Serious Case Review

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On behalf of an unnamed local safeguarding children board

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Sexual abuse by a local authority foster carer

March 2019

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1. INTRODUCTION

1.1. Between June 2017 and September 2018, the Safeguarding Children Board (the LSCB) conducted a Serious Case Review (SCR) in relation to the sexual abuse of eight primary school aged children by an approved local authority foster carer. The foster carer was a man in his 50s and along with his wife had fostered more than 30 children, placed by the local authority since their approval in 2001. When the allegations were made two other children – who were not in local authority care – were living in the household as a result of orders made in the family courts.

1.2. The first allegation of sexual abuse was made in May 2012 though at the time it was not considered to be credible. Further allegations were made in 2014 and 2015. These led the local authority to remove children who were in local authority care from the home and in December 2015 the local authority fostering panel deregistered the foster carers.

1.3. The first criminal convictions were secured in 2016 and a larger number of convictions for more serious offences followed in December 2017 as a result of allegations made by children who were known to have lived in the foster home. The offences include voyeurism, sexual assaults and rape; the victims range in age from 1 year 9 months to 11 years at the time of the offences. With one exception all the victims were girls. The male foster carer was given a lengthy custodial sentence.

1.4. The SCR was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a *'rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1] This document sets out the SCR findings in full.

1.5. To protect their privacy, where it is necessary to understand the issue being discussed the children who are the subject of the review are referred to as Child 1 – Child 8. The foster carers are referred to as male and female foster carer and the other children who are part of their household are Child A and Child B.

Reasons for conducting the Serious Case Review

1.6. The Safeguarding Children Board became aware of allegations of abuse against the foster carer in August 2016. At this point the allegations were limited to two children and the board chair decided that a local

[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.6

learning review would be conducted. Work began on this review and an independent reviewer was appointed.

1.7. During the following 12 months further allegations were made, resulting in criminal charges being brought in relation to five further children. Allegations by one child were investigated but the Crown Prosecution Service judged that a successful prosecution was unlikely. As a result of the new information available to her the LSCB Independent Chair decided in December 2017 that the circumstances met the criteria for a SCR on the grounds that the victims had suffered serious harm and there was cause for concern about the way in which agencies had acted to safeguard the children.[2]

The focus and scope of the Serious Case Review

1.8. The SCR has focused its attention on the services provided between 2000 (when the assessment and approval of the foster carers began) and December 2014 when the first proven sexual abuse allegations were made. The board has been provided with information to indicate that the investigations which followed these allegations were well conducted, as well as resulting in successful prosecutions. The children involved were protected and supported and there are no serious concerns about the practice after December 2014.

1.9. The work of the SCR has therefore focused on the following areas of policy and practice:

- The recruitment and approval of the foster carers
- How placements of children were arranged and made
- The supervision and monitoring of the care provided by the foster carers
- The response of agencies when concerns were expressed, or allegations made (including the allegations made in 2012)
- Provision made by the children's schools and by health services

1.10. The process through which perpetrators make potential victims more vulnerable and less likely to report sexual assaults – often referred to as 'grooming' - is well documented in the literature on sexual abuse. Findings of reviews of abuse by foster carers and the wider literature about abuse of children by those in a position of trust show that, in order to be successful, abusers need to be able to manipulate and groom the network of professionals around the child so that it appears

[2] The relevant criteria are in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, 5 (2) (a) and (b) (1)

that they are providing safe care for the child and so that if there are allegations or suspicions they are more likely to be discounted.[3]

1.11. There may be features of services, or the way in which they are provided – at the individual professional, team or service level – that make professionals easier to 'groom'. The review has sought to understand how this occurred in relation to each of these aspects of service provision. This requires not only understanding whether procedures were followed, for example whether looked after children's review meetings took place and children were seen regularly by their social workers, but also how the local authority fostering service and other professionals viewed the foster carers and interacted with them.

Agencies involved

1.12. The SCR considered the work of the following agencies and contracted professionals, all of which are one local authority area:

- Local authority children's services / social care)
- Schools
- General Practice
- Police
- The community health service provider (health visiting and school nursing service, looked after children's health assessments).

The review also received information from child and adolescent mental health services that provided counselling or therapeutic support for some of the young people concerned after their allegations were made. These services have not been reviewed.

How the review was undertaken

1.13. Details of the principles underlying the approach to review and the steps taken to carry it out are set out in the Appendices. Section 2 of the report sets out some limitations in the work that could be undertaken and the reasons for them. This includes details of the efforts made to involve the young people who were victims of abuse.

Parallel investigations and proceedings

1.14. The allegations of abuse were investigated by the police and the foster carer was convicted of two sets of offences. Information gathered during the course of the criminal investigations has been made available to the SCR and because the police inquiries were at an advanced stage before the SCR was initiated they have not limited the way in which the review was conducted.

[3] See list of SCRs in Appendix V. Also M Erooga (ed) 2012 *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them* (Wiley)

2. METHOD OF REVIEW AND LIMITATIONS OF THE FINDINGS

2.1. The review relied largely on records to understand how tasks such as the foster care assessment were undertaken and whether professionals followed expected practices such as visiting children and seeing them alone. The most effective way of understanding how professionals saw and interacted with the foster carers is through interviews with key members of staff. In relation to both there have been gaps in the information available.

Records

2.2. The following are examples of records that could not be located:

- The minutes of the fostering panel at which the foster carers were approved in 2001
- Minutes of a second panel in 2002 at which their approval should have been formally reviewed (according to guidance)
- Subsequent fostering panel minutes at which agreements to allow the couple to foster numbers of children above their existing approval should have been discussed and documented
- Records of police checks that should have taken place every three years after the initial approval
- Full records of some file entries are not completed – for example, a visit by the social worker to see a child states only '5 November Child Looked After visit'
- The social work files have no copy of significant legal orders relating to Child A and Child B
- The majority of the daily logs and diaries kept by the foster carers about the daily activities of a number of children are missing
- On Child B's case file psychology reports are referred to but not on the file (one such report was found on the legal service files)
- Some Looked After Child review minutes are missing.

2.3. The gaps appear to be explained by the loss or premature destruction of records, or in the case of the foster carer's logs a lack of clarity about what should have happened to the records. Transfer of some records during past upgrades of the electronic client record system has been poorly carried out and with insufficient quality control and checking.

2.4. The reviewer has no reason to suspect that any records were lost or destroyed deliberately because they related to these children. It is not possible to be certain how many other children's records might have similar gaps. It is not possible to say whether information in missing records would have changed the SCR findings.

Staff discussions

2.5. The SCR was assisted by a small number of interviews with members of staff who had had a significant involvement with the foster carers or the children in their care. However the majority of staff members who might have contributed to the review had left the authority because many of the events under review took place some years ago and because for some groups of staff such as social workers there has been a high turnover of staff. This is less true of staff in health and education settings, but they knew the foster carers less well.

Children and young people

2.6. The LSCB, independent reviewer, police officers and social work staff made substantial efforts to enable the children and young people who had been victims of abuse to contribute to the review through a variety of means, including if they wished face to face interviews. The intention was to discuss their experiences of the services that they had received and whether the way in which professionals had worked had made it more likely that abuse could take place or less likely that it would be detected.

2.7. Contact was made, directly and using the assistance of a number of intermediaries, with all of the children and young people to explain the purpose of the review and answer questions about how it would take place, including what information might be published. Two of the eight children and young people felt able to contribute. Another made an appointment but cancelled it at the last moment.

2.8. The others conveyed directly or through foster carers or others that they did not wish to participate, mainly because having given evidence quite recently in criminal proceedings they now had other things in life that they wanted to focus on, and did not wish to revive memories of their time in the foster home. The review has made a recommendation in relation to the continuing care of these young people in Section 5.

2.9. The experience of the two young people who did participate has informed the report throughout and Section 4.4 in particular. The LSCB is grateful for their contribution and the assistance provided by their current foster carers and social worker. All of the young people were given an opportunity to hear about and discuss the outcome of the SCR.

The foster carers

2.10. The male foster carer is serving a lengthy custodial sentence and despite the overwhelming evidence and his conviction continues to deny that the offences took place.

2.11. The female foster carer was given detailed information about the review and asked to contribute, but did not wish to do so.

3. BACKGROUND AND KEY EVENTS

3.1. This section provides a brief summary of important events involving the foster carers and the children in their care, concentrating on the victims of abuse. In total over 30 children were placed in the foster home. Children other than the 8 who are believed to be victims of abuse are only mentioned where this provides significant background information (for example if it made the home very crowded).

1998	The couple's first application to foster was made in 1998. It was rejected on the basis that the male applicant had a conviction for burglary and theft nine years earlier, as well as other offences committed as a juvenile. The contemporary policy was that applications could not be considered if there had been a conviction in the last ten years. The local authority encouraged the couple to reapply once the ten years had expired.
2000	The couple reapplied and despite reservations being expressed by the social worker who made the initial visits about the belligerent attitude of the male applicant, the assessment proceeded
January 2001	The fostering panel approved the couple as foster carers for 2 children (or a larger sibling group) aged 5 – 18. Fostering of under 5s was not allowed because the female applicant smoked. The reservations expressed during initial contacts were not referred to in the report recommending approval or discussed at the panel. The restriction in relation to not placing children under 5 was soon and persistently breached
2001	The local authority placed a group of three siblings with the family. They stayed for a year, then returned home and then returned to the placement for another four years. Child 1 was part of this group. Records show reports of the children having suspicious bruises and one child with a possible physical symptom of sexual abuse. There is no record that these were investigated. The female foster carer befriended the children's mother and remained in contact with her for some years after the placement ended. Child 1 made allegations against the male foster carer in 2015.
March 2002 – March	Three sets of siblings were placed in the foster home for short periods of full time foster care or part time respite care. Each of these placements would have needed to be specifically

2003	authorised as it would have taken the number of children in the household over the approved limit. On two occasions in 2002 formal reports were made that the foster carers had made rude and unprofessional comments and gestures to the parents of looked after children. These were followed up by the fostering service team manager and discussed at the annual fostering review which referred the carers for discussion at the fostering panel. The foster carers accepted the need for more training.
2003	An infant Child A was placed with the foster carers. She remained in their care until 2004 when she returned to her family. Later she returned informally and without the knowledge of the local authority as a privately fostered child. Her position was regularised through a court application in 2014.
Sep 2003 – Sept 2004	Two further children had periods of day and respite care
2004	Child B was placed in the household and also subsequently became a permanent family member. Early in her placement she was closely monitored by health professionals because of her faltering growth. She also exhibited a physical symptom which might have been indicative of sexual abuse. There was no record of an enquiry into this. Early in her placement her birth mother noted on contact visits that the child was watchful and withdrawn. There is no record that this was investigated.
2004	In September 2004 a group of three siblings was placed in the foster home, including Child 2. The placement lasted 9 months and Child 2 reported offences in 2015 In late 2004 and early 2005 a social work assistant supervising contact for Child A noticed bruises on both sides of her face which her birth father said had been caused at the foster carers. There is no record of the bruising being investigated although body maps (showing the size and location of bruises) were completed on several occasions
2005	In January 2005 a further child was placed for a short period. Child 2's social worker contacted the Fostering Service because Child 2 was believed to be adversely affected by the number of children in the placement, including additional children who received respite or after school care.

2005	The local authority became aware that the foster carers had been regularly leaving the children in the sole care of the female foster carer's sister and her husband without notifying the local authority. The extent of the arrangement is unclear. When a police check was undertaken it identified the male babysitter as the co-defendant in the foster carer's last recorded criminal offence (1989).
2005	A boy and a girl were placed with the foster carers for six months. No allegations have been made by these children.
2006	Child 3 and Child 4 (aged 1½ and 3½) were placed with the foster carers. They remained in placement until 2008 when they moved to an adoptive placement. The foster carers were noted to be hostile and unhelpful during the planning of this placement. Signs of sexualised behaviour identified while the children were living in the adoptive placement were not investigated. The fostering panel medical advisor recommended that the couple should only foster children with whom they already had a significant relationship because the male foster carer was suffering from a range of medical conditions to a degree that might significantly reduce his life expectancy. This appears not to have been agreed as placements continued to be made as before.

2008	Child 5 and Child 6 (aged 11 and 9) were placed with the foster carers. The older child's placement ended in November 2012 and the younger remained in the household until December 2014 when she was removed in the light of the allegations made by other children. Both girls were in placement throughout the time that Children 7 and 8 lived with the foster carers. During that period Child 5 went missing from the placement on several occasions.
2011	Child 7 and Child 8 (aged 9 and 7) were placed with the foster carers. Child 8 had severe behaviour difficulties at the beginning of the placement. The placement lasted for a year and the children returned to the care of their mother.
Late 2011	Child 8 made allegations of sexual abuse to his mother implicating an acquaintance of hers. He also showed patterns of behaviour consistent with abuse. The investigation proved inconclusive.
2012	A solicitor acting on behalf of Child 8's mother contacted the local authority with complaints about the male foster carers' attitude and behaviour towards the mother. The local authority spoke with the foster carer and then wrote to the solicitor saying that the allegations were untrue.
2012	3 months after the children returned to her care, Child 8's mother reported that he had made allegations of sexual abuse against the male foster carer. She told the local authority that the foster carer had made him watch pornographic videos and had performed oral sex on him. Child 7 made less serious allegations that would have constituted unacceptable care by the foster carer, but were not treated as an allegation of crime and she was not interviewed formally by the police. The case did not go forward as a possible criminal allegation because the allegations had so many complicating and undermining features that it was very unlikely that there would be a successful prosecution. The local authority took the view that the allegations were untrue. Soon after Child 8 behaved in a sexualised way with a younger child. His behaviour was not linked to his stay in foster care or his previous allegation.
2012	The allegations were presented to the fostering panel in July 2012 with a recommendation that no further action was needed. It was reported that child protection procedures had been followed. The panel was told that the concerns would be addressed and monitored by the fostering service though there is no indication as to what this meant in practice.

2012	Child 5's placement ended in late 2012, prior to this another child had been placed with the family for a short period. The foster carers felt that Child 5 was showing very difficult and unmanageable behaviour – a view which was not shared by the child's social worker who felt her behaviour was normal. Child 5 had a week's respite in another placement. It had been assumed that she would return but the foster carers said that they did not want this. This was viewed as surprising and disappointing given that she had lived with them for four years. A placement disruption meeting was held at which the children's social worker expressed the view that the stability of the placement had not been helped by the addition of two further foster children to the family
2013	Child 6 remained in placement along with the two children who were considered permanent members of the family. Three other children were (separately) placed for short periods.
May 2013	The fostering panel changed the carers' approval to include children under the age of 5 because it was understood that the female foster carer had stopped smoking in March 2012. The panel noted that the foster carers had not attended any training for over two years and asked for this to be addressed with an updating report in six months' time. The male foster carer's work commitments were noted as a reason for the level of training attendance. The report was prepared in March 2014. The panel made no reference to attendance at supervision meetings or attendance at support groups or wider fostering activity.
Feb 2014	Child A was made the subject of Residence Order giving the foster carers shared parental responsibility and confirming that she would continue to live with them. The application was made by the foster carers and supported by the child's birth mother and Cafcass.
March – August 2014	Two further children lived in the household on short term placements
Dec 2014	In late December 2014 Child 3 and Child 4 made allegations of sexual abuse against the male foster carer. A strategy meeting was held and the male foster carer was arrested. His phone, laptop and camera were seized but not immediately examined. Based on the evidence of the two children (who were aged 9 and 11 and reporting events that had occurred between 6 and 8 years previously) the CPS decided that there was no realistic

	prospect of a conviction. Child protection assessments were made in relation to the safety of Child A and Child B and these immediately raised concerns about the female foster carer's ability to protect the children, as she did not believe the allegations and was allowing her husband to have telephone contact with the girls in spite of his bail conditions barring this. Child 6's placement ended as a result of the allegations
2015	Examination of a computer seized during the arrest revealed indecent video images of two female foster children made covertly. Initially neither child made any allegation of any contact offence, though later Child 6 did. As a result, in 2016 the male foster carer was convicted of the first set of sexual offences and given a custodial sentence.
	During the investigation, contact was made with children who had spent a substantial period of time living in the foster home, as well as children in the family network who might have been at risk. The allegations made by these children resulted in the further convictions in 2017. The male foster carer was given a further lengthy custodial sentence. Child A and Child B have not made allegations of abuse and remained part of the household under close judicial supervision.

4. SERIOUS CASE REVIEW FINDINGS

4.1. Overview of the findings

Introduction

4.1.1. This section of the report presents the findings.

4.1.2. Section 4.2 evaluates the recruitment and approval of the foster carers

4.1.3. Section 4.3 describes the way in which foster placements were made and considers whether this added to the vulnerability of the children who were victims of abuse

4.1.4. Section 4.4 considers the steps taken by the local authority to monitor the welfare of children in the foster home

4.1.5. Section 4.5 considers the investigation of concerns and allegations when these arose in the placement. This includes the allegations of sexual abuse made against the male foster carer in 2012

4.1.6. Section 4.6 considers the contribution of other agencies, particularly health services and schools

4.1.7. Section 4.7 summarises findings about the ways in which the male foster carer was able to manipulate and groom professionals with safeguarding responsibilities and how wider systems failed to recognise and combat this.

4.1.8. Section 4.8 describes the current arrangements for the oversight of safeguarding of children who are looked after by the local authority.

4.2. Recruitment and approval of prospective foster carers

Information from the narrative

The fostering application and assessment

4.2.1. The foster carers made two applications to foster. The initial application, made in 1998, was refused on the grounds that the male applicant had criminal convictions within the past 10 years which automatically excluded the application. The couple were encouraged to reapply when the ten year limit had expired.

4.2.2. The second application was made in 2000. Before the full assessment began and references were taken up, a social worker from the fostering service held exploratory visits. These highlighted concerns about the male applicant who it was noted had a belligerent and angry attitude, particularly when mention was made of his criminal convictions, which he refused to discuss in detail. He explained that he 'had always had a problem with authority figures' which was coming out in the discussion. Although this was a potential concern a manager in the fostering team decided that the assessment should continue.

4.2.3. It was common practice at the time for local authorities and other fostering agencies to summarise and present the findings of the assessment on template forms published by the British Association for Adoption and Fostering (BAAF) referred to as the Form F.

4.2.4. Part 1 of the Form F contained basic factual information (such as names, dates and family details). Part 2 contained a more subjective description of the carers and an analysis of their potential capacity to become successful foster carers. Headings included the following: family background, employment, previous and current relationships, lifestyle, views of the family's children, support network, how they have cared for their own children, evidence of working with others, understanding children's identity, working with families from a range of cultural and religious backgrounds, motivation to foster and understanding of safer caring.

4.2.5. In 2000 the practice in the local authority fostering service was to use Part 1 of the template and then to complete a word document for the part 2, following the same headings as the BAAF form. The reasons for this aren't clear.

4.2.6. The assessment of the foster carers contains the information expected in Part 1. Part 2 is brief in comparison to other assessments undertaken at the time (according to the estimate made by an experienced manager about half the length) and not all of the headings were completed. There was no discussion in the report of their parenting ability and nothing on how well equipped the foster carers seemed to be to deal with children and families from a range of backgrounds. Little was said of the male applicant's difficulty in discussing his offences and there was very little analysis of the possible implications of this for his proposed role as a foster carer.

4.2.7. In line with normal practice the fostering team sought three referees, but only two responded. No enquiries were made as to why the third had failed to provide a reference and whether any negative inference should be drawn from this.

4.2.8. The assessment refers to the male applicant having been neglected in his childhood but the meaning and implications of this were not explored. His persistent adolescent offending was not addressed, either as a potential risk to young people or in the positive sense as being experience that he had learnt from and could use to help other people.

The fostering panel

4.2.9. The foster carers were approved by the fostering panel in January 2001. At some point centrally held copies of the fostering panel minutes were destroyed on the assumption that sections relating to specific foster carers would be held on individual foster carers' files, however this did not happen in this case. The timing of these decisions and the reasons for them cannot be established. As the local authority was not able to provide the minutes of the meeting, it is not possible to describe the discussion that led to the approval of the carers in detail.

4.2.10. It has been established from correspondence that was exchanged ahead of the meeting that the panel medical advisor twice strongly recommended that the female applicant should only be considered as a short term respite carer because of the possibility that she might suffer from an inherited medical condition, for which she did not wish to be tested. This advice was not adopted by the local authority fostering service and it was rejected by the fostering panel which approved the couple as foster carers for children aged 5 - 18.

4.2.11. It is not possible to establish whether the reservations expressed in the initial foster carer assessment screening visit were discussed at the panel. This seems unlikely as they were not referred to in the assessment report.

No caveats or particular conditions were attached to the approval in recognition of the reservations that had been expressed.

4.2.12. This meant that details of the original reservations were not retained in the service. The fostering support worker who was most closely in touch with the foster carers for over a decade told the SCR that she had no knowledge of the early concerns and that it had not been noted in records or mentioned in her handover.

Learning and wider implications

4.2.13. The assessment and approval process fell substantially below both current expectations and the standard that would have been expected at the time. It was characterised by a lack of rigour and thoroughness. Most importantly the male applicant's history of offending was not discussed and his anger when asked to discuss it was not properly understood, challenged or reflected in the assessment. A stated dislike for and difficulty in working with 'authority figures' was clearly a potential risk in fostering which relies heavily on the development of openness and trust in discussing children's needs and progress.

4.2.14. Important information about this was not included in the written report and so not shared formally with the fostering panel. It is impossible to know if more senior members of the fostering service or the panel chair had been aware of these concerns. It is not possible to be certain why these shortcomings occurred and why they were not challenged.

4.2.15. It is also not possible to know whether the weaknesses identified here reflect approaches that were common at the time. The evidence suggests that the local authority was very keen to recruit the foster carers. This may have been because there was a shortage of local authority foster carers at the time, possibly because of competition from private or independent fostering agencies, which were very active in this area. The desire to recruit a couple who lived in a community where many children coming into the care of the local authority had been brought up might also have led to a lowering of standards and expectations.

4.2.16. There is further evidence later in the case history that the views and recommendations of the panel's medical advisor were sometimes given little weight. The disregard for the policy of not placing children under the age of five in the foster home because the female foster carer smoked strongly suggests a wider disregard for agreed standards. [4]

4.2.17. Approaches to fostering recruitment and assessment are usually 'competency based', that is to say they identify the abilities that a foster carer will need in order to deal with situations that are likely to occur in

[4] Under 5s were placed almost from the outset but it was only in 2012-2013 that the female foster carer reported that she had stopped smoking and the registration was changed

caring for a child. The F form requires the assessing social worker to provide evidence of this drawing on the applicants' past experience or their ability to apply this to new circumstances. A recent SCR has highlighted possible risks in this approach if it encourages the search for evidence of activity and knowledge but leads to a limited analysis and discussion in the assessment or in the fostering panel of past events and patterns which may be relevant to understanding the emotional stability of applicants and the safe care of children.[5]

4.2.18. Section 4.4 highlights concerns about annual foster carer reviews which take a similar approach.

Recommendations

4.2.19. The SCR recognises that the events described occurred almost two decades ago. It has been told by the local authority that its practice in relation to assessment and approval have changed substantially. It is also clear that some of the factors that may have shaped practice in this case remain relevant. There remains a high demand for local authority fostering placements that are close to the communities where children in care have lived.

4.2.20. Knowledge of the patterns of behaviour adopted by adults who may pose a risk of sexual abuse towards children has increased substantially in the past 20 years. As a result safer recruitment practices have developed for residential workers, teachers and others (including foster carers) who have frequent unsupervised contact with children. The experience of recruiting this couple underlines the importance of discussing in detail concerning or unusual features of an applicant's past. Two decades ago a fostering assessment would not have included a detailed discussion of the applicants' attitudes to sex and relationships, including the abuse of power, but today it should.

4.2.21. When carers are approved but there remain reservations on particular issues, the fostering panel must ensure that specific measures are put in place to ensure that these are followed up.

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[5] Bridget Griffin (2017) Serious case review on Child Claire Croydon Local Safeguarding Children Board notes that because of '*the use of an assessment form primarily focussed on a list of competencies, the decision making about suitability can become inadvertently led by a need to ensure these competencies have been met, rather than assessment and decision making involving critical appraisal and analysis that may reveal important information on the question of suitability'*.

'The structure of the Form F encouraged an approach that appeared primarily to focus on making sure the eighteen competencies and seven standards had been met, by posing questions throughout the form inviting information to be provided to evidence these competencies and standards. Analysis is only prompted at the end of the form and this appears to encourage a summary of how the competencies and standards have been met, rather than prompting critical appraisal and analysis'.

4.2.22. The LSCB needs to be certain that the local authority is applying the best standards of practice to all aspects of the recruitment of foster carers (which should be taken to include foster carers, adopters, short-term and respite carers, and those who already form part of the child's family network where they apply for care of the child).

4.3. How placements in the foster home were made

Introduction

4.3.1. This section of the report describes and evaluates the following:

- The way in which children's placements were arranged and made
- The overall number of children living in the home
- Patterns of placements that can be observed in hindsight

Information from the narrative

How placements were made

4.3.2. Guidance (both national and local) on services for children looked after stresses the importance of identifying a child's needs and matching the child with a placement that can meet them. From the information provided to the SCR it is apparent that in practice the most important factor in placement choice was availability. Indeed it is hard to discern what particular or specialist skills or attributes the foster carers had, other than female foster carer's fondness for the children in her care, their flexibility and willingness to fit children in when urgent placements were needed.

4.3.3. According to their long standing fostering support worker, placements with the foster carers were usually made in an emergency, even if a breakdown in the child's care was anticipated or seen as inevitable at some point. Consultation would take place between the fostering support worker and the female foster carer and then approval would be sought from a manager in the fostering service. Once agreement had been reached there was rarely much meaningful consultation with the child's social worker who would be told that 'this is the best or the only available family'.

4.3.4. Placements would continue unless there was a compelling reason for moving the children and placement decisions were rarely revisited as long as the arrangement seemed satisfactory (even if it had not initially been seen as ideal).

4.3.5. The needs of children already in placement would be considered by the fostering service by consulting the foster carer. If there was a disagreement (for example, with the social worker responsible for a child already in placement), but the carers thought that the placement would

work, the fostering service tended to have the final say and could over-ride concerns of children's social workers about the impact on other children. Fostering services had the final say over the matching and continuation of placements once made, not least because the child's social worker would be reliant on the service to find an alternative placement.

Arrangements for placements of children above the approved level

4.3.6. Throughout the period under review the number of looked after children placed in the foster home was above or outside the original approval (two children aged 5 – 18 or a sibling group of three within this age range). The first placement included a sibling group with a child under the age of five. Subsequently many children were placed for respite or short term placements, or groups of siblings overlapped. For the local authority this flexibility and the willingness to take children at short notice was an extremely positive feature of the carers, who came to be seen as flexible, helpful and able to cope. At times there appear to have been up to 7 or more children in the placement.[6]

4.3.7. The process of agreeing an exemption to the number of children placed was for it to be signed off as an emergency measure by a senior manager in the fostering service and then agreed at the fostering panel. Although it is impossible to reconstruct the entire history in detail, the SCR has been told that most, possibly all of the exemptions were signed off by senior managers in the fostering service. Only a small number were authorised by the fostering panel, mainly prior to 2005 and after 2011.

4.3.8. Written records indicate that little conscious consideration was given to the impact that the large numbers on children in the household would have on individual children, though this was raised as a concern by social workers and independent reviewing officers on a small number of occasions.

4.3.9. Annual foster carer reviews were held on schedule but did not consider this issue. Section 4.4 evaluates the effectiveness of the reviews in more detail.

4.3.10. Visits were made by the fostering support worker who was aware of the number of children in the household. Her understanding was that as more senior and qualified staff were always aware of and had approved the number of placements, it was not a matter that she should act on.

4.3.11. In October 2012 a disruption meeting held in relation to Child 5 noted concerns expressed by the child's social worker that the stability of the placement had not been helped by the placing of two further foster

[6] It is impossible to be absolutely certain because some placements were part time (a number of days respite placement per week), end dates of some placements were uncertain because children had gone home but the placement was kept open, or a full time placement had evolved into a part time one

children in the household. Prior to the breakdown in her placement the social worker and the fostering support worker had visited and noted concerns about the lack of emotional support being given and the negative attitude that the foster carers had towards the child.

Learning and wider implications

4.3.12. In hindsight a clear pattern can be seen. The foster carers had more than 30 placements. Of these the vast majority (numerically) were very short term placements of between a few days and a few months, some of which were part time, or a series of short respite arrangements. Among this group of children there were examples of concerns about the conduct of the carers, mostly recorded in their first 3 years as foster carers. The family never fostered an adolescent, despite being approved for children up to the age of 18.

4.3.13. There were five much longer placements (of 9 months, 12 months, 2 years, 5 years and 6 years).[7] These were all sibling groups of primary school aged children (almost exclusively of girls). The placements often lasted longer than would have been expected for short term placements made while assessments were completed and permanent plans made for children. The SCR has not examined why this happened in each case, or what the original intention had been when the placements were made. Drift in placements may have been due to failures in child care planning but there were also episodes in which the foster carers discouraged moves to planned placements. The report is not able to document placements that were considered unsuitable or refused and the reasons why this happened as this is not systematically documented.

4.3.14. The 8 children who made allegations were all in this group of placements and it is clear that the male foster carer had a sexual preference for children of this age. It would be wrong to suggest that this pattern of placements was in itself necessarily suspicious. Although there were regular visits to the household, mechanisms that might have spotted this unusual pattern such as the annual foster carer review, were not effective.

Recommendations

4.3.15. The local authority must provide assurance to the LSCB that children's placements are made as far as possible by matching with carers who have been assessed as being able to meet their needs. If placements are made out of necessity as an emergency with carers who appear not to be suitable, this should be addressed in the care plan.

[7] The last placement was in fact two placements with a break of a couple of months during which the children lived with their mother

4.3.16. The local authority must provide assurance to the LSCB that its systems for granting exemptions to the approved number of children placed in a foster home operate in line with the fostering regulations and do not negatively impact on children's welfare. Assurance needs to be provided of the effectiveness of arrangements for annual foster carer reviews.

4.4. Oversight and monitoring of the quality of care and the success of placements

Introduction

4.4.1. This section of the report evaluates the effectiveness of five aspects of practice that are designed to monitor and improve the quality of care being provided:

- Police background checks and references[8]
- Supervision from the fostering service
- Training
- Annual foster carer reviews
- The role of children's social workers and reviewing officers

4.4.2. This part of the report considers everyday practice. Section 4.5 focuses on the response of agencies to specific reports of concern or allegations of abuse. Section 4.7 provides an overview of the way in which the male foster carer was able to exploit weaknesses in the local authority and other agencies.

Information from the narrative

Police background checks

4.4.3. Police checks were properly undertaken on the foster carers during their recruitment. Checks should have been taken up again in 2003 and 2006 but there is no evidence that this was done. The police have a record of a check being requested in 2007 but there is no record of this check in the local authority and the next reference found to this issue in the fostering service records is an entry by the team manager in 2008. This drew attention to the fact that there had been no check since the second fostering application in August 2000.

4.4.4. There is no evidence that either foster carer came to the attention of the police during this period, so the additional required background checks that were missed would not have affected their continuing registration. However the gaps and the inconsistency in agency records are of wider concern because they appear to have gone unnoticed for several years,

[8] Known at different points as police checks, CRB (Criminal Record Bureau) and DBS (Disclosure and Barring Service) enhanced checks

suggesting that the fostering service had no reliable mechanism for renewing checks or auditing that checks had been conducted. This was confirmed as late as 2013 when it began to be addressed in the Fostering Improvement Plan.[9]

Role and activity of the fostering support worker

4.4.5. On their approval as foster carers the social worker who undertook the assessment became the fostering support worker. In this situation there is always a possibility that having got to know them well, advocated for their approval by the fostering panel, watched the foster carers develop new skills and knowledge and supported them through initial placements, the supervising social worker may develop a 'loyalty' which makes it harder to recognise weaknesses and shortcomings.[10]

4.4.6. Supervisory responsibility was taken on by an unqualified fostering support worker in 2004 shortly after she joined the fostering service, having previously had substantial experience as a family support worker where she had worked with parents and also undertaken direct work with children. Within the fostering service it was normal (until 2014) for unqualified members of staff to take on supervisory responsibilities, reporting to a social worker. The fostering support worker made regular visits and liaised with the foster carers and children's social workers. The social worker chaired annual foster carer review meetings (which are discussed further from Section 4.4.17). For the first few years the social worker who had assessed the foster carers prior to their approval took this role.

4.4.7. The fostering support worker told the SCR that supervision meetings took place regularly, approximately once every four weeks during the period of her involvement. Records of visits from the files show that this was true for some periods, but that at other times visits were much less frequent, with a total of 124 supervisory visits being made in 14 years.

Recorded supervisor visits to the foster carers (taken from the local authority management review)

2001	16	2008	5
2002	13	2009	9
2003	11	2010	4
2004	9	2011	5

[9] See section 4.7 for further discussion

[10] This may become even more difficult if the person is promoted to a management role within the fostering service. See for example Serious case review report (2014) The sexual abuse of children in a foster home, Hackney Safeguarding Children Board

2005	12	2012	6
2006	9	2013	10
2007	7	2014	8
Total	**77**	**Total**	**47**

It is recognised that some visits may have not been recorded, or that visits to specific children may have been noted on other records. The greatest number of visits took place in the three years after the foster carers' approval and after the first allegations were made in 2012.

4.4.8. Visits usually took place in the morning after the school run. They were almost all with the female foster carer, though the male foster carer (who sometimes worked away from home) would often 'pop in' and be part of the discussion. The foster children (and others living in the household) would only have been seen at this time during school holidays.

4.4.9. Asked if the male foster carer was checking what his wife was telling the local authority or making his presence felt in some way, the fostering support worker said that she couldn't be sure. From her perspective having him there was helpful as she got to know what he was thinking and could address his concerns about the way that the local authority was dealing with individual children (which she sometimes felt had some validity). This was an opportunity to get him to see different points of view or ways of handling situations. She had a reasonably good rapport with the male foster carer and relied on a degree of banter, rather than confronting him directly which other members of the fostering service found would cause an arrogant, negative response.

4.4.10. The fostering support worker was responsible for negotiating placements with the foster carers. She found the female foster carer extremely helpful, characterising her typical response as being: '*she would take an emergency placement if she had a room*'. If the dialogue was directly between the female foster carer and the support worker she would agree to placements being made over the phone; with other members of the team she would always say that she had to defer to her husband. The reasons for this are not clear.

4.4.11. Immediate day to day supervision of the foster family was provided by the unqualified fostering support worker who was in turn supervised by a social work member of the team. During the 12 years that she worked with the family she reported to at least five social workers and her account is that all were readily available to discuss any concerns that arose, both in regular supervision sessions and in more informally between sessions. There were no specific supervision sessions dealing with safeguarding concerns. Supervising social workers only attended

home visits to foster carers for annual reviews and in exceptional circumstances (for example after the allegations made by Child 8).

4.4.12. The review has been told that after 2004 all of the events and concerns documented in Section 3 of this report were brought to the attention of supervisors, but with the exception of the allegations made by Child 8 in 2012 (page 12 above) none triggered further substantial discussion. Until 2014 none led to a thorough review of past events. The patterns of interaction between the male and female foster carers and different members of the fostering service (described above) were not something that the support worker was ever encouraged to reflect on or discuss in her supervision. The manipulative behaviour of the male foster carer is considered further in Section 4.7.

Training

4.4.13. Training records held by the fostering service may be incomplete and so may not capture all the training courses attended. The female foster carer did not like attending training, though she would do so as part of a small group of female foster carers who also met regularly as an informal support group.

4.4.14. Training records which begin in 2003 show that in the following 10 years the female foster carer attended 22 courses. Her attendance tended to fall off as time passed (4 courses in 2004 and an average of 2 course per year thereafter; one in 2011 and none in 2012; 3 in 2013). There is no obvious pattern to the course titles or content and it seems that she mostly attended courses that were put on at convenient times.

4.4.15. In 2013 her poor attendance was identified because of the introduction into the service of a competency framework linked to specific training programmes. Prior to that it had not been identified at annual reviews, normally because the female carer has usually attended some training and would offer to improve her record.

4.4.16. There is no record of the male foster carer attending any courses at all and this is confirmed by the fostering support worker. As a result he was never observed interacting with other foster carers, other members of the fostering service or external trainers (which he is likely to have found very difficult to do without getting into conflict of some kind). The SCR has been told that during the period under review there was no expectation that the person not designated as the 'main carer' would attend training other than for a small number of mandatory courses such as the preliminary 'skills to foster' course and mandatory e-learning on the government anti-extremism 'Prevent' strategy.

Annual foster care review

4.4.17. Fostering regulations require an annual review of the foster carers' work. The outcome of the first review should always be reported to the fostering

panel. After that there is no formal requirement for this and each fostering agency will adopt its own threshold for reporting progress and concerns to the panel. Annual review is a formal process which should consider whether the foster carer's approval should continue and the need for changes to their terms of approval.

4.4.18. The records show that annual reviews took place as required on the foster carers but the level of detail in records varies from one year to another.

4.4.19. The annual review is designed to offer an appraisal of strengths and weaknesses based on information from all those who have lived with or worked with the carers over the previous 12 months: the foster carers; looked after children placed with them; their own children and other professionals such as social workers (the latter being notoriously difficult to obtain). However for much of the period under review, reviews in this case are reported to have taken the form of an informal discussion between the foster carers, their support worker and her supervisor, with very limited feedback or input from children living in the household or other professionals. The social worker chairing the review had little or no detailed day to day knowledge of events in the household so relied on the fostering support worker to provide this. The failure to address the fact that Child A was living as a permanent member of the household under an unregistered private fostering arrangement strongly suggests a lack of curiosity and challenge in the reviews.

4.4.20. Like the initial fostering assessment, annual reviews followed a competency approach. The fostering support worker told the SCR that her work with the foster carers in the build up to reviews was to encourage them to gather and present information which demonstrated their skill and knowledge in relation to each of the competencies. Where there was a shortfall, further information could be obtained or opportunities and mechanisms for improvement identified. This approach encouraged the gathering of positive evidence and did not encourage the review to discuss or explore concerns.

4.4.21. The competency based approach remains in place and the report format has become larger and more detailed, calling for information to be obtained from a larger number of sources. It is reported that some information remains difficult to obtain, including information from allocated children’s social workers.

4.4.22. The SCR has been told that since 2017, an independent fostering review team (independent from the district fostering teams) conducts all foster carer annual reviews. This should reduce the risk of loyalty to foster carers unduly influencing reviews. The authority also uses a risk assessment tool to aid discussion of concerns. This is said to apply to newly approved carers and in cases where a concern has been identified. The system therefore relies on concerns being identified and reported.

Quality of input from the children's social workers

4.4.23. SCRs have shown that children are more vulnerable to abuse in foster care and the abuse is less likely to be uncovered when there is a poor quality service from children's allocated social workers and their managers.[11] Standards of practice are harder to maintain when there are frequent changes in staff and managers. The two victims who spoke to the SCR reported frequent changes in social workers. Review of the authority's records points to a large numbers of team managers and reviewing officers being involved. These figures should be treated as estimates. [12]

Numbers of allocated and linked workers for each child (from the local authority client information system)

	Social workers	Managers	Others such as reviewing officers	Period
Child 1	5		1	1996-2001
Child 2	9	17	2	2004-14
Child 3	12	5	6	2003-14
Child 4	14	5	6	2003-14
Child 5	10	5	1	2004-14
Child 6	6	3	1	2004-14
Child 7	4	5	2	2010-14
Child 8	6	11	2	2010-14

4.4.24. Some of the children's local authority social work records show long gaps between visits and little evidence of children being seen alone on visits to their placements.

[11] For example Hackney LSCB (2014)

[12] The numbers are taken from information produced from the local authority client record system. Such systems may miss workers whose details have not been entered or include workers allocated only briefly to fulfil specific roles or tasks. They may therefore an overestimate of the number of social workers who should have been expected to form meaningful relationships with the victims of abuse, and should be treated as indicative of the scale of the problem, rather than being precise. The figures cover the period the children were in care up to the time that the 2014 allegations were made. The figures cover a longer period in care not just the periods when the children were not in the foster care placement. Older figures appear not to note details of managers involved.

4.4.25. Although they were both very young when living with the foster carers, the two children who spoke to the SCR had a clear recollection of social workers visiting them, though not most of their names. With the exception of their current allocated social worker their overriding impression was that social workers had not been reliable i.e. were usually late, often missed or cancelled appointments and sometimes failed to do things they had promised. They both said that it was extremely unlikely that as young children they would ever have confided in a professional about something like sexual abuse that was so confusing and hard to explain. If they believed that professionals such as social workers were unreliable about such basic things, this made it even less likely that they would confide in a social worker about anything complicated or difficult.

4.4.26. This echoes themes consistently identified in research with children who are in contact with professionals because of child protection concerns.[13] Young people value professionals who do simple things properly and do what they say that are going to do. The opposite applies.

Social work priorities

4.4.27. Even when the best intentioned and most diligent social workers are working intensively on a child's case, their priority is often to complete aspects of the work required by courts or local authority and multi-agency procedures. These is always time consuming and often challenging and an easily distract attention from the task of visiting children, seeing them alone and developing a detailed understanding of their experience in their current placement.

4.4.28. Accounts of behaviour and events provided by children's placements are often used to inform the assessment of need being provided by the social worker. The social worker may therefore be more concerned to hear from the carer about the child rather than understanding how the child is experiencing the placement. Efforts to obtain the voice of the child will often be focused on the need to inform the long term plan rather than to the quality of the care in the current placement.

4.4.29. One example taken from the case records of Child 2 during November 2004 – March 2005 includes the following social work activities:

- Meetings with the birth mother (4)
- Supervised contact sessions (11)
- Core group meeting
- LAC review
- Personal Education Plan meeting at school
- Meeting with fostering service to discuss contact

[13] For example Roger Barford (1993) *Children's Views of Child Protection Social Work*. Norwich: Social Work Monographs. (Social work monographs, no.120). NSPCC Library at QLJ JD, ISBN 1857840097

- Other professionals meetings (2)
- Home visit to extended family to commence core assessment

The social worker evidently saw the child many times but mostly while in the course of doing something else. No visits are noted where the purpose was specifically to talk to the child, though the social worker or colleagues are likely to have spent some time with her driving her to contact sessions. There was one brief social work contact with the female foster carer, fitted in after dropping Child 2 from a supervised contact visit. The social worker's reflection on this centred on the difficulties that the female foster carer had in arranging contact because she had four children in placement plus two in day care i.e. it was a concern for a co-worker's ability to implement the agreed plan, rather than a reflection on how this crowded placement might be affecting the child.

4.4.30. Sometimes records acknowledged that the focus of work has shifted from the needs of children to those of a parent. One supervision note on Child A states that '*the focus in contact at the centre should be on (Child A's needs, however (the mother's) needs superseded this, which is unacceptable'. The worker acknowledged that she has 'experienced a steep learning curve in this case, not only with the proceedings but also in keeping [a] focus on the child'.* This underlines the importance of supervision in ensuring that front line staff listen carefully to what children have to say about their placements and carers.

What can social workers and other professionals hope to achieve?

4.4.31. Social workers and other professionals should of course see children regularly, be reliable and keep appointments. However simply visiting children in line with the statutory requirements (or more often if that were possible) will not necessarily enable children to talk more freely to social workers about experiences such as sexual abuse. Children who have been abused most often chose to confide in adults with whom they have been able to build a close and trusting relationship over a period of time. Given the current range of roles and responsibilities of social workers employed by local authorities the development of such relationships is difficult to achieve.

4.4.32. Looked after children may not be able to talk to social workers about all of the most difficult issues in their lives. However it is absolutely essential that the child should see the social worker as someone who is reliable, has a good knowledge of his or her past, knows the important people in the child's life, observes the child carefully, asks thoughtful questions, listens to their views and explains things clearly. If a child has something very distressing to tell, they may well not choose to disclose it to the social worker, but they need to have a strong sense that the social worker is part of a group of people around the child who can understand and deal

effectively with troubling information. That would significantly increase the likelihood of the child choosing to tell someone.[14]

Looked after reviews

4.4.33. Activity to ensure that the voice of the child has been heard should come together through the looked after review (LAC review). Regulations require that each looked after child has a review within defined periods after coming into care and then at least every six months. The purpose is to ensure that there is an agreed care plan, the child (among others) has contributed to it, and that it is being implemented in a purposeful way.

4.4.34. Over recent decades expectations in relation to reviews have changed, requiring greater opportunities for children and young people to contribute to reviews, both at meetings and in individual dialogue with social workers and reviewing officers and more independence in the chairing and oversight of reviews. More recently reviewing officers are expected to have some contact with looked after children and monitor their care plan between review meetings.

4.4.35. The LAC reviews of children placed with the foster carers took place over a period of 14 years during which different expectations applied. Until late 2002 most reviews would have been chaired by team managers (or in some instances by social workers themselves) who had limited independence.

4.4.36. Even as new standards were implemented it is not always possible to find evidence of good practice. Information provided by the local authority indicates that not all copies of review minutes could be found, children did not always attend their reviews or send in their views via consultation leaflets, file records do not always indicate if children were seen alone prior to their review and independent reviewing officer caseloads were often high so that engagement of children and oversight of placements between reviews was limited.

4.4.37. As a result of all of these factors the SCR has not seen evidence that the concerns and allegations detailed in the chronology were considered in detail as part of the build up to review meetings or featured in plans made at reviews.

Is the protection of children hampered by a belief that 'children in care are safe'?

4.4.38. It has been proposed that professionals may have been less curious about the possible abuse of children in care because there is an underlying belief that 'children in care are safe'. As a general proposition this seems unlikely. No sensible person would openly make this claim because it is

[14] Hackney LSCB (2014)

widely recognised that children go missing, make allegations against carers and are sometimes exposed to abusive behaviour from their peers. Most professionals know of cases which would refute the general proposition. However professionals are more likely to form the view that the individual child for whom they are responsible is safe, because they believe that in the individual case competent colleagues have vetted and trained the carers and well-tried systems are in place to supervise and inspect placements. They may also form the view that the child is safer than he or she was in their home environment.

4.4.39. Professionals have a responsibility to consider how they can maintain a healthy scepticism about the safety of the individual child while maintaining their confidence in the system as a whole and not raising unnecessary anxiety.

Learning and wider implications

4.4.40. There is a strong case that shortcomings in procedures and practice in all of the areas reviewed will make looked after children more vulnerable to abuse and less likely to report it. The SCR recognises that in all of these aspects of practice expectations about what constitutes normal practice have changed over the years as a result of which policies and practice have evolved. Procedures in fostering services need to reflect current knowledge about the way in which those who want to harm children think and act, so that staff are sufficiently aware of risks. The capacity of any local authority to provide a high standard of care also depends to a considerable degree on its capacity to attract and retain good staff.

4.4.41. The local authority has provided a range of additional information to the SCR about changes to its policy and practice in relation to fostering that have taken place since 2014, including the Fostering Improvement Plan (2013). These have brought its policies and procedures into line with current fostering regulations and reflect the learning from previous reviews. Arrangements for the supervision of foster carers and their annual review have been revised and higher standards of care are in place for looked after children. Three yearly changes are made in the allocation of supervising social workers which should reduce any potential risk of collusion.

4.4.42. The local authority also accepts that recording of events in fostering records is not always of an acceptable standard and that chronologies of key events are not always complete. The local authority does not have a system which enables foster carers to add their daily diary to other children's notes in the client record system, so that they can be read at any point by the child's social worker and the fostering service.

4.4.43. In November 2017 the local authority carried out an audit of safeguarding arrangements in fostering services which made a series of recommendations. These have been shared with the LSCB and are

reproduced as Appendix 4 of this report. The LSCB should seek continuing assurance that the actions required by these recommendations have been taken.

Recommendations

4.4.44. The local authority must provide assurance to the LSCB that arrangements for the supervision and oversight of the work of foster carers are safe and effective.

4.4.45. The local authority must provide assurance to the LSCB that and that the findings of its November 2017 internal audit of fostering safeguarding are implemented.

4.4.46. The local authority must provide assurance to the LSCB that its systems for care planning and safeguarding for looked after children keep them safe

4.5. Investigation of concerns and allegations

Introduction

4.5.1. This section considers the response of the local authority when there were concerns raised about standards of care provided by the foster carers. The most important event was the investigation of allegations made by Child 8 in May 2012.

Information from the narrative

Individual signs of possible abuse

4.5.2. Review by the local authority of case records has highlighted a number of episodes when children exhibited behaviours or symptoms that could have been an indication of sexual abuse. In the main these were one off presentations that merited further discussion and investigation. Examples included:

- Two girls of pre-school age presenting with soreness in the vulva
- Instances of sexualised behaviour
- Young girls dressed in an unusual or sexualised fashion

4.5.3. There were also instances in which foster children had unexplained bruising that could have been consistent with physical abuse. These episodes were documented but the review has found no evidence that they were investigated so it is impossible to be any more certain.

4.5.4. In most of these instances the bruises were noticed by members of the child's family and were reported to have taken place at the foster carers' home and then seen during a contact visit. The fact that concerns were reported by family members who may have already harmed or failed to safeguard a child may have reduced the credibility of the report.

4.5.5. Over the period under review a number of other complaints by members of birth families or social workers about the conduct and attitude of the foster carers were refuted, sometimes after apparently cursory investigation.

4.5.6. On one occasion Child 5 told the female foster carer that she '*did not like being left alone'* with the male foster carer, for example when the female foster carer went out with friends in the evening. This was noted in her daily log where it was read by the fostering support worker. They explored why this might be and discussed what could be done about it. The fostering support worker told the review that at the time it did not occur to her that this could signify a serious concern. She mentioned it to her supervisor and worked with the female foster carer to find practical solutions, but the diary entry was not investigated further.

Allegations of sexual abuse in May 2012

4.5.7. In May 2012 Child 8 told his mother that he had been sexually assaulted by the male foster carer. His sister made less serious allegations that would have amounted to poor and unacceptable care, but not a criminal offence.

4.5.8. The allegations were investigated by the police, but a number of factors led the police to conclude that the allegations were probably not true and that there was little likelihood that a criminal prosecution would be successful.

4.5.9. Child 8 was a young child with severe behaviour problems who was already receiving a high level of additional help at his school. There was some evidence that he had often been untruthful with professionals when discussing events at school and his own behaviour. He gave inconsistent or incomplete accounts at different times. The allegations were first reported to his mother, who it was feared might have coached Child 8. The allegations were not passed to the CPS because the police decided that there was no realistic prospect of securing a conviction.

4.5.10. The local authority made no separate enquiries. Although this was a reasonably detailed, specific and unusual account, and no motive was ever found to explain why Child 8 would have made them up, the local authority also decided that the allegations were unfounded. It did this without talking to other children in the household (who might have been able to provide useful circumstantial evidence) or without considering the wider context, including the recent unexplained sexualised behaviour of Child 8. No LADO meeting was convened which would have been an opportunity for multi-agency scrutiny of the circumstances. [15] A well

[15] The Local Authority Designated Officer (LADO) should be involved when there are allegations or suspicions about a person working in a position of trust with children

chaired and thorough meeting would also have led to a review of the foster carers' history and highlighted the list of concerns described in Sections 4.5.2 – 4.5.6 above.

4.5.11. No proper distinction was drawn between the focus of the criminal investigation and the local authority's safeguarding responsibilities, nor between the different thresholds that should have applied. The factors considered by the police did substantially reduce the prospect of a criminal prosecution, but recognising that should not have automatically led to the belief that on balance the allegations were false. The local authority did this without making its own detailed enquiries. As a result insufficient attention was paid to risks to other children in the household.

4.5.12. The episode was later reported to the fostering panel, in the main to confirm that the child protection procedures had been followed. The panel was told that the 'concerns' would be followed up by the fostering team, though it is unclear what this referred to because the consensus was that the allegations had been false.

4.5.13. Shortly after this a further episode of sexualised behaviour by Child 8 became known to the local authority but no consideration was given to what was by then an emerging pattern.

Discovery of a privately fostered child in the household

4.5.14. In 2011 – 12 the local authority identified a privately fostered child living in the household. This was Child A. The foster carers made an application for a Special Guardianship Order (SGO) and the local authority was required to undertake an assessment of her needs. The records show that a considerable amount of detailed work was undertaken with Child A to find out how well the family was meeting her needs and to establish her wishes and feelings about where she should live. Her own parents were unable to care for her and a Residence Order was made.

4.5.15. In contrast to the care taken in working with Child A records do not show any challenge being offered as to why the foster carers had not complied with the law and local policies and reported this arrangement to the local authority for several years. The assessment highlighted the lack of risk assessment of visitors to the household, but there is no evidence that this was explored further, then or later by the fostering service.

<u>Learning and wider implications</u>

4.5.16. The narrative shows that (prior to the allegations made in 2012) there were a significant number of concerns and complaints. Some were held in the case records of individual children and may not have been reported to the fostering service. When reported, the fostering service did not record concerns in a systematic way that would have given professionals working with the family an easily available overview of separate episodes and

would have made it more likely that members of the fostering service would become curious about the pattern. The fostering service had no collective memory of the concerns that had been aired in the original fostering assessment.

4.5.17. As a result new concerns were treated as one off events. Carers' explanations for incidents were accepted. No one in a senior position or with substantial safeguarding experience reviewed the history. Although it is hard to demonstrate conclusively from the information available it is likely that there was insufficient curiosity about some events rooted in an assumption that these children were safe in care and that any symptoms of abuse had been caused by their experience before coming into care. The fact that many individual concerns were reported by birth parents may have meant that they were treated less seriously.

4.5.18. The local authority decided not to continue its own enquiries under Section 47 Children Act 1989 after the police decided that the allegations made by Child 8 could not be pursued. This demonstrated a misunderstanding of differences in the focus and thresholds between a criminal investigation and a safeguarding enquiry. This failure to understand the distinct and separate responsibility has been reported in other authorities.

4.5.19. The local authority has told the SCR that the fostering service now uses a standards of care toolkit and a foster carer risk assessment for each carer which will provide an accessible overview of all allegations and concerns.

<u>Recommendations</u>

4.5.20. The LSCB must seek assurance that in safeguarding cases when there is no police prosecution the local authority exercises its responsibility to evaluate risks to children affected.

4.5.21. The LSCB must seek assurance from the local authority that the threshold for referral to the LADO is correct and that there are thorough investigations of allegations against foster carers.

4.5.22. The local authority has provided the SCR with a list of the recommendations made in other reviews of fostering services. These cover the following areas:

- Training for foster carers, including awareness of sexuality and sexual abuse
- Sexual health services for looked after children
- Young people's use of social media
- Mental health of young people in care
- The involvement of male foster carers and their oversight by the local authority
- Focus on safeguarding during visits to foster homes

- Strategies to deal with carers who are perceived as 'difficult'.

4.5.23. The local authority must provide the LSCB evidence that these recommendations have been implemented and are having a positive impact on the lives of looked after children.

4.6. The role of schools and health agencies

Introduction

4.6.1. This section of the report evaluates the provision made by schools and health agencies for the children and the relationships of professionals in these agencies with the foster carers.

Schools

4.6.2. All of the children attended school well. With the exception of Child 8, who experienced severe difficulties in behaviour and learning, records and discussions with staff who knew the children reveal little that is unusual.

4.6.3. The schools were aware that the children were looked after by the local authority and were diligent in attending looked after reviews. Children had personal education plans (PEPs) required by guidance. The form of these has changed over the period under review. Schools worked closely with the female foster carer and found her to be caring and diligent in the steps she took to aid the children's education.

4.6.4. In contrast the male foster carer was a far less frequent visitor to schools and when he did attend largely did not mingle with other parents. One senior and experienced member of staff told the review that he found him 'a bit intimidating'. This gut reaction did not lead the professional to question whether his presentation might have an adverse effect on children placed in his care. This may be because as far as the school could see the male foster carer was apparently not much involved in the care of the children.

4.6.5. There is no evidence that any specific signs, symptoms or allegations of abuse were missed or not responded to by schools. Child 8 was by some way the most difficult among the children who were victims of abuse. He had been identified as having special educational needs when he arrived at the school. His move to the foster placement when he became looked after by the local authority a few months later coincided with a marked deterioration in his behaviour which continued throughout the placement. This led eventually to his permanent exclusion which is noted as being highly unusual for a child of his age.

4.6.6. Such a deterioration in a child's behaviour is not unknown when coming into care but it was so marked that it should have merited closer investigation, particularly after his allegations against the foster carer in May 2012. This would have been much more likely to have happened had the school been properly notified about the allegation and had there been a properly constituted LADO meeting.

Health agencies

4.6.7. A range of health providers were involved with the 8 children who were victims of abuse and the two who became permanent members of the foster carers' household. This included children who were monitored closely because of health and problems such as their slow or faltering rate of growth, sometimes continuing a pattern of care that had been put in place before the child came into local authority care. Current expectations about the level of monitoring that should be applied to such children (for example detailed clinical guidance from bodies such as NICE) were not in place throughout the period under review. As a result there were presentations that would have been responded to more robustly today than they were historically. None of these suggest that information about signs or symptoms of sexual abuse was overlooked or not responded to.

4.6.8. Others were seen by health visitors and school nurses as part of normal provision. A number of children received speech and language therapy (SALT) assessment and interventions. Child 6 began to attend SALT sometime after moving to the foster carers, but it appears to have been assumed that her difficulties arose from her experiences before coming into care.

4.6.9. All looked after children received health assessments. Standards in relation to these have also developed over the period under review. In particular there are higher expectations about recording who attended with the child and seeing young people alone. More recently greater attention has been paid to young people's sexual health. The only adolescent in this cohort was correctly referred for additional sexual health advice, though this was not linked to any thoughts or discussion about possible abuse by the foster carer.

4.6.10. Health assessments for looked after children under five take place every six months and once a year for older children. There are clearly limits to what can be done by a professional seeing a child relatively infrequently, even if there are no changes in personnel. It is therefore important that health assessments are integrated closely with other planning arrangements. Specialist nurses, social workers and other professionals are encouraged to work closely to ensure that developmental checks and assessments are informed by a good understanding of the child's background, circumstances and plan, particularly any safeguarding concerns. In this way health colleagues will have pointers to areas that should be discussed and will be better placed to pick up on comments made by the child.

4.6.11. Social work staff should be given the findings of assessments and checks and there should be no barriers to information sharing between professionals in these circumstances. Timing of looked after reviews and health reviews should be planned and coordinated.

Recommendations

4.6.12. The management review prepared on behalf of schools and education services has made recommendations in relation to safe recruitment and practice approaches. These are summarised in Section 5 and their implementation will be monitored by the LSCB.

4.6.13. Management reviews prepared by health trusts have made recommendations in relation to the following areas:

- health assessments which take account of members of the family
- record keeping
- guidelines for weighing and measuring children
- capturing children's wishes and feelings in the records
- audit of practice in relation to these areas
- the introduction of age appropriate sexual health questions.

4.6.14. Although there is suggested innovation in some areas most of the recommendations made relate to the implementation of existing safeguarding processes and procedures. Their implementation will be monitored by the LSCB

4.7. How professionals were manipulated and groomed

Introduction

4.7.1. This section of the report considers some of the factors that made it less likely that the abusive acts committed by the male foster carer would be recognised by professionals responsible for safeguarding the children in his care. It considers three elements: 1) deliberate behaviour by the perpetrator; 2) the circumstances of the foster family and the way it came to be seen by the local authority 3) patterns in the response of agencies, particularly the local authority.

Behaviour of the perpetrator

4.7.2. The framework within which the behaviour of the perpetrator is described makes use of the existing literature on offenders who have abused positions of trust in order to abuse children.[16] Quayle and Sullivan have identified a number of patterns of behaviour in perpetrators, termed 'manipulation styles' which have the effect of disarming other professionals. These are summarised below. [17]

[16] M Erooga (ed) 2012 Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them (Wiley)

[17] Chapter 5 in Erooga (ed) lists 1) integrity manipulation style in which the perpetrator stresses their high standard of work and altruistic, magnanimous motives 2) intimidating manipulation style 3) suffering manipulation style – in which the perpetrator presents

4.7.3. The male foster carer used a number of tactics that fall within this framework. In the main he avoided direct professional contact and normal oversight of his practice, did not attend support groups for foster carers or attend training sessions (blocking and obstructing). One member of school staff reported finding the male foster carer 'intimidating', even though he was 'taciturn', had little to do with the school where a number of the children placed in his home attended over the years.

4.7.4. Many of those who saw him in the home environment say that he was arrogant and controlling, self-evidently the more powerful adult in the marriage and dictatorial in his attitude to the children. This pattern of behaviour had been observed at the beginning of the fostering assessment and continued in some relationships. His pattern of making his presence felt by 'popping in' to his wife's supervision discussions with the fostering support worker might fall into this category.

4.7.5. However to have adopted an aggressive, insidious or overt controlling approach in his dealings with all of the professionals that he encountered would have jeopardised his position as a foster carer, not least because such patterns of behaviour do not sit easily with the culture favoured by 'liberal' professionals. It was therefore not surprising that he struck a different tone in situations where he was more observed by a number of people.

4.7.6. The fostering support worker found him occasionally difficult but never offensive or angry with her or in review meetings with social workers. She had substantial experience working with difficult people as a family support worker and may have had a higher threshold for tolerating his lack of 'sensitivity'. Her robust, down to earth character and personality probably made her less prone to be offended or put off by his attitude. She told the SCR that 'lots of people didn't like him', but that there was 'never any hard evidence'.

4.7.7. In line with the 'martyr' style of manipulation, the male foster carer made the most of any shortcomings in the professional system, of which over time there were many: social workers who missed or were late for appointments, poor planning and choice of placements, repeated changes in social workers, mis-scheduling and re-scheduling of meetings. Abusers who notice that children are made anxious or upset by professionals who are unreliable will emphasise how 'useless' they are, further distancing the child from the professionals charged with protecting them.

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himself as a martyr 4) liberal manipulation style – in which the perpetrator presents himself as broad minded or radical in relation to sex and 5) the blocking manipulation style – where the perpetrator attempts to avoid or close down interactions with those who might thwart them

Perceptions of the foster family and its importance to the fostering service

4.7.8. In isolation these patterns of behaviour might easily have led to a breakdown in the relationship with the fostering service were it not for the very positive view that the service had been formed about the foster carers. This relied largely on the positive reputation of the female foster carer (though there is no evidence that this was part of a deliberate strategy).

4.7.9. It is not clear from the fostering assessment and approval what the couple's motivation to foster was or that they offered anything special as carers. They had one adult child of their own, no extensive family or community network of children and no work experience with children. Nevertheless from the beginning the fostering service valued them highly because of their flexibility and willingness to offer a range of placement. The female foster carer was noted to be very good at winning the confidence of and making relationships with the parents and extended families of children placed in their care, especially with local families who often did not otherwise cooperate with professionals.

4.7.10. From the viewpoint of the fostering team the female foster carer was an ideal colleague, good at keeping in contact and asking for advice at appropriate points, not a foster carer who was totally self-reliant or with the highest level of skill, but one who knew when to share difficulties and seek advice.

4.7.11. Along with the couple's track record of providing placements that lasted and appeared to meet children's needs, this may well have reduced the level of concern when complaints were made, or the foster carers failed to comply with some normal expectations such as attending training programmes.

Patterns in the response of agencies, particularly the local authority

4.7.12. The third group of factors concerns the safeguards to prevent or detect the abuse of children that are built into the arrangements for the care of looked after children. These systems failed to detect or recognise the importance of background risk factors and patterns of poor or unacceptable behaviour. Details of these shortcomings have been set out in Sections 4.2 – 4.5 of this report and they are summarised here.

4.7.13. During the fostering assessment and approval, initial concerns about the male applicant's belligerent attitude and self-confessed difficulty in dealing with authority figures were not properly explored. They were not incorporated in the assessment document so were not known to staff who would become involved later. The applicant's criminal record should not have excluded him automatically but his offences (which all involved dishonesty) and his attitude to them, particularly the one committed as an adult, should have been discussed in detail. It seems likely that the desire

to recruit foster carers led to insufficient weight being given to the quality of carers recruited, their skills or motivation.

4.7.14. Arrangements for making placements of children were too heavily shaped by business considerations (i.e. was there a placement available?) rather than by the needs of individual children.

4.7.15. Key safeguards were insufficiently robust. Expectations in relation to the training of foster carers were too vague for most of the period under review and there was no expectation for those who were not the main carer (most likely to be men) to participate. Supervision of the foster carers took the form of regular visits from an unqualified member of staff who was diligent in recording and reporting concerns, but her own supervision and management did not enable her to be more reflective about the foster carers or more challenging to them.

4.7.16. Annual foster care reviews were too informal for much of the period under review and later on gave too much emphasis to validating the foster carers' competency and self-esteem and not enough emphasis on understanding concerns that had arisen.

4.7.17. When concerns did occur they were not documented in a way that enabled professionals to form an overview, hence they were treated as one off events. The allegations made by a child in May 2012 provided an opportunity for professionals to form this overview and evaluate the safety of children living in the household. During the same period an assessment was being made of Child A's unreported private fostering arrangement, which should have raised concerns further. That opportunity was missed because professionals too quickly formed the view that the allegations were false.

4.8. Corporate and multi-agency oversight of the safeguarding of children who are looked after by the local authority

Introduction

4.8.1. The SCR has established the arrangements for the local authority and multi-agency oversight of the safeguarding of looked after children in order to consider whether they need to be made more effective.

4.8.2. The responsibilities of Local Safeguarding Children Boards (LSCBs) in relation to looked after children during the period under review were set out in the statutory guidance for LSCBs in 2006 and 2010. Both versions of the guidance identify looked after children as being '*potentially more vulnerable than the general population*' and therefore likely to require

specific services and procedures to safeguard their wellbeing.[18] More recent guidance leaves greater discretion to local safeguarding partners and makes no specific statement about the safeguarding of looked after children.[19]

4.8.3. The Ofsted inspection framework which applied at the end of the period under review expected LSCBs to provide '*regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children'* The focus should include contact with safeguarding arrangements throughout 'the child's journey' including provision for looked after children.[20].

4.8.4. Overall responsibility for the welfare of looked after children sits with the the local authority Corporate Parenting Panel, which is chaired by an elected council member. It is attended by council members and senior officers of the local authority and other agencies as well as foster carers and representatives of advocacy groups, children in care councils and care leavers, making it a large forum.

4.8.5. The overall brief of the group is to ensure that the welfare and achievements of looked after children are promoted as part of the wider council objective of improving the quality of life of children and young people, paying particular attention to their health and education and seeking to ensure that the views and experiences of young people in care shape the way in which services are provided. The panel often hears directly from young people themselves about their life in care.

4.8.6. The Corporate Parenting Panel regularly considers matters that have a bearing on the safety of young people in care such as children who go missing and child sexual exploitation. Since 2016 the panel has had two substantial discussions which touch specifically on the safety of children in foster care: in March 2016 it received an update on the county council's fostering improvement plan and in November 2017 it discussed the local authority strategy document on safer care for children living away from home. This would seem to be an appropriate mechanism through which elected members receive reports on the safeguarding of children in care though it is not possible to be certain from the minutes how much close scrutiny of safeguarding policy and practice takes place.

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[18] For example, Working *Together to Safeguard Children 2006* Section 3.13 and *Working Together to Safeguard Children 2006* section 3.14.

[19] *Working Together to Safeguard Children 2018*

[20] OFSTED (2014) *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers - Reviews of Local Safeguarding Children Boards.*

4.8.7. The Safeguarding Children Board receives occasional updates from the Corporate Parenting Panel, though these are largely limited to its organisational arrangements and membership.[21]

4.8.8. Given its existing brief in relation to the welfare and safeguarding of children and young people 'throughout the child's journey', and the findings of this and other Serious Case Reviews in relation to the vulnerability of some looked after children, the LSCB should consider how it can develop mechanisms which enable it to have a much more detailed working knowledge of the quality of provision made for this group of children and their safety. The need for clarity over this will be greater as the local authority, health services and the police implement the revised 2018 statutory guidance, since this leaves greater discretion as to how the safeguarding of looked after children should be overseen.

5. Recommendations

Introduction

5.1.1. The review has made recommendations in the following areas of practice and service provision:

- Continuing support for the victims of sexual abuse by the foster carer
- Improvements in he local authority fostering services
- Oversight and scrutiny of the safeguarding of children in foster care by the LSCB

5.1.2. These recommendations are designed to complement recommendations already made by individual agencies in their individual management reviews. Activity to address the agency recommendations will be reported by each agency to and monitored by the LSCB Quality and Effectiveness Group.

5.1.3. The LSCB response to this report will confirm what progress has been made in the implementation of these recommendations.

Serious Case Review recommendations

5.1.4. A number of the events that have been reviewed occurred many years ago and the review has been told that there have been significant subsequent changes in policy and practice. It is not the role of the SCR to determine whether these changes have already addressed the concerns identified. This is for local authority and other agencies to explain in their response to the SCR and for the LSCB to monitor in its future work.

Recommendation 1

[21] The SCR has been made aware of three agenda items in 2016 and one in 2017.

5.1.5. The local authority must devise an unobtrusive means of keeping in touch with the victims of sexual abuse by the foster carer in order that further opportunities for support remain available. Oversight of the further response must sit with a senior manager and not lapse when personnel change.

Recommendation 2

5.1.6. The LSCB must satisfy itself that the local authority is applying standards of good practice to all aspects of the recruitment of foster carers (which should be taken to include foster carers, adopters, short-term and respite carers, and those who already form part of the child's family network where they apply for care of the child).

Recommendation 3

5.1.7. The local authority must ensure that when foster carers are approved but there remain reservations on particular issues the fostering panel will put specific measures in place to address the concerns and implement them.

Recommendation 4

5.1.8. The local authority must provide assurance to the LSCB that foster care placements are made as far as possible with carers who have been assessed as being able to meet their needs. If placements are made out of necessity as an emergency with carers who will not fully meet this criterion over the medium / long term, this must be urgently addressed in the care plan.

Recommendation 5

5.1.9. The local authority must provide assurance to the LSCB that its systems for granting exemptions to the approved number of children placed in a foster home operate in line with the fostering regulations and do not negatively impact on children's welfare.

Recommendation 6

5.1.10. The local authority must provide assurance to the LSCB that arrangements for the supervision and oversight of the work of foster carers are effective, including arrangements for annual foster carers reviews.

Recommendation 7

5.1.11. The local authority must provide assurance to the LSCB that and that the findings of its November 2017 internal audit of fostering safeguarding are implemented, (see Appendix 4).

Recommendation 8

5.1.12. The LSCB must seek assurance that in safeguarding cases when there is no police prosecution the local authority exercises its responsibility to evaluate risks to children affected under Section 47 Children Act 1989

Recommendation 9

5.1.13. The LSCB must seek assurance from the local authority that the threshold for referral to the LADO properly reflects potential risks to children in care and is being consistently referred to in practice

Recommendation 10

5.1.14. The LSCB must develop mechanisms which enable it to have a much more detailed working knowledge of the quality and safety of provision made for looked after children and an appropriate scrutiny arrangement with the local authority Corporate Parenting Panel. This must be considered as part of the introduction of revised safeguarding partnership arrangements required by the implementation of *Working Together to Safeguard Children 2018.*

Appendices

Appendix 1	Principles from statutory guidance informing the Serious Case Review method
Appendix 2	How the review was undertaken
Appendix 3	SCR panel members
Appendix 4	Recommendations from the local authority fostering service audit 2017
Appendix 5	References and background reading

Appendix 1

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Appendix 2

How the review was undertaken

1. The LSCB asked member agencies to compile a chronology of key events based on the written and electronic agency records.
2. The LSCB established a review panel to oversee the conduct of the review consisting of the independent lead reviewer and senior staff from participating agencies and commissioners who had not been involved in the work with the family. To provide additional independence the review panel was chaired by a senior local manager whose agency had not been involved in the case
3. Agencies prepared individual management reviews setting out learning for their own agency
4. Members of the review team held individual interviews with members of staff and managers, supported by review of records where this assisted
5. The lead reviewer sought the involvement of victims and conducted interviews when the victim was willing
6. The lead reviewer drafted findings which were discussed with the review team
7. Further drafts of the report were prepared and circulated to the LSCB Serious Case Review group members
8. The LSCB discussed and agreed the report and recommendations

Appendix 3

SCR REVIEW TEAM MEMBERSHIP

Independent and LSCB representatives	
LSCB member	Independent Panel Chair
Keith Ibbetson	Independent Lead Reviewer
Business Manager	Safeguarding Children Board
Project Officer	Safeguarding Children Board
Review Team Representatives	
Agency	**Designation**
Police	Detective Chief Inspector
Local authority	Independent Reviewing Officer Team Manager
	Principal Officer
	Head of Quality and Safeguarding, Public Health
Clinical Commissioning Group	Designated Nurse
Community NHS provider	Named Nurse for Safeguarding

Appendix 4

Recommendations from the local authority 12 plus Foster Carer Audit 2017

1. Foster carers to have access to training about adolescent development.

2. Young people in care to have access to supportive and flexible sexual health services.

3. Foster carers to have training to be aware of, and learn how to mitigate, some of the risks to children / young people where sexuality is concerned.

4. Foster Carers need to be aware of how various Social Media platforms (snapchat, Instagram, Facebook, etc.) operate.

5. The Fostering Service needs to develop a plan to ensure that SDQ's are completed for children in care.

6. The FSW and the child's SW to routinely review whether they are having contact with all carers within the placement, specifically any male carer who appears 'invisible'.

7. All visits to the placement by the FSW and the child's SW to have the safeguarding of the child or children in placement as the priority and this must be clearly evident in the recording of these visits.

8. Any carer or carers who are considered 'difficult' to work with must be flagged up the relevant Service Manager (SM) in the first instance, and the SM to lead a review on why this appears to be the case and the implications for the welfare of children in placement.

9. Professionals must speak to the male foster carer to ensure that the Local Authority understands that they understand their roles, responsibilities, relationships, attitudes and values of the fostering household in the broadest sense.

10. All allegations to be reported to the LADO

Appendix 5

References and background reading

Statutory Guidance and inspection framework

HM Government, *Working Together to Safeguard Children – 2010 - 2013*

Ofsted (2014) *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers - Reviews of Local Safeguarding Children Boards*

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Utting, W. (1997). *People Like Us: The Report on the Review of Safeguards for Children Living Away from Home*. London: The Stationery Office

Warner, N. (1992). *Choosing with Care: The Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes*. London: HMSO

Serious Case Reviews on the abuse of children in foster care

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Nottinghamshire Safeguarding Children Board (2011) Serious Case review DN 11

Rotherham Safeguarding Children Board (March 2010) Mr and Mrs B

Commentary on the Wakefield Council Local authority inquiry into the abuse of children by foster carers, B Parrott et al, Wakefield Metropolitan District Council Publication (2007)

http://www.theguardian.com/society/2007/sep/12/guardiansocietysupplement.childrensservices

Bridget Griffin (2017) Serious case review on Child Claire Croydon Local Safeguarding Children Board

Keith Ibbetson (2014) The sexual abuse of children in a foster home, Hackney Safeguarding Children Board