Extended Child Practice Review Report

CYSUR 2/2018

Date report presented to the Board: 17th October 2019

Child/Adult Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children/Adults Board

Extended Child/ Practice Review Re:
CYSUR 2/2018

Brief outline of circumstances resulting in the Review

To include here:

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

An Extended Child Practice Review (ECPR) was commissioned by CYSUR: The Mid & West Wales Safeguarding Children's Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews*[2] (Welsh Government, 2016). The criteria for this review are met under Chapter 7 Extended Child Practice Reviews.

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 (LA) or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for extended child practice reviews are laid down in *the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[4].

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and a family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations about what needs to be done differently to improve future practice.

Additionally, as part of an extended review there will be an additional level of scrutiny which will include consideration of the following issues:

[1] Social Services & Well-being (Wales) Act 2014

[2] Working Together to Safeguard People – V2 – CPRs (Welsh Government,2016)

[3] Local Authority or relevant partner means a person or body referred to in s.28 of *the Children Act 2004* or body mentioned in s.175 of *the Education Act 2002*

[4] Regulation 4(4) of the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*

- Whether previous relevant information or history about the child/family members was known and considered in professionals' assessment planning and decision making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child.
- Whether the child protection plan (and /or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.
- Whether the plan was implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan.
- The aspects of the plan that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and the family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and contextual issues). (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016)[5].

The Terms of Reference for this Extended Child Practice Review are at **Appendix 1**

Circumstances Resulting in the Review

The young woman was an 18 year old care leaver who was tragically found dead at her flat by the Police on the 22nd January 2018, following their mother's request for a welfare check to be made. The cause of her death following the post mortem, was recorded by the pathologist as a natural death, as a result of Hyperglycaemic Ketoacidosis, Type 1 Diabetes Mellitus[6].

The young woman had been accommodated by the Local Authority (LA) since January 2010, (she was 10 years old at the time) with a full care order being granted for her on the 6th October 2011, relating to a complex family history of her being at risk of sexual, physical, emotional abuse and neglect; with specific concerns in relation to her mother's inability to manage her diabetes at home, which had led to her being hospitalised on numerous occasions.

There was a long history of Social Services' involvement with the young woman and her siblings; which had included care proceedings, periods of child protection registrations (the last one was current up to the point of her 18th birthday), 5 secure order applications, and the young woman having been in the care of the LA, with a Care Plan and as a care leaver in receipt of a Pathway Plan (held by the Looked After Young Person Social Worker) at the time of her death.

Due to the concerning circumstances of her death, her history, self-neglect, and self-mismanagement of her diabetes, alongside the extensive involvement of a range of agencies, it was felt that there should be a referral for consideration under the Child Practice Review process, as the criteria for an Extended Child Practice Review(ECPR) had been met.

Time Period Reviewed and Why

To reflect the significant amount of information and multi-agency involvement that is covered in the two years prior to the young woman's death, the timeline of the review has been extended, to the maximum period permitted. The timeline reviewed was from the 23rd January 2016 to the 22nd

[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government,2016)

[6] Diabetes Mellitus (DM) is the Latin name for diabetes. Type 1 diabetes mellitus occurs when a person cannot produce insulin which is needed to control blood glucose levels. www.diabetes.co.uk.

January 2018. However, in order to understand the necessary context, the learning process did take account of relevant historical information, concerning her difficult and unsettled childhood.

The focus of the analysis is on current practice, the young woman's Care Plan, Sexual Exploitation Risk Assessment Framework (SERAF), Child Protection Plan (CPP), Legal Planning considerations, and her subsequent Pathway Plan/transition arrangements. The review is informed by an understanding of what would have been possible at the time, with the knowledge/guidance available then.

It should be noted that there was no concurrent Police investigations or judicial proceedings or any parallel reviews of practice being undertaken at the time of the ECPR. There had, owing to the natural cause of death, been no necessity to hold an inquest, and the extensive Police investigation which commenced at the time of the young woman's death was concluded with the post mortem outcome.

Young Woman's Family History and Contextual Information

The young woman was, up until her 18th birthday, a child whose name was placed on the Child Protection Register (10th October 2016). She had also been in the care of the LA, and, at the time of her death, she was a care leaver in receipt of a Pathway Plan and had been previously placed in Secure Accommodation. The young woman at the time of her death was living independently with a multi-agency package in place to support her.

Relationships within the family were complex, as were contact arrangements (which were at the outset of the timeline mainly supervised). The young woman could be threatening towards her mother, who admitted to being frightened of her daughter's behaviour towards her on occasion.

During the period of the review the young woman was in direct contact with two of her older half siblings and her mother, alongside a foster carer who had previously supported her. Written communication had taken place between the young woman and their elder half-brother. The foster carers of her youngest sibling, with whom she did not have contact, had provided her with some photographs and information, which she had found helpful. There had also been contact with the young woman's half (younger) brother, some time prior to her death, but this had not gone well. Contact was made with the young woman's father in February 2017 and then again in March 2017, where her father confirmed that he did not wish to have contact with his daughter. The LA, however, explained to him the current circumstances in respect of the young woman at that time. Contact with the young woman's father was attempted (following a formal request by the LA) on notification of her death, but as he had moved, with no forwarding address, the Police were unable to make the requested contact.

The young woman was described by her family and former foster carer to be an articulate, bright, bubbly, loyal, likeable, knowledgeable, kind hearted, caring, loving, feisty and strong-minded young woman. She knew her own mind, and was someone who was not afraid to stand her ground or to say what she was thinking. 'She said it how it was, and always thought that she knew best'. Challenging, stubborn, and at times, aggressive and volatile, she felt that respect had to be earned and would on occasion test the boundaries. Trusting (mainly inappropriately), and perpetually vulnerable to people and situations. She valued the importance of contact with her family and always said 'thank you' when she felt that people (including professionals) had listened, cared, and stood by her. The important words to her were *'Remember, Family, Loyalty and Trust'.*

The young woman was not consistently engaged in education, employment and/or training[7], outside of the Secure Unit. On leaving the Unit she engaged briefly with a training provider, whilst

[7] Welsh Government: Youth Engagement and Progression Framework.
Youthengagementandprogression@wales.gsi.gov.uk

trying to secure a place at a Further Education College. Frequent changes of placement had affected her educational journey. However, the young woman was intelligent, and did succeed, demonstrating her academic prowess when she achieved a grade B in Maths, and displayed an aptitude for Art in the Secure Unit. Her English Language skills were also strong and prose from her workbook, which was shared with her former foster carer illustrated this. The young woman spoke with pride when she confirmed that she had passed her GCSEs, and was pleased that she had done so. The young woman communicated well, and had good interaction with Careers Wales. She was aspirational towards her future, changing vocational pathways during the course of the timeline. The young woman who was forthright in providing her opinions had also requested to register with 'Diabetes UK,' to offer to go into schools to speak to young people about the condition. This was something that she felt that she could do well.

Careers Wales provided careers advice/guidance and made the necessary referrals under 'Youth Engagement/Guarantee'[8] when the young woman returned to their local area and formed part of her Pathway Plan under education.

Choices[9] were involved intermittently with the young woman because of her disclosure (since the age of 14) of substance misuse (heroin, cocaine, speed, ecstasy, amphetamines and cannabis). In 2017, the young woman stated, 'I got in the wrong crowd and started drugs, drinking and staying out.'

The young woman would not always engage with the help and support that was offered to her by services. She demonstrated no insight into her vulnerabilities and believed that measures that had been put in place to support her were 'unnecessary and draconian'[10]. She expected to access support on her terms and very often when a crisis situation had arisen. The young woman reacted to things unreasonably and impulsively, causing her to make sudden inappropriate choices/decisions. She would often 'violate rules and boundaries set down by parental or authority figures, such as professionals, who were trying to help her, as she had been used to chaos in the past and found structure too restrictive.'[11]

An Initial Child Protection Conference was held under the 'All Wales Child Protection Procedures 2008'[12] on the 10th October 2016, due to the escalating risk of significant harm regarding the young woman, in regards to sexual exploitation, going missing and the mismanagement of her diabetes. The young woman's name was placed on the register under the category of sexual abuse. This was seen as an additional safeguard put in place by the LA to monitor, review and manage the presenting risks. It was 'unusual'[13] to have a young person simultaneously on the Child Protection Register whilst being Looked After, and illustrated how seriously the LA took their concerns and endeavoured to manage the presenting risks.

Throughout the timeline of the review (outside of the young woman's 3 periods in Secure Accommodation) there were reoccurring themes of Child Sexual Exploitation (CSE), absconding and a risk of harm because of the mismanagement of her diabetes. There was also repeated breakdowns in foster care and respite placements, where placing the young woman with their mother (as this would be the only place they would go) was done to mitigate and manage risk. There was evidenced long term impact of the neglect/abuse that the young woman experienced

[8] Welsh Government: Youth Engagement and Progression Framework. Youthengagementandprogression@wales.gsi.gov.uk

[9] Choices are drug and alcohol services for young people, they provide information, advice and support to any young person under the age of 18.

[10] Secure Accommodation Review 15th March 2017

[11] Psychiatric Report 14th May 2017

[12] All Wales Child Protection Procedures 2008

[13] ICPC Minutes 10th October 2016

as a child and this presented challenges for professionals, who were trying to influence longstanding patterns of detrimental behaviour in relation to her health and well-being.

Multi Agency Review Strategy meetings were held, professional discussions and Core Group Meetings which again highlighted the ongoing concerns surrounding sexual exploitation, association with older males, absconding and mismanagement of the young woman's diabetes. A recommendation of the Strategy Meeting held in August 2016 was that a Legal Planning Meeting should be held to consider an application for Secure Accommodation. This was the commencement of a series of Legal Planning Meetings. In total, the LA made 5 applications for a Secure Order, 3 of which were agreed by the Court. On 2 occasions, applications by the LA for Secure Orders were refused by the Court, on the basis that the criteria were not met. The Courts' refusals occurred when the LA were of the view that the young woman needed more time in the Secure Unit and the Court deemed that was not appropriate in light of how well the young woman had responded whilst at the Unit.

This illustrated the dilemma that was faced by the LA in that Secure Orders are permissive and time limited orders, meaning that a young person can only be held as long as they continue to meet the criteria. A psychiatric report prepared in May 2017 for the Court confirmed that whilst the young woman had derived benefit from being in the Secure Unit, she wished to be discharged; and that whilst there were risks involved, that would need to be managed with her discharge back into the community, it was better that this was done at the time, in order to 'try and form her co-operation and agreement, rather than keeping her at the Secure Unit further against her will.'[14]

During the interim periods of these meetings, significant efforts were made by the LA to work with the young woman and her mother, to manage the identified risks prior to seeking a more restrictive order. There was also consideration of a longer-term plan in regards to the young woman turning 18, and her consistently stated wish that she wanted to live independently and to be 'free' of service involvement (this was evidenced from her being 16 years of age).

The young woman on being placed in Secure Accommodation on 3 occasions, did make progress and was supported in managing her health especially her diabetes and associated medical problems. She felt safe at the Unit and a package of care was put in place during these periods, which ensured that she maintained a specific focus on transitioning back into the community, for when she was placed there. A focus remained on the onset of her 18th birthday, and the wish of the young woman to live independently and the transition process that would entail.

On the third occasion of the young woman being securely accommodated, she applied for supported accommodation in the area of the Secure Unit. She would in addition to the continued LA support also have received ongoing support from the Secure Unit and a Project Officer in the accommodation, alongside access to staff on a 24/7 basis. There was an understanding by the young woman and all agencies involved with her, that she had been accepted for the supported housing placement.

It was following a multi-agency meeting, and the proposed accommodation's receipt of the young woman's Care Plan, that a decision was communicated on the 8th November 2017 to the LA that her application had been rejected. Staff had raised concerns that the move to the placement was 'too soon' following her current stay in Secure Accommodation and that her current abstinence from substance misuse was predominantly down to her being in the Secure Unit. This decision came 9 days before the young woman's 18th birthday. With no contingency plan in place this gave the LA very little time to make alternative arrangements for her. The young woman could however have been reassessed for the accommodation after a 2-month period, had the proposed action plan been implemented by her.

[14] Psychiatric Report dated 15th May 2017.

The young woman who was reported by the Secure Unit to be upset and demoralised, decided that she wished to return to her local area. As a result, a package of support and accommodation was put in place by the LA for her to return. Matters did not progress well, and the young woman's return saw a reoccurrence of the previously presenting concerns.

In the 3 months following the young woman's 18th birthday, the LA arranged accommodation for her in a licensed flat in her local area, with monitoring and support. Local agencies were also contacted by the LA to inform them that the young woman was returning to the local area, and that she would need their support. Given her age, agencies acknowledged that she would be at the point of transition to Adult Services, and the support would include transition planning as part of the arrangements put in place for her. The transition arrangements were initially put in place for 3 months. Services providing and offering support were the LA, Choices/Dyfed Drug and Alcohol Service (DDAS), Specialist Child and Adolescent Mental Health Services (Sp-CAMHS), Adult Mental Health Services, Specialist Diabetic Nurse and the GP's Surgery.

2 visits per day were arranged at the flat with the intention that the young woman would be physically seen. The Police also supported this monitoring through the deployment of PCSOs during the Christmas period of 2017. However, engagement with services was not forthcoming on the part of the young woman, and she was prior to her death stating that she did not want support from services and was refusing to meet/engage with them.

Additionally, within a very short period of time, the previous risks from substance misuse, associations with older males (both locally and via social media), CSE and mismanagement of her diabetes re-emerged and escalated. It was also apparent that the young woman had a constant stream of visitors to her flat. Young people within the locality provided intelligence to professionals and as a result, supportive discussions were held with her as well as highlighting to her, the longer-term potential consequences of her actions. The young woman's family were concerned, as was her previous foster carer.

Immediately, prior to her untimely death, the young woman had stated a wish to relinquish her tenancy and move to England, where she had stated that she had found accommodation and a job. Communications evidenced over the Christmas/New Year period of 2017, between the young woman and professionals, confirmed this, and it was understood that the young woman had been in England immediately prior to her death.

Young Woman's Voice

The young woman was not afraid to make her views known to professionals. She described in her workbook, her triggers which were: 'arguing with my family, being bullied and made fun of, ending relationships and saying "bye" and people making comments about my weight.' She also commented on what people could do to help her, this was to: 'talk to me and ask me how I am feeling, phone my mental health team to get me some help and support, let me know that they are doing this, or encourage me to do this.'

Above all, the young woman had a mantra of 'earned respect.' A professional who had worked with her since the age of 13 years noted at the Learning Event for practitioners, that she was always more responsive to professionals when 'they put the pen down and talked to her.'

Her family stated that the young woman 'would test professionals to see if she could respect them. When she said she did not want support, she would then take up all of the support that was offered.' The young woman 'was not someone that you wanted to be on the wrong side of. She said it as it was. What she wanted was to be loved'.

In the latter part of her life the young woman recorded that she did not feel that she was being communicated with. On a previous occasion she also commented that what she wanted 'was for a Social Worker to do what they were supposed to do'.

There was clear evidence of the young woman being offered and accepting the support of an advocate on many occasions. This included having an advocate for 3 Secure Accommodation reviews. It was unclear however, if advocacy was offered at all points of the review of her plans.

Throughout the timeline of the review the young woman felt that she should no longer be Looked After and that her involvement with Social Services had caused all of her problems. She repeatedly requested that agencies left her alone as she could look after herself, and felt that she had proved that she could live independently, her way. Once she turned 16 years, the young woman did not consider herself to be under any Order and that as a result the LA had no say in what she did. She firmly believed that it was up to her who she chose to be with and what she did with her life.

Agencies that were Involved with the Young Woman

The agencies involved are listed on page 26.

Practice and Organisational Learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances.

The identification of the practice and organisational learning has been drawn from the following key elements of the review:

- The production of a merged multi-agency timeline and agency analysis;
- Two Learning Events;
- The young woman's family's perspective and that of a former foster carer;
- Discussions within the Review Panel's meetings;
- Consultation with Professionals directly involved;
- Case record review; and
- Lead and Second Reviewers / Chair's analysis.

Multi Agency Partnership Working, Communication and Record Keeping

- The young woman was supported by a comprehensive range of agencies, who collaborated well in a variety of forums. Record keeping and reporting was strong, and was compliant with safeguarding statutory guidance and agency protocols. The difficulty arose in getting the young woman to openly, honestly and consistently engage with the support. She was clear in her view that she wanted to live independently but would not engage with the plans or support in place to assist her to do so. The young woman could in her own words, "look after myself."

- There was strong evidence of multi-agency professional discussion and decision making. However, owing to the young woman's presentation, work was often reactionary and responsive as opposed to innovative, progressive and proactive. There was limited success in getting her to engage for a sustained period of time, or to get her to engage with professionals with whom she did not wish to speak.

- There was consistency, as far as was possible, with agency staff who supported the young woman. However, during the period of the timeline, there were changes in Social Workers and some more than others were favoured by the young woman.

- Emanating from the Learning Events that were held for professionals, there emerged a communication issue for agencies with regards to closure following the young woman's death. As there had been no inquest for her, and no onward communication as to the cause of death, professionals and her former foster carer, were felt to be left in abeyance. It was especially difficult for them, given that there was speculation surrounding the cause of her death that suggested the possibility of foul play. Professionals had found this stressful and difficult to manage and looked to the Learning Event as part of the review process to bring them closure. Closure for professionals in this regard had not appeared to have been forthcoming in a timely manner.

Identified Good practice

The continuing best efforts, support and engagement that agencies put in place to work with the young woman; despite the ongoing presenting challenges and the young woman's self-belief that she neither wanted nor needed their assistance/involvement.

The LA's persistence (3 occasions) in securing the same Secure Accommodation provider and prioritising the young woman's applications even after they had been denied by the Court.

The multi-agency transition arrangements that were put in place for the young woman, once she had left the Secure Unit (following her 18th birthday) for 3 months.

Families/ Foster Carer Perspective

Members of the young woman's family felt that she had received more support from agencies (more so than another family member). The family understood and recognised her presenting issues and behaviours. However, there was a concern that intelligence was not always acted upon when she was living independently. They were also aware of how the young woman could test the boundaries with professionals and actively sought to do so.

Family members felt that there had been a high turnover of Social Workers working with the young woman and it was not always clear as to who was working with her, or that their concerns were being listened to, or that they were being given a straight answer. Following the young woman's death they felt that they had never seen as many Social Workers present in one room and the system had let the young woman down.

Learning

Where possible there should be consistency in the allocation of workers across services/ agencies and clear communication with families if and when changes are made.

For multi-agency senior lead partners (particularly the Police), to consider the wider matter of closure for professionals with regards to the communication of a post mortem outcome, in order that necessary supervisory support may be secured for the professionals involved in a timely manner.

For the LA to implement on publication, the Mid and West Wales Regional Safeguarding Board's Multi Agency Professional Protocol for sharing information when there is a death of a young person aged 18-25. (This protocol has been piloted in a neighbouring LA and will be presented to the Regional Safeguarding Board for adoption at a future meeting).

For LAs to share more widely with partner agencies, information concerning Looked After Children, particularly at the point of transition. Most notably to Education and Careers Wales, involving them in reviews and transition planning, where necessary.

Complex Family Relationships

- The young woman's relationship with her family was complex, inconsistent, and at times described as volatile. There were occasions when the young woman's mother was frightened of her and the young woman had on 2 occasions threatened to kill her. Her mother had subsequently concealed important information from agencies as she was fearful of reprisal from her daughter.

- Family, however, remained important to the young woman, and she was clear about wanting contact with her half siblings and her mother. There were however, complicated issues with regards to the contact arrangements with her siblings. The young woman spoke about her feelings on social media in this regard. She expressed that she was not clear about the reasons for the decisions that were made around contact.

- Due consideration was given to the young woman's wishes regarding supervised and unsupervised contact with her mother. It was evidenced that appropriate risk assessments were made when contact was requested by the young woman. It was also reassuring that the Placement with Parental Regulations had been adhered to as per the Child Protection Plan (CPP).

- The previous history of the family was documented and considered in all assessments, reviews and plans, including where the young woman was returned from missing episodes to her mother. 'Contracts of Expectation' were used, and the placements closely monitored. Review meetings took place appropriately and welfare checks were also undertaken. It was felt by the LA that despite the risks on these occasions, it was in the best interests of the young woman, if she would not consent to be in foster care, to be with her mother.

- The young woman would sometimes choose not to attend her review meetings, but would always have input (or have the opportunity to contribute), beforehand. Her mother was evidenced to be in attendance and to make contributions, sharing their concerns for the young woman. The involvement of the family was important and maintained by the LA, including contacting the young woman's father at the time of going into Legal Planning Meetings, despite the young woman not having seen him since the age of 6.

- Supported contact arrangements with the family were also put in place when the young woman was in Secure Accommodation, and when she moved to independent living.

Identified Good Practice

The continued support of the LA to review and facilitate contact for the young woman and her family, even when she was in the Secure Unit. Where contact was not possible to facilitate directly, it was maintained through the appropriate professionals, and indirect information was provided that was helpful to the young woman.

The Implementation by the LA of the 'Signs of Safety Framework'[15] and the training that is currently being provided for LA and partner agency staff to implement the framework and inform their practice. The model seeks to enhance family and support networks for young people.

Family's and Foster Carer's Perspective

The young woman was closest to one of her half-sisters whom she would keep in touch with, even when she ran away. Her half-sister couldn't understand why the young woman could not have lived with her when she left the Secure Unit.

The young woman's mother stated to the Lead Independent Reviewer, that she had 'held her hands up to her children, that she had messed up and felt that she had previously let them down'. However, she had regularly attended meetings, and stated openly, her concerns for her daughter.

The young woman's mother wanted to be a part of her daughter's life, even though things could be complicated between them. At times, she admitted to being fearful of her, and felt powerless to contain her daughter's anger and self-destructive behaviour.

Learning

For the LA to continue the implementation of 'Signs of Safety' and facilitate 'Signs of Safety' training for all professionals and practitioners.

In accepting the inherent complexity of many contact arrangements for Looked After Children, the LA should seek to ensure young people have an updated and ongoing understanding of those arrangements and their rationale.

Foster Placements/Respite Arrangements

- All the foster carers involved with the young woman demonstrated a real commitment to care for her. At the outset of the timeline the young woman had moved from the local area with her foster family to England and it has been referred to in the contextual information surrounding the review, as being her most settled time.

- However, as with the majority of the placements in the timeline, the placement broke down because the young woman wished to leave. In some instances, it was the location where the foster carer resided, not the placement itself that influenced the young woman's decision.

[15] Turnell Andrew & Edwards Steve: Signs of Safety (A solution and Safety Orientated Approach to Child Protection Casework), USA, WW Norton& Company, 1999.

- There was a strong commitment by all of the foster carers to support the young woman with her diabetes and all of them demonstrated interaction with Health Services when they needed support. They also took the trouble to learn, train and engage with the young woman, realising the significance of diabetes management for her. The young woman however, alleged vocally that she was being placed with foster carers who did not know about diabetes, and regarded this to be a lack of a 'duty of care'.

- It was noted at the Learning Event for managers that there was a shortage in the local area of foster placements for more challenging young people, particularly as a young person moved towards the age of 18.

- A 'When I am Ready'[16] arrangement was not available to the young woman with her foster carer of choice and this was disappointing to her, as the foster carer had another placement. However, the situation was well managed, and in such a way that relationships were able to be maintained between the young woman and the foster carer.

- The LA had a strong Family Placement Team that were highly supportive of the foster carers both in and out of hours, and who ensured that appropriate boundaries were maintained and that the foster carers were both protected and supported.

- 'Contracts of Expectation' were clear, well written and effective use was made of them in relation to both placements with mum and a foster carer. It was ensured that they were signed by all parties and were used as 'live' documents to monitor progress. They were also referred to in reviews and in legal planning documentation. However, it was also observed that in the foster carer's 'Safe Caring Plan', there was no mention of the risk of CSE, at a time when the young woman was known to be at risk.

Identified Good Practice

All the foster carers engaged with training to support the complex health needs of the young woman.

Family's perspective

The family had a positive view of the foster care placements that were provided for the young woman.

The family had anticipated that the young woman would return to a particular foster carer on her release from the Secure Unit.

Learning

The importance of LAs having choice in local foster care placements to meet the needs of complex and challenging young people locally.

[16] When I am Ready - Good Practice Guide, March 2016. Welsh Government 28047.

Professional Escalation and Challenge

- It is apparent that all agencies acted with the best of intentions, endeavouring to keep the young woman safe, whilst also listening to her wishes and feelings. There were occasions where professionals were not unanimous in their views concerning actions for her. However, this did not extend to the invoking of the dispute resolution protocol under the 'CYSUR Mid and West Wales Safeguarding Board's Protocol for the Resolution of Professional Differences'[17].

- Health staff were confident to provide challenge at meetings and they asked for multi-agency meetings to take place, in order to share their concerns regarding the risks presenting to the young woman and the lack of progress in securing a Secure Order for her.

- The Independent Reviewing Officer (IRO) acknowledged that on reflection they could have challenged one of the decisions not to apply for a Secure Order. Their reluctance to do so at that time was down to their inexperience as an IRO and inexperience with what was an untested escalation protocol at that time.

- The LA have since 2017 strengthened the IRO escalation process.

- The IRO who remained consistent for the young woman was valuable, supportive and approachable. Professionals appreciated the IRO role and that of their line managers and senior managers, in providing support and where appropriate professional challenge. The idea of a 'fresh pair of eyes', lay at the heart of Lord Laming's approach where he argued that 'high quality supervision is critical to good practice'[18]. 'It is through supervision that there is an opportunity to challenge assumptions and judgements and to agree plans of action'[19].

Identified Good Practice

The consistency of the IRO throughout the young woman's care.

The action the LA has taken since 2017 to strengthen the IRO escalation process.

Family's Perspective

The family perceived that there had been a lack of safeguarding in regards to the young woman, they stated: "We point the finger at the lack of safeguarding, you can put rules and regulations in place, but you have to follow them, this is the reason that safeguarding audits are in place. They need to be adhered to".

[17] CYSUR Mid and West Wales Safeguarding Board Protocol for the Resolution of Professional Differences
[18] Laming, H (2009) The protection of Children in England. TSO
[19] Laming, H (2009) The protection of Children in England. TSO

Learning

For all staff to feel empowered to use the dispute resolution process, or escalate disagreement with a decision to a senior level and to provide professional challenge across agencies, where they do not feel the outcomes are right for a young person, or a course of action is not or will not meet their needs.

Child Sexual Exploitation (CSE)[20]

- There had been concerns for a number of years that the young woman was vulnerable to CSE. Her vulnerabilities were linked to: abuse or neglect by parent/carer/family member; history of local authority care; breakdown of family relationships; and low self-esteem. The young woman's behaviours during the timeline of the review included significant risk indicators, consisting of: periods of going missing overnight or longer; associations with older males/boyfriend; physical/emotional abuse and disclosure of sexual/physical assault followed by a withdrawal of the allegations.

- There were throughout the timeline allegations that the young woman made with regards to sexual abuse and assault. These were investigated fully on 2 occasions and no further action was taken. Consideration was given at the Learning Events as to how those communications had been made to the young woman and the impact upon her. What was not considered outside of the health reports, was the wider historical contextual information which may have given rise to the allegations. The psychiatric report completed for the Family Court in 2017 made reference to them and felt that the young woman could 'well have been referring to recent experiences but also to past events'.

- The young woman also made allegations following missing episodes that were not made formal.

- The young woman was open to MACSE[21] and had a completed SERAF, denoting significant risk. In accordance with the 'All Wales Procedures for Safeguarding and Promoting the Welfare of Children who are at Risk of Abuse through Sexual Exploitation' and the 'Barnardo's Cymru Sexual Exploitation Risk Assessment Framework'[22], appropriate Multi-Agency Strategy meetings were convened to ensure the effective exchange of information with multi-agency partners to agree a safety plan.

- MACSE has been strengthened within the LA, and meetings are held on a quarterly basis. There is also a staff lead for CSE within the LA who is a source of expertise and is there to guide, advise and support their colleagues.

[20] Child Sexual Exploitation is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones, and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the young woman and the grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent. All wales Child Protection Procedures, all wales Protocol, Safeguarding and Promoting the Welfare of Children who are at Risk of Abuse through Sexual Exploitation, November 2013.

[21] MACSE (Multi Agency Child Sexual Exploitation)

[22] Barnardo's Cymru 2007 – Sexual Exploitation Risk Assessment Framework, October 2007, Sam Clutton and Jan Coles.

- The Police were aware of the young woman becoming involved in CSE on several occasions. Where it was appropriate to do so, they exercised their powers under Section 46 of the Children's Act 1989, when they felt it was necessary to protect her from likely significant harm. This action was always followed appropriately with a referral to Children's Services in accordance with the 'All Wales Child Protection Procedures 2008'[23]. Strategy meetings were then consistently held as per the procedures.

- The issue that presented to services was that as the young woman was protected from one potential perpetrator, new associations and friendships were formed with other potential perpetrators.

- The 'Contract of Expectation' between the young woman and her mother did contain the management of CSE risk. This proved challenging for her mother and she was reliant on the extensive support of professionals, when situations and issues arose.

- Legal planning meetings, sitting alongside the other care planning forums, had also taken place to protect the young woman owing to her significant risk of CSE.

- The young woman was entitled to receive after care services under the 'Social Services and Well-being (Wales) Act 2014, Part 6 Code of Practice (Looked After and Accommodated Children)'. The Pathway Planning process, Complex Needs Panel and the CPP all recognised her vulnerability to CSE.

Identified Good Practice

The arrangements and support that were put in place by the LA and Police, which were over and above the All Wales Procedures and their strong utilisation of MACSE and SERAF frameworks.

The introduction and appointment by the LA of a CSE lead to provide additional support for professionals and practitioners.

Family's and Foster Carer's Perspective

The family felt that there were not many Police Officers who did not know the young woman. They acknowledged and were concerned about the risks presenting to her from CSE. 'She would answer her phone when she went missing, but would not tell you where she was, unless she was as high as a kite on weed.' The young woman was described by them 'as being a magnet to these men'. They didn't know where she met them.

Learning

Further develop best practice, ensuring the lead practitioner or manager for CSE is

[23] All Wales Child Protection Procedures 2008.

informing partner agencies on how their service can contribute to risk reduction work and a Safeguarding Plan.

Multi-agency professional meetings should continue to monitor the safeguarding arrangements for young people who present at risk of significant harm when they turn 18. All foster carers should have Safer Care Plans in place for the duration of the placement as good practice.

Missing / Absconding / Risky Behaviour

- The young woman's history of absconding led her to be at risk of significant harm from: CSE; risks from unsuitable associates; financial exploitation; involvement in drug use; and the mismanagement of her diabetes, which placed her life at risk. 'Established research and practice evidence have demonstrated a strong correlation between children and young people going missing and being at risk of sexual exploitation.'[24]

- The young woman started to abscond towards the end of the period of her long-term stable foster placement, where she possibly used this as a ploy to end her placement.

- At a Strategy meeting which took place on the 30th June 2016, it was noted that the young woman had gone missing on 4 occasions with 2 periods being in March 2016. A further Strategy meeting held on the 18th November 2016 recorded a further 5 missing reports concerning the young woman had been made, illustrating an escalation in her behaviour and in the associated risks presenting to her.

- When the young woman was located, she was often found by the Police with older males and in locations sometimes some distance away from home. On 4 out of the 5 occasions, the young woman had gone missing from foster care. 'Contracts of Expectation' that were in place were explicitly clear about where the young woman should reside and that if the young woman failed to return home after 21.00 hours or left the house between the period of 21.00 pm - 07.00 am without the agreement of Social Services, the foster carer was to contact the Police.

- There was also 1 instance where the young woman had gone missing twice within a single 24-hour period. On both occasions she was found with two older males. Through multi-agency working a 'Child Abduction Warning Notice' (CAWN) was issued by the Police.

- The timeline and the Learning Event for managers, noted that out of the young woman's 13 missing episodes, there should have been 4 Llamau de-briefs, but only 1 had occurred because of the young woman either being in Secure Accommodation or an out of county foster placement.

- The Llamau Debrief Service has no contractual responsibility for engagement with missing persons when they are placed in Secure Accommodation or a placement outside the Dyfed Powys Police area. This presented a missed opportunity for an appropriate conversation to be held at the right time with the young woman. When a young person returns from a missing episode, they may feel anxious and as in the case of the young woman, reluctant to disclose their feelings surrounding the 'missing episode'. They have

[24] Smeaton, E (2003) 'Running from hate to what you think is love: The relationship between running away and child sexual exploitation.' Barnardo's, Barkingside.

worries and concerns which may not be apparent, and they may want to/feel obliged to be able to return to the places/and or people they have been with in the future. They may also be afraid of reprisals from the perpetrators. As in this case, the young woman at a later date did make disclosures to family members and or professionals rather than to the Police.

Identified Good Practice

The use of 'Contracts of Expectation' surrounding missing episodes and the welfare checks that were undertaken.

Learning

The placing Authority, Police and or multi agency partners, to ensure appropriate debrief arrangements are made for young people who go missing and who are found in other areas, outside of the Dyfed Powys Police area and for whatever reason do not return.

Health Concerns/ Mismanagement of Diabetes

- The young woman had type 1 diabetes which required careful management with insulin. It was noted by professionals who worked closely with her that she historically referred to her diabetes as "her baby", and would use this as a 'tool' to manage her whole situation. Through the course of the timeline she had had a number of admissions to hospital, due to unstable ketones and blood sugars. Concerns surrounding the risks of her diabetes had been a significant contributory factor in the young woman being placed in care in 2011 and taken into the Secure Unit on 3 successive occasions; where it was felt by the LA that once she had settled, she could be introduced to support services that would assist her to manage her 'emotional well-being, health and drug use.' The further transition plan from the Secure Unit also involved the support of these services being replicated in the community.

- The young woman was supported additionally by the Hywel Dda University Health Board via their Paediatric Team, Specialist Diabetic Nurse, LAC Nurse, Sp-CAMHS, and by the Welsh Ambulance Service (WAST) when she went into Diabetic Ketoacidosis[25] (DKA) and was admitted to hospital. The young woman had also been referred to the Willows project[26] and had attended twice. The service had been reoffered but the young woman had refused to engage.

- Her engagement with health services (outside of the Secure Unit) was superficial and appointments were routinely missed. The young woman was not managing or attending to her health issues, namely mismanagement of her diabetes. This was a significant concern

[25] **Diabetic Ketoacidosis (DKA)** is a serious problem that can occur in people with diabetes if their body starts to runout of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. DKA mainly affects people with type 1 diabetes, but can sometimes occur in people with type 2 diabetes. NHS.org.uk

[26] **Willows Project** – is a registered charity offering counselling services to children and young people aged between 6-19 yrs who are affected by emotional and mental health issues.

for all agencies, and a serious presenting health risk. Concerns in this regard were consistently mentioned in all documentation and reviews pertaining to the young woman and identified her to be at significant risk.

- During hospital admissions, the young woman would be unable to give an answer as to whether she had been giving herself her insulin doses or not. Her diet appeared to be poor and she was not eating regular or proper meals. In order for the young woman to achieve a safe and optimum control of her diabetes, she needed to be self-motivated to test and inject herself. Her prescribed medication was also routinely not taken.

- Referrals that were made to Sp-CAMHS were not met with engagement by the young woman and hence in accordance with service guidelines, her case was closed.

- Hospital admission also identified serious sexually transmitted infections and sexual health issues. The Review Child Protection Conference minutes from 2017 stated that 'her health was really concerning and she was at significant risk of harm as a result.'

- A Libre diabetic tool[27] was purchased for the young woman by the LA as a means of support to assist her in the self-management of her diabetes.

- Throughout the timeline of the review, there was evidence and disclosure by the young woman of substance misuse. Her engagement with Choices was sporadic and on transition the young woman was referred to DDAS. She was subsequently closed to the service because of her failure to engage.

- Health appointments were not always attended by the young woman over the course of the timeline and these would have benefitted from being followed up with her. However, LAC health assessments were undertaken appropriately. The young woman also stated that she had depression and anxiety problems and was prescribed anti-depressants. Escalating concerns surrounding the young woman's health were documented in the Initial Child Protection Conference Report, Care Plans and Reviews. These concerns were in relation to all aspects of the young woman's health, mentally, physically and emotionally.

- Health colleagues at the Learning Event for managers wished that they had escalated their concerns through safeguarding in the Hywel Dda University Health Board, and provided more challenge in the multi-agency arena.

- Concern was expressed at the Learning Event for practitioners in regards to the young woman's spoken wish to not have professionals resuscitate her, in a conversation that she had had with her GP prior to her death. The Safeguarding Health Team and the LA were unaware of this. This was a concern for all agencies present and it was felt that an escalation outside of the GP's surgery to Mental Health Services would have been appropriate.

- Concerns surrounding the transition thresholds between Adult and Children's Health Services, and the young woman's access to continued support, were well managed by the implementation of a transition arrangement that was put in place for 3 months post her transition. The difficulty however, was in getting the young woman to engage with the specialist professionals/services.

[27] **Libre Diabetic Tool** – is a 'Flash Glucose Monitor', which is used to check and record glucose (sugar levels) throughout the day. It is small sensor that is worn on the skin. Diabetes.uk

Identified Good Practice

The consistency and continuity of Consultant led care within the Diabetes team and provision of Mental Health Services routinely offered to the young woman.

Transition arrangements for the young woman which were put in place between Adult and Children's Health Services, for 3 months following the young woman's 18th birthday.

The support, training and advice provided to the young woman's foster carers on an open-door basis, to assist them in the management of her diabetes.

The consistent support provided to the young woman despite their aggression and volatility on some occasions.

The appointment by Sp-CAMHS of a designated link professional with Adult Services for a young person when they reach the age of 17.

The urgent attention that was given to the young woman's DBT referral, which could have taken two years had it not been treated with pivotal importance.

Learning

The request that the young woman made to their GP, namely 'do not attempt resuscitation', should have been referred outside of the GP's Practice to Safeguarding professionals and the Mental Health Services supporting the young woman.

For a child or young person who has more than one speciality such as diabetes and safeguarding to have one identified GP and for them to attend LAC reviews, providing a more proactive avenue for information sharing.

For Health professionals to ensure the escalation of their concerns if they feel it necessary to do so.

Any missed appointments for a Looked After Child should be notified to, and followed through by the young person's Key Worker.

Child Protection Plan

- It was not normal practice given all of the plans that were already in place to hold an Initial Child Protection Conference for a young person. The Conference was held because of the presenting risks of significant harm to the young woman, most notably their risk of harm through sexual exploitation; their refusal to engage with services; unrealistic concerns regarding their housing options; associations with older males; absconding; not managing or attending to their own health needs; their volatility in relation to their relationships with family members; their inability to see things as they actually were; possible substance misuse; alongside depression and anxiety problems. There was also concern at the time of holding the initial conference that the young person was not complying with the 'Contract of Expectation' that had been agreed.

- The CPP did mirror the young woman's My Care and Support Plan and was a reflection of how seriously the LA viewed the escalating situation with regards to her; their wish to protect her from harm and to hold all agencies to account, for their support and care of her, whilst moving the young woman forward, to a safer and more risk reduced lifestyle. The plan as a whole was about setting safe boundaries and influencing safer behaviours, taking a holistic view of addressing the risk of CSE.

- The plan was appropriately and effectively monitored and reviewed and was referenced in subsequent legal planning documentation (legal planning meetings were held throughout the period the young woman was the subject of child protection registration). A decision was made to apply for a Secure Order within approximately a month of the Initial Child Protection Conference being held.

Identified Good Practice

The significant advantage of the use of the Child Protection Register as the recognised and standardised flag to indicate a current risk of significant harm.

Learning

Consider the appropriateness of LA plans alongside Child Protection Plans and identify and record a clear advantage as to having a Child Protection Plan when simultaneous plans are already in place.

Pathway Plan

- When the young woman was about to turn 16, the LA prepared a Pathway Plan (in accordance with statutory requirements) to assist the young woman with her transition to adulthood and leaving care. The Pathway Plan, which remained in place once she turned 18, incorporated her Care and Support Plan, which was subsumed within the Pathway Plan and also incorporated her Personal Housing Plan.

- The Pathway Plan, whilst called a 'plan', also acts as a contractual document that allows/ enables a young person to hold a LA to account, if they do not do as they say they will. The Plan, written in discussion with a young person, should contain detail and specific information within it, as well as detailing who is responsible for what, and by when the actions should be completed.

- The pathway assessment and planning process also determined and recorded what information, advice and assistance was necessary from the LA and all parties involved in supporting the young woman, as she prepared for leaving care and transitioning to Adult Services.

- The young woman's plan was found to need attention in this regard and had limited ownership, accountability and outcomes within mutually agreed timescales.

- However, in order for arrangements to be made in a proper way, with the appropriate professionals, and in a timely manner, co-operation between the young woman and their Personal Advisor (PA) would have been absolutely key. This would have needed to include direct and pro-active communication between them. The young woman would have needed to provide their PA (Personal Advisor) with full information about what they

would need, be co-operative with them in communication and with others who needed to be liaised with, and ultimately have written the plan together. Given the modus operandi of the young woman this would have been difficult to achieve, particularly as the young woman felt that after turning 18, she 'was no longer owned by Social Services'.

- The young woman had complex needs, which required continuing services as they transitioned to adulthood. The Pathway Plan endeavoured to ensure that their transition was seamless and she was further supported by consideration at the LA Complex Needs Panel.

- Timely reviews were held at each stage of the young woman's transition and of the Pathway Plan.

Identified Good Practice

The LA have implemented a mid-point review meeting between the IRO and the Social Worker to monitor the implementation of Care and Support Plans. There is a reporting template completed by the Social Worker and monitored by the IRO. Ahead of the annual review meeting the IRO will meet with the Social Worker to ensure everything is in place prior to the review.

The IROs continue to review care leavers' Pathway Plans at 18 years plus to ensure robust planning, which is best practice and is not a statutory requirement.

Learning

Detailed transition, support, monitoring and contingency arrangements need to be built into Pathway Plans as a matter of routine.

There was in this instance an opportunity for a family group conference meeting to be held, in order that the family could have recorded their views on the young woman's transition from the Secure Unit, and how they could have made a contribution to supporting her Pathway Plan, going forward.

Secure Accommodation Applications /Legal Planning / Adjustment

- A Secure Order is at the extreme end of the Court's powers and it enables LAs to deprive young people of their liberty, in the interests of protecting their welfare. Their use for a LA would always be as a last resort.

- A national scarcity of secure beds for welfare applications prevented the LA being able to pursue Secure Accommodation as a means of support for the young woman on a number of occasions.

- Applications could only be considered if the secure criteria were met and a bed had been identified and secured prior to making their application. The LA made 5 applications for a Secure Order, between the initial application and the young woman's 18th birthday. On 2 of these occasions, applications by the LA were refused by the Court as the criteria were not met. The Court deemed those applications to ensure that the young woman

remained in Secure, were not appropriate in light of how well the young woman had responded whilst at the Secure Unit.

- The decisions which also took account of the young woman's wishes and their age ultimately impacted on the available time that the young woman could spend in the Secure Unit. This left professionals feeling on the young woman's 18th birthday that they had run out of time, at a time when significant improvements for her had been made, but with ongoing work yet to be done.

- This was an impossible situation for the professionals concerned and one that weighed heavily upon them. For that work to have continued the engagement and co-operation of the young woman would have been necessary in the community.

- For professionals, what the Secure Order had in reality afforded was a period of safety, where anxiety about the young woman's safety was reduced.

- For the young woman, the Secure Order placement provided a period of stability for her in regards to her health and well-being and an opportunity where she could thrive away from the risks that presented to her in the local area and online, which she could not manage. She was also able to derive benefit from the care provided and flourish in an area where she would have stayed had the opportunity been afforded to her. A rapport was established with the staff in the Unit and the young woman was fulsome in her praise of them, on her release, acknowledging this in a thank you card to them. It was also evident that benefit was derived from the young woman being able to return to the same Unit. The results may not have been the same for her had different placements been allocated.

- There is no doubt that when the young woman returned to the community after turning 18 years of age, free from the confines and constraints of the secure placement, where she had benefited in terms of her health, aspiration and well-being, that there was a deterioration in her self-management and marked increase in risk.

Identified Good Practice

The LA progressing with the Court hearing in 2017, despite there being no identified bed available, demonstrating that they were prioritising the needs of the young woman.

Family's Perspective

The family were supportive of the Secure Application being made, owing to the young woman's escalating risky behaviour. Her mother did not feel that her daughter could keep herself safe. The young woman was stated to be furious initially, when she went into the Secure Unit. However, she thrived in there, and her diabetes was managed. However, she didn't like being the eldest there. She looked really healthy; even the judge picked up on this.

Learning

Earlier interventions are necessary to provide more preventative services in the community, to enable young people to be supported there, before their needs become critical.

For the CYSUR Mid and West Wales Regional Safeguarding Board to consider highlighting the ongoing challenges regarding the availability, scarcity and accessibility of secure accommodation and for this to be referred to the National Safeguarding Board/Welsh Government and the Children's Commissioner.

Transition Planning and Post 18 Independence

- It was felt by all professionals that the young woman needed 'more time' to move from the Secure Unit from which she had clearly derived benefit, and been settled into independent living. 'Care leavers need the same sort of opportunities, assistance and support that all parents try to give their children as they start to make their way in the world.'[28] Care needs to be taken to prevent as happened in the young woman's situation, 'a milestone often being an abrupt event rather than a supported process'.[29]

- In accordance with 'Hidden Ambitions[30]' and the Welsh Government's 'Housing Positive Pathway'[31] and the 'Care Leavers Accommodation and Support Framework'[32] the LA had a guide which gave young people clear information on leaving care and the support that they were entitled to.

- Professionals were hindered by the time that they had to make the final transition arrangements for the young woman, because the plan for housing her outside of the Secure Unit could not proceed. There was no contingency plan in place in a timely manner prior to her 18th birthday, because of the implied understanding that all had had, that the young woman was going to remain in the vicinity of the Secure Unit.

- The significance of transition for the young woman was considerable, due to their dependence on other services including the Diabetic Nurse and Sp-CAMHS. On turning 18 she had to transfer into Adult Mental Health Services. Whilst supportive arrangements for 3 months were in place, it was stated by professionals at the practitioners' Learning Event just how significant the withdrawal of all the services the young woman had always known and utilised would have been for her. It was felt that going forward, risk assessments in this regard should be put in place.

- In preparation for the young woman's return to live in the community from the Secure Unit, transition arrangements were put in place between Children's and Adult Services in regards to: Mental Health Services; Substance Misuse Services and Diabetic Services.

- The work surrounding reintegration had taken place outside of the home area. Of poignancy were the young woman's own words on being told of their rejection from the supported housing placement, "right, I just give up then, just send me back to Wales." The feelings of despondency and the old adage of being 'let down again' were witnessed by staff. Professionals too found this frustrating, and found themselves disheartened about the process. The Secure Unit staff have reflected that they could have as part of the contingency plan, sought to continue to support the young woman beyond the age of 18 in a non-secure setting. They reflected that they could have applied for an extension

[28] Hidden Ambitions, 'Wales commitment to young people leaving care.'
[29] When I am Ready -Good Practice Guide, March 2016. Welsh Government 28047
[30] Hidden Ambitions, 'Wales commitment to young people leaving care.'
[31] Preventing Homelessness and Promoting Independence: A positive Pathway to Adulthood, Welsh Government 2016.
[32] Care leavers accommodation and support framework for Wales. Barnados,2015. www.barnados.org.uk

for her, but in reality, this would have only been permitted for a few weeks, if it had been granted at all.

- There was no formal evidenced record keeping or structure to record the visits that were undertaken to the young woman at her flat, after she turned 18. However, supplementary information was provided that confirmed that the young woman was expected to receive daily visits from the LA and other professionals who were working with her. Professionals however, had not informed one another of the dates of their visits, so generally, it was sessional workers that undertook the visits on a daily basis. Dates provided illustrated some gaps in both attendance and recording. It was also not clear or evidenced where if anywhere these visits and their outcomes were formally recorded or followed up.

- When the visits were undertaken (morning and evening) professionals recorded that the young woman would rarely answer the door to them, nor would she answer her telephone. It was apparent to professionals that the young woman was inside the flat, and with others, as laughter and a dog barking could be heard on occasion.

- The Pathway Plan Review on the 10th January 2018 noted concern from the young woman's Social Worker in this regard. It was explained that the young woman was stating that the Sessional Workers were going to the outside door of the building and not directly to her flat front door; as with the one exception of her PA, they did not have the PIN number to enter the premises and knock on her door directly. The young woman's family stated that the PA was 'persistent in not going away until she had seen and spoken to her directly.' The young woman had also requested that the Sessional Workers were given her telephone number and she given theirs; in order that she could contact them if she was not going to be at home. It was formally recorded by the Social Worker in the Pathway Plan Review that there was concern that the 'plan at the moment wasn't working'. That, there was a lack of co-ordination and that should the young woman not answer, the Sessional Workers should not 'just be walking away.' It was also concerning that the Social Worker and the PA were not being kept informed about the visits, and whether or not they had been successful. An action from the Pathway Plan Review meeting was for a plan to be put in place to address the concerns of not being able to access the young woman's flat, to enable the assessment of her to progress. The required date for completion was the 24th January 2018 (outside of the review's timeline). There was no evidence received at the close of the review to illustrate action had been taken in this regard.

- It was also evidenced how quickly the young woman returned on release (despite their support package) to her old behaviours and exploitative relationships. This appeared to confirm that she was not ready for unsupported independent living, something that the young woman had always stated she wanted.

- There was intelligence which had been reported as to the young woman's substance misuse and males entering her flat. There was a feeling from a professional at the Learning Event for practitioners that the young woman was 'in a situation that she could not get out of' and despite the support that was being offered and the genuine attempts that were being made to give her words of advice, there was an escalating risk in regards to the young woman.

- There was no record of a welfare check being requested by professionals to be carried out by the Police, despite the accelerating concerns, or documented evidence as to what was being done in regards to safeguarding checks and intervention.

Identified Good Practice

The transition support that was put in place between Adult and Children's Services across multi agencies to assist the young woman for 3 months post her 18th birthday.

The implementation by Sp-CAMHS of changes already made and their appointment of a designated link with Adult Services for a young person when they reach the age of 17.

Family's Perspective

The family had held a family meeting, and had understood that the young woman was returning to her former foster carer. Her closest half sibling would have shared a flat with her, if they had been allowed to.

The young woman found the transition from Secure Accommodation to independent living difficult and there was concern over the mismanagement of her diabetes. The family felt that nothing was done.

The young woman had told her half-sister that she wanted to stay in the Secure Unit because she knew that she wouldn't make it on her own.

Panic buttons should be fitted for young people who are at risk and who live alone.

Learning

The transition potentially from Children's to Adult Services and the threshold criteria between them are complex and disparate, leaving vulnerable young people at risk if they cannot meet the adult threshold. A 'Transition Protocol' needs to be implemented across the CYSUR Mid & West Wales Regional Safeguarding Board to support young people who are in transition (14-25), who are at risk, and who do not directly meet the entry threshold of Adult Services.

In transition planning, professionals must take into account the number of services that have supported a young person prior to them becoming 18, and risk assess the impact of the withdrawal of those services, so there is not an abrupt end, but a seamless transition, or supported withdrawal.

Transitional planning recorded in a young person's Pathway Plan should include a contingency plan, from the outset, which considers on a simultaneous basis, both in and out of locality arrangements.

Professionals need to practice 'professional curiosity' and apply 'respectful uncertainty', applying critical evaluation to any information that they receive and by maintaining an open mind, consider a young person's circumstances holistically.

Records of planned daily visits and support should be formally maintained, with an escalation/risk plan in place, which is clearly documented in a young person's Pathway Plan. If a young person is not adhering to the plan or concerns emerge, appropriate action should be taken by the relevant professionals.

The encouragement of reflective practice and challenge should be ensured within professionals' supervisions and in preparation for staff who are required to attend Learning Events.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

There was substantive practice put in place by agencies to support the young woman and to mitigate against her presenting risks. Agencies understood her needs and did their utmost to support her. However, despite all their best efforts, the young woman's return from Secure Accommodation to the community, evidenced a resurgence of concerns and risks, which were unable to be effectively managed. The following learning has been identified to inform practice and systems improvement for the future:

Learning 1: For the CYSUR Mid and West Wales Safeguarding Board to escalate the situation with regards to the scarcity of secure beds available in Wales, along with the need to look at more robust multi-agency alternatives to secure care, to the National Safeguarding Board/Welsh Government and the Children's Commissioner.

Learning 2: For all Regional Board Partner Agencies to ensure effective communications are in place, to best support their staff in safeguarding young people. These communications should recognise professional difference and encourage appropriate challenge and escalation across organisational boundaries.

Learning 3: For all agencies and partners accountable to the Regional Safeguarding Board to continue their training of staff to consistently implement and deploy the 'Signs of Safety' framework in their professional practice.

Learning 4: For the Regional Safeguarding Board to commission a 'Transition Protocol for Young People aged 14-25', which can be used by all partners to deliver and support best practice in this regard, particularly where there is not a direct transition to Adult Services and in recognition that risk does not change with the onset of an 18th birthday.

Learning 5: For the debrief of a young person to not solely be the responsibility of the Police or statutory agencies, but rather the responsibility of all multi-agency partners, with an identified Key Worker for a young person.

Learning 6: For all agencies to ensure that staff apply and promote professional curiosity and reflection in their practice, which will ensure the management of risk and intervention in escalating situations.

Learning 7: For the Regional Mid and West Fostering Framework Group to enhance the recruitment of foster carers to improve the choice of foster care and 'When I Am Ready' placements to meet the needs of complex and challenging young people.

Learning 8: For LAs to ensure that all appropriate family members are given the opportunity to participate in a family meeting to provide input into transitional living arrangements of a young person and for their voice to be heard.

Statement by Reviewer(s)			
Reviewer 1	Maxine Thomas	**Reviewer 2** *(as appropriate)*	Matthew Brown
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)* Maxine Thomas.		**Reviewer 2** *(Signature)* M J Brown	
Name **Maxine Thomas** ……. *(Print)*		**Name** **Matthew Brown** ……. *(Print)*	
Date 21st October 2019		**Date** 21st October 2019	
Chair of Review Panel *(Signature)*			
Name **Darren Mutter** ……..…….. *(Print)*			
Date 21st October 2019 ……			

Appendix 1: Terms of Reference

Appendix 2: Summary Timeline

Child Practice Review Process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Child Practice Review Process

The young woman and her family had a long history of Social Services involvement, which included care proceedings, periods of child protection registrations and secure order applications. The young woman, who had been in the care of the LA, sadly died two months after her 18th birthday, and had been on the Child Protection Register up to her 18th birthday. The young woman at the time of her death, was a care leaver in receipt of a Pathway Plan and the LAYP's social worker continued to hold her case. Due to the concerning circumstances of the young woman's death and the information known, the criteria for an Extended Child Practice Review had been met. The matter was considered at the Local Operational Group (LOG), and referred to the Child Practice Review Sub group, who made a recommendation to the Chair of the Regional Safeguarding Board, for an Extended Child Practice Review (ECPR) to be undertaken. The Chair of the Regional Safeguarding Board approved that an ECPR should be undertaken.

In accordance with the guidance an Extended Child Practice Multi Agency Review Panel was convened to manage the review. The services represented on the panel are:

- Welsh Ambulance Service (WAST);
- Police;
- LA Families and Children's Social Services;
- Hywel Dda University Health Board;
- Specialist Child Adolescent Mental Health Services (SP-CAMHS);
- Substance Misuse Services;
- LA Housing Services; and
- CYSUR Mid & West Wales Regional Safeguarding Board Manager.

An Independent Chair for the Panel was appointed from a neighbouring authority who has senior management experience of services, but who has had no involvement, knowledge or awareness of the young woman or her case.

As this is an Extended Child Practice Review a Lead Reviewer and Second Reviewer were appointed who had both not been involved in the case management, who understood the local context and who were able to contribute external professional challenge and experience. Both Reviewers have the relevant experience, abilities, knowledge and skills as required by the case.

The Learning Events

In accordance with the ECPR guidance, two Learning Events for this Extended Child Practice Review were held on the 21st May 2019, facilitated by the Lead and Second Reviewers. The Chair of the Extended Child Practice Review Panel was also in attendance, to represent the Panel and to ensure that the questions and issues identified by the Review Panel were addressed. There was a total of 23 participants at the Practitioners Learning Event and 15 managers at the Managers Learning Event. The purpose of the two events was to:

- Give practitioners and managers the opportunity to directly contribute and input to the review;
- Share the perspectives of family members and a foster carer;
- Enable the professionals involved to reflect and listen to each other whilst contributing and identifying the learning;
- Clarify, explore, question and inform the detail of the merged multi agency timeline;
- Identify and explore through the following seven questions, using the methodology of Signs of Safety[33] participants' individual and agency practice with regards to the young woman:

    1. What went well?
    2. What were the areas of good practice?
    3. What do you feel did not go well?
    4. What would you do differently as an individual or as an agency?
    5. Would you still make the same decisions today and take the same actions?
    6. Has there been learning for you/your agency?
    7. What are the actions you need to take? To ensure things you/your agency have learned, change what you do in the future.
- Inform the findings, learning and actions for this Report; and
- Consider the additional remit of an Extended Child Practice Review, as per the guidance Social Services Well-being (Wales) Act 2014, *Working Together to Safeguard People, Volume 2 -Child Practice Reviews.*

Practitioners and Agencies Represented at the Learning Events were from:

- Welsh Ambulance Service (WAST);
- Police;
- LA Families and Children's Social Services;
- Hywel Dda University Health Board;
- Specialist Child Adolescent Mental Health Services (SP-CAMHS);
- Nugent Health Care;
- Education;
- Substance Misuse Services;
- GP Surgery;
- Local Training Provider;
- Careers Wales;
- CYSUR Mid and West Wales, Regional Safeguarding Board Business Manager; and
- LA Housing Services

Evaluations from the respective Learning Events recorded very successful events, where reflection and learning had taken place at both an individual and agency level. Actions to

[33] Turnell Andrew & Edwards Steve: Signs of Safety (A solution and Safety Orientated Approach to Child Protection Casework), USA, WW Norton& Company, 1999.

improve practitioner and agency working were identified and have been reflected within the Extended Child Practice Review Report.

Family Participation in the Review Process

Members (where appropriate) of the young woman's family were fully engaged with the review process and welcomed that the Extended Child Practice Review was taking place. The young woman's family including her parents and the majority of her half siblings either met directly with the Lead Reviewer or spoke to them on the telephone or communicated via text/email. Where it was not appropriate to meet or speak directly to two of the young woman's half siblings; professional advocates for them spoke and or met directly with the Lead Reviewer and conveyed their feelings and perspectives with regards to her.

The family's views, recollections, feelings and identified areas of learning were then conveyed as a pivotal part of the Learning Events by the Lead Reviewer and were included within the professional learning from the events; their perspectives were also taken into consideration and documented as part of this Review Report. The family have received updates throughout the review process, in writing, at all key stages, and have been offered further meetings with the Lead Reviewer/Second Reviewer and/or the Chair of the Panel prior to the publication of the Extended Child Practice Review Report.

The young woman's mother has also maintained telephone communication with the Lead Reviewer, who forwarded any presenting immediate concerns to the LA, in accordance with safeguarding procedures.

A Foster Carer who had fostered the young woman in 2016/17 and who was close to her was also spoken to by the Lead Reviewer, in the presence of their Supervising Social Worker. They were able to provide significant information in enabling the Lead Reviewer to gain an insight into the young woman's perspective, which they were able to disseminate and share at the professionals' Learning Events. They have been offered a further meeting with the Lead Reviewer and the Supervising Social Worker on publication of the Extended Child Practice Review Report.

For Welsh Government use only

Date information received: …… *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1 Terms of Reference for CYSUR 2/2018 (ECPR)

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the Board.
- Examine the effectiveness of interagency working and service provision for the child and family.
- Determine the extent to which decisions and actions were in the best interests of the child and outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings relating to the case.
- Hold a multi-agency learning event for practitioners and managers (respectively) and identify required resources.

As this is an Extended Child Practice Review, in addition to the Review Process, to have Particular Regard to the Following:

- Whether previous relevant information or history about the child/family members was known and taken into account in professionals' assessment planning and decision making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child?
- Whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.
- The effectiveness of transition planning (as appropriate)
- Whether the plan was implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan.
- What aspects of the plan worked well, what did not work well and why?
- The degree to which agencies were held to account regarding the effectiveness of the plan, including progress against agreed outcomes for the child.
- Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and the family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and contextual issues).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the Review Panel in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewers and Panel membership.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewers a learning event for practitioners and managers respectively, to include identifying attendees and arrangements for preparing and supporting them, pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the family members prior to the event.
- Receive and consider the draft Extended Child Practice Review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the CPR Sub-Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- Review panel members will adhere to the principles of GDPR when handling personal information as part of the Child Practice Review process (see section on Information sharing and Confidentiality).

Specific Tasks of the CPR Sub Group

- Agree an approve draft terms of reference (ToR) for each case recommended for ECPR/CPR.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Monitor ECPR/CPR action plans to ensure all recommendations are carried out on behalf of the Board.

Specific Tasks of the CYSUR Safeguarding Children's Board

The Board will:

- Inform Welsh Government of the undertaking of a ECPR/CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final ECPR/CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on the Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned and originated by them.

Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel as appropriate.

A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared:

- In working with sensitive information in relation to an extended Child Practice Review/Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
- The Panel meeting is called under the Guidance of '*Working Together to Safeguard People Volume 2 – Child Practice Reviews' from the Social Services and Well-being (Wales) Act 2014.*
- The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of all agencies involved.
- If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
- However, the ultimate responsibility for the disclosure of information to a third party from the Multi agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.