Southampton
Safeguarding Children Board
Serious Case Review

Allegations Against Foster Carers
and the
Abuse of Children in Foster Care

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1 BACKGROUND TO THIS REVIEW

1.1 In February 2012, a police investigation (Operation Z) resulted in a male foster carer (known throughout this report as Perpetrator 1) being convicted of 18 offences of historical sexual abuse. Perpetrator 1 had been a registered foster carer from the early 1970's until 2003 and fostered children for Hampshire County Council until 1997 and after that date for the newly formed Southampton City Council.

1.2 As a result of this conviction, in March 2012 Southampton Safeguarding Children Board serious case review committee commissioned a partnership review[1] focusing on the work of Police and Children's Services in order to understand the circumstances that had resulted in children in care being sexually abused by Perpetrator 1.

1.3 Following consideration of the issues arising from the partnership review, the chair of Southampton Safeguarding Children Board decided on 26th November 2013 that the case met the criteria for a serious case review as set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006. The reason for this decision was the children and been seriously harmed and there were concerns as to the way in which the authority, their Board partners or other relevant persons had worked together to safeguard the children concerned.

1.4 At the point that a decision was made to conduct a serious case review, it was also known that in September 2013, a female had disclosed that her uncle had indecently assaulted her when she was 13 and 15 years of age. It was identified that the uncle (Perpetrator 2) had been a foster carer for Southampton City Council between 1994 and 2008. These allegations were being investigated by Hampshire Police (Operation A).

Serious Case Review Phase 1

1.5 An independent chair and overview author were appointed to lead the serious case review supported by a panel of senior professionals from agencies with responsibility for children in care. It was agreed that the aim of the serious case review would be to "examine the multi-agency response to two individuals who were registered foster carers in Southampton and have subsequently been convicted of offences or are currently being investigated for offences against children". The period under review was agreed as being from January 1994 – September 2013. Since prior to April 1997, the responsibility for the fostering service covering Southampton sat with Hampshire County Council, and a representative from Hampshire was invited to join the panel.

[1] A partnership review is a local learning review where a case is not deemed to meet the criteria for a serious case review.

1.6 Due to the ongoing police inquiries relating to Perpetrator 2, the serious case review initially focused on Perpetrator 1. The partnership review was revisited, the fostering file for Perpetrator 1 was re reviewed and a narrative of children's social care involvement with Perpetrator 1 was produced. Interviews took place with children's social care staff still in post. A list of victims was compiled and the panel chair and overview author completed one victim interview.

1.7 During this phase of the review in January 2015, further potential offences involving Perpetrator 1 came to light and the serious case review was suspended due to ongoing police investigations.

Events following phase one of the serious case review.

1.8 As a result of further intelligence, the Police operation was widened to cover other non-recent child abuse. This included consideration of allegations made against foster carers. On 16th May 2016 Perpetrator 1 was convicted of further offences and given an extra four years in prison.

1.9 Perpetrator 2 had admitted downloading images of children but as a result of Operation A he was indicted for a total of 13 offences:

- 2 x rape of a foster child
- 1 x rape of a family member
- 1 x indecent assault of a foster child
- 7 x indecent assault of a family member (1)
- 2 x indecent assault of a family member (2)

1.10 At court he was found guilty for all four counts against family member 2 but was not found guilty of the rape of another family member.

1.11 In May 2016 Hampshire police confirmed that the serious case review could re-commence and a new panel and lead reviewer were appointed.

1.12 Southampton LSCB agreed to lead the review with Hampshire County Council being represented on the panel. The chair of Southampton Safeguarding Children Board discussed the proposed terms of reference with the lead reviewer and members of the serious case review subcommittee. It was agreed that a proportionate approach should be taken and that it was not feasible to review all the past records of children who had been placed with the foster carers in question. The file review should focus on the selection, recruitment and monitoring of the carers concerned, young people known to be affected (now adults) should be offered an opportunity to contribute their views to the review and the focus of the final report should be on analysing progress since the abuse came to the attention of the local authorities concerned.

Serious case review phase two

1.13 The detailed terms of reference and methodology were agreed at the first panel meeting on 3rd August 2016. The review purpose was agreed as:

The overarching purpose of this review is to identify lessons that can be learnt both locally and nationally to improve the safety of children and young people in foster care.

This review does not aim to review in detail the circumstances surrounding the abuse of the individual young people who were the victims or alleged victim of Perpetrator 1 and 2. It does aim to:

1. *Review practice by agencies during the period during which the abuse took place and identify areas for improvement. In particular, practice in relation to:*
    - *Foster carer recruitment, quality assurance and support (including the role of health professionals in the recruitment process)*
    - *Monitoring and managing staff performance within the foster care service of the local authority.*
    - *Opportunities to hear the "voice" of children and young people and recognise indicators of abuse (including the role of health checks).*
2. *Consider the response by agencies after the abuse came to light and actions taken to improve safeguarding arrangements relating to children in foster care. This will include responses to national changes to legislation and guidance.*
3. *Review current safeguarding arrangements for children in foster care in Hampshire and Southampton in the light of 1 and 2 above.*

2 REVIEW PROCESS

2.1 It was agreed that the review process would include:

- A review by Southampton Children's Services, of the records of foster carers where convictions or serious allegations of abuse were known to Hampshire Police, or other partner agencies. This meant that as the first stage of the review had involved a review of Perpetrator 1's fostering file, the task for Southampton Children's Services was to complete a similar review of Perpetrator 2's file and the files of two foster carers who had been identified via Hampshire Police operations but had not been charged with any offence.
- A review of information from Hampshire and Southampton Children's Services about action taken between 2012 and 2016 to improve the safety of children in foster care.
- Offering known survivors of abuse in foster care an opportunity to contribute to the review.

- Speaking to practitioners from all partner agencies about their perceptions of current practice as it relates to keeping children safe in foster care.
- Speaking to children currently or recently in care about their experience and thoughts about how children in foster care can be kept safe from harm.
- Offering known perpetrators an opportunity to contribute to the review.

2.2 In order to progress this stage of the review reference group meetings were held with the following groups from across Southampton and Hampshire.

- Children in Care Social Workers
- Fostering Social Workers
- Education staff
- Health Staff
- Foster carers
- IROs/ LADOs/police investigators

2.3 These groups considered current strengths, weaknesses, opportunities and threats in relation to:

- Foster carer recruitment, quality assurance and support
- Hearing the voice of the child in foster care
- Monitoring and managing staff performance

2.4 Although the review has not focused in detail on individual children, it has always been the intention of the review to hear from abuse survivors and other people who had been in the care of known perpetrators. During the first stage of the review known victims of Perpetrator 1 were contacted and one mother and daughter came forward wishing to speak. They were seen by the chair and first lead reviewer. During the second stage of the review a comprehensive list of all those who made complaints resulting in charges against Perpetrator 1 and 2 was compiled. This resulted in the Hampshire Police representative on the panel:

- Contacting six victims of Perpetrator 1 in his role as foster carer. One victim agreed to e-mail contact from the lead reviewer but there was no response when this was attempted. Another agreed to contribute to the review and was seen by the lead reviewer.
- Reviewing information in relation to five victims of Perpetrator 1 who were abused outside foster care. These victims have not been contacted as none of the women were fostered by Perpetrator 1 and the officer in charge of the case advised that due to the trauma experienced by the women they were concerned about opening old wounds. After the final trial the women indicated that this needed to be a closure point for them.
- Reviewing the four victims whose complaints against Perpetrator 2 resulted in charges. Only one victim had been fostered by him. All alleged victims were sent letters asking if they wished to contribute to the view. Although attempts were made to arrange meetings, for a variety of reasons, these did not take place.

2.5 The two convicted perpetrators were both offered the opportunity to contribute to the review. Perpetrator 1 declined but Perpetrator 2 accepted and was seen by the review chair and the lead reviewer. Where relevant, information from this meeting is included in this report.

Delays to the review process

2.6 Over a year after the start of stage 2 the serious case review had not yet received information from Southampton Children's Services in respect of:

- Audits and corrective action since 2012
- File reviews in respect of Perpetrator 2 and consideration of any learning from a review of files of other foster carers where there had been allegations.

2.7 Delay was also caused by difficulties arranging to meet with the Children in Care Council as a result of changes in the way that their work was commissioned by Southampton City Council. This meeting eventually took place in April 2018.

2.8 A major problem was the LSCB and serious case review panel received a number of assurances that information required by the review would be available by specific dates, but this did not materialise. With hindsight this can now be understood within the context of a service undergoing a number of structural changes and managed by a series of locum service manager. It was only with the appointment of a new permanent service manager responsible for the fostering service that communication improved, and information provided to the review.

3 THE CONTEXT: LEGISLATION, REGULATIONS AND PRACTICE

3.1 This review spans several years during which time there have been significant changes in the way that foster carers are recruited, assessed and monitored. In 1994 (the start of this review period) fostering was regulated by The Boarding Out of Children (Foster Placement) Regulations 1988 which specified that children could only be placed in approved households. The criteria for approval included checking for any criminal convictions relating to people in the household and obtaining two personal references and arranging for those persons to be interviewed. These regulations were superseded by 1991 by a further set of regulations[2] which moved from the approval of a household to the approval of an individual foster parent and set out expectations regarding the need for annual reviews. By this time, the children Act 1989 had come into force and the accompanying guidance[3] noted that the manner in which foster carer approval was carried out would be a matter for each local authority.

Authorities should make known to prospective foster carers the arrangements

[2] The foster placement (children) regulations 1991
[3] The Children Act Guidance and Regulations Family Placement Vol 3

for reaching decisions about approval. The arrangements must reflect the importance of the decision and the need for accountability within the authority. Local choice will vary. (3.37)

3.2 During the 1990's reports[4] raised concerns about the protection of children in public care[5] and following further research studies commissioned by central government, the Children (Leaving Care) Act 2000 came into force, designed to improve the life chances of young people living in and leaving local authority care. This was followed in National Minimum standards for fostering in 2002 and 2011. In 2013 regulations[6] were amended to include a two-stage process of approval allowing some applicants to be filtered out early based on accommodation, references or prior to fostering difficulties.

3.3 Local authorities are therefore required to adhere to minimum standards for fostering but the exact mean by which the approval and monitoring of foster carers takes place has room for flexibility. This is pertinent for this review as due to local authority reorganisation in 1997 Southampton and Hampshire became separate local authorities with their own structure, practice and procedures in relation to fostering.

3.4 Although there are local variations, the standard tool used across the UK for the assessment and approval of foster carers in the "Form F". This was first developed by BAAF[7] and since 2000 this has adopted a competency approach to assessment. There had been criticism that this focus on demonstrating competencies could become a tick box exercise and not focus well enough on relationships or an analysis of the information gathered[8]. As a result, the Form F was significantly revised tin 2014 and has now removed the competency grid and contains text boxes headed 'analysis'.

3.5 In relations to care planning for children in care and monitoring the safety of children in foster care, during this review period the primary legislation has been the Children Act 1989 and accompanying guidance. Children in care will have their own social worker responsible for their overall care plan whilst there will also be a supervising social worker responsible for supporting foster carers and monitoring standards within a foster home. In addition, the role of an independent reviewing officer (IRO) was introduced in 2004 by the Adoption and Children Act 2002 s.118. The IRO is independent from the immediate line management of the child's social worker and is responsible for ensuring that the child has regular reviews, the local authority is fulfilling its duties and functions and that the child's views are taken into consideration. The Children and Young Persons Act 2008 and accompanying

[4] For example Utting (1997) *People Like Us: The report of the review of safeguards for children living away from home.* London: The Stationary Office
[5] Department of Health (1998) *Someone Else's Children*. *Inspections of Planning and Decision Making for Children Looked after and the Safety of Children Looked after.* London: Department of Health
[6] Care Panning and Case Review and Fostering Services (Miscellaneous Amendments) Regulations 2013
[7] British Association for Adoption and Fostering : now Coram BAAF.
[8] Alper,J. & Howe, D (2014) *Assessing Adoptive Parents Foster Carers and Kinship Carers: Second Edition.* London: JKP

regulations and guidance strengthened the role of the IRO as, in addition to chairing statutory reviews, they became responsible for monitoring cases on an ongoing basis.

3.6 The role of other professionals working with children in care has also adapted to the requirements of the primary childcare legislation and guidance, with a greater involvement of providing information and working with the local authority as part of foster care assessment and review. There are now dedicated health professionals with responsibility for children in care. Health providers take an active role in providing information as part of the foster care and review process and undertake health needs assessments and provide other services for children in care. The Children and Families Act 2014 amended the Children Act 1989 to require local authorities in England to appoint at least one person for the purpose of discharging the local authority's duty to promote the educational achievement of its looked after children, wherever they live or are educated. That person (the virtual school head) is expected to work together with the child's social worker and IRO.

3.7 The other key role in relation to the protection of children in foster care is the Local Authority Designated Officer (LADO) who is responsible for overseeing and providing advice and guidance where there is an allegation that a person who works with children may have harmed a child. This includes foster carers.

4 NON-RECENT PRACTICE

4.1 Although fostering practice has changed dramatically during the time period covered by this review, it should not be forgotten that the review came about because children and young people in the care of the local authority experienced abuse at the hands of those given responsibility to care for them. Whilst it may be thought that this abuse is "historic" and will have little relevance for current practice, this review has started from the position of wanting to understand how foster carers came to be in a position of trust where they could abuse, whether there were opportunities to recognise their unsuitability to foster and how the voices of children in their care were heard.

4.2 The following is a brief resume of the fostering history of the foster carers concerned in order to provide a context for the lessons identified by this review.

Perpetrator 1

4.3 Perpetrator 1 and his wife were first approved as foster carers by Hampshire County Council in the 1970's and in 1982 they were approved as carers for the Hampshire teenage family care scheme. Records also note that in 1983 a 14 year old child was fostered by Perpetrator 1's mother who was living in the household.

4.4 There are several issues on the file that should have informed action and decisions before 1994 (the start of the terms of reference for this review). Of significance are:

- Several comments during preparation for fostering interviews regarding inappropriate boundaries including, “he quickly gave the impression of trying to flirt or confuse me or provoke me by flip comments he made”.
- Delay in informing the local authority that Perpetrator 1 was subject of an assault charge for which he pleaded guilty (1983).
- In November 1983 there is a file record that Perpetrator 1’s wife slapped a foster child’s face twice and Perpetrator 1 “tanned her backside”.
- Perpetrator 1’s affair with a married woman he had met in a pub and the fact that they gave up fostering for a few years due to marital difficulties (1984).
- Perpetrator 1’s brother having been convicted of an indecency charge (1988).
- Racist comments by Perpetrator 1 (1989).
- Reluctance to engage with a new review system (1990).

4.5 The recruitment process picked up on Perpetrator 1’s controlling behaviour but failed to address it, thus allowing him early on to gain an inappropriate level of power within the system. There seems to have been an approach which was one of giving the carers the “benefit of the doubt” and engaging with them as colleagues.

4.6 In 1994 Perpetrator 1 and his wife were approved by Hampshire Family Placement Panel as Project Carers. This scheme paid carers an enhanced rate for providing intensive care and support to young people who were deemed to have the most challenging behaviour and needed highly skilled foster care support. This is significant as a theme throughout the fostering file is the view that Perpetrator 1 and his wife were willing to work with young people that other carers had given up on.

4.7 The family were in some financial difficulties and in 1994 Perpetrator 1 started employment as a night superintendent at a school for children with emotional social and mental health needs.

4.8 Perpetrator 1 and his wife quickly became powerful figures who would readily challenge decisions and went on to use the complaints system as one way of controlling the authorities.

4.9 For example, in April 1995 there is a note on the file that a decision had been made not to place a girl with them as she would be with two boys. This decision was challenged by Perpetrator 1’s wife who said that neither she nor her husband were happy with this decision as they felt that this implied they were incompetent. Within two days, the placement of a girl had been agreed.

4.10 A further example is that in 1995 a complaint was made to the fostering team by the head teacher of a school adjacent to Perpetrator 1’s home. There had been an altercation between Perpetrator 1 and some of the pupils during which he grabbed one by the shirt, raising his fist as if to punch him. A support assistant broke up the fight and sustained bruising, whilst the boy involved had marks on his upper body. The head teacher said that this was not the first occasion that Perpetrator 1 had crossed the fence and threatened the children. On receiving this information, the

fostering team notified the social workers of children placed with Perpetrator 1 which resulted in him saying that he felt unsupported and that he was packing the children's cases. He refused to attend a subsequent household review and threatened to make an official complaint against a member of staff at the school. The decision of the review was to undertake an assessment using "Form F" which was completed and noted that "I expect Perpetrator 1's bark is worse than his bite but sometimes it can create the wrong impression."

4.11 Other concerns were raised about Perpetrator 1's behaviour including failing to work with the department and discriminatory remarks. Raising these concerns led to a formal complaint by Perpetrator 1 and his wife which was independently investigated and not upheld.

4.12 During the time that the complaint was being investigated, Perpetrator 1 was suspended from work. At this time, he was working in a supported hostel in the Hampshire area and was suspended for five days after an allegation of sexual harassment by a 17-year-old girl. The outcome of a police investigation was that there would be no further action and Perpetrator 1 was re-instated. During the episode the file indicated that the fostering team's position was clearly one of support with a file note: "Rang [wife] to support. No news re. concerns re. children. Told her they were in our thoughts."

4.13 A further complaint was made by Perpetrator 1 in 1996 about the actions of social workers, followed by a complaint to the ombudsman in February 1997 saying that social workers had made serious allegations against him that were untrue; he had no letter of apology; all letters about the issue should be removed from his file; those responsible for causing distress should be disciplined. The reply from the investigator in ombudsman's office concluded that "I do not think I would be justified in pursuing your complaint further."

4.14 In April 1997 due to Local Government Reorganisation responsibility for Perpetrator 1 passed to the newly formed Southampton City Council.

4.15 One theme throughout the fostering file is that Perpetrator 1 and his wife would be quick to point out to social workers "sexualised behaviour" exhibited by children placed with them.

4.16 One child whose "sexualised behaviour and language" had been set out in a letter from Perpetrator 1 to children's services was removed. She had been taken in by Perpetrator 1 and his wife as a result of a continuing relationship with her mother (an ex foster child). This informal placement had meant the family were over numbers.

4.17 After her move the new foster carers raised concerns about the actions of Perpetrator 1 including several disclosures of sexual abuse. Two joint interviews took place with Hampshire Police and as no further disclosures were made during formal interviews and no further action was taken in respect of Perpetrator 1 and his wife who continued to foster. After more disclosures by the same child a strategy

meeting was held which concluded that there was insufficient evidence to follow child protection investigation and no evidence of current harm to young people.

4.18 The first fostering review with Southampton City Council was positive but the theme of Perpetrator 1's controlling behaviour continued with a note that he would refuse to have one reviewing officer in his home. Tensions also continued relating to payment of expenses for damage to the home and there were further complaints from a foster child to his grandmother about his treatment in the foster home.

4.19 In December 1998 the fostering service was notified that Perpetrator 1 had been suspended and then sacked from his job in the hostel due to a number of boundary violations and inappropriate behaviour with a 17-year-old girl. The decision was that no placements should be disrupted but that the fostering service would carry out enquiries. An independent review was commissioned which included a psychiatric report. The conclusion of the psychiatrist and the review was that no further placements should be made, and Perpetrator 1 and his wife should be deregistered. A fostering review in February 1999 recommended that they would cease to be approved as foster carers once the two young people with them had ended their "care lives". Deregistration did not take place until August 2003.

4.20 Meanwhile, further specific allegations of sexual abuse by Perpetrator 1 towards her and other children were made by the foster child who had made the previous allegations. Police made some initial inquiries but due to an error in the investigation did not have sufficient evidence to arrest Perpetrator 1. A strategy meeting did not take place for two months and all enquiries were negative and no further action was taken.

4.21 In March 2007 a further allegation of sexual abuse was made against Perpetrator 1 by an adult who had stayed with him as a young person. These were denied by Perpetrator 1. Later that year another adult logged a compensation claim alleging sexual abuse by Perpetrator 1. A strategy meeting in November 2007 noted that there was significant indication that Perpetrator 1's sexual behaviour was of concern and agreed that attempts would be made to contact other children who had been cared for by him. By the time of the next strategy meeting in January 2008 the police did not attend as they had stepped aside from any enquiries as no one was willing to make a formal complaint. The meeting concluded that Perpetrator 1 and his wife should be made aware of the concerns and should not have unsupervised contact with young girls or take any role as foster carers. There followed a joint visit by police and social care in February 2008 to Perpetrator 1. The concerns were discussed informally rather than this being part of any formal child protection process.

4.22 A further allegation in August 2010 resulted in a police investigation and the eventual conviction of Perpetrator 1.

Perpetrator 2

4.23 Perpetrator 2 and his wife were approved as foster carers by Hampshire County Council in 1994. They had raised four children, all boys who were teenagers at that time. The fostering assessment (Form F) is probably representative of assessments at the time in that it relied on self-reported information with very little analysis or challenge. For example, Perpetrator 2's wife described an unhappy childhood but there was little exploration of how this might affect her own parenting. The assessment noted some marital discord without detailed exploration and Perpetrator 2's wife talked about resenting the involvement of health visitors, GPs and other professionals, when her children were young telling her how to look after her children.

4.24 References were taken up both of which were negative. One reference wondered how they would cope with fostering as they were not very organised and would not seek help if needed and the other thought that Perpetrator 2 was a "Peter Pan" figure who preferred the company of young people and his wife was unsure of herself. Instead of exploring the issues raised further two more references were sought which provided positive comments.

4.25 A child (Child A) was placed the day after approval and when returned home to her mother spoke of being smacked at the foster home. This was denied by the carers. The same child returned to their care at her mother's request in September 1995 and was eventually adopted by Perpetrator 2 and his wife in 1999.

4.26 In January 1995 a second child (Child B) was placed and by Spring 1995 Perpetrator 2 and his wife were pushing to be approved as project carers (or paid project care rates) for this child. The theme of pushing to become project carers continued until 1999 when they were approved.

4.27 Although Local Government reorganisation did not take place until 1997, the supervision of Perpetrator 2 and his wife was transferred to the Southampton area in 1995.

4.28 There were ongoing concerns noted about the care of Child B mostly in relation to whether Child A was receiving preferential treatment. By August 1996 Child B's placement was breaking down, she said she wanted to leave and "knew something about Perpetrator 2 that meant they would never foster again".

4.29 In May 1998 Child A (age 6) told her school that she walked home alone from the school bus and mummy was not at home when she got in. It seems that following discussions it was accepted that one of the teenage sons was in the house if neither Perpetrator 2 nor his wife were at home.

4.30 There is evidence of Perpetrator 2 and his wife resisting challenge and exerting a degree of control over decisions as, after the adoption order, they threatened to transfer elsewhere if the local authority insisted on them having a break from fostering for six months after the adoption order was made for Child A. The local authority retracted their decision and the half siblings of Child B (Child C and Child D) were placed in August 1998.

4.31 The parents of Child C and D made a referral in November 2000 criticising the care of the children. Perpetrator 2 and his wife denied all the allegations and this was accepted. This referral was within the context of a difficult relationship with the children's parents and Perpetrator 2 (unusually) gave evidence in court against them in around 2000. Subsequent allegations were understood in this light and seen as intimidatory behaviour by the parents concerned.

4.32 Child C's school noticed that her personal hygiene was deteriorating and she had missed an event at school because of something wrong at home. This information was passed to the medical advisor who informed Children's Services when a medical appointment for the children was cancelled by the foster carers. The fostering file noted that this was followed up and the wife of Perpetrator 2 was offended by the comments.

4.33 In February 2001 there is evidence of tensions between the social worker for Child C and D and the supervising social worker (responsible for the foster carers). It was the view of the supervising social worker that there had been insufficient support in relation to Child C's deteriorating behaviour. The same month, Child C and D's school referred information that the children were not collected from school and walked home with a dinner lady and let themselves into an empty house. The explanation from the carers to the supervising social worker was that their youngest son was "usually" at home and this appears to have been accepted without further exploration.

4.34 In March 2001 at Child D's annual health assessment, what looked like fingertip bruising was noticed on her back and Perpetrator 2's explanation that this was caused whilst they were playing on their bunk beds was accepted. In February 2002 the LAC nurse wrote to Children's Services (belatedly) about Child C arriving at a community event without any lunch and having had no breakfast.

4.35 In May 2002 Child B alleged that Perpetrator 2 had sexually abused her when she was in placement. This resulted in a child protection investigation which involved two strategy meetings in August and October 2002 and the arrest Perpetrator 2. He disputed whether the offence could have taken place at the time and place alleged by Child B and the conclusion of the investigation was no further action. It seems that Child B's allegation may have been discredited on the basis that she had made an allegation[9] about a carer in a placement that she had moved to after leaving Perpetrator 2.

4.36 By July 2003 the plan was for Child C and D to remain with Perpetrator 2 and his wife "into adulthood".

4.37 In July 2004 Child C made an allegation of sexual abuse by Perpetrator 2. Child C stayed with her parents for the summer holidays and Perpetrator 2 was advised not to be alone with Child A and D. During the period that the allegation was being investigated Perpetrator 2 and his wife raised concerns about a plan for Child D to

[9] From the fostering file this allegation was thought to be credible

see her social worker outside the family home at a family centre. There is a note on file that the social worker told a strategy meeting that if she met Child D in the foster home Perpetrator 2 and his wife would listen at the door and question them both about what had been discussed and when she was seen.

4.38 A file note in October 2004 noted that the allegation was "ongoing" and Perpetrator 2 and his wife were needing "lots of support +++" The allegation was closed down with no further action and Child C did not return to the placement and stayed with her parents. The "stress caused by the allegation" was discussed at the next household review in January 2005 and at the same meeting problems with Child C's behaviour was seen as the cause of other children in the household missing out.

4.39 The parents of Child C and D made a complaint about the investigation of Child C's allegation of abuse in April 2005 and asked for Child D to be moved.

4.40 A further child (Child E) was placed in July 2005. During 2005 Perpetrator 2 was on a steering group for the recruitment and retention of foster carers and his wife was training as a child play therapist. By 2006 Perpetrator 2 was buddying two prospective foster carers and was providing day care for a child who had a history of making allegations against carers.

4.41 In July 2007 Child C made a further allegation that she had been sexually abused by Perpetrator 2 and again the outcome of this investigation was no further action.

4.42 Also, in July 2007 a close family member of Perpetrator 2 alleged that he had sexually abused her as a child. He denied the allegation.

4.43 Child D's placement ended in May 2008 after eight years. This was as a result of Perpetrator 2's wife saying that she could not continue caring for her if she insisted on having contact with her birth family. During this period Child D made a number of allegations about poor care in the foster home and that she did not feel safe there.

4.44 A competencies report on the foster carers in June 2008 noted three key deficit areas:

- An unwillingness to work to support contact with families
- An unwillingness to listen to children placed
- Not working in Partnership with professionals.

4.45 There was a formal meeting to discuss practice issues and the primary focus was on the breakdown of Child D's placement. There were no actions from the meeting and Perpetrator 2 was reassured that he would be placed back on the emergency fostering list for the out of hours service.

4.46 Three weeks later Perpetrator 2 and his wife were suspended. Four reasons were given:

- The disclosure of abuse by the close family member
- An incident when Perpetrator 2 filmed Child C and D after their placements had ended. This related to an incident where he filmed them apparently

swearing and gesticulating at him and, in his view, this was justified to illustrate the level of hostility from their family.

- Reports that Child D was frequently staying overnight with other family members and Child D's social worker was unaware
- A report that Perpetrator 2 had discussed his case with others (this related to Perpetrator 2 talking to the mother of Child E and asking her to write a letter of support).

4.47 An independent report was written by a social worker not involved in the case which recommended deregistration and this was also the recommendation of the household review in September 2009. Deregistration was then recommended by the fostering panel and approved by the Decision Maker on 19th November 2009.

4.48 Nearly four years later in October 2013, Police informed children's social care that indecent images were being downloaded from a computer at the address of Perpetrator 2.

Themes from non-recent practice

4.49 One important feature that stands out from the file reviews is that on several occasions, children and young people did say what was happening. There were clear allegations that were not handled appropriately and the message to the young people concerned must have been that either they were not believed or that no one was willing to listen to them. Some young people had important advocates in their birth families and social workers but there were still unacceptable delays in bringing the perpetrators to justice. Where there are no criminal convictions this could remain an outstanding issue for many young people.

4.50 Although much of the day to day practice will have changed particularly in the recruitment process and response to specific allegations of abuse, there are a number of factors that are apparent from the file reviews which need to be taken into consideration in reflecting more generally on the safety of children in foster care. These factors outlined below are picked up in the findings from this review.

4.51 The carers concerned were seen as a useful resource as they were willing to look after children whose behaviour was deemed to be challenging. The focus on the challenging behaviour which at times included the child's history of making allegations meant that too often the problem became the child's, rather than being seen as potentially caused by the care they were receiving in placement.

4.52 There is a pattern of controlling behaviour on the part of the carers which was not addressed and allowed, particularly Perpetrators 1 and 2, to gain an inappropriate level of power within the system. There seems to have been an approach which was one of giving them the "benefit of the doubt" and engaging with them as colleagues, which meant that unacceptable behaviours were not dealt with. This

may have been fuelled by the knowledge that foster carers are a limited resource and the need to recruit as many as possible.

4.53 Overall, the focus was on supporting foster carers rather than challenging their behaviour. Whilst providing support to foster carers is crucial this needs to be balanced with effective supervision and challenge. Fostering social workers need to develop skills in balancing these two aspects of their role and organisations need to support and monitor this aspect of their practice.

4.54 There are several instances where supervising (fostering) social workers and the social workers for the child were in conflict and this split between the two social work teams was clearly identified by Perpetrator 2 when interviewed for this review. Whilst challenge is helpful in these cases the antagonism allowed foster carers to "divide and rule" rather than the focus remaining firmly on the needs of the child.

4.55 The accumulation of concerns was not recognised and patterns of behaviour such as using the complaints system to deflect attention away from challenges to their behaviour was not understood sufficiently as a cause for concern.

4.56 One final issue relates to situations where there is no police investigation but foster carers are removed (or resign) from the foster carers register following concerns about their behaviour. There is no requirement to notify the disclosure and barring service and there is nothing to stop them from applying to other jobs or volunteering in roles which involve close contact with children and young people.

5 ACTION TAKEN 2012-2016

Practice audit by Hampshire Children's Services

5.1 As a result of the emerging concerns about abuse within foster care in 2012, Southampton and Hampshire Children's Services agreed a tool for auditing foster carers who had been approved pre the Foster Placement (Children) regulations 1991.

5.2 Hampshire audited 25 foster carers and found five cases where there were concerns about the way in which complaints had been handled. One key issue was the way in which complaints had been managed in relation to the identification of patterns of behaviour and concerns. This audit resulted in a 17 point action plan and a further audit (using the same tool) was carried out of all foster carers who were approved from 2011 onwards and had received level two or three complaints.

5.3 The audit activity identified possible barriers to responding to patterns and complaints as well as potential actions. These are discussed further in finding four below.

Internal case review by Southampton Children's Services

5.4 Another case involving foster care practice came to the attention of Southampton LSCB who asked for information from Southampton Children's Services in December 2016. This case is relevant to this review since it highlights a number of more recent issues relating to work with foster carers that have similarities to some of the historical concerns raised throughout this serious case review.

5.5 Pertinent issues in the case are:

- A child sustained significant injuries whilst in the care of his foster carers and children's services reported that two other incidents relating to a different child had previously been raised regarding injuries sustained whilst in the care of the same foster carers. Both were investigated and deemed to be accidental, although in relation to one of these incidents there was a query regarding the explanation of the foster carers and the injury sustained but no record this was addressed any further.
- There was an emerging picture of practice concerns and issues relating to the foster carers
- There was no medical examination at the time of the injury and no referral to the LADO as would have been expected practice
- Little was known about the role of the foster carer's birth son within the household including whether he had any caring responsibilities.

5.6 The case resulted in an action plan (for completion March /April 2017) by children's services linked to the following recommendations:

- Clear recording is needed to evidence detailed discussion with applicants and their children during the fostering assessment and as part of the annual review process is needed regarding the expectation that birth children in the household do not provide any caring responsibility for children placed.
- The fostering service needs to consider how it monitors and tracks issues and concerns regarding foster carers to identify emergent and ongoing practice issues to inform the annual review process and, outside of this, enable patterns to be identified and addressed.
- All relevant staff and managers are aware that medical examination is sought for injuries to the face or head to inform the health needs of a child and confirm the assertion of an accidental injury or otherwise.
- All relevant staff and managers are aware that the need to use formal child protection procedures may arise, when children are in the care of the local authority.
- Where a child has sustained an injury and there is any concern regarding the account provided as to how the injury was caused a Strategy Discussion under s47 of the Children Act 1989 takes place and investigations and assessments are conducted without delay and meet all procedural and good practice requirements to include:
    - being consistently directed by a manager
    - the child is seen alone within 24 hours
    - consulting with those who have parental responsibility
    - making thorough agency checks

        - specialist assessment or advice is sought
        - key decisions, including a decision to take no further action, are clearly recorded and authorised by a manager.
    - All relevant staff and managers are aware of the need to refer to the LADO (Local Authority Designated Officer) to inform decisions relating to child protection procedures.

5.7 The action plan from this audit is being monitored by the Southampton Safeguarding Children Board serious case review sub group.

Audit activity undertaken by Southampton City Council

5.8 Although there was some delay due to changes in senior personnel, audit activity relating to foster care services has now taken place in Southampton.

- There was a review of the fostering service in the summer of 2017 with an action plan produced which informed the improvement plan for the service.
- Staff from the internal audit unit undertook an audit in December 2017 with the outcome of "Reasonable Assurance".
- A safeguarding audit has been commissioned undertaken by an independent social worker with knowledge and experience of the issues being considered by the serious case review and this commenced in February 2018.The draft report has been received and, at the time of writing, is being reviewed by senior management. Outcomes are being aligned with existing improvement activity; which is monitored by the Children's Social Care management team, with input from the Quality Assurance Unit.

5.9 A current audit is underway, commissioned from the Quality Assurance department, auditing 15 carers who have been approved pre the Foster Placement (Children) regulations 1991.This was commissioned to bring Southampton in line with the work undertaken in Hampshire. The results of this are not yet available but there will be an action plan and continued work undertaken as a result of the findings of this audit

5.10 The serious case review had been informed that the fostering service remains under a high level of scrutiny internally to support the development of a continually improving service and the delivery of a robust service. The Southampton Local Safeguarding Children Board will need to be assured that all actions from audit and improvement work are sustained and contribute to the safety and wellbeing of children and young people in foster care.

6 WHAT DO CHILDREN AND YOUNG PEOPLE TELL US?

6.1 Two young people seen individually and the Children in Care Council both helped this review to think about what might help or hinder keeping children safe in foster care. The review would like to thank them for their time and their very thoughtful comments.

6.2 The routes to obtaining support and telling people about anything that may be bothering them in foster care will vary from individual to individual. Some young people feel strongly that staff at school would be first port of call, where others do not. Some would always call their friends. Some would talk to social workers whereas others would not.

6.3 What is clear, is that trust and a feeling that they will be listened to is vital and this will be built up over time in a variety of ways. Where children and young people have had a bad experience with any one person this makes it highly unlikely that they would go to them when they were in any kind of trouble.

6.4 Young people gave the example of feeling that social workers were not always honest (e.g. by saying they would return to parents when this did not happen) and this meant that they would not trust them with other aspects of their lives. They also were wary of social workers who spoke to foster carers about their behaviour (such as self-harm) without speaking to them first about why they were unhappy.

6.5 Within schools some young people felt that their confidentiality was not always maintained with teachers talking about them being in care in front of groups. This behaviour would not encourage them to talk to staff at school about any personal matters including worries about their foster placement.

6.6 There were some specific issues that would help children and young people such as being allowed to talk and confide to friends on line and the challenge for the system is to make sure that this can be achieved safely.

6.7 Southampton children's services are now engaging with the Coram BAAF Bright Spots project[10] which includes using an on-line survey with children in care in order to hear their views on their experiences within the care system. Findings from this survey will contribute to developing a system which provides a range of opportunities for children in foster care to talk about their experiences both positive and negative.

7 REVIEW FINDINGS

Finding One

The split between social workers responsible for fostering and practitioners responsible for individual children in care can lead to a fragmented, rather than a "whole family" approach to working with the child within the family.

7.1 Whilst the individual roles of the social worker responsible for the foster parents (known as the supervising social worker) and social workers for children in care has developed for good reasons, one issue that has emerged from many of the discussions, is the interface between social workers whose prime "client" is the foster family and social workers responsible for the child. This is not new and was

[10] http://www.coramvoice.org.uk/brightspots

identified by the inquiry in 2007 in Wakefield into the sexual abuse of children in foster care[11]. In that case it was noted that the social workers responsible for the foster carers could not hear negative information about the carers from others including the children's social workers. This was also an issue in the recent serious case review within Croydon[12] and is likely to be even greater where foster carers are provided by an organisation outside the local authority. Relevant points are:

- Supervising social workers might be aware of stresses in the family and may not be shared with children in care social workers. The systems that are in place do not easily facilitate this; for example, children in care social workers do not always contribute to household reviews and similarly do not routinely receive feedback from the reviews.
- No one worker is maintaining a "whole family" approach and understanding the dynamics of the family as a whole.
- Foster carers who are abusing children may "divide and rule". Perpetrator 2 for example, noted that the fostering social worker was likely to support the carer whereas the children's social worker would not.

7.2 A literature review of research into the role of the supervising social worker in foster care[13] identified similar issues in relation to the need for all those surrounding the child to work effectively together. This is necessary for ensuring foster carers can meet the child's needs and the literature review notes the desire of foster carers to be part of the team around the child. It recommends "*Public and independent fostering services need to consider ways of enhancing the working relationships between supervising social workers, foster children's social workers and foster carers, by the use of such concrete activities as joint training".* It also explores the tensions inherent in the foster carer role as being both "client" and "colleague". This is particularly significant in relation to keeping children safe as both the supervising social worker and the social workers for children placed in the home need to understand the evolving dynamics of the household and any factors that might impact on parenting capacity. Communication should be designed to serve the purpose of supporting the carers to meet the child's needs but also continually assess any support or other action needed to keep the child safe in the home. Perpetrator 1 and his wife for example had a number of problems but it is not clear that these were known to social workers placing children.

7.3 Although not necessarily a direct result of the fragmentation between social worker teams, the information gathered for the review suggests that the lack of a whole family approach includes, at times, limited understanding of the role of men in the family. Men are very involved in the recruitment phase but from then on may become invisible and are generally not present for supervision sessions or even

[11] Parrot, B., McIver, A. & Thoburn J. (2007). Independent inquiry report into the circumstances of child sexual abuse by two foster carers in Wakefield, Wakefield Metropolitan District Council
[12] Croydon LSCB (2017) Serious Case Review "Claire"
[13] Cosis. H., Brown,J., Sebba J., & Luke, N. *The role of the supervising social worker in foster care An international literature review* Rees Centre University of Oxford. http://reescentre.education.ox.ac.uk/research/publications/role-of-the-supervising-social-worker-in-foster-care/

household reviews. Women are likely to be seen as the main carer and more available in working hours when the fostering social workers visit; although Hampshire have now implemented a standard stating that it is expected practice for both carers to be present at the annual review and every second supervision visit. A similar standard has recently been developed within Southampton.

7.4 At the other end of the spectrum men (or women) may exert a great deal of power and influence. In relation to Perpetrator 1 and 2, both men were very involved in the whole fostering process and Perpetrator 1 was described variously as controlling and volatile and both he and his wife were known to frequently use the complaints system to control social work decision making. Perpetrator 2 did not work, having taken early retirement and became influential through his work with various foster carer groups. This would seem to suggest that there is a need to aim for a balanced approach whereby no one person is either excluded from ongoing monitoring and review or exerts inappropriate influence on others in the system.

7.5 A whole family approach will take proper account, from recruitment onwards, of the role of siblings within the family. There is little evidence of consideration being given to the role that that the son of Perpetrator 1 had within the family and a survivor has now referred to him as “creepy” and a “risk to other people”. This may also be relevant in the context of today’s practice as the recent internal review noted that although there is no evidence that the carer’s son posed a risk to children, it remains unclear how effectively the recruitment process addressed the potential implications of his learning difficulties within the household. All children will change and develop over time and household reviews will need to consider the evolving dynamics between foster carer’s children and children in care and share any relevant information with the children in care social worker.

Recommendation One
Hampshire and Southampton Children’s Services should consider the most effective way to maintain a whole family approach for children in foster care which includes joint working between the social worker for the carers and the social worker for the child. Consideration should be given to arrangements for joint supervision of social workers where a child is in a long-term foster placement.

Recommendation Two
Southampton Children’s Services should provide evidence to the Safeguarding Children Board that the newly developed approach to involving men/partners in foster care is effectively implemented, in order to ensure that, as a minimum, all members of the family are involved in household reviews.

Finding Two

Although recruitment and quality assurance processes have developed over time, practice will be enhanced where:

- **relevant information from other agencies about foster carers is routinely shared with Children's Services**
- **social workers are trained and supported by their organisation to challenge foster carers where there are concerns about their practice**
- **relevant information regarding foster carers who are removed from the register or resign following concerns about behaviour are shared if they seek other roles working with children and young people.**

7.6 Recruitment procedures are now much tighter than they were when Perpetrator 1 was approved and current foster carers told the review that no area of their life is left unexplored. The results of the "Form F" assessment are presented to an independent fostering panel for review. Fostering panels consist of members who have relevant personal and/or professional experience or expertise in looking after children and they review the written report and ask relevant questions to enable them to make a recommendation. The recommendation of the panel is sent to the Agency Decision Maker who has the final decision on approval of foster carers.

7.7 One potential gap may be in the health information to the fostering panel if GPs are not aware of the significance of information within their records or the records have not been coded to make the identification of vulnerabilities easy. Unless the patient record is clearly coded, a GP may not be aware that a patient with a condition that may affect parenting capacity is in fact a foster carer. This has been recognised as a potential issue within Hampshire and training for GP practices is being rolled out locally to address this. Within Southampton there are current discussions between health organisations and the local authority regarding a process for making sure that GPs are aware when one of their patients has been approved as a foster carer.

7.8 Although foster carers believe that they are heavily scrutinised, the file reviews and discussions with current practitioners highlight the skills needed to manage and work with articulate people. Some practitioners report not feeling confident to challenge powerful individuals particularly in long term placements where the message from others in the system might be "do not rock the boat." This is significant as evidence from research shows that in cases of substantiated concerns most carers had been fostering for a substantial period of time; over half for more than five years.[14] The same research noted a case where carers were openly rude and uncooperative to work with, yet it appears that professionals had not challenged them sufficiently.

7.9 The issue regarding foster carers who are de-registered or resign following concerns about behaviour and there has been no police investigation and/or criminal conviction had been noted earlier in this report. In such situations a referral would not be made to the disclosure and barring service (DBS) and it would not be impossible for carers to apply to foster in a different area or obtain paid or voluntary work with children without their fostering history being revealed. This appears to be

[14] Biehal B. Cusworth L.,Wade J. with Clarke S.(2014) *Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care. Final Report.* University of York and NSPCC. Page 84

a gap in the system whereby serious concerns about a person's capacity to work with children may not be known to subsequent employers.

Recommendation Three

Southampton LSCB should ask Southampton children's social care to provide evidence that the system in place for assuring the quality of foster care practice is focused on the needs of the child and that social workers are equipped with the skills, support and supervision to enable them to challenge poor practice.

Recommendation Four

Southampton LSCB should ensure that a system is in place for GPs to be made aware when a Foster Carer is approved. They should also seek assurance that any health concerns that may impact on a patient's capacity to foster are shared with Children's Services.

Recommendation Five

Southampton LSCB should bring to the attention of the Department for Education the apparent gap in the system whereby concerns regarding the behaviour of a foster carers is made available should they wish to work with children in a paid or voluntary capacity.

Finding Three

Although there is common understanding about the importance of hearing the voice of the child there may still be barriers ensuring that the children's "voice" whether through behaviour or verbal communication is heard.

7.10 Evidence suggests[15] that children placed in foster care are likely to face a number of obstacles to reporting abuse. They may be silenced by the carers who tell them that they should not speak about the abuse, they may have several changes of workers and in the worst cases, their expressions of unhappiness about a placement may be ignored. In seven of the 10 reported cases of sexual abuse in the research sample, the abuse was not disclosed until a considerable time after the child left placement.

7.11 The situation of children placed in foster care can be compromised by the meaning professionals ascribe to their behaviour, as well as the opportunity to speak freely outside the foster home to a trusted adult. It is likely that the previous life experiences of children in care may lead to a range of behaviours which all too

[15] Biehal B. Cusworth L.,Wade J. with Clarke S.(2014) *Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care. Final Report.* University of York and NSPCC. Page 96-7

easily label them as “difficult” or “hard to place”. Both Perpetrator 1 and 2 were known to be willing to take such children and were payed an enhanced rate as “project carers”. Children’s “difficult” behaviour in placement was too easily understood as either their problem or (sometimes) resulting from their past experiences. The foster carers were praised for being able to manage this when others could not and there was too little attention paid to whether the behaviour might be resulting from current distress.

7.12 There are examples of children speaking out either at the time or afterwards, but these allegations were not responded to appropriately. It is ironic that one victim commented that due to previous abuse she could easily “spot a perpetrator” but this was not taken into account when she tried to warn her social worker about the foster carer as she was leaving the placement.

7.13 A victim has spoken about the importance of regular visits from social workers but social workers are currently limited in the time they can devote to seeing the child. Practitioners spoke of lack of time to see a child outside of placement as statutory visits have to be in the home and they have to see the child’s bedroom. Social workers also have described lacking the skills in direct work that they need to communicate effectively with children and young people. Despite this many practitioners in agencies other than children’s social care assume that the social worker is the person who will be key in hearing the voice of the child.

7.14 From one victim’s perspective, children will be most likely to share with social workers who “accept me for me”. The best social workers were described as warm and kind and really care about the children they are working with. They also need training and to feel confident, as this victim did speak to the “best social worker I ever had” about sexual abuse in a residential home but she was newly qualified and did not know what to do. It has meant a lot to this victim that the social worker has since called her to apologise. Another young person told the review that his experience of social workers varied but currently they would talk to their current social worker as they were reliable and “really tries to get to know you”.

7.15 Forums such as contact with school staff and discussions with children in care nurses at annual health checks may also provide important opportunities for children to speak and two young people told the review that they would speak to staff at school if they were worried.

7.16 However, there can be limitations in the systems in place to gain the views of the child. The paperwork for formal reviews inviting a contribution from the child may be filled in with the assistance of the foster carer and there are particular issues where a child is placed outside the local area. For these children health assessments may be delayed whilst a local provider is found and in some areas health checks are not provided for out of area children. There are advantages and disadvantages to both scenarios. Children seen locally may be more likely to be linked in with local services but, conversely, where the home authority maintains responsibility consistent relationships are more likely to be maintained over time. The problem is

that systems vary from area to area. In some locations there is a lack of capacity to offer out of area assessments and because of the variations children may fall down between different approaches in different areas.

7.17 The review has heard that within schools, as in other settings, there may be confusion in understanding that challenging behaviour may be a result of current abuse and not just past abuse. However, schools can be a positive place where children's voices can be heard and the role of schools work best where designated teachers for children in care have the authority within the staff team to make sure their needs are met through working closely with the head of year and pastoral team. The concerns of young people outlined in section five of this report need to be heard and thought given to ensuring the privacy of children in care in order to provide a culture where they feel they can talk about personal matters and confidentiality will be maintained.

Recommendation Six

All partner agencies should provide Southampton and Hampshire Safeguarding Children Board with evidence that staff working day to day with children in care have knowledge and skills to understand the meaning of children's behaviour and recognise when this may be communicating distress or information about abuse.

Recommendation Seven

Southampton LSCB should ask children's social care to provide evidence that social workers and relevant others are spending time with children in care both inside and outside the foster home in order to provide sufficient opportunities for effective communication.

Recommendation Eight

Southampton LSCB should bring to the attention of the Department for Education and the Department of Health the lack of a national policy regarding the provision of health checks for children in care placed away from home.

Finding Four

Understanding the significance of accumulating concerns and complaints is key to keeping children safe in foster care.

7.18 From the review of the perpetrators and alleged perpetrators files it is clear that insufficient attention was paid to accumulating concerns over time and there was a lack of recognition of patterns of behaviour that may cause concern. This chimes with research which found that in cases where allegations of abuse by foster carers

had been substantiated[16], 43% had been the subject of earlier allegations and in some cases there had been a string of low level complaints over the period of time that the carers had been fostering[17]. The research also found that where the accumulation of complaints had been recognised it was more likely that a particular allegation would result in deregistration and/or criminal prosecution.

7.19 The internal audits carried out by Hampshire Children's Services indicated that further work was needed to ensure that all staff recognised the significance of concerns and complaints and considered what these might mean. The findings from the audit were discussed with practitioners at a fostering services workshop in November 2016 and included in full here as a good example of proactive action that has taken place with one local authority since the abuse by Perpetrator 1 came to light.

7.20 Possible barriers identified by auditors were:

- Work pressure
- Poor working relationships
- Not taking complaints seriously or believing the allegation
- Difficulties in challenging foster carer
- Lack of chronologies or using those that were available
- Understand what a recurring pattern might look like.

The actions to consider from the audit were:

- The possibility of an independent worker managing the complaint
- An independent worker completing unannounced visits
- Group supervision using case studies to develop consistent practice
- A chronology workshop refresher
- A chronology prompt template for supervision
- Sharing chronologies with carers more openly and regularly to discuss patterns
- Using the child's ICS number in case records
- Having a workshop on the new complaints and allegations policy
- Peer inspection
- Using titles in recording to identify common themes
- Having a clear process of consequences in response to foster carer patterns and behaviour.

7.21 The results of internal audit work in Southampton will also be needed in order to inform the final recommendations from this serious case review.

[16] This related to all forms of abuse; not just sexual abuse
[17] Biehal B. Cusworth L.,Wade J. with Clarke S.(2014) *Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care. Final Report.* University of York and NSPCC.

Recommendation Nine

Hampshire Safeguarding Children Board should ask children's social care to provide information regarding actions taken as a result of their foster care audit activity and the impact of these actions on practice.

Recommendation Ten

Southampton LSCB should requite children's social care to provide a summary report on the findings of all recent audit and quality assurance activity relating to children in foster care and include progress against actions identified.

Finding Five

Although investigations into allegations about abuse in foster care have improved during the time period covered by this review, all partner agencies need to consider whether children in care receive the same quality of response as children not in the care of the local authority.

7.22 Historically it is clear that the investigation process failed to keep children safe but police investigators have described to the review a change in culture over the last 15 years. Previously any 1:1 allegations did not result in action whereas now it is possible to explain to the alleged victim that it is possible that they are not the only one and to look for other potential victims. This was previously seen as an inadvisable “fishing trip” that could harm a prosecution. The change has come via a changed approach within the Crown Prosecution Service stemming from changed guidance from the Director of Public Prosecutions[18].

7.23 In Southampton, until recently there were issues within the investigation system linking to whether the allegation was from a child already known to children's social care. A referral for a child not known is reviewed via the MASH system which will include an immediate sharing of information and a strategy discussion. Where a child is known (and by definition this will include foster children) the allegation went to the children in care team who then considered who to involve; there was no mechanism for instant sharing of information. This caused delay and there are indications that the focus of attention became wider issues to do with the placement rather than a standalone risk to the child who might need urgent medical assessment. This system effectively disadvantaged children in care. The review has been informed that now, all allegations are considered by MASH and the LSCB will need to be assured that this system is embedded and working well.

[18] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-abuse/complex-investigations

7.24 The role of the Local Authority Designated Officer (usually referred to as the LADO) is significant and the recent internal review of a child in Southampton has shown that social workers are not always clear when to inform them of concerns about a person caring for a child. In addition, there appears to be some confusion about boundaries of the LADO role. The Southampton LADO described being responsible for oversight of all allegations made against carers working for organisations whose head office is in the Southampton area. This may include allegations investigated by police forces some distance away. This may be problematic and it appears there is no national consensus as to how boundaries function in these circumstances.

7.25 Both police investigations and the serious case review have been hampered by poor record keeping on file and problems in locating the files themselves. Whilst it must be acknowledged that historically record keeping was often handwritten, hard to read and not on standardised documentation, local authorities do have a responsibility to keep a child's records safe and accessible and this has not been achieved within the local area. A victim told this review that she was very concerned to find that there were chunks of her record apparently missing.

Recommendation Eleven

Southampton LSCB should seek assurance that children in care are not disadvantaged where an allegation is made regarding potential abuse. The process of investigation should be the same as for all children.

8 SUMMARY OF RECOMMENDATIONS

Recommendation One
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