Extended Child Practice Review Report

CYSUR 6/2021

Date report presented to the Board:
22nd October 2024

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Extended Practice Review Re:
CYSUR 6/2021

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 & West Wales Safeguarding Children Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews*[2] (Welsh Government, 2016).

The criteria for this review are met under Chapter 7, *Extended Child Practice Reviews*:

A Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- *Died; or*
- *Sustained potentially life-threatening injury; or*
- *Sustained serious and permanent impairment of health or development;* ***and***

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

- *The date of the event referred to above; or*
- *The date on which a Local Authority (LA) or relevant partner*[3] *identifies that a child has sustained serious and permanent impairment of health and development.*

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

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

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

Circumstances Resulting in the Review

This Child Practice Review relates to two young people, who will be referred to as Child X and Child Y throughout this report. Both young people were Looked After by the Local Authority, and each spent a period of time placed with Foster Carer (FC) Adult Z. Their placements overlapped for a three-month period from June to September 2017.

Child X was open to the Disability Service due to the care and support needs of a sibling. In January 2017, at the age of eleven years, Child X was accommodated under s.76 of the Social Services and Well-being (Wales) Act (SSWBA) 2014. This followed a period of child protection registration due to concerns for his welfare for which his parent received a police caution for child neglect. Care proceedings were issued, and Child X subsequently became 'looked after under orders'[6].

In February 2017, Child X was placed in the care of FC Adult Z. This was an emergency placement and was his fourth placement in very quick succession.

Foster Care placement referrals sent to independent fostering agencies had proved unsuccessful. Following early positive progress, and considering Child X's wishes and feelings, the existing foster placement was extended from its temporary status and Child X remained in the care of FC Adult Z. In September 2017, Child X's foster placement with FC Adult Z ended following an altercation with Child Y (aged 15), who had been placed with FC Adult Z since June 2017.

Child Y, who was subject to a Full Care Order, remained in the care of FC Adult Z, and the placement was felt to be positive. In 2020, after three years in the foster care of Adult Z, and at the point of Child Y nearing departure to university, arrangements were in place in relation to a When I'm Ready (WIR) arrangement, so that Child Y could return to the placement in between terms.

In April 2020, Child Y reported to a trusted tutor at college that FC Adult Z had sexually assaulted him the previous night. Child protection procedures were implemented, resulting in immediate safeguarding actions, and an alternative foster care placement was sourced.

FC Adult Z was arrested and subsequently found guilty of sexual assault of a child, and sexual assault of a child by a person in a position of trust. FC Adult Z received two twelve-month sentences, to be served concurrently and suspended for two years.

Since becoming a foster carer in 2008, a total of twenty-seven children and young people had been placed in the care of FC Adult Z. Child Y's report of abuse triggered a series of Exit Interviews

[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)
[6] The Children Act (TCA) 1989 s.31

undertaken by the Local Authority with relevant children and young people who had been fostered by FC Adult Z. This included Child X, who made no reports at this time.

In March 2021, and following a series of 'missing/absent from placement' episodes (from a subsequent foster carer), Child X reported that FC Adult Z had sexually assaulted him four years earlier during his time in his care. Safeguarding procedures were implemented, however, there was a delay in convening the strategy discussion and in seeing Child X. The Crown Prosecution Service initially decided not to proceed with the prosecution, however, following an appeal by the Police and Child X, the case was taken to Court. Following trial, FC Adult Z was found not guilty of the charge against him.

A referral was submitted to the Child Practice Review Sub Group in respect of Child Y. Having determined that the referral met the threshold for an Extended Child Practice Review, subsequent consideration of a referral in respect of Child X was also determined by the Sub Group to meet the threshold criteria. This report is therefore one Extended Child Practice Review Report in respect of two subjects.

It is important to note that Child X and Child Y are the only two subjects of this Child Practice Review, as they have made statements of sexual abuse perpetrated by FC Adult Z. However, references to incidents that occurred in placement involving other children relevant to the context of events will be made, where this is considered relevant and proportionate to the themes and issues identified as occurring in placement during the respective review timelines.

Language and Terminology

It is acknowledged that criminal proceedings in respect of Child X and Child Y's reports of abuse led to different outcomes. In the interests of consistency of language within this report, however, the words "report" and "statement" will be used to describe the reports of sexual abuse which have been made by both young people who are subjects of this Review.

Time Period Reviewed and Why

The timeline period for Child X was 1 January 2017 to 31 May 2018. The panel elected to extend the timeline from the usual twelve-month period, to enable consideration of Child X's placement (February – September 2017), the post-placement period and subsequent Child Looked After Review, and two annual fostering reviews of suitability in respect of FC Adult Z (January 2017 and May 2018).

The timeline period for Child Y was 15th April 2019 – 15th April 2020, capturing the twelve months leading up to his report of abuse.

The two individual timelines collectively span an approximate three-year period (2017 to 2020), which provided an opportunity to consider whether the practice and organisational factors highlighted during 2017 – 2018 remained evident and relevant factors during 2019 – 2020.

Legislative, Regulatory and Policy Context[7]

The timeline periods bridge and at times straddle differing contexts. The relevant context to practice at the time will be referenced throughout this report.

Organisational Context – The Local Authority Children's Services

It is relevant to note that some of the review timeline covers a period in which the Local Authority was subject to an improvement plan, following an inspection undertaken by Care Inspectorate Wales (CIW) in 2017:

"Children and young people do not appear to be well served by the current arrangements for accessing support services in Powys. A lack of assessment, care and support planning combined with an inconsistent approach to working in line with the child sexual exploitation guidance and the management of sexual exploitation and risk assessment framework process placed children at risk of harm. In addition, child protection processes did not always comply with statutory guidance with delays in investigations and assessments being undertaken and completion of statutory visits." (CIW 2018)

In September 2020, CIW found the local authority had made significant progress, and Powys County Council were removed from enhanced monitoring. This information is provided as an aspect of organisational context to the timelines forming the focus of this Child Practice Review.

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

Vulnerability and Developing a Narrative

It is important to highlight at the outset that both children/young people were identified as being vulnerable as a result of their previous experiences.

Child X had been exposed to multiple childhood adverse experiences whilst in the care of his parents, had a diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD), and his complex care and support needs had been identified by the local authority. The timeline demonstrated significant challenges and difficulties experienced by Child X throughout his time in placement.

As well as experiencing childhood abuse, Child Y had experienced significant bereavement and loss, the ongoing impact and implications of which were prevalent during the timeline period.

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[7] *The Children Act 1989; Social Services & Well-Being (Wales) Act 2014 including Part 6 & Code of Practice (Looked After and Accommodated Children) and related regulations including the Care Planning, Placement and Case Review (Wales) Regulations 2015; the Local Authority Fostering Services (Wales) Regulations 2018 & Code of Practice which displaced the 2003 Fostering Regulations and National Standards; The Fostering Panels (Establishing & Functions) Wales Regulations 2018); Part 7 Safeguarding & Working Together to Safeguard People Volume 5; The Wales Safeguarding Procedures (WSP) November 2019 which displaced the All-Wales Child Protection Procedures (2008).*

However, there is no evidence that these sensitive aspects and any arising implications for the care and support needs of Child Y led to a Well-Being assessment, as would have been expected in accordance with the departmental policy.

Despite many elements of adversity, protective and resilience factors including educational achievement, the capacity to make and sustain positive relationships and having clear personal and professional aspirations, have promoted Child Y's sense of self and his well-being outcomes, which was evident during his discussions with the reviewers.

A significant proportion of children and young people, whether 'accommodated'[8] or 'looked after under orders'[9], will have 'adverse childhood experiences'[10]. When in an alternative caregiving setting, the child may have difficulties adjusting to the new environment, as coping strategies or behaviour previously relied upon may no longer be appropriate. The challenge facing the substitute caregiver cannot be underestimated, nor the impact of a child's lived experiences and care and support needs on the family relationships and dynamics, particularly when there are other children or young people in placement.

Evidence suggests that children looked after are vulnerable to abuse, harm and neglect as their adverse childhood experiences and ongoing trauma make them susceptible to misunderstand and misinterpret situations and actions, and to be unable to 'distinguish between appropriate behaviour from trusted people and harmful relationships or activities'[11].

However, practitioners should not assume that known previous trauma 'explains' or 'mitigates' a behaviour or expressed concern or statement.[12] All possible explanations should be pursued, including that of abuse by a foster carer or caregiver: a small proportion of foster carers may deliberately abuse, neglect and/or harm a child in their care. Cleaver & Rose (2020) use the term 'assumption of safety' to highlight that agencies and practitioners do need to 'think the unthinkable, believe the unbelievable and imagine the unimaginable'.

The assumption of behaviour being a result of previous trauma can lead to the development of a narrative in respect of a child or young person, which was evident within this review in respect of Child X's behaviours. There were a series of incidents of concern/reports of physical conflict involving Child X at school during the timeline period. It has not been possible to determine whether these incidents were dealt with in accordance with the Anti-Bullying and related policies (due to recording methods), or whether sufficient regard was given to his known vulnerabilities. It has not been confirmed that these incidents resulted in direct referrals to the local authority, other than discussions with the foster carer.

It is important to note that Child X did not make a direct report of assault against FC Adult Z whilst in his care. However, Child X did express concerns and make statements relating to other children/young people in the placement, as well as peers at school.

In the first expressed concern in May 2017, FC Adult Z notes in foster carer recordings that Child X had been punched in school by another pupil, and that the school raised doubts about Child X's

[8] SSWBA 2014 s.76
[9] TCA 1989 s.31
[10] Welsh Government Policy 2021
[11] The Independent Inquiry into Child Sexual Abuse (IICSA) 2019
[12] Serious Case Review H&CSCB 2014 1.20

account. FC Adult Z records that Child X admitted to being untruthful and that FC Adult Z intended to work with him on being truthful.

The following week, Child X was reported to be upset during contact and told his father that: 'another pupil at school had punched him on the nose and knocked him out and then sat on him and tried to strangle him'. Another foster carer recording in June reports that Child X visited the GP after being 'punched in the head at school'. There is no evidence that this incident was followed up by the GP.

In a September 2017 education communication, it is reported that '[FC Adult Z] has had difficulty with allegations made against him and [one of the other children] at home with him, all of which are unfounded'. The use of the term 'unfounded', which has a specific meaning within safeguarding procedures (implying that an allegation has been disproven following an investigation), is potentially misleading, as it bestows an inaccurate status on the statement and suggests it has been investigated and proven 'unfounded' as an outcome.

It is positive that the school was proactive in its communication with Child X's foster carer; however, it is not clear whether these concerns were being channelled more formally, in accordance with the relevant guidance.[13]

It appears that a narrative was developing of Child X as being untruthful, built upon by FC Adult Z. FC Adult Z's recordings report challenging behaviour, describing him as "being disrespectful", "making suggestive comments out of innocent comments spoken by others", and remarking in one entry, "is this the real [Child X] now showing!". FC Adult Z documented taking on the responsibility for addressing these behaviours, via "encouraging [Child X] to be truthful as opposed to lying" and "reinforcing the importance of telling the truth".

It was apparent from agency records and from discussion at the Learning Event, that this was thought to be a pattern of behaviour for this child. Historically, during a school meeting held in respect of Child X in June 2017, practitioners shared that when Child X lived at home, his parents had told him to lie to Social Services, adding that Child X may not understand the importance of telling the truth.

As a result of this narrative being attached to Child X, some of the incidents and events he described during his time in placement appear to have been minimised and, at times, he was not believed.

Depicting a child/young person as unreliable increases their vulnerability to being abused and discredited or not believed and decreases the likelihood of them reporting if they are harmed. In their review of Serious Case Reviews of children placed with alternative caregivers, Cleaver & Rose (2020) conclude that this is a functional and deliberate strategy by a perpetrator to create an environment conducive to harm or abuse.

As well as isolating the child or young person, other professionals and agencies may accept and reinforce the narrative, without question. 'Hypothesis or confirmation bias' is the term used to

[13] 'Keeping Learners Safe 'The Role of local authority governing bodies and proprietors of independent schools under the Education Act 2002' 5.28-5.30 (Bullying); 5.35-5.36 (Child Looked After) (WG updated March 2022); 'Rights, Respect, Equality. Statutory Guidance for Governing Bodies of Maintained Schools' 2.9 Bullying (WG November 2019); 'Making a Difference: A Guide for the designated person for looked after children in Schools' (WG November 2017).

describe the limitations of assumptions. If practitioners assume or accept stated explanations or reasons for a child or young person's presentation or behaviour, there is a danger that alternative and more accurate explanations may be discounted.

In 'The Report of the Independent Inquiry into Child Sexual Abuse' (October 2022), Professor Alexis Jay et al conclude that professionals remain 'too willing to take the side of foster carers and to disbelieve the child'. It appears that professionals' trust in FC Adult Z, who was seen as a good and dedicated foster carer, inhibited objectivity or professional curiosity about incidents occurring in placement, thereby reinforcing a positive narrative in respect of FC Adult Z, in contrast to the negative narrative in respect of Child X.

Identified Good Practice

- Consistent and regular CAMHS appointments were offered, historic Child Looked After health documents had been uploaded onto the WCCIS information system, and prescribed support was maintained when Child X moved out of area. This good practice demonstrates positive steps taken to support Child X in light of his identified vulnerability.
- The school undertook regular and proactive communication with other partners, foster carer, and Children's Services in respect of Child X.
- Routine health assessments were held in respect of Child Y. One was held during the timeline period, with appropriate health advice and guidance given.
- There is evidence of sensitive consideration of the matters affecting Child Y by the practitioners involved in meeting his care and support needs

Review Subjects' Perspectives and Reflections

- Child X wants those involved with children and young people in care to listen to what they have to say, and not discount or disbelieve them just because they are in care or because they think they are lying.
- Child X expressed to the reviewers the need for practitioners supporting young people to consider alternative explanations for presenting behaviours, to listen and to *hear*, and to 'check out' how the child or young person is, which can mean asking again, and again.

Learning

<u>All Agencies</u>

- It is evident that meeting Child X's care and support needs was, for a combination of factors, challenging, however, there was also a potential for developing a 'child-blaming narrative' in respect of him. There does appear to have been an assumption that the concerns or statements made by Child X were untrue, and that his presenting behaviours were a result of known past lived experiences. Questioning or revisiting this assumption at key stages may have provided an opportunity to consider alternative possibilities or explanations.

<u>Education</u>

- It is suggested that the Virtual School model, which was not yet in place during Child X's timeline period, is an appropriate forum to raise awareness of the safeguarding vulnerabilities of children looked after and accommodated, and of the responsibilities detailed in relevant guidance (see Footnote 12 above), and to share learning from this review.

Young Person's Wishes, Feelings and Lived Experiences

The allocation of an Independent Advocate for Child X demonstrates good practice; a CAFCASS Children's Guardian was appointed for Child X during the care proceedings conducted during the timeline period. The involvement of the CAFCASS Children's Guardian was not identified until the Learning Event, and unfortunately, it has not been possible to obtain any views or contributions from this service to inform this review process.

Whilst Child X's placement with FC Adult Z was intended to be a temporary placement, as it did not meet all of his care and support needs, the placement was extended. A determining factor was that Child X was making good progress and that he had told his independent advocate, ten days into placement, that he wished to remain there.

Whilst it is positive that due regard was given to Child X's stated wishes and feelings and to the views of the Independent Advocate and Children's Guardian, a more rigorous and longer-term approach may have afforded a more fully informed balancing exercise between Child X's stated wishes and feelings and his longer-term well-being and welfare. It is relevant to note that the tight timescale afforded by the Care Proceedings' timetable may have added to the need for the local authority to clarify longer term arrangements.

It is relevant at this juncture, however, to echo earlier comments within this report in relation to Child X not being believed at times when he used his voice to raise concerns. This learning will not be repeated here, but is key to consider within the context of capturing and centring decision-making around the young person's voice; whilst his wishes and feelings were heard and informed decisions around him remaining in placement, his voice is not given this same weight during the placement, particularly when it contradicted that of FC Adult Z.

In respect of Child Y, there is evidence of practitioners sensitively considering matters affecting him as they sought to meet his care and support needs, and of positive use of advocacy, with Child Y's voice and wishes and feelings being central.

Identified Good Practice

- Child X was allocated an Independent Advocate.
- Child X always attended Child Looked After reviews and his views were recorded with Independent Advocacy provided.
- A personal visit to Child X was made by the Team Manager following a complaint Child X made, with written follow up detailing Child X's concerns and the process for response.

- There is evidence of positive use of advocacy with Child Y's voice and wishes and feelings being central, for example, within the August 2019 Pathway Plan which was developed in partnership with him.

Placement Planning and Matching

Throughout the merged review period timeline of 2017 – 2020 that included Child X and Child Y's placement with FC Adult Z, it is evident other multiple placements of children with complex histories and profiles were made. These included When I'm Ready arrangements, hosting young people in placement beyond their 18th birthday. Some of the known behaviours of these children were identified to potentially present a risk to younger or more vulnerable children and they were assessed as needing sole and/or ringfenced placements, with restrictions on the numbers of other children who should be placed with them. Amendments were made to FC Adult Z's registration status weeks before Child X's placement, and this enabled both him and other children to be placed in the household alongside existing placements.

The reviewers have not seen evidence to confirm that appropriate pre and post placement risk assessments were routinely undertaken as was required, neither in respect of the multiple placements of young people with known complex profiles and histories, nor in the context of Child X's identified care and support needs when he is placed in 2017. This includes a review by the Fostering Panel which should have taken place to consider When I'm Ready Arrangement to reflect change of circumstances, including the potential impact of the changed status on children/young persons in placement.

Child X

In recognition of Child X's Adverse Childhood Experiences and identified needs, the Fostering Placement Request form notes that a foster carer 'who can provide Child X with a high level of care, support and supervision' is required. In addition, Child X needed to remain in the local area so that he could continue in his current school and maintain important relationships and links to the community.

At the Initial Child Looked After review, the Independent Reviewing Officer (IRO) directs that independent fostering agency placements be pursued. Children's Safeguarding report notes there is no evidence on Child X's file that this was pursued; however, the Fostering Service report notes 'extensive searches …both internally and externally…with several IFAs being approached'.

Direct communication between the fostering service and children's services appears to have been limited, with no open access to fostering records – as is the case in all local authorities. This highlights the importance of having mechanisms to facilitate the sharing of/access to appropriate information. The practitioners' understanding at the Learning Event was that this was due to confidentiality and incompatible systems. The need to proactively and regularly share information between practitioners and across organisations is well documented[14] and frequently emerges as a theme in learning arising from Practice Reviews. Convening of Professionals' or Planning Meetings involving all the social workers of children in placement and the fostering social worker would have

[14] SSWBA Guidance Working Together Information sharing to safeguard children 2019

ensured the shared understanding and approach required to inform care planning and to appreciate the collation of concerns.

Whilst an Essential Information Record had been completed in respect of Child X's placement, completing a more detailed Matching Document would have ensured a consideration of the care and support needs of the young persons already in placement. Child X's placement with FC Adult Z was within the foster carer's fostering registration terms of approval, and the most recent review of foster carer suitability advised careful matching if placing another child or young person with the two young persons in placement.

In 2017, it was evident that placement changes within FC Adult Z's household were frequent. Child Y's placement with Adult Z in June 2017 is the second placement made within a thirteen-day period. Other children in the household left the placement in an unplanned way for reasons that remain unclear, and statements were made by other children that FC Adult Z was seen to be drunk to the extent he had passed out whilst in care of the children.

Eight young people in total were placed for short periods of time during Child X's review period, with eight temporary changes of approval. It is not clear whether there were rigorous processes in place in respect of matching to adequately consider the known complex needs of the other young people in placement. Information from FC Adult Z's annual review does not detail how the differing individual needs and any associated risks are to be managed.

The above portrays a reactive placement planning approach devoid of the expected proactive management and matching of placements, of assessments of risk, and analysis of incidents or events and their implications, not only for the resource but most importantly, for the individual children and young person(s) within the placement; in respect of whom the local authority exercised statutory corporate parenting duties and responsibilities.

Of the five young persons in the foster placement during the period June – September 2017, the ending of Child X's placement is the third unplanned ending, again triggered by challenges in managing behaviours.

There are references to a Disruption Meeting following Child X's departure from placement, however, it is not possible to verify whether this meeting took place or not, due to contradictory information from a variety of sources. There is a reference to a November 2017 decision that Child X should be placed alone in subsequent placements.

Cleaver and Rose's (2020) review of Serious Case Reviews involving children and young people placed with alternative caregivers is relevant in this regard. They conclude that failing to appreciate a child/young person looked after's particular vulnerability is a common finding, with assessment and matching not always taking into account the complex care and support needs of young people. This resulted in a resource-led rather than a needs-led, 'conveyor belt approach to placements', a concept which could be applied to the frequent changes evident in FC Adult Z's household.

It is difficult to determine which children/young persons were in placement at any specific time, and whether the foster carer's terms of approval, including exemptions, consistently reflected the children/young persons placed. There is a sense of the terms of approval being amended to reflect a continuously changing placement composition and the young persons in placement, rather than the terms of approval providing a structured framework for appropriate placements.

For example, a fostering exemption to enable the placement of four children/young persons covers a five-day period in June 2017. This was a 'verbal agreement', with the documentation signed by the Agency Decision Maker in November 2017, and it is unclear whether all temporary approval changes were presented or reported to the fostering panel. There is no record that the respective social workers nor IROs of the children/young persons in placement had been consulted about this proposal (as would be expected).

More robust quality assurance would have resulted in exploration of key areas including previous concerns, the rationale for respite placements and for the increase in numbers only six months after the previous decision, and how these changes are reconciled with the advice for careful matching.

The local authority is required to ensure that placements safeguard and promote the child's well-being and meet their needs as set out in the child's Part 6 Care and Support Plan (which is reflected in the Placement Plan). They must also ensure the placement is the most suitable one in regard to all the circumstances, and that the proposed placement is consistent with the foster carer's terms of approval.[15]

A robust assessment of care and support needs as reflected in the child/young person's Care and Support Plan[16] (CSP) ensures a fully informed matching process. The Placement Plan[17] should reflect the CSP and be supported by a fit for purpose Safe Care Agreement and Risk Assessment[18].

Limited resources and lack of placement choice highlights the difficult professional judgements required in balancing complex variables in care planning and placements. Emergency placements of up to six days are permissible, via a time limited exemption to the agreed foster carer terms of approval, on the basis that: 'the carer has the capacity to meet the child's needs, taking into account the needs and feelings of any other children in the household'.[19]

Child Y

Child Y had been in placement since June 2017, approximately 22 months prior to the start of the review timeline period. Child X was already in placement when Child Y was placed, however, it does not appear that the views of Child X's social worker were sought as part of Child Y's placement planning, as would have been expected in terms of robust matching practice. Furthermore, Child Y's matching form did not capture a consideration of the other young people in placement, nor did it reflect all of the relevant issues which were significant in terms of safe care.

During Child Y's timeline period (from April 2019 onwards), whilst there is another When I'm Ready arrangement which ends in an unplanned way, generally placements appear to be more selective, with regard given to Child Y's educational needs.

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[15] The placement of children and young persons with foster carers is governed by the Care Planning, Placement and Case Review (CPPCR) (Wales) Regulations 2015 and the Social Services and Well-being (Wales) Act 2014 Part 6 Code of Practice (Looked After and Accommodated Children).
[16] CPPCRR 2015 r.5 & Schedule 2
[17] CPPCRR 2015 r.10 & Schedule 3
[18] e.g. Adams CoramBAAF 2021
[19] Part 6 Code of Practice para.171

Identified Good Practice

- Education strived to maintain Child X's place on school roll in order to support continuity for him, with a desire to maintain this in his long-term placement.
- The Fostering Service undertook extensive searches for an appropriately matched fostering placement, including independent fostering agencies, supported by an updated positive profile of Child X.

Learning

- The nature of placement planning activity during the timeline period clearly demonstrates the need to ensure that placement planning is undertaken with due consideration to the needs of the child/young person, all those currently in placement and members of the household, to ensure this is needs-led rather than resource-led.

Monitoring and Reviewing the Child's Placement

The role of the Independent Reviewing Officer (IRO) is enshrined in legislation and regulations[20] and is pivotal to the monitoring and review of placements. The IRO should be informed of any significant change in the child's circumstances, including safeguarding concerns involving the child, and their views sought in respect of any changes which may impact on the child or young person.

However, the Child Looked After review is not a substitute for safeguarding procedures:

'The focus of a child looked after review is on care planning, not on risk management and safety planning. Risk and safeguarding issues are not routinely discussed, and the full multi-agency group is not included' (Cleaver & Rose 2020).

Any proposed change in the child's plan should be considered at a review, and the IRO must be informed of any significant failure to action review decisions or any significant change of circumstances occurring after the review that affects those arrangements.[21]

Positive aspects of practice included consistency of IRO during the timeline period, by an IRO who had also chaired the relevant previously held Child Protection Conferences. Child X attended the majority of his Child Looked After Reviews, and his wishes and feelings were ascertained and supported at reviews by an Independent Advocate. However, statutory visits to Child X and child looked after reviews did not consistently comply with the relevant legislation and regulations. These were undertaken by several different social workers, and his family time with members of his birth family was supervised by four different contact supervisors. In addition, changes to his care plan

[20] Social Services & Well-Being (Wales) Act 2014 s.99 – 102; The Care Planning, Placement & Review of Cases Regulations 2015; Code of Practice Part 6 Children and Young People Looked After and Accommodated; Independent Reviewing Officer (IRO) Protocol between CAFCASS Cymru and the Association of the Directors of Social Services (ADSS) Cymru (2018); Practice Standards and Good Practice Guide Reviewing & Monitoring of a Child or Young Person's Part 6 Care and Support Plan (AFA / WG).

[21] Care Planning Placement and Case Review (Wales) Regulations 2015 r.43

were not always ratified by the IRO, and there appears to have been very little supervision of the social worker during Child X's placement, and 'minimal evidence of managerial oversight'.

Child Y had a stable and consistent IRO for two and a half years. The same IRO was responsible for Child Y's siblings, which ensured an overview and enhanced understanding of the individual and group care and support needs. The IRO endorsed changes in the contact arrangements and met with Child Y prior to his Pathway Plan Reviews, which Child Y attended. The reviews were held within timescales and were outcome based, denoting attributable actions and timescales.

The IRO Review Report contains the statement, 'Child Y's placement with [FC Adult Z] has been excellent'. The local authority has expressed that, in its view, the IRO should reference the social worker assessments, rather than make a direct unqualified assessment of the placement quality. These learning points helpfully identified by the service are a good example of early learning being identified and implemented.

Identified Good Practice

- Children's Safeguarding Analysis Report evidenced a high level of communication between the children's team and the foster carer during Child X's placement, and with birth family, with a high level of supervised contact.
- There was a consistent Supervising Social Worker (SSW) and Team Manager support during Child X's placement period, along with regular weekly diary recordings, countersigned by the SSW and shared with Child X's social worker.
- Changes to Child Y's Care Plan were ratified by the IRO.

Learning

IRO Service

- The IRO service must audit statutory visits and report non-compliance with legislation and regulations.
- The IRO service must audit whether changes to the child's Care Plan are ratified by the IRO.
- IROs should utilise social worker assessments to support and inform assessment of placements.

Suitable to Foster/Continuing Suitability and Supervision of the Foster Carer

FC Adult Z and his household were approved as 'suitable to foster'[22] in 2008, with a total of twenty-seven placements of children/young people over a twelve-year period. This Child Practice Review does not consider FC Adult Z's total fostering career, as the consideration is limited to the timeline periods of January 2017 – May 2018 (Child X) and April 2019 – April 2020 (Child Y).

[22] In accordance with the Fostering Services (Wales) Regulations 2003 r.27 & r.28

After this initial approval, annual reviews[23] would have been held to determine whether the foster carer and his household continued to be 'suitable', and that the terms of the approval continued to be appropriate.[24] Any significant change of circumstances and/or concern about the foster carer or household suitability in the intervening periods would necessitate an earlier review of suitability. The first review must be presented to the Fostering Panel, whose recommendation informs the Agency Decision Maker's decision making. The Chair of the Fostering Panel must be independent of the fostering service.[25]

The January 2016 Review had limited registration to the two young persons in placement.

The January 2017 Review had extended the registration to three children, with clear directions to carefully match with the two children/young persons in placement.

The May 2018 annual review was overdue by four months and due to a change of Supervising Social Worker, did not cover the period of Child X's placement (February – September 2017) at all, during which many concerns had been highlighted. As a result, this review was not fully informed and should have resulted in a panel deferment for more information. The panel's recommendation of continuing suitability then informed the Agency Decision Maker's endorsement.

There were several incidents which should have triggered an early assessment of continuing suitability and formal consideration by the Fostering Panel (detailed in the next section under **Concerns Continuum)**; these incidents were not always included in subsequent reviews of suitability. Some of the incidents should have been considered in accordance with the relevant safeguarding procedures[26].

The local authority operates two foster panels, a 'main' fostering panel and a 'foster carer annual review panel', at which annual reviews that do not require consideration at the main or 'full' foster panel are presented. This 'review' panel consists of a Panel Chair, (Independent Chair of the main Fostering Panel), Panel Adviser (Team Manager) and Panel Minute Taker. A full fostering panel including designated roles and independent panel members, in accordance with fostering panel regulations, is held for all new assessments and new approvals and any reviews where there has been a significant change of circumstances or a report/complaint/standard of care concern.

The Fostering Service queried within the review process the independence of the current foster carer annual review panel and recommends a review of the membership and function of this panel. The reviewers agree with this recommendation as a means of ensuring robustness, considering the critical role of the fostering panel in ensuring the well-being and welfare for children looked after and accommodated. However, it is also important that a mechanism is in place to ensure that all reviews are directed to the appropriate 'fostering panel' for consideration.

Concerns Continuum

The timelines attached to this review detailed a number of concerns in relation to activity in the placement, which will be outlined below.

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[23] Under the Fostering Regulations 2003 or subsequent Fostering Panel Regulations 2018 r.8 & r.9
[24] Fostering Regulations 2003 r.29(4)(6)): Fostering Panel Regulations 2018 r.8 & r.9
[25] Fostering Panel Regulations 2018 r. 4 (1)(a)
[26] 'All Wales Child Protection Procedures 2008 Part 3 'The Child Protection Process', Part 4.3.2. 'Allegations of abuse against a foster carer'

Visitors to Placement

There were a number of individuals who visited and/or stayed in the placement without this being fully understood by services, leading to an incomplete picture of the household and of the daily lived experiences of the children and young people placed there. Within this context and during this period, a number of concerns and incidents came to light within the placement. This includes statements made by children in respect of the actions of other children within the placement, serious questions regarding FC Adult Z's care and supervision arrangements of the children and young people he was responsible for within the home, and inappropriate and unauthorised persons visiting the home.

Information submitted as part of the timelines and analysed by the reviewers and panel has identified a clear pattern of behaviour by FC Adult Z, and inaction by the local authority fostering team, in which FC Adult Z minimised and dismissed the concerns and incidents. His view, opinions and account of events were believed above and beyond the children's, with inadequate questioning and professional curiosity, and safeguarding procedures were not instigated when they should have been.

For example, in one incident where Child X reports that he has been physically and verbally assaulted by another young person, it is recorded that safeguarding advice was sought and obtained: 'for this to be investigated and SW to visit today and decide whether it warrants a strategy and possible s.47 investigation'. On reflection and with the benefit of hindsight, a strategy discussion/meeting involving the police should have been held in advance of any 'investigative' visit (as had been directed by a Safeguarding Manager). This would have provided a multi-agency opportunity to quantify concerns and agree a coordinated response. The social worker visit 'to investigate' replaced the strategy discussion/meeting and resulted in a decision that should not have been determined in a vacuum outside of the safeguarding procedures. Defensible decision making requires that a decision not to take any further safeguarding action must be fully informed, evidenced, and recorded, and fed back to the referrer. A decision was made not to instigate formal safeguarding procedures, and this is one of many instances in which FC Adult Z's account was accepted without question or further interrogation.

In addition, there are three known incidents during May – August 2017 of young people other than those formally placed visiting, and in the case of two incidents, staying at the foster placement. Later, in June 2019, during a telephone conversation between FC Adult Z and a supervising social worker, reference was made to an 'overseas visitor' staying at the house. It was not the focus of the discussion, nor does there appear to have been any planning, seeking permission or consent given for this arrangement; there are no action points noted. It is not known whether this was an isolated incident, whether it had happened before or whether it was a regular occurrence. This serves to illustrate the incomplete picture as to other persons visiting and/or staying in the household, and that risk assessment processes appear not to have taken place in terms of the well-being of children and young people within the placement.

Alcohol

Concerns relating to the consumption and use of alcohol by FC Adult Z has been identified as a theme throughout the review timeline period, as expressed by one young person in June 2017 at the end of their placement (documented earlier in this report).

Further information contained within Child Y's timeline adds further context and indicates FC Adult Z recorded in his weekly foster carer recordings in December 2019 that Child Y had been at a party and had been drinking alcohol. A second alcohol incident is noted during March 2020 at another party. The use of alcohol features in the report of abuse, with references to both Child Y and FC Adult Z drinking alcohol, and to FC Adult Z having helped Child Y to bed on a couple of other occasions.

Concerns related to Technology

The review timelines evidenced multiple concerning incidents related to technology use within the placement, which did not appear to have been fully recognised, explored and/or addressed in terms of whether the young people in placement were being appropriately supervised in their technology use. Furthermore, FC Adult Z was identified to have an unmet training need in respect of IT, which was not followed up despite technology-related concerns arising on more than one occasion across the review timelines.

Incidents leading to Police Involvement

There were four incidents which resulted in Police involvement. In August 2017, a call was made at 2am by Child X and Child Y to the Police expressing concern about 'noise downstairs'. There is reference to the Police attending and leaving, following a discussion with FC Adult Z. This was a very strange incident which has still not been properly explained. It was clearly understood from the Police record that this was a foster carer household, however, it is not clear whether this incident resulted in a Police report to Children's Services, neither is there a record that this incident was followed up by local authority by liaison with the Police.

It does not appear that these incidents were identified and responded to by the local authority as safeguarding concerns, nor as concerns about the suitability of a person in a position of trust under safeguarding procedures; nor as concerns of 'continuing suitability to foster' under the fostering regulations.

There are many entries from a variety of sources regarding an incident in September 2017, of a reported physical altercation between Child X and Child Y, whereby the police attended following a call from Child X. FC Adult Z reported that the police were of the opinion that the incident did not warrant a 'call out' and had advised Child X to take his medication. FC Adult Z requests that Child X leaves the placement, noting that: 'Child X is a high risk not only to him but also to the other two young people in his home'; as a result, Child X was placed in another foster placement.

This incident of physical conflict between two young persons in placement necessitating Police intervention does not appear to have resulted in a Police referral to children's services, despite it clearly being identified as a foster placement. There is no evidence that the Police were contacted by children's services for further information or clarity about the incident. Child X's case file contains a reference to him having made an allegation against FC Adult Z, however this is not expanded on further. It also notes that there is no evidence that Child X was asked about what had happened on that evening, nor indeed about his time in placement, until the Exit Interview in May 2020, almost three years later.

There is no evidence that the incident was considered in respect of the suitability of the placement or foster carer. There is reference to FC Adult Z completing a 'Low Level Concern Report' in respect

of this incident; the status of this mechanism is unclear, as is whether any further consideration was given to this. This incident is not referenced nor addressed in the next annual foster carer review of suitability in May 2018.

Identifying and Responding to Concerns

A child may be subject to abuse, neglect, or other kinds of harm by any individual(s) and in any setting. The concepts of safeguarding and protection are not separate nor distinct from a looked after or accommodated child, nor from alternative care settings or caregivers. A child who is looked after or accommodated may require care and protection, as well as care and support, at any time.

It is important to clarify that no report of abuse or harm, nor expression of concern that FC Adult Z posed a direct risk to children or young people, was received from any source, including from those working with or alongside FC Adult Z.

Expressions of concern about the welfare and well-being of children and young persons are not limited to direct reports of abuse, neglect and/or harm in respect of a specific child or children. There is a fluid continuum which extends and encompasses expressions of concerns, complaints, standard of care matters and allegations. The Fostering Network document 'Allegations, Concerns and Complaints' (2022) contains helpful definitions in the context of fostering, including of 'complaint', 'concern', 'standards of care', and 'allegation'.

The local authority and fostering service must have policies and procedures which distinguish between these aspects and detail the appropriate response, whether under the Complaints and Representations processes; reporting to regulatory bodies such as Care Inspectorate Wales in respect of standards of care; and/or implementing safeguarding procedures.

The exercise of professional judgement is required to quantify the level of concern, harm and/or risk and to determine whether a concern or complaint or a standard of care matter constitutes a higher level of concern necessitating a different response. The nature of a concern or complaint or an accumulation of expressed concerns or complaints, when considered together, may culminate in a consideration under safeguarding procedures and/or of suitability to work with children.

Where there is 'reasonable cause to suspect' that 'a child is experiencing or is at risk of experiencing abuse, neglect, or other kinds of harm'[27] or the local authority 'have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'[28], safeguarding procedures must be implemented. It is noted that these procedures do not appear to have been formally triggered in response to incidents and expressions of concern in this case.

Individual children's Safe Care Plans are relevant in this regard[29]; the reviewers note references to post placement 'Safe Care Plans' within the Fostering information provided to the review, however,

[27] SSWBA s.130
[28] TCA 1989 s.47(1)(b)
[29] Adams (CoramBAAF 2021): 'Safer caring is about keeping children safe in foster care, but it is equally about protecting foster carers and their families from complaints and allegations… [Safe Care Plans] should exist, should be reviewed on a regular basis, and should be updated where necessary. As a minimum, this should be at each foster carer review, and following the placement of any child into the foster home, taking into account any identified new risks that this may bring'.

it does not appear that individual Safe Care Plans were routinely applied in practice, nor amended in response to reported incidents and stated concerns.

Person in a Position of Trust

The consideration of safeguarding concerns involving a foster carer as an 'adult in a position of trust' is a key theme in this review. The respective procedures must be applied when it is alleged that a person who works with children has: behaved in a way that has harmed/may have harmed a child; may have committed a criminal offence against a child/that impacts a child, or behaved towards a child in a way that indicates they are unsuitable to work with children, or where there are concerns about their ongoing suitability to work with children. Concerns about a member of the foster carer household must also be reported.[30] Where, upon receiving a report of a safeguarding concern, a strategy discussion is held to decide if threshold has been met for a Professional Strategy Meeting under Section 5 of the Wales Safeguarding Procedures. If threshold has been met, the Designated Officer for Safeguarding (as delegated by the Local Authority Designated Officer) will convene the strategy meeting. In respect of a foster carer and household, a decision not to trigger child protection procedures does not mean that the matter should not result in a consideration of continuing suitability under the fostering regulations, as they are differing thresholds. Despite the points of concern noted earlier in this report, there is no evidence that there had been a consideration of implementing either the Person in a Position of Trust nor the 'continuing suitability' procedures.

It has not been determined whether a record of previous complaints and/or concerns in respect of FC Adult Z and/or other members of the fostering household including young persons placed exists. This is a regulatory requirement[31] which ensures that professional judgements about continuing suitability and placement 'matching' are fully informed and robust.

It was evident from discussions at the Learning Event that FC Adult Z was held in very high esteem by his peers and the professionals he worked with; professionals expressed that they 'were in awe of him'. FC Adult Z was an experienced foster carer over many years and was involved in the preparation of foster carers.

For this reason, it appears that the weight given to the accounts of the foster carer himself at times overshadowed a consideration of the children's own experiences in placement. It is possible, therefore, that the established status of FC Adult Z as a good and trustworthy foster carer preceded him and made it difficult for professionals to identify and escalate areas of concern.

The risk factors in the placement, including the individual and combined complex care and support needs of the children/young persons, do not appear to have been fully appreciated. The emerging information/concerns about developments and issues in placement did not trigger the required multi-agency safeguarding and/or early assessment of continuing suitability and formal consideration by the Fostering Panel, as would have been expected. Only one of the concerns was included in the May 2018 review of suitability presented to the review fostering panel.

[30] All Wales Child Protection Procedures 2008 Part 4.3.2 (during Child X's timeline) and the Social Services & Well-Being (Wales) Act 2014 Part 7 Code of Practice Volume 5 (paras 60 – 64) and The Wales Safeguarding Procedures 2019 Section 5 'Safeguarding Allegations / Concerns about Practitioners and Persons in a Position of Trust' (Child Y's timeline).

[31] The Fostering Regulations 2018 r.20(4)

Supervision of the Foster Carer

Whilst supervision visits were generally held monthly, they did not always cover what was happening for all the children/young persons in placement (including post 18 arrangements) and lacked evidence of robust challenge. Records indicated there were plenty of opportunities to explore in detail with FC Adult Z his version of some events that occurred in placement referenced throughout this report, particularly in response to some of the statements made by some children against others, however, it appears his version was accepted irrespective of there being a wider context to some of the incidents that occurred.

Foster carer diaries were completed weekly, signed, and shared with Child X's social worker, which was good practice. These recordings provided opportunities to explore the foster carer's actions and thinking in more detail; in one record, a reference is made to Child X being "in need of attention" and "seeking out comfort". Further discussion of this may have informed the safe care planning that was known to be needed within the context of matching and potential risks and vulnerabilities linked to other young people in placement.

There is no evidence that entries reflecting the challenges of caring for three children/young persons with complex care and support needs were followed up with further visits and actions. It does not appear that FC Adult Z was encouraged to become more trauma informed in his caregiving approach.

In relation to supervision of the foster carer during Child Y's timeline, the annual review of suitability was held within timescales, and was informed by the views of young people in placement including Child Y. It also included reference to the two 'When I'm Ready' arrangements' proposals (one proposed), for which Head of Service approval had been given. It is evident that the 'When I'm Ready' arrangements were more well embedded during this period than during the earlier timeline.

However, the annual review should have considered details of all the young people cared for during the review period, including any other change in household membership, as well as visitors. Individual safer care agreements should have been on file and updated to reflect known developments, such as alcohol use and other sensitive matters highlighted earlier. In addition, any Agency Decision Maker (ADM) agreement to a 'change in approval terms' should be in writing as well as given verbally, and a foster carer's 'Personal Development Plan' should include identified training needs. The need for IT training for FC Adult Z, in respect of his own IT literacy and in respect of the management and monitoring of IT use by young people in placement, had been an identified need over a period of many years, as has been evidenced earlier in this report.

It is reported that there was regular supervision throughout the timeline period, including weekly phone calls due to the Covid-19 restrictions during the month preceding the report of abuse, with informative weekly diary foster carer records.

There is no evidence, however, that the identified sensitive aspects of Child Y's care and support needs, including the use of alcohol, were considered during supervision sessions; nor was the reference to an overseas visitor. Supervision needs to be curious, questioning and reflective, with clear actions, and with outcomes and progress revisited at each supervision.

Reflections throughout this review have further concluded that there had been an unidentified training need in respect of the foster carer in respect of meeting some of Child Y's individual needs.

We did not find that this aspect was a central theme in this review, however, this does not minimise the importance and relevance of those findings, and the agency has identified lessons to be learned in this regard.

Foster Carer Role

The role of the foster carer is detailed in the Foster Carer Agreement: 'provide care and support to a child placed…in accordance with the child's Care and Support Plan and in a way which maintains, protects and promotes the safety and well-being of a child'.[32] This theme will be explored below with consideration of Child X and Child Y's timelines.

FC Adult Z's foster carer recordings are a central and primary source of information for the timeline. This appears to reflect his central role in the 'management' of Child X's case.

Generally, FC Adult Z appears to have had a disproportionate amount of control/exercise of delegated parental responsibility and influence. In the absence of a delegated authority document, and as a foster carer with no element of formal parental responsibility, FC Adult Z undertook a great deal of liaison and discussion with key personnel, birth parents and school. This would be expected of a foster carer in respect of day to day management of matters. However, it is evident that FC Adult Z's role and remit extended beyond this at times: in the management and monitoring of a medication reduction programme; in the setting of rewards and consequences as part of behaviour management, including withholding of swimming sessions and a school holiday; in holding and controlling the child's money in the foster home; and in permitting the partners of young people in placement to stay.

Extending FC Adult Z's role may have been functional for the local authority, particularly in the context of limited resources and a willing, experienced, and perceived competent foster carer. However, more oversight may have highlighted the need to realign expectations. FC Adult Z's extended role and remit resulted in a corresponding blurring of boundaries and accountability, placing him in a perceived and actual position of control in orchestrating key areas. This would serve as an additional barrier to a report or expression of concern by a child/young person, and in respect of exercising professional challenge. Once established, it would be difficult for those demarcation boundaries to be reinstated. It is known from earlier information within this report that FC Adult Z did not always accept the advice and guidance of social workers regarding safe care practices and other young people who visited the home.

'Disguised compliance' can be manifested as 'the apparent willingness to co-operate with agreed plans that are not followed through, and is used as a way to keep practitioners at a distance'.[33] It is known to have an eroding impact on practitioner confidence and their capacity to challenge:

'Professionals should not unquestioningly accept presenting behaviour, excuses or reassurances that carers have changed or will change the way they care for children'.[34]

In practice, this is generally applied to birth parents, however, it is equally relevant to others, including foster carers.

[32] The Fostering Panels Regulations 2018 at Reg. 2 & 11(2)(e) and Schedule 3
[33] Reder et al 1993 in Cleaver & Rose 2020 p.105
[34] Cleaver & Rose 2020 p.104

If there is no opportunity for reflectiveness and in the absence of rigorous supervision or a critical friend approach, these barriers can become impermeable, and result in an environment which is vulnerable to exploitation of both the professional relationship and of children and young people looked after or accommodated.

It is known that FC Adult Z held and controlled money gifted to Child X by his parent. There are no recorded discussions with the Social Worker/Supervising Social Worker regarding these financial arrangements. The Fostering Regulations 2018 confirm the importance of clear procedures to safeguard the foster carer, and the child/young person from financial abuse.[35]

FC Adult Z's caregiving approach is not reflective of trauma-informed caregiving; this is demonstrated in the decisions taken by FC Adult Z to withhold swimming and cancelling Child X's school holiday. FC Adult Z is central in the arrangements for the proposed school holiday; it is FC Adult Z who provides the consent forms for Child X's birth parent, and Child X reports to a family member that FC Adult Z is paying for the holiday. There is no evidence that the decision to exclude Child X from the holiday was a joint one, nor that there had been any discussion with the local authority, Child X's corporate parent. It is reported that FC Adult Z had decided that Child X will not be going as he had failed to complete sufficient homework. This decision was taken during a period when Child X was experiencing a great deal of personal turmoil and isolation.

FC Adult Z also had a pivotal role in Child Y's life: in supporting contact with key family members, and with issues of bereavement and loss; in taking Child Y to view universities; in providing transport to and from parties; and in providing a listening ear to personal worries and concerns including personal relationships, mental health and aspirations for the future.

Health records note that during an annual Child Looked After health assessment, Child Y was given routine health advice and advised to 'report any concerns to [FC Adult Z] or GP'. Whilst it is noted that Child Y was seen alone by the health professional, it is evident that FC Adult Z was present for part of the consultation. Within the context of the subsequent report, this aspect does warrant a further consideration of how to balance the valid role of foster carers in promoting health with the need to ensure that appropriate parameters are set.

During October 2019, Child Y's post 18 arrangements are discussed and confirmed. It is reported that Child Y confides in FC Adult Z about his personal relationships, and FC Adult Z is very involved in dealing with and supporting Child Y in respect of highly sensitive family issues. It is noted that Child Y had shared information with FC Adult Z about his mental health and that Child Y did not want this information shared with the social worker in case it affected his education and job; 'Child Y wants to 'be successful and get a good job so that he can look after his own children properly'.

There are two references to Child Y's use of alcohol, both at friends' parties. It is noted that FC Adult Z provides transport and ensures that Child Y gets home safely. Previous concerns about the use of alcohol had been expressed by another young person in June 2017. In the months preceding the report of sexual assault, it is reported that Child Y is drinking alcohol at friends' parties. Ensuring a young person's safety is a key foster carer competence; FC Adult Z provided transport and the incident is recorded in the weekly foster carer recording. The use of alcohol features in the report

[35] (Reg.45(2)).

of abuse, with references to both Child Y and FC Adult Z drinking alcohol, and to FC Adult Z having helped Child Y to bed on a couple of other occasions.

The Placement Plan clarifies how the day-to-day parenting tasks will be shared between the foster carer and the local authority and set out the circumstances in which the foster carer must obtain prior approval by the local authority or parent.[36] In respect of 'accommodation', the birth parents retain sole parental responsibility[37]; when the child is looked after under orders, parental responsibility is shared between the birth parents and the local authority as corporate parent[38]. Irrespective of the child's legal status, the foster carer has no parental responsibility for the child. To ensure that the child's daily lived experiences are as normal as possible, elements of parental responsibility are delegated by the means of a Delegated Authority document. However, no such arrangements were in place in respect of FC Adult Z, despite him having played a central role in numerous matters relating to the care of both Child X and Child Y.

The Reports of Abuse

The accommodated or looked after child is doubly disadvantaged, being more vulnerable to abuse, harm and neglect and inversely less likely to report abuse for a variety of reasons including conflicted feelings, foster carers' positive reputation and concern that they may not be believed.[39]

The Independent Inquiry into Child Sexual Abuse recommends the following steps to reduce barriers to reporting: ensure that children are listened to; have access to a trusted adult outside of placement, including independent advocacy; have clear complaints and whistle blowing procedures; and effective Missing/Absent from Home protocols.

Whilst Child Y reported promptly following the incident of abuse, Child X did not make a report for a number of years. This section will consider facilitators of and barriers to reporting abuse, through the lens of Child X and Child Y's timelines and their own perspectives and views.

Child X

In total, Child X was involved with four social work teams, six social workers and five different Independent Reviewing Officers. During the reviewers' meeting with him, Child X confirmed that whilst he had developed positive relationships with individual practitioners and continued to have contact with some, changes in key personnel made it difficult to develop trusting relationships and to be able to express concerns to trusted adults. Child X did not feel that he would be listened to and was unsure as to who his trusted adults were.

During a clinic appointment Child X attended following the ending of the placement, he referred to the altercation between him and Child Y in September 2017. Whilst it is noted that the incident had been reported to the police at the time, the Health Board analysis notes a need to triangulate information and promote professional curiosity, as this information had not been further verified at the time.

Following the ending of Child X's placement, he complained of physical pains in his stomach. During a November 2017 contact session, Child X reported a further medical complaint, which could have

[36] Part 6 Code of Practice paras 241 – 261
[37] S. 76 of the SSWBA
[38] The Children Act TCA 1989 s.31, s.38
[39] Cleaver & Rose 2020 p.65-66

prompted concern as a potential indicator of child sexual abuse. It is reported that there is no evidence on file that this was explored further or shared with health professionals.

Whilst the review timeline in respect of Child X does not expressly include the statement of abuse and the months preceding this, it is relevant and appropriate to consider available learning. The statement was made following a series of 'missing from home/absent without permission' episodes; six separate instances in total over a ten-month period prior to his report. Child X's 'missing from home' incidents were noted to have been a significant behavioural change which followed his 'Exit Interview', conducted following the report made by Child Y.

This highlights the importance of consistently applied protocols[40] and is particularly significant when considering research in relation to child sexual abuse[41] that highlights the "pressure cooker effect" that can be experienced by young people that wish to report but feel unable to, or unsure as to how to do so. It is important, therefore, to emphasise earlier learning identified which encourages the consideration of whether new triggers may underpin a child or young person's behaviour.

In relation to the Exit Interviews, Child X remarked that a one-off interview not instigated by the young person is unlikely to lead to the sharing of such sensitive information, particularly if the young person has not been believed in respect of previous concerns. This report has set out examples within Child X's timeline of his accounts of events not having been believed, and in particular, the accounts of FC Adult Z having been put above his.

Child X suggested that this should have been a process rather than a one-off meeting, and that 'follow ups' and information about support would be helpful. Child X recommended the use of the 'A Mind of My Own One App' (Action for Children) as a means of facilitating direct access to trusted adults in a safe and timely way, and felt that this mechanism would be more effective than relying on the child to share concerns during a social worker visit in the home of a foster carer, who may be the source of the concern. This highlights the importance of statutory visits and seeing the child outside of the placement, as well as within the home.

The statement itself was made outside of office working hours, and as a result, was not dealt with in accordance with the timescales set out in the Wales Safeguarding Procedures. There is a need to ensure that the Emergency Duty Team is equipped to respond to child protection concerns/reports and to comply with procedures.

Child X did not attend court as he had been able to give his evidence on video beforehand; he had also prepared a Personal Impact Statement. He regretted not having had 'his day in court' and would have valued being able to share his 'Personal Impact Statement'. It is understood that the Personal Impact Statement is considered formally only on conviction.

Child Y

Child Y had a supportive friendship group, from which he had sought advice prior to making the statement of abuse. He confirmed that it was a combination of these supportive environments which enabled him to report; 'I talked to my friends, and they told me what to do'. Whilst it is not possible to determine what may have happened if Child Y had been less well supported, the absence of

[40] Fostering Regulations 2018 r.25 and the WSP 'Missing from Home or Care' Good Practice Guide.
[41] See, for example, McElvaney, Greene, and Hogan (2012)

support would have increased his vulnerability, particularly within the context of the Covid-19 restrictions which had just been put in place and which were to extend for significant periods of time.

A counselling service and pastoral care was available at college. Child Y developed a supportive relationship with his college tutors, and he reported the assault to a tutor via a telephone call the day after the incident, even though college was technically closed due to the March 2020 Covid-19 restrictions. This serves to emphasise earlier learning highlighted in relation to the importance of children and young people having trusted adults who they feel able to approach for support, noted at the beginning of this section as being a key means of reducing barriers to reporting[42].

Following the telephone call, his social worker went to meet him. Child Y reported that his experience of reporting, though stressful, had been positive with an immediate and positive response, with effective and responsive compliance of child protection procedures post report from all agencies. The successful conviction endorsed and validated his experiences of abuse and related trauma.

Identified Good Practice

- At the point of Child X's report, all actions were taken in a timely manner by the Police, who sought to engage and build rapport with Child X, and explained the use of the 'Victims' Code Rights to Review' process[43], with Child X supported to appeal the Crown Prosecution Service's decision not to proceed to court.
- Child Y's report was dealt with in accordance with procedures.
- Early identification of support needs in terms of emotional support and procedural compliance by Education colleagues following Child Y's report.

Review Subjects' Perspectives and Reflections

- Child X appreciated the support given to him by the Police before the trial and court process which took place in 2021, but he would have valued this after the trial as well, particularly considering the outcome.
- Child X wants those involved with children and young people in care to ask them often if they are ok and ask again and again.
- Child X suggested that social workers 'walk and talk' with a child or young person as well as talk to them in placement, where there are other people in the home.
- Child X recommends that an organisation such as 'Smash Life', founded by care experienced individuals, provides training for practitioners.
- Child Y explained that he had reached out to his friends before making the report and they had advised and supported him. He feels that this highlights the importance of young people generally being informed about what to do.

[42] Independent Inquiry into Child Sexual Abuse
[43] Code of Practice Right 6.7

- Child Y felt that it was his good relationship with college staff which enabled him to report.

Learning

- Practitioners must understand barriers to children reporting and consider the ways in which these can be reduced.
- New and challenging behaviours can be indicative of children or young people expressing a trauma/wishing to share something but feeling unable to do so.
- Developing relationships with trusted adults is key in providing young people with an avenue through which they can feel safe to make a report, or to share a concern.
- When young people feel they are not listened to or believed, this can inhibit future reporting, as well as wider trust in professionals as people they can talk to for support.
- 'Disguised Compliance' is not limited to birth parents and is equally relevant to other groups including foster carers. Practitioners should exercise 'professional curiosity' in all spheres of their work.
- Mechanisms should be in place to ensure that any Police contact with a foster carer and/or fostering household leads to a report by the Police to the local authority.

Conclusions

A child who is looked after or accommodated by the local authority may require care and protection, as well as care and support at any time. The legal duty under SSWBA 2014 s.130 to report a child 'at risk' is equally as relevant to a child accommodated or looked after as it is to any child in the general population.

A child or young person accommodated or looked after is doubly disadvantaged, being both more vulnerable to abuse, harm and neglect and inversely less likely to report for a variety of reasons (Cleaver & Rose 2020 p.65-66). In addition, there are identified practitioner and organisational blocks and barriers to identifying and responding to risk, harm, abuse or neglect (J Horwath in Calder (2015); Cleaver & Rose (2020); Adams (2016 citing Munro 2018 p.6)).

Identifying abuse, harm and neglect and managing and responding to concerns, complaints and reports against foster carers demands exacting professional judgements and careful balancing of many complex variables; including the duty to safeguard and promote the welfare of the child, and at the same time, to give due regard to the rights of the foster carer to be treated professionally, consistently, and fairly.

A situation of zero risk is not attainable, however, risks can be minimised. Having clear, effective, and robust:

- opportunities for hearing the child's voice and viewing the world through the child's prism;
- placement, risk assessment and matching procedures;
- assessments of suitability and ongoing suitability to foster;

- monitoring and oversight arrangements;
- support and supervision arrangements (for both foster carer and practitioner);
- safeguarding procedures for identifying and responding to concerns and allegations, including against those in a position of trust;

creates a safer environment, conducive to making defensible and fully informed judgements, and better ensures that concerns are highlighted in a timely manner.

Considering Child Y's timeline in isolation, the reviewers acknowledge Child Y's statement, 'No one saw this coming, everyone trusted him, didn't they?', words which crystallise the absolute regard with which FC Adult Z was held. The realisation of the assault and the conviction was almost disabling in its impact and resulted in an overwhelming and absolute reality of, and sense of, betrayal. In his criminal offending against a young person, FC Adult Z betrayed agencies and practitioners, he betrayed his fellow foster carers and most importantly of all, he betrayed children and young persons entrusted to his care. This sense of betrayal was palpable in the learning events and in our meetings with Child X and Child Y.

It could not have been foreseen that FC Adult Z posed a direct risk to children and young people in placement. However, the lack of rigour and the unquestioning regard for FC Adult Z, and at times noncompliance with reviewing of suitability to foster (of foster carer and household) and with safeguarding procedures (demonstrated during Child X's timeline) enabled an environment conducive to exploitation to develop. If these elements had been more rigorously applied and considered alongside FC Adult Z's known reluctance to take advice and modify approaches, a key competence expected of a foster carer, it is probable that FC Adult Z would not have been a registered foster carer by the time of Child Y's disclosure in 2020.

The purpose of a Child Practice Review is to highlight lessons to be learnt, not to attribute cause nor criticism to individual practitioners. Hindsight provides a very privileged vantage point from which to reflect and draw conclusions. It takes place in a vacuum devoid of the competing demands and priorities and real-life challenges facing agencies and individual practitioners at the time. There is a tendency to underestimate the resource and operational challenges facing the agency and practitioners at the time, and to overestimate the capacity to have mitigated those challenges and have done something differently. The reviewers have strived to do justice to everyone involved whilst recognising that our overwhelming responsibility is to the subjects of this review and to identifying practice and organisational learning points.

Improving Systems and Practice

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

Practice and Organisational Recommendations

1. Powys Fostering Services to review their policies and processes in respect of the recruitment, review and supervision of foster carers, with a specific focus upon the quality and robustness of:
   - foster carer supervision and record keeping
   - the management of allegations against foster carers
   - placement planning and matching processes, to ensure that decisions are made with full knowledge and consideration of the needs of the child/young person and those of others in placement, with robust risk assessment mechanisms, in adherence with terms of approval and including relevant professionals in decision making
   - the annual review process including “continuing suitability”, ensuring this incorporates a robust framework for identification, consideration and escalation of any concerns or risk.
2. Fostering teams to ensure that robust processes and procedures are in place in respect of Individual Safe Care Plans, Foster Carer Agreements and Delegated Authority Agreements within the context of understanding the principles of the Social Services and Well-being (Wales) Act 2014, and the concept of who holds parental responsibility and is able to give consent regarding key aspects of a child’s care.
3. Fostering teams to ensure mechanisms are in place to facilitate children and young persons looked after’s voices and views being captured as part of placement supervision and annual reviews, including channels through which they can communicate with trusted professionals, and to seek opportunities to strengthen this.
4. Powys Learning and Development Services to review the content and availability of safeguarding training available to staff, ensuring it complies with requirements under groups C and D of the National Safeguarding Training, Learning and Development Standards and Framework. This should include role specific training for Powys Fostering Services Practitioners and Managers and the Fostering Panel, with a particular focus upon:
   - Triggers and Thresholds for Section 47 Enquires (Children Act 1989, Wales Safeguarding Procedures), including the application of these procedures to children looked after when safeguarding concerns are identified
   - Safeguarding allegations/concerns about practitioners and those in positions of trust (Section 5 Wales Safeguarding Procedures)
5. The Police and Social Services to review together the criteria and threshold for referrals for sharing information between the Police and Social Services in relation to fostering households where Police have attended an incident.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td>Non Davies</td><td>REVIEWER 2 (as appropriate)</td><td>Cathy Richards</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">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</td><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

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<tr><td colspan="2">Reviewer 1
(Signature)</td><td colspan="2">Reviewer 2
(Signature)</td></tr>
<tr><td colspan="2">Name Non Davies
(Print)</td><td colspan="2">Name Cathy Richards
(Print)</td></tr>
<tr><td colspan="2">Date 11/10/2024</td><td colspan="2">Date 18/11/24</td></tr>
<tr><td colspan="4">Chair of Review Panel
(Signature)</td></tr>
<tr><td colspan="4">Name
(Print) Mandy Nichols-Davies</td></tr>
<tr><td colspan="4">Date 19/11/2024</td></tr>
</table>

Appendix 1: Terms of Reference

Child Practice Review process

To include here in brief:

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

As reviewers we have benefited from comprehensive timelines and carefully considered agency analyses, which proved invaluable in assisting the reviewers to navigate and understand a significant volume of complex information and documentation; and from the scrutiny of the Child Practice Review Panel, which consisted of representation from the following agencies:

- Local Authority Children's Services
- Local Authority Fostering Services
- Health
- Education
- Police

Learning Events (LE)

A series of Learning Events were convened during November 2023, consisting of a day each for practitioners involved with the relevant young person and a third day for managers. The learning events were facilitated by the Chair of the Child Practice Review Panel and the joint reviewers, with administrative support provided by the Regional Safeguarding Board Business Unit and local authority personnel.

These sessions were very well attended by multi-agency colleagues and proved invaluable in providing added value and in informing the review. The Chair, reviewers and the panel wish to thank attendees for their openness and for their contributions and commitment to achieving the learning outcomes. The sessions provided an opportunity to reflect on key questions:

- What went well, what good practice have you identified?
- What do you feel did not go well, are there areas which concern you?
- What do you feel agencies could have done differently?
- What actions do you feel agencies need to take going forward, to ensure any learning informs future practice?
- Any other comments or observations you would like to make?

Subjects' Involvement in the Review

Despite the challenges facing practitioners and agencies, we have identified elements of good practice. We were particularly heartened during our meeting with both Child X and Child

Y that they had developed positive relationships with key practitioners, and that they felt currently well supported. We were impressed by their selflessness and their aspirations to support other children accommodated and looked after; both have immeasurable contributions to make. This is a testament to them and those who have supported them.

As reviewers we have been impressed by the careful and considered arrangements for involving Child X and Child Y in this review, and for the pastoral support provided to them before, during and after our meetings.

Child X

We were unable to meet with Child X prior to the Learning Events. Fortunately, practitioners who had worked closely with him attended, and they presented a helpful portrayal of Child X, his experiences, his hopes and aspirations and the challenges facing him. This assisted the reviewers in developing a sense of Child X, and of his experiences as a care experienced young person.

We were extremely pleased to be able to meet with Child X after the Learning Event. Child X's contributions to this review have been extremely valuable to the reviewers, and we would like to express our deepest gratitude to Child X for agreeing to meet with us. His views and perspectives have been captured throughout this report and are used to directly inform aspects of learning arising from this review.

Child X is now being supported by practitioners whom he has previously worked with and he values this, as he is living independently. He feels that he has a lot to give to children and young people in care, and in informing the way people involved with them view them and support them. He hopes to continue to contribute to the local Participation Group.

Child Y

We met with Child Y prior to the Learning Event. This proved to be helpful as we were able to share his feedback with attendees, and it was evident at the Learning Event that he was highly thought of by practitioners. Child Y expressed to us that he had developed close working relationships with practitioners working with him, to the extent that he had invited one to his graduation. These working relationships are still in place.

We are sincerely grateful to Child Y for agreeing to meet with us, and have captured his views throughout the report in relation to good practice and learning gleaned from the review process. Child Y did not feel that this outcome could have been foreseen by anyone, 'No one saw this coming, they trusted him'. He felt shocked and betrayed by the assault and questioned whether fostering was a 'means to an end'.

It was clear that Child Y valued the court outcome and saw this as validation of his experience. He stated that he felt supported throughout the investigation and court process.

Child Y is aspirational and reported that he wishes to have a career where he can be an advocate for children and young people in care.

☐ Family declined involvement

For Welsh Government use only

Date information received ………………………..

Date acknowledgment letter sent to SCB Chair …………………………

Date circulated to relevant inspectorates/Policy Leads …………………………

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Terms of Reference for Extended Child Practice Review
CYSUR 6 2021 (Powys)

- **Nominated Safeguarding Lead** – Stephanie Jones
- **Review Panel Chair** – Mandy Nichols-Davies
- **Independent Reviewer(s)** – Non Davies, Cathy Richards

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 each child and their respective families.
- Determine the extent to which decisions and actions were in the best interests of each 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 each child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of each child, their respective families and their circumstances. How that knowledge contributed to the outcome for each child?
- Whether the XXXXXXX Plans were robust, and appropriate for each child and their circumstances.
- The effectiveness of transition planning.
- Whether any 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 each child.
- Whether the protocol for dispute resolution was invoked.
- Whether the respective statutory duties of agencies working with each child

and families 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 timelines 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 for each child.
- 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 individuals 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 Practice Review 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).

Specific tasks of the Practice Review Sub Group:

- Agree and approve draft ToR for each case recommended for CPR/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 CPR/APR 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.