Extended (Hybrid) Child Practice Review Report

CYSUR 4/2020

Date report presented to the Board:

15th January 2024

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Extended (Hybrid) Child Practice Review Re:
CYSUR 4 2020

A 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*

Legal Context

An Extended Child Practice Review was commissioned by CYSUR, the Mid and West Wales Safeguarding Board, on the recommendation of the Child Practice Review Subgroup under the Social Services and Wellbeing [Wales] Act 2014[1] and accompanying statutory legislation in section 139 of the guidance in Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).[2]

The criteria for this review are met under Chapter 6, 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 either on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) 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 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

[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 refeed to in S.28 of the Children Act 2004 or body mentioned in s.175 of the Education Act 2002.

[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015)

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 consideration of what needs to be done differently to improve future practice (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**.

Relevant Contextual Information

The core issue underpinning this child practice review is a lack of compliance with statutory regulations, policies and procedures by the Local Authority fostering service regarding arrangements for respite care in February 2020. While the multifaceted pressures on fostering provision, nationally, have been identified for more than a decade, the adherence to regulated procedures facilitate safeguarding decisions. Instead, this review learned the fostering service had previously responded to the multiple pressures with a culture of informal and ad-hoc decision-making. That culture negated the inclusion of key professionals in decision-making and placed a child at risk of significant harm from the behaviours of a vulnerable young adult. Both Child A and the vulnerable young adult were reliant on the Local Authority for their care and wellbeing.

The brief but profound intersection of the lives of Child A and the young adult occurred due to decisions made by those with the responsibility for their care. It was vital the learning process had a symbiotic approach that enabled practitioners and managers to reflect on how to meet complex, competing and divergent needs with limited resources. Therefore, the review has been hybrid in design, with the Learning Events bringing together relevant professionals across children and adult services. Two hybrid Learning Events were completed, one for practitioners and one for their managers.

Child A and the young adult had no prior relationship or subsequent role in the other's life. As such, an extended child practice review report and an extended adult practice review report will be completed. Their experiences are their own, and the learning gained from the harm that occurred should be considered independently from each perspective. To that end, this child practice review report will only include pertinent information regarding the young adult if it assists the understanding of Child A's experience. However, where there is learning that is of equal value, it will be included in each report. A separate adult practice review report titled CWMPAS 2 2020 will be completed with a detailed focus on the needs of the young adult.

This child practice review received contextual information regarding Child A, which reflects that after suffering significant harm, they and their sibling had been adopted. Subsequently, concerns were raised resulting in the breakdown of the adoptive placement. The two siblings were initially placed with emergency foster carers (foster carers E) in November 2019, who provided them with a temporary but secure base while plans for their future were made. Care proceedings were initiated to enable the Local Authority to acquire shared parental responsibility. After a short period of time with foster carers E, the siblings were placed with a newly registered long-term foster carer (foster carer L), in December 2019. During the siblings' placement with foster carer L, respite care was arranged to provide support.

In February 2020, the siblings had their first and only respite care stay with respite foster carers R. Regrettably, during that stay, Child A suffered significant harm, which was not disclosed until May 2020. Furthermore, although Child A was effectively supported following the disclosure,

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

sadly, the siblings' placement with foster carer L eventually ended. Positively, Child A and his sibling are happily placed with foster carers P and are reported within the context of their experiences, to be thriving.

Key	Definition
Foster Carers E	**E**mergency foster carers
Foster Carer L	**L**ong term foster carer
Respite Foster Carers R	**R**espite foster carers
Foster Carers P	**P**resent long term foster carers

Circumstances resulting in the review

In February 2020, Child A and their sibling had a short stay with respite foster carers R. Respite foster carers R were experienced carers; they had a large home and were child focused. Previously, they had also fostered teenagers and had, several years earlier, provided respite care to the young adult, Adult V. However, in late 2019, they were subject to an annual review that recommended they only provide care to children under 12 years of age and that this should be limited to only two or three children at any one time. These conditions included the needs of Child A and their sibling. That recommendation had been widely shared by the Independent Reviewing Officer (IRO) throughout the children's services department by February 2020. Following significant disruption caused by the onset of the COVID-19 pandemic from March 2020, the foster panel ratified this decision in June 2020.[6] However, they had not been aware of the respite arrangements made in February 2020.

Shortly before the February 2020 half-term break, the fostering service approached foster carers R to request they provide respite care for Child A and their sibling. These arrangements were initially discussed informally during a Local Authority training event. Long-term foster carer L was also at the training event and participated in the discussions. During this review, foster carer L expressed their frustration and profound disappointment they were not made aware that anyone else would also be placed with foster carers R at the same time. Foster carer L has reported they would not have agreed to the respite arrangement had relevant information been shared with them.

The young adult, Adult V had been in the care of the Local Authority since early childhood. At the time of the incident that led to this review, he was placed with a When I'm Ready (WIR) Carer[7]. The WIR carer had previously fostered the young adult for several years. Unfortunately, the young adult's complex vulnerabilities and subsequent behaviours undermined the wellbeing of the WIR carer for whom respite was a necessity. In response to this need, contrary to fostering regulations, the Local Authority fostering service decided to place a young adult for a short break in February 2020, with respite foster carers R. Although contrary to fostering regulations, that decision was made when it was considered that respite foster carers R would have no children placed with them.

Foster carers R have reported once they understood the respite care dates required for Child A and his sibling overlapped with the young adult's respite placement, they initially refused to have

[6] An IRO is an experienced social worker employed by a Local Authority to scrutinise children's care plans by overseeing the review process.

[7] When I'm Ready placements provide a supportive home for previously looked after children once they become adults in order to bridge the transition from foster care to independent living.

the siblings. The high support needs of the young adult and the risk of his harmful sexual behaviours towards children were known. Reportedly, verbal challenges were expressed to the fostering service manager responsible for the respite placement decisions but were not formally escalated per the Local Authority policies. Respite foster carers R reported being pressured to agree to the request.

Regrettably, the regulatory procedures required to determine the appropriateness of the fostering services' decisions when matching children to placements were not completed. Furthermore, neither Child A's social worker nor the young adult's personal advisor was included in the respite care arrangements decision-making, thus preventing further risk assessment completion. The lack of compliance with regulated fostering processes contributed to practice decisions that resulted in Child A being placed at risk and suffering significant harm.

The practice outcome of the above was that on several days in February 2020, Child A, their sibling, and the young adult were placed with respite foster carers R. The days were reportedly filled with child focused activities, including days out where the children had fun and played together. Mindful of the potential risk presented by the young adult, foster carers R did not leave the children unattended during the day; however, overnight arrangements were a concern for them given the young adult's known history. They had a large house and placed the young adult in a bedroom far away from the siblings to mitigate potential risks. The occurrence of significant harm was not known until May 2020, when Child A told long-term foster carer L he had experienced sexual harm while in the respite placement.

Response to the Disclosure

Following the disclosure from Child A, the Local Authority, school, police, Cafcass Cymru and health services ensured every step was taken to respond effectively to the traumatic impact of the abuse. The child focused approach meant Child A and their sibling were well cared for through a devastating time. Long-term foster carer L, the social worker and the police supported Child A through the sensitive process of gathering the best evidence. The young adult admitted their actions, and a timely outcome was achieved within the justice system to allow Child A and their sibling to begin to rebuild their future. The young adult received a custodial sentence. Disappointingly, the compounded needs of Child A and their sibling and the impact of COVID on service provision left foster carer L feeling a lack of support from the foster service at a time of high need. Regrettably, they eventually ended the foster placement for Child A and their sibling.

The Local Authority and foster carer L continued to work in a child focused manner, and therapeutic support was commissioned for the siblings. Another long-term foster placement was found with foster carers P with the assurance that this placement could be responsive to the siblings' enduring childhood needs. The young adult recognised the risk of his behaviours and welcomed the available expert intervention and support. The adult practice review report will address the complexity of the young adult's needs.

Child A did not want to participate in the review because they wanted a '*normal life*'. However, they were happy to reveal the aspects of their life that they love, including fun pastimes and hobbies. They asked to be graphically represented during the Learning Events with the image of a bright, dynamic children's icon.

The Time Period of Review and Why

Before its commencement, the review awaited the outcomes of the criminal and care proceedings, which enabled the Board to be better informed of the multifaceted nature of the harm suffered by Child A. The agreed timeline for this review is following child practice review guidelines; the review panel recommended twelve months to ensure appropriate focus on current practice at the time of the incident. The review panel wanted to include the time when the disclosure was made; as such, the review will centre on the period from the 12th May 2019 to 12th May 2020. That timeline also captured an understanding of Child A's experience of placement changes and decisions taken about the provision of respite care. The timeline was supplemented by contextual background information that assisted the review in understanding the impact of events on the child's needs.

Given the hybrid nature of the review, timelines, chronologies, and organisational analysis were received for both Child A and the young adult by all agencies. Those submissions were discussed in detail during the panel meetings and Learning Events and, alongside the contributions of family members, have informed the learning included in this report.

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 were informed, their views were sought and represented throughout the Learning Event, and feedback was provided.*

The process followed by the Board and the services represented on the Review Panel

This review was undertaken per statutory legislation in section 139 of the Social Services and Wellbeing (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

An Independent Panel Chair and two Independent Reviewers were commissioned who were, per the guidance, independent of the case management and had the relevant experience, abilities, knowledge and skills as required by the case and circumstances under review. The Lead Reviewer was wholly independent of Wales, and the second reviewer was able to provide a regional context and perspective to the learning identified.

The Review Panel consisted of representation from the following services, all of whom had had an involvement with the individuals at the centre of this review:

- Local Authority Children and Adults Services (including Fostering)
- Health Board
- Police
- Education (including Further Education)
- Cafcass Cymru

Ten panel meetings were held in total.

Two Learning Events were conducted on 24th and 25th May 2023, as outlined in the section above. Practitioners and managers from all panel agencies attended one of the two Learning Events. The reviewers are grateful to those who attended the Learning Events, which focused on crucial safeguarding matters, for their invaluable contribution to the process that has informed the learning identified in this report. Their willingness to engage in understanding, critical reflection and seeking solutions for safeguarding challenges is commended.

Family involvement in the review

Participating in a child practice review when your child has suffered harm in the care of the Local Authority is an incredibly difficult and sensitive process for any parent or family member. The reviewers respect the decisions made by the family members who declined to participate and those who contributed to the review process. Child A's adoptive parents continue to hold shared parental responsibility, and the lead reviewer wrote to inform them that a review was taking place and invited them to participate. The adoptive parents kindly wrote back and explained they did not wish to participate.

This review has benefitted from the kind participation and thoughtful reflections of family members. These include Child A's birth mother, to whom the reviewers wish to extend their gratitude for her valuable and child-focused contributions to the learning process. Additionally, the review includes the insightful perceptions of foster carer L and respite foster carers R. These views are presented in later sections of this report.

The Learning Events

Given the time that has elapsed since the events at the centre of this review, not all staff working directly with Child A or the young adult remained in post at the time of the Learning Events. Therefore, whilst many professionals who had worked directly with the child or young person attended the events, where this was impossible, alternative representation was sought from professionals who now hold those roles. The time that has passed did not lessen the challenging nature of reflecting on the events at the centre of the review. It was evident that professionals had worked extremely hard to support recovery for Child A and a safe pathway forward for the young adult. Attendees offered rich contributions to the learning process and benefitted from hearing from each other about the learning and progress made since the harm occurred. Those who attended the Learning Events were congruent, engaged, and reflective. Attendees valued the opportunity to listen, share and learn from the experience of Child A, the young adult, family members and the agencies they represented. Those agencies are listed in the table below.

Practitioner Attendees	Manager Attendees
Local Authority **Education** **Health** **Child And Family Court Advisor and Support Service (Cafcass Cymru)** **Police**	**Local Authority** **Education** **Health** **Child And Family Court Advisor and Support Service (Cafcass Cymru)** **Police**

The format of each day consisted of a presentation of the Learning Event process. It conveyed the responses to the invitation to respond from Child A, the young adult, and family members. Practitioners were divided into two groups to identify further themes from the timeline, discuss areas of learning, and identify areas of good practice. The groups were then brought together to identify and share their learning facilitated by questions based on the signs of safety approach.

1. What went well, and what good practice have you identified?
2. What could have been done differently by your organisation?
3. What are your biggest learning points?
4. What actions do you feel agencies need to take to ensure any learning informs future practice?

There was a congruence between the responses provided during the two Learning Events and those provided by the agency representation on the practice review panel. These will be summarised below as they pertain to Child A.

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.

During the review process, it was widely accepted that a lack of compliance with regulatory processes was fundamental to the harm experienced by Child A. The analysis undertaken by practitioners, managers and agencies assists in understanding the background context within which practice occurs. The valuable contributions from family members provide insights into their experiences that assist the learning process.

The following themes were drawn from the timeline, agency analysis, Learning Events and contributions from family members.

The importance of compliance with regulatory policies and procedures in the context of a lack of appropriate fostering resources.

This practice review confirmed the necessary policies and procedures were in place to safely regulate the placement of children and young people in foster placements. Those policies included matching needs and completing risk assessment processes in line with fostering regulations and statutory guidance. Regrettably, these were not duly followed, and a practice culture developed within the foster care team that limited quality and accountability. More specifically, the respite provision for an adult in a WIR placement should not have been in a foster care provision. Furthermore, not following procedures inhibited the involvement of the social worker and personal advisor and their ability to identify the risks.

In response to the above, Section 5 Wales Safeguarding Procedures, professional concerns processes were followed, with the strategy meetings chaired by a Safeguarding Officer from a different Local Authority. A safeguarding investigation was completed by an Independent Social Worker whose subsequent findings were addressed. Policies and procedures were reviewed, and recommendations were implemented, including a change in the management structure. The now termed Foster Care Service lies under the responsibility of the Direct Services management, which manages all regulated care services within the council. That service is separate from Safeguarding and Planned Care service in terms of their structure.

Arguably, had there not been a shortage of experienced foster carers, Child A and their sibling would not have needed respite care at that time. Foster care remains an effective alternative to family-based care for children who cannot live with their birth families. However, that provision has been under increasing strain for over a decade. In 2008 (p.113), Pithouse and Lowe, highlight *'The single biggest challenge to contemporary fostering in Wales is generating sufficient numbers of well-trained carers who can create effective attachments in order to promote resilience in children who need to cope with adversity and resist dysfunctional responses to abuse or neglect."* Despite that awareness, Local Authorities across England and Wales have faced increased cuts

to services[8] via government austerity[9] measures alongside an increase in the number of looked after children.

Furthermore, the stress of conflicting demands for and availability of foster care services has been compounded by an increase in the complexity of the needs of young people. Those higher-level needs are perpetuated by a decline in the availability of children and adolescent mental health resources, often leaving foster carers supporting children with unmet needs. That worrying landscape becomes increasingly fragile as the increased workload for supervising social workers also means they have less time to support foster families (Jagger, 2018).

Foster carers remain motivated to continue caring to make a positive difference in a child's life. However, when children's needs outweigh foster parents' abilities, they may feel less able to undertake that role. The supportive relationship foster carers have with their supervising social worker is key to helping them respond effectively to the children's needs. Jagger's (2018) focus group data reflects the closeness experienced between foster carers and their supervising social workers, the complexity of communication, and the powerlessness inherent in professionalised systems.

Family perspectives and reflections

Child A's birth mother

Child A's birth mother described the devastating impact of learning her child had experienced significant harm in the care of the Local Authority stating, "*All the people who were meant to safeguard them have let them down tremendously*". Reflecting on all the siblings had experienced in their young lives, Child A's mother felt heartbroken for her *"beautiful children".* She pondered the limitations of sorrow and her desire to play her part in her children's recovery. At present, although it has been deemed Child A and their sibling would benefit from a relationship with their birth mother, at the bequest of the children contact remains indirect. As such, she is on the periphery of their lives and must simultaneously manage the mental distress created by the limits of her opportunity to soothe her children and knowing they need time and stability to recover from their traumatic experiences.

Foster carer L

Foster carer L was distressed at the harm suffered by Child A. She felt the decisions made regarding the respite care arrangements in February 2020, undermined the care and compassion that was experienced by Child A and their sibling from herself and others.

Foster carers R

Foster carers R were distressed that Child A had experienced significant harm in their care. They had fully engaged with the Section 5 Wales Safeguarding Procedures and described in detail the efforts they made to resist the pressure to simultaneously have the siblings and young adult in their care. The events have contributed to their decision to cease fostering.

[8] https://www.wcpp.org.uk/wp-content/uploads/2019/05/Analysis-of-Factors-Contributing-to-High-Rates-of-Care-2.pdf

[9] https://thefosteringnetwork.org.uk/sites/default/files/2022-03/State%20of%20the%20Nation%202021%20-%20Spotlight%20on%20Wales%20-%20ENG_2.pdf

Learning – Organisational Analysis

- Policies and procedures were in place for placing children and young people in foster placements, including matching needs and risk assessment processes as per fostering regulations and statutory guidance. However, these procedures were not followed in the arrangements for respite foster care in February 2020.

- There was no analysis of respite foster carers R's ability to manage to provide care for children or young people aged over 12, despite this being a recent recommendation of their continuing registration at that time. Foster carers R were also aware that their registration was changing when they agreed to care for the young adult.

- Young adults in a 'When I'm Ready' placement should not have been placed in a foster care placement for respite.

Learning Events Themes

- A tension between the needs of foster carers and looked after children is evident within the chronology. In this matter, some practitioners experienced a lack of clarity as to which part of the service had authority to make the final decisions on placements. Informal procedures developed within the fostering service that did not comply with policies and procedures. Inappropriate pressure was applied to respite carers and insufficient information regarding children's needs and risks was shared.

- The children's social worker had concerns about the premise of respite care meeting the needs of young children who had recently experienced an adoptive placement breakdown. The social worker had not been included in decision-making about this respite placement and was denied an opportunity to visit beforehand, only becoming aware of the decision a couple of days in advance. Equally, the young adult's personal advisor from the leaving care team was not informed. Had they both had the full details of the respite care arrangements, they would have raised concerns. The school also said they should have been informed of respite care arrangements as they are children's first point of contact after a weekend.

Communication and accountability: The importance of escalating professional concerns

Respite foster carers R were aware of the known risks of the young adult and reported that despite refusals, they were pressured to simultaneously care for the siblings and the young adult. They did not formally escalate their concerns prior to the siblings being placed in February 2020. Mid and West Wales Safeguarding Board have in place a Resolution of Professional Differences Protocol[10] that provides a framework for professionals to raise concerns. However, it is important to recognise the complex professional-parenting role that is unique to foster carers. For example, within this review, foster carers were designated as 'family' as opposed to being included with practitioners in the Learning Event. As such, it would be useful to consider reviewing that protocol and consider if the language and framework should be adapted for foster carers.

[10] https://www.cysur.wales/media/bjpprbqn/resolution-of-professional-differences-protocol-approved-20230124.pdf

More generally, Child A's social worker had advocated for the siblings to have a foster placement that did not require respite breaks; however, she had not felt heard. The Practitioners' Learning Event expressed a lack of clarity as to service structure decision-making. That clarity was obtained at the Managers' Learning Event who explained the restructuring that had occurred. Consideration should be given to creating an infographic that easily explains the decision-making protocols and highlights the routes to escalate if concerns arise.

Family perspectives and reflections

All family members expressed their support for the learning process to understand what had led to Child A suffering significant harm and how to improve communication and accountability.

Learning – Organisational Analysis

Communication and lines of accountability needed to be clearer when placing children and young people in terms of the social work planned care team and the foster care service.

Learning Event Themes

Evident within the chronologies is a tension between the needs of foster carers, looked after children, and young adults in WIR placements. In this matter, some practitioners experienced a lack of clarity about which part of the service had authority to make the final decisions on placements.

Communication and accountability: What best practice looks like

The best practice was evidenced by the relationship-based practice experienced between Child A and their sibling and professionals, and between practitioners. That practice included being child focused and completing joint visits. There was evidence of practitioners receiving support when their counterparts could respond effectively within the expectations of policies and procedures. This review provided opportunities for all agencies to revisit their written records and these, outside of the fostering service arrangements for respite care, were found to be in good order with only isolated recommendations. Additionally, foster carer L and health agencies noted there was scope for improvement in communicating the health needs of children who move between carers.

When services are negatively impacted by structural factors such as reduced resources, it places increased pressure on those who remain. These factors include less time available for relationship-based practice and creating an experience of isolation. Those factors were further impeded by the social restrictions in place due to the COVID pandemic. Although the pandemic did not factor into the decision-making prior to February 2020, it impeded the opportunity for in-person relationship-based practice thereafter. Positively, the social worker, foster carer L and the police provided Child A and foster carer L with support during the pandemic, but their interaction with other services was affected.

Family perspectives and reflections

Child A's birth mother

Child A's birth mother was happy the Local Authority had continued to keep the siblings placed together. She also had praise for the school and the social worker. She was grateful the school had supported the children, monitored their welfare and advocated for them, commenting, *"I'd like to thank them from the bottom of my heart*". Child A's birth mother's gratitude extended to the children's social worker, whom she stated was child focused.

Foster carer L

The foster carer L felt the children's social workers had provided a good service to them. Additionally, she described the police officer who supported Child A as 'amazing'. However, she also suggests there was room for improvement with communication about the health needs of children as there had been a significant delay in her receiving information.

Learning – Organisational Analysis

- Cafcass Cymru noted although there was good evidence of full and detailed recording, the information regarding the visit to the siblings on the 14th February 2020 could have been fuller.

- Health agencies identified foster carer L had limited knowledge of Child A's medical needs. Notably, Child A was received back into the care of the Local Authority following an adoptive placement breakdown, but further consideration should be given to how important health information can be transferred between carers. There was also recognition of the impact of COVID delaying the follow-up of an ENT appointment.

Learning Event Themes

- The joint working between the social worker and the children's school provided a child-centred approach that supported the transition from adoptive to emergency to an initial long-term foster care placement. After disclosing significant harm, the child-centred approach supported Child A and their sibling through distress. Of note was the support the siblings gained from their peers at school. The decisions made about maintaining the children at that school ensured they had the wider support of their school community. The school ensured good communication with carers and raised any concerns promptly. They provided emotional support sessions to Child A throughout his registration period at the school.

- The social worker supported and advocated for Child A and their sibling.

- Health reports reflect that the person who brought Child A to appointments was documented, which is of particular importance for looked after children who may have different individuals including social workers, foster carers and adoptive carers, bringing them to appointments. An in-person health assessment was completed in full. Child A was regularly seen and reviewed.

- Child A and their sibling were subject to care proceedings during the incident. Cafcass Cymru ensured the children were heard during the proceedings. They scrutinised local authority plans and raised issues such as further psychological assessment and placement requirements.

- Following the incident of significant harm, the police supported Child A and ensured a timely conviction was given.

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:

1. Reinforce via supervision, training, and communication to staff the importance of escalating concerns and the whistleblowing process when there are concerns about decisions being made concerning risk and safeguarding. To review that protocol and consider if the language and framework should be adapted for foster carers.

2. Clarify the decision-making process for deciding respite care when there are conflicting needs of children and foster carers.

3. Ensure social work staff in the foster care service fully understand risk management and safeguarding of vulnerable children to ensure matching decisions are made with full knowledge of children's history.

4. Clinicians to be mindful that if they do not have access to a complete medical history, they should follow this up with the appropriate contact for the child and young person who holds that information.

5. Health professionals should be reminded to document the time and dates when health assessments are undertaken.

6. New foster care placements should be furnished with information about children's health background to allow them better insights into health needs that have been previously raised by other carers.

7. Local Authority to give assurances that childcare teams are fully consulted and central in decision making for respite provision and matching – and policies are being followed.

8. Clarify if the regional Resolution of Professional Differences protocol can be used for internal disputes.

Statement by Reviewer(s)			
Reviewer 1	Dr. Donna Peach	**Reviewer 2** *(as appropriate)*	Dr. Holly Gordon
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)* 		**Reviewer 2** *(Signature)* 	
Name *(Print)*	Dr. Donna Peach	**Name** *(Print)*	Dr. Holly Gordon
Date	21st March 2024	**Date**	21st March 2024
Chair of Review Panel *Rebecca Robertshaw* *(Signature)*			
Name *(Print)*	Rebecca Robertshaw		
Date	21st March 2024		

Appendix 1: Terms of Reference

Terms of Reference for Extended Child Practice Review

CYSUR 4 2020 (Ceredigion)

- **Nominated Safeguarding Lead** – Liz Upcott
- **Review Panel Chair** – Rebecca Robertshaw
- **Independent Reviewer(s)** – Dr Donna Peach, Dr Holly Gordon

Core Tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of names services and Board.
- Examine the effectiveness of inter-agency 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 related to the case.
- Hold a multi-agency learning event for practitioners and identify required resources.

For this Extended Review – In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the child and/or 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 Care and Support Plan/Child Protection Plan/Interim Care Plan were robust, and appropriate for that child and their circumstances.
- Whether the plans were effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency plans?
- What aspects of the plans worked well, what did not work well and why? The degree to which agencies were held to account regarding the effectiveness of the plans, including progress against agreed outcomes for the child.
- Whether the protocol for dispute resolution was invoked.
- Whether the respective statutory duties of agencies working with the child and 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 other contextual issues).

Specific tasks of the Review Panel

- Identify and commission reviewers to work with the *Review Panel* in accordance with guidance for 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, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft 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 draft report 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 the Data Protection Act 2018 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).
- Explore specific policies relevant to the review, including:
  - Matching Policy
  - Statement of Purpose: Fostering
  - Child/Young Person's Safe Care Plan in Foster/Kinship Care Placement

Specific tasks of the CPR Sub Group:

- Agree and approve draft ToR for each case recommended for 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 CPR action plans to ensure all recommendations are carried out on behalf of the Board

Tasks of the CYSUR Safeguarding Children Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- 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 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 or 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 a 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 & Wellbeing [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 the 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.

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			