Serious Case Review

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On behalf of an unnamed local safeguarding children board

Serious Case Review – Young Person 'F'

Overview Report – Anonymised.

July 2018

1. Introduction

This is a report of the Serious Case Review (SCR) into the life of Young Person 'F', who was removed from his birth parents at a very young age due to concerns regarding abuse and neglect. 'F' was placed in foster care as a young child and made subject of a Care Order and subsequently a Freeing Order. Over the last 5 years of his foster placement, concerns were raised regarding a failure to thrive and the care being provided by his foster carers.

2. Scoping period

The focus for the review was a seven-year period to November 2015. This covered the period where there were concerns regarding 'F's physical and emotional wellbeing.

The learning and recommendations in this report should be read alongside the LSCB response document as there have been significant changes in current practice since the end of the scoping period.

3. Young Person 'F' and the foster family context

Young Person 'F' was placed with foster carer 1 (female foster carer) and foster carer 2 (male foster carer).

4. Key practice episodes

The period to December 2009

1. 'F' was placed with his foster carers in 2005, having previously had respite care with them.
2. A psychological assessment of 'F' in 2008 indicated that 'F' presented with complex developmental trauma. During a CiC health assessment, it was noted that 'F' had difficulty swallowing. Because of this he was referred to the Community Paediatrician who in turn referred 'F' to the Ear, Nose and Throat department due to long standing eating and swallowing difficulties.
3. In 2008, 'F's social worker was visiting the placement more frequently to provide support as the foster carers were struggling with 'F's behaviour. The social worker described a tense atmosphere and that foster carer 1 would shout at the children. Despite a comprehensive package of support being in place, including increased frequency of social work visits, housing support, additional funded educational support for 'F' and ongoing art therapy, the foster carers were dissatisfied with the levels of support being offered. 'F's social worker subsequently requested that the case be reallocated due to complaints foster carer 1 had made against them and the difficulties in their working relationship.
4. A professionals meeting was held in June 2008, which included the foster carers. 'F' had been receiving weekly art therapy for 3 years. The Child Health records state that during this meeting it was shared that 'F' was demonstrating sexually inappropriate behaviours. The outcome of the meeting was that funding would be sought for a 'wrap around service' for 'F' including 24/7 therapeutic support to the carers. It was recorded in the education records that the inclusion of the carers in the meeting meant that professionals were not able to share their emerging concerns about the placement.

5. In August 2008, the new social worker spoke with the CAMHS Psychiatrist to discuss a plan for ‘F’ to be placed in a specialist residential unit. The psychiatrist was opposed to the plan as in his view any move would cause him trauma by severing the attachment between him and foster carer 1. The psychiatrist was opposed to the social worker meeting with ‘F’ alone and suggested that she should observe ‘F’ with foster carer 1 rather than form a relationship with him. This social worker only remained allocated to ‘F’ for 2 months before the case was reallocated. The reason for this is not recorded and there was a period when ‘F’ did not have an allocated social worker.

6. In November 2008, ‘F’ disclosed in school that foster carer 1 gets mad with him, is nasty to him and did not like him. He stated that he preferred school to home as he can then get away from her. He described his morning routines and toileting issues and being sent backwards and forwards ‘like a yo-yo’. He stated that he was late for school as his foster carer would make him do things over and over. A copy of the record was sent to the Social Care manager and as a result of this, a strategy meeting was held in December 2008. It was agreed that ‘F’ and 1 would be spoken to simultaneously regarding the allegation. When ‘F’ was subsequently seen by a social worker, he made no disclosures.

7. In January 2009, ‘F’ was discharged from the Ear, Nose and Throat Department as a ‘video swallow’ was normal and no physiological reason was determined for ‘F’s swallowing difficulties.

8. During supervision between the social worker and their manager in February 2009, it was recorded that ‘F’ would be presented to the county panel with a request for a therapeutic residential placement. Discussion also took place about a wraparound support package for the foster placement which was the option being proposed by the Connect service (CAMHS). During supervision in March 2009, it was recorded that the social worker needed to see ‘F’ on their own without foster carer 1 as this had proved difficult in the past.

9. A CiC review was held in March 2009, and it was recommended that a therapeutic residential placement be sought as the placement was not meeting ‘F’s needs. Connect workers who recommended the wrap around service were not present at the review.

10. in March 2009, ‘F’ attended an appointment with the community paediatrician. Foster carer 1 described many concerning behaviours including aggression, withholding stools and excessive washing.

11. ‘F’s social worker continued to struggle to see ‘F’ on his own during visits and so decided to visit him in school. It is not clear whether this happened as there is no record. Reference was also made during the social workers supervision in April 2009 of ‘F’ having disclosed sexual abuse by his birth father during his weekly art therapy. A strategy meeting was subsequently held but led to a single agency enquiry. No further action was taken.

12. The interagency county panel meeting was held in April 2009. The panel did not support the request for a residential placement or for the wraparound service. A multi-agency meeting and further educational psychology and psychiatric assessments were recommended and for the case to be presented again in July 2009 although this does not appear to have occurred.

13. ‘F’s social worker left in July 2009. Foster carer 1 had not allowed the social worker to see F alone and was refusing support with respite or activities despite describing extreme aggressive behaviour from ‘F’ in the placement. A meeting was held in August 2009 between local authority, Education and Connect staff where it was agreed that there was a need to strengthen joint working.

14. In September 2009, the CAMHS psychiatrist wrote to ‘F’s new social worker recommending that ‘F’ remain in his current placement. Foster carer 1 however continued to describe very difficult behaviours, including sexualised behaviours. ‘F’s IRO raised the concern that there were differing professional opinions regarding where ‘F’s needs would be best met. The newly allocated social worker reported in September 2009 that they were making progress in establishing a relationship with ‘F’ and his foster carers and that interagency working was improving. However, after arranging to see ‘F’ alone in school, foster carer 1 reported feeling undermined by this.

The period January 2010 to January 2012

15. In January 2010, an area resource panel was held to consider the request for funding for an agency respite foster placement. This was not approved as it was felt that ‘F’ could see it as a rejection. It was suggested that a residential school be pursued which would allow ‘F’ to return to his current foster carers.

16. In February 2010, the school raised many concerns with foster carer 1 regarding ‘F’s behaviour, ranging from physical contact with girls to head banging, crawling on the floor and talking to ‘ghosts’. The school also contacted the social worker to express concern regarding ‘F’s deteriorating behaviour.

17. A CiC review was held in February 2010 where it was recorded that the CAMHS psychiatrist supported the placement continuing. It was recorded that the foster carers were controlling ‘F’s food intake as he appeared to be unsure when he was full.

18. In May 2010, it was agreed that foster carer 1 would receive therapy on her own right from Connect. During this time, the relationship between foster carer 1 and ‘F’s school became increasingly strained and the school felt that foster carer 1 was hyper critical of ‘F’. Foster carer 1 wished for ‘F’ to be home schooled. It was recorded that foster carer 1 had stated that ‘F’ must change in a separate room for PE and that he was not allowed money for the tuck shop as medical people had advised that he must eat seeds. ‘F’ had reported within school that he was unhappy at home.

19. By June 2010 it was agreed that a residential placement would no longer be pursed for ‘F’ and that ‘F’s psychiatrist supported him remaining with his foster carers. Respite care was still being sought for ‘F’ and foster carer 1’s sister was identified as a possibility.

20. In July 2010, ‘F’s school informed ‘F’s social worker that they had received anonymous information in June that foster carer 1 had been seen in a supermarket with ‘F’ who had his arms crossed around his chest and foster carer 1 was holding his hands behind his back. A professionals meeting was held in August 2010 where this was discussed alongside concerns regarding ‘F’s persistent lateness to school. It was agreed that a LADO strategy meeting should be held, this occurred the next day. It was agreed that the allegation would be investigated but s47 enquiries did not commence.

21. A further LADO strategy meeting was held in August 2010 and considered the allegation as well as concerns regarding foster carer 1’s care such as verbal and written messages to school about monitoring ‘F’s intake of water, lack of praise and controlling behaviour.

22. Respite was being refused and this was supported by the CAMHS psychiatrist. It was agreed that a meeting be held with the CAMHS psychiatrist to highlight the safeguarding concerns regarding foster care 1 and the concern that she may be splitting and manipulating

professionals. It was also agreed that a fostering assessment of foster carer 1's capacity to change be undertaken and for the expectation of the foster carers about respite, be put in writing to them. A review strategy meeting was to be held in 4 months' time.

23. In September 2010, 'F's social worker completed a transfer summary as the case was reallocated as they were leaving the team. It was recorded that foster carer 1 was manipulative of 'F' and controlling of him. It was also recorded that she rejects support from the local authority and would play the social worker off against 'F's art therapist. It was also recorded within the transfer summary that the CAMHS psychiatrist did not encourage the role of the corporate parent and this acted to empower the foster carer.

24. A meeting was held between the locality manager, Head of Fostering and the CAMHS psychiatrist in October 2010. There was also difference of opinion regarding the appropriateness of respite. Also on this date, foster carer 1 contacted 'F's social worker to state that he had alleged that she had hit his hand away from his penis whilst he was urinating.

25. A LADO strategy meeting was held in October 2010 where it was agreed that the threshold for s47 was not met but that the social worker would explore the matter with 'F'. It was concluded that the allegation was unsubstantiated.

26. A foster carer review panel was held in November 2010 where an improving picture was discussed. The foster carers were re-approved as permanent carers for 'F'.

27. In April 2011, 'F' was late for school which he said was because he had to do 200 laps of the garden. By July 2011, the foster carers had not engaged with introductions to the respite carers.

28. 'F' had another change in social worker, due to a restructure within the service. Foster carer 1 was very upset by this as she felt that the social worker's intervention had been positive.

29. 'F' had been referred to an advocacy service yet despite having seen 'F' on 5 occasions, foster carer 1 was always present. The advocate felt that some of 'F's wishes and feelings were being directed by foster carer 1.

30. In September 2011, 'F' was late for school and reported that this was due to his breakfast being taken away as he was being told off for eating too fast. He expressed confusion at being told at night to eat quickly. In September, the fostering social worker informed 'F's previous social worker that the police had been called a week earlier due to an incident where foster carer 1's biological son had become aggressive towards her. 'F' was present during the incident, following this the biological son left home to live with an aunt for a 3-month period.

31. In October 2011, the school were made aware by an anonymous source that 'F' had been seen in the garden at 10pm running around and crying. The person saw water being thrown on 'F', and reported having seen a similar incident the previous month. 'F's social worker visited him in school the following day but no disclosures were made. In October 2011

32. In November 2011, a LADO strategy meeting was held. The SENCO reported that 'F' had reported that if he eats his meals too fast then it is taken away from him but if he does not eat quickly enough it is also removed. School staff were concerned that 'F' had lost a lot of weight.

33. ‘F’ had also reported that foster carer 1 wanted him to go to the toilet so she could see if he had been eating his sunflower seeds. It was decided that a meeting should take place between social care and the CAMHS psychiatrist to look at concerns and that ‘F’ should be weighed on a regular basis. It is not evident that this occurred.

34. ‘F’ disclosed in school in November that foster carer 1 had been shouting at him, criticising his work and throwing it away and calling him a ‘f**ing idiot’. He alleged that she had pushed a chair towards him and that it had hit him on the arm.

35. At a CiC review held in November 2011, it was recommended that an application for a special guardianship order be considered although the team manager stated that this would not be appropriate to be considered for the next 6 months.

36. The IRO for ‘F’ visited him at home in December 2011 but foster carer 1 prevented her from seeing him alone. It was noted that the house was in chaos. The IRO informed the team manager of her grave concerns about the placement but not until December 2011.

37. In December 2011, a fostering panel review was held and the panel unanimously reregistered the foster carers and spoke positively of the couple’s commitment to ‘F’.

The period January 2012 to January 2014

38. Foster carer 1 spoke with ‘F’s art therapist in April 2012 to state that ‘F’ had been unsettled since returning from a school trip to France and wanted to dress up and wear make-up and have sex hormones. In April 2012, foster carer 1 informed the social worker that ‘F’ had stolen food from the bin at school. School later confirmed that he had picked food from the floor and eaten it and watched other children eat. School staff noted that ‘F’ was very slim but that he was sent with a substantial snack and lunch to eat at school.

39. In May 2012 ‘F’s social worker emailed the CiC nurse to enquire whether a referral should be made to a dietician as ‘F’ was eating food off the floor and from bins. In a subsequent report written by the social worker for a CiC review it is stated that professionals believe that ‘F’ stealing food is related to his emotional state rather than being a physical concern. The review took place in May 2012, and it was agreed that monthly meetings would take place due to ‘F’s complex needs. It was recorded that ‘F’ had recently asked about wearing girl clothes, growing his hair long and having his penis removed. This was to be explored further in therapy.

40. ‘F’ was seen by the Speech and Language Therapy Clinic in May 2012. Foster carer 1 reported that ‘F’ would eat some foods whole and had been taking food from bins and would eat constantly from the fridge at home. In May 2012 the GP referred ‘F’ to hospital because of static growth over the last nine months.

41. In June 2012, the school emailed ‘F’s social worker to state that he had stolen money from a teacher’s wallet with the intention of buying food.

42. School staff were increasingly concerned about his food stealing and that he would take cookery books from the library and hide in the toilets to read them.

43. ‘F’ was seen in the paediatric clinic in August 2012. Foster carer 1 described him eating huge portions, swallowing without chewing and undigested food in his stools. General examination was normal and it was agreed to review in 3 months.

44. In September 2012, the school made a referral to children's social care regarding concerns conveyed to them by Foster carer 1 about 'F' and another boy engaging in sexualised behaviour and that 'F' had said that he was going to have sex with the boy in the toilet. A strategy discussion took place with the police and it was agreed that single agency s47 enquiries would be completed and a core assessment was commenced.

45. A CiC review was held in October 2012. Concerns about 'F's weight, lateness to school and sexualised behaviour were discussed. It was agreed that an urgent appointment with the CAMHS psychiatrist should be sought which was held in October 2012.

46. A core assessment was completed by 'F's social worker in November 2012 and it was recorded that due to a history of sexual abuse and current sexualised behaviour, 'F' is a potential risk to others.

47. In January 2013, concerns were raised by the school nurse in respect of 'F's physical health, that he was not growing or gaining weight and was undergoing investigations and had black feet which the GP had diagnosed as chilblains. The dietician had sent a food diary to be completed which was completed by Foster carer 1 and stated that 'F' consumed 3500 calories a day. He was therefore discharged as this was a one-off dietetic assessment.

48. In February 2013, during supervision, 'F's social worker shared that they had discussed with the CAMHS psychiatrist referring 'F' to the NSPCC programme for young people who show sexualised behaviours. The social worker made the referral two days later.

49. In February 2013, a fostering panel review was held, and it was formally clarified that 'F's placement was a permanent one. At a Personal Education Plan (PEP) meeting held the next day it was recorded that 'F' had been found eating food from a bin at school.

50. A CiC review was held in March 2013, and it was noted that there had been no further incidents of sexualised behaviour in school. Concerns about weight were discussed and it was agreed that he should be re-referred to a paediatrician. Monthly meetings between the key professionals were also being held due to 'F's complex needs.

51. 'F' attended a paediatric appointment in March 2013 regarding his weight loss and further investigations were ordered including a MRI scan.

52. In early June 2013, foster carer 1 informed the school that 'F' had groomed another young person which led the school to be concerned about another person being at risk of grooming. At a meeting held in June 2013, foster carer 1 informed professionals that 'F' had become sexually aroused at school and had taken himself to the toilet. In June 2013, foster carer 1 informed 'F's social worker that he had disclosed a sexualised dream/fantasy where he kidnapped and forced sex with a young girl from school. The NSPCC worker was informed.

53. In July 2013, the NSPCC completed the AIM2 assessment which stated that 'F' was of medium risk and should undertake a specialist treatment programme for adolescents displaying harmful sexual behaviours.

54. In July 2013, a CiC review was held and it was noted that 'F' had been diagnosed with ADHD, PTSD and attachment disorder and that his weight was being monitored by a paediatrician (there is no evidence of these diagnoses being made within the records). In July 2013, a paediatric appointment was held and as all tests to date were normal it was agreed that a second opinion should be sought.

55. At a meeting held between the school and social worker in September 2013, it is recorded that the NSPCC wished to have sessions with ‘F’ without foster carer 1 being present and that she infantilises him. It was recorded that ‘F’ was not a sexual risk to others.

56. A fostering review panel was held in October 2013, and it was noted that the panel should have been made aware of the additional person in the household back in February.

57. In October 2013, a letter was sent from the dietician to the paediatrician to state that the family had not engaged with the dietetic service as the food diary had not been returned. ‘F’ was seen in the paediatric clinic in November 2013 and ‘F’ described pain coming from inside and pointed to his abdomen. Foster carer 1 stated that she locks the kitchen door to stop him eating. The conclusion was that there was no clear endocrine disorder but there would be further tests and an abdominal scan. The scan results were normal.

58. In November 2013, foster carer 1 reported to ‘F’s social worker that he was fantasising about inflicting physical pain on his female Teaching Assistant, who subsequently felt unable to work with ‘F’.

January 2014 to the end of the review period.

59. On 13th March 2014, the paediatrician noted that there was no identified cause for weight and growth loss and considered a referral to the gastrology team at Addenbrookes hospital.

60. Foster carer 1 reported that ‘F’ disclosed sexual abuse by his father when in his parents’ care which led to a strategy discussion being held with the police. The outcome was a joint investigation between the police and social care.

61. A professionals meeting, including the foster carers was held in April 2014 where it was recorded that the NSPCC were of the view that ‘F’ presented a low risk of sexual harm to others.

62. By May 2014, concerns were increasing regarding poor school attendance and being late. Concerns continued throughout June, with the additional concerns that ‘F’ had lost weight and presented as glazed and withdrawn at school.

63. A CiC review was held in June 2014, where it was recorded that the NSPCC work had completed. It was agreed that an urgent meeting was required with the psychiatrist to explore issues relating to school, transition to adulthood and further work about sexualised behaviour.

64. In July 2014, ‘F’ was absent from school for 4 weeks. An urgent meeting was requested. It was subsequently agreed that ‘F’ would attend a Pupil Referral Unit (PRU). In July 2014, ‘F’s social worker and the psychiatrist completed a joint home visit to discuss his anxiety about school. It was recorded that the psychiatrist did not feel that ‘F’ posed a sexual risk to children.

65. A meeting was held in September 2014, attended by the psychiatrist, PRU and foster carer. The psychiatrist was clear that getting into school late was a learned behaviour and that foster carer 1 needed to break the cycle.

66. During an art therapy session in October 2014, ‘F’ was recorded to walk into therapy in a half crouching position, talking to himself and constantly watching foster carer 1.

67. In October 2014, ‘F’ attended a gastrology appointment but discharged as no indicators of concern. School reported during October that ‘F’ was always looking for food.

68. A CiC review was held in December 2014 where it was recorded that ‘F’ had unexplained poor growth/weight gain.

69. The art therapist was to offer sessions to foster carer 1. The concerns were communicated to the fostering team who offered support which was refused by foster carer 1.

70. In February 2015, the head teacher at the PRU raised significant concerns regarding ‘F’s emotional and physical health and raised the possibility of fabricated illness. The social worker subsequently sought the opinion of the paediatrician who admitted to not having objectively assessed ‘F’s dietary intake. The social worker received a report from the paediatrician in March 2015 which stated that there was no specific reason to suspect fabricated illness. Concern regarding stealing food continued.

71. By the end of March 2015, ‘F’ was in receipt of home tuition. In April 2015, transition work commenced for ‘F’ to transfer to the Leaving Care team.

72. In paediatric clinic in May 2015, it was agreed that ‘F’ would be admitted to hospital for a week to observe his dietary intake. Concerns were also expressed about ‘F’ appearing blue about the face and having non-healing wounds to his toes. Foster carer 1 stated that if admitted she would have to be present throughout the stay to safeguard others from any potential risk posed by ‘F’.

73. A CiC review was held in May 2015. The report does not include significant events since the last review. Foster carer 1 was not in attendance.

74. In June 2015, the paediatrician informed ‘F’s social worker that the admission could not go ahead due to the risk ‘F’ posed to other children. The social worker sent the paediatrician the NSPCC risk assessment. It was determined that it was not safe to admit ‘F’ to a children’s ward.

75. Following a CiC health assessment, the CiC specialist nurse wrote to the paediatrician on 9th July 2015 expressing concern about ‘F’s weight loss and that foster carer 1 was videoing what he is eating. He had blue lips and cold feet.

76. A professionals meeting was held in July 2015 during which the therapist stated that ‘F’ had told her that foster carer 1 does not always let him eat his meals and she will throw it away if he is being slow although she told him to eat slowly because of the risk of choking in the past. The social worker agreed that she would consult with their manager about requesting a strategy meeting.

77. In July 2015, a LADO strategy meeting was held. Concerns were raised that ‘F’ was either not being fed correctly or had an eating disorder. Plan was for admission for observation without foster carer 1 being present but with the support of a mental health nurse. This was conveyed to foster carer 1 the next day who was upset about being excluded from attending the hospital, became angry and threatened to end the placement. The psychiatrist later advised that foster carer 1’s concern regarding separation anxiety should not be a barrier to admission.

78. Admission to hospital occurred on in August 2015 for 5 days to an adult ward. ‘F’ gained 4.6kgs during this period. Intrusive parenting by foster carer 1 was observed by ward staff. ‘F’ did not demonstrate any fussiness over food or any ritualistic behaviour.

79. In August 2015 (prior to discharge) a LADO strategy meeting was held. It was agreed that respite placement would be arranged and that ‘F’ would be weighed monthly. High levels of multi-agency support/monitoring to the placement were agreed, including a greater role being played by foster carer 2 regarding ‘F’s diet.

80. In August 2015, ‘F’ was seen alone by the social worker as part of on-going s47 enquires. ‘F’ stated that he was happy in his placement and wanted to remain there..

81. In September 2015, ‘F’ was visited by his social worker. He informed them that when he told foster carer 1 that he liked a girl at college her response was to say that he was gay.

82. In September 2015, a review LADO strategy meeting was held. It was discussed how since the last meeting foster carer 1 had fitted an alarm to ‘F’s bedroom door, apparently due to him wandering at night. Foster carer 1 reported that this was to safeguard her from sexual assault by ‘F’. The psychiatrist expressed concern about overly punitive parenting and factitious disorder by foster carer 1. It was agreed that the concerns that ‘F’ was not being fed by his carers were substantiated.

83. ‘F’ went to his respite placement from September 2015 until October 2015. He was observed to be relaxed and eating without difficulty. No night wandering or sexualised behaviour was observed.

84. In October 2015, a professionals’ meeting was held. It was agreed that the foster carers did not have the ability to sustain the changes required and that a new planned placement should be sought.

85. In November 2015, the fostering panel decided to deregister the foster carers.

5. Analysis of practice and key learning points from the review

Key Learning Point 1 – Some statutory processes for Children in Care (CiC) were not always fulfilled.

Young person 'F' was not routinely seen alone by social workers or by the IRO, particularly during the early part of the scoping period.

CiC reviews were not always contributed to by all the key professionals, leading to a disconnect between 'F's emotional and physical health needs and a lack of oversight of the care plan and quality of care. 'F' received minimal contact from the CiC specialist nursing team as he was under the care of a paediatrician. This affected planning and communication as they were not always one of the key professionals reviewing 'F's care plan.

Key Learning Point 2 – The Independent Reviewing Officer (IRO) needs to ensure that the CiC review process is effective.

The statutory role of the IRO in chairing CiC reviews is to provide an independent, consistent oversight and ensure the care plan is progressing. During the scoping period, 'F' had many different IROs. This led to inconsistent evidence of robust challenge, resulting in lack of progress of the care plan to ensure F's needs were met.

Key Learning Point 3 – CiC Health assessments should be holistic, including all relevant information about the child's physical health and emotional wellbeing.

A health assessment should result in an outcome focussed health care plan, which is informed by all health agencies working with the child. It should address their physical health and emotional wellbeing.

Had the CiC health assessment process been consistently overseen by the CiC specialist nurses and considered information from all health professionals, it would have resulted in a more effective, multi-agency health care plan.

Key Learning Point 4 – Every agency and all foster carers need to understand the statutory requirements for Children in Care to be seen alone. 'F's voice and lived experiences were not sufficiently captured and taken into account.

There was inconsistency in 'F's independent views being included in planning by some agencies.

A common feature was foster carer 1's refusal to allow 'F' to be seen alone by his social worker, as she felt that the social workers did not know 'F' well enough. The child must be placed at the centre of all interventions with children in care and those caring for them.

Key Learning Point 5 – Generalisations were viewed as fact and not evidence based.

Throughout this case, there is evidence of descriptions and generalisations becoming viewed as fact and going unchallenged by professionals, which led to inappropriate and possibly harmful

interventions. An example of this being the suggestion that 'F' displayed inappropriate sexual behaviour. This led to 'F' being labelled as a young person who posed a risk to others, with little evidence to support this. This meant that his interactions with peers were significantly restricted and closely monitored by his foster carers, which has likely impacted negatively on his ability to develop age appropriate friendships and social skills.

There was lack of professional curiosity to identity obvious concerns with a tendency of professionals to resort to complex psychological explanations rather than more straightforward, factual exploration of reasons for some of F's worrying behaviour.

Key Learning Point 6 – There needs to be appropriate challenge to the views and opinions of foster carers

The was an assumption by professionals that as 'F' was a Child in Care, he was safe. The fostering panel did not provide effective challenge to 'F's foster carers, allowing their actions to often go without scrutiny and recommendations.

Supervision of foster carers was not effective in that there was not sufficient challenge from the supervising social workers in relation to concerns about their care, with the relationship between foster carers and their fostering social workers becoming uncritical. This was further complicated by the manipulative behaviour of the female foster carer who manipulated part of the professional network by forming "alliances".

Key Learning Point 7 – The lack of recording of foster carer 2's involvement with 'F'.

There is very little recording of any meaningful engagement with foster carer 2 and his role in the care of 'F'. Fostering records described him as avoidant and professionals described him as becoming disengaged in 'F's care. The fostering supervising social worker, manager and panel need to ensure that both fostering partners are effectively managed.

Key Learning Point 8 – The balance of influence and power between the professionals was not appropriate and there has been a culture of practitioners and managers from all agencies deferring to the views of "expert" professionals. The Local Authority must take responsibility for being the lead agency for Children in Care.

The Local authority as the lead agency for planning for Children in Care, had a responsibility to ensure that 'F's needs were met. This was not supported by all professionals and some of these had a disproportionate influence on the planning and direction of the case.

Professionals from all agencies involved with 'F', did not consistently demonstrate confidence in their decision making in relation to 'F's care planning and support having a tendency to defer to opinions of the professionals deemed to be "expert" without challenging these even when they were in contradiction with statutory requirements in relation to care planning for children in care.

Key Learning Point 9 –The LADO process was not robust enough in progressing action plans.

Many LADO strategy meetings were held in respect of allegations in relation to the female foster carer's care of 'F'. The outcome being s47 enquiries only occurred once despite allegations of physical harm and inappropriate restraint.

Each LADO meeting considered the presenting concern, there was not always sufficient analysis of the history of concerns or effective following through of resultant action plans.

Key Learning Point 10 – Safeguarding concerns raised by professionals having direct, day to day contact with 'F' were not given sufficient weight in decision making regarding planning for 'F'.

Whilst some LADO strategy meetings were held following safeguarding referrals from 'F's schools, they did not result in sufficiently robust responses. Some of the safeguarding concerns raised appropriately by schools with the social work team responsible for 'F' did not result in initiation of LADO strategy meetings or Section 47 threshold meetings, instead they were dealt with as part of routine care planning processes.

Key Learning Point 11 – There should be effective supervision and management oversight of cases that are not progressing or are stuck with appropriate escalation in place where differences of professional views within multi-agency context are not resolved and/or they impact negatively on the progress of the child's care plan.

Case management supervision across all the agencies involved with 'F' was not robust enough, in some cases leading to prolonged interventions with 'F' with no clearly defined outcomes for him to be achieved.

Each agency needs to ensure that professionals have the knowledge and the confidence to raise concerns when a case is not progressing and utilise the LSCB Professional Disputes policy.