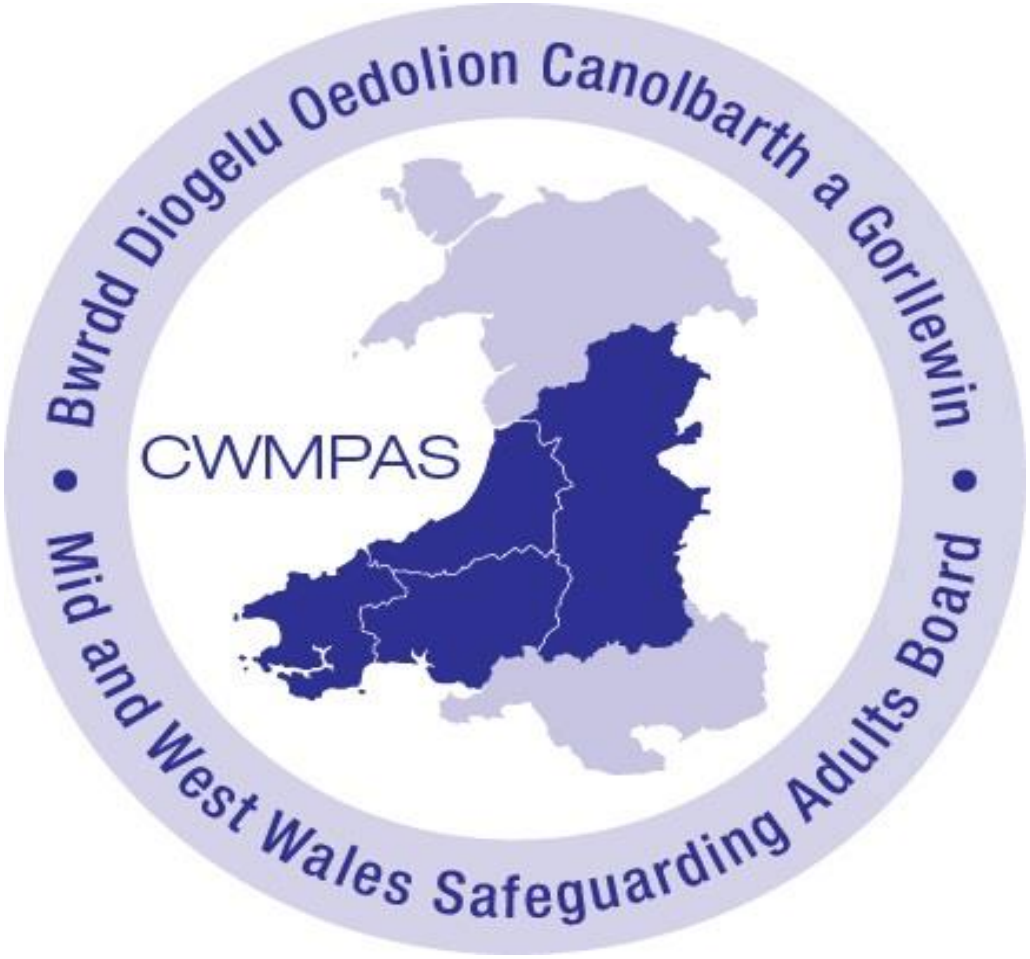

Extended (Hybrid) Adult Practice Review Report

CWMPAS 2/2020

Date report presented to the Board:

15th January 2024

Adult Practice Review Report

CWMPAS: Mid & West Wales Safeguarding Adults Board

Extended (Hybrid) Adult Practice Review Re: CWMPAS/2/2020

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 adult practice review was commissioned by CWMPAS - the Mid and West Wales Safeguarding Adult Board, in accordance with statutory legislation set out in Section 139 of the Social Services and Well-Being (Wales) Act 2014[1] and accompanying guidance "Working Together to Safeguard People Volume 3 – Adult Practice Reviews" (Welsh Government 2016)[2].

The criteria for this review is met under Chapter 7 of this statutory guidance for Extended Adult Practice Reviews:

A Board must commission an extended adult practice review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

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

The criteria for extended adult practice reviews are laid down in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015[3].

The purpose of this review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail of agencies' work with an adult and their family. The outcome of a review is intended to generate professional and organisational learning and promote improvement for future inter-agency practice. This report informs of the circumstances which led to this review being undertaken. It includes recommendations about what should be done differently to improve future practice.

The Terms of Reference for this Extended Adult Practice Review are included at **Appendix 1**.

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

[2] Working Together to Safeguard People – V3 – APRs (Welsh Government, 2016)

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

Relevant Contextual Information

The core issue underpinning this adult practice review is a lack of compliance with statutory regulations, policies and procedures[4] 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 vulnerable young adult who is the subject of this adult review at risk of harming a child (Child A). Throughout this report, the young adult will be referred to as Adult V (V is for vulnerability) as a reminder of his lived experience with complex vulnerabilities.

The brief but profound intersection of the lives of the Adult V and Child A 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 of vulnerable adults and children with limited resources. Therefore, the review has been hybrid in design, with the Learning Events bringing together relevant professionals across adult and children's services. Two hybrid Learning Events were completed, one for practitioners and one for their managers.

Adult V and Child A had no prior relationship or subsequent role in the other's life. As such, an extended adult practice review report and an extended child 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 adult practice review report will only include pertinent information regarding Child A if it assists the understanding of Adult V's experience. However, where there is learning that is of equal value, it will be included in each report. A separate child practice review report will be completed with a detailed focus on the needs of Child A, titled CYSUR 4 2020.

Adult V had been a looked after child placed with a long term foster family T since early childhood and was a vulnerable young adult at the time of the incident that prompted this review. This report will present and analyse positive aspects of Adult V's behaviours, in addition to those that created vulnerabilities for him and for others within the learning process. Early in Adult V's childhood, the Local Authority had cause to safeguard him, which included him being removed from the care of his birth parents. As a Looked After Child, Adult V was identified to have needs regarding his cognitive development and potential Foetal Alcohol Spectrum Disorder (FASD)[5]. Throughout his childhood and adolescence, these needs affected Adult V's ability to sustain friendships and relationships.

Concerns about Adult V's cognitive development and subsequent behaviour were longstanding, and he was diagnosed with ADHD, DCD/Dyspraxia. Although there was also concern expressed that he displayed some features of FASD and autism, these did not sufficiently correspond with the diagnostic criteria. Because not all Adult V's presenting neurodevelopmental behaviours

[4] Statutory Guidance - Fostering Services (gov.wales)

[5] FASD is caused when the development of a foetus is impaired by alcohol consumed by the mother. The effects can be physical, cognitive, social and emotional.

wholly met the diagnostic criteria, he and those who cared for him experienced barriers to accessing diagnostic-based services. Those barriers continued into adulthood.

Despite those challenges, Adult V completed school and had started to attend college. Adult V is musically talented and can achieve much with these skills. He is quick to develop new skills and developed an aptitude for carpentry.

The teenaged Adult V had a known history of harmful sexual behaviour toward children younger than himself. In 2017, an AIM2 assessment and a 12-week intervention programme was completed.[6] The resultant comprehensive non-clinical assessment report noted the complexity of his vulnerabilities, and the history of his sexual development and sexually harmful behaviour, meant he required a high level of supervision.

The AIM2 report notes that Adult V's limited cognitive ability meant he was less able to understand the impact his behaviour had on those he victimised. At that time, it was recorded that Adult V was almost completely reliant on others to keep him safe until he was able to develop his own internal skills and strategies. Additionally, it was recognised that Adult V was vulnerable to harm from others and had significant social impairments, particularly in unstructured situations. At the end of the AIM2 intervention programme, Adult V was deemed to be low risk of causing harm, with a caveat that this was subject to change should his life become unstable.

Adult V's placement with his long term foster carers T broke down and he went to live with foster carers, with whom he remained under a Welsh Government 'When I'm Ready' arrangement (WIR) as he entered adulthood. As such, Adult V was a care leaver, and the WIR arrangement was not subject to fostering regulations. In a WIR arrangement, the relationship between the former foster carer and young adult is as a landlord and an excluded licensee. The young adult can be asked to leave the property without the carer needing to apply for an eviction notice. Additionally, as per the WIR arrangements, Adult V had a pathway plan and a personal advisor.

The personal advisor supported Adult V to maintain his college place. The college had undertaken a risk assessment of Adult V's ability to learn safely in a carpentry environment in which there were sharp tools. However, there was no risk assessment of the potential harmful sexual behaviour he could potentially pose to others. The college have reflected that due to the Adult V's misuse of alcohol and drugs, they could have suspended him earlier. However, they employed their wellbeing support effectively, maintaining communication with Adult V and navigating the complex and fluid nature of his needs and risks. That support extended into the COVID pandemic with the wellbeing officer maintaining contact with Adult V via text messaging.

Unfortunately, the behaviour of Adult V became of increased concern with the onset of misusing alcohol and drugs. There was an occasion when a third party reported Adult V was being abused by his foster carer, but when spoken to, Adult V had no recollection of making the allegation and explained he was heavily intoxicated at that time. Adult V did not repeat the allegation. Socially and financially, Adult V was increasingly vulnerable to exploitation within the community; although the personal advisor provided additional support, caring for Adult V began to take its toll on the WIR carer. The Local Authority sought to support the WIR arrangement and provided respite care

[6] Aim2 is a Nice guideline [NG55] approach for boys aged 12-18 years who exhibit sexually harmful behaviours. Notably, the guidelines include a cautionary note on the use of the assessment to predict future offending behaviour when the potential offender has a learning disability.

with respite foster carer B. Regrettably, she too began to find it increasingly difficult to maintain her support and withdrew. As such, the Local Authority had responsibility for supporting a young adult whose complex vulnerabilities and subsequent behaviours had a negative impact on the wellbeing of his carers with limited to no identified suitable supported care alternatives.

Key	Definition
Foster Carers T	Long Term Foster Carers for Adult V as a child
Respite Foster Carer B	Respite Foster Carer for Adult V
Respite Foster Carers R	Respite Foster Carers (Where incident occurred)
WIR Carer	When I'm Ready Carer
Foster Carer L	Long Term Foster Carer for Child A and sibling

Circumstances resulting in the review

In February 2020, arrangements were made by the Local Authority's fostering service for Adult V to have respite care with respite foster carers R, who were experienced carers. Previously, they had also fostered teenagers and had, several years earlier, provided respite care to Adult V. 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. Additionally, 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. That recommendation had been widely shared by the Independent Reviewing Officer (IRO)[7] 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. 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. The siblings' foster carer L was also at the training event and participated in the discussions, but remained unaware of the simultaneous presence of Adult V in the respite placement.

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 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 Adult V's personal advisor nor Child A's social worker were included in the respite care arrangements decision-making, thus preventing further risk assessment completion. The lack of

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

compliance with regulated fostering processes contributed to practice decisions that resulted in Adult V being placed where he was at risk of harming a child.

The practice outcome of the above was that on several days in February 2020, Adult V was placed with respite foster carers R alongside Child A and their sibling. 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 Adult V, foster carers R did not leave the children unattended during the day; however, overnight arrangements were a concern for them given Adult V's known history. They had a large house and placed Adult V 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

Adult V 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. Adult V received a custodial sentence. Since that time, Adult V has been supervised, he is aware of the risk his behaviours present and welcomes the support he receives. Adult V's neurodevelopmental needs remain undiagnosed, but he is now in receipt of support through adult mental health services. After reflection, Adult V decided not to participate in the practice review, but shared that he felt supported in his current highly supervised setting. He has developed pastimes and strategies that help him to manage his mental and physical wellbeing.

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 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 Adult V and Child A. The agreed timeline for this review is following adult 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 centred on the period from the 12th May 2019 to 12th May 2020. Given the hybrid nature of the review, timelines, chronologies and organisational analysis were received for both Adult V and Child A 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.

Adult 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.*

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

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

An Independent Panel Chair and two Independent Reviewers were commissioned who were, in accordance with 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 to Wales, and the second reviewer was able to provide a regional context and perspective to 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's 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 practice review when a child has suffered harm in the care of the Local Authority is an incredibly difficult and sensitive process for any parent or family member. Equally, the impact of events had life changing consequences for Adult V. This review has benefitted from the kind participation and thoughtful reflections of family members. These include Adult V's When I'm Ready carer, foster carer B and foster carers R, to whom the reviewers wish to extend their gratitude for their valuable contributions to the learning process. 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 Adult V or Child A 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 a safe pathway forward for Adult V and Child A. 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 Adult V, Child A, family members and the agencies they represented. Those agencies are listed in the table below.

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

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 placed Adult V in a position where he could cause harm, despite the efforts of respite foster carers. 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 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.

[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

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

Birth parents

Sadly, Adult V's birth parents are deceased.

The WIR carer

The Lead Reviewer visited the WIR carer, who was devastated by the significant harm caused to Child A. He described the complexity of caring for Adult V, who had remarkable musical skills, but also the impact of caring for someone whose complex needs were not adequately diagnosed. He described Adult V as being somewhat detached from an interpersonal connection with reality. He felt the safeguards around the young person limited his social learning as he did not experience consequences for his actions. The WIR carer explained Adult V was vulnerable to exploitation in social settings with peers and would also misuse alcohol and drugs.

The WIR carer described how caring for Adult V became increasingly impossible. The WIR carer's health had deteriorated significantly, and he believed that the stress of caring for the young adult was a contributory factor. He expressed guilt and regret for the impact of the significant harm on Child A and the repercussions for the practitioners involved. "*They were trying to get respite, I needed it, I was ill. They were between a rock and a hard place*." The WIR carer states the provision in February 2020 with respite foster carers R was planned in advance and his understanding was that Child A and their sibling were placed in an emergency.

The WIR carer felt the Local Authority worked hard to support the young adult's placement and protect the WIR wellbeing by providing respite care. The WIR carer felt he had been well supported by members of the fostering service and continues to be a foster carer. However, the WIR carer also remarked he had not received full and detailed information on the needs of the young adult, noting that he only learned about past harmful sexual behaviours on the foster care 'grapevine'.

Respite foster carer B

Respite foster carer B is an older person who explained that teenagers would often perceive staying with her as akin to their grandmother. She had provided respite care to Adult V for several years; she states that when she first started to care for him, "*the paperwork didn't relate completely to what you are getting*". Respite foster carer B explained she learned about the young adult's harmful sexual behaviours via a previous foster carer, she remarked "*I never got anything from the office*".

Respite foster carer B described how Adult V could be pleasant and always made her a cup of tea. She commented on his musical talent. Unfortunately, as time went on, Adult V's behaviours and needs outstretched the abilities of foster carer B and she declined to offer further respite care. Respite foster carer B explained she felt guilty about this decision, but the situation had become unsafe and untenable. Respite foster carer B also remarked on the inadequate documentation and information received about the young adult's needs and was also reliant on the informal sharing of information between foster carers.

Foster carers R

Foster carers R were distressed that Adult V had been placed at risk of causing harm and that Child A had experienced significant harm while in their care. They had fully engaged with 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.

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 decision when matching children with a foster placement. 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 use of respite care when responding to the needs of young children who had recently experienced an adoptive placement breakdown. Regrettably, the social worker was not included in decision-making about this respite placement, as the decision was made solely by the fostering team. As such, the social worker was denied an opportunity to visit beforehand, only becoming aware of the decision a couple of days prior to the placement. 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 sharing and 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[8] 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.

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 Adult V being placed where he was at risk of harming a child and how to improve communication and accountability.

Learning – Organisational Analysis

Local Authority

- Inclusive communication is also supported by clear actions being derived from discussions and a shared understanding of the decision-making structure beyond looked after reviews. Feedback to those who raise concerns is important to ensure they feel heard. Mid and West

Wales Safeguarding Board have in place a Resolution of Professional Differences Protocol that explains the process of escalating concerns[10].

- Reinforcing via supervision, training and communication to staff the importance of escalating concerns and whistleblowing process when staff are concerned about decisions that are made in relation to risk and safeguarding.

- Communication and lines of decision-making and accountability needed to be clearer when placing young adults and children in terms of the social work planned care team and the fostering service.

- There were opportunities missed in relation to making referrals to Adult Safeguarding when there were concerns about Adult V being financially exploited by other people.

Local Authority and Health

- Concerns regarding Adult V's level of understanding and capacity could have been managed differently. For example, health services report there is no follow up apparent when Adult V was declined to be assessed by the Community Team for Learning Disabilities. It is questioned if Adult V should have been referred to Child and Adolescent Mental Health Service for psychology/psychiatry assessment at that point.

Police

- The police note in the timeline there is an occasion when a third party reports the young adult was abused by his foster parent. Although the young adult denied this and stated that if he did say it then it was because he was heavily intoxicated, there is no record of this information being shared with the Local Authority.

- Furthermore, the police note an intelligence log stating that the young adult was in contact with a 13-year-old and the contact was sexual. It appeared the information was not corroborated, and it is not known what was done to try and corroborate, despite Adult V receiving a conditional caution in 2017 for Harassment that was of a sexual nature.

Education

- The college note they could have suspended the young adult at an earlier stage due to being under the influence of alcohol and drugs in college, although they note that the decision could have had a negative impact on him.

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.

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

Communication and accountability: What best practice looks like

The review saw evidence of best practice in the commitment demonstrated by multiple practitioners and foster carers to safeguard and support Adult V. Excellent working practices and good communication between practitioners and foster carers ensured Adult V had developmental opportunities within the scope of his complex vulnerabilities. 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.

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.

Family Perspectives on what went well

The WIR Carer

The WIR carer spoke highly of the personal advisor, "*a lovely, fabulous bloke"* who went above and beyond, providing support for the young adult both with arranging college, finances and voluntary employment for the young adult. Furthermore, he would go beyond the scope of his role to assist in safeguarding the young person and supporting the WIR placement.

The WIR carer felt the Local Authority worked hard to support the young adult's placement and protect the WIR wellbeing by providing respite care. The WIR carer felt he had been well supported by members of the fostering service and continues to be a foster carer.

Learning – Organisational Analysis

- Primary care met Adult V's health needs and responded to concerns from carers and followed up accordingly. There is evidence of the GP engaging with Adult V himself when foster carers contacted the GP practice, supporting his independence skills.
- The personal adviser worked closely with Adult V, his WIR carer and college to provide consistent and valuable support, often exceeding expectations.
- The police worked well with partner agencies, Adult V and Child A to ensure a conviction was given.
- The college employed their wellbeing support effectively. Adult V's well-being worker maintained regular communication with him, navigating the complex and fluid nature of his needs and risks.

- The college demonstrated good practice in communicating and sharing information with multiple agencies, with particular reference to the personal advisor.

Learning Event Themes

- The joint working between the WIR carer, the personal adviser and the college provided a person-centred approach that supported Adult V and the goals in his pathway plan. The cohesive multi-disciplinary partnership working supported Adult V when the complexity of his needs, behaviours and vulnerabilities exceeded the capacity of a WIR arrangement.

- There was discussion around Adult V's complex needs and how they warranted a longer-term form of support for him as an adult, but that pathways for this were unclear for young people without a medical diagnosis underpinning those needs.

- The chronology shows that the WIR carer, personal adviser and wellbeing worker worked tirelessly to support Adult V to succeed.

- Following the incident of significant harm, Adult V was supported as he took responsibility for his action and continues to receive the appropriate support and supervision he requires.

- There was benefit in hosting the learning event in a hybrid format as it permitted a greater understanding of the needs of Adult V and Child A and the circumstances that led to the significant harm.

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 When I'm Ready carers and foster carers.

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

3. Ensure practitioners involved in arranging respite care for young adults in When I'm Ready placements and foster placements fully understand risk management and safeguarding of vulnerable adults and children to ensure matching decisions are made with full knowledge of their histories.

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 adult who holds that information.

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

6. All carers should be furnished with information about the needs of vulnerable adults and children to allow them better insights into their needs.

7. There needs to be clear pathways and processes in place to ensure that young people subject to the pathway planning process with complex needs, without a medical diagnosis, are assessed on a needs-led basis which supports effective transition planning into adult services.

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

9. 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 Adult Practice Review

CWMPAS 2 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 named services and Board.
- Examine the effectiveness of inter-agency working and service provision for the adult and family.
- Determine the extent to which decisions and actions were in the best interests of the adult and outcome focused.
- Seek contributions to the review from appropriate family 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 adult and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult, the family and their circumstances. How that knowledge contributed to the outcome for the adult?
- Whether the Care and Support Plan was robust, and appropriate for that adult and their circumstances.
- The effectiveness of transition planning
- Whether the plan was effectively implemented, monitored and reviewed. Did all agencies contribute 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 adult.
- Whether the protocol for dispute resolution was invoked.
- Whether the respective statutory duties of agencies working with the adult 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 adult 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 APR 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 Adult Practice Review process (see section on Information Sharing & Confidentiality).
- Explore specific policies relevant to the review, including:
  - Matching Policy
  - Statement of Purpose: Fostering
  - Adult/Young Person's Safe Care Plan in Foster/Kinship Care Placement
  - When I Am Ready Protocol

Specific tasks of the APR Sub Group:

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

Tasks of the CWMPAS Safeguarding Adults Board

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a APR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final APR 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 Adult 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 3 – Adult 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			