual programme of multi-agency professional forums;

(j) to cooperate or act jointly with any similar body situated in any jurisdiction where the Board considers that this will assist it to fulfil its objectives;

(k) to obtain specialist advice or information relevant to the attainment of the Board's objectives;

(l) to undertake practice reviews in accordance with regulation 4."

15. Regulation 4, which provides for Practice Reviews, contains provisions that, for present purposes, are similar to those formerly applying to Child Practice Reviews. In particular, regulation 4(5)(l) requires that the Board must make the practice review report publicly available.

### **Summary of the Facts**

16. Child M was born in May 1997. In December 2011 she became a "Looked After Child" under the care of the Council. At the beginning of April 2012 she took her own life.
17. The Serious Case Review in respect of Child M was commenced in 2012 and was thereafter continued and completed in accordance with the provisions of the 2004 Act and the 2006 Regulations. The Executive Summary of the Report was published on 24 January 2014 and the Report itself was probably produced on or about the same date. The claimant was given a copy of the Executive Summary but has never been given a copy of the Report itself.
18. In June 2015 the coroner, when concluding that Child M had taken her own life, stated that, although there had been "communication issues" between some agencies, "this did not in any way cause or act as a contributory factor in Child M's death."
19. The claimant made a formal complaint about the Council to the Ombudsman, who requested sight of the Report and was given it strictly on the terms that it was to be used solely for the purposes of the investigation and with no onward circulation. The Ombudsman did not make a finding of maladministration against the Council.
20. Over the years the claimant has made repeated requests for a copy of the Report from PSCB and the Council, but her requests have been refused. Most recently, in April 2021 she made a request to CYSUR. CYSUR replied to the effect that it had not existed when the Report was published and that it had referred the request for a copy of the Report to the Council. The claimant then made her own request to the Council.



Having received no substantive response, on 12 August 2021 the claimant, who was acting in person, sent a pre-action letter to the Council, intimating an intention to commence proceedings for judicial review if the Council either declined to make a decision about disclosure of the Report or decided not to disclose it.

21. As well as being the Council's Head of Children Services, Mr Mutter was also the chairman of the Pembrokeshire Local Operational Group ("the Group"), a sub-group of CYSUR. The claimant's request for a copy of the Report was placed on the agenda for a meeting of the Group on 6 September 2021.
22. Mr Mutter prepared a Briefing Paper for the meeting. Apart from the subsequent letter that was sent to the claimant to inform her of the Group's decision, the Briefing Paper is the only evidence of how the Group dealt with the claimant's request. After a brief survey of the background, it continued:

"In the absence of any provisions for Regional Safeguarding Boards to attend to unfinished or further business of the now defunct Pembrokeshire LSCB, legal advice has suggested that the [Group] should deal with any request for disclosure of information contained within an Overview and that the statutory framework and guidance applicable to the now defunct LSCBs should be the point of reference."

The Briefing Paper referred to regulation 7 of the 2006 Regulations and noted, "Children's Services may therefore be deemed to hold the Overview Report as one of its records." It then referred to and quoted from the Guidance and concluded:

"The overview is a thus confidential report and decisions about its disclosure to interested parties, of whom M's mother is of course one, are decisions for an LSCB and not for any of the individual represented bodies by themselves."

After a further reference to paragraph 10.35 of the Guidance, the Briefing Paper continued:

"We therefore need to review this request, the content of the (unpublished) Overview Report and the (published) Executive Summary in light of this non exhaustive list of factors and I as chair of the [Group] invite you on behalf of your representative organisations, to identify how these factors apply to the circumstances of this request by Sarah Pollock for a copy of the Overview Report.

This is not the first time such a request has been made by M's mother. This repeat request does not mean that we are absolved of a duty to consider the request in full and in light of the above considerations and indeed any new relevant considerations. Since M's passing it is certainly the case that we have moved into an era of increased transparency and this is referred to specifically in the current guidance on Child Practice Reviews. It is also the case that there has been no suggestion, regulation

or legislation implemented by the Welsh Government to require publication or dissemination of SCR Overviews either to the public in general or to interested parties such as relatives of children. A call for transparency in my view therefore sits in the background *but not alongside* the factors that we must take into consideration in relation to this request for release of the Overview.

Finally and just a reminder (as if you needed it) it is stated ‘There are difficult interests to balance’. We are not required to rank them in order or weigh one in turn against each of the others: we are required instead to come to a decision on balance which I suggest means taking a holistic and reasoned approach to the decision that we need to make.”

23. It is, I think, clear from the Briefing Paper and the subsequent decision that the members of the Group were provided with copies of the Report in order to inform their deliberations. No minutes of the meeting of the Group have been disclosed.
24. On 6 October 2021 Mr Mutter, as the Council’s Head of Children’s Services, wrote to the claimant to inform her of the decision to refuse her request for a copy of the Report:

“I confirm that on 6<sup>th</sup> September 2021, Pembrokeshire’s Local Operational Safeguarding Group (LOG) met and, as part of its business, discussed your request to release [the Report]. All of members (sic) of the LOG were of a view that the Overview Report should not be released to you in any format. I as co-chair of the LOG and Head of Children’s Services—which is the agency that is required to treat the records of the Board which produced the Overview Report as its own records—endorse the recommendations of the group not to release the Overview SCR. In arriving at this decision the group had to balance and take into account a number of considerations including:

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others;
- the accountability of public services and the importance of maintaining public confidence in the process of internal review;
- the need to secure full and open participation from the different agencies and professionals involved;
- the responsibility to provide relevant information to those with a legitimate interest; and

- the present culture of greater transparency and openness in an era of accessibility to social media.

The rationale for the decision, as variously voiced by those present, included the following:

1. When information was provided by various agencies and individuals to assist the person undertaking the review, it was done so on the clear understanding that the information would not be made public.
2. The Overview Report contains sensitive and personal information and duties of confidentiality arise.
3. Anonymising of individuals mentioned in the report would not prevent their identification and a risk of inappropriate approaches being made to individuals in a context of indications that such approaches have been made to individuals in the past.
4. In light of the availability of social media and its potential for the proliferation of both information and misinformation, a decision to release the Overview Report now has implications that were unforeseen at the time of the preparation [of] of the report, not least the impact of information or sections of the report being taken out of context and widely posted and published. The circumstances of [Child M's] death were examined at her inquest and the subject of public interest at the time.
5. The report was written in line with guidance at the time and this differs from the guidance now in place in relation to Child Practice Reviews that would be undertaken in similar circumstances today.
6. The present climate of transparency is a relevant consideration but does not override all other considerations.
7. The Executive Summary that was released reflected the conclusions and recommendations contained within the Overview Report.

I appreciate that you will be disappointed by this decision and cannot expect you to agree with it. I hope that you are able to accept however that it was not made lightly and that full and impartial consideration was given to the decision.”

25. The claim form was filed on 30 December 2021, identifying CYSUR as the defendant and the Council as the interested party.

**Did CYSUR have the power to release the Report to the Claimant?**

26. The argument advanced by Mr James on behalf of the claimant may be summarised as follows:

- 1) CYSUR's power to disclose the Report to the claimant derives not from any powers inherited from PSCB but directly from the statutory regime in the 2014 Act and the 2015 Regulations. Specifically, the power is incidental to the function set out in regulation 3(2)(c). He also referred, with diffidence, to regulation 3(2)(b), (g), (j) and (k).
- 2) If not incidental to the function in regulation 3(2)(c), the power is implied by the 2015 Regulations. They do not establish a comprehensive statutory code regarding the release of material or information and disclosure of an overview report prepared under a different (and no longer extant) regime is not inconsistent with the 2015 Regulations or the 2014 Act.
- 3) The question whether PSCB had any power to disclose Overview Reports to persons other than the recipients identified in regulation 4 of the 2006 Regulations is irrelevant to the question of CYSUR's powers, although it might possibly be relevant to the exercise of such a power by CYSUR if it has it. Similarly, it is irrelevant to point to any supposed inconsistency of such a power on the part of CYSUR with the statutory regime in the 2006 Regulations, because that regime had been repealed before CYSUR ever came into existence. Similarly, it is irrelevant to observe that regulation 7(2) of the 2006 Regulations deemed the Report to be part of the Council's records, because that provision has been repealed.

27. The argument on behalf of CYSUR and the Council may be summarised as follows:

- 1) The Report was an Overview Report prepared by PSCB as a Local Safeguarding Children Board in the course of a Serious Case Review. PSCB was a creature of statute. It was created by section 31 of the 2004 Act and its functions and powers were conferred by the 2006 Regulations.
- 2) PSCB's only statutory functions in respect of Overview Reports were those in regulation 4 of the 2006 Regulations, namely: to produce the Overview Report; to produce an anonymised summary of the Overview Report; to make the anonymised summary available for inspection at the Board's principal office; to provide a copy of the Overview Report and of the anonymised summary to the National Assembly for Wales; and to provide a copy of the anonymised summary and (unless it considered it inappropriate) a copy of the Overview Report to each representative body. PSCB was given no statutory power to release the Overview Report to any other person. No such power can be implied.
- 3) CYSUR, as the successor to PSCB, could not have inherited any greater power of disclosure of an overview report than PSCB had.
- 4) The provisions of regulation 4A of the 2006 Regulations are not in point, because (a) they did not apply to any death occurring before 2013 and (b) they concerned Child Practice Reviews and consequent reports, not Serious Case Reviews and Overview Reports.

- 5) CYSUR did not initiate or carry out the Serious Case Review in respect of Child M; it did not produce the Report; it does not hold a copy of the Report or have control over the Report. It has no statutory functions at all in respect of Serious Case Reviews or Overview Reports pursuant to the 2006 Regulations. Its statutory functions relate to Practice Reviews under the 2015 Regulations.
  - 6) The Council accepts that it is the holder of the Report, by virtue of regulation 7 of the 2006 Regulations. It denies that it has any power under the 2006 Regulations to provide the Report to the claimant. It says that any requests under the Freedom of Information Act 2000 would be considered in the usual way. (No decision of the Council is subject of challenge in these proceedings.)
28. In my judgment, the defendant is right to submit that it had no power to disclose or to direct disclosure of the Report.
  29. I think that a convenient starting point is to ask what the Report has to do with CYSUR. The answer seems to me to be, Nothing. The Report is an Overview Report arising out of a Serious Case Review. Serious Case Reviews were abolished more than three years before CYSUR was created. The Report was produced in January 2014, more than two years before CYSUR was created. It was produced by PSCB, which was abolished immediately before CYSUR was created. Mr James rightly accepts that CYSUR did not assume statutory responsibilities and liabilities that had formerly rested on PSCB; its functions and powers were those created by the 2014 Act and the 2015 Regulations. The distinctions between PSCB and CYSUR and between Serious Case Reviews and Practice Reviews are not merely terminological, although there is an obvious degree of overlap between the compositions of the respective bodies and between the functions of the respective reviews.
  30. More particularly, the Report played no part in the exercise of the functions that were given to CYSUR under the 2014 Act and the 2015 Regulations. The only actual relation between CYSUR and the Report arose from the fact that CYSUR was asked to disclose, or to approve the disclosure of, the Report. That is no relevant relation: one can ask anyone to disclose anything, but that does not give that person any right, power or obligation to disclose the thing in question.
  31. Mr James responds to this objection by reference to regulation 3(2) of the 2015 Regulations. His argument depends on establishing that the disclosure of the Report fell within CYSUR's functions. He relies on sub-paragraph (c): "to undertake relevant reviews". I do not see that this assists the claimant. CYSUR was not carrying out any relevant review; as I have said, its only relation to the Report was that it was requested to disclose it or to approve its disclosure. The meaning of "relevant reviews" must be ascertained by reference to the statutory objectives of Safeguarding Children's Boards as specified in section 135(1) of the 2014 Act. CYSUR was not carrying out a "relevant review"; it is therefore unnecessary to decide whether, if it had been doing so, it might have had the power to disclose documentation received by it in the course of such a review, though I can see that it might very well have had such a power. The other sub-paragraphs mentioned by Mr James take matters no further. Sub-paragraphs (b), (j) and (k) have no conceivable bearing on the matter. As for sub-paragraph (g), it may be that the claimant believes

that the Report would disclose matters from which lessons could be learned. But to assert that CYSUR had a power to disclose this Report in the exercise of a function to “facilitate research” is to strain the regulation beyond breaking point.

32. There was some argument before me regarding the implication of statutory powers, with particular reference to the decision of the Divisional Court in *R (SXM) v Disclosure and Barring Service* [2020] EWHC 624 (Admin), [2020] 1 WLR 3259. I do not think that this argument advanced matters. It was principally focused on the extent, if any, to which LSCBs had power to disclose Overview Reports to persons other than the recipients identified in regulation 4 of the 2006 Regulations. As Mr James did not rely on any powers under the 2006 Regulations, the argument has largely fallen away. Whatever may have been the position under the 2006 Regulations regarding the power to disclose Overview Reports<sup>2</sup>, it is clearly a necessary condition of the implication into the 2015 Regulations of any power to disclose information or documents that the alleged power relates to the exercise of a statutory function under the 2015 Regulations.
33. It follows that I do not consider CYSUR to have been the appropriate body to make any decision in respect of the disclosure of the Report or that it had any power to do so. Despite my inevitable sympathy for the claimant, I reach this conclusion without regret. One might stand back for a moment. Judge Jarman KC has conclusively determined as a finding of fact that the decision under challenge was taken by CYSUR, and neither would I wish to nor could I go behind his finding of fact. However, I do not think it irrelevant to note that the facts as stated above show why it was not entirely unreasonable of CYSUR to dispute that it was the proper defendant and to deny that it was the decision-maker. The request for disclosure to which the answer was given in October 2021 had been made to the Council (though, of course, that request followed one made to CYSUR). It was the Council via its Head of Children’s Services who procured and communicated to CYSUR the advice that the Group “should deal with” the request for disclosure of the Report, although CYSUR had not even existed when the Report was prepared and (so far as the evidence goes) did not have the Report before it was asked to consider its release to the claimant and had regard to it for no other purpose. The Decision was communicated not by CYSUR but by the Council, in terms that, though at one point describing the Decision as CYSUR’s, also refer to CYSUR’s “recommendations” as “endorse[d]” by Mr Mutter as chairman of “the agency that is required to treat the records of the Board which produced the Overview Report as its own records”.
34. The Council accepts that it holds the Report as part of its records. It also accepts that any request for disclosure of its contents under the Freedom of Information Act 2000 would have to be considered on its own merits. The present proceedings concern a specific decision by CYSUR. Despite the breadth of the argument before me, I do not consider it appropriate to venture into a discussion of the bodies from whom disclosure of the Report might be sought or the grounds on which it might be sought.

### **The Claimant’s Grounds for Review**

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<sup>2</sup> It is by no means clear to me that the Guidance was correct to assume that such a power existed, but the point does not fall for decision. For the avoidance of doubt, I do not accept Mr James’s submission that such guidance from the executive is an admissible tool for statutory interpretation.

35. In the circumstances, the claimant's grounds for challenging the Decision do not fall for consideration. CYSUR did not defend the claim by reference to the grounds and accepted that, if I held that it had power to decide on the disclosure of the Report, the Decision ought to be quashed and the matter remitted to it for redetermination. Accordingly, and as I heard no argument on the grounds, I shall confine myself to observing that they did not immediately appear to be compelling and explaining briefly why that is. Mr James maintained the following five bases of challenge to the Decision.

*Ground 2—unlawful policy:* The complaint was that CYSUR adopted an unlawful policy by proceeding on the basis that it had no power to disclose the Report. However, if CYSUR had taken such a stance and done so wrongly, this would have constituted a simple legal error, not the adoption of an unlawful policy. In fact, and to the contrary, CYSUR proceeded on the basis that it did have the power to make the Decision. In that regard it was, in my judgment, mistaken.

*Ground 3—inadequate reasons:* Mr James's submissions on this point were based on the words, "The rationale for the decision, as variously voiced by those present, included the following" (my emphasis) in the letter of 6 October 2021. He argued that this meant that, on CYSUR's own case, there were reasons that were not set out in the decision letter. This might be thought to represent an overly literal and unduly picky approach to reading the letter and that all it was seeking to do was to explain the reason (the "rationale": singular) for the Decision by reference to the ways in which the factors that had been balanced had been expressed by representatives. I have difficulty in thinking that anyone could be in genuine doubt about the basis of the Decision; any difficulty will lie solely in the minds of those looking to find grounds on which to mount a legal challenge.

*Ground 4—wrongful application of the 2006 Guidance:* The essence of this ground was that CYSUR wrongly proceeded by applying the 2006 Guidance as though it were an LSCB under the regime in the 2004 Act and the 2006 Regulations, instead of properly recognising that the old regime had been revoked and that CYSUR was operating under new provisions. At times the exposition of this ground slipped perilously close to a collateral challenge to the adoption of the Serious Case Review procedure in the case of Child M. The problem with the ground seems to me to be that CYSUR did in fact take account of the "present climate of transparency", and so did not approach the matter purely on the basis of the former regime, but was at the same time properly aware that the Report was an Overview Report after a Serious Case Review and was not prepared and produced under the current regime.

*Grounds 6 (irrelevant considerations) and 7 (fettering discretion):* These grounds again amounted to the contention that CYSUR had not properly exercised its discretion because of its focus on the nature of the Report as an Overview Report and the review as a Serious Case Review. It is doubtful whether they add anything of substance to Ground 4 and even more doubtful whether any of the matters taken into account by CYSUR could be characterised as irrelevant.

*Grounds 9 (Article 8, ECHR) and 10 (Article 10, ECHR):* Mr James advanced these grounds on the basis simply that CYSUR had given no consideration to the

engagement or application of Articles 8 and 10. In view of the factors taken into account by CYSUR and the balancing exercise that it ostensibly performed, it is not clear that these grounds do more than propose a tick-box criterion for review or that there would have been any likelihood that explicit consideration of Article 8 and Article 10 would have resulted in a substantially different outcome.

*Ground 11—irrationality:* This ground adds nothing. It is impossible to say that the only reasonable decision would be to disclose the Report, even if one thought that a decision to disclose it would be reasonable.

## **Conclusion**

36. CYSUR had no power to disclose or to direct the disclosure of the Report. Insofar as it purported to do so, it exceeded its powers. There is no purpose in purporting to quash its decision not to disclose the Report; it has no effect. The claim for judicial review is dismissed.
37. Consequential matters will be dealt with at a short further hearing.